STATEMENT OF RESEARCH
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Statement of Research

As a health communication scholar, my goal is to improve the quality of care for minority and marginalized populations by shaping the practices of health professionals and health organizations through theory-driven, field-based research. My research interests focus on interpersonal issues in health contexts, with an emphasis on cross-cultural care. I have been involved in research on bilingual/cross-cultural health care for over 15 years. Translational research is a central part of my program as I aim to apply my research findings to ensure the quality of care and well-being of language-discordant, minority, or marginalized patients.

I was tenured and promoted to Associate Professor in 2010. Since then, I have published one single-authored research monograph with Routledge, 12 journal articles[1], 6 book chapters[2], 11 encyclopedia entries, and 1 book review. I have published in many top journals in different fields, including *Journal of General Internal Medicine* (#1 in primary care[3]), *Patient Education & Counseling*[4], *Social Science & Medicine* (#2 in social science, general[1])*, Qualitative Health Research*, *Health Communication*, *Journal of Applied Communication Research,* and *Journal of Immigrant and Minority Health*. I am a member of the Stephenson Oklahoma Cancer Center and a research mentor at the Oklahoma Clinical and Translational Science Institute at the University of Oklahoma-Health Science Center. Since arriving at the University of Oklahoma, I have received over $230,000 in external funding as a PI, including an NIH R03 grant and a Fulbright scholarship.

My scholarship is well-recognized in diverse disciplines. In 2015-2016, I serve as the Chair of the health communication division of the National Communication Association (NCA), the largest professional organization in my field. Since 2010, I have received top paper awards in three NCA divisions, including health communication, language and social interaction, and the communication and aging division. In 2014, I was invited to speak at Clinical Ethics Grand Rounds at the University of North Carolina at Chapel Hill, one of the top medical schools in the US. I was the keynote speaker at the 2015 National Symposium on Healthcare Interpreting, hosted by St. Catherine University, the first and only education program in the US to focus on training American Sign Language interpreters to work in healthcare industries. I was invited as an on-site reviewer for the cross-cultural care curriculum of the College of Nursing at the Ohio State University. I was invited to contribute a top-level, major entry on healthcare interpreting for *Routledge Encyclopedia of Interpreting Studies*. I have been named as one of the most active scholars for interpreting studies since 2000 in the *Encyclopedia of Applied Linguistics*[5]. I have served as a reviewer for faculty tenure and promotion cases at the National University of Singapore (communication) and the University of New Mexico (linguistics). I have also served as a reviewer for R01/R21/R03 grants for the National Institutes of Health. I have been an Associate Editor for the *Journal of Immigrant and Minority Health* since 2010, reviewing about 150 manuscripts per year.

I currently pursue two lines of research dealing with health communication for non-English speaking and/or minority patients. My objectives with these two lines of research are (a) to develop

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[1] Among which 9 as the first author; 2 as the single author; and 1 with 4 or more authors.
[2] Among which, 5 as the first author; and 3 as the single author.
[3] According to Google Scholar Metrics
[4] Ranking 6th out of 95 journals in Social Sciences, interdisciplinary category (2014 ISI Journal Citations Report)
[5] Furmanek, O. (2012). Professionalization of Interpreters. In C. A. Chapelle (Ed.), The Encyclopedia of Applied Linguistics: Blackwell. doi: 10.1002/9781405198431.wbeal0959

theoretical frameworks that not only explain the phenomenon of interest but also guide best practices in healthcare settings, and (b) to expand the theoretical development of health communication theories by incorporating nonwestern perspectives. My theoretical approach and a list of selective publications for each area is listed in the appendix.

