INTERPRETAZIONE di TRATTATIVA INGLESE – ITALIANO 2018-2019

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CALENDARIO A.A. 2018-2019

DATA	ORE	ARGOMENTO	DOSSIER/GLOSSARIO	DEADLINE GLOSSARIO	ASSIGNMENT (DISPENSA)
17/10/2018	2	Introduzione			Mason 1999; Mason 2009
19/10/2018	4	By-pass coronarico	-		Pathology notes
24/10/2018	6	Presentazione Gruppo 1	Gruppo 1		Roberts 1995; Mesa 1999 (per PRESENTAZIONE GRUPPO 1)
26/10/2018	8	Bronchite	Gruppo 1	23/10/2018	Pathology notes
31/10/2018	10	Presentazione Gruppo 2	Gruppo 2		Wadensjo 1995; Pochhacker 1999 (per PRESENTAZIONE GRUPPO 2)
02/11/2018		***SOSPENSIONE***			
07/11/2018	12	Calcoli renali	Gruppo 2	04/11/2018	Pathology notes
09/11/2018	14	Presentazione Gruppo 3	Gruppo 3		Wadensjo 1993; Hlavac 2010 (per PRESENTAZIONE GRUPPO 3)
14/11/2018	16	Parto podalico	Gruppo 3	11/11/2018	Pathology notes
16/11/2018	18	Presentazione Gruppo 4	Gruppo 4		Meyer 2002; Metzger 1999 (per PRESENTAZIONE GRUPPO 4)
21/11/2018	20	Morbo di Crohn	Gruppo 4	18/11/2018	Pathology notes
23/11/2018	22	Presentazione Gruppo 5	Gruppo 5		Merlini 2009; Garrett 2009 (per PRESENTAZIONE GRUPPO 5)
28/11/2018	24	Cancro del colon	Gruppo 5	25/11/2018	Pathology notes
30/11/2018	26	Presentazione Gruppo 6	Gruppo 6		Pochhacker & Kadric 1999; Cambridge 1999 (per PRESENTAZIONE GRUPPO 6)

05/12/2018	28	Appendicite	Gruppo 6	29/12/2018	Pathology notes
07/12/2018	30	Ripasso e simulazione esame	-		

PROGRAMMA DEL CORSO

- **CONTENUTI**

Il corso è incentrato sull'interpretazione dialogica come attività di traduzione del discorso orale, che verrà presentata agli studenti nella sua complessità linguistica, interculturale, sociale e deontologica, privilegiando un approccio spiccatamente pratico.

Le attività previste comprenderanno:

- esercitazioni di memorizzazione di brevi frammenti dialogici,
- traduzione a vista,
- esercizi di ascolto, sintesi e riformulazione,
- simulazione di situazioni di interpretazione dialogica in ambito socio-sanitario
- riflessione attiva e discussione in classe dei principali nodi teorici che costituiscono la letteratura in materia di interpretazione dialogica.

- **OBIETTIVI**

Il corso mira a formare e/o consolidare le capacità di ascolto, sintesi e presentazione degli studenti, stimolare la loro riflessione critica circa le responsabilità e attività che compongono i compiti dell'interprete dialogico, nonché perfezionare la produzione linguistica in italiano e in inglese.

- **TESTI/BIBLIOGRAFIA**

Agli studenti verrà fornita una dispensa con una selezione di articoli e materiali di preparazioni per le simulazioni e l'esame finale.

Testi e articoli consigliati:

FALBO, C, **RUSSO**, M. & **STRANIERO SERGIO**, F. (1999) *Interpretazione simultanea e consecutiva. Problemi teorici e metodologie didattiche* Hoepli
BERSANI BERSELLI, G., **MACK**, G. & **ZORZI**, D. (a cura di) (2004), *Linguistica e interpretazione*. CLUEB: Bologna. 169-188.
GAVIOLI, L. (a cura di) (2009) *La mediazione linguistico-culturale: Una prospettiva interazionista*. Perugia: Guerra Edizioni.
WADENSJÖ, C. (1998) *Interpreting as interaction*. London/New York: Longman.

- **VALUTAZIONE**

L'esame consisterà nella simulazione di un'interazione dialogica EN<>IT vertente su uno degli argomenti affrontati durante l'anno, nonché un breve colloquio orale in lingua inglese su due argomenti a scelta di teoria dell'interpretazione trattati in classe.

GLI STUDENTI **NON FREQUENTANTI** NON POTRANNO SCEGLIERE GLI ARGOMENTI DI TEORIA E DOVRANNO PREPARARSI SULL'INTERO PROGRAMMA DELLA DISPENSA.

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The Translator
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rtrn20

Introduction

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Published online: 21 Feb 2014.

To cite this article: Ian Mason (1999) Introduction, The Translator, 5:2, 147-160, DOI: 10.1080/13556509.1999.10799038

To link to this article: http://dx.doi.org/10.1080/13556509.1999.10799038

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The Translator. Volume 5, Number 2 (1999), 147-160 ISBN 1-900650-21-5

Introduction

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It is now more than twenty years since Ranier Lang (Lang 1978) observed the work of an interpreter in a Papua-New Guinea courtroom and published findings which effectively constituted the beginnings of empirical research into the work of the dialogue interpreter. At the same time, Brian Harris (Harris 1978) was drawing our attention to evidence of the behaviour of 'natural' interpreters, bilinguals with no training as interpreters, who were – and still are – frequently called upon to act as interpreters in a variety of professional contexts. What they observed were phenomena not generally found, or considered as applying to, the work of conference interpreters, hitherto the only object of research interest in interpreting studies. Role conflict, in-group loyalties, participation status, relevance, negotiation of face – all of these being issues which are now recognized objects of enquiry – were implicitly or explicitly present in these early studies. We now know far more about these and other issues, thanks to the work of a small but increasingly important body of research carried out over the years since then. What are these studies? What insights into the work of the interpreter do they afford us? And what is the current state of our knowledge and understanding of the phenomenon investigated in this volume?

In order to set the scene for the studies brought together here, we need to define our terms, especially those used in the title of this special issue of *The Translator*. We then need to sum up the 'state of the art', the stage we have reached in investigating dialogue interpreting and how the studies in this volume add to our understanding of the process. This in turn leads us to consider new directions in dialogue interpreting research, the as-yet-uncharted areas which are bound to receive attention in years to come, in what is a burgeoning field of research.

1. Defining the field

For the purposes of this issue, dialogue interpreting includes what is variously referred to in English as Community, Public Service, Liaison, Ad Hoc or Bilateral Interpreting – the defining characteristic being interpreter-mediated communication in spontaneous face-to-face interaction. Included under this heading are all kinds of professional encounters: police, immigration and welfare services interviews, doctor-patient interviews, business negotiations, lawyer-client and courtroom interpreting, and so on. Dialogue interpreting is

ISSN 1355-6509 *© St Jerome Publishing, Manchester*

thus to be distinguished from Conference Interpreting (both simultaneous and consecutive), which is typically monologic and does not involve face-to-face interaction (although dialogue encounters do take place on the fringe of conference activity). It should be noted that our definition includes the simultaneous mode, when used in face-to-face encounters (see, for example, Riddick 1998)[1] but, strictly speaking, excludes telephone interpreting. The latter however is an instance of dialogue and shares so many characteristics with the forms of interpreting considered in this volume that an investigation of the difference in communicative outcomes between telephone and face-to-face interaction (Wadensjö, this volume) is of particular interest. By the same token, signed-language interpreting (Brennan, this volume) is not strictly conducted face-to-face – or rather, the face-to-face relationship is between producer and receiver of signs instead of between the 'principal' participants or interlocutors. But all parties are present and active in the exchange so that this mode falls within the general interpersonal category we are considering.

Of course, one can cut up the interpreting cake in many different ways, and equally valid in its own right is the situational distinction, often made, between conference and community interpreting. For example, in terms of power and distance – two variables of prime importance in the investigation of interpreting, whereas conference interpreting often, or even typically, involves equal-to-equal relations, in community encounters there is almost always a power differential, which in itself places a range of additional constraints on the interpreter. Likewise, the stressful and sensitive situations in which community encounters take place are less familiar to the conference interpreter. But whereas situational descriptions can account for a number of important factors, it is the interpersonal dimension which, we submit, is the prime determiner of the range of concerns which dialogue interpreters experience in their day-to-day work. A glance at the issues listed below, as they emerge from studies carried out over the last two decades, shows quite conclusively the centrality of face-to-face dialogue in the interpreters' dilemmas, role-adopting and decision-making processes.

Within these boundaries, a wide range of user variables may be involved. As already observed, the **mode** may be consecutive or (less frequently) simultaneous. Where simultaneous mode is involved, it may be conducted by *chuchotage* (typical of some courtroom interaction), signing (signed-language interpreting) or via headsets and microphones. **Fields** include all those mentioned above, most research hitherto focusing on either courtroom interaction (e.g. Berk-Seligson 1990, Hale 1997, Morris 1989, 1995) or police and immigration interviews (Wadensjö 1992, 1998). Medical consultations are also the subject of a number of studies (e.g. Englund-Dimitrova 1997) and are prominent in this volume. It is, of course, the particularly sensitive and face-threatening nature of much of this interaction which sets these fields apart from other, less investigated fields such as business meetings or diplomatic

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negotiations, an issue we shall return to below. But tensions arise in these encounters too and the interpreter may feel herself to be under just as much pressure. In general, wherever a particular outcome is of vital importance to one or both parties, pressures on the interpreter increase and go well beyond those experienced in routine conference simultaneous work. Finally, addresser/addressee relationships (**tenor**) may vary and deserve much greater attention than merely recording that there is a power differential between the principal participants. The interpreter herself may enjoy greater or lesser prestige within the exchange, demoted to the role of 'speak when I say so' or promoted to the role of genuine intercultural mediator and counsellor. For Anderson (1976: 218), the interpreter, as the sole bilingual in an exchange, enjoys "the advantage of power inherent in all positions which control scarce resources". In some cases, principal participants may be observed virtually to ignore their interlocutor, addressing all their remarks and questions directly to the interpreter. In other cases, however, primary participants conduct dialogue with each other directly, almost as if no interpreter were present; in such cases they may short-circuit the process, over-riding the interpreter's turn where they are able to understand each other without the latter's assistance. All of these attitudes, perceptions of attitudes, displays of deference or condescension are bound to surface in the linguistic and paralinguistic features of the exchange, the way they are (or are not) translated and, most importantly, the observable outcomes of the event.

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2. The state of the art

Within this diversity, what are the findings of studies conducted so far into dialogue interpreting? It is, of course, impossible within the confines of this introduction to include mention of (let alone do justice to) all the work that has been done and all of the observations made. For although the research field is in its infancy, it is now attracting a lot of attention and many of the studies have been scrupulously thorough. Nevertheless, there is a striking convergence between very different studies in terms of what they reveal about dialogue interpreting encounters, and it is this consensus which we shall attempt to describe here. The consensus is best captured in a number of recurring themes, identified by various scholars in the context of different kinds of interpreted events.

The first of these is the gross mismatch between, on the one hand, commonly held perceptions (among the public at large and users of interpreting services alike) of the dialogue interpreter as a kind of 'translating machine' which simply transfers language products from one language into another and, on the other, the observable reality of a situation in which meaning is subject to constant negotiation, literal translations lead to misunderstandings while, conversely, attempts by interpreters to convey intended meaning may

sometimes lead them into hot water; and there is constantly shifting ground as the speech event unfolds. This issue is not a new one. It was Reddy (1979) who coined the term 'conduit metaphor' to describe commonly held assumptions about language communication, noting that the way we talk about language ('getting one's message across'; 'sending the wrong message'; 'I can't get through to him', etc.) reveals what is tacitly assumed about the nature of communication. It is interpreters who find themselves at the sharp end of the consequences of such mistaken assumptions. Roy (1990) shows how the pervasiveness of the conduit metaphor and and its applicability to dialogue interpreting have led to confusion among interpreters about the nature of their own role. Often it is assumed that what is missing is a code of ethics; but, as Roy (1990:84) observes, quoting a view put forward and warmly applauded at a conference of practitioners, "Interpreters don't have a problem with ethics, they have a problem with the role". Berk-Seligson (1988, 1990) draws attention to the fact that training for court interpreters in the United States explicitly enjoins them to translate closely and accurately. Standards of Professional Conduct include statements such as "The interpretation should be as close to verbatim and literal in content and meaning as possible".[2] She is then able to show how relaying complex English passive constructions, used by attorneys in a very deliberate way to avoid attributing blame in their cross-examinations, is highly problematic in a language such as Spanish, in which the standard passive is dispreferred but a variety of alternative formulations are available, none of which is a literal translation of the English passive. Morris (1995) documents the tension which results from the legal profession's insistence that interpretation (a specific judicial process) should be the exclusive domain of lawyers and judges and that translation – the activity allotted to the court interpreter – should consist of verbatim rendition of utterances and nothing more than that. Specifically, interpreters may not mediate by relaying their own understanding of speaker meanings and intentions: this must be left to the court.

Roy (1993), observing a very different kind of encounter – that between an academic in a university and a Deaf doctoral student – is able to explode the 'conduit' myth by showing that it is simply untenable as an account of the interpreter's actual behaviour in resolving problems of overlapping talk. In effect, the interpreter's decisions about who will be awarded the next turn appear to depend on his or her sociolinguistic competence in deciding what is appropriate within the social situation of an interview between student and professor. In other words, the interpreter is not a neutral and uninvolved machine but rather an active participant in the talk exchange, fulfilling a crucial role in coordinating others' talk – a central theme in the research of Wadensjö (e.g. 1992, 1997; see below).

In the courtroom, however, interpreters do not enjoy such latitude. Hale (1997) adduces telling examples of the ways in which the literal translations

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which court interpreters are exhorted to produce may be seriously misleading. Thus, when a Spanish-speaking witness insists:

> Yo soy una persona educada/ siempre he sido educado/ Yo puedo probar que soy una persona educada

and is interpreted:

> I'm an educated person/I've always been educated/I can prove I'm an educated person

those present in the courtroom, including monolingual speakers of English, may feel that the translating machine is functioning properly, but the magistrate's response to the last offer ('No thank you!') shows that something has gone wrong: the repeated claim is seen as irrelevant to the current communicative situation. But in fact, the witness, by referring to his respectable upbringing (*educación*), is implying that he would never behave in a particular manner, previously referred to in the exchange. Pragmatic meaning, derivable only through matching of words uttered to the sociocultural and sociotextual context in which they are uttered, cannot possibly survive the injunction to translate literally in this way. Yet pragmatic meaning can be shown to be central even to monolingual exchanges in the courtroom, where presupposition, implicature and inference are exploited by defence and prosecution lawyers (cf. Berk-Seligson 1990:22-25).

The pretence of the interpreter's invisibility cannot, however, be sustained. Whereas cross-examination or any question-and-answer session may for part of the time proceed as if the interpreter were no more than a mechanical device assisting a two-way exchange between primary interlocutors, many studies document the multiple ways in which attention is inevitably drawn to the interpreter's presence. These include correction of interpreters' errors by other bilingual participants in an exchange (Morris 1995:33-34), untrained and very nervous witnesses who persist in addressing the interpreter directly instead of addressing all their answers to the judge or attorney who has asked them a question (Berk-Seligson 1988), officials such as immigration or police officers who address remarks to the interpreter which they do not intend them to translate (Wadensjö 1992:238-39), and other courtroom witnesses who, under extreme pressure, turn on the interpreter who has relayed a threatening question posed by a prosecuting lawyer (Harris 1981:198).

Such incidents as these bring us to the second major preoccupation of researchers in recent years, namely the participation framework (Goffman 1981) of dialogue interpreting encounters. Keith (1984) was the first study to draw attention to the relevance of Goffman's work to the analysis of liaison interpreting and to make use of the concept of 'footing' to characterize the interpreter's and speaker's relationship to each other. But it is Wadensjö's

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(1992, 1998) analysis of 'footing' that has had a major impact on our understanding of the interpreter's status and role within a speech exchange. Footing (Goffman 1981:227; see also Metzger, this volume) is defined as "the alignment of an individual to a particular utterance, whether involving a production format, as in the case of the speaker, or solely a participation status, as in the case of the hearer". That is, participants adopt different – and shifting – roles and attitudes vis-à- vis each other and vis-à-vis what is uttered. "Participants over the course of their speaking constantly change their footing, these changes being a persistent feature of natural talk" (ibid:128). Speakers may behave as 'principal', showing commitment to and ownership of what is expressed; as 'author', responsible for the thoughts expressed and the words uttered; or merely as 'animator', a sounding-box or talking machine. Correspondingly, there are reception roles, in the sense of the set of attitudes assumed by or ascribed to an individual towards the utterances of other parties. Wadensjö (1992:124) classifies these as the roles of 'responder' – listening in anticipation of speaking as a primary participant or 'principal'; 'recapitulator' – listening in order to repeat or give an account of what was said as 'author'; and 'reporter' – an assumed or ascribed role of listening in order to repeat words heard without assuming any responsibility for them. An interpreter may, at various stages in an exchange, adopt all three such roles. For example,

> as *responder*: (to a courtroom witness who has addressed the interpreter directly) 'Please address your remarks to the attorney, not to me'.
>
> as *recapitulator*: (relaying the request: 'Ask him to spell his name, please') 'Please spell your name'.
>
> as *reporter*: (following a primary party's injunction: 'Spell your name, please') 'Spell your name, please'.

It is important to realize that these stances are not just the result of a free choice on the part of the interpreter but also a reaction to what is assumed by the principal parties as being the appropriate interpreter role. Evidence for this comes from the way the primary interlocutors address each other. As Wadensjö (1997:48) observes, there are four possibilities here: third-person (he, she), first-person inclusive (we), second-person (you) or avoidance (no address forms used). The choice is not necessarily consciously made and, as many authentic samples quoted in the literature show, the shift of footing reflected in a shift of pronoun of address is commonplace in interpreter-mediated exchanges of this kind. Thus, the footing of each party is subject to constant renegotiation, with the stance of the primary interlocutors often influencing the interpreter's style. Harris (1981) cites a case of a court interpreter deliberately opting for the indirect, third-person style throughout a trial with

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the explicit aim of creating a certain distance between herself and what, in the context of a war crimes trial, was bound to be a particularly stressful and sensitive set of exchanges. But even when such distance is created, the exchange remains essentially a three-party interaction. Thus, as Wadensjö (1992: 4), following Simmel (1964), observes, such events must be seen as triadic as well as dyadic. Indeed, a major contribution by Wadensjö (e.g. 1992, 1995) to our understanding of dialogue interpreting is her investigation of the interpreter's role as a *coordinator* of others' talk.

The dynamics of the interaction are, it seems, subject to negotiation not only by means of linguistic cues but also through the strong influence of paralinguistic features: gaze, posture, gesture. By such means, primary parties can signal inclusiveness or exclusiveness vis-à-vis the interpreter. On the basis of his observation of court interpreting in Papua New Guinea, Lang (1978:241) concluded:

> Although his official role is that of a passive participant as far as the origination of primary conversation is concerned, the realisation of that role depends on the active cooperation of his clients and the extent to which they wish to include him as an active participant not only linguistically but also gesturally, posturally and gaze-wise. Likewise it is the interpreter who can by these means actively involve himself, or abstain from such involvement.

