Doctor, do you speak English?

An analysis of pragmatic strategies to achieve mutual understanding during GP consultations in English as a Lingua Franca in the Netherlands

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Abstract

In a world of rapid trends in immigration and globalization, healthcare professionals are often caring for patients from diverse cultural and linguistic backgrounds (Nash, 2014). In the Netherlands, government funding for professional interpretation for non-Dutch speaking patients in health care was cut in 2012 (Kwant, 2017). Since then, health care professionals and non-Dutch patients must fall back on alternative means to bridge the linguistic and cultural barriers they face during medical consultations.

One such method is the use of English as a Lingua Franca (ELF), whereby it is not the native language of one or both interlocutors (Cogo, 2009; Jenkins, 2011). Since previous research on ELF in the medical context appears limited, the current research aim was to establish the communicative characteristics of GP consultations in ELF in the Netherlands.

This thesis builds on a body of research that has investigated the use of certain pragmatic strategies which appear to facilitate communication in ELF. The current study investigates whether these pragmatic strategies are used by doctor and patient. Next to facilitative characteristics, it was investigated which characteristics of the ELF consultations hindered doctor-patient communication.

Misunderstanding occurred infrequently in the ten ELF consultations recorded for this study, and it was confirmed that pragmatic strategies facilitate communication. However, when misunderstanding arose, it was usually repaired by employing the aforementioned pragmatic strategies.

The current study contributes to research on ELF communication and intercultural doctor-patient communication. It further stresses the importance of actively using pragmatic

strategies to enhance communication, as well as expressing intercultural awareness to establish common ground between doctor and patient.

1. Introduction

The key element for a successful doctor-patient relationship is communication. Establishing open lines of communication to foster a good doctor-patient relationship have been shown to improve health outcomes (Shipman, 2010). In a globalizing world with rapid trends of world immigration, healthcare providers are often caring for patients from diverse cultural backgrounds (Nash, 2014). Language and culture barriers in the doctor's office are often met with a too reductionist approach, whereby only specific aspects of the communication process are taken into account (Schouten et al. 2020). For example, a specific body of research focuses on doctor-patient interactions where (informal) interpreters are present (see Schouten et al. 2020, for an overview). Even though these studies show how language and culture barriers can be overcome in doctor-patient interactions, in the Netherlands, interpretation is expensive and troublesome in administration. Health care providers thus often do not use such services (Meeuwesen & Twilt, 2011). Besides, from 2012 onwards, government funding for professional interpretation in the doctor's office was cut (Kwant, 2017). Patients and physicians in this situation often fall back on alternative methods to overcome linguistic and cultural barriers. Informal interpretation by family members and even children is common, and sometimes preferred over professional interpreting by patients, but especially in the case of child interpreters this is considered problematic (De Ridder, 2021; Meeuwesen & Twilt, 2011). In case informal interpretation is not available or preferred, oftentimes English as a *lingua franca* is used, whereby it is not the native language of one or both interlocutors, but a shared (second) language to establish communication between doctor and patient (SGE-International, personal communication; Bakó, 2014).

Research on the ways in which speakers adapt to their interlocutor when they use English as a lingua franca (ELF) shows that accommodation to context and the use of specific contextual cues to signal mutual understanding is very important for adequate ELF communication (Cogo, 2009; Kaur, 2010). However, research on ELF communication in the doctor's office appears limited. The current study aims to investigate ELF communication in a specific setting; between physician and patient, using knowledge from earlier research on ELF communication and applying it to study how it occurs in the doctor's office. Studying ELF in this specific setting is especially relevant in the Dutch context, since interpreting facilities appear limited in the current healthcare system in the Netherlands (Kwant, 2017; De Ridder, 2021).

As there is limited research on ELF communication between physician and patients, the current study will build on a body of research that has studied the facilitative and impeding characteristics of ELF communication, i.e. the circumstances under which communication runs smoothly or not. This research shows that certain pragmatic strategies, such as other-repetition or clarification and confirmation procedures, facilitate ELF communication. The current study aims to explore whether these pragmatic strategies are employed by both physician and patient during their interaction in ELF, and whether in this context they do indeed make the communication more efficient. To provide a more complete picture of the interactional practice, the current paper also aims to investigate the characteristics of miscommunications in ELF, and how these relate to the aforementioned pragmatic strategies. The current study contributes to research on doctor-patient communication, and how it can be improved, specifically focusing on situations where doctor and patient have different linguistic and cultural backgrounds.

This thesis is structured as follows. First, the theoretical framework will outline previous studies on the characteristics of ELF communication in different settings (sections 2.1-2.3), as well as research on (intercultural) communication in the medical setting (sections 2.4 and 2.5). After the theoretical framework, the research questions for the current study will be introduced, and afterwards the method, results and discussion will be presented respectively. The final section will outline the conclusions that can be drawn from the current research.

2. Theoretical framework

2.1 Bridging the communicative gap using English as a Lingua Franca

English has been spreading across the world and developing as a global language for several centuries (Brutt-Griffler, 2001) and is recognized as such by many scholars and media in different countries (see Crystal, 2012 for an overview). English serves many purposes across the globe, but one salient purpose seems to be the use of *English as a lingua franca* (ELF), which is defined as English that is used as a medium to bridge language barriers, and therefore is not the native language of one or both interlocutors (Cogo, 2009). However, in ELF communication, interlocutors often have very different cultural and linguistic backgrounds, therefore common ground between speakers cannot be assumed as easily as compared to speakers using a shared native language. Therefore, in ELF, speakers have to accommodate their speech to their interlocutor to facilitate communication. Speakers can accommodate their speech to more closely resemble that of their interlocutor, for example through code-switching, i.e. switching from one language into another, or other-repetition,

by which is meant the repetition of (part of) an utterance of the other speaker, as opposed to self-repetition (Cogo, 2009).

What follows from this accommodation and negotiation of differences in conversation, is a different kind of English compared to what native speakers use amongst themselves or what is taught in foreign language learning. However, this does not mean that this type of English is by definition worse or less effective for communication compared to a native variety. Nevertheless, many speakers still see native English (i.e., British or American English) as the most desirable form of English (Jenkins, 2011). This view is referred to as the English as a Foreign Language (EFL) perspective, and as such, language errors and code-switching are seen as deficits, while in an ELF approach they are seen as variation or even pragmatic strategies to accommodate to the communicative situation at hand. The perspective that will be taken in this thesis is that of ELF, which is focused on mutual understanding and communicative outcome (Jenkins, 2011; House, 2003). Even though differences in the level of English spoken in ELF interaction play a role in the outcomes of the communication, and previous studies have attempted to outline what ELF looks like in terms of grammatical features (Jenkins, 2011), the current paper is focused more on how interlocutors achieve mutual understanding in ELF interaction, and thus takes the ELF approach.

