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# Creating space for interpreting within extended turns at talk

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## ABSTRACT

In consecutively interpreted conversations, long multi-unit turns pose an interactional problem, as the interpreter may need to intervene into the turn space of the current speaker to interpret. This paper explores multimodal practices employed by medical professionals and interpreters to manage the *temporary suspension* of extended turns-in-progress. Using data from video-interpreted hospital encounters, we show how video-mediation poses challenges to the fine-tuned coordination involved in creating temporary suspension. We identify one practice used by medical professionals by which they produce turns in several chunks, or 'installments', temporarily suspending the ongoing turn and allowing the interpreter to begin interpreting. When a medical professional does not suspend their longer turns, the interpreter more actively signals the medical professionals, for instance through use of pre-beginning signals, to suspend the progressivity of their turn and yield for interpreting. We explore at what place during medical professionals' ongoing multi-unit turns interpreting is made relevant, how this is done and by whom.

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## 1. Introduction

Turn-taking models for consecutive interpreting suggest that interpreters produce their renditions after each of the participants' individual turns (Gavioli, 2015). However, when it comes to longer contributions by one party, the interpreter might intervene during an ongoing turn at talk due to limitations to their short-term memory (Wadensjö, 1998, p. 234). If speakers produce and complete longer contributions without allowing for interpreting, this prevents the speaker from monitoring the reception of the turn along the way and adjusting its course according to the addressee. Both the speaker and the interpreter may thus have an interest in dividing an extended contribution into installments and interpreting smaller chunks at a time.

This paper investigates the multimodal practices used by medical professionals and interpreters in consecutively interpreted hospital encounters to temporarily suspend multi-unit turns in progress and allow the interpreter to start interpreting. We propose to call this place in interaction, where interpreting is made relevant through the temporary suspension of an ongoing turn, a *temporary suspension place* (TSP). More specifically, we explore how TSPs are designed in video-mediated interpreted interactions.

The data for the study are video recordings of hospital encounters in which the interpreter participates via video from a remote location. Features of video-mediation may be relevant for what resources the participants have available in the creation of temporary suspension places. We show that the fine-tuned, split-second coordination involved in creating

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temporary suspension places may be hampered by features of the video technology, such as delay and participants' limited visual access to each other.

We show that medical professionals may design their multi-unit turns as a series of installments, that is, they may decompose their multi-unit turn into two or more component parts and present them one at a time, thereby creating space for interpreting. Interpreters may also invite these temporary suspensions of a turn by producing pre-beginning signals (Schegloff, 1996) towards the end of a potentially complete turn constructional unit in the speaker's multi-unit turn. Although participants in medical meetings may have experience with interpreted interaction and thus have a common understanding of the need to divide longer turns into shorter installments, we demonstrate how the length of each installment and hence the timing of the temporary suspension of a longer turn is locally negotiated by participants in collaboration.

### 1.1. Multi-unit turns in conversation

Multi-unit turns suspend the general turn-taking rule that the completion of a turn constructional unit (TCU) establishes the opportunity for speaker shift, a transition relevance place (TRP) (Clayman, 2013; Selting, 2000). Participants in interaction may use specific practices to introduce a multi-unit turn, for instance pre-sequences such as story prefaces (Sacks, 1992) and 'pre-pre's' in complex questioning turns (Schegloff, 1980). During the production of a multi-unit turn, particular practices may be used to signal the continuation of the turn beyond the TCU in progress, for instance leaning forward at the initiation of a multi-unit turn and maintaining the pose across the TCU boundaries (Li, 2013). In institutional activity types, the turn-taking system may be specialized to license multi-unit turns in the encounter as a whole or in certain phases of it. Questions in news interviews, for instance, generally invite answers in the form of extended accounts rather than just a single TCU (Clayman and Heritage, 2002). The multi-unit turn is an interactional achievement, which suggests that it is co-constructed, recipient designed and recalibrated and reorganized moment-to-moment by the participants in interaction (Schegloff, 1996).

A speaker may invite recipient contributions during a multi-unit turn by 'speaking in installments' (Svennevig, 2018). This involves speakers dividing their multi-unit turns up into smaller chunks in order to elicit response from the interlocutor along the way. The speaker leaves a pause after each installment and monitors the recipient by means of gaze, thereby creating an opportunity space for the recipient to produce a response, verbal or embodied (such as nodding). The response provided is most commonly a continuer (Schegloff, 1982) or some other claim of understanding, but the slot provided also provides the recipient with the opportunity to initiate repair at an early stage (Robinson, 2014). The speaker projects continuation of the turn by producing each installment with slightly rising intonation, or gesturally by holding or continuing a gesture beyond the completion of each installment. The action performed may also display pragmatic incompleteness in that it does not fulfill the sequential projection of a prior turn. In this way, the multi-unit turn is designed to allow interpolated contributions by the interlocutor while simultaneously securing the right to continue the turn. In the current article, we argue that a similar practice is used to create temporary suspension places that allow for interpretation in the course of a multi-unit turn.

### 1.2. Interpreting and turn-taking

Interpreters' utterances in interpreter-mediated interaction bridge a linguistic gap (between two languages) and a social or interactional gap (between two or more language users) (Wadensjö, 1998, p. 109). Just by taking the turn every now and then, Wadensjö suggests, the interpreter coordinates the other participants' utterances. Accordingly, the interpreter is generally described as central to the process of turn-taking in interpreter-mediated encounters (Englund Dimitrova, 1997), and turn-taking is considered to be a basic part of the interpreter's coordinating task (Frøili, 2001). Although the interpreter has been described as central to the coordination of turn-taking in interpreter-mediated interaction, other parties have also been observed as contributing to this process of coordination, such as when other participants encourage the interpreter to take action (see Baraldi and Gavioli, 2012).

For the interactional accomplishment of consecutive interpreting, the interpreter may need to intervene into the turn space of the current speaker during a longer turn of talk. Studies of interpreting in forensic contexts have shown that in the process of giving their testimonies, minority speakers may be deprived of the possibility to complete their account by the fact that other speakers self-select after the interpreters' rendition and thereby curtail the minority speaker's turn (Licoppe et al., 2018; Licoppe and Veyrier, 2020). As such, the interpreters' intervention into another speaker's multi-unit turn may have consequences for the speaker's possibilities to resume the floor and to complete their narrative. It has also been shown that interpreters may in some cases be more reluctant to interrupting the longer turns of some participants such as arbitrators or attorneys than regarding the longer turns of for instance litigants (Angermeyer, 2015). As the organization of turn-taking is fundamental to the organization of interaction, turn-taking has been topicalized in a range of studies of interpreter-mediated interaction (such as in Davitti, 2019; Gavioli and Baraldi, 2011; Wadensjö, 1998, 1999). However, the collaborative achievement of the interpreter's intervention into other participants' turn spaces has to our knowledge not been systematically explored.