Lang was here writing, of course, of non-trained interpreters operating in an unregulated (save by tradition) courtroom situation. In many countries nowadays, the role of the court interpreter is pre-defined, even if prescribed behaviour and actual behaviour are frequently at variance, creating a constant tension (see, for example, Pym in this volume). But in many other situations, no rules have been laid down and one may observe constant shifts of footing, posture and so on within a single institution or a single exchange. For example, in a televised documentary on illegal immigration shown in the UK on Channel Four (*Cutting Edge*, 'Illegal Immigrants', 30 September 1997), it can be seen that, in interview, some immigration officers seek to make eye contact with the interpreter while others direct their gaze solely towards the immigrant being interviewed. Some of the persons interviewed make eye contact with the interpreter only, averting their gaze throughout from the officer interviewing them, while interpreters seek to establish eye contact with both primary parties. Naturally, such matters as seating arrangements, often regarded as peripheral, exert a strong influence on who faces – or is forced to face – whom.

One interesting concomitant of all of these uncertainties among participants is the phenomenon, well known to dialogue interpreters, of 'ownership' of meaning. Thus, a particular lexical choice selected by the interpreter to relay one interlocutor's meaning may be taken up or challenged by the other

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interlocutor as if it emanated not from the interpreter but from the other speaker. Wadensjö (1992:74) cites the example of a medical consultation involving Russian and Swedish in which the doctor suggests, in Swedish, that a thyroid problem has been 'worrying' the patient; this is then relayed to the patient by the interpreter, using a Russian word which relays the dual notion 'disturbing/worrying'. But the patient objects to the term, stating that the thyroid has not been 'disturbing/worrying' her; it has just got bigger. The objection is, of course, to a lexical item selected by the interpreter, not by the doctor. How then can the objection be relayed back to the doctor in a manner which is coherent with the doctor's original utterance in Swedish? The interpreter's response, here back-translated into English, shows her awareness of the problem that has arisen and the need to handle it: 'No, it is not that I feel worried or it hurts, but it seems to have grown bigger'. This expanded rendition attempts to make more explicit for the doctor the locus of the patient's disagreement. In other cases, the lexical item(s) at issue may be altogether more crucial. Krouglov (this volume) cites the case of a murder investigation in which a key lexical item uttered by a suspect is interpreted in three different ways by three different interpreters. Fortunately, the fact that the source of each of the three renditions (I'll kill you/I'll get you/I will stitch you up) was one lexical item was picked up and indicated to the police investigators, who thus avoided attributing to the suspect one particular lexical choice made by the interpreter.

Other phenomena investigated in research carried out include the interpreter's role and status as a cross-cultural mediator. Reporting on the relative dominance of one language over the other in bilinguals, Anderson (1976:213) states that "[i]n general, it is expected that the greater the linguistic dominance the more likely an interpreter will identify with the speakers of the dominant language, rather than with clients speaking his "other" language". It has been observed, for example, that, in a situation of unequal power distribution such as Latin American accused persons or witnesses in a United States courtroom (Berk-Seligson 1988, 1990), interpreters are sensitive to in-group loyalties towards relatively powerless participants whose language and culture they share. Indeed, the neutrality of the dialogue interpreter, referred to in instruction manuals and codes of practice, is not nearly as unproblematic as is often assumed. Wande (1994) reports similar findings from a research project involving Swedish/Finnish community interpreting. In other situations, the interpreter may easily be perceived by powerless parties to be an agent of an oppressive institution. Barsky (1994) documents in some detail the loss of status, even of identity, of applicants for asylum whose voice is heard only through the official interpreter. In order to succeed in gaining refugee status, applicants are obliged to construct an identity for themselves as appropriate refugees, all other aspects of their personal history being deemed irrelevant to the Convention Refugee hearing. Yet applicants are unfamiliar with the particular Western image they have to construct and, in a situation in which

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interpreters are required to translate 'accurately' and 'faithfully', "variation between the speakers' intended meaning and the text that emerges is, by the very nature of the procedure, inevitable" (Barsky 1994:41). Another study of interpreting across a wide cultural divide is Baker (1997), who analyses the performance of an interpreter in a televised interview by Trevor Macdonald, the British political interviewer, of Saddam Hussein just before the commencement of the Gulf War. In this case, the injunction to translate 'accurately' comes not from the employing institution but rather from the highly sensitive nature of the event, watched by millions of viewers and potentially influential on the evolution of diplomatic relations and the possible outbreak of war. In such circumstances, as Baker argues, interpreters will want to minimize the threat to themselves involved in either committing a highly visible error or through incurring the wrath of two primary participants whose interpersonal relations deteriorate as the interview proceeds. Consequently, the interpreter seeks to relay at all times the closest semantic sense of the words used by Saddam, even offering several alternatives, ostensibly to 'play it safe' and cover his own back; for example:

> Let us... we must rather... we must choose or take or adopt a single criterion or a single standard.

As Baker (1997:117) points out, repetition and hesitation of this kind are not a feature of Saddam's speech so that a monolingual Western viewer is liable to form a false impression of the coherence of his speech.

These studies of cross-cultural interaction involve well trained interpreters who, for all their expertise, are influenced in their interpreting behaviour by situational constraints: role conflict (cf. Anderson 1976), in-group loyalties, stress in a sensitive situation, perceptions of power and distance, and so on. Another fertile strand of research has been into the performance of what Brian Harris calls natural, i.e. untrained, interpreters. Indeed, it can be convincingly argued that, if we wish to understand the basic (cognitive and non-cognitive) mechanisms involved in the process of dialogue interpreting, then we should investigate not the results of training, based as it is on sets of normative assumptions about what constitutes appropriate behaviour, but rather the spontaneous behaviour of bilinguals who can and do interpret in a wide variety of social situations, prior to any norms of behaviour inculcated by training. This point should not, of course, be construed as in any way implying that it is appropriate for untrained individuals to interpret in community interpreting situations which demand professional expertise. The deleterious consequences of relying on children, for example, to act as interpreters in sensitive and stressful medical situations are well known in the profession. Studies included in this volume (Cambridge; Pöchhacker and Kadric) bear witness to what is at stake when untrained staff serve as interpreters in medical consultations. But the investigation of such situations can

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indeed provide insights into the nature of the very issues outlined so far in this introduction to the field.

As suggested above, awareness of different client needs and expectations in cross-cultural encounters can be a powerful influence on interpreter behaviour. An early study of natural interpreting, Harris and Sherwood (1978), relates the case of a business negotiation conducted between an Italian immigrant to Canada and an English-speaking Canadian, interpreted by the former's bilingual daughter. Both primary parties behave according to their own cultural norms and when, at a crucial point in the negotiation, the Italian – appropriately, within his own cultural expectations – calls the other man a fool, the untrained interpreter exhibits both bi-cultural awareness and an instinctive move to save face all round:

Father:	Digli che è un imbecille!
Daughter (to 3rd. party):	My father won't accept your offer.

What the natural (as opposed to the trained) interpreter may not have considered is how such a move can backfire. In this case, the father, whose English is apparently good enough for him to monitor his daughter's performance, immediately interjects (in Italian): "Why didn't you tell him what I told you?".

The natural interpreter's awareness of the need to preserve face is among the issues investigated by Knapp-Potthof and Knapp (1986), in an experiment involving discussions between Germans and Koreans, interpreted by a Korean student in her mid-twenties. They found that, whereas the interpreter does not relay many markers of politeness from German into Korean (e.g. *vielleicht*, 'perhaps'; *mal*, 'just'), she also introduces her own politeness strategies which "strongly suggest that [she] is very much concerned with saving her own face" (Knapp-Potthof and Knapp 1986:198). For example, when the German speaker asks to know the age of his interlocutors, the interpreter introduces this intrusive question by saying "what interests him" and "what he wants to know", thus disowning responsibility for any threat to face in the question. It is significant that these deictic transformations had not occurred previously in the interpreter's output and are clearly linked to this particular speech act. Many other examples are available in the evidence presented by these analysts, who conclude (1986:199) that the interpreter "regards her role as that of an independent, active party in the interaction, who, too, has a face to lose". We return to the issue of face below but, for the moment, let us note the similarity of these conclusions to those reported in many other independent studies.

3. Research directions

The articles in this volume speak for themselves and I shall not attempt to summarize them here. What is striking though is the number of common

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themes, issues and interrelated observations in a variety of different dialogue interpreting settings. At one and the same time, these observations provide corroborative evidence for many of the hypotheses advanced and attested in earlier work and point to new directions in interpreting research. Reference has already been made to some of these topics but at this point let us try to identify some of the most salient strands.

3.1 Participation framework

Franz Pöchhacker and Mira Kadric's observation of a natural interpreter in a medical setting picks up many of the themes alluded to above. Let us highlight just one incident which contributes to our understanding of shifts of footing. In the data, a shift from first-person to third-person style is clearly initiated by one of the primary parties when she says: 'do you understand me? Tell him to ...'. The shift of addressee from patient to interpreter seems to coincide with a sudden loss of confidence in direct therapist-patient interaction and an appeal to the interpreter to act as intermediary. This incident highlights not only the fact that primary participants are often influential in determining the interpreter's footing, as suggested above, but also that shifts of footing are motivated rather than random. Thus, in the data presented here by Helen Tebble, it is striking that a shift of footing by a doctor coincides with having to announce relatively bad news to a patient: the distancing effect of asking the interpreter to address the patient is an option which participants are instinctively aware of. Likewise, in the courtroom interaction which is the object of Mary Brennan's investigation, a lawyer's shift of footing in questioning ('Did he actually see ...', instead of 'Did you see ...') is probably traceable to the fact that the lawyer cannot establish eye contact with the Deaf witness, who is bound to face the interpreter rather than the questioner. Cecilia Wadensjö, whose previous work on footing was referred to above, is able to show here how participation framework is inevitably and radically affected by the different situational context of telephone interpreting. Such comparative studies are of great relevance to users of interpreting services who need to know more of the communicative effects of different forms of provision. From our perspective, these studies, taken together, open up a rich vein of future research: what motivates shifts of footing? How does the participation framework respond to the situational constraints of particular modes and settings?

3.2 Lexical choice and discoursal value

The way in which an interpreter chooses to relay a particularly salient lexical item has been shown to have repercussions on later talk and especially on the attribution of responsibility for use of the term to an interlocutor who has

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not, in fact, used it. Mary Brennan shows how a lawyer, cross-examining a witness, takes up the exact terms used by the interpreter but not by the person interpreted. Given what is at stake in courtroom interaction, it will be appreciated that such decisions can have far-reaching consequences (see also Anthony Pym's discussion of the key terms *hit* and *slap* in an exchange from the O. J. Simpson trial). The issue of interpreting in sensitive contexts, investigated by Baker (1997, see above) also surfaces in the work presented here by Helen Tebble, Jan Cambridge, Cecilia Wadensjö and Alex Krouglov. What happens, in cross-cultural contexts, to the discoursal value of lexical selections? A hospital doctor addressing a patient may well refer to a 'problem with the waterworks' rather than a 'genito-urinary tract' problem; the discourse adopted is one which acts as an appropriate sign (informality, friendly bedside manner) within its culture; if used cross-culturally without interpreter mediation, it may meet with a look of blank incomprehension or, worse, result in offence being taken. Of similar discoursal significance is the key term discussed by Alex Krouglov ('I'll kill you/I'll stitch you up'), which belongs in the source language to a non-standard dialect. Such lexicalizations are marked – in the sense of unexpected and therefore dynamic – and are bound to take on additional discoursal values within their own culture; how can such values be relayed and, if they cannot, is the interpreter then drawn into assuming the role of expert witness by explaining what is involved? How, indeed, do interpreters negotiate appropriate discourses and genres (cf. Hatim and Mason 1997) across cultural boundaries, especially in situations of unequal access by all parties to what is culturally sanctioned within particular settings?

3.3 Visibility and audience design

The fact that primary parties, who are not entirely monolingual, often monitor their interpreter's performance is well attested in the literature and an issue discussed by Anthony Pym in this volume. In the O. J. Simpson trial, the interpreter is called upon not because the witness knows no English but rather because, in a courtroom whose language is English, the Hispanic witness is at a disadvantage and must be seen to be offered linguistic protection. Moreover, many officers of the court know Spanish so that, as Pym observes, "despite apparent invisibility, the interpreters are being checked on all sides". The interpreter is therefore aware of being highly visible and is bound to design her output for various categories of receivers. Following Bell (1984), we may distinguish between direct addressees (e.g. the witness, the counsel), auditors (ratified participants who are not being directly addressed, e.g. counsel for the defence while prosecuting counsel is cross-examining), overhearers (who are present but not ratified participants, e.g. the public), and eavesdroppers (whose presence the participants are not currently aware of, e.g. the

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analyst, observing the trial on television). Francesco Straniero Sergio illustrates similar diversity of receiver groups in a very different setting, that of the television chat show. In media interpreting of this kind, the influence exerted on the interpreter's audience design is even more apparent. The extent to which each of the categories (addressee, auditor, overhearer) influences interpreter style – in contrast to, say, the interpeter in the private medical consultation – is an obvious area for future research to investigate.

3.4 Power and face

There is a sense in which power within the speech event resides with the interpreter who, as gate-keeper, controls the attribution of turns at talk (cf. Anderson 1976, cited above). As bi-cultural and bilingual, the interpreter may also enjoy certain other forms of power within the interaction by virtue of his/her knowledge. But it is the overall power dynamic formed among the triad of primary parties and interpreter within a particular social setting which acts as main determinant of how the event proceeds. In the medical consultation, asymmetrical power relations may result in important information being skewed or overlooked. All parties seem tacitly to acknowledge the right of the doctor to control the exchange. Englund-Dimitrova (1997) shows how a doctor, by interrupting the interpreter's turn, potentially misses an important response by a patient. Similarly, Mary Brennan notes in her paper in this volume how the sign language interpreter's turn management is usurped when speakers ignore some of the actions of signers and take their turn before the relay of meaning is complete. In the illuminating data studied by Mira Kadric and Franz Pöchhacker, it is apparent that the natural interpreter feels able to take unwarranted initiatives of her own when addressing the ten-year-old boy patient but would be much less likely to offer directive advice to the therapists who are the other primary parties in the interaction. Above all, there seems to be evidence, in accordance with previous research mentioned above, that interpreters are keenly aware of threats to face and adopt politeness strategies (Brown and Levinson 1987) aimed at protecting their own or their addressee's face: downtoning or hedging (see Helen Tebble's analysis); introducing conventional apologies (see Mary Brennan's data, in which a sign meaning 'Again?' is interpreted as 'I'm sorry what do you mean?'). What these papers collectively show is that there is undoubtedly scope for a much more far-reaching investigation of the negotiation of face in interpreted encounters in relation to the variables of power and distance.

These then are some of the issues which surface in the studies brought together here and which suggest interesting directions that future research might take. In conclusion, let us note that all of these pointers lead away from concern with the measurement of 'interpreter error', 'correctness', 'equivalence', and so on and thus away from a narrow source-text/target-text

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comparison towards a more procedural account. Viewing the interpreter as a gatekeeper, coordinator and negotiator of meanings within a three-way interaction, descriptive studies have much to gain from linking observation of the process to pragmatic constraints such as power, distance and face-threat and to semiotic constraints such as genres and discourses as socio-textual practices (cf. Hatim and Mason 1997) of particular cultural communities.

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Notes

1. This mode is new in the healthcare setting and is known as 'remote simultaneous'. That is, whereas the primary interlocutors (e.g. doctor and patient) remain face-to-face, the interpreter is at a separate location and relays each turn via headsets (Riddick 1998:45).
2. Standards of Professional Conduct and Responsibilities for Members of the Judiciary Interpreters Association of Texas, cited in Berk-Seligson (1990:232).

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For other references, see the Bibliography at the end of this volume.

Role, Positioning and Discourse in Face-to-Face Interpreting

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Abstract. *Whereas "role" and "role conflict" have been key terms in the research and development of public-service interpreting, this paper proposes, following Davies and Harré (1990), to substitute the notion of "positioning" for that of "role" in order to reflect the constantly evolving nature of interaction among participants in interpreter-mediated encounters. Positioning differs from footing in that, rather than being the choice of an individual speaker, it evolves as a result of joint negotiation among all the participants (i.e. positions adopted by one participant are either accepted and adopted by other participants or rejected and replaced). The main source of data is a series of televised immigration interviews that illustrate a variety of positioning behaviours. A number of (para)linguistic and pragmatic categories will be suggested to illustrate ways in which participants, by their discursive practices, position themselves and others and are, in turn, affected by each other's positionings. These discursive practices are seen as emanating from social institutions or "communities of practice" (Wenger 1998), which play a part in shaping the perceptions, stance, behaviour and utterances of all those involved.*

1. Introduction

The research perspective within which this study is situated is (1) interactional and (2) descriptive. Instead of seeking to observe interpreter behaviour in isolation from that of the other key participants in the public service encounter, it is expected that, by close observation of interaction between all participants, we may find regularities of behaviour that will improve our understanding of the nature of such interpreter-mediated events. Research in the field of face-to-face dialogue interpreting has evolved from the prescriptive account of what does or does not fall within acceptable professional standards towards non-judgemental observation of events and detailed description of what actually happens. In this spirit, we shall not consider participant moves in terms of their professional acceptability but rather in terms of their potential impact on the event and its internal evolution.

2. From role to positions

Roy (1990) reports an incident from a conference of practitioners, at which the topic of codes of ethics for interpreters had arisen. One delegate received warm applause for the assertion "Interpreters don't have a problem with ethics, they have a problem with the *role*". Indeed, "role" and "role conflict" are frequently cited topics in the literature on PSI (e.g. Anderson 1976; Niska 1995; Roy 1990, 2000; Pöllabauer 2004; Inghilleri 2003, 2005) and the debate between the interpreting profession and users of interpreting services about what the margins are within which interpreters operate remains unresolved. Investigations into the roles actually adopted by participants in a variety of settings are consequently a useful contribution to our understanding of the consequences of particular behaviours. Discussion of the interpreter's role can, however, give the impression that a role is a fixed stance, adopted in advance and sustained throughout an encounter. In this respect, a useful distinction is made by Wadensjö (1998), following Goffman, between "activity role" and "participation status" or "footing". Whereas an activity role involves mostly pre-determined stances deemed to be appropriate for fulfilling a particular socio-professional task, the "footing" adopted by participants is of a temporary and evolving nature. Loosely defined by Goffman (1981:128) as "the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance", footing is perceptible through the frequent shifts enacted by participants, often within a single utterance. These shifts may be from one addressee or group of addressees to another, say, or they may have to do with the ownership or non-ownership of the meanings one seeks to express. Footing, as an analytical category, has been applied with great insight to the work of the interpreter by Wadensjö (e.g. 1998, 2004).

The distinction between the global activity role and these local shifts of footing brings to mind a similar distinction made in a seminal article by Davies and Harré (1990). "Role", they claim, is a fairly static concept, which might imply that participants are somehow locked into pre-determined patterns of behaviour. They offer the term "positioning", on the other hand, as a dynamic feature of talk, one that is constantly changing and subject to negotiation among participants. By their conversational moves, participants position themselves and others and are, in turn, positioned by others' moves. Davies and Harré's account is, in particular, about "the force of discursive practices and the way people are positioned through those practices" (*ibid.*:43). A simple example is provided by a recent event

in UK politics. A Labour-government Home Secretary's use of the term "swamped" in reference to the number of claims for asylum in the UK provoked immediate controversy for its evocation of a notorious previous use of the same term in the 1960s by a Conservative politician in a speech widely condemned at the time for its racist overtones. Thus, the very use of such an emotively charged term positions the utterer. It does so in two ways. The speaker, in opting to employ the term rather than some other, wittingly or not, aligns himself with the discourse that it is associated with. And hearers, whether well-disposed or not, cannot avoid making the association if it has become part of their own socialisation. (It can, of course, be argued that not all hearers were in a position to make this association – i.e. not all of them would have been familiar with the type of discourse mentioned here – and that the media played a fundamental role in bringing the original use of the term to public attention).