2.2 Studying ELF through conversation analysis

In face-to-face interaction, contextual cues that signal understanding are fundamental to communication. Contextualization is defined by Gumperz (1992) as: "speakers' and listeners' use of verbal and non-verbal signs to relate what is said at any one time and in any one place to knowledge acquired through past experience, in order to

retrieve the presuppositions they must rely on to maintain conversational involvement and assess what is intended." (Gumperz, 1992, p. 230). In other words, contextual cues are signs used in conversation to signal the relationship between what is being said in conversation and presupposed or established common ground between speakers. According to Gumperz (1992) contextual cues can be observed on the following levels of speech production: prosody, paralinguistic signs, code choice and choice of certain lexical forms or formulaic expressions. Prosody involves intonation, pitch and stress in speech. Paralinguistic signs involve changes of tempo and latching or overlapping of speaking turns, which cue important information about coherence of discourse. Code choice does not involve choice of language only but may also involve using language from a specific register or domain, e.g. in the medical context, specific for body parts may be used while in other contexts this is not as common. In ELF communication, code-switching has been shown to be an important pragmatic strategy and is thus also a contextual cue (Cogo, 2009). Choice of lexical forms or formulaic expressions are important to certain inferential processes that interlocutors may undergo during interaction. For example, in opening and closing routines, or metaphoric expressions, that may differ cross-culturally (Gumperz, 1992). For example, in a study on ELF interactions in the context of immigration in Italy, a participant using a Nigerian variant of ELF used the expression "they were kicking me" to express that people disregarded him. This non-literal interpretation was missed by the interlocutors due to of a variety of factors, but it is an example of a metaphoric expression that is used differently cross-culturally (Guido, 2012, p. 234). Analysis of contextual cues is referred to as conversation analysis, which involves the analysis of both pragmatic and linguistic features of communication.

2.3 Pragmatic strategies to achieve mutual understanding in ELF

Pragmatic accommodation strategies[1] in ELF interaction, which can be found by studying contextual cues through conversation analysis, have been explained in the academic literature for example by Cogo (2009), who describes two main pragmatic strategies that facilitate ELF communication: code-switching and repetition. More specifically, she refers to repetition of part or all of the utterance of the other speaker, within the same conversation. Cogo (2009) clarifies that o*ther-repetition* as opposed to *self-repetition*, is a pragmatic strategy to acknowledge understanding in ELF conversations. Code-switching, i.e., switching from one language into another, is regarded in sociolinguistics as a way to make full use of one's linguistic repertoire (e.g. Matras, 2009). Cogo (2009) views code-switching as "an additional resource to achieve particular conversational goals in interactions with other intercultural speakers" (p. 268). Moreover repetition, paraphrase and confirmation and clarification procedures have also been described as strategies to address problems of understanding if they occur, and with use of such strategies arrive at mutual understanding in interaction (Kaur, 2010).

Besides these accommodating strategies, Baker (2011) points out the importance and prevalence of intercultural awareness in ELF interaction. Intercultural awareness seems to be a factor that guides the degree of accommodation in ELF, and each intercultural interaction shows different traits depending on the level of intercultural awareness as well as the cultural differences between speakers. Baker (2011) presents a three-level model of intercultural awareness, which he exemplifies using conversational data. The three levels of

[1] Throughout this thesis and in the academic literature the terms "accommodation strategies" and "pragmatic strategies" are used interchangeably. Both terms refer to strategies used to achieve mutual understanding in interaction. In the context of ELF these can be considered accommodation strategies, since the speaker accommodates their speech to their speech partner in an ELF mode, while in a general, non-ELF context these strategies can be considered pragmatic strategies (i.e., when accommodation is not at play).

the model are as follows: (1) *Basic cultural awareness,* where one has a general awareness of the role of cultures on our own and communication of 'others'. (2) *Advanced cultural awareness* where one takes the complexity of cultures into account (3) *Intercultural awareness* where one is aware of the role of cultures in intercultural communication. The three levels, and their corresponding concepts and practices, are shown in greater detail in the model in Figure 1. In practice, the three levels correspond to different outcomes in interaction. For example, for the first level, it seems participants are able to articulate their own cultural perspective, as well as to compare cultures at a general level. Next, at the second level, participants are able to move beyond cultural generalizations and stereotypes and to compare and mediate between cultures with the awareness that there are possible mismatches and miscommunications between cultures. At the last level participants are able to negotiate and mediate between different emergent and contextually grounded communication modes and frames of reference. That is to say, speakers at the last level are aware that forms and frames of reference are related to specific cultures but are also dynamic and emergent in different intercultural interactions.

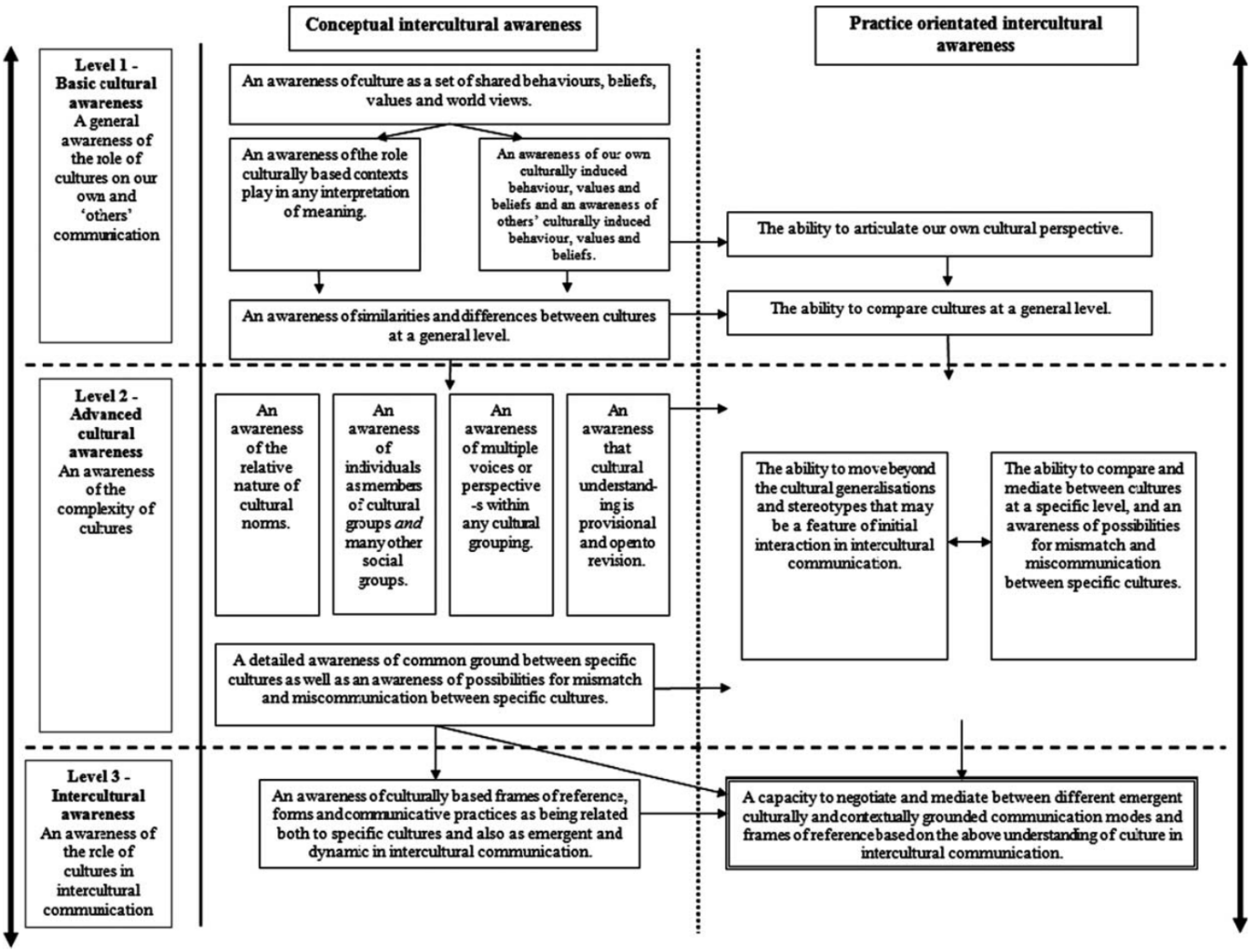

Figure 1 The model of intercultural awareness by Baker (2011, p. 203). It shows the three levels (vertically) as well as its corresponding conceptual intercultural awareness and practice oriented intercultural awareness (horizontally).