A. <u>Research Line 1: Interpreter-Mediated Medical Encounters and Cross-Cultural Care</u>

This is my most mature research line. With my research monograph (Routledge), I have synthesized the field of healthcare interpreting and proposed a systematic theoretical framework that is innovative and significant. In particular, I have proposed to situate interpreter-mediated medical encounters in the larger communicative event, provider-patient interaction, as we consider the various evaluative criteria for the quality and process of interpreter-mediated interactions in healthcare settings. The proposed theory will have important impacts on the training models for and the practices of interpreter-mediated medical encounters. I have focused on two areas: (a) contextual factors for interpreter-mediated encounters and (b) normative approaches to cross-cultural care. First, the most significant contribution I have made in the area of bilingual health care is the systematic examination of contextual factors that have been largely overlooked in the literature. In particular, by situating interpreters in provider-patient interactions and recognizing interpreter agency in healthcare delivery, I have examined how interpersonal trust, emotional work, authority, and clinical specialties may influence the process and content of interpreter-mediated medical encounters. Second, I have worked to provide innovative approaches to reconsider interpreter-mediated interactions and cross-cultural care. I explore how interpreters and providers may hold different normative rules and expectations, resulting in challenges to provider-interpreter collaboration. This area of research allows me to situate my research not only in the field and traditions of interpreting studies, but also in the fields of health communication (provider-patient communication, in particular) and clinical care generally.

B. <u>Research Line 2: Social Support and Health Literacy in Cultural Contexts</u>

By recognizing illness management as a coordinated activity between the patient and his/her supportive others, I am interested in how social support can be coordinated in such a way that promotes individuals' health literacy. Although health literacy traditionally has been viewed as a fixed, internalized, individual skill, I view health literacy as an interactive, coordinated accomplishment of all parties involved in the illness event. This is because in my research of bilingual health care, I have demonstrated that interpreters' and family members' coordination with patients in the management of illness events (e.g., participation in provider-patient interactions) can enhance or compromise a patient's health literacy. My work centers on two areas: (a) patient empowerment and (b) nonwestern cultures. First, my work on bilingual health communication has merged into the larger literature on health disparities and patient empowerment. Following the traditions of social activism in health research, I explore different approaches to patient empowerment in both research design and health delivery. Second, by examining marginalized populations in the US and in other international locations (e.g., Japan and Indonesia), my advisees and I explore culture-specific understandings of health and illness that shape individuals' illness management. We examine how marginalized populations in nonwestern countries manage their health and illnesses. By incorporating the traditions of medical sociology, we focus on communicative practices of nonwestern patients as they manage and negotiate their illness experiences within their social networks. The goals for this area of research is to expand existing theories in health communication, which are often developed in the West.

C. Future Research Directions

My two research lines complement each other as I examine individuals' coordination in an illness event to achieve optimal outcomes. The grants I have received reflect my theoretical interests and future research directions. More specifically, for research line 1, I aim to incorporate patients' perspectives into my model of bilingual health communication, explore interpreters' roles in patients' management of illness events, and develop a comprehensive model of communication for all parties involved in bilingual health care. In addition, I hope to expand my model to include informal interpreters in healthcare settings, such as family interpreters and volunteer interpreters. In addition to further develop my theoretical model, I am also collaborating with scholars from different universities to (a) explore healthcare interpreting in specific clinical contexts (e.g., mental health), and (b) consolidate literatures in spoken language interpreting and signed language interpreting.

For research line 2, I have collected data from a longitudinal study, including tracked video-recorded medical encounters and a series of interviews, of how individuals coordinate with their supportive others to manage their cancer diagnoses in the US. Funded by Fulbright, I will spend Fall 2015 in Taiwan gathering data about how foreign immigrants from Southeast Asia in Taiwan manage their illness events in everyday life. In the next few years, I will continue to collaborate with my advisees to collect data in nonwestern countries to develop my theoretical model of coping. The model of coping situates a patient's changes in and management of health literacy and social support during the progression of an illness event. By examining the variables that influence individuals' health literacy, their interrelationships, and causal pathways, I aim to generate a theoretical model of coping that incorporates the complexity of culture in illness management.