More broadly, the discourses we choose to employ and the way they are reacted to by co-participants position us within the interaction. Such positioning is by no means always deliberate. Davies and Harré (*op. cit.*:55-57) provide a "worked example" of "how people can be living quite different narratives without realizing that they are doing so". Two academics, a male (A) and a female (B) meet at a conference. B is unwell and A offers to lead her to a pharmacy where she may be able to obtain medication. After a long walk they fail to find a pharmacy that is open for business. The following exchange then takes place:

A I'm sorry to have dragged you all this way when you're not well.
B You didn't drag me, I chose to come.

A dispute then arises between A and B as to their behaviour and intentions towards each other. What A saw as a genuine apology on his part was taken up by B as an assertion of power and control, as a positioning of B as weak and helpless. In this way, a distinction has to be made, in the analysis of speech, between **intended** meanings and **hearable** meanings, the latter depending on take-up, the hearer's disposition towards what is uttered and their reaction to it. An application of these notions to the field of dialogue interpreting becomes immediately apparent: if misunderstanding of this kind can arise naturally in a dyadic exchange between two interlocutors sharing the same language and (presumably) similar cultural backgrounds, how much more likely is it that people may "hear" each other's meanings differently in triadic exchanges where participants' attempts to represent

their own and each other's meanings have to cross linguistic and cultural boundaries? Discourses signify within their own cultural environment and may not be hearable (in the way intended) by receivers whose cultural context is distinct (see for example, Sequences 9 and 10 below). By the same token, the inability (through lack of familiarity) of certain speakers to adopt particular discourses in a context in which they are the expected currency may lead to marginalization or exclusion.

Barsky (1994) gives a compelling account of the Canadian Convention Refugee Hearing, in which he suggests that the task of the asylum seeker is, in the terms of the work's title, to "Construct a Productive Other". Projecting the self, including aspects of linguistic and other behaviour imported from the culture of origin, is unlikely to lead to success in these interviews. The nature of the event is such, he suggests (*ibid.*:60), that "one (albeit cynical) hypothesis is that the hearing could be seen as a test of the claimant's ability to construct an appropriate version of the 'Convention Refugee'". In other words, what counts is projecting the right persona and adopting the right linguistic comportment – those valued by the host country – rather than those imported from the home country. If Barsky is correct, then it will be appreciated that the intervention of the interpreter in a site of linguistic (and cultural) difference such as the Convention Refugee hearing will be crucial in relaying or constructing the required image. How do refugees position themselves and how do interpreters re-position them for target-language receivers? How do participants react to each other's positionings? The interface between source language and target language evinced in the interpreter's performance throws into sharp relief the cultural relativity of language behaviour.[1]

At the interpreter's swearing-in during these hearings, s/he is enjoined to "Translate faithfully, correctly and to the best of your ability" (*ibid.*:41). How is this task to be accomplished by verbatim translation, except in an imagined world of cultural (including linguistic) uniformity? Berk-Seligson

[1] In a monolingual linguistics it is possible to treat language, and even language use (cf. some conversation analysis), as a culture-independent entity. In Translation Studies, on the other hand, where the raw data are situated at the interface between two languages, it is impossible (or futile) to conduct analysis independently of cultural considerations, including perceptions of power, status, role, socio-textual practices, etc. This is perhaps where the true link between Translation and Interpreting Studies and applied linguistics lies: contributing to the study of linguistic difference by providing evidence of the relativity of (cultural) factors that may be treated as constants in monolingual exchanges.

(e.g. 1990), Morris (1995), Hale (e.g. 1997) among others have conclusively demonstrated not only the impossibility but also the inadvisability of such an undertaking. Recognition of this opens up an area of sociolinguistic enquiry (of interpreter behaviour in three-way exchanges) that is still relatively neglected, despite recent pioneering work in the field (e.g. Wadensjö 1998; Inghilleri 2003).

Barsky's work points the way to a power- and discourse-sensitive linguistic analysis of such events but does not actually conduct such an analysis. The data samples in the work are all cited in English, thus effacing the question of linguistic difference, and the analysis is of content rather than discourse. Yet analysis of personal reference devices in one or two of the dialogues he cites would bring to light some interesting features. For example the contrast between the systematic use of agent-deleted passives in the Counsel's questions ("you were held", "you were beaten", etc.) and the all-encompassing "they" of the claimant's answers ("they beat me", "they asked", etc.). This non-specific third-person plural is used to refer to unidentified kidnappers and torturers, but also to employers and doctors (in the words of the claimant, "because they control everything, the people from the government", (Barsky *op. cit.*:138)). The claimant's pronominal use thus brings together (positions) in a single, undifferentiated category individuals who, from the perspective of the host culture, might be seen as belonging to very different categories.

What follows is an attempt to show, via evidence from several interpreter-mediated events, some of the ways in which all participants, by their discursive practices, position themselves and others and are, in turn, affected by each other's positionings. These acts of positioning are effected linguistically and paralinguistically. A number of discrete categories have been identified to be illustrated below: orientation to others, attempts to control responses, contextualization cues, markers of in-group solidarity, gaze and discoursal choices. The primary source of evidence is a series of immigration interviews, shown on a terrestrial television channel as part of a documentary about illegal immigration.[2] Although this is a small dataset and did not allow either participant observation or the opportunity for post-interviewing the participants, it does illustrate a variety of positioning behaviours and is thus useful for our purposes here. Other data sources are cited, here and there, to corroborate or further illustrate the point at issue.

[2] *Cutting Edge*, "Illegal Immigrants", broadcast on the UK's *Channel Four*, 30.09.97.

3. Orientation to others

As suggested by Reddy (1979), our use of language about language provides evidence of some of our fundamental attitudes towards communication: how we conceptualize it and how we treat it. In similar vein, a cursory observation of the terms and metaphors commonly used to refer to the interpreting process reveals an image of interpreting as an automatic process and of the interpreter as a "non-person", a mere conduit through which people speak and listen. Thus, we are often presented, on news programmes, with foreign statespersons "*speaking through* an interpreter", a metaphor which offers a belief both about the (non-)status of the interpreter and about the ability of communicators using interpreter services to make their own voice directly heard by each other. Similarly, the interpreter's task is often referred to as that of "conveying a message" in another language, as if, somehow, meaning will remain invariant and input equals output (except that the code has changed). According to this outlook, the interpreter would enjoy no power at all, simply responding automatically when prompted to do so, to a determinate stimulus.

Indeed, as attested by Berk-Seligson (1990) among others, the mode of interpreting adopted in United States courtrooms reflects this conception. Interpreters are required to give a close rendition only and are not to intervene on their own behalf. Thus, in Sequence 1 (taken from the trial for murder, in 1995, of the American football star, O.J. Simpson), it is apparent that the interpreter may not supply information which is evident to her, but must ask the witness to supply it. When the witness does so erroneously, she relays the error (of which she cannot fail to be aware).

Sequence 1

Att. What is the name of the airline?
Int. ¿Cuál es el nombre de la línea?
Wit. Es TACA
Int. It's TACA
Att. Could you repeat that? And spell it please?
Wit. TACA
Int. ¿Lo puede deletrear?
[*Can you spell it?*]
Wit. T-A-C-K
Int. T-A-C-K

[Key: Att = attorney; Int = interpreter; Wit = witness]

Thus, for legal reasons, the interpreter may not herself take responsibility for spelling TACA and is duty-bound to repeat the witness's misspelling. Later in the same cross-examination, the Attorney asks the witness to spell the Spanish first name "Josefina". The witness confesses she is unable to do so. The attorney continues to press the question, without success, until finally the judge intervenes and asks the witness, "Is it spelled in the normal way?", to which the witness replies in the affirmative. At no point in the exchange does the interpreter offer the spelling (which, for her, would be a wholly straightforward task), nor would she be expected to do so. She is, quite simply, not considered to be a participant in the communicative exchange. By translating "verbatim", she is deemed to be offering to the court an exact version of what has been said in another language. Let us note, in passing, that in behaving as required, the interpreter also positions herself as belonging to a "community of practice" (Wenger 1998) – the court of law – whose practices she has internalized and constantly reproduces. In such circumstances, the interpreter's own actions and those of other participants *position* her as a "non-person". At the same time, of course, this positioning positions other participants as being responsible for their own utterances. Thus, positioning can be both reflexive (i.e. positioning oneself) and interactive (as when one positions another participant by one's own moves; see Davies and Harré *op. cit.*:48).

The stance illustrated in Sequence 1 above, while it positions the interpreter as not authorized to intervene, does recognize the right of the "primary" participants to control their own responses (e.g. to make errors or to mislead) without interference. In this sense, it is, to a limited extent, empowering of witnesses or interviewees, who might be deemed to have very little power in the context of a courtroom cross-examination or a police interrogation. The instrumentality of the interpreter in allowing or disallowing this empowerment is illustrated in Sequences 2 and 3, taken not from court interpreting but from immigration encounters involving Russian/Swedish and Polish/English respectively. They show diametrically opposed interpreter stances.

Sequence 2

(An applicant for residence status in Sweden claims to have Greek nationality and suggests that her passport shows this)

Pol. [hands passport to Int] Can you show me where?
Int. [hands passport to Applicant] And can you show where?

(quoted from Wadensjö 1998:155 – cf. also Wadensjö 2004:110)
[key: Pol = police officer; Int = interpreter]

Sequence 3

Imm. [addresses Int.] So he understands why he's here.
Int. [to Imm.] Yes he does. [to PM] Pan rozumi dlaczego pan tu jest, prawda?
[*You understand why you're here, don't you?*]
PM. Tak
Int. Yes, he does.[3]

[key: Imm = immigration officer; Int = interpreter; PM = Polish man]

The essential difference between the two exchanges is one of footing (Goffman *op. cit.*). In each case, the initial move is made by the institutionally powerful participant (police, immigration officer), who addresses a question to the interpreter ("can you…"), referring to the other participant in the third person ("he understands…") and thus positioning the interpreter as his interlocutor. In Sequence 2, the interpreter appears to behave as animator (in that she reflects in Russian almost exactly the words uttered in Swedish by the interviewer) but in fact she alters the framework by projecting the question as if it had been posed directly to the interviewee.[4] In Sequence 3, on the other hand, the interpreter assumes responsibility for the belief expressed ("Yes, he does"), a role which Goffman designates as that of Principal. The importance of this distinction lies not so much in the categorization of interpreters' strategies and options as in the *effect* of the selected footing on the footing and status of the other parties involved. As noted, in both sequences, the interviewer initiates a particular participation framework by directly addressing the interpreter. The latter then has

[3] Cf. a further instance from the same data, in which an immigration officer offers pen and paper to a Polish man she is interviewing:
Imm [to PM] – Your passport's still with this woman? Will you write down her name for me?
Int [in Polish] – Write down her name [*takes pen offered by Imm to PM and writes*]

[4] Cf. Wadensjö (2004:115), where it is pointed out that the interpreter "authors" a new version. The police officer's "you" and the interpreter's "you" do not have the same referent and the officer's reference to himself ("can you show me") is omitted by the interpreter. As Wadensjö comments: "It also shows how interpreters can promote the primary parties' mutual attention by *positioning* the preceding speaker *as the current "principal"*, simultaneously as they withdraw from an *anticipated position of "responder"* (my italics).

the choice of prolonging this framework by responding to the interviewer (Sequence 3) or re-directing the question to the interviewee (Sequence 2). In Sequence 3, however, the interpreter, having initially accepted the dyadic exchange with the interviewer, then hastily revises her footing (perhaps out of professional conscience?). She turns to the interviewee and asks the interviewer's question, but selects her own words and syntax (question form), adopting the footing of Author – a matter to which we return below. Receiving the interviewee's reply, she relays this as Principal ("Yes, he does", rather than "Yes, I do"), thus reverting to the interviewer's and her own initial footing. While in Sequence 2 the interviewee is positioned as having full participation status by the interpreter's choice of footing, being invited to interact directly with the interviewer, the interpreter's choices in Sequence 3 set up two separate dyads: immigration officer with interpreter and interpreter with Polish immigrant. The effect of this is manifestly to exclude the interviewee from direct interaction with his interviewer, thus positioning him as a bystander.

The literature abounds with instances of such exclusion, often in the form of asides to the interpreter, which the latter is not expected to relay to the other participant (see e.g. Wadensjö 1998:256-57). The question that arises is: can other participants override the interpreter's gate-keeping by re-positioning themselves as primary interlocutors in the exchange? It would seem that they can, but only if they are recognized as having power within the exchange. Wadensjö (*ibid.*:166-75) relates the case of a patient having difficulty in expressing his venereal disease symptoms in a consultation involving a female interpreter and a female nurse. There is a long dyadic exchange between patient and interpreter, in which the patient fails to complete his utterance (describing his symptoms) while the interpreter back-channels and inserts encouragements such as "don't be embarrassed". The Swedish nurse, excluded from this dialogue in Russian, loses patience at her exclusion and interrupts, saying to the interpreter: "Would you break off and say what he says now?" She thus asserts her right to inclusion, founded no doubt upon the assumption that the social occasion (genre) of the medical consultation allows direct medical staff/patient dialogue only. The community of practice acknowledges norms and privileges to which the nurse, as the recognized medical expert in the exchange, can appeal.

The absence anywhere in the literature of any converse examples of the power-less participant (immigrant, patient, etc.) successfully intervening in this way points conclusively to an unstated assumption about positions across a range of genres within interpreter-mediated

exchanges. The interpreter has power to sustain or interrupt the normal turn-taking sequence.[5] This power may, occasionally, be challenged – but only if the challenger is recognized as having the status and authority to do so. Otherwise, the third party is effectively (if temporarily) excluded and positioned as bystander. The regularity of this behaviour points to an interpreter community of practice, overlapping with the other communities of practice, of which they become part by their professional activity.

4. Attempts to control responses

In an earlier study (Mason 2005), I cited instances of shifts in the form of questions, whereby a question inviting a yes/no answer is interpreted as one which suggests a preferred response. For example, a question such as "Did you speak to immigration at Dover?" may become something like "You spoke to immigration at Dover?" – which merely seeks confirmation of an assumption. Pöllabauer (2004:155) cites a sequence, reproduced as Sequence 4 below, in which an interpreter transforms "the officer's yes/no question into a suggestive question". A refugee is asked about an incident cited as grounds for seeking asylum.

Sequence 4

Imm Were there dead people or anything else?
Int People were killed in the course of the incident or?

[key: Imm = immigration officer; Int = interpreter]

What is striking about such cases is the frequency with which they are attested. In the literature on court interpreting, the reverse process is frequently attested. Hale (2006:210) cites an instance (reproduced here as Sequence 5) quoted in Berk-Seligson (1999:39), noting that the effect of omitting the tag ("did you not?") is to make the question put by the attorney less coercive.

[5] For Anderson (1976:218), the interpreter, as the sole bilingual in the exchange, enjoys "the advantage of power inherent in all positions which control scarce resources". Where the interpreter is not the sole bilingual participant, this power may be challenged: see Pym (1999).

Sequence 5

Att You made a report about this incident, did you not?
Int (in Spanish) Did you make a report about this incident?

[key: Att = attorney; Int = interpreter]

Hale (2006) also reports on research showing that Spanish-to-English court interpreters often omit question tags in this way.

From the point of view adopted in this paper, the relevant point is that participants in three-way exchanges (police officers, attorneys – and also interpreters) may from time to time seek to control the replies of their interlocutors by asking preferred-response questions. In doing so, they position themselves as making a prior assumption about the truth of some state of affairs and position their interlocutor as likely to agree with their assumption. The interlocutor can, of course, refuse to accept this positioning by denying the assumption. However, such dispreferred responses require more elaboration, rendering acquiescence with the offered positioning more likely, as in Sequence 6 below, reproduced from Mason (2005:37). Here, the interpreter's positioning of the interviewee goes much further than the immigration officer's yes/no question, suggesting a whole rationale for the interviewee's presence in the United Kingdom.

Sequence 6

Imm. Did you look round for a job in Poland?
Int. [*in Pol.*] Did you look for work? You looked for work and there wasn't any?
PM Tak
Int. Yes, he was looking for work but there was no work.

[key: Imm = immigration officer; Int = interpreter; PM = Polish man]

In this instance, the interpreter may appear to show some solidarity with the immigrant in suggesting an appropriate response. These temporary positionings shift, however, within the exchange and elsewhere in the same interview the interpreter may appear to position herself as much closer to the immigration officer, in fact as co-investigator with the latter, as in Sequence 7.

Sequence 7

Imm What did they say?
Int I co oni powiedzieli?
[*And what did they say?*]
PM Że pojedziemy do pracy do Anglii.
[*That we'll travel to work to England*]
Int Co znaczy pojedziemy? Bo było więcej?
[*What does it mean "we'll travel"? Because there were more?*]
PM Tak
[*Yes*]
Int Yes they said they'd go and work in England because apparently he wasn't the only one, there were several people involved.

[key: Imm = immigration officer; Int = interpreter; PM = Polish man]

Thus, whereas "role" in the sense of activity role is generally taken by all concerned (interpreters, users of interpreting services) to be unvarying within an assignment, the evidence presented here (and in the work of other scholars) suggests that positioning shifts and, with each shift, brings about a potential realignment of the exchange.

5. Contextualization cues

"Contextualisation cues" is the term used by Gumperz (1982:131)[6] to refer to constellations of linguistic features which signal the ways in which speakers intend and hearers accept the meanings of their utterances. They include code-switching and style-shifting, prosodic cues, lexical and syntactic choices and the use of, or deviation from, standard formulae. The meanings of these cues are not semantically encoded. They are implicit and therefore have to be inferred from the particular context in which they occur. What is typically involved is a departure from normal (unmarked) linguistic behaviour. As such, the cues frequently give rise to misunderstandings, particularly at sites of linguistic or cultural difference, where judgements are likely to differ as to what constitutes the norm and what a departure from the norm may signal.

[6] "Roughly speaking, a contextualisation cue is any feature of linguistic form that contributes to the signalling of contextual presuppositions".

In the set of immigration interviews drawn on here (see footnote 2), the genre is highly routine. An immigration officer, by means of a fairly standard set of questions, seeks to establish (1) that the immigrant entered the UK as a tourist, (2) that the immigrant has been in paid employment, (3) that, therefore, deception has occurred. A supplementary goal in some interviews is to discover the identity and whereabouts of any third party who may have organized travel and employment for a group of illegal immigrants. Once these facts have been established, the interview is effectively at an end. The questioning is conducted in a brisk manner and rarely departs from the routine. At a particular juncture in one interview, however, the interviewer's shift of pitch and intonation, in conjunction with multiple self-reference ("I") for the first time in the interview, appears to intend to signal a reduction of distance and a general benevolence – in striking contrast to the formality and coldly detached tone of what had preceded. This is clear evidence of reflexive re-positioning. It is as if, now that formal business is at an end, the immigration officer seeks to position herself as showing a human side and concern for the plight of the would-be immigrant.[7] These utterances by the interviewer (also discussed in Mason *op. cit.*) are reproduced here as Sequence 8, including the main paralinguistic features involved.