From the model described by Baker (2011) it is not completely clear yet how the three levels can be discerned from discourse. Ten Thije's (2006) notions of *perspective* and *perspectivising* may allow us to see how speakers mediate and reflect on their own cultural knowledge in intercultural interactions. Ten Thije (2020) exemplifies a strategy of three steps to achieve intercultural understanding in interaction. In this example, the speaker is a Dutchman in Russia, where it is much more common to make many toasts during dinner, he takes the three steps to show his awareness of this cultural difference. The first step of this strategy is *generalizing*, whereby the speaker considers his speech action as cultural

standard from their own point of view, e.g., “in my culture it is not common to make so many toasts”. The next step is *perspectivising,* placing the speech action in the specific speech situation, and taking into account cultural standards of the other, e.g., “in Russia I will make another toast”. The last step is *contrasting cultures*, whereby the speaker enables the hearer to compare the speaker’s cultural standards to his own and as such to attain an adequate interpretation of the discourse, e.g., by using a contrastive word such as “but” between step 1 and step 2. The example in full would be: “In the Netherlands it is not common to make many toasts, but here in Russia I would like to say one more.” (Ten Thije, 2020, p. 19).

The studies presented in the current section have investigated ELF communication in different settings, for example in informal discussions between university students about course work (Kaur, 2010), in casual conversations between foreign language teachers working at the same institution (Cogo, 2009) or in the more formal context of immigration (Guido, 2012). However, there currently seems to be a lack of research published on ELF communication in a medical setting, even though it appears that ELF communication frequently occurs in the Dutch medical setting when professional or informal interpretation is not available or deemed necessary. Due to the lack of research on ELF communication in the medical domain, the next section will describe research intercultural doctor-patient encounters which serve as background for the current study.

2.4 Intercultural communication between doctor and patient

“Active patient participation and shared decision-making are considered crucial components of adequate health communication because they are positively associated with improved patient outcomes, such as better fulfillment of patients’ information needs,

better understanding, higher patient satisfaction and more adherence to treatment." (Schouten et al. 2020, p. 2606). Migrant patients have been shown to be more passive during medical encounters compared to non-migrant patients. A focus group study by Schinkel et al. (2019) showed that migrant patients in the Netherlands perceive a variety of language and culture barriers to participation in the doctor's office. Amongst those were cultural factors such as collectivistic values, power distance and uncertainty avoidance. Moreover, they had a preference for an indirect communication style and experienced their low Dutch proficiency as a barrier. According to Schouten et al (2020), language and cultural barriers can be bridged through combining multiple strategies, such as use of interpreters, intercultural training of physicians, and digital tools. However, they do not mention what happens in the absence of an interpreter, which is when oftentimes ELF is used to bridge the language gap (SGE-I, personal communication; Bakó, 2014). The lapse to using ELF when no other means of bridging language and culture barriers is also supported by the fact that English as a global language is often used in other contexts where there is no other shared language (Crystal, 2012).

Moreover, in a literature review by Schouten & Meeuwesen (2006) of several studies on medical intercultural communication, only two of the studies in the sample were performed in a non-English speaking country (i.e., the Netherlands), and these were not investigating the communication in ELF in this context, specifically. Some studies from the USA have specifically looked into language factors, however. For example, Seijo et al. (1991) compared consultations where the doctor and patient both spoke Spanish (i.e. the doctor was a bilingual Spanish and English speaker) to consultations where the doctor was a monolingual English, but the patient only spoke Spanish. This early study found that

patients had better recall and asked more questions when the doctor spoke the same language as them, showing that shared language is an important factor in doctor-patient communication. The situation in ELF is quite different however, since in those interactions, English is not the native language of both doctor and patient. In the context of ELF, English may be a shared language, but the communicative situation and outcomes may be very different compared to the situation described by Sejio et al. (1991).

Nevertheless, previous studies on doctor-patient communication, whether it be in a shared language or not, are relevant to the current paper. Therefore the next section will elaborate on the general structure or doctor-patient interactions, to provide a baseline for the examination of the data in the current study.

2.5 The structure of doctor-patient interaction

Before the research questions of the current study are presented, it will be important to address the general structure of a doctor-patient encounter, as this will enable us to distinguish what elements of the consultation are due to cultural differences, and which are likely to happen in any doctor-patient encounter. Every consultation at the doctor's office has approximately the same structure, this structure is also taught to GP's that are in training in the Netherlands (Dielissen, Van der Jagt & Timmerman, 2016).

In doctor-patient interaction there are clear roles for both doctor and patient, and both roles come with their specific goals in the conversation. The doctor has the goal to find the diagnosis, to help the patient, and to explain to the patient what their treatment options are, while the patient has the goal to find out information about their problems and the diagnosis, and how the doctor is going to treat them. The consultation is always structured by the physician. However, the level of participation of the patient is deemed important for the communicative outcomes of the consultation (Nash, 2014).

Table 1 The Framework of the Calgary Cambridge guide. An evidence-based guide for doctors which explains the skills needed to enhance communication between doctor and patient. (Kurtz, 2002:28)

Initiating the Session
- establishing initial rapport
- identifying the reason(s) for the patient's attendance

Gathering Information
- exploration of problems
- understanding the patient's perspective
- providing structure to the consultation

Building the Relationship
- developing rapport
- involving the patient

Explanation and Planning
- providing the correct amount and type of information
- aiding accurate recall and understanding
- achieving a shared understanding: incorporating the patient's perspective
- planning: shared decision making
- options in explanation and planning
  if discussing opinion and significance of problems
  if negotiating mutual plan of action
  if discussing investigations and procedures

Closing the session

The structure of consultations is exemplified in Table 1 (Kurtz, 2003), and can be explained further as follows: first, the session is initiated by the doctor, establishing rapport and identifying the reason for the patient's attendance. Second, information is gathered by the doctor. In this part, the doctor asks questions, and while the patient answers, the doctor

is in a listening mode. This becomes apparent from the use of phatic expressions like 'yeah' and making agreeing sounds. This is also referred to in the academic literature as backchanneling (e.g. Heinz, 2003).

Oftentimes the doctor will also conduct a physical examination to find out more information about the patient's complaint. In this part of the consultation, verbal communication will be less foregrounded, but it is always pertinent that the doctor explains what they are doing and why. Rapport is also very important at this stage.

Next, the doctor will explain the diagnosis and the treatment options, as well as the planning of the treatment. In this part of the session, the patient will be in a listening mode, so the roles in the interaction are more or less reversed compared to the information gathering stage. However, during the treatment planning, there will be some shared decision-making. That is to say, the patient has a say in how the treatment will go, and shared decision-making occurs during this phase. Once the treatment is clear and the patient has been given the opportunity to ask final questions, the session will come to a close.

The current section has explained the structure of doctor-patient interaction in general, while this thesis aims to investigate how doctor-patient interaction in ELF is structured and which characteristics of the interaction facilitate or impede effective communication. The next section will thus elaborate on the approach of the paper, and specific research questions that the current study puts forward.

3. Approach and research questions

As the current thesis is investigating intercultural communication in interaction and analyzing the linguistic and paralinguistic characteristics of ELF communication in a specific context, it will be taking the *interactive approach* to intercultural communication. The interactive approach is concerned with face-to-face interaction, and this thesis will be as well (Ten Thije, 2020). As such, the research questions for the current thesis are formulated as follows:

Main question: What are the communicative characteristics of doctor-patient interactions in ELF?