While studies of interpreted interaction have traditionally focused on verbal interaction, more recent studies have shown how the organization of interpreted interaction is conducted multimodally, e.g. through the handling of objects and changes in gaze, torque and movement (Bagini et al., 2017; Davitti, 2013; Davitti and Pasquandrea, 2017; Licoppe and Veyrier, 2017). Paying attention to the multimodal organization of interaction, we explore in this study how participants other than the interpreter, in this case medical professionals, participate in the coordination of interpreters' utterances. We explore how medical professionals and interpreters negotiate the length of installments and the temporary suspension of medical

professionals' multi-unit turns. How do speakers construct their talk in ways that facilitate interpreting at certain places while still projecting more talk to come, how do they *create space for interpreting*?

### 1.3. Video-mediated interaction

While video-technologies provide participants-in-interaction with visual and auditory access to each other, the video-mediated environment has proven to be both enabling and constraining to the accomplishment of interactional practices (Arminen et al., 2016). Some features of the video-mediated environment become especially relevant in the organization of turn-taking. Time lag, a delay in the transmission of signals from the one site to the other, has been found to disrupt the turn-taking system (Ruhleder and Jordan, 2001). The interactional space is of an asymmetric nature due to participants' lack of full bodied co-presence (Arminen et al., 2016; Luff et al., 2003). A study of video-interpreted (and thus video-mediated) hospital encounters found that the ways participants organize their virtual and physical space may limit participants' access to embodied resources, which in turn might affect the organization of turn-taking (Hansen, 2020). Related to this, the distribution of participants in video-mediated environments has proven to be relevant for what resources the interpreter has available for instance in the management of turn-taking (Licoppe et al., 2018; Licoppe and Veyrier, 2020). In the current study, we investigate the organization of turn-taking within medical professionals' extended accounts during video-interpreted encounters. We investigate how the collaborative achievement of a temporary suspension place may be affected by affordances of the video-mediated environment, such as delay, asymmetric and limited visual access, and reduced mutual audibility, especially of simultaneous talk (and other vocal sounds).

## 2. Data and method

The data for this study consists of video-recordings of 11 meetings that involved video-mediated interpreting, that is, where an interpreter participated from an interpreting studio off-site<sup>1</sup>. The recordings are from visits in hospital outpatient clinics and meetings with admitted patients. These visits vary in length, number of participants, aims and topics, as well as phases and procedures. Norwegian is the majority language spoken in the meetings and seven other languages are involved in the interpreting: Albanian, Arabic, Bosnian/Croatian/Serbian, Mandarin, Polish, Thai and Vietnamese. The medical professionals and interpreters had various experience with video-mediated interpreting. Some were experiencing it for the very first time, while others had extensive experience. What information the interpreter received in advance also varied. The interpreters often took notes during the sessions to support their memory for interpreting.

As stated earlier, the interpreters were situated at a different location than the other participants and carried out interpreting via video-technology. The interpreting studios were equipped with videoconference units about the size of a personal computer. Some of the hospital wards in the study had videoconference units similar to the ones in the interpreter's studio, while others had full videoconference systems.

Seven of the meetings were video-recorded with two cameras simultaneously, one placed in the interpreter's studio and the other placed at the ward. Three meetings were video-recorded from only the interpreter's studio, and one was recorded from the ward. Working with video-recordings from the interpreter's studio gives insights into the interpreter's perspective in the interaction – what the interpreter has visual and auditory access to. Analyzing the interaction from both perspectives gives insights into possible differences between the two sites.

The article focuses on the sequential organization of interaction, and the analysis is carried out within the theoretical framework of multimodal conversation analysis (e.g. Deppermann, 2013; Hazel et al., 2014; Mondada, 2014). The transcripts are based on Mondada's (2001) conventions for multimodal transcription (see Appendix).

## 3. Analysis

In the following sections, we analyze extracts where interpreting occurs within medical professionals' multi-unit turns. The first part of the analysis describes the interactional accomplishment of temporary suspension places. We start by speaker-initiated TSPs, i.e. cases where the medical professional actively accommodates interpreting by suspending the turn in progress and inviting the interpreter to take the next turn. We go on to explore TSPs initiated by interpreters, i.e. cases where the interpreter signals the relevance of suspending a multi-unit turn in progress by producing pre-beginning signals at potential places of conditional entry. Finally, we juxtapose extracts from the interpreter's studio and the ward in order to explore the differences in visual and auditory access to the various participants and show how video-mediation may challenge the negotiation of a TSP.

### 3.1. Speaker-initiated TSPs

The following extract (1) shows a sequence where a medical professional constructs a longer turn in installments, thus temporarily suspending the turn at particular moments to facilitate interpreting. The meeting is video-recorded from the

<sup>1</sup> The study is conducted with permission from the Norwegian Centre for Research Data and the involved hospitals. All participants involved in the recorded meetings have given consent.

interpreting studio, which provides access to the interpreter's perspective in the interaction. The extract is from a meeting with several participants present. There are four medical professionals present at the ward in addition to the patient (PAT) and the next-of-kin, while the interpreter (INT) interprets between Norwegian and Bosnian/Croatian/Serbian. The extract is from an ongoing extended turn in which one of the medical professionals, an occupational therapist (OT), presents future goals for the patient.

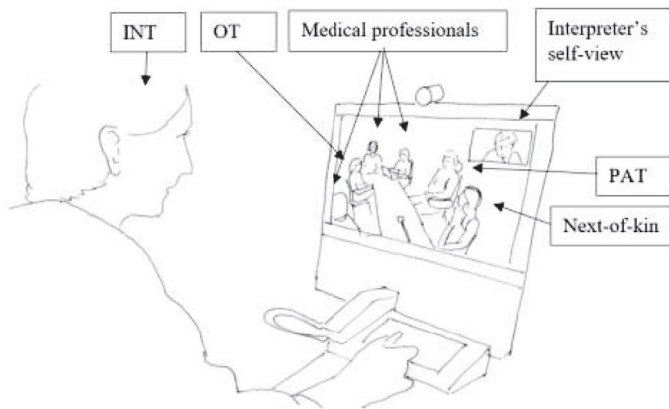


Figure 1.1: The interpreter's studio

Extract (1)

1 OT: e:: videre: skal vi: e  
e:: further we will e

2 du skal få lære: å e: spise mat med gaffel,  
you will get to learn to e: eat food with a fork,  
3 ⌘(0.4)

int: ⌘gaze up, opens mouth-->

4 INT: #a nadalje +naučiti jesti vilicom hranu (.)  
and furthermore you will learn to eat food with a fork  
ot: +turns to screen/cam-->

fig: #fig1.1

5 INT: dakle +unositi vilicom hranu.  
so ingest food with a fork.  
ot: +turns back to center/patient-->

6 INT: naučiti to.  
to learn this.  
7 (0.7)

8 OT: med ⌘eller uten hjelpemidler,  
with or without aids,  
int: -> ⌘gaze down-->

9 (0.5)

10 INT: ⌘be:z ili s pomoćnim sredstvima.  
without or with aids.  
int: ⌘gaze up, occasional glance at notes-->

11 (1.3)