Sequence 8

Imm Because I'm going to go and try to get your PASSport back off her. (...)
[smiles] Well I'll see if she wants to give you the money before you go [nods] (.) [smiles] I think that {would be good.

Int {Ona, Liza, postara się o te pieniądze nim pan odleci, nim odlecisz ona, Liza, postara się o pieniądze.
[*She, Lisa, will try to get the money before you (formal) depart, before you (informal) depart she, Lisa, will try to get the money*].

Imm I'll tell her where you are, and I'll bring her over and see if she'll pay you (.) OK?

Key:
Imm = immigration officer; Int = interpreter

[7] It is, of course, equally possible that the officer is seeking to exhibit to *the interpreter* a human side to her character. In terms of Bell's (1984) audience design, the interpreter could be said to be influential on the speaker's style as an auditor. In Sequence 8, however, the officer's gaze is directed towards the interviewee only.

CAPS = emphasis
(...) = omitted sequence
{ = overlapping talk
(.) = brief pause
. = falling intonation
, = continuing intonation
? = rising intonation

In addition to the contextualization cues already mentioned, there is a noticeable style-shift in the relatively colloquial formulations "go and try", "get... back off her", "see if", etc. These cues appear not to have been relayed by the interpreter. Moreover, by explicitly referring to the interviewer in the third person, the interpreter makes it clear that she is adopting her own voice – as Principal – rather than the interviewer's – as Author. She positions herself as an independent actor, commenting on what has been uttered by the interviewer. On this footing, the contextualization cues, which belong to the interviewer's speech style, cannot be translated, for any attempt to do so would be attributed by the hearer to the interpreter rather than to the participant referred to in the third person. This may explain the interpreter's momentary uncertainty over which second-person form of address to use and her odd use of the officer's forename in her rendition as a way of signalling reduced distance.

It is, in any case, difficult to imagine how an interpreter could relay such cues in a manner that might communicate the intended values. Wadensjö (1998:246-8), following Goffman, makes a distinction between "displaying" and "replaying" others' talk. In the former case, the interpreter tends to adopt neutral prosodic features, eliminating most of the expressive features of the utterance being translated and thus signalling detachment from (or non-ownership of) the words being used. Alternatively, the interpreter may seek to "replay" the expressive features, temporarily positioning herself as adopting the persona of the participant being translated. For a variety of reasons, however, such behaviour is hazardous. Crucially, it may not communicate what it intends to communicate and/or it may be perceived as disrespectful mimicry by the participant being translated. For it seems to be characteristic of many contextualization cues that they are intimately personal, belonging uniquely to the speaker, in a way that semantically encoded meanings are not. How, for example, might the interpreter in Sequence 8 seek to replay (without over-playing) the prosodic shift and the implicatures in "I'll see if she wants to give you the money before you go, I think that would be good"? It is not surprising, in such circumstances,

that the interpreter adopts here an explicit third-person footing. Yet again, though, the interpreter becomes the arbiter of which discourses are and which are not relayed. An attempt by the Immigration Officer to reduce distance and establish more direct contact with the interviewee has failed because the re-positioning has not been taken up. A further way in which attempts at direct communication fail is examined under section 8 below.

6. In-group solidarity

Consideration of Sequence 8 also suggests another parameter affecting communication rights. It will have been noted that the interpreter makes use of the T-pronoun when interpreting the interviewer's question to the Polish interviewee. Most dialogue interpreters would no doubt consider this to be entirely non-standard, or even unethical, behaviour. But this anomalous use brings to light another area where power differentials are signalled. Expression of power, deference, solidarity, distance may all be either signalled or filtered out and taken up or ignored. Hearable meanings depend on take-up. Berk-Seligson (1988) cites the case of the use of honorifics by monolingual Spanish-speaking witnesses in US courtrooms. She notes the inevitable in-group solidarity of interpreters and witnesses who belong to the same ethnic group in a (largely) monocultural event and notes that interpreters often initiate a "cycle of politeness" by using honorifics (*señor, señora*) in addressing the witnesses. But they may or may not translate the same honorifics, uttered by the witness, when interpreting for the benefit of the court. Berk-Seligson's research suggests that the presence or absence of these markers of deference (i.e. interactive positioning) makes a great deal of difference to the perception by jurors of how trustworthy and convincing the witness is.

It is a commonplace of studies of the use of T/V pronouns, ever since Brown and Gilman (1960), that speakers' choices are affected by, and at the same time affect, perceptions of power and solidarity. In our data, the same intra-ethnic solidarity that Berk-Seligson perceived in her interpreters may have motivated the Polish interpreter to address her fellow-countrymen and women with T, even though these were no doubt total strangers to her prior to the encounter described here. Corroborating clues lie in the (non-source-text-motivated) use of colloquialisms here and there by the interpreter, signalling a reduction of distance in the interaction (perhaps unwanted by the interviewee). Yet, whatever the real motivation for the use of T by the interpreter (in Sequence 8, but also throughout the interview),

the effect of non-reciprocated use of T in situations of unequal power can only serve to reinforce the power differential. Indeed it may be perceived as an attempt by the interpreter to place on record a difference of status. Here too, the issue of footing is involved. Were contemporary English to involve a T/V distinction, it is inconceivable that the immigration officer would, herself, initiate a cycle of T-address. The tenor of her questions is formal throughout. Therefore the interpreter's use of T concerns *her own* relationship with the addressee: the translated voice cannot be that of the immigration officer. The interpreter is in fact presenting evidence that she is speaking in her own voice – positioning herself as Principal in Goffman's terms – thus establishing direct communicative contact between herself and the interviewee, rather than facilitating contact between officer and immigrant. The interviewee is thus positioned as a direct interlocutor of the interpreter (only), in that a communicative norm is established of two dialogues, between interviewer and interpreter and between interpreter and interviewee but not, crucially, between interviewee and interviewer. In section 7, we find further evidence of the Polish interviewees' acceptance of this impoverished participation framework.

7. Gaze

The potential of such paralinguistic features as gaze to signal not only a participation framework but also the negotiation of turn taking has long been recognized in studies of face-to-face interpreting. In a pioneering study, Lang (1978) recorded evidence of gaze, posture and gesture among participants in court proceedings in Papua New Guinea and noted in particular how inclusionary or exclusionary strategies are signalled by these means. By averting gaze while speaking, an interpreter can signal his/her own voluntary exclusion from what is deemed to be a two-way dialogue between other participants. Similarly, by not directing their gaze towards the interpreter, other participants can treat each other as addressees, relegating the interpreter to the role of auditor, a ratified participant whose role is to relay others' speech as an animator of others' voices.

In our (limited) dataset, a number of behaviours can be observed. In some circumstances, for example recording basic details of identity or asking routine questions (cf. Sequence 3 above), an immigration officer may direct gaze solely towards the interpreter, who reciprocates with gaze towards the Officer, as in Figure 1.

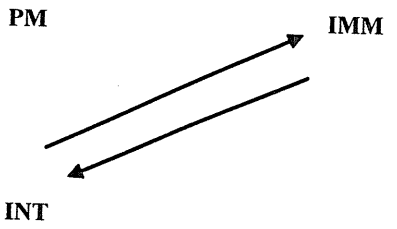

Figure 1: Speaker's gaze in an immigration interview: Option 1

Key: PM = Polish man
IMM = immigration officer
INT = interpreter

Such a strategy clearly excludes the linguistically-different (i.e. Polish-speaking) participant. This arrangement, however, is not the preferred option in these interviews. On most occasions, the immigration officer, when asking questions, directs gaze towards the interviewee only, perhaps reflecting a behaviour acquired through training. The interpreter, meanwhile, seeks eye contact with each interlocutor in turn as she translates from English to Polish and from Polish to English. To do this, she has to turn her head from one interlocutor to the other. She thus signals her want to be included as a participant in triadic exchange. The Polish-speaking interviewee is seated facing the Immigration Officer on the opposite side of a table. In two of the interviews, there is a distinct tendency for the interviewees (male and female) to direct gaze to the interviewer only when being addressed *but not when speaking*. In responding to questions, these interviewees invariably turn their gaze towards the interpreter. The pattern of speaker's gaze is as illustrated in Figure 2.

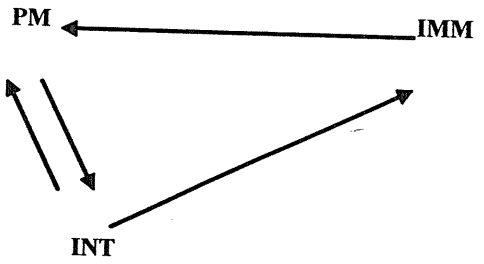

Figure 2: Speaker's gaze in an immigration interview: Option 2

On this evidence, the interviewees position the interpreter as their only interlocutor. The possible motivations for such behaviour are many and varied. Prominent among them may be simple linguistic insecurity, a lack of confidence in their ability to communicate with anyone except in their own language. (The immigration officer's stance in Figure 1 could be attributed to the same cause). But whatever the real reasons for the pattern of gaze shown in Figure 2, the effect is to deny the interviewees any chance of projecting a persona of their own to the immigration officer. By their gaze-shift, they position themselves as excluded onlookers and, by implication, interactively position the immigration officer and the interpreter as joint deciders.

8. Relaying discourses

In section 5 above, it was seen that a number of contextualization cues combined to signal a discoursal shift on the part of the interviewer, from official interrogator to conciliatory sympathizer. The shift could not be relayed to the interviewee by an interpreter adopting the footing of Principal. As I have reported elsewhere (Mason 2004), the interpreter also controls the selection of which discourses are represented and which are not. A lexical item which is reiterated no fewer than seven times in the responses of the Polish woman and man in the two major interviews featured here is *szkoły* (lit. "school"). This is partly accounted for by the fact that attending an educational course may, in certain circumstances, be counted as a legitimate reason for seeking entry to the UK. Yet the word is also used (see Sequence 10) to refer to activities undertaken in Poland before leaving that country. The item clearly covers a wide range of educational activities, from the academic to training in manual skills. But the frequent reiteration of the same term adds a discoursal value to it. Education (*szkoły*) becomes an aspiration, an activity which it is good to be engaged in, and thus, an element of self-esteem for these deportees, who have, prior to the interview, been positioned as illegal and deceitful. Sequences 9 and 10 exemplify this reflexive positioning and show how it is at least attenuated, if not effaced, in translation.

Sequence 9

Imm How is it that you're still IN this country?
Int Dlaczego tutaj dalej jesteś?
[*Why are you still here?*]

PW Bo chciałam iść tutaj do szkoły, do tej pory udało mi się, musiałam zarobić pieniądze, żeby iść do szkoły bo szkoła jest dosyć droga,
[*Because I wanted to go to school here, till now I've managed to, I had to earn money to go to school because school is quite expensive.*]

Int I had to/ my intention was to attend an English course here, but I didn't have enough money so I had to earn the money in order to pay for the course.

PW I do tej pory (.) chodzę do szkoły, chodziłam raz w tygodniu (.) niestety.
[*And I still go to school, I did go to school once a week, unfortunately.*]

Int And I have been attending an English course once a week,

[key: Imm = immigration officer; Int = interpreter; PW = Polish woman]

Sequence 10

Imm What were you doing before that in Poland.

Int A coś robił przed przyjazdem tutaj do Anglii w Polsce.
[*And what were you doing in Poland before coming here to England.*]

PM Znaczy (.) uczyłem się w szkole.
[*I was learning at school.*]

Int Jako student?
[*As a student?*]

PM Nie, mechanik samochodowy.
[*No, a car mechanic.*]

Int Right um he was attending (.) um a course um a car mechanics course.

[key: Imm = immigration officer; Int = interpreter; PM = Polish man]

The dissipation of the cohesive device of reiteration, in conjunction with other interpreter selections (e.g. deletion of "wanted to", "managed to", "unfortunately" in Sequence 9) combine to restrict the meaning potential offered in the Polish utterances to something more instrumental and non-committal in English. One plausible reading of this sequence would be that the immigrant positions himself as having been in full time education, the interpreter asks him to specify whether this involved intellectual or manual activity and then re-positions him to the officer as a manual worker.

Perceptions of status and value attaching to education and manual labour may well be involved. Significantly for our purposes here, the interpreter in Sequence 10, by her independent question to the interviewee, re-positions herself once more as co-investigator. This is reinforced by her use of the utterance-initial "Right", suggesting a successful outcome to her initiative.

9. Conclusion

In this short study of participant behaviour in a small set of data from interpreter-mediated encounters, I have sought to highlight the range of moves, both linguistic and paralinguistic, which may signal attempts at reflexive and interactive positioning and the take-up of these by other participants. Gate-keeping, footing, manipulation of preferred/dispreferred responses, contextualization cues, in-group identity, gaze and lexical choice were all seen to be involved in the process. Following Davies and Harré (*op. cit.*), we have suggested that positioning provides a useful alternative to the rather static notion of "role" and we have sought to widen our focus from the interpreter's role to the positions adopted by and suggested to *all* participants in the exchange. Positions evolve as an exchange develops and are the subject of joint negotiation among all involved. In some ways, then, positioning is similar to footing. The latter, though, may be treated as a choice of an individual speaker (like, say, code-switching in conversation) whereas, in the treatment of positioning here, I have sought to stress its interactive nature: positionings are either accepted and adopted by other participants or rejected and replaced.

In the particular interviews that have formed the main focus of our attention, the interpreters' strategic choices were unlikely to affect the outcome of the events, which was more or less pre-determined. "Illegal immigrants" had been arrested and were about to be deported, immediately following a routine interview that was little more than a legal requirement. The interviewees accept without demur the positioning of them offered by the other participants. However, the same linguistic and paralinguistic parameters are involved in situations (such as those described by Barsky *op. cit.*) where there is altogether more at stake. The positions adopted and accepted by participants, it has been suggested here, may exert considerable influence on the likely development of the exchange. Yet the impact of participants' choices remains under-investigated. Indeed, large-scale empirical investigations of actual participant behaviour in interpreter-mediated face-to-face exchanges are still relatively few (e.g. Berk-Seligson 1990; Wadensjö 1998) and much work remains to be done, both in the ethnography and in the linguistics and pragmatics of such communicative events.

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Interpreting and Translating in Public Service Settings

Policy, Practice, Pedagogy

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Edited by

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Isabelle A. Perez
Christine W. L. Wilson

St. Jerome Publishing
Manchester, UK & Kinderhook (NY), USA

TJA 123[illegible]

Published by
St. Jerome Publishing
2 Maple Road West, Brooklands
Manchester, M23 9HH, United Kingdom
Telephone +44 (0)161 973 9856
Fax +44 (0)161 905 3498
ken@stjeromepublishing.com
http://www.stjerome.co.uk

InTrans Publications
P. O. Box 467
Kinderhook, NY 12106, USA
Telephone (518) 758-1755
Fax (518) 758-6702

ISBN 978-1-905763-16-0 (pbk)

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Printed and bound in Great Britain by
TJI Digital, Padstow, Cornwall

Typeset by
Delta Typesetters, Cairo, Egypt
Email: hilali1945@yahoo.co.uk

British Library Cataloguing in Publication Data
A catalogue record of this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Interpreting and translating in public service settings : policy, practice, pedagogy / edited by Raquel de Pedro Ricoy, Isabelle A. Perez, Christine W.L. Wilson.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-905763-16-0 (pbk. : alk. paper)
1. Public service interpreting. I. De Pedro Ricoy, Raquel. II. Perez, Isabelle, 1962-
P306.947.I58 2009
418'.02--dc22

2009011524

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Interpreting and Translating in Public Service Settings

Policy, Practice, Pedagogy

Edited by
Raquel de Pedro Ricoy, Isabelle A. Perez and Christine W. L. Wilson

Translation, interpreting and other forms of communication support within public sector settings constitute a field which deals, quite literally, with matters of life and death. Overshadowed for many years by interpreting and translating in other domains, public sector interpreting and translating (PSIT) has received growing attention in recent years, with increasingly mobile populations and human rights, diversity and equality legislation shining the spotlight on the need for quality provision across an increasing range and volume of activities.

Interpreting and Translating in Public Service Settings offers a collection of analytically-grounded essays by researchers and practitioners in both translating and interpreting and in the public sector. Against a backdrop of breaking down barriers in PSIT, it aims at providing new insights into the reality of the interaction in public sector settings and into the roles and positioning of the participants by challenging existing models and paradigms. Issues of local need, but with global resonance, are addressed, and current reality is set against plans for the future. The triad of participants (interpreter/translator, public sector professional and client) is investigated, as are aspects of pedagogy, policy and practice. Empirical data supports the study of topics related to written, spoken and signed activities in a variety of professional settings. The studies presented here point to a clear need for cooperation, as well as scope for collaborative developments, across professional boundaries and international borders. Indeed, new directions in research and practice will only be fruitful if all three groups of participants come together, as decisions regarding practice should be based on theoretical tenets underpinned by empirical research.

Bringing together academics and practitioners from different countries in order to explore the multidisciplinary dimension of the subject, this collection should serve as a valuable reference tool, not only for academics and students of public sector interpreting and translating, but also for practising linguists, providers of language services and policy makers.

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Doctor–patient consultations in dyadic and triadic exchanges[1]

Carmen Valero Garcés
University of Alcalá

This article presents the results of a study on doctor–patient interaction in dyadic and triadic exchanges. The analysis is based on transcripts of recordings done at healthcare centres in northern Madrid, Spain, and Minneapolis, USA. The methodological approach is that of institutional discourse analysis as developed by Drew and Heritage (Drew & Heritage 1992; Heritage 1995, 1997; Drew & Sorjonen 1997). Three different types of doctor–patient interaction are examined: (1) doctor/foreign-language patient; (2) doctor/ foreign-language patient/ad hoc interpreter; (3) doctor/ foreign-language patient/trained interpreter. Topics such as the assignment of participant roles, changes in the general structure, turn-taking, and asymmetrical relationships are explored. The study is mainly descriptive and qualitative, but also includes some comparative quantitative analyses.

1. Introduction

This paper sheds light on some salient features of cross-cultural doctor–patient interaction in three configurations: Type 1: doctor/foreign-language patient; Type 2: doctor/ foreign-language patient/ad hoc interpreter; and Type 3: doctor/ foreign-language patient/trained interpreter. The theoretical and methodological framework used (see Section 3.1) is that of institutional discourse analysis as developed by Drew and Heritage (Drew & Heritage 1992; Drew & Sorjonen 1997; Heritage 1995, 1997). Inspired by the work of Wadensjö (1992) and related discourse-analytical approaches (e.g. Mason 2001; Davidson 2002; Meyer 2001; Meyer et al. 2003), this study follows previous analyses of monolingual interactions between doctors and immigrant patients (Valero Garcés 2001, 2002, 2003). The article offers a comparative analysis of dyadic (monolingual) and triadic (bilingual interpreter-mediated) exchanges in doctor–patient interaction. The approach is primarily descriptive and qualitative, but also includes some quantification.