Subquestions:

1. Which pragmatic strategies facilitate mutual understanding in ELF in doctor-patient interactions?
2. Which characteristics hinder mutual understanding in ELF in doctor-patient interactions?

4. Method

4.1 Setting

The current study was conducted at Stichting Gezondheidscentra Eindhoven – International (further referred to as SGE International). SGE are an organization of healthcare clinics with first-line healthcare (e.g. general practitioners, physiotherapists, psychologists) across Eindhoven. SGE International is one of their clinics and is especially geared towards non-Dutch speaking patients. The main languages that are used in the practice are English and Dutch.

4.2 Participants

A total of 10 consultations at the GP office were recorded. The patient population at SGE International is quite diverse, but generally it is assumed that the population of SGE International is of slightly higher socioeconomic status, compared to non-Dutch speaking patients in other clinics from SGE. This is because the clinic is specifically geared towards a demographic in Eindhoven that works at Brainport - a large hub for tech companies such as Philips and ASML - or works or studies at Eindhoven university of technology (SGE, personal communication). The participants in this study were between the ages of 19 and 39 years old (*M* = 27.4 yrs, *median* = 27 yrs). In terms of gender, four participants indicated they identified as female, while six indicated they identified as male. The first language (L1) of participants varied, Table 1 below provides a list of the age, gender and L1 of each participant.

Table 2 Demographic information of participants

age (yr)	gender	L1
28	male	Romanian
26	male	Arabic
39	male	Portuguese
32	male	Russian
23	female	Romanian
31	male	Kannada (India)
26	male	Spanish
29	female	Ukranian
21	female	Indonesian
19	female	English

Besides ten patients, two general practitioners agreed to participating in this study. Both had Dutch as their native language.

4.3 Procedure

The consultations in the GP office were audio recorded. The two healthcare professionals agreed before the start of their workday to participate in the study, they were given an information letter in Dutch and they signed an informed consent form in Dutch (see appendix A). The participating patients were recruited in the waiting room of the practice by the main researcher. They were asked if they wanted to participate in a study on communication in the doctor's office and were given an information letter in English (see appendix B), which they all read before signing the informed consent form in English[2]. Once they were called into the office, the researcher turned on the recording device on the doctor's desk and left the room so that the consultation would proceed as it normally would. Both patient and doctor were provided the option to stop the recording at any time if they were uncomfortable or wished to withdraw their participation.

Not everyone at the practice was willing to participate in the study, the non-response percentage for the healthcare professionals was 33% (n=3). The non-response percentage for patients was 23,1% (n=13), sometimes because they were not comfortable being recorded, other times because it turned out they were too young to participate (i.e., younger than 16 years old).

4.4 Transcription

The recordings were manually transcribed using Microsoft Word. The transcription conventions were as follows. These are based on Jefferson (2004), however, only the

[2] The current study was approved by the Faculty Ethics Committee (FEtC) of the Faculty of Humanities of Utrecht University.

features that were deemed relevant to the current study, i.e. features that seemed facilitative or impeding to the communication, were transcribed and as such those symbols were selected from the overview by Jefferson (2004):

- *a dash* indicates a hesitation, stutter or cut-off of a word or phrase

.. *two dots* indicate a short pause

(h) *a parenthesized "h"* indicates plosiveness, an audible exhale, for example starting laughter

(hh) *two parenthesized "h"s* indicate laughter

[*a left bracket* indicates the start of overlapping speech, the overlap is with the speech transcribed in the line below

] *a right bracket* indicates the end of overlapping speech.

= equal signs indicate no break or gap. A pair of equal signs, one at the end of a line and one at the beginning of the next, means there is no break between the two lines.

( ) *empty parentheses* means the speech was unintelligible to the transcriber. The width of the space indicates the length of the speech that was unintelligible.

(maybe) *parenthesized text* indicates slightly unintelligible speech, approximation of what was said

apotheek *italic text* indicates codeswitching: anything that was said that was not in English

((silence)) *double parentheses* indicate a description by the transcriber

4.5 Analysis

The approach to analyze the data was mainly inductive. However, special attention was paid to specific features of ELF communication which have been described in previous academic literature. Among these were pragmatic strategies such as code-switching, other-repetition, clarification and confirmation or paraphrasing (for more detail see section 2.3 of this thesis). However, since the main research question focuses on the factors that facilitate ELF communication, some general, inductive observations about the data were made as well. These have to do with the specific nature and structure of doctor-patient communication, which may be different from other kinds of ELF interaction that has been studied in previous literature, for example between students or in other international settings. This structure has been described in section 2.5 and examples of this structure have also been recorded in the results section. This part of the analysis is relevant to the current study to see which elements of the conversation are part of the structure of consultations between doctor and patient in any setting, for example in the native language, and which elements are due to the intercultural nature of the interaction.

In terms of elements of ELF communication, some codes for the analysis were pre-determined by previous literature. First, attention was paid to the pragmatic strategies in ELF as defined by Cogo (2009), see also section 3.1 of the current thesis. Among these were codeswitching and other-repetition, which indeed occurred in the data. Next, it was confirmed that paraphrase and confirmation and clarification procedures occurred in the data (cf Kaur, 2010), and checked how these influenced the communication outcomes. Lastly it was investigated whether participants used the three steps to expressing intercultural awareness in interaction as described by Ten Thije (2020) (see also section 2.2)

namely generalizing, perspectivising and contrasting cultures. Nvivo (Nvivo 12, 2021), a program designed for qualitative analysis, was used to code the data.

5. Results

5.1 The structure of doctor-patient interactions

The structure of doctor patient-interactions found in the current data appears comparable to the structure that is described in the professional literature, see also section 2.5 of this paper (Dielissen, Van der Jagt & Timmerman, 2016; Kurtz, 2002).

The first stage is the information gathering stage, where the doctor asks questions and while the patient answers, the doctor is listening. This listening mode becomes apparent through the use of phatic expressions such as 'yeah' and agreeing sounds which have been indicated in the transcipts with 'hmhm'. This is also referred to as backchannelling and is exemplified in Example 1 below. In all examples in this results section, the letter P indicates the following sentence was said by the patient, while the letter D indicates it was said by the doctor. Before each example the demographic information of patient (P) are indicated.

Example 1

P = male, 39 years old, L1 Portuguese

1. D: Yeah. Tell me about that.
2. P: I have something in my ear, sometimes or both but mostly on the right one.
3. Sometimes when I wake up the- it was blocked. [Some]times I feel it's a little
4. D: [yeah]
5. P: bit swallowed and it hurts a little [bit] I have an history of ear inflammation=

6. D: [yeah]

7. P: =of infection so I don't know if I have something right now.

Next, the doctor will often conduct a physical examination, whereby verbal communication is less foregrounded, but rapport is very important as there will be some form of physical contact between doctor and patient. The doctor explains what they are doing, while the patient complies and answers short questions. See Example 2, which illustrates the physical examination stage, below. In this example it becomes clear that non-verbal communication and indexation (i.e. pointing and using demonstrative determiners) appears predominant. For example, in line 2 the doctor asks "is this painful?", and uses more demonstrative determiners throughout.