D. Teaching as Applied Research

One of the areas that has evolved significantly is my teaching. Increasingly, I view teaching as a critical component of my applied research. In 2012, I was invited to translate my work and theoretical model into a 3-credit hour graduate seminar for a MA program on healthcare interpreting at York University, Toronto, Canada. Because many of the students are also working healthcare interpreters, their feedback has been essential in examining the validity and practicality of my theory and training model.

In the last few years, I have asked undergraduate students to organize community-based, field-implemented, and theory-driven health campaigns, some of which were supported by funding that I have secured from various sources. Some of the campaigns include oral health in local elementary schools, hearing health in daycare centers, active lifestyles in elderly homes, healthy diets for OU students, and various interventions for homeless people in Norman, Oklahoma. Many of the students have become long-term volunteers at the sites where they offered interventions. Some have even created long-term structural changes in local NGOs to help those organizations create new revenue streams and maintain resources for the people they serve. The University of Oklahoma Press is currently reviewing an edited volume on homelessness that is derived from the student-lead, community based campaigns in my undergraduate classes. The edited volume includes essays from homeless people and undergraduate students as well as individual interviews between undergraduate students and homeless persons about the experience of being homelessness (all approved by IRB). This is one of the most gratifying and exciting projects I have done in recent years.

Appendix: Theoretical Approach and Selective Publications for Each Research Area

A. Research Line 1: Interpreter-Mediated Medical Encounters and Cross-Cultural Care

Within this line of research I have evolved significantly in my theoretical focus and provided important contributions to the field of bilingual health care that have advanced both its theoretical scopes and clinical practices. In particular, I have focused on the following areas for interpreter-mediated medical encounters.

A.1. *Area 1: Contextual Factors for Interpreter-Mediated Medical Encounters*

The most significant contribution I have to the field of healthcare interpreting is the systematic examination of contextual factors that have been largely overlooked in the literature. Echoing research from scholars (e.g., Angelelli, 2010; Green, Free, Bhavnani, & Newman, 2005; Leanza, Boivin, & Rosenberg, 2010; Rosenberg, Seller, & Leanza, 2008) who have argued that different types of interpreters may have different strengths depending on the contexts and tasks involved, I have examined how specific contextual factors may influence the process and content of interpreter-mediated medical encounters.

In particular, by situating interpreters in provider-patient interactions and recognizing interpreter agency in healthcare delivery, I have examined interpersonal trust, emotional work, authority, and clinical specialties may influence the process and content of interpreter-mediated medical encounters. My representative publications in this area include:

Hsieh, & Nicodemus, B. (in press). Conceptualizing emotion in healthcare interpreting: A normative approach to interpreters' emotion work. *Patient Education and Counseling*.

Objectives: By juxtaposing literature in signed language interpreting with that of spoken language interpreting, we provide a narrative review to explore the complexity of emotion management in interpreter-mediated medical encounters. *Methods*: We conduct literature search through library databases and Google Scholar using varied combinations of search terms, including interpreter, emotion, culture, and health care. *Results*: We first examine (a) interpreters' management and performance of others' emotions, (b) interpreters' management and performance of their own emotions, and (c) impacts of emotion work for healthcare interpreters. Conclusion: By problematizing the roles and functions of emotion and emotion work in interpreter-mediated medical encounters, we propose a normative model to guide future research and practices of interpreters' emotion management in cross-cultural care. *Practice Implications*: Quality and equality of care should serve as the guiding principle for interpreters' decision-making about their emotions and emotion work. Rather than adopting a predetermined practice, interpreters should evaluate and prioritize the various clinical, interpersonal, and therapeutic objectives as they consider the best practice in managing their own and other speakers' emotions.

Hsieh, E., Pitaloka, D., Johnson, A. J. (2013). Bilingual health communication: Distinctive needs of providers from five specialties. *Health Communication, 28*, 557-567.