2. Corpus

The data in the study described below comes from six recordings made in hospitals and healthcare centres in northern Madrid, Spain (Type 1 and Type 2), and in Minneapolis, USA (Type 3). The data from Spain are part of the corpus of medical interviews collected by the FITISPos[2] research group at the University of Alcalá. The corpus is currently made up of 60 audiotaped monolingual and multilingual medical consultations of Type 1 and Type 2 recorded in healthcare centres, primarily in the departments of pediatrics, obstetrics, gynaecology and internal medicine and in the emergency room. Languages in the corpus include Arabic, Bulgarian, Polish, Portuguese and Romanian as well as Spanish. The participants are Spanish-speaking doctors and nurses, immigrant patients with some or practically no command of Spanish, and bilingual relatives of the patients, acting as ad hoc interpreters.

The Type-3 consultations were audiotaped at a hospital in Minneapolis and belong to a research group coordinated by Bruce Downing at the University of Minnesota, of which the author is a member. The Type-3 consultations from Minnesota were used for lack of such data in the Spanish corpus, since there are as yet few, if any, professional hospital interpreters in Spain. The interpreter involved in both Type-3 consultations had received two semesters of formal training at the University of Minnesota and had been working as an interpreter in a hospital for two years.

The consultations analysed in this paper are numbered from C1 to C6, and their main features (languages, participants, place, complaint) can be summarised as follows:

Type 1 — doctor/ foreign-language patient

C1 (Spanish): general practitioner (male) — Bulgarian patient (male) who knows some Spanish; healthcare centre in Guadalajara; leg problems.

C2 (Spanish): general practitioner (male) — Arabic-speaking patient (female) who knows some Spanish; healthcare centre in Alcalá de Henares; stomach problems.

Type 2 — doctor/foreign-language patient/ad hoc interpreter

C3 (Spanish-Arabic): general practitioner (male) — Moroccan patient (female) who does not speak Spanish — patient's husband acting as ad hoc interpreter; healthcare centre in Alcalá de Henares; stomach pains.

C4 (Spanish-Arabic): general practitioner (male) — Moroccan patient (female) who does not speak Spanish — patient's husband acting as ad hoc interpreter; healthcare centre in Alcalá de Henares; neck and back pains.

Type 3 — doctor/ foreign-language patient/trained interpreter

C5 (English-Spanish): specialist doctor (female) – Mexican patient (female) who does not speak English — interpreter (female) at a hospital in Minneapolis; vaginal infection.

C6 (English-Spanish): general practitioner (female) — Latino patient (female) who does not speak English — interpreter (female, same as in C5) at a hospital in Minneapolis; depression.

3. Analysis

3.1 Methodological framework

Research on institutional discourse shows that participants in institutional encounters use a series of linguistic and interactional resources specific to the situation, and in accordance with the participants' linguistic and cultural competencies. Many of these resources are also used in everyday conversation and are not exclusive to institutional encounters; they are, however, used in a specific way.

These resources are based on the following assumptions:

1. The participants have specific roles;
2. Each institutional context imposes certain constraints;
3. Each institution has its particular inference markers and its particular procedures.

According to Heritage (1997: 164), these assumptions are manifested in conversation through the use of linguistic and extralinguistic resources such as specific grammatical structures, turn exchanges, lexical choices and body language. The nonconventional or 'unexpected' use of these resources may change the assignment of participant roles, problems in understanding the intended meaning, and variation in the nature of relations with the institution as well as in the type of contribution. In the following sections these aspects of the three types of doctor–patient consultations described above will be analysed with the aim of investigating similarities and differences in the use of language.

3.2 Changes in the assignment of participant roles

The specific roles assigned to participants in doctor–patient encounters are similar to those seen in other interactions involving a professional-client relationship. The imbalance between the two parties is not an exception to the rule, but is intrinsic to the institutional context. If this system is altered, variation in the client's

participation (Heritage 1997: 165) may result, including changes in the interaction order, the contribution types and the participants' expectations. These changes are all the more pronounced when one of the participants — the patient in our case — does not know the official language and the patterns of institutional organization. In such cases, processes of accommodation will take place, as shown in previous studies (Valero Garcés 2002).

Data from the present corpus also shows some changes in the use of Spanish in monolingual consultations (Type 1): the non-native-speaker patient speaks broken Spanish and takes on a more active role, e.g. by asking more questions or introducing topics that are not necessarily related to his/her illness. These may include documents or administrative procedures, such as appointments, as illustrated in Excerpt 1 (from C1):

Excerpt 1[3]

The doctor (D) wants to know when the patient (P) will be going to another hospital for an appointment.

10 D: Y aquí pondrían 1003… ¿Cuándo tienes que ir a la consulta?
And here it would say 1003 … When do you have to go to the appointment?

11 P: ¿Cuál día?
Which day?

12 D: Sí
Yes

13 P: Yo primero hablar con jefe… Cuando descanso un día… Es que tu escribir un día… ¿puedo así?
Me first speak with boss … When I rest one day … when you write one day … can I do like that?

14 D: Es que… yo te puedo citar para verte yo… um.. Yo puedo decir cuando vienes tú aquí… pero no cuando vas tú al hospital. Eso tiene que ser hospital quien dice cuando vas ¿vale?
The thing is that … I can make an appointment to see you … um … I can say when you come here … but not when you go to the hospital. It is hospital that says when you go. Okay?

15 P: Sí, sí
Yes, yes.

In this example, the patient speaks in broken Spanish and the doctor uses simplified structures. Specifically, we see that the patient needs clarification and asks a question (13) instead of answering the question asked by the doctor. The patient fails to respond because he lacks knowledge of the institutional reality, and it is the doctor who can provide him with the required information.

In Type-2 encounters, the ad hoc interpreter also takes this active role. He is the one who asks the doctor questions, makes comments, adds information or even omits it, as seen in Excerpt 2 (from C3):

Excerpt 2

The patient complains of stomachache and pain after eating. She has had thyroid surgery. Her husband, acting as ad hoc interpreter, is telling the doctor where his wife feels pain.

51 I: Le molesta aquí y por eso no puede ni vomitar ni nada, aquí
It bothers her here and for that reason she can neither vomit nor anything, here

52 P: (????) bocio
(????) goitre

53 I: Dice a ver si va ser el bocio, el bocio imposible porque ya te han quitado (????) el tiroides
She says it must be the goitre; it can't be the goitre because they have already taken out (????) the thyroid

54 D: Dile que el bocio es un aumento del tamaño del tiroides, que es una glándula
Tell him that the goitre is an increase of the size of the thyroid, which is a gland

55 I: قالك واحد الطرف دلحم كيقطعوه ما كيرجعشي
He says that it is a piece of flesh that they remove, and it doesn't return

56 D: Y ya no tiene tiroides, entonces no puede aumentar el tamaño porque ya no tiene
And she no longer has a thyroid, so it cannot increase in size because she no longer has

57. I: نتنا حيدو لك تيرويديس، ويلا ماكاينشي ما يقدارشي يخلق، هو كيخلق من التيرويديس
They have taken out your thyroid, and if there is none it can't be born, it is born of the thyroid

58 P: من العنق ديالي (؟؟؟؟)قلو هادي ست شهور وانا هايدا
Tell him I take this way six months (????) of my neck

59 I: Ella dice que a veces me siento como mareada y mal y ella cree … y es lo que le digo que el tiroides no puede claro, es lo que le explico y ella no me hace caso
She says that sometimes I feel dizzy and sick, and she believes… and it is what I tell her that it can't be the thyroid …, right, it is what I explain to her, but she doesn't pay me attention

In this example we see that the husband is including information that neither the patient nor the doctor has given (55, 59). They are personal remarks based on information he has about the patient. The interpreter seems to act as the patient's

advocate, counselling her and adding or omitting information. (For further references about the distinction between the advocacy and the impartial model, see Cambridge 2003: 57–59.) There are no examples of role changes of this kind in Type-3 consultations.

3.3 Changes in the interaction order

The general structure of doctor–patient interaction is usually that of an interview organized so as to include the following activities (see Heath 1992: 237; Borrell i Carrió 1999):

- Initial greetings
- Enunciation of problems
- Evaluation and discussion of the patient's condition
- Discussion and prescription of the treatment and/or of check-ups
- Farewells

Two other common characteristics studied by Díaz (1999) in oncological interviews and also considered in a previous study of monolingual medical encounters (Valero Garcés 2002) are:

- casual inserts or 'circumstantial conversation', made up of comments on topics or aspects of daily life not related to the medical consultation;
- bureaucratic negotiations, or comments by the doctor to help the patient solve difficulties related to the institution (comments on how to fill out forms, explanations on how to get a prescription or check-up, instructions on how to request an appointment with a specialist, etc.).

In the corpus under study, these features are more frequently used and rather longer in the case of Type-1 consultations, as was seen in Excerpt 1. They are not as frequent in Type-2 encounters, where the ad hoc interpreter has usually been in the country for some years and knows how the institutions work and is thus also familiar with the bureaucracy of healthcare institutions. However, there are examples where the general structure is changed, for example when talking about symptoms or treatment, as in Excerpt 3 (from C3):

Excerpt 3

72 D: El jarabe lo tiene que tomar si tiene ganas de vomitar
She needs to take the syrup if she feels like vomiting

73 I: Solamente, ¿no?
Only then, right?

74 D: Si con estas cápsulas se le quitan las ganas de vomitar no hace

If she doesn't feel like vomiting while taking these pills, then she doesn't
75 I: No
D (cont'd.): falta que tome el jarabe, pero ahora que siga tomándolo ¿eh?
need to take the syrup, but for now she should keep taking it. Okay?
76 I: ¿Ahora sí?
Now, yes?
77 D: Ahora sí. Si se le quitan las ganas de vomitar que lo deje
Now, yes. If she doesn't feel like vomiting, then she can stop
78 I: فهمتي قالك هاد الخارابي شربو غير ملي يكون عندك غاناس دي بوميتار
دابا شربو .ملي يحيدلك ما تبقاشي تشربو .
You know, he says to take this syrup only when you have to throw up, when you don't feel like it you can stop; take it now

The doctor explains three times (72, 74, 77) that the woman can stop taking the syrup "if she doesn't feel like vomiting", whereas the interpreter only relays this to the patient after the second repetition, and not without omitting some of the information.

There are no such examples of changes in the interaction order in Type-3 consultations. There, when the patient asks for information, it is usually related to the reason for the consultation. Furthermore, the interpreter may ask for clarification or repetition, as seen in Excerpt 4 (from C5):

Excerpt 4

90 D: Now, just one more comment about … um … because Chlamydia is a sexually transmitted disease … um … it is reported and … um … someone may be calling you. They may not. That … I'll just write something to the Department of Health stating that you have been treated, so you probably won't be contacted. However, um … because it is a sexually transmitted disease, we also want to offer to you HIV testing …
91 I: Hang on. I'm sorry.
92 D: That's right. Too much. Um … where do I want to start? Um … Do you want to tell her what you want to and then … or should I … um … okay, we'll back up. Um …

Another change in the general structure of the interview is associated with the use of extralinguistic resources by the doctor. In the treatment section of the two Type-1 consultations (C1, C2), strategies such as repetition, the use of notes, or drawings on a piece of paper generally accompany the doctor's explanations so as to ensure that the patient has understood.

In the case of triadic exchanges mediated by an ad hoc interpreter (Type 2), the same strategies are present — doctor's repetitions, reformulations, yes/no questions — making the consultation longer and harder to follow, as shown in Excerpt 5 (from C4):

Excerpt 5

95 D: ¿De cuándo son los análisis?
From when are the tests?
96 I: دشمن شهر ؟
From what month?
97 P: قولو (؟؟؟؟)قولو شمن شهر؟ راه كاملين كتبو هوملك واعطاو هم لك
What month? From every month she has bring here, with you
98 I: De todos meses ella tienes traído aquí, contigo
From every month she has bring here, with you
99 D: Ya, pero los últimos ¿de cuándo son?
Okay, but the last ones. from when are they?
100 I: وقاش شبرتهم؟
The third month?
101 D: Del mes tres
The month three
102 P: شي، شي شهر هيداك
About a month ago
103 I: Un mes, un mes está en casa
One month, one month she is home
104 D: ¿Hace un mes sólo?
Only one month ago?
105 I: Sí
Yes
106 D: *¿Tiene análisis?*
Does she have tests?
107 I: Sí
Yes
108 P: (????)
109 I: Si quiere, tráelo
If you want, bring it
110 D: Yo quiero verlos
I want to see them.

In the above example, D formulates his first question twice (95, 99), then asks for confirmation (104), and finally uses a direct statement (110) that sounds like an order to explain what he wants and thus finish this exchange. As for the interpreter, he answers the doctor's questions and generates new ones, without relaying them to the patient (except once, in turn 96). Finally the interpreter makes an offer (109) that could pragmatically be considered an order because of the linguistic form used, indicating a certain lack of knowledge of the contact language, in this case Spanish.

3.4 Changes in the contribution types

Some parts of interactions conducted in institutional settings are associated with specific discourse sequences, including series of routine activities performed by the respective participants (Drew & Heritage 1992; Drew & Sorjonen 1997; Heritage 1995, 1997). This means that, depending on the service provided by the institution or the moment of the interaction, specific linguistic forms are expected. Thus, in the medical evaluation section, the interaction is characterised by question–answer sequences, in which the question is a routine formula used by the supplier of services and the answer is provided by the patient. In this sense, the doctor usually tries to get information, and this function is generally performed with questions that can vary in form — direct or indirect — and may also involve the manipulation of intonation. At times the doctor may offer a list of options, but more often the patient will be told what to do, using the imperative, the immediate future, or the present. When the doctor speaks of bureaucratic negotiations s/he usually gives advice, and often uses conditional sentences or other linguistic structures associated with this function.

Concentrating on question–answer sequences in triadic exchanges (Type 2 and Type 3), the corpus analysis yields the quantitative findings summarised in Table 1.

Table 1. Questions by participants and interpreters' actions following the questions

	Total no. of questions	Doctor	Patient	Interpreter
C3	9	8	1	5 answered directly (56%) 2 translated (22%) 3 new questions
C4	28	25	3	12 answered directly (43%) 3 translated (11%) 4 new questions
C5	30	24	5	All translated, 1 new question
C6	31	28	3	All translated

Out of a total of 9 questions, the ad hoc interpreter in C3 answers 5 directly (56%) and translates only 2 (22%), while asking 3 new questions. Similarly, in C4, he answers 12 questions out of 25 (43%), translates only 2 (11%) and asks 4 new questions. In both Type-3 consultations, in contrast, the interpreter translates all questions, and in one instance asks for clarification.

Other changes that are common in Type-1 and Type-2 consultations are accommodation processes seen in the utterances of both doctors and ad hoc interpreters. In the case of the doctor, these include: short sentences; simplified language; more

شمن شهر؟ قولو
, *with you*

5, 99), then asks for
that sounds like an
e. As for the inter-
es, without relaying
preter makes an of-
use of the linguistic
ct language, in this

careful pronunciation; formulation of alternative questions (either … or); formulation of yes/no (direct) questions; generic vocabulary and avoidance of technical terms; ungrammatical sentences, with omission of articles, prepositions and auxiliary verbs, or the use of infinitives instead of conjugated verb forms; frequent reformulation; and moves to take/recapture the initiative.

In our corpus these strategies are illustrated in Excerpts 6 (from C1) and 7 (from C3).

Excerpt 6

22 D: ¿Qué trabajas?
What do you work?
23 P: Hoy descanso
Today rest
24 D: Hoy descanso… ¿qué trabajas todos los días?
Today rest… What do you work every day?
25 P: No, dos ó tres horas… siete por la mañana tres horas
No, two or three hours … seven in the morning three hours
26 D: ¿Vas a las siete y estás tres horas…?
You go at seven and you are there for three hours … ?
27 P: Yo … por la mañana desde las siete hasta las tres
Me … in the morning from seven o'clock to three o'clock.
28 D: Vas a las siete hasta las tres… O sea trabajas de siete a tres
You go from seven o'clock to three o'clock … That is to say you work from seven to three
29 P: Si, si
Yes, yes
30 D: O sea 7 a.m. a 3 p.m. ((writes this on a piece of paper and shows it to P)) ¿vale?
So, 7 a.m. to 3 p.m.
Okay?
31 P: Sí, si
Yes, yes
32 D: ¿Todos los días? ¿menos uno o dos libres a la semana?
Every day? Except one or two days off a week?
33 P: Uno a la semana fiesta. Hoy descanso.
One a week free. Today rest.

Thus, the doctor in Excerpt 6 uses simplified, colloquial language, even ungrammatical sentences (22), and reformulates the non-native-speaker patient's words (24, 30). His questions are direct, requiring simple answers (26, 32).

Examples of this kind are also found in Type-2 consultations. In Excerpt 7 (from C3), the doctor gives an explanation using three different forms (90):

Excerpt 7

88 D: Vale. ¿Usted tiene pastillas para no tener niños?
Okay. You have pills for not having babies?

89 I: Sí, si
Yes, yes

90 D: Bueno, las pastillas disminuyen, hacen más pequeña la regla, menos sangre; ¿Lo entiende?
Good, the pills lighten, make your period smaller, less blood. Do you understand?

91 I: Um
Uh huh

92 D: Y esto está bien para el hierro. Está bien. Además no puede tener niños, que es lo que queremos
And this is good for her iron. It's good. Besides she can't have babies, which is what we want

93 I: Vale
Okay

94 I: Sí. ((to his wife))
كيعملك الباستيات باش ميهبطولكش الدم بزاف وما يكونوش عندك الدراري
Yes. ((to his wife)) *He will give you pills so that there won't be much blood and don't catch*
((to D)) ¿Pastillas menos sangre y no coge el el niños, ¿no? Vale
((to D)) *Pills less blood and don't catch … babies, right? Okay.*

The ad hoc interpreter, like the non-native-speaker patient in the monolingual interview, introduces questions, provides short answers, occasionally uses monosyllabic utterances, and sometimes does not even answer unless the doctor insists, or else, he provides more information than required and uses ungrammatical utterances with abundant repetition.

In Type-3 exchanges, the processes of accommodation by both the doctor and the patient are less evident; the doctor uses more technical words, and does not usually repeat or reformulate information. As for the interpreter, she still has some problems with language, and her translations are sometimes too literal and inaccurate. Excerpt 8 (from C5) illustrates some of these difficulties:

Excerpt 8

36 D: Well, I'm going to be giving you some medicine for you … to take.

37 I: Y le voy a dar medicamentos para que usted tome
And I'm going to give you some medicine for you to take

38 D: And your partner will also need to be treated

39 I: Y su compañero va a necesitar tratamiento
And your partner is also going to need treatment

40 P: ¿Por qué mi compañero?

Why my partner?
41 I: And why my partner?
42 D: This is an infection that we know is passed sexually
43 I: Esta es una infección que es pasada sexualmente
This is an infection that is passed sexually

In the above example the doctor offers the patient clear information, using short sentences and avoiding specialised language. The interpreter translates literally, sometimes producing deviant utterances in Spanish (43).

3.5 Variation in lexical choice

Heritage (1997: 167) also states that the type of lexical choice made by participants in an institutional setting is indicative of the understanding and handling of the situation and of the speakers' command of the language (codes, styles, general or specific terms) as well as their awareness of the Other.