Example 2

P = male, 26 years old, L1 = Arabic

1. D: Yeah, ehmm I would like to check your stomach we can go over there

((some rustling and unintelligible speech))

((Pause 30 seconds))

2. D: Is this painful?

3. P: Yeah

4. D: Also connected to the pain you had?

5. P: Yeah yeah

6. P: (yeah that's sore)

7. D: Is that the spot where you feel the cramps as well?

8. P: ehm I'm not ah- not sure

9. D: Okay let me check on the right side

10. P: Ooh yeah that was (h)

11. D: oh sorry

12. P: oh no, no its okay

13. D: (and then when I let go?)

14. D: Can you breathe in deeply? ( ) Alright

15. There as well?

16. P: Uhuh.

The next phase is the diagnosis and planning stage. The doctor explains the diagnosis and treatment options, and the planning of the treatment. During this explanation, the patient is listening, which is characterized by backchanneling as in the information gathering stage, except here the patient backchannels as opposed to the doctor (Example 3, lines 3, 5, 7, 9, 11, 13). This explanation phase is illustrated in Example 3. However, during the treatment planning some shared decision-making takes place, which is illustrated in Example 4. Here, the patient is deciding whether she needs to get an x-ray for her finger and asks the doctor for advice in her decision. The doctor then clarifies that it is the patient's decision to get the x-ray or not (lines 5-6 and 18). In this part of the consultation, there may be a shift in who structures the conversation as the patient is given the opportunity to participate and decide on the treatment. This is also visible in Example 4, line 7 and 8, where the patient interrupts the doctor to explain her situation, so that the doctor can give her specific advice.

Example 3

P = male, 26 years old, L1 = Arabic

1. D: So ehm I think eating three meals a day is alright,
2. [ehm] it's important to eat enough fruit, [to] drink enough water [and]=
3. P: [uhuh] [yeah, yeah] [yeah]
4. D: =to eat enough fibers ehm and we could try ehm to add a bit of fibers [to]=
5. P: [hmhm]
6. D: =make the stool a bit more thin, [so]metimes even a bit like [too] thin so=
7. P: [hm] [yeah]
8. D: =you know for sure this is all.. [go]ing through and then we can see if the=
9. P: [(going)]
10. D: =pain goes away [bec-] because if it does then there is no problem in the=
11. P: [okay]
12. D: =stomach [and] it is just, like, in the bowel. [Ehm] but if its not helping=
13. P: [hm] [yeah,yeah]
14. D: =enough I would like to say we have to have a look further into it.

Example 4

P = female, 23 years old, L1 = Romanian

1. D: I don't think it's broken, eh but because it's your hand ehh ehm you want to
2. be sure. Ehh we have a few more days like if you- eh because if it is broken
3. you will get like a cast around your finger. If it happens now or next week for
4. the repairment it will not matter. So we have some time to wait. But it's very
5. personal if you- like, how you are with the way things are. So that's why I give
6. you the decision. Like for me it's alright to wait until next week, because if it
7. feels better and better and better I don't think it's broken. [But if-]

8. P: [yeah] but the
9. problem is that I have like deadlines for example you know and I have to code
10. and type and stuff like that so then I don't know which way is [better.]
11. D: [oh okay]
12. P: with the cast and every[thing]
13. D: [yeah] it's less painful with a cast eh it stays in the
14. same position and it helps with the pain. But ehm it's not a problem to move
15. your finger but when you type a lot this (h) can be annoying with a painful
16. finger yes.
17. P: eh okay.
18. D: yeah so it's up to you if it like if works for you to know it sooner? for for you
19. knowing how to use your finger. you can do it right away. Alright?

The current section has illustrated that the different phases in the doctor-patient interaction as described in previous literature, also occur in the current data, i.e., in GP consultations in ELF as opposed to consultations in the native language. Furthermore, these examples emphasize the characteristics that facilitate the communication between doctor and patient, such as backchanneling. However, because it has been shown that these are part of the structure of any consultation, these characteristics are not exclusive to ELF communication between doctor and patient. Nevertheless, the current data further support the idea that maintaining this structure throughout each consultation is important for efficient and effective doctor-patient communication.

5.2 Code-switching

In the current dataset, codeswitching was not so frequent, the examples currently presented are the only occurrences of code-switching in the present data. However, when interlocutors code-switched, it seemed to occur with intent. Code-switching was used to indicate knowledge about the Dutch healthcare system, as it was initiated by the patient, as opposed to the doctor. See examples 5 through 7 below.

Example 5

P = male, 39 years old, L1 Portuguese

1. P: I have high blood pressure and I make use of (?) eh the medication and my
2. medication I brought from Brazil is almost ov[er].
3. D: [I] can imagine that's alright.
4. P: When I make appointment they asked me to bring the medication. So there is
5. ( ) 30 milligrams and ( ) 5 milligrams. I even brought
6. the *recept* from Brazil I don't know if it makes any use.

Example 6

P = male, 39 years old, L1 Portuguese

1. D: Don't think we will be open on Monday but Tuesday then. alright, everything
2. clear?
3. P: Yep. for the medicine I just need to go to the *apotheek*?
4. D: Yes I will make the recipe and send it over there.

Example 7

P = female, 23 years old, L1 Romanian

1. D: who did you talk with?
2. P: Uhmm it's the *huisartsenpost* I think it's called I don't have a GP that's
3. just. my boyfriend is Dutch and he gave me this number.

In Examples 5 through 7, code-switching is initiated by the patients, and it pertains to words that have to do with the Dutch healthcare system. In Example 5, line 6, the patient uses the word *recept* for 'prescription' and in Example 6, line 3 he uses the Dutch word *apotheek* for pharmacy. In Example 7 line 2, the patient uses the word *huisartsenpost*, which is a general practice that is open for emergencies in the evening hours and on weekends. The reason for using these words might be that these words are strongly related to the Dutch medical system. That is to say, even though they are translatable to English, in the context of this conversation between doctor and patient in the Netherlands, there is no direct equivalent of these words in English. This kind of code-switching seems intended to show the common ground between the interlocutors, and therefore facilitates communication, specifically in the current ELF context.

5.3 Other-repetition

The pragmatic strategy of other-repetition, whereby one interlocutor repeats (part of) what their speech partner has uttered, was often used to indicate understanding. Other-repetition was especially used by the doctor in the information gathering stage, as exemplified in Examples 8 and 9.

Example 8

P = male, 28 years old, L1 Romanian

1. P: Ya it works but, still [not] completely [not-] [not-]
2. D: [Okay] [yes] [for] how much percentage did it
3. work? ..do you..
4. P: Thirty percent.
5. D: Thirty percent, and you used it for? How long?
6. P: hmm it was two weeks I think I now use it a little bit over that

In Example 8, the doctor in line 5 immediately repeats what the patient had said before in line 4. This is most likely used to signal understanding, or to process what the patient has said.

Example 9

P = male, 28 years old, L1 Romanian

1. D: So how were you able to stop? With that?
2. P: I just quit it
3. D: You just quit. And then? Did it became worse?

Example 9 is similar to Example 8 in that the doctor immediately repeats what the patient said, to indicate understanding (lines 2 and 3). As this pragmatic strategy appears to be an important part of the information gathering stage, this is also used in consultations where both doctor and patient speak a shared native language (Kurtz, 2002; Yin & Watson, 2020).

As such, this pragmatic strategy is not specific to ELF communication. Yet, this kind of pragmatic strategy seems to facilitate communication since it signals mutual understanding.

5.4 Confirmation and clarification

A lot of confirmation and clarification procedures occurred in the current data. Akin to other-repetition, this appears related to the nature of two stages of the consultation: the information gathering stage and the explanation and planning stage. In these stages, confirmation and clarification is needed to effectively communicate and confirm the information necessary for a successful consultation. One interesting example is illustrated below: the doctor uses the word 'picture' throughout the consultation to refer to an x-ray. Once the consultation comes to the point where the planning of the x-ray takes place, the patient asks for clarification about the word 'picture'.