12 OT: #å: e: få til å ⌘drikke med vanlig kopp eller glass,  
and e: manage to drink with ordinary cup or glass,  
int: ⌘gaze down--> ⌘gaze up -->

13 (0.5)

14 INT: +učiti piti iz uobičajene šalice ⌘ili čase  
to learn to drink from an ordinary cup or glass  
int: --> ⌘gaze down -->

ot: +gaze to screen/cam -->>

15 (1.0)⌘  
int: -->⌘gaze up-->>

Throughout the extract, the occupational therapist directs her gaze and bodily orientation toward the patient and glances toward the camera/screen representing the interpreter every now and then during the interpreter's speech. After a self-repair, the occupational therapist's first utterance (line 1–2) takes the form of a complete syntactic unit, a main clause. Prosodically, it is produced with slightly rising intonation, continuing intonation, indicating that the turn has not reached completion. However, the speaker does not continue speaking. Displaying an orientation to the position following the occupational therapist's utterance as a possible TSP, the interpreter lifts her gaze to the screen and opens her mouth. This constitutes a pre-beginning signal. After a pause of 0.4 s (line 3), the interpreter starts interpreting (line 4). Although the turn is not complete, both the occupational therapist and the interpreter orient to the sequential slot following the occupational therapist's utterance (line 1–2) as a place relevant for interpreting.

After the interpreter has completed the rendition, the occupational therapist resumes her turn (line 8). This utterance is even shorter than the previous one and constitutes a syntactic increment to it, a prepositional phrase specifying the verb phrase. The utterance again ends in slightly rising intonation, indicating that the turn has not yet come to completion. However, rather than continuing to speak, the occupational therapist suspends her turn, and the interpreter takes the floor after a 0.5 s pause (line 10).

After the interpreter has interpreted, the occupational therapist resumes her turn and produces yet another turn component (line 12). This is also an increment to the sentence introduced in line 1–2 and continued in line 8, as line 12 constitutes a new syntactically dependent complement to the main verb *lære* (learn) (in line 2). The utterance ends with slightly rising intonation, projecting continuation, and a pause, once again making it possible for the interpreter to produce a turn.

The occupational therapist's three utterances in line 1–2, 8 and 12 all end at a point of syntactic completion and thus present the talk produced up until that point as a potentially complete TCU. However, the slightly rising intonation projects continuation of the turn. The same can be said about the pragmatic status of the action produced, as each installment constitutes an item on a potentially longer list of therapeutic measures to be presented. Thus, after each chunk of the incrementally extended turn, it is clear that the occupational therapist has not finished her turn, yet she pauses and leaves a silence. By presenting her multi-unit turn in installments, the medical professional actively accommodates interpreting. The interpreter also orients to the pause as an opportunity space for her to intervene and start interpreting. Although the occupational therapist does not turn her gaze away from the patient, she does not treat the interpreter's turns (line 4–6, 10 and 14) as interruptive or misplaced. On the contrary, she seems to adapt to this rhythm of alternating by continuing to produce short installments and leaving pauses after each of them. The result is an alternation of speakership with rather short gaps and no overlaps, leading to a smooth coordination of speaking turns. In this way, the interlocutors collaborate to create and recognize these temporary suspension places in the course of the multi-unit turn.

The installments found elsewhere in the data are seldom as short as those presented in the extract above, however. Usually, the medical professional speaks for a longer time before letting the interpreter intervene. How long each installment should be is a matter of online negotiation between the parties. In extract (2), a doctor (DR) and a patient (PAT) are present at the ward, while an interpreter is available on video. The doctor produces several TCUs realizing different pragmatic actions before turning to the screen and thereby inviting the interpreter (INT) to intervene. The transcript is made from the ward's perspective.

#### Extract (2)

```

1  DR:  *og vi ser sa#mme som vi så under graviditeten din,
      and we see the same as we saw during your pregnancy,
      dr:  *gaze to pat-->
          #fig2.1
2  at du har veldig god effekt,
      that you have very good effect,
3  og vir[us]*mengden &faller&* (.) .h <dramatisk>,
      and the virus count is falling (.) .h dramatically,
4  INT:  [°.h°]
      dr:  *gestures down *
      pat:  &nods &
5  DR:  du hadde jo: (0.3) mange hundre (.) millioner (0.5) e::::
      you had (particle) many hundred (.) millions (0.5) e::::
6  >me virus<kopier.
      of virus copies.
7  (0.5)

```

8 e:: og så faller det til under to tusen.  
 and then it falls to under two thousand.  
 9 >og det er< det vi ønsker,  
 and that is what we want,  
 10 under to tusen da som er .h som er e: bra.  
 under two thousand then which is .h which is e: good.  
 11 >så vi er< veldig fornøyd,  
 so we are very pleased,  
 12 &(0.3)\* (0.3) &(0.7)  
 dr: --> \*turns head to int/screen-->  
 pat: &nods &turns head to int/screen-->  
 13 INT: ((begins to interpret))

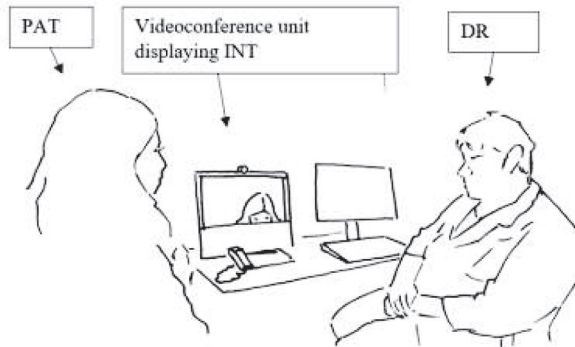


Figure 2.1: The hospital ward

Both in line 2 and 3, syntax and pragmatic aspects converge to mark the contribution as potentially complete, while the intonation is rising, thus projecting continuation. In the previous extract (1), we saw that such points were used to create a temporary suspension place. In this case, however, the doctor does not suspend the turn, but continues by initiating new syntactic constructions and new pragmatic actions, in line 3 adding new information and in lines 5–7 specifying the decrease in the virus count. The interpreter produces a pre-beginning signal, an audible in-breath, in line 4, but due to time lag, it is not audible at the ward until the doctor has begun to produce a new TCU. The doctor does not interrupt his talk and does not orient to the in-breath as a signal of incipient speakership. In line 8, the specification is potentially complete, and both syntax and intonation converge in marking the TCU as potentially complete. However, the doctor expands the turn by adding a conjoined sentence with initial increased tempo (in line 9). This new component links syntactically to the previous TCU, but pragmatically, it introduces a new type of action, a report about the standards used for evaluating the results of virus counts. After this, he extends the turn even further by adding two new actions, an object-side assessment in line 10 (an assessment not referring to the speaker), and a subject-side assessment, formulating the doctor's stance toward the results in line 11 (see [Edwards and Potter 2017](#)). Only at this point does the doctor display an orientation to the relevance of interpreting both by leaving a silence and by turning his head and gaze from the patient to the screen (line 12), thus selecting the interpreter as the next speaker.