The use of appropriate vocabulary contributes to making communication more effective, but in the case of non-native-speaker patients and ad hoc interpreters who are not fluent in the language, this task is extremely difficult. The tendency is then to use generic terms, repetition, borrowings, invention of new words, code switching, or an inconsistent mix of registers. The rate of use of these resources is generally related to an asymmetry of knowledge between the patient and the doctor, on the one hand, and to problems derived from an incomplete knowledge of the language, on the other. Some examples found are: '*examen de oreja y ojo*' ('ear and eye examinations') instead of '*examen de vista y oído*' ('hearing and eyesight examinations'), or 'cuando abrimos la television'' ('when we open the television') instead of '*cuando ponemos la television*' ('when we turn on the TV'), or the use of very colloquial expressions, as in '*yo tengo de cuidar una vieja*' ('I have to watch that old lady'), using highly colloquial Spanish to refer to an elderly woman, instead of '*tengo que cuidar de una anciana*' ('I have to take care of an elderly woman').

In Type-3 consultations, there were no problems of this kind, although specialised terms and expressions also proved difficult for the interpreter, as can be seen in Excerpt 9 (from C5):

Excerpt 9
30 D: The discharge and also the pain … the bleeding with intercourse
31 I: *El flujo y también el sangramiento cuando tiene relaciones*
The discharge and also the bleeding when you have relations
32 D: *And the pain with intercourse you're having*
Y el dolor cuando tiene relaciones sexuales
33 I: *Y el dolor cuando tiene relaciones también.*

In this exchange, we find words such as 'discharge,' 'bleeding,' and 'intercourse,' terms which can be considered specialized if the context in which they were used is taken into account. The translation strategies used are a literal translation for 'discharge' and 'bleeding', with different results. The translation 'flujo' is acceptable, while *'sangramiento'* does not exist in Spanish, and the translation for 'intercourse' (*relaciones*) is incomplete since it does not specify what kind of relations are meant.

Generally speaking, we could say that, in all three types of encounters, the doctor sometimes tries to adapt his/her speech to the patients' command of the language by replacing technical terms with descriptive words, synonyms, repetitions, direct forms, and even ungrammatical sentences; that is, the doctor tries to offset or to reduce the communicative distance by adapting the grammar and vocabulary to both the patient's and the interpreter's knowledge of the language.

4. Quantitative comparison

Some similarities and differences can be distinguished and quantified by comparing the pattern and content of monolingual interviews (Type 1 — C1, C2) to the two interpreted interview types (Type 2 — C3, C4; Type 3 — C5, C6). Table 2 provides information about the total number of speaker turns in each recorded conversation as well as the rate of participation of each participant.

Table 2. Speaker turns in C1–C6

	C1	C2	C3	C4	C5	C6
Doctor	98 (55%)	70 (54%)	31 (39%)	41 (37%)	71 (37%)	78 (31%)
Patient	79 (45%)	60 (46%)	13 (16%)	21 (19%)	28 (14%)	73 (29%)
Ad hoc Interpreter			36 (45%)	48 (44%)		
Trained Interpreter					94 (49%)	99 (40%)
Total	**177** (100%)	**130** (100%)	**80** (100%)	**110** (100%)	**193** (100%)	**250** (100%)

As seen in Table 2, the number of turns in the monolingual interviews shows a similar distribution between doctor and patient, with the former producing 8%–10% more turns. In Type-2 encounters, the largest share of turns is recorded for the ad hoc interpreter, who is responsible for a higher percentage of turns (44%–

45%) than the trained interpreter in C6 (40%). In C5, nearly 50% of the turns are produced by the interpreter, which is what one would expect if the interpreter rendered both the doctor's and the patient's utterances in the other language.

Obviously, the principal difference between the monolingual and the interpreted interviews is the amount of 'direct interaction' between doctor and patient. In the monolingual interviews, doctor and patient use the same language and therefore have the potential to understand one another. However, since the patient has only a limited command of the language and insufficient knowledge about administrative procedures, the monolingual, dyadic encounters show processes of accommodation as well as changes in interaction patterns and in the distribution of time and roles.

In the case of the triadic interviews, the only way to establish verbal interaction between doctor and patient is through the bilingual husband acting as ad hoc interpreter (C3, C4) and through the hospital interpreter (C5, C6). Thus, only those utterances by the bilingual agent that are interpretations of another's speech constitute "direct interaction" between the doctor and the patient in these interviews. In Type-2 encounters, however, the ad hoc interpreter not only translates, but also adds or omits information or gives advice, while in Type 3, the interpreter mainly reproduces what the doctor and patient say in the other language. This was seen in the quantitative analysis of questions and their fate in the bilingual mediated encounters (see Table 1). In Type-2 consultations, only 5 of the 37 questions (14%) were translated, while in Type 3, all the questions asked by the doctor were interpreted directly to the patient.

5. Conclusion

The comparative analysis of dyadic and triadic doctor–patient consultations presented in this paper has yielded a number of relevant findings. In the monolingual mode (Type 1), while there is direct one-to-one communication between healthcare professional and patient, the patient's limited language proficiency and lack of institutional knowledge result in changes in the assignment of participant roles, in the interaction order and in the contribution types. Similar phenomena can be observed in Type 2 encounters: The ad hoc interpreter's linguistic competence is not very high, although he has better knowledge of how the institution works and some other interactional resources, which tend to reduce the occurrence of bureaucratic explanations or casual inserts. Nevertheless, the rate of direct one-to-one communication is quite low, as the husband-interpreter moves freely between the roles of interpreter, patient advocate and husband, frequently taking over the

doctor's role of questioning and counselling the patient or providing information about the patient directly to the doctor. Whenever the ad hoc interpreter speaks directly to either the doctor or the patient, no interpretation is available to the other party, and replies are often not translated.

Finally, in Type-3 consultations, mediated by a trained hospital interpreter, the bilingual third party was found to be quite skilled in interpreting and to maintain a narrowly defined interpreter role. However, there was evidence of some problems with terminology and with memory for longer stretches of discourse.

Comparison between the three types of encounters also indicates that Type 1 and Type 2 share some features related to the use of certain communication strategies (frequent questions, repetitions, reformulations, etc.) and that these affect the general structure of the interview and the participants' roles. In the case of Type 2, the ad hoc interpreter acts more as an advocate and husband than solely as an interpreter. While his failure to relay utterances by the doctor and the patient to the other participant may save time, it constitutes a considerable communicative risk: the doctor feels that the husband knows his wife's (i.e. the patient's) problem but he cannot be sure about the husband's skill and ability to interpret accurately and hence often uses similar resources as in the monolingual interview (Type 1).

The interpreter in the two Type-3 encounters maintains an impartial role and uses specific strategies such as direct rendition of questions or asking for reformulation when she has difficulties (e.g. with terminology or long utterances). Thus, whereas the ad hoc interpreter fails to translate or avoids technical terms (e.g. using "back" when the doctor says "spine"), the hospital interpreter asks the doctor for clarification. The trained interpreter also uses the first person, whereas in consultations involving an ad hoc interpreter the three participants frequently use the third person ('tell her', 'ask her', 'she says').

In conclusion, this study illustrates some differences and similarities between three different types of interaction between doctors and immigrant patients with some or practically no command of the official language: monolingual vs. bilingual, mediated either by an ad hoc interpreter or by a trained hospital interpreter. Though most of the study is descriptive, it also serves as a reminder of the importance of using professional interpreters in medical consultations. Furthermore, the use of examples taken from this corpus can be valuable for educational purposes, both in the training of future healthcare interpreters and in initiatives to help doctors work effectively with interpreters.

Notes

1. The research carried out for the writing of this paper is part of two projects, one funded by the University of Alcalá (Ref. UAH OI 2004/010) and focused on the quality of communication between healthcare staff and foreign patients at one of the biggest hospitals in Madrid, and the other (still in progress) funded by the Spanish Ministry of Education (Ref. HUM2004-03774-C02-02-FILO) (2004–2007) and centred on the quality of communication between healthcare staff and foreign patients and on the development of proposals for training. I also want to thank Franz Pöchhacker, Brook Townsley and two anonymous reviewers for their helpful comments.

2. Since the creation of FITISPos (*Formación e Investigación en Traducción e Interpretación en los Servicios Públicos* / Training and Research in Public Service Translation and Interpreting) in 1998, the corpus has been extended, thanks to several research projects funded by public or private institutions.

3. The numbers in the examples indicate the turn in the conversation. The translation offered is a literal one, reflecting as much as possible the often nonstandard use of Spanish in the original. The transcription code, which for the sake of readability has been reduced to a minimum, is as follows:

(????)	unintelligible
?	interrogative rising intonation
...	pause
((...))	extralinguistic comment
}	overlapping

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Healthcare Interpreting

Discourse and Interaction

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John Benjamins Publishing Company
Amsterdam / Philadelphia

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI z39.48-1984.

Library of Congress Cataloging-in-Publication Data

Healthcare interpreting : discourse and interaction / edited by Franz Pöchhacker, Miriam Shlesinger.
p. ; cm. -- (Benjamins current topics, ISSN 1874-0081 ; v. 9)
Includes bibliographical references.
1. Medicine--Translating. 2. Health facilities--Translating services. 3. Physician and patient. I. Pöchhacker, Franz. II. Shlesinger, Miriam, 1947- III. Series.
[DNLM: 1. Professional-Patient Relations. 2. Translating. 3. Communication Barriers. W 62 H4347 2007]
R119.5.H43 2007
362.1--dc22 2007007385
ISBN 978-90-272-2239-8 (alk. paper)

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John Benjamins Publishing Co. · P.O. Box 36224 · 1020 ME Amsterdam · The Netherlands
John Benjamins North America · P.O. Box 27519 · Philadelphia PA 19118-0519 · USA

Table

The Cultural Interpreter: An Appreciated Professional

Results of a Study on Interpreting Services: Client, Health Care Worker and Interpreter Points of View

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Abstract

After four years in operation, the Inter-regional Interpreters Bank was the object of a study in which close to 500 Montreal users (clients, health care workers and interpreters) expressed their opinion on the Bank's services.

This study made it possible to confirm that interpreters meet the expectations of clients and health care workers. It also served to measure the degree of client and health care worker satisfaction with the Bank's services and their confidence in professional interpreters versus other types of interpreters.

With regard to ways of working together, findings showed that the opinions of interpreters and health care workers converge. The study also brought to light their perceptions of one another and led to the publishing of a reference sheet on how to work more efficiently with an interpreter.

The complete results of the study summarized here are featured in a report entitled *L'interprète culturel : un professionnel apprécié.*

Introduction

According to 1996 Canadian census data, over 60 000 residents of the Greater Montreal area are unable to carry on a conversation in French or in English.

They represent close to 85% of all persons with similar difficulties in Quebec. This means that they do not have full access to public services. These 60 000 people are therefore likely to need an interpreter, particularly in order to receive health care.

These difficulties are not new. They have, in fact, been taken into account by the Government of Quebec over the last 20 years. *An Act respecting health services and social services*, adopted in 1991, provides rules designed to ensure access to these services. Article 2.7 advocates a way of organizing services aimed "to foster, to the extent allowed by the resources, access to health services and social services in their own languages for members of the various cultural communities of Quebec." Article 15 furthermore stipulates that English speakers have the right to receive services in their own language[1].

This Act and all professional orders connected to the health care sector refer to the importance of establishing good communication with the client.[2] Certain orders are more specific, and stipulate the obligation to give the client relevant information. Some, such as the College of Physicians, go even further and make it necessary for their members to obtain free and informed consent from the client.[3]

In a number of situations, clients and health care professionals must call upon an interpreter. In order to adapt services to the various cultural communities' needs, the *ministère de la Santé et des Services sociaux du Québec* asked the *Régie régionale de la santé et des services sociaux de Montréal-Centre*—the organization in charge of planning and coordinating services on the Island of Montreal—to create the Inter-regional Interpreters Bank. This Bank has been in operation since 1993. It employs 70 cultural interpreters and offers services in some 50 languages. These interpreters serve the institutions of the Greater Montreal area. Quebec's other urban centres also have interpreter banks to reach similar clients. Each bank is organized in its own way, but they all share the same concept of the cultural interpreter's role.

Concept of the Cultural Interpreter's Role

Two main schools of thought come through in the literature on the interpreter's role. According to the first, "[...] the interpreter merely translates whereas, in the second, he is considered to be one of the members of the social support team [...] and becomes a mediator-interpreter."[4]

Our interpreters are halfway between these two schools. In fact, their role is neither one of cultural mediation nor of advocacy. They are not guides, counsellors or intermediaries who serve or defend underprivileged clients as defined by Roberts (1995: 13).

Our definition of the interpreter's role is based on two principles. First, the professionals in the health care and school systems, referred to hereafter as "workers," are the masters of their professional intervention. Second, clients' autonomy and ability to make decisions regarding their own person must be respected, in the spirit of the Charte des droits et libertés de la personne.[5]

The Bank's interpreters serve the client and the health care worker equally. This is clearly stated in their Code of Ethics and stressed during the preliminary training workshops. They transmit all verbal and non-verbal information in strict confidentiality, while helping each party to understand the values, concepts and cultural practices of the other. They do all this with neutrality, and using vocabulary adapted to each party.

After four years in operation, the Bank commissioned a study to find out whether this role still corresponded to client and health care worker expectations and to measure their degree of satisfaction with its services.

The Study

The study was designed to:

1. examine the expectations of clients and health care workers with regard to interpreters;
2. measure client and health care worker satisfaction with the service;
3. examine the expectations of health care workers and interpreters with regard to work methods;
4. examine the perception that health care workers and interpreters have of the work as it is conducted in the field;
5. identify indicators that could be used to improve service.

We therefore consulted each of these parties, from November 1996 to May 1997. Focus groups made it possible for us to hear from 38 clients, 33 health care workers and 12 interpreters. Finally, 66 clients who spoke 11 different languages, 288 health care workers from 30 institutions and 40 of the Bank's most experienced interpreters answered our questionnaires.

All of the results of the study summarized here are featured in a report entitled *L'interprète culturel : un professionnel apprécié.*

Methodology

We began by using the exchanges that took place during the focus groups of clients, health care workers and interpreters to draw up questionnaires for each of these groups. Only the questionnaires aimed at health care workers and interpreters included a section for comments. It was not possible to do this with the clients' questionnaire. They would have answered in their own language, which would have meant extra translation costs and more time.

Clients

We asked four community organizations that provide assistance and support to new immigrants to recruit participants for the focus groups. These meetings took place in Arabic, Cantonese, Spanish and Russian. The questionnaires produced were translated into these same languages and tested with the clients to make sure they were understandable regardless of schooling. Following the testing stage, we had the questionnaires translated into the 12 languages for which there is the most demand at the Bank, i.e. Arabic, Bengali, Cambodian, Chinese, Creole, Laotian, Portuguese, Russian, Spanish, Tamil, Turkish and Vietnamese.

The questionnaire enabled clients to express their preferences regarding the different types of interpreters and to indicate which type they trusted the most. We also included 10 statements and asked clients to signify whether they agreed or disagreed.

Finally, interpreters gave the questionnaires to clients aged 14 and over. In order to prevent the interpreter's presence from influencing the clients' answers, the latter were instructed to return the questionnaire in an attached pre-addressed, stamped envelope the week after the session with the interpreter.

Health Care Workers

With the help of our computerized files, we were able to identify the health care workers from the 30 institutions who had made the most use of our interpreters' services over the last two years. These files enabled us to draw up a list of participants for the focus groups, as well as a mailing list for the questionnaires.

We organized three focus groups with health care workers from local community service centres (CLSCs),[6] hospitals, youth protection centres and a hearing disorder rehabilitation centre.

The questionnaires produced by these focus groups touched on health care workers' expectations, their perception of the service and their perception of work methods. For each question, the health care worker was asked to assess the performance of the Bank's interpreters and that of volunteer interpreters (relative, colleague, volunteer, friend or neighbour).

Interpreters

The interpreters were also consulted in a focus group. We then drew up a questionnaire to gauge their expectations regarding work methods with the health care workers, as well as their perceptions of situations in which they had acted as interpreters.

Response Rate

The questionnaire's response rate was 27% for clients, 91% for interpreters and 35% for health care workers. We noted a proportional over-representation of answers from social workers working in youth protection centres in relation to answers from health care workers in a hospital setting. This is not surprising, since social workers use our services the most.

Methodological Limitations

We came up against a number of difficulties, including the illiteracy of certain clients and the language limitations of some English-speaking health care workers. The Quebec government made French the province's official language in 1974. Since that time, it has upheld French as the common language of public administration. The questionnaire aimed at health care workers was therefore in French, which could explain the very low response rate from English-speaking institutions.

Results

Clients' Answers

The 38 clients who participated in the focus groups spontaneously spoke of

linguistic problems as being the main obstacle to accessing the health care system. It should be noted that a large majority of these clients had not benefited from the services of a professional interpreter trained by the Bank. While our sample was too small to represent all immigrants, we feel that the comments made during the focus groups reveal the communication difficulties experienced.

The clients' primary expectation with regard to interpreters is linguistic expertise. They spoke of their reluctance to ask for a favour from people who are close to them; of the limited availability of volunteer interpreters (family members, friends or neighbours); and of the feeling of being under obligation to the volunteer interpreter. "The man who came to the hospital with me wanted me to join his church. He pressured me and implied I owed him." (Spanish-speaking participant)

Clients told us of their reticence to relate intimate details in front of a volunteer interpreter. "We fear that our problems will not always be kept confidential and the whole community will end up finding out about them. There are certain problems that we do not want to share with our neighbours." (Arabic-speaking client)

This explains why 76% of the 66 clients who answered the questionnaire said they preferred to deal with a professional interpreter when consulting medical personnel, and 85% expressed the same preference when seeing a social worker. As for the school milieu, 68% of these clients expressed their preference for a professional interpreter. Regardless of the situation, only 5 to 9% of clients said they preferred a relative, friend or neighbour to interpret for them.

Furthermore, the answers to the questionnaire show that clients believe a professional interpreter will give a faithful translation. With regard to accuracy, 88% trusted professional interpreters more than volunteers (8%). In other words, clients had ten times more confidence in the accuracy of a professional interpreter than in the accuracy of a relative, friend or neighbour.

As for discretion, 83% of clients trusted the professional interpreter more than a relative, friend or neighbour (11%).

By way of extra information, here are some of the answers taken from the clients' questionnaire. The statements below were formulated based on the expectations expressed by clients in the focus groups. The high percentage of *I agree* and *I totally agree* answers confirms that the Bank meets these expectations in a more than satisfactory manner.

	I agree and I totally agree
The interpreter from the Bank knew both my language and the language of the health care worker well.	96%
He spoke to me in words that I was able to understand.	98%
He listened to me carefully and was sensitive to my problem.	95%
He helped me to understand the situation and to say what I had to say.	97%
He respected my values and beliefs.	95%

Health Care Workers

For the 33 health care workers who participated in the focus groups, good communication is of primary importance and an interpreter is essential when dealing with this type of clientele. Indeed, they related the difficulties they had establishing a diagnosis or accurately assessing a situation when communication with the client was inadequate. They also mentioned the risks associated with misunderstanding treatments.

The results of the 288 questionnaires received corroborate these concerns and show that health care workers have equally high expectations regarding the interpreter's proficiency in the client's language (96%) and their ability to inform them when the client does not understand (92%). They also rely on the interpreter to remind them to clarify technical jargon.