Understanding providers' expectations and needs for medical interpreters can provide important insight into the dynamics and process of interpreter-mediated medical encounters. This is one of the first mixed-methods studies on the similarities and differences of providers' views of interpreters across five specialties (i.e., obstetrics/gynecology, emergency medicine, oncology, mental health, and nursing). The two-stage studies include interview data with 39 providers and survey data with 293 providers. We used principal component analysis to identify three components in the survey data that represent providers' views of interpreters: Patient Ally, Health Care Professionals, and Provider Proxy. We then used the interview data as exemplars to illuminate

the quantitative findings. Patient Ally was the only component that reached significant differences between different specialties. Providers from different specialty areas differ significantly in their expectations on interpreters' ability (a) to assist patients outside of medical encounters and (b) to advocate for the patient. In particular, nursing professionals place more importance on these two abilities than mental health providers and oncologists. Based on our findings, we proposed three research directions necessary to advance the field of bilingual health communication: to reevaluate and reconceptualize interpreters' appropriate performances with special attention to the Patient Ally dimension, to examine the commonly held attitudes for all providers and the potential tensions within these attitudes, and to identify contextual factors that influence participants' perceptions, evaluations, and choices of interpreters and their corresponding impacts.

Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research, 20***, 170-181.**

In this study we examined the challenges to providers' and interpreters' collaboration in bilingual health care. We conducted in-depth interviews and focus groups with 26 medical interpreters (speaking 17 languages) and 32 providers (from four specialties) in the United States to provide an empirically based framework of provider—interpreter trust. Constant comparative analysis was used for data analysis. We identified four dimensions of trust, theoretical constructs that can strengthen or compromise provider—interpreter trust: interpreter competence, shared goals, professional boundaries, and established patterns of collaboration. In this article we describe how these dimensions highlight tensions and challenges that are unique in provider—interpreter relationships. We conclude with practical guidelines that can enhance provider—interpreter trust, and propose future research directions in bilingual health care.

Hsieh, E., & Hong, S. J. (2010). Not all are desired: Providers' views on interpreters' emotional support for patients. *Patient Education and Counseling, 81***, 192-197.**

Objective: This study examines (a) providers' expectations and concerns for interpreters' emotional support, and (b) the complexity and dilemma for interpreters to offer emotional support in health care settings. Methods: We recruited 39 providers from 5 specialties to participate in in-depth interviews or focus groups. Grounded theory was used for data analysis to identify providers' expectations and concerns for interpreters' emotional support. Results: From the providers' perspective, interpreters' emotional support: (a) is embodied through their physical presence, (b) is to be both a human being but also a professional, (c) represents the extension of the providers' care, and (d) imposes potential risks to quality of care. Conclusion: Emotional support in bilingual health care is accomplished through the alliance of providers and interpreters, complementing each other to support patients' emotional needs. Practice implication: Interpreters should be vigilant about how their emotional support may impact the provider-patient relationship and the providers' therapeutic objectives. Interpreters should be aware that providers also rely on them to provide emotional support, which highlights the importance of giving medical talk and rapport-building talk equal attention in medical encounters.

A.2. *Area 2: Normative Approach to Cross-Cultural Care*

I have worked to provide innovative approaches to reconsider interpreter-mediated interactions and cross-cultural care. In particular, by examining providers' perspectives when working with interpreters, I have highlighted potential problems of behavioral norms in provider-interpreter collaborations and proposed meaningful solutions to address normative expectations in cross-cultural care. My research in this area echoes with many physician researchers' (e.g., Diamond, Luft, Chung, & Jacobs, 2012; Jacobs, Diamond, & Stevak, 2010) work by recognizing the complexity and practical limitations of clinical care. I explore how interpreters and providers may hold different normative rules and expectations, resulting in challenges to provider-interpreter collaboration. This area of research

allows me to situate my research not only in the field and traditions of interpreting studies, but also in the fields of health communication (provider-patient communication, in particular) and clinical care.