During this sequence, the interpreter contributes to letting the doctor expand his talk by holding back her talk and pre-beginning signals at points of potential completion (apart from the in-breath in line 4). For instance, the pause in line 7 provides an opportunity for the interpreter to start interpreting which is not taken. While the first extract demonstrated the occurrence of TSPs even after short installments, this extract demonstrates that not all points of potential completeness are necessarily oriented to (by either party) as temporary suspension places. As a result, speakers may construct rather complex, multi-unit and multi-action components before they leave space for the interpreter to intervene. In this way, the size of each installment is the result of co-construction and collaboration, to which both parties actively contribute by either turn holding practices or turn initiating practices. In order to create a temporary suspension place, both the interpreter and the medical professional have to orient to a specific point in an ongoing longer turn as relevant for interpreting.

### 3.2. Interpreter-initiated TSPs

While extracts (1) and (2) show how medical professionals design turns in installments for interpreting, the following section focuses on how the interpreter can invite the temporary suspension of a turn by producing pre-beginning signals.

Extract (3) is from a meeting with a medical professional (MP), patient (PAT) and next-of-kin present at the ward in addition to the researcher. The interpreting is in Polish. After the researcher (RES) has informed about the research project and asked for consent, the medical professional jokingly states that the medical professional, the patient and next-of-kin from now on should pretend that the researcher is not present.

Extract (3)

```

1  MP:  nå skal vi-
      now we shall
      mp:  --> gaze to pat and nok -->>
2  da skal vi prøve å overse:: ((gestures to researcher))
      then we shall try to ignore
3  RES:  ja hehehe
      yes hehehe
4  MP:  henne, for resten av samtalen,#
      her for the rest of the conversation,#
      fig:  #fig3.1
5  INT:  .hh (.) wobec te@go spróbujm@y zapomnieć
      .hh (.) then we try to forget
6  e:: o niej [@tutaj siedzącej@ ]
      e:: about her sitting here
7  [((participants at ward laugh))]
8  ((INT continues to interpret))

```

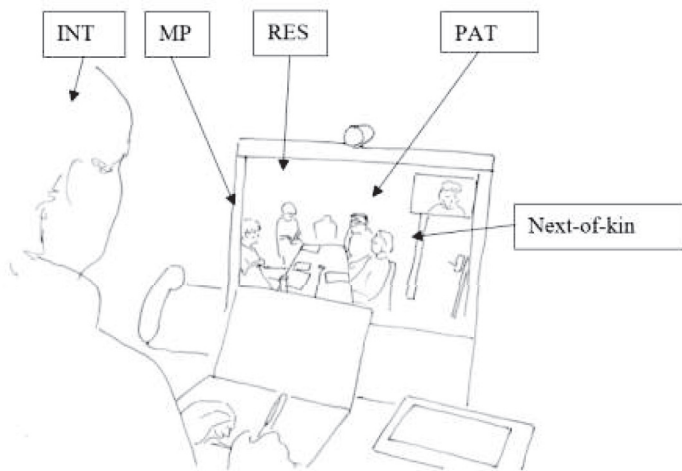


Figure 3.1: Interpreter's studio

The medical professional is seated facing the patient and next-of-kin. She produces a syntactically complete TCU ending with rising intonation (line 2–4). Pragmatically, the fact that this is the opening phase of the meeting projects more talk by the medical professional, who acts as the meeting chair and thereby is expected at this point to present the purpose of the meeting and the agenda. The medical professional continues to gaze toward the patient and next of kin at the TCU boundary (see Fig. 3.1). At that point, without waiting to see whether or not the speaker will pause, the interpreter produces an audible in-breath (line 5), signaling incipient speakership. The medical professional continues to gaze toward the patient and next-of-kin but withholds further talk during the interpreter's in-breath and the following micro-pause, thus leaving space for the interpreter to start interpreting. In this case, then, the interpreter signals the relevance of suspending the turn-in-progress by producing pre-beginning signals and the medical professional aligns by withholding further talk. Both the medical professional and the interpreter thus orient to this point in the interaction as a temporary suspension place.

In some cases, however, the interpreters' attempts to create a temporary suspension place are not equally successful. The medical professionals do not always react to pre-beginning signals produced by the interpreter, and the result is a mismatch between the parties in calibrating the size of the turn-in-progress and thus when a temporary suspension place should occur. In the next extract, we can observe how the interpreter is not given space to intervene despite several attempts to initiate a

## Extract (4)

1 MP: **hh+ ha:næ e: lager e: (0.2) hjelpemidler e: for e:-**  
*hh he e: makes e: (0.2) technical aids e for e:-*  
 mp: >+turns to center-->  
 int: g.scr ꞑ --gaze notes-->

2 **for hendene dine,**  
*for your hands,*

3 **(.)**

4 INT: **.h ((opens mouth))**

5 **(.)**

6 MP: **>så du< kan e:: m (.)e bruke en kjøkkenkni:v,**  
*so you can e:: m (.)e use a kitchen knife,*

7 **(0.3)**

8 INT: **.h ((opens mouth))**

9 **(.)**

10 MP: **en elektrisk tannbørste, og en barbermaskin.**  
*an electric tooth brush and a shaving machine.*

11 **(0.3)**

12 INT: **.h (.)#ꞑ[on-]**

13 MP: **[da ] få:r du utstyret sammen**  
*then you get the equipment together*  
 int: --> ꞑgaze up, nods ꞑgaze down again-->  
 fig: #fig4.1

14 MP: **med et sånt (0.6) spesialtilpasset grep.**  
*with such a (0.6) specially adapted grip.*

15 INT: **.h (.) +dakle on ꞑradi na izradi pomocnih sredstva**  
*.h (.) so he is working on making aids*  
 int: --> ꞑgaze up -->>  
 mp: -->+turns to screen/cam-->

16 INT: **((continues interpreting))**

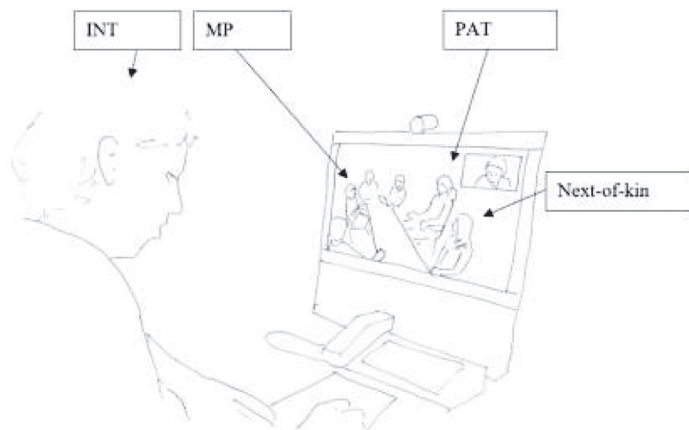


Figure 4.1: Medical professional continues speaking.

turn. The extract is from a meeting with several participants present and the interpreting is in Bosnian/Croatian/Serbian. The medical professional is presenting plans for rehabilitation.