The translation must furthermore be precise and accurate. This is why health care workers are concerned with semantic distortions as well as additions and censorship of information. As pertains to accuracy, health care workers trust trained, professional interpreters more (83%) than volunteer interpreters (3%). "It is often too difficult for a family member to accurately translate what is being said." (hospital nurse) It is interesting to note that they trust the accuracy of the professional interpreter twice as much as that of their own colleagues (42%).

It is important to remember that communication goes beyond words. Health care workers seem aware of this and say that they appreciate working

with an interpreter because "he,or she, often facilitates their initial entry into the family circle." The interpreter can also help them establish a treatment plan that will be compatible with the client's values and culture, and will therefore stand a better chance of being understood and followed.

However, expectations concerning explanations about the culture are among those that received the lowest percentage of *very important* answers from health care workers, whereas 72% of interpreters considered it *very important* to be able to provide such explanations. Another thing that should not go unnoticed is the health care workers' answers with regard to clarifying non-verbal communication (only 42% deemed this to be *very important*). There is a similar reaction with regard to the risk of upsetting the client with a question that could be judged inappropriate or hurtful (only 58% considered this *very important*). These answers seem contradictory when compared with the importance health care workers attached to the respect of values and beliefs (78% found it *very important*).

Given this situation, it may be useful to emphasize the influence of culture and non-verbal communication in training programs for health care workers in order to avoid misunderstandings that could prejudice the intervention.

Health Care Worker Satisfaction

According to health care workers, the Bank's interpreters meet their expectations twice as often as volunteer interpreters when it comes to knowledge of the health care worker's language (93% versus 46%), accuracy and precision when translating (78% versus 38%), respect of values (89% versus 40%), confidentiality (93% versus 39%), and remaining neutral (80% versus 37%). "A professional interpreter is more neutral. For example, if the family asks him 'What should I answer the social worker?', he will translate this sentence to me." (social worker, youth protection centre) Furthermore, health care workers consider professional interpreters to have a greater capacity to keep an emotional distance (79%) than do volunteer interpreters (39%).

> Clients' relatives, friends or neighbours cannot remain neutral. The interests of their family will prevail over translation. We cannot afford to use a social worker as an interpreter. Our sense of analysis, of assessment and of psychological interpretation will colour our translation. A volunteer is there to help the client and this role will influence the quality of his translation. (social worker, youth protection centre)

The smallest gap between the two types of interpreters concerns knowledge of the client's language (95% versus 80%) and culture (87% versus 76%).

As far as discretion is concerned, health care workers trust the Bank's interpreters (80%) more than they do their colleagues (49%) or the client's relative, friend or neighbour (3%). "Screening for confidentiality will have to be improved when using volunteer interpreters." (general practitioner, local community service centre)

The Bank's interpreters also have the advantage of being more available than one's colleagues. "The head of the department has to release the employee. We feel under pressure as the colleague is subjected to pressure from his department if he is away from his job for too long." (hospital health care worker)

It is therefore not surprising that 88% of health care workers declare themselves to be *satisfied* or *very satisfied* with the services offered by the Bank.

Interpreters

During the focus group, interpreters expressed similar opinions about the work methods they needed to follow in order to interpret well and create a bridge between the two cultures. We found that their expectations match those of health care workers on a number of points.

In fact, with regard to the information made available prior to the meeting, 48% of interpreters and 52% of health care workers find it very important. As for explaining the objectives of the intervention, 45% of interpreters and 50% of health care workers find it very important. Both also stress the importance of introducing the interpreter and the health care worker to the client (60% and 74% of *very important* answers). "We have to be prepared so that everybody can trust us." (Spanish interpreter)

Interpreters and health care workers also attach a significant level of importance to flow of speech and pauses (76% of health care workers versus 68% of the interpreters), explanations about the culture (61% versus 73%) or debriefing after the intervention (43% versus 40%).

Let us now consider the perception that health care workers and interpreters have of one another. They differ significantly on the availability of

information prior to the meeting (87% of health care workers believe they *always* provide it and 40% of interpreters confirm this fact); on introducing both parties to the client (85% versus 54%); and on debriefing after the intervention (89% versus 33%).

How Interpreters Perceive their Role

During the interpreter's training, the importance of neutrality is emphasized. This role seems to be well understood since 78% feel *a little uneasy* or *very uneasy* telling the health care worker what decision they would make in his place.

Consequently, 83% of interpreters feel *a little uneasy* or *uneasy* siding with the health care worker (48% have never done it and 38% indicated that the question does not apply); and 53% of interpreters are *a little uneasy* or *uneasy* about explaining vaccinations, laws or a diagnosis in the health care worker's place. Indeed, 73% declare they have never done it or the question does not apply.

Thus, both parties have similar expectations with regard to work methods. Interpreters meet the expectations of health care workers. The relationship between workers and interpreters seems excellent. Indeed, health care workers do not want interpreters to intervene in their place, and 89% of the interpreters state that health care workers have neither asked them to do this, nor requested that they assume the role of assistant. Furthermore, 98% of interpreters say that health care workers have never made any unreasonable requests. "We feel respected and appreciated, they [the health care workers] often thank us for the help we have provided." (an interpreter)

Analysis

The study's findings show that the situation of clients, health care workers and interpreters in Greater Montreal is not very different from that in Europe and the rest of North America. For example, in a study on adapting services for young immigrant families, Heneman (1994: 104-105) finds that linguistic factors (37%) outweigh all others (economic, geographic, administrative and lack of information) when it comes to accessing the formal network.

The clients we consulted also spontaneously raised the issue of linguistic problems as the main obstacle to accessing the health care system. Some clients

told us that they would wait for their pain to go away, and only consult a doctor when they felt the problem was serious. While our sample is too limited to represent all allophones[7] who speak neither French nor English, we might suppose that these clients receive less preventive care than clients with no linguistic difficulties. Care provided at a later stage of the illness runs the risk of being more intensive and therefore more expensive.

This situation is also touched on by Woloshin (1995: 725) in an article in which he writes about communication difficulties leading American doctors to prescribe additional tests, not to mention the human and financial risks tied to misunderstanding the care plan.

Language barriers also have an effect on our health care workers. They highlighted above all the complexity of making a diagnosis or an accurate and precise assessment of the situation when communication with the client is inadequate. Regardless of whether the treatment is medical or psychosocial, clients and health care workers want to understand what is being said and be understood. It is, in fact, essential for clients to understand what is happening if we want them to participate in shared decision-making, know what they are signing and comply with suggested service plans. This point was particularly stressed by psychosocial health care workers in the youth protection field.

In order to achieve this, the translation must be precise and accurate. In this respect, the expectations of the health care workers who participated in this study were similar to those observed in other studies. They worry about semantic distortions as well as added or censored information.

However, the fact that health care workers find culture to be of little importance in this issue leads us to believe that they are not totally aware of the problem addressed by Kaufert and O'Neil (1990: 46), i.e. interference of the interpreter's explanatory models in the translation process, particularly when the interpreter is a relative of the client.

Carr (1995: 271) highlights the fact that cooperation from an untrained interpreter can sometimes have unfortunate results. In particular, she mentions the doubtful validity of consent to certain types of treatment and reiterates the impact that inadequate interpretation can have on the accuracy of the diagnosis and on confidentiality.

On this subject, we noticed that the health care workers who participated in our study seemed to lend greater importance to confidentiality than the clients did. We should point out that the clients who participated in the focus groups expressed concerns about confidentiality when assisted by a relative or volunteer

interpreter. However, they never mentioned concerns of this kind with respect to the health care worker or the professional interpreter.

Conclusion

As a result of this study, we can see that the Bank's interpreters meet the expectations of clients and health care workers. Clients and health care workers are highly satisfied with the Bank's interpreters, and express their clear confidence in and preference for this type of interpreter.

> The Bank stands out because of the availability of its interpreters, the possibility of having the same interpreter in case of follow-up, not having to change interpreters every time, the appropriate knowledge of the languages used and the interpreters' professionalism. (social worker, local community service centre)

However, despite both parties' preference for a professional interpreter, health care workers have told us that they often call upon the services of volunteer interpreters or colleagues. The main reason for this is concern about the cost of using the Bank. Health care workers seemed unaware of the fact that the Montreal institutions that used our services in 1996-1997 ended up spending barely 0.01% of their annual budget on provision of interpreting. None of the health care workers mentioned the cost of calling on a colleague, but if we examine the study carried out by Bruners (1994), these costs could be as high as $11 000 a year.

It would be interesting for other researchers to study the use of professional interpreters in terms of the resulting savings. Such a study could take into account missed appointments, examinations that could have been avoided if the professional had understood the client properly, and the costs generated by care provided when the illness is already at an advanced stage. It would also be relevant to measure the hidden costs tied to using a colleague as an interpreter, which results in work overload for those who must do his job while he is elsewhere interpreting, and affects the quality of care.

Notwithstanding the cost issue, health care workers must assume the responsibilities they have under the Act and the various codes of ethics. A Canadian Supreme Court ruling recently specified that a health care institution's

refusal to provide a sign language interpreter infringed upon the client's right to equal treatment. Let us point out that this right is guaranteed by the Constitution. It would be a shame for allophone clients to have to wait for a similar ruling for persons who have trouble communicating due to linguistic limitations.

One way for institutions to control interpreter costs without affecting the quality of services and the degree of satisfaction on the part of the various users would be to adopt a policy on the use of interpreters. As for actions to be taken by workers, they might consult our reference sheet on how to work efficiently with an interpreter and continue to participate in training sessions devoted to the provision of care in an intercultural context.

Notes

1. Article 15 stipulates "English-speaking persons are entitled to receive health services and social services in the English language, in keeping with the organizational structure and the human, material and financial resources of the institutions providing such services, and to the extent provided by an access program referred to in section 348." 1991, c.42, S.15.

2. For more information, see Appendix 2 of *Giving Voice to Our Future: The Inter-regional Interpreters Bank 1993-1996, Portrait of a Successful Experience*, Isabelle Hemlin and Anne-Marie Mesa, Régie régionale de la santé et des services sociaux de Montréal-Centre, Canada, December 1996. 24 pages.

3. Collège des médecins du Québec, *Recueil des lois et règlements*, Canada, May 1995, taken from the physicians' code of ethics, art. 2.03.28.

4. « L'interprétariat en milieu social », Transcripts of the Symposium, Report from Workshop No. 2, Strasbourg, France, October 1995, p. 75.

5. Charter of rights and freedoms adopted in Quebec in 1975.

6. These public centers offer first-line medical and social services.

7. This word is used in Quebec to refer to persons whose mother tongue is neither French nor English.

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Volume 31

Roda P. Roberts, Silvana E. Carr, Diana Abraham and Aideen Dufour (eds.)

The Critical Link 2: Interpreters in the Community.
Selected papers from the Second International Conference on Interpreting in legal, health and social service settings, Vancouver, BC, Canada, 19-23 May 1998.

THE CRITICAL LINK 2: INTERPRETERS IN THE COMMUNITY

SELECTED PAPERS FROM THE SECOND INTERNATIONAL CONFERENCE ON INTERPRETING IN LEGAL, HEALTH AND SOCIAL SERVICE SETTINGS, VANCOUVER, BC, CANADA, 19–23 MAY 1998

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JOHN BENJAMINS PUBLISHING COMPANY
AMSTERDAM/PHILADELPHIA

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences — Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Library of Congress Cataloging-in-Publication Data

International Conference on Interpreting in Legal, Health, and Social Service Settings (2nd : 1999 : Vancouver, B.C.)
The critical link 2 : interpreters in the community : selected papers from the Second International Conference on Interpreting in Legal, Health, and Social Service Settings, Vancouver, BX, Canada, 19-23 May 1998 / edited by Roda P. Roberts ... [et al].
p. cm. -- (Benjamins translation library, ISSN 0929-7316 ; v. 31)
Includes bibliographical references and index.
1. Translating and interpreting--Social aspects--Congress. 2. Translating services--Congresses. 3 Human services--Translating--Congress. I. Title: Critical link two. II. Roberts, Roda P. III. Title. IV. Series.
P306.2 .I55 1999
418.02--dc21 00-058578
ISBN 90 272 1636 3 (Eur.) / 1 55619 790 X (US) (alk. paper)

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John Benjamins Publishing Co. • P.O.Box 75577 • 1070 AN Amsterdam • The Netherlands
John Benjamins North America • P.O.Box 27519 • Philadelphia PA 19118-0519 • USA

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Christmas lunch (turkey, stuffing, Christmas cake, Christmas pudding, flambé, money, mince pies). Anything else, as an advert for plump Christmas turkeys states, "just isn't Christmas".

Clearly, many individuals and groups have other 'variant' rituals, which equally form part of the same culture. Also, Ritchie (1981:223) points out that "what a people believe themselves to be is not invalidated by lack of performance in keeping with the belief". We will now turn to what lies behind the beliefs cultures hold, and what motivates people within their cultures to behave in their various patterned ways.

9.2 Cultural Orientations

In this section we distinguish between general orientations, also known as learning styles, and culturally formed orientations.

- ***Orientations***

- Meta-programs
- Chunk Size
- Separate shapes – Single picture

The word 'orientation' is another case of a nominalization (in this case, a de-verbal noun), suggesting a frozen state. The verb 'to orient' means "to adjust or align oneself according to surroundings or circumstances" (CED 1991). People, in fact, tend to orient their way of doing things consistently over a wide range of circumstances, according to their character or personality. In NLP, these orientations are called 'meta-programs': "perceptual filters that we habitually act on" (O'Connor and Seymour 1993:149). Orientations tend to be consistent, but this is not always the case (emphasis in the original):

> Metaprograms are systematic and habitual, and we do not usually question them if they serve us reasonably well. The patterns may be the same across contexts, but few people are *consistently* habitual, so metaprograms are likely to change with a change of context. What holds our attention in a work environment may be different from what we pay attention to at home.

In Chapter 4.7, we noted that much of our imprinting is fully developed by the end of school-age. Likewise, meta-programs, and hence personality, are relatively fixed by that stage. But, as O'Connor and Seymour mention above, our orienting can change across contexts.

It is our orientations which govern *how* perception is generalized, distorted and deleted. A well-known example of how an orientation distorts reality is as follows:

a bottle that has been opened and drunk from, can either be perceived as being half empty or as half full. Our perception of it has little to do with that actual bottle and the quantity of liquid inside (reality). Perception is distorted to fit in to the way we orient ourselves to the world in general. Our perception of the contents ultimately has to do with who we are. In this case, optimists or pessimists.

One of the orientation meta-programs suggested in NLP regards chunk size. Chunk size has already been introduced during the discussion on local and global translation styles. The polar-opposites of chunk size are the generalities (the context) or the details (the individual words themselves). This chunking orientation has an important place in Gestalt therapy, and is now understood to be a major factor in learning.

To see how we normally and unconsciously chunk, we can look at the following example. The diagram can be perceived in at least four different ways, depending on this local/global orientation.

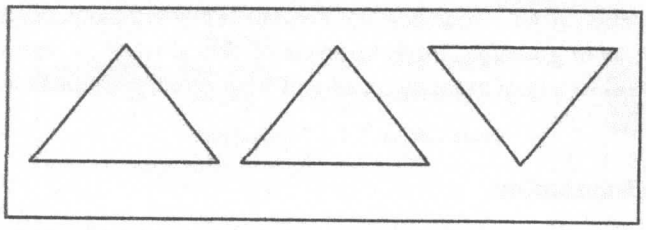


Figure 37. Testing Orientation: Local or Global?

Example descriptions of this diagram are as follows:
1. there are three separate shapes
2. there are some triangles, one upside down, in a picture
3. there is a picture with two identical triangles and one upside down
4. there is a (single) picture of triangles

All four answers are correct, just like the bottle being half-full or half-empty. This sorting of information comes under a variety of names[6] depending on the field and the application. The terms below come from Gestalt psychology, cognitive psychology and linguistics. Apart from 'sorting' and 'mismatching' which is only to be seen in NLP literature, the other terms now tend to be used across all disciplines:

Separate Shapes	Single Picture
• field independence	field dependence
• sorting for different	sorting for same
• mismatching	matching
• deductive	inductive
• specific	general

[6] See also Laura Gran's (1989:94) study on brain hemisphere function for a further list of names.

• local/part	global
• analytic	synthetic
• atomist	holistic

Response number one shows a definite orientation towards the left hand column (separate shapes) while number two begins to notice the differences first, and then focuses on the picture. Answer three, instead, begins at the right, focusing on "a single picture" and then moves to the left. Finally, response four focuses exclusively on the whole: the gestalt. "Gestalt" actually means an organized configuration or pattern of meaning.

It should always be remembered that the idea of polarization is a convenient model (deleting, generalizing and distorting the far more complicated reality), and that any orientation is, as the word suggests, no more than a tendency towards one way of perceiving the world. Creating taxonomy of these orientations is necessarily limiting. However, if we remember that none of the orientations operate in isolation, and that, as in grammar, we have levels of delicacy and exceptions, then we can begin to build a useful grammar primer of what actually happens in the context of culture.

• *Cultural Orientations*

- Kluckhohn's Value Orientations
- Hofstede's Four Dimensions
- Brake's Ten Orientations

• *The Cultural Iceberg*

A cultural orientation is a shared meta-program: a culture's tendency towards a particular way of perceiving. The orientation or meta-program influences how reality is modelled, i.e. which aspects are to be generalized, distorted and deleted. An orientation is based on a number of complex and interrelated (and sometimes conflicting) values, which, as we have seen, are also in dynamic relation with a number of other factors. At the heart lie the fixed and totally-out-of-awareness core values. Figure 38 illustrates the relation between values and orientations.

There are relatively few core values. These generate a number of more context-defined values, (see figure 38 overleaf). A cluster or set of these specific values will result in a certain orientation towards or away from a particular way of perceiving, interpreting and behaving in a number of contexts. Reality, then, within a specific culture will be distorted, generalized and deleted to suit the cultural orientation.

Many authors (and disciplines) have come up with a taxonomy of cultural orientations. Florence Kluckhohn (Kluckhohn and Strodtbeck 1961:341) coined the term 'value orientation', and defined them as follows:

> Value orientations are complex but definitely patterned (rank-ordered) principles, resulting from the transactional interplay of three analytically

distinguishable elements of the evaluative process – the cognitive, the affective, and the directive elements – which give order and direction to the ever-flowing stream of human acts and thoughts as these relate to the solution of 'common human' problems.

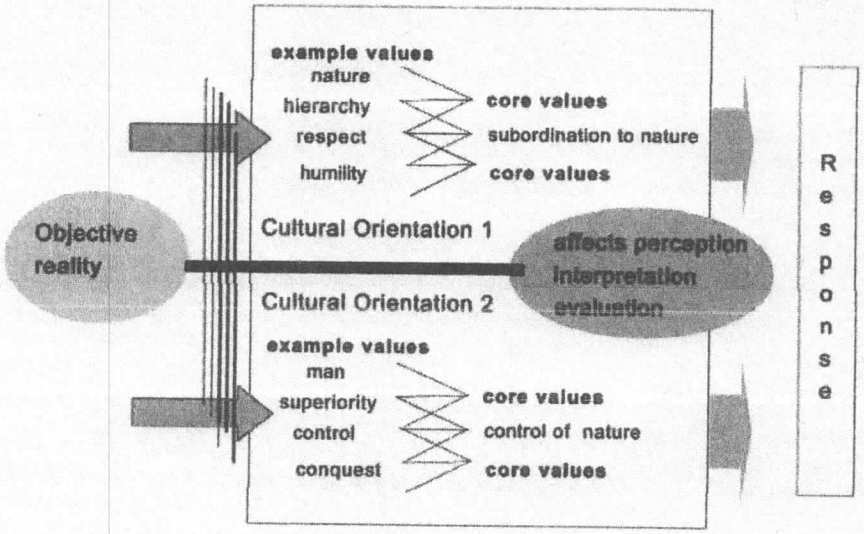


Figure 38. Cultural Orientations

She (ibid.:10-20) suggested that there were five basic problems or concerns common to all human groups, and also mentioned a sixth common human problem, the conception of space, but admitted that the orientation had "not been worked out sufficiently well to be included":

1. What is the character of innate human behaviour?	*Human Nature Orientation*
2. What is the relation of man to nature (and supernature)?	*Man-Nature Orientation*
3. What is the temporal focus of human life?	*Time Orientation*
4. What is the modality of human activity?	*Activity Orientation*
5. What is the modality of man's relationship to other men?	*Relational Orientation*

For each of these questions there are three possible responses that constitute a culture's (dominant or variant) value orientations (see table in page 232).