Example 10

P = female, 23 years old, L1 Romanian

D: Until next week. If you don't feel improvement you can make the picture then anyway. Is that something that sounds alright?

P: yeah, sure. By picture you mean radiography right?

A: yeah ehh like eh x-ray.

In Example 10, but also in other interactions where confirmation and clarification occurred in the data, the clarification and confirmation procedures are used to clarify or repair any missing information, and to confirm the information that was previously communicated. They seem to be important to successful communication and thus facilitative characteristics

of doctor-patient communication. Again, this type of pragmatic strategy functioning to achieve mutual understanding also occurs in consultations in a shared native language (Haq, Steele, Marchand, Seibert & Brody, 2004; Kurtz, 2002). However, clarification and confirmation may be especially important in ELF since meaning can be construed if information is not confirmed or clarified frequently.

5.5 Generalizing, perspectivising and contrasting cultures

In one of the consultations the patient initiated some perspective on the Dutch medical system and how it is different from the system in Russia. This is illustrated in Example 11 below.

Example 11

P = male, 32 years old, L1 Russian

1. P: it's so interesting for me now how many things a GP in the Netherlands can
2. do
3. D: (h) yeah that is different from other countries
4. P: yeah for example in Russia we need to go to eh [special]
5. A: [yeah], yeah that is
   different organization, yeah that is normally eh, yeah

The patient initiates a generalization about the GP in the Netherlands in line 1, and the doctor confirms it in line 3. Then the patient contrasts this to Russia and puts it in perspective in line 4. This example occurred during a silence in the consultation. That is to say, the doctor had to fill out some things on the computer, therefore it was not as much an

essential part of the communication during the consultation. It seems the patient was trying to make small talk with the doctor, but it might also be a way to show his awareness of the differences in the medical system in two countries. This was facilitative to the communication because it established more common ground between doctor and patient; the doctor was made aware of the fact that the patient knew the differences between systems.

5.6 Misunderstanding and repair

Up to this point in the results section, focus has been put on communicative characteristics that facilitate communication. However, in some cases in the data, which will be elaborated below, communication was not optimal. There seemed to be some misunderstanding, which appears to be repaired by using the pragmatic strategies described previously, such as clarification or paraphrasing. One such case is illustrated in Example 12 below. The doctor asks how long the patient uses their menstrual cup (line 1), and then the patient explains that they used it for two weeks (line 2) and goes on to explain their symptoms and complaints. A bit later in line 13, the doctor asks again how long the patient is using the menstrual cup, and then clarifies that he means how long she uses it each time (line 13). This seems to be indication that he meant to ask this question already in line 1, but the patient interprets it differently and explains the time that she used it for (lines 2-12). The slight misunderstanding that may have taken place here, seems to be resolved by repetition; the doctor repeats the question he asked before (lines 13-15), and emphasizes the word ‘long’ (line 15), to indicate an alternate meaning of the word. Even though this repair was made by self-repetition, it could also be classified as a clarification, because he changes the prosody the second time to signal an alternate meaning of the word.

Example 12

P = 19 years old, female, L1 English

1. D: and how long do you use this? The menstrual cup?
2. P: yeah I used it for ehm two weeks so a week before my period and then
4. a week for my period and then I like for the past two or three days I had ehm
5. itching like a near my vulva but yeah I didn't understand why it was
6. happening because it wasn't the yeast infection itching.
7. D: it was different?
8. P: yeah like there was no discharge like there was no yeast infection discharge
9. it was just a normal discharge that you get after your period so I don- I think
10. it's probably because the quality of the menstrual cup is not good.
11. D: or you have a irritation about it
12. P: yeah ex[actly]
13. D: [how] long are you using it you said you used it two weeks in a row=
14. P: =[yeah]
15. D: =[but] for how long are you using the menstrual cup
16. P: oh yeah so I would use it for around uhm 10 to 12 hours at most and then I
17. would switch it wash it put it back.

Next, in Example 13 the patient has a complaint about his tongue, he says that his tongue feels the way it feels when he drinks tea, but this is not clear to the doctor, the doctor attempts to find out his exact complaint but it takes a while. The first misunderstanding seems to stem from some linguistic difference between English and Dutch. The patient says

in line 1-2: “it’s burn like when I drink hot tea.” by which he seems to mean that he has a burning sensation that feels like drinking hot tea. The doctor however interprets that he feels a burning sensation when he drinks hot tea. The word “when” in this case has a different meaning to the doctor than it does to the patient, because of the influence of Dutch conjunction meanings. The doctor keeps asking for clarification, but it’s not completely resolved until the end. The complaints remain slightly vague, and the doctor decides to do a physical examination instead. The strategies used by both patient and doctor to try and resolve the miscommunication seem to be clarification (lines 9, 12, 28), paraphrasing (lines 21, 30, 34) and repetition (lines 7, 20, 21, 30, 32).

Example 13

P = male, 28 years old, L1 = Romanian

1. P: After this can I also speak to my (tongue) and I feel like ehh.. it’s burn like
2. when I drink hot tea, also some points, pain points on the tongue.
3. D: Okay, how long is that .. appearing?
4. P: hmmm ehm six months?
5. D: Six months, is it painful or? Itchy or?
6. P: Sometimes painful
7. D: Sometimes painful, okay. And can you eat everything, ehh okay
8. P: [Yeah, yeah
9. D: When hot water comes the[re-]
10. P: [No] the feeling is like when you drink hot water
11. or when you drink hot tea or you get the tongue is .. sensitive
12. D: Oh yeah? Okay, like a burning sensation

13. P: Ya

14. D: Okay, when you drink hot coffee as well? Or only with [tea]

15. P: [I] don't drink coffee

16. D: Oh oh okay, other hot ..

17. P: ya

18. D: Is it the temperature or is it the tea?

19. P: I think also the taste .. [I think] Because ( ) salt

20. D: [the taste] yeah

21. D: So you have a salt taste whenever you drink tea? Afterwards, okay. Ehh did

22. you try changing the tea?

23. P: Noo, I drink normally I drink (only) water, nothing else

24. D: yeah, and then there is no problem?

24. P: No

25. D: Okay but when-=

26. P: =when it's cold, very cold then I feel also, it's ehh.. also now I have this

27. sensation, (like hot or cold)

28. D: Yeah? And what kind of sensation?

29. P: Burn

30. D: A burning sensation on the back of your tongue?

31. P: umm on.. no on the front. [Part of the] front

32. D: [On the front..] okay, alright um. Did you burn it?

33. P: no

34. D: No okay ehh since half a year, yeah okay. We can have a look

One note about Example 13 is that the complaints of the patient throughout the consultation appear rather vague. One reason for this may be that after the physical examination, the doctor asks if the patient has any more questions, to which the patient answers that he would like to speak to a psychologist. It is suspected that there may be a cultural taboo at play here, as research shows that in Romania -the country of origin of this patient- mental health is still stigmatized in society (Friedman, 2006). Therefore, the patient may not have brought it up immediately or when making his appointment with the GP. This context is important for the interpretation of the misunderstanding in this example, since it appears that the pragmatic strategies used by the doctor (i.e., clarification, paraphrasing, repetition) do not work immediately, but this may have to do with the fact that the patient has a different underlying goal for the consultation.

In Example 14 the doctor and patient are talking about the electronic system where doctor and patient can send each other messages. This is not the same as regular email, but that is not very clear to the patient. The miscommunication is resolved when the doctor distinguishes between Gmail and the e-mail system of the practice (lines 13-16). Which are considered clarification and paraphrase.