Both in lines 4 and 8, the interpreter treats the slight pause in the medical professional's talk as a potential slot for interpreting, producing an audible in-breath and opening her mouth. However, the medical professional does not react to these pre-beginning signals and continues her turn-in-progress before the interpreter has produced any vocal sounds. At the end of line 10, there is a convergence of syntactic, prosodic, and pragmatic aspects of turn completion. Again, the interpreter treats this as an opportunity to start interpreting, and this time she starts producing the first vocal sounds of an utterance (line



12). However, the medical professional overlaps with an expansion of the turn in the form of a new syntactic, prosodic, and pragmatic unit (lines 13–14). Only when this is brought to completion does she let the interpreter take the floor to translate. Thus, the interpreter orients to every TCU ending as a temporary suspension place, while the medical professional repeatedly blocks her entry into the turn space by continuing to speak. In this way, the calibration of a unit relevant for interpreting is the result of an ongoing process of negotiation, in which turn holding and turn yielding practices are used to propose, accept and resist the establishment of a temporary suspension place.

An important question is then whether or not the interpreter's pre-beginning signals are perceivable to participants at the ward, and due to delay, at what interactional point do such signals become perceivable to the participants at the ward. In the following section we present and compare extracts from both the interpreter's studio and the ward in order to investigate this further.

### 3.3. Negotiating TSPs in video-mediated environments

The previous sections demonstrated how medical professionals may produce a longer turn in installments and how interpreters might use pre-beginning signals such as hearable in-breath to indicate the relevance of interpreting at a specific point in the interaction. This section addresses the negotiation of the length of installments and the creation of TSPs in the video-mediated environment. We explore how delay in the transmission of the video signal has consequences for the split-second coordination of turn-taking. Furthermore, we address challenges posed by limited audibility and visibility. In order to do this, we will compare video recordings made at the wards with video recordings made at interpreters' studios.

We start by considering the effects of delay. Extract (5) shows how delay may affect the interpreter's possibilities to signal the relevance of suspending the medical professional's ongoing turn by producing a pre-beginning signal. In the following extract, the interpreter's pre-beginning signal is transcribed twice (in line 5 and 7) marked with A and B. A is when, from the interpreter's perspective, the interpreter produces the audible in-breath. B indicates at what point in the interaction this in-breath becomes audible at the ward. In this consultation, a medical professional and a patient are seated in front of a videoconference unit. The medical professional is in the course of summing up the progress in the treatment and the prognosis of the illness.

#### Extract (5)

```

1  PAT:  mm%
   pat:  -->> oriented to mp -->>
   pat:  %nods
   mp:  ->>gaze to pat -->
2  MP:  .hhh (0.4) veldig sjeldent kan hepatitt c viruset
   .hhh (0.4) very rarely the hepatitis c virus can
3  komme tilbake etter at behandlingen er ferdig.
   return after the treatment is over.
4  (.)*
   mp:  *lifts hands-->
5  A INT:  .hh (.) e-
6  MP:  (det# [he-])
7  B INT:  [.hh] (.) e-
   fig:  #fig5.1
8  (0.4)*(0.5)*#(0.8)π(0.3)
   mp:  *releases gesture, turns to screen, right hand to chin-->
   *slight nod to screen
   int:  %nods
   fig:  #fig5.2
9  INT:  ((begins interpreting))

```

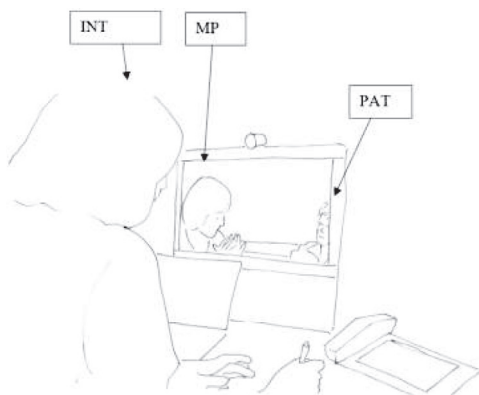


Figure 5.1: Medical professional continues speaking.



Figure 5.2: Medical professional pauses turn.

The medical professional produces a syntactically complete sentential TCU with falling intonation (line 2–3), both features indicating potential completion. Pragmatically, however, it is clear that the activity of presenting the prognosis is not complete, and the report of a possibility of a relapse projects further talk about how such a problem would be addressed. In addition, and more concretely, the medical professional lifts her hands in the following micro-pause (line 4), positioning them for an upcoming gesture (Kendon, 2004), thus projecting immediate continuation. At this point, the interpreter produces an audible in-breath (line 5), a pre-beginning signal proposing a temporary suspension place. This in-breath is transcribed as it occurs in the interpreter's studio. However, due to delay caused by the video-technology, the in-breath is not yet perceivable at the ward. Line 7 renders the same in-breath from the perspective of ward. As can be seen, it becomes perceivable to the medical professional only as she produces the first vocal sounds of a new TCU (line 6–7). At that very moment, she cuts herself off and turns her head to the camera, thereby allocating the next turn to the interpreter. She also moves her right hand to her chin (line 8), thus displaying alignment as a recipient through embodied action. In this case, then, the delay in the transmission affects the precision-timing of the pre-beginning signal and leads to a hitch in the coordination of the temporary suspension place.

Extract (6) is from a similar setting and involves even greater delay, leading the doctor to abort a TCU well underway. Similarly to the previous extract, line A refers to the point in the interaction when the interpreter produces the audible in-breath while line B indicates at what point it becomes audible at the ward. The image below to the left shows the interpreter's view and how the participants at the ward are represented on the interpreter's screen. The image to the right is from the ward, where the doctor and patient are seated in front of the desk and the screen representing the interpreter is placed on the desk. The extract is from a sequence where the doctor is summing up the progress of the treatment so far. Just prior to this, the interpreter has interpreted the doctor's previous utterance.