My representative publications in this area include:

Hsieh, E. (2015). Not just "getting by": Factors influencing providers' choice of interpreters. *Journal of General Internal Medicine*, **30, 75-82.**

Background: Providers consistently underutilize professional interpreters in healthcare settings even when they perceive benefits to using professional interpreters and when professional interpreters are readily available. Little is known about providers' decision-making processes that shape their use of interpreters. Objective: To understand the variety of considerations and parameters that influence providers' decisions regarding interpreters. *Design*: A qualitative, semi-structured interview guide was used to explore providers' decision making about interpreter use. The author conducted 8 specialty-specific focus groups and 14 individual interviews, each lasting 60–90 minutes. Participants: Thirty-nine healthcare professionals were recruited from five specialties (i.e., nursing, mental health, emergency medicine, oncology, and obstetrics-gynecology) in a large academic medical center characterized as having "excellent" interpreter services. Approach: Audio-recorded interviews and focus groups were transcribed and analyzed using grounded theory to develop a theoretical framework for providers' decision-making processes. *Key Results*: Four factors influence providers' choice of interpreters: (a) time constraints, (b) alliances of care, (c) therapeutic objectives, and (d) organizational-level considerations. The findings highlight (a) providers' calculated use of interpreters and interpreting modalities, (b) the complexity of the functions and impacts of time in providers' decision-making process, and (c) the importance of organizational structures and support for appropriate and effective interpreter utilization. *Conclusions*: Providers actively engage in calculated use of professional interpreters, employing specific factors in their decision-making processes. Providers' understanding of time is complex and multidimensional, including concerns about disruptions to their schedules, overburdening others' workloads, and clinical urgency of patient condition, among others. When providers make specific choices due to time pressure, they are influenced by interpersonal, organizational, therapeutic, and ethical considerations. Organizational resources and guidelines need to be consistent with institutional policies and professional norms; otherwise, providers risk making flawed assessments about the effective and appropriate use of interpreters in bilingual health care.

Hsieh, E., & Kramer, E. M. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling, 89*, **158-162.**

Objective: This study explores the tensions, challenges, and dangers when a utilitarian view of interpreter is constructed, imposed, and/or reinforced in health care settings. *Methods*: We conducted in-depth interviews and focus groups with 26 medical interpreters from 17 different languages and cultures and 39 providers of five specialties. Grounded theory was used for data analysis. *Results*: The utilitarian view to interpreters' roles and functions influences providers in the following areas: (a) hierarchical structure and unidirectional communication, (b) the interpreter seen as information gatekeeper, (c) the interpreter seen as provider proxy, and (d) interpreter's emotional support perceived as tools. *Conclusion*: When interpreters are viewed as passive instruments, a utilitarian approach may compromise the quality of care by silencing patients' and interpreters' voice, objectifying interpreters' emotional work, and exploiting patients' needs. *Practice implications*: Providers need to recognize that a utilitarian approach to the interpreter's role and functions may create interpersonal and ethical dilemmas that compromise the quality of care. By viewing interpreters as smart technology (rather than passive instruments), both providers and interpreters can learn from and co-evolve with each other, allowing them to maintain control over their expertise and to work as collaborators in providing quality care.

Hsieh, E. (2010). Provider-interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions. *Patient Education and Counseling, 78*, 154-159.

Objective: This study examines (a) providers' and interpreters' perception of their competition in controlling the content and process of provider-patient interactions, and (b) the challenges to providers' and interpreters' collaboration in bilingual health care. *Methods*: I recruited 26 professional medical interpreters from 17 languages and 39 providers from 5 specialties to participate in in-depth interviews and focus groups. Grounded theory was used for data analysis to develop themes in areas where providers and interpreters compete and assert their expertise. *Results*: Providers and interpreters experience conflicts over their expertise and authority due to their practice in (a) adopting different speech conventions, (b) controlling the other's narratives, and (c) overstepping expertise and role boundaries. *Conclusion*: A successful bilingual medical encounter is dependent on the interpreters' and providers' ability (a) to understand, communicate, and negotiate their and others' communicative strategies/goals and (b) be adaptive of and responsive to others' management of the communicative process. *Practice implications*: Authority in bilingual health care should not be established through pre-existing categories or expertise but negotiated and coordinated during the interactive process, which would allow individuals to be adaptive to the issues emerged in the communicative process.