Example 14

P = male, 26 years old, L1 = Spanish

1. A22: I – I- I send you a mail a testing mail [so]
2. P07: [I] have it another one but it's more or
3. less the same
4. A22: yeah more or less the same. Try to see to- to ehh to ehhm send me a a good

5. pictures when they are and I will prescribe you someth-
6. P07: you have sent me an email where?
7. A22: Bu- No what I've done I've sent you a message by email you email address is
8. X ?
9. P07: yes
10. A22: That's it. You have looked to I can see you have a a log in on the tenth of
11. March 21 so I think.
12. P07: Okay so it's to that [website]
13. A22: [You can-] we have contact so normally you should receive a
14. message from me that I have send you a save mail it's save mail so it's not
15. direct in your gmail you get in your gmail an -a message that I send you a mail
16. then you open up the NGN
17. P07: okay, okay okay it's is this that kind of website where the (doctor) thing is
18. here

In the current section, miscommunication seems to be caused by a variety of factors. There may be linguistic misalignment, for instance in Example 13, where the meaning of the word "when" is interpreted differently by the doctor compared to the patient. Next, there may be some general misinterpretation, such as in example 12 and 14. From the current data it is not clear whether all miscommunication stems from the fact that the communication is in ELF, however, it is more likely that misunderstanding occurs due to linguistic or cultural differences.

Furthermore, in all examples of miscommunication in this section, it seems that the miscommunication is repaired by using one or more of the pragmatic strategies as described

in Results section 5.3 and 5.4, namely other-repetition and confirmation and clarification. This further confirms the facilitative quality of these pragmatic strategies, as they may also serve as repair strategies in cases where mutual understanding seems to go astray.

6. Discussion

In the current study, intercultural communication in consultations at the GP office in the Netherlands has been investigated. More specifically, this thesis addresses how English as a Lingua franca is used in this context, and which communicative characteristics hinder or facilitate effective communication with ELF. To investigate this, ten consultations with non-Dutch speaking patients at a GP office in the Netherlands have been recorded and analyzed.

It appears from the current data that doctor patient consultations follow a specific structure where both doctor and patient have specific roles in the conversation. This confirms what has been described in previous academic and professional literature, namely that participation of the patient in the conversation differs depending on the consultation phase (Nash, 2014). In the information gathering stage, the doctor asks questions, and the patient explains their complaints. The patient needs to actively engage and participate in the conversation to adequately express their problems, but as they are answering questions, they do not have much control over the direction that the conversation will take. The doctor has the power to steer the conversation with the right questions, to gather the relevant information needed to set the diagnosis. In the final stage of the consultation, the doctor explains the diagnosis and treatment options to the patient. Here the patient has to engage as well, but in a different manner, they have to listen and indicate whether they understand the explanation by the doctor, for example by backchanneling. Furthermore,

patients have to engage to participate in shared decision-making. The doctor can also probe the shared decision-making by giving options and clarifying that the patient has a say in the treatment. With the exemplification of the structure of medical consultations in the data, the current study has confirmed the baseline characteristics of doctor-patient communication in ELF. In respect of structure, the consultations in ELF do not appear to differ from consultations where doctor and patient share a native language.

Next, pragmatic accommodation strategies such as code-switching and other-repetition have been found in the current data, which confirms research by Cogo (2009) who has attributed these accommodation strategies to enhanced ELF communication. Other accommodation strategies, described earlier for example by Kaur (2010), such as confirmation and clarification procedures also play a big role in the current data, and appear to facilitate communication as well. Clarification and confirmation procedures were used multiple times in the current data and appear to function to prevent or resolve misunderstanding.

That is to say, it appears that pragmatic strategies such as clarification and other-repetition can actually serve as a repair strategy when miscommunication or misunderstanding occurs. This is a new finding which underlines the importance of these pragmatic strategies in achieving mutual understanding in ELF communication.

The pragmatic strategies found to be facilitative to ELF communication in the current study, may also be useful to facilitate communication in general (i.e., between two native speakers). However, since in ELF there is more chance of miscommunication due to differences in cultural and linguistic background, it will be important to implore these pragmatic strategies consciously and frequently, to ensure communication is smoother and more efficient.

In terms of intercultural awareness and the interactive approach of the current thesis, one example of generalizing, perspectivising, and contrasting cultures was found in the current data (Ten Thije, 2020). The example seemed to occur in a more informal part of the conversation, there was a silence and the patient reflected on something specific about the Dutch medical system. Thus, although this type of reflection strategy appears not to be central to intercultural communication in a medical setting, they might serve as an important tool to compare and contrast healthcare systems in different countries, which may increase understanding about this topic for both doctor and patient during the medical consultation. Furthermore, for health care professionals, utilizing these three steps during the consultation can serve as a strategy to establish more common ground with their patients, by expressing their intercultural awareness.

The current thesis has looked at ELF communication in a specific setting and has done so purely by looking at language use in interaction. An important aspect of communication that is beyond the scope of this study is the appraisal of communication, that is to say, how the communication is evaluated by the interlocutors, and the attitudes towards such intercultural interactions. Therefore, a next step to understand the results of this thesis is to study how patients and doctors evaluate conversations and how these evaluations relate to the behaviors in interaction.

Furthermore, due to privacy and ethical considerations the consultations in the current study were only audio recorded. Therefore, it was not possible to analyze any non-verbal communication, even though this is an important feature of communication in general, but especially of intercultural communication and ELF communication. During transcription it also became clear that the interlocutors would sometimes point at things or show pictures (also shown in section 5.1). For example, when a patient came to the GP

office because they caught their hand in the door, it was audible that she walked to the door to physically show the doctor how it had happened. Furthermore, it was confirmed in an informal conversation with the healthcare professionals in this study, that they often use visual aids such as drawing or showing pictures on the computer screen to explain the diagnosis or treatment to the patient. Other non-verbal communication such as nodding, gaze or hand gestures may also be very important during medical consultations (Nash, 2014; Krystallidou, 2014), although there may also be cultural differences in the meaning of certain gestures. For example, in the US vertical nodding means 'yes' while in Bulgaria this means 'no' (Andonova & Taylor, 2012).

Conversation analytic research has shown that a holistic view of communication as embodied action is pertinent to meaning making in interaction (Goodwin & Goodwin, 2012). Further research into the non-verbal cues used during ELF communication will give more insight into cultural differences in multimodal interaction, and also into the workings of ELF communication in specific settings, for example in the doctor's office.

The current study gives insight into how doctor-patient communication in ELF can be improved, namely through the use of specific pragmatic strategies. It also appears from the data presented in this study, that miscommunication in ELF is not frequent, and can be resolved through the use of said pragmatic strategies. Although this thesis implores qualitative methods, the current corpus collected is relatively small, and it is therefore difficult to extrapolate the results of the current study to a larger general population. Therefore, I still argue that communication in ELF is not ideal for such a high-stake context as in health care. Some patients may find it difficult to fully express themselves or their symptoms in a second language, while doctors may find it difficult to explain certain concepts in full. Furthermore, the data also shows that there may be cultural differences in

how certain complaints are addressed; directly or indirectly, for example in the case of mental health issues.

Even though the current paper shows that mutual understanding can be signaled by both physician and patient, it also shows that mutual understanding is not always achieved. The current thesis seems to offer solutions for a problem that should not exist. As is already stressed in many studies (e.g. Schouten et al., 2020), the ideal situation for non-Dutch speaking patients in the Netherlands would be that professional interpreters can be used if necessary, so that any language and culture barrier can truly be bridged.