## Extract (6)

```

1   DR:  .hh det bildet %viser at medi%sinene virker bra,#
      .hh that picture shows that the medicines work well,
      dr:  -->> gaze to pat -->
      dr:  %counting gesture-->
      pat:  >>gaze to scr %turns to dr -->
      fig:  #fig6.1
2   (0.4)
3   A   INT:  .hhh
4   DR:  %og så er det [så]nn# at e:m:
      and then it is so that e:m:
5   B   INT:  [.hh]
      fig:  #fig6.2
      dr:  %releases gesture, lifts hands, palms together
      dr:
6   (0.4)
7   DR:  ja (0.2) %du kan si %det først# du [m%mm,]
      yes (0.2) you can say it first mm,
8   INT:  [ja.] .hhh
      yes. .hhh
      dr:  %gestures, glances to scr -->%turns to pat-->>
      pat:  -->>gaze to dr --> %turns to screen/int-->>
      fig:  #fig6.3

```

9 INT: ((begins interpreting))

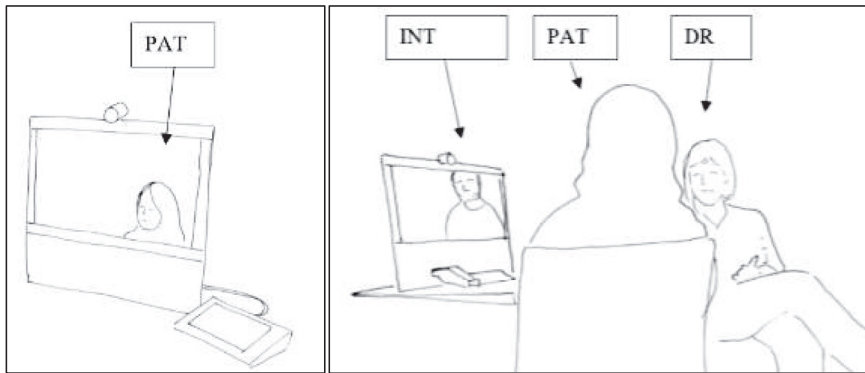


Figure 6.1: Interpreter's studio to the left. Only the patient is visible on the interpreter's screen. The ward to the right: Videoconference unit is placed on the desk.



Figure 6.2: Doctor is speaking.



Figure 6.3: Doctor turns to screen.

The doctor produces a TCU with rising intonation, summarizing the general ‘picture’ concerning the effect of the treatment (line 1). The interpreter produces an audible in-breath shortly after the completion of the doctor's first TCU (line 3). Due to delay, the interpreter's pre-beginning signal is not perceivable to the participants at the ward until the doctor has produced the first words of a new TCU (line 4). Shortly thereafter, the medical professional cuts off the utterance in progress and explicitly allocates the turn to the interpreter, both verbally and by turning her head and upper body towards the screen (line 7). Neither the movement nor the gaze is visually available to the interpreter, but the verbal turn allocation secures that the interpreter takes the next turn and starts interpreting. The delay here thus again leads to problems of coordination and progressivity, leading to an aborted TCU and an explicit meta-communicative turn allocation.

Problems of visibility have already been observed in the previous example, but here we will see how both visibility and audibility problems may affect the coordination of a temporary suspension place. Extract (7) and (8) are from the beginning of a meeting with six participants at the ward, one patient and five medical professionals. Extract (7) demonstrates how the participants have trouble coordinating the interpreter's contributions due to limited mutual audibility. We start by looking at the recording made at the ward (7A) and then analyze the same extract as it appears to the interpreter in the remote studio (7B).

Extract (7A): Ward's perspective

```

1   DR:  hei benjamin,
      hi benjamin,
2   jeg skal #oppsummere #det som e <skjedde>,
      i will summarize that which e happened,
   fig:  #fig7A.1
   pat:  >> gaze to dr --> #turns to screen/int-->
3   # (0.5)
   pat:  #turns back to dr -->
4   DR:  .hh (.) e*:: du hadde da en e forgiftning med koka|in
      .hh (.) e:: you had an e intoxication with cocaine
   int:  *sits back -->

```

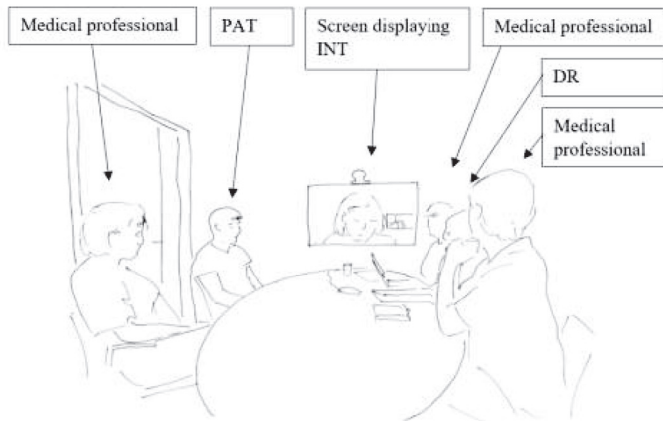


Figure 7A.1: Doctor orients to patient.

The doctor greets the patient, addresses him by name and is oriented toward him through gaze and bodily orientation throughout the extract. The preface in line 2 is a potentially complete TCU in that it constitutes a complete syntactic clause and an independent pragmatic action. It is produced with rising intonation, but the doctor leaves a 0.5 s silence after it (line 3). Consequently, this point in the interaction appears like a place where the interpreter could have self-selected but did not.

However, this transcription is based on the recording at the ward and captures only how the situation appeared to the participants present there. If we see the same extract from the recording in the interpreter's remote studio, we get a different picture:

Extract (7B): Interpreter's perspective

2 DR: jeg skal oppsammere det som e <skjedde>,\*  
i will summarize that which e happened,  
int: -----> \*sits back  
pat: #gaze to screen-->

3 (0.5) #  
pat: --># gaze to part at ward, away from screen -->

4 DR: .hh  
5 (.)

6 INT: [°mm°]

7 DR: [e::]# du hadde da en e forgiftning med\* koka;in  
e:: you had an e intoxication with cocaine  
int: ---> \*gaze notes-->  
fig: #fig7B.1

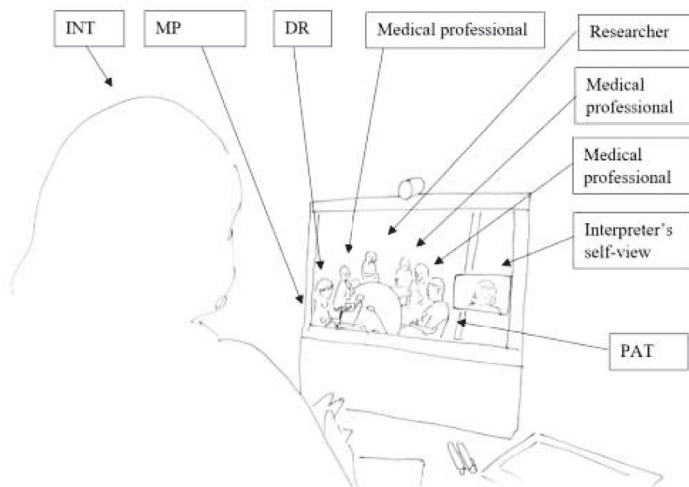


Figure 7B.1: Doctor orients to patient. The medical professional seated to the doctor's right is outside the camera frame and therefore not visible to the interpreter.

From this perspective, it is clear that the interpreter treats the silence following the doctor's utterance as a potential opportunity to start interpreting. She begins to produce a vocal sound (line 6). However, the interpreter's attempt to take the floor is not audible to participants at the ward, as the doctor starts producing a prolonged vocal sound (line 7), signaling continuation of the turn and blocking access to the floor by other participants. The interpreter orients to this by aborting her turn beginning and thereby loses the opportunity to begin interpreting at this point. The problem in this case seems to be restricted mutual audibility caused by the video technology. It may be that the interpreter's voice has been muted by the noise cancellation function in the technology, or simply that the sound rendered over the loudspeakers is so low in comparison with the doctor's onsite voice that it is drowned by it.