B. <u>Research Line 2: Social Support and Health Literacy</u>

  My second line of research is influenced by Brashers' and Goldsmith's work on uncertainty management and social support (Brashers, 2001; Brashers, Neidig, & Goldsmith, 2004; Goldsmith, 2000, 2004). Research Line 2 is also influenced by the theoretical traditions of Language and Social Interaction (e.g., Beach, 2009; Robinson et al., 2008; Street, Cox, Kallen, & Suarez-Almazor, 2012), viewing illness management as a socially constructed activity that requires effective and appropriate coordination between various individuals through communicative activities. In addition, I am interested in how culture influences individuals' understanding, interpretation, performance, and negotiation of supportive behaviors.

  By recognizing illness management as a coordinated activity between the patient and his/her supportive others, I am interested in how social support can be coordinated in such a way that promotes individuals' health literacy (i.e., the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions). I view health literacy as an interactive, coordinated accomplishment of all parties involved in the illness event. This is because in my research of bilingual health care, I realized the interpreters' and family members' coordination with the patient in the management of an illness event (e.g., participation in provider-patient interactions) may enhance or compromise a patients' health literacy.

  Research lines 1 and 2 both share my view of examining communication as a coordinated activity between all individuals involved. In addition, my research in bilingual health care allows me to explore how culture may influence individuals' coordination of social support and health literacy in an illness event.

B.1. *Area 1: Patient Empowerment and Applied Communication Research*

  This is an area that my work in bilingual health communication has merged into the larger literature on health disparities and patient empowerment. Following the traditions of social activism in health research (e.g., Brashers, Haas, Neidig, & Rintamaki, 2002; Dutta, 2010), I explore different approaches to patient empowerment in both research design and health delivery.

  My representative publications in this area include:

Hsieh, E., Bruscella, J. S., Zanin, A., Kramer, E. M. (in press). "It's not like you need to live 10 or 20 years": Challenges to patient-centered care in gynecologic oncologist-patient interactions. *Qualitative Health Research*.

The literature suggests that the patient-perspective approach (i.e., eliciting and responding to patients' perspectives, including beliefs, preferences, values, and attitudes) to patient-centered care (PCC) is not a reliable predictor of positive outcomes; however, little is known about why the patient-perspective approach does not necessarily lead to positive outcomes. By using discourse analysis to examine 44 segments of oncologist–patient interactions, we found that providers' use of patient-perspective contextualization can affect the quality of care through (a) constructing the meanings of patient conditions, (b) controlling interpreting frames for patient conditions, and (c) manipulating patient preferences through strategic information sharing. We concluded that providers' use of patient-perspective contextualization is an insufficient indicator of PCC because these discursive strategies can be used to control and manipulate patient preferences and perspectives. At times, providers' patient-perspective contextualization can silence patients' voice and appear discriminatory.

Hsieh, E. (2013). Health literacy and patient empowerment: The role of medical interpreters in bilingual health care. In M. J. Dutta & G. L. Kreps (Eds.), *Reducing health disparities: Communication intervention* **(pp. 41-66). New York: Peter Lang.**

Individuals with Limited-English-Proficiency (LEP) experience language barriers in health care settings, which negatively affect their access to and quality of health care. There is an urgent need to develop effective interventions to improve the quality of health care services received by individuals with LEP, one of which is to provide interpreters in health care settings. Using excerpts of interpreter-mediated medical encounters and interviews with interpreters and providers, I investigate how interpreters' specific strategies (i.e., making inexplicit information explicit and providing means of self-efficacy) may influence patient health literacy and patient empowerment. Interpreters' active involvement is essential in securing patient autonomy. By anticipating patients' communicative needs, they provide the necessary conditions (e.g., health literacy) that enable patients to make autonomous decisions. Their interventions not only facilitate the immediate provider-patient interactions but can also have long-lasting impacts on providers' and patients' communicative competence.