7. Conclusion

The present study has investigated how doctor-patient consultations in ELF take place. Since research on the characteristics of ELF in the medical practice is limited, the main aim of this study was to investigate the specific characteristics of ELF communication between doctor and patient, and which characteristics facilitate or hinder the communication outcomes.

From the data presented in this study, it can be concluded that in some respects ELF communication between doctor and patient is similar to the communication that can be expected during GP consultations where doctor and patient speak a shared native language. That is to say, the results show that the structure and the different phases of the consultations are similar to what is described in previous academic and professional literature (Kurtz, 2002; Dielissen, Van der Jagt & Timmerman, 2016).

Furthermore, the current data shows that pragmatic strategies described in previous literature on ELF communication, namely code-switching, other-repetition, confirmation and clarification, are facilitative to communication in the medical practice as well.

Additionally, in cases where communication was not optimal and some misunderstanding seemed to arise, these pragmatic strategies also seemed to serve as repair strategies for misunderstandings.

In terms of intercultural awareness, it appears that using the three-step strategy to communicate intercultural awareness (ten Thije, 2020), may be an effective tool to establish more common ground between physician and patient. However, only one example of the use of this strategy was found in the current data. This may be because it takes place during an informal part of the consultation but also because the collection of more data was beyond the scope of the study, as no previous research on ELF in this specific context has been conducted to date.

Still, the current study presents new findings which can contribute both to the body of research on ELF communication, as well as doctor-patient communication. It highlights the importance of the use of pragmatic strategies to facilitate understanding and repair misunderstanding in ELF communication, as well as the importance of expressing intercultural awareness to further establish common ground between doctor and patient, and as such, achieving mutual understanding.

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Appendix

Information letter

Two versions of the information letter and the informed consent form were used in this study. One letter was intended for the health care professionals that participated in this study and was written in Dutch. The other letter was the same, but in English as it was intended for the patient respondents. The letter and form presented below is the English version:

Information about participation in

Intercultural Communication at the GP Office

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1. Introduction

This letter is about participation in a scientific study on intercultural communication at the GP office. The study will be conducted at Stichting Gezondheidscentra Eindhoven International (SGE International). The manager of SGE International, in the person of Robert Hazenberg, has given his consent to conduct this study. The study has been reviewed and approved by the ethics committee of the Faculty of Humanities of Utrecht University. The main researchers of this project are dr. Rena Zendedel (main supervisor) and Prof. dr. Jan ten Thije (final responsibility), and the main contact person is Veerle Schoon. After reading this letter you will be asked to sign an informed consent form, to indicate you give your consent to participating in this study. If at any point you would like to withdraw your consent to participation, you can do so at any time, by indicating this to Veerle Schoon. You do not have to provide reasons for withdrawing your consent, and all your data will be deleted and destroyed (see also section 4 and 8 about collection of your data).

2. What is the background and purpose of the study?

This study is designed to analyse intercultural communication in a specific setting, namely the GP office. The purpose of the study is to investigate the use of English as a Lingua Franca and which circumstances, particularly in relation to language use, facilitate efficient communication in English in the GP office. The research is thus geared towards the linguistic and communicative aspects of the conversation, and not on the content. More knowledge about the course of conversations in English as a Lingua Franca is the first step to improve such communication in a medical setting.

3. How will the study be carried out?

The study will be carried out by analysing audio recordings of consultations in the doctor's office. The recordings will be made on a secured audio recorder. The recording will be started, and then the researcher will leave the room, to let the consultation proceed like it normally would. Furthermore, there will be a short form on which you indicate your age, gender and language background.

4. What is expected of you?

Even though your consultation at the office will be recorded, you are expected to carry out the consultation like you normally would, therefore the researcher will not be in the room while your consultation is in session. If at any point you feel uncomfortable or wish to stop the recording, you can do so by pressing the pause button on the recording device. The recording will be stopped and deleted directly after the consultation, once you indicate this to the researcher. If you want to withdraw your consent afterwards, you can indicate this immediately to the researcher who is present in the waiting room, and all your data will be deleted. Also, when you have second thoughts about us using your audio recording at a later point in time, you can contact the researcher to delete the recording. However, once the data has been analyzed and written up in a scientific article, these can no longer be deleted.

5. What are the possible advantages and disadvantages of participating in this study?

You will not benefit directly from participation in this study. However, the study may provide insights into how English is used in this specific context and can help to advance the field of intercultural communication in this domain. A potential disadvantage may be that you find the recording of your consultation uncomfortable, or you may feel self-conscious during the consultation because of being recorded.

6. Voluntary participation

Participation is voluntary. If you decide that you do not want to participate after all, no action is necessary on your part. You do not need to sign anything. In addition, you do not need to explain why you do not want to participate. If you decide to participate, however, you can always change your mind and stop at any time — including during the study. In addition, you can still withdraw your consent after you have taken part. If you choose to withdraw at any point, your research data will not be included in the analyses. However, as mentioned in section 4, once processed and written down in an article, they cannot be deleted from the analyses.

7. For what purpose will the data collected be used?

Your personal data (name or address) will not be collected in this study. Other privacy sensitive data (the audio recording) will be managed by the three researchers in this study,

Jan ten Thije, Rena Zendedel and Veerle Schoon. If you wish to have your data deleted, you can contact Veerle Schoon at v.m.schoon@students.uu.nl. Your data will be given a code that is only known to you and the researchers directly involved in this project (e.g. "respondent 1"). This code is stored in a file which also contains your age, gender and mother tongue. Please store this code carefully. If you contact us to have your data deleted, we need this code to delete the data that is linked to you personally, so please refer to this code when contacting.

The data collected in this study will be stored on a secure server of Utrecht University. After the completion of this study, this data will be archived and stored for 10 years. The file that stores the code together with your age, gender and mother tongue, will also be stored for 10 years. The only people that have access to this data are the three researchers directly involved in this project: Jan ten Thije, Rena Zendedel and Veerle Schoon. The researchers of this project reserve the right to reuse this data for further research on the communicative and linguistic aspects of the consultations, not the content.

8. Is any reimbursement provided for participation in the study?
Unfortunately, no funds are available to provide you with reimbursement for participation in this study.

9. Approval of this study
The Faculty Ethics assessment Committee - Humanities (FEtC-H) has approved this study. If you wish to submit a complaint about the procedure relating to this study, please contact the FEtC-H secretary, email: fetc-gw@uu.nl, or Utrecht University's privacy officer, email: privacy@uu.nl

10. More information about this study?
If you have any more questions about the study, before, during or after the data collection, please feel free to contact the researchers:

	Email:	Phone:
Veerle Schoon	v.m.schoon@students.uu.nl	+316 41084036
Rena Zendedel	r.zendedel@uu.nl	
Jan ten Thije	j.d.tenthije@uu.nl	+31 30 253 6337

11. Appendices:
A. Declaration of Consent

DECLARATION OF CONSENT for participation in:

Intercultural Communication at the GP Office

I confirm:

- that I have been satisfactorily informed about the study via the information letter;
- that I have been given the opportunity to ask questions about the study and that any questions I may have asked have been satisfactorily answered;
- that I have had the opportunity to carefully consider my participation in this study;
- that I am voluntarily participating.

I agree that:

- the data collected will be obtained for scientific purposes and retained as stated in the information letter;
- the collected research data may be reused by the researchers in this study, for follow-up research with the same research question;
- audio recordings will be made for scientific purposes.

I understand that:

- I have the right to withdraw my consent for the use of data, as stated in the information letter.

Participant code: _____

Signature: _____