Another limitation of video transmission concerns mutual visibility. The camera frame only captures a limited part of the interpreter, and this may have consequences for the visibility of the interpreter's gestures to the participants at the ward. In addition, the seating arrangements and the placement of the camera at the ward may give the interpreter limited visual access to certain participants. We will see an example of this in the next excerpt (8), which follows directly from the end of extract (7). The participants at the ward are seated around a table facing each other and thus have to turn their head sideways to see the interpreter. The doctor (DR) speaking in the extract is seated just barely within the camera frame, and a colleague of hers (MP) is seated to her right, just outside the camera frame. We start by showing the transcript from the recording at the ward.

Extract (8A): Ward's perspective

4 DR: .hh (.) e\*:: du hadde da en e forgiftning med koka;in  
 .hh (.) e:: you had an e intoxication with cocaine  
 int: \*sits back -->

5 DR: \*#attende februar,#  
 eighteenth of february,  
 pat: #turns to screen/int and back again#  
 int: \*gaze down to notes-->

6 (0.2)

7 DR: .hh og grunnet det hh gjennomgikk du e  
 .hh and due to this hh you went through e

8 hjerte o::\*g ee:: respirasjonsstans,  
 heart and ee: respiratory failure,  
 int: \*looks up and down again-->

9 # (0.5) #

pat: #nods #

10 DR: og var innlagt akutt på </Sykehus/>,  
 and was hospitalized urgently at /Hospital/,  
 11 (0.2)

12 .hh e:: så da det \*#var\* litt \*komplisert forløp,#%  
 .hh e:: so then there was a little complicated process,  
 dr %to scr  
 pat #to scr  
 int: \*gaze up, nod \* gaze down-->  
 \*fingertips\*  
 fig: #fig8A.1

13 (1.4)

14 DR: #%og du [had]de da-\*  
 and you had

15 INT: [.hhh]

dr: %turns back to pat-->  
 pat: #turns back to table -->  
 int: \*gaze up-->

16 (0.4)&(0.4)&# (0.7) &  
 mp &stop gest&point, gaze to scr& turns to dr-->  
 pat: #turns to int/screen -->  
 fig: #fig8A.2

17 INT: \*kan tolken eh\* bare& avbryte litt?  
 may the interpreter uhm just interrupt a little?  
 int: \*finger appears on screen\*  
 mp: --> &gaze to screen-->

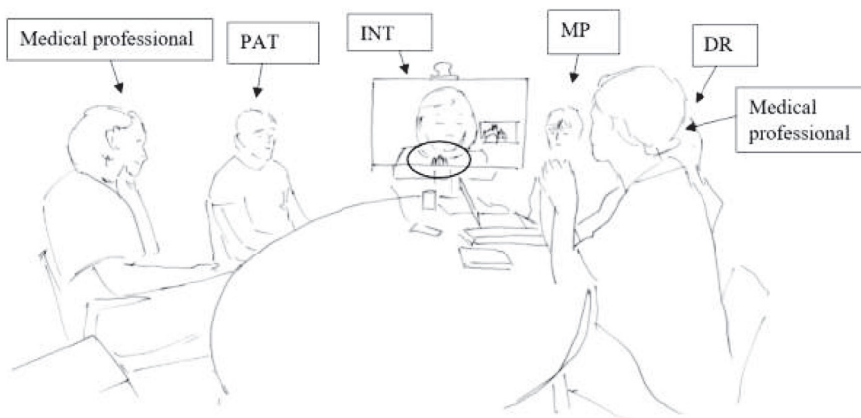


Figure 8A.1: Interpreter raises her hand; fingertips become visible on the screen.



Figure 8A.2: Medical professional makes stop gesture and points to screen.

The doctor produces an extended report of the events in a series of TCUs ending in rising intonation, projecting continuation (line 4–12). During this period, there do not seem to be any signs of the interpreter trying to take the floor. During the doctor's utterance in line 12, the participants at the ward can see the interpreter looking up from her notes to the screen, and her fingertips appear briefly at the low end of the screen (see Fig. 8A.1). However, the fingertips disappear quickly, and the interpreter looks down again to her notes and stays in that position during the 1.4-s silence in line 13. During this silence, the doctor and the patient both gaze at the screen, displaying an expectation that the interpreter will take the floor. However, as this does not happen, the doctor turns back to the patient and resumes the report by initiating a new TCU (line 14). Only as the doctor resumes her speech, does the interpreter's in-breath become audible to the participants at the ward (line 15). The doctor cuts off her utterance shortly after the interpreter's audible in-breath (line 15). The medical professional seated outside the camera frame also responds to the interpreter's in-breath by producing a stop gesture (line 16). She then turns her head and gaze to the screen and points to the screen, hence allocating the turn to the interpreter (line 16, Fig. 8A.2). Although the doctor has suspended her turn and the medical professional allocates the turn to the interpreter by the use of a gesture (line 16), the interpreter does not begin to interpret but produces an explicit request to intervene (line 17).

From the ward's perspective, it may seem that the doctor initiated a temporary suspension place by allowing an extensive pause (line 13) and turning to the interpreter. This was not made use of by the interpreter. From the same perspective, the interpreter's move, a hearable in-breath, is only perceivable at the ward after the doctor has resumed her turn, seemingly interrupting the doctor's ongoing speech. However, if we look at the focal lines (12–17) from the interpreter's perspective, we can see that the situation looks rather different.

Extract (8B): Interpreter's perspective

```

12  DR:  *.hh e:: &så# da det var &litt komplisert forløp,##*
      .hh e:: so then it was a little complicated process,
      dr:                                     -->          %to scr
      pat:                                     -->          %to scr
      int: * looks up to screen                --->          *
      int:      &stop gest --> &
      fig:      #fig8B.1

13  (0.5)

14  INT: .hh e

15  DR:  ##*og &du ha&dde da-
      and you had prt
      dr:  %turns back to pat-->
      pat: %turns back to participants at the ward-->
      int: *gaze up to screen -->
      int:  &stop gest&

16  (0.7)*(0.3)
      int: *raises her hand (finger) -->

17  INT: kan #tolken *eh bare *avbryte litt?
      may the interpreter uhm just interrupt a little?
      int: -->*releases *gaze down to notes-->
      fig: #fig8B.2

```

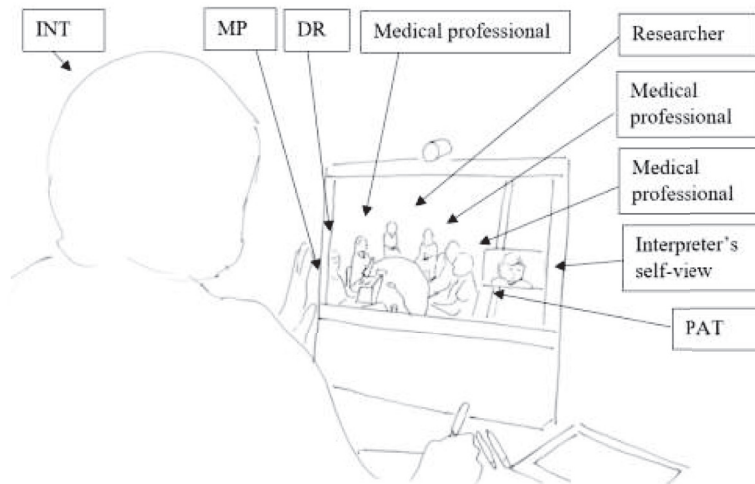


Figure 8B.1: Interpreter raises her left hand in a stop gesture.