Hsieh, E. & Terui, S. (in press). Inherent tensions and challenges of provider-patient communication: Implications for interpreter training in health care settings. *Journal of Applied Communication Research.*

By examining actual medical encounters, we identify specific communicative characteristics inherent in gynecologic oncologist-patient interactions in the US that may lead to challenges and barriers to successful bilingual health care. By using monolingual medical encounters, we aim to address the research design challenges in the field of bilingual health care and to generate new approaches to the research and training of healthcare interpreting. In total, 44 segments (553.25 minutes) of the first medical visits to a gynecologic oncology clinic were included in the study. Using discourse analysis and a grounded hermeneutic approach, we found that oncologist-patient communication poses challenges for interpreters' management of medical encounters in the following ways: (a) speakers' inconsistent, ambiguous talk, (b) incompatible sociolinguistic norms, and (c) providers' multilayered identity performances. Our findings highlight the importance of educating interpreters to be not only responsive but also proactive in managing the various intended and unintended meanings emerged in the discursive process.

B.2. *Area 2: Nonwestern Cultures and Health Communication*

Although the literature of health communication has grown tremendously in the last three decades, it has been dominated by the Western perspectives. As researchers and practitioners acknowledge the complex interrelationships between culture and health, little is known about the roles

and processes of non-western cultures in shaping one's experiences of health and illnesses. Culture is often treated as a caveat rather than a central component in theoretical models.

This is an area that I have collaborated heavily with my advisees, many of whom are international students. By examining minority populations in the US and in other international locations (e.g., Japan and Indonesia), we explored culture-specific understandings of health and illness that shape individuals' illness management. We are also interested how marginalized populations (e.g., patients with language barriers or low socioeconomic status) in nonwestern countries manages their health and illnesses. By incorporating the traditions of medical sociology, we focus on communicative practices of nonwestern patients as they manage and negotiate their illness experiences within their social network. The goals for this area of research is to expand existing theories in health communication, which are often developed the West.

Pitaloka, D. & Hsieh, E. (in press). Health as submission and social responsibilities: Embodied experiences of Javanese women with type II diabetes. *Qualitative Health Research.*

By examining women's experiences with type II diabetes, we explore how illness can provide resources to construct meanings of everyday life in Javanese culture. We conducted in-depth interviews with 30 female participants in Central Java, Indonesia, and adopted grounded theory for data analysis. We identified four themes that diabetes serves as resources for women in Indonesia to (a) normalize suffering, (b) resist social control, (c) accept fate, and (d) validate faith. We concluded by noting three unique aspects of Javanese women's illness management. First, through the performance of submission, our participants demonstrated spirituality and religiosity as essential elements of health. Second, diabetes empowers individuals in everyday suffering through two divergent processes: embracing submission and resisting control. Finally, diabetes provides opportunities for individuals within a social network to (re)negotiate social responsibilities. In summary, diabetes provides unique resources to empower our participants to obtain voices that they otherwise would not have had.

Kong, H., & Hsieh, E. (2012). The social meanings of traditional Chinese medicine: Elderly Chinese immigrants' health practice in the United States. Journal of Immigrant and Minority Health, 14, 841-849.

We situate elderly Chinese immigrants' utilization of traditional Chinese medicine (TCM) in social contexts (e.g., family and social networks), exploring how TCM is used as a tool, a resource, and a product of meaning-construction in their everyday life. We conducted in in-depth interviews with 20 elderly Chinese immigrants in the United State, exploring the complexity of their understanding and practice of TCM. We used grounded theory to identify the set of meanings that are particular to elderly Chinese immigrants' use of TCM as a part of their health practice. For our participants, TCM is not just a resource for illness management. Instead, incorporating TCM in their health practice allows them to: (a) perform and reaffirm their cultural identity as Chinese, (b) maintain their moral status and fulfill their social roles, and (c) pass down health knowledge and cultural heritage. Clinical implications were discussed.

C. Grant Activities

During 2010-2015, I have received two major external funding. Although I have applied for federal funding and obtained favorable rating as a PI and Consultant, none was eventually funded.

Core Fulbright U.S. Scholar, Arts, Education, Humanities, Professional Fields and Social Sciences--Research (Award #5130), Taiwan. Period: 07/01/2015-01/31/2016

The mix-method project is part of my larger, international research program that aims to examine the barriers and facilitators to quality care for language discordant patients (i.e., patients who do not share the same language with their healthcare providers). Based on my previous NIH funded work, I am convinced that to further advance the theories and quality of care for language discordant patients, it is important to examine how specific contextual variables may shape the content and process of interpreter-mediated medical encounters. In particular, the unique demographic, sociopolitical, and sociocultural contexts of language discordant patients in Taiwan (e.g., large number of foreign residents from Southeast Asia) can provide significant insights into (a) health disparities experienced by these marginalized patients, and (b) meaningful interventions to improve the quality of care for these patients. The specific aims of the project include:

- Examining the characteristics and practice of healthcare interpreting in Taiwan
- Identifying the unique contextual variables that influence providers, patients, and interpreters' attitudes, and practices of healthcare interpreting in Taiwan
- Exploring similarities and differences in providers, patients, and interpreters' attitudes, and practices of healthcare interpreting.
- Generating long-term collaborations with researchers, healthcare practitioners, and local NGOs in Taiwan

Medical Interpreters and Patient Communicative Competence in Gynecologic Oncology. Sponsored by University of Oklahoma-Health Sciences Center/Oklahoma Tobacco Settlement Endowment Trust. Role: Principal Investigator. Period: 01/01/2012-06/30/2012. $60,335.

This longitudinal study represents a pioneering work by examining health literacy in temporal and interpersonal contexts. We define communicative competence as the collaborative and evolving ability to acquire and use health information to achieve optimal health outcomes, which is a form of enacted health literacy. Communicative competence: (a) can empower participants to address their priorities and concerns, (b) is established through individuals' communication, negotiation, and execution of their needs and goals, and (c) is evolving and situated in individuals' illness experiences. The specific aim of the study is to identify changes in communicative competence over the course of an illness event. We are particularly interested in how communicative competence may evolve (a) during the emergent, dynamic interactions within a single medical encounter (e.g., sequential development of a medical discourse), and (b) over time across multiple medical encounters (e.g., changes of communicative strategies across multiple medical encounters). In addition, we are interested to examine providers' and interpreters' role in influencing the changes of patients' communicative competence. Our study can provide insights into how communicative competence is not an individual property but rather an emergent characteristic of certain kinds of interaction, an area identified as critical in advancing current research.

The study includes both qualitative and quantitative research designs and incorporates a variety of data. The study represents a pioneering work by juxtaposing actual practice with the participants' perceptions and evaluation of the quality of provider-patient communication (e.g., interviews). We will track 40 patients (i.e., 20-Spanish-speaking and 20 English-speaking patients) over a 6-month period, collecting a total of 160 video-recorded medical encounters. The total number of the medical encounters of the proposed study (n=160) is comparable to (in fact, slightly more than) other studies with similar research design for monolingual medical encounters. We also conducted interviews with providers and patients. The longitudinal design also provides insight into how providers, patients, and interpreters can develop effective strategies to coordinate care over time. The quantity and quality of the data is unprecedented in research on bilingual health care.

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