Figure 8B.2: Interpreter raises her hand (finger).

From this perspective, we can see that the interpreter looks up at the screen already while the doctor is drawing her breath and producing a vocal sound (in the beginning of line 12). After this, the interpreter lifts her hand in a stop gesture, prompting the doctor to refrain from continuing. Due to restricted visual access and delay, this gesture is only partially visible to participants at the ward during the doctor's ongoing utterance (extract 8A, line 12, Fig. 8A.1). Furthermore, in the interpreter's studio, the long silence following the doctor's utterance (extract 8A, line 13) lasts for only 0.5 s (line 13) before the interpreter draws her breath and produces a vocal sound, thereby projecting turn initiation (line 14). Upon hearing that the doctor continues speaking after this, the interpreter makes a new stop gesture (line 15), which is not visible at the ward. Following this, the doctor cuts herself off (line 15). However, the interpreter cannot see that the medical professional to the doctor's right, who is seated outside of the camera frame, has turned toward the screen and allocated the turn to the interpreter by means of a gesture (extract 8A, line 16, Fig. 8A.2). During the silence that follows (line 16), the interpreter raises her hand to take the turn before she begins speaking. Interestingly, she does not just begin interpreting, but produces a meta-communicative preface, requesting permission to intervene (line 17). By doing so, she orients to and accounts for the coordination problems that have occurred by taking the blame for 'interrupting' the doctor (Robinson 2006).

Extracts 7–8 show how both delay and limited visibility challenge the interpreter's attempts to initiate the temporary suspension of the doctor's longer turn. Her stop gestures are partly or completely invisible to the participants at the ward, and the medical professional's go-ahead gesture is invisible to her. Furthermore, both the interpreter's stop gestures and her in-breath occur so delayed in the ward that they come across as misplaced, occurring in the middle of the doctor's utterances rather than at TCU boundaries. The silence following the doctor's installment is seemingly not made use of by the interpreter,



which in turn leads to the continuation of the doctor's turn, rather than the temporary suspension of the turn and the successful exchange of turns. The consequence is a lack of smooth coordination between the parties, leading the interpreter to resort to explicitly requesting permission from the doctor to speak.

#### 4. Discussion

The article has demonstrated how the temporary suspension of a medical professional's extended contribution for the purpose of interpreting is achieved through joint effort by the interpreters and medical professionals in collaboration. The temporary suspension of a multi-unit turn can be facilitated by medical professionals designing their turns in shorter installments. These may vary in length and may span from prosodically, syntactically and pragmatically incomplete to more complete. By designing a turn as a series of installments, medical professionals contribute to creating temporary suspension places, temporarily halting the progress of the turn to allow for interpreting. In addition to pausing their speech, they use a range of resources allowing and even inviting the interpreter to speak, such as gazing toward the interpreter, gesturing to the interpreter (for instance pointing or turning to the interpreter's screen) and explicitly addressing the interpreter. The interpreters can contribute to creating suspension places for interpreting by producing pre-beginning signals, such as audible in-breaths, using gestures, and explicitly asking for the floor. The interpreters' signals display an orientation to certain points in the medical professional's longer contribution as relevant for interpreting. The medical professionals can pre-empt the temporary suspension of a turn by continuing past points in the interaction potentially relevant for interpreting and not leaving a silence. Similarly, the audible in-breath can serve to halt the medical professional's ongoing utterance. The temporary suspension place is conditioned by both involved participants' orientation to a specific point in the interaction as relevant to interpreting.

While the construction and design of installments may be similar in situations where the interpreter is co-present as well as in mediated settings, this study shows how video mediation poses specific challenges to the negotiation of installment lengths. Delay can cause problems for the participants in negotiating the position of temporary suspension places. Furthermore, the video-mediated environment and the participation frameworks created for video-mediated interpreting in these settings restrict the resources available for signaling attempts at interpreting. Different technological settings and placement of participants and technology may give the participants varying visible and auditory access to each other.

Previous research has shown how decomposing a multi-unit turn into smaller chunks and delivering them in installments may be used to elicit listener responses and secure mutual understanding incrementally (Svennevig, 2018). This study expands on the use of this practice to include other activity types and other forms of interpolated contributions by interlocutors, namely interpreting. In addition, it shows how the length of each installment is a matter of online negotiation between the parties.

While studies on interpreting may focus on the interpreter's actions, leaving much responsibility on the interpreter for the coordination of the interaction, this study contributes to an understanding of interpreting as interactionally achieved through collaboration. The study shows how participants other than the interpreter are involved in the achievement of the interpreter's turns.

The findings reported here can be practically useful for practitioners in the field, both interpreters and medical professionals. Professionals can be trained to produce longer contributions in installments in order to create space for interpreting. Interpreters on their side can be and are in many cases trained to signal pre-beginnings. The video-mediated environment provides a complex interactional space challenging the fine-tuned moment-by-moment negotiation of turn space. Awareness of the complexities of negotiating turn space in a mediated environment would be beneficial to both interpreters and medical professionals. The medical professionals may need to leave longer pauses after their installments and the interpreter's pre-beginning signals may need to be more explicit in order to be perceived by the participants at the ward.

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#### Declaration of competing interest

The authors have no financial, general, and institutional competing interests to declare.

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## Appendix: Transcription key for multimodal annotation

Transcription key developed by Lorenza Mondada (2001). Available online: [https://franzoesistik.philhist.unibas.ch/fileadmin/user\\_upload/franzoesistik/mondada\\_multimodal\\_conventions.pdf](https://franzoesistik.philhist.unibas.ch/fileadmin/user_upload/franzoesistik/mondada_multimodal_conventions.pdf)

- \* \* Descriptions of embodied actions are delimited between
- ▣ ▣ two identical symbols (one symbol per participant and per type of action)
- % % that are synchronized with correspondent stretches of talk or time indications.
- \*---> The action described continues across subsequent lines
- >\* until the same symbol is reached.
- >> The action described begins before the excerpt's beginning.
- >> The action described continues after the excerpt's end.
- int Participant doing the embodied action is identified in small caps in the margin.
- fig The exact moment at which a screen shot has been taken
- # is indicated with a sign (#) showing its position within the turn/a time measure.

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