It should be pointed out that every culture and every individual will, in theory, have access to every orientation, but will tend to favour the use of one orientation over the others, and conversely will have difficulty in comprehending the other orientations. A cultural mediator, on the other hand, should have almost equal access to all orientations. This may of course result in disorientation through too much choice, as we shall see in Part 4.

Concerns/ Orientations	Possible responses based on core out-of-awareness beliefs		
Human Nature What is the basic nature of people?	**Evil** People ae basically bad and need to be controlled. People can't be trusted.	**Mixed** There are both good and evil people in the world. you have to check people out.	**Good** Most people are good at heart. They are born good.
Man-Nature Relationship What is the appropriate relationship between man and nature?	**Subordinate to Nature** People really can't change nature. Life is largely determined by external forces, such as fate and genetics. What happens was meant to happen.	**Harmony with Nature** Man should, in every way, live in harmony with nature.	**Dominant over Nature** The great human challenge to conquer and control nature. Everything from air conditioning to the "green revolution" has resulted from having met this challenge.
Time Sense How should we best think about time?	**Past** People should learn from history, draw the values they live by from history, and strive to continue past traditions into the future.	**Present** The present moment is everything. Let's make the most of it. Don't worry about tomorrow: enjoy today.	**Future** Planning and goal setting make it possible for people to accomplish miracles, to change and grow. A little sacrifice today will bring a better tomorrow.
Activity What is the best mode of activity?	**Being** It's enough to just "be". It's not necessary to accomplish great things in life to feel your life has been worthwhile.	**Becoming** The main purpose for being placed on this earth is for one's own inner development.	**Doing** If people work hard and apply themselves fully, their efforts will be rewarded. What a person accomplishes is a measure of his or her worth.
Social Relations What is the best form of social organization?	**Hierarchical** There is a natural order to relations, some people are born to lead, others are followers. Decisions should be made by those in charge.	**Collateral** The best way to be organized is as a group, where everyone shares in the decision process. It is important not to make important decisions alone.	**Individual** All people should have equal rights, and each should have complete control over one's own destiny. When we have to make a decision as a group it should be "one person one vote".

Trompenaars and Hampden-Turner (1997) follows Kluckhohn's dimensions adding a further two taken from Talcott Parsons' (1982) 'five pattern variables'. Hofstede

(1991) has four orientations, which he terms 'dimensions', adapted from the sociologist Alex Inkeles and the psychologist Daniel Levinson (Inkeles and Levinson 1969:447), who suggested four issues which qualified as common basic problems world-wide:

Inkeles and Levinson	**Hofstede**
1. relationship to authority	Power Distance
2. concept of self, in particular:	
a. the relationship between the individual and society	Individualism/Collectivism
b. the individual's concept of masculinity and femininity	Masculinity/Femininity
3. ways of dealing with conflicts including the control of aggression and the expression of feelings	Uncertainty Avoidance

Brake *et al.* (1995:39) have ten orientations, an amalgamation of Kluckhohn, Talcott Parsons, Hofstede and Hall.[7] Their taxonomy is the most comprehensive in the literature (to date), and forms the framework for the following sections. At this point we should look at the cultural iceberg (see Chapter 2.4.) once again:

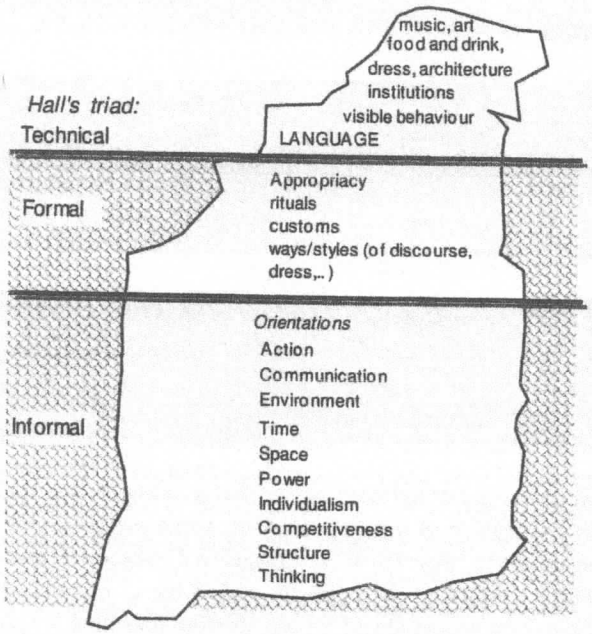
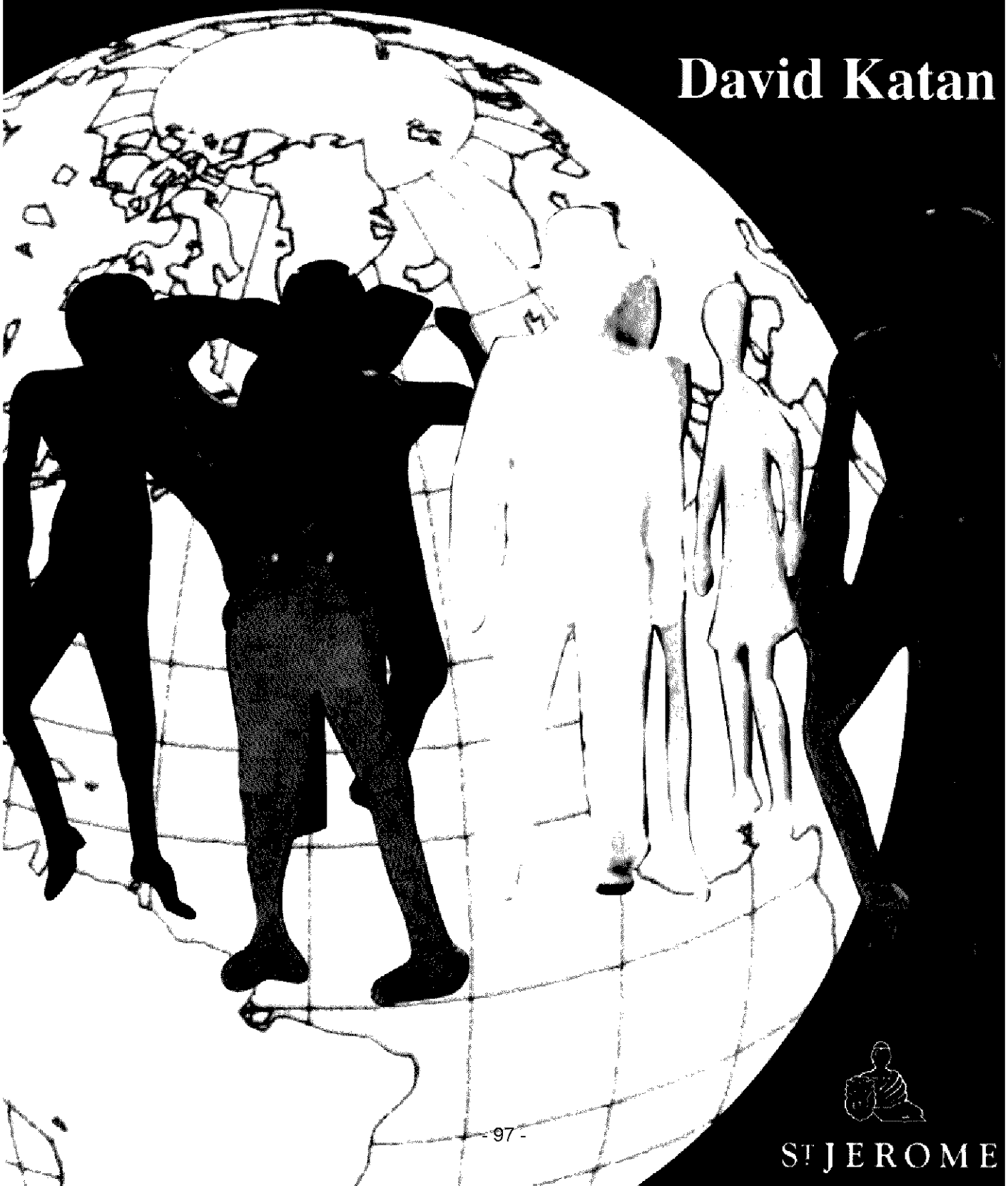


Figure 39. Brake's Iceberg of Cultural Orientations

[7] Brake *et al.* have integrated other authors too, but those of most interest here are the five orientations introduced by Kluckhohn (Kluckhohn and Strodtbeck 1961); Hall's (1982, 1983, 1990) time, space and contexting, and Hofstede's (1991) four dimensions.

Translating Cultures

An Introduction for Translators, Interpreters and Mediators



David Katan

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Each of the items below the waterline is a cultural orientation. In the following chapter we will focus our attention on two cultural orientations which automatically influence the way we use language to communicate: the orientations towards action and communication.

The other orientations directly influence behaviour, and hence communication in a wider sense. A short explanation of these orientations, and the possible options according to Brake *et al.* (1995) is given below, both to give the reader an idea of the array of possible combinations, and also because a number of these orientations will be referred to in our discussion on action and communication orientations. Where there is a significant difference in labelling, the authors responsible have been shown.

9.3 A Taxonomy of Orientations[8]

The first two orientations are discussed in detail in Chapter 10.

• *Action*

Brake et al.	*Hofstede*	*Trompenaars*
• be/do	masculine/feminine	affective/neutral

• *Communication*

Hall	*Trompenaars*
• High Context Communication	Diffuse
• Low Context Communication	Specific

• *Environment*

Brake et al.	*Trompenaars*	*NLP*
• control	inner-directed (internal)	proactive
• harmony		
• constraint	outer-directed (external)	reactive

If we accept that cultures are animate agents for a moment, we can then say that they vary in their perception of the environment: some may feel that they can control the environment, as in "Just Do It" discussed in Chapter 5.4, and feel in charge of their own destiny. Others, at the opposite end of the cline, will believe that the environment – including supernatural forces, destiny and luck – has a measure of control over them (*Che sarà sarà, Inshalla*).

[8] For more details on indicators of orientations and statistics regarding a culture's orientation see, in particular, Hofstede (1991); Hampden-Turner and Trompenaars (1993); Trompenaars and Hampden-Turner (1997).

The United States is a prime example of a control orientation, from its insistence on air-conditioning to the conquering of space and "the buck stops here". Southern Europe, on the other hand is closer to a constraint orientation, with people more willing to accept the importance of *force majeur* and acts of God.

A third perception of the environment is the dominant Native-American and Eastern orientation, which is to operate in harmony with real or perceived environmental forces. The following extract from "Isho: the vigyana bhairava tantra[9] offers us a glimpse of how the two polar orientations differ in their fundamental perception of what really happened:

> **When Hillary reached to the highest peak of the Himalayas, Mount Everest, all of the Western world reported it as a conquering – a conquering of Everest. Only in a Zen monastery in Japan, on a wall newspaper, it was written, "Everest has been befriended" – not conquered! This is the difference – "Everest has been befriended"; now humanity has become friendly with it. Everest has allowed Hillary to come to it. It was not a conquering. The very word 'conquer' is vulgar, violent. To think in terms of conquering shows aggressiveness. Everest has received Hillary, welcomed him, and now humanity has become friendly; now the chasm is bridged. Now we are not unacquainted. One of us has been received by Everest. Now Everest has become part of human consciousness. This is a bridging.**

• *Time*

Brake et al		*Hall*	*NLP*	*Trompenaars*	*Kluckhohn*
• single-focus	fixed	monochronic	through time	sequential	Past/Present/Future
• multi-focus	fluid	polychronic	in time	synchronic	

• *Monochronic/Polychronic Time*

Hall (1983) devotes most of his book to the cultural understanding of time. Monochronic time cultures perceive time as the frame. The focus is on the task rather than the relationship; and schedules are important and adhered to. According to Tannen (1992) and Pease and Pease (2001) men in general are more task oriented than women. With regard to national cultures, rather than gender, Northern Europeans and Americans also tend towards this orientation. Those with this orientation would consider it rude to interrupt a meeting, client or phone call to attend to another person. The word "interrupt" is itself a monochronic word.

Polychronic or multi-focus cultures, on the other hand, place greater emphasis on the relationship, and multi-tasking. Tasks will be completed according to relationship needs rather than time needs. In a bank, serving only one person, and not

[9] http://www.oTantra.net/VBTv2/chapter03.html

answering the phone or another important person would be considered rude. Mediterranean, Arab, South American and Asian cultures tend towards this orientation.

• *Fluid/Fixed Time*

Fixed time cultures perceive time technically. A minute is sixty seconds: "Time is money", and can be spent, used and wasted. "On time" means technically 'on time', and apologies are expected between 1 and 5 minutes after, depending how close to fixed time the culture is. Time management, 'Just in Time' and 'Time and Motion' studies work well in these cultures. American, German and Swiss cultures are particularly conscious of technical time.

Fluid time defines punctuality with more flexibility. *Subito* in Italian technically means "immediately". It is the standard reply given by those in the service industry when being asked for service. The informal meaning is "I'll be with you when I have finished what I'm doing". In fluid-time cultures, delays are expected and tolerated. A meeting can start fifteen to thirty minutes late depending on the culture without undue tension being created. Those with a fixed-time orientation have difficulty in comprehending the Italian informal but institutionalized *quarto d'ora accademico* / "the university fifteen minute sliding start" much loved by Italian academics and students alike. It is always useful to check which time is being talked about: e.g. "German time", "Italian academic time", "Neapolitan time", "Milan time", and so on.

From Spanish Abroad, Inc.[10]

The fabled Mexican attitude toward time – 'manana, 'manana,...' – has probably become legendary simply from comparison with the USA. But it's still true. Especially outside the big cities, that the urgency Europeans and North Americans are used to is often lacking. Most Mexicans value *simpathia* (congeniality) over promptness. If something is really worth doing, it gets done. If not, it can wait. Life should not be a succession of pressures and deadlines. According to many Mexicans, life in the 'businesslike' cultures has been desympathized. You may come away from Mexico convinced that the Mexicans are right!

• *Past/Present/Future*

Past-oriented cultures emphasize tradition. Any change tends to take place over a long period and in relation to the past. The historical context is paramount to understanding the present, and history itself is highly valued. This is certainly true of Italy with many of its road names recording an event or personality in history. Television interviews (both in Britain and in Italy) tend to concentrate on the background of the subject in question, much to the irritation of the American guest who wants to talk about 'now'.

[10] http://www.spanishabroad.com/mexico/country_guide/mex_society.htm

Present-oriented cultures, such as America, emphasize the here and now. "History is bunk", said Henry T. Ford. The future also is not so important: "time waits for no man"; "take care of today and tomorrow will take care of itself". Long-term planning tends to be in terms of five to ten years at maximum (Hall 1990:141).

Future-oriented societies can plan ahead to the next generation. Japanese business plans take account of the past and can plan for the next hundred years in "the eternal cycle" (Adler 1991:30-1; Hampden-Turner and Trompenaars 1997:138; Brake *et al.* 1995:52). Italy also has a future orientation in terms of relationships. Once formed they are expected to be long term, with dues and favours to be repaid over a long period.

The terms "enduring" and "infinite" need to be interpreted against these orientations. President Bush's use before the 2nd Gulf War is discussed below (in *The Denver Post* 28/11/01) in terms of everything but enduring or infinite. To a large extent both the past and the future are deleted, and for many will only go to strengthen negative stereotyping:

TO SPIN OR NOT TO SPIN

Rick Jacobs, principal and owner of Monigle Associates, corporate identity and branding consultants in Denver, says names like 'Infinite Justice' and 'Enduring Freedom' are really more like 'brands'.

His company, by the way, just unveiled a new logo for Fort Lewis College in Durango, hoping to change its reputation as 'Fort Leisure'. One of the problems with the college's old logo is that it showed beckoning mountains in the background with a book in the foreground. A closed book.

This is the sort of stuff Monigle does for its 800 clients, 95 percent of whom are outside Colorado. So Jacobs knows his brands.

'I was a bit surprised at how they're using branding principles in order to rally the troops, if you will', Jacobs said.

There is, of course, the example of 'Desert Storm', the brand name for the 1991 Gulf War. It seemed to catch on.

'I think we saw in Desert Storm the value of being able to define something with terms that allow people to rally behind it. It's a very interesting use of branding', Jacobs said.

'Something like "Enduring Freedom" doesn't have as much of an action associated with it. 'Desert Storm' clearly is action-oriented, and it sends very powerful, visual signals to people. But that's what it was. That was an appropriate name for that kind of an engagement.

'"Enduring Freedom" seems more long-term than a storm, and I think the nature of this engagement is going to be exactly that. This is likely not going to be a huge front where we send in massive troops, but a long-term, precise, very surgical kind of operation that is going to go for years'.

It takes a completely different orientation to approach the subject as Arundhati Roy does. Here, we have an orientation which focuses on everything *but* the present:

> Could it be that the stygian anger that led to the attacks has its taproot not in American freedom and democracy, but in the US government's record of commitment and support to exactly the opposite things – to military and economic terrorism, insurgency, military dictatorship, religious bigotry and unimaginable genocide (outside America)? It must be hard for ordinary Americans, so recently bereaved, to look up at the world with their eyes full of tears and encounter what might appear to them to be indifference. It isn't indifference. It's just augury. An absence of surprise. The tired wisdom of knowing that what goes around eventually comes around ... But war is looming large. Whatever remains to be said must be said quickly. Before America places itself at the helm of the "international coalition against terror", before it invites (and coerces) countries to actively participate in its almost godlike mission – called "Operation Infinite Justice" until it was pointed out that this could be seen as an insult to Muslims, who believe that only Allah can mete out infinite justice, and was renamed "Operation Enduring Freedom".

• *Space*

• Private/Public	Individual privacy v more public use of space
• Distance/Proximity	Preference for distance/low physical contact v. proximity/ high physical contact
Trompenaars:	
• Specific orientation	Open access to personal life space; but access, position and authority etc., segregated according to context
• Diffuse orientation	Selected entry to individual's private life space, but relationship, position, authority, etc., crosses contexts

The Japanese have an orientation towards public space and distance, with open-plan offices, and small communal living quarters, but very little physical contact (public/distance). In comparison, an American or European house or office will tend towards the private, and higher levels of proximity are tolerated (private/proximity). We have already mentioned (in Chapter 4.1) Hall's appropriate distances for white North Americans when discussing culture at the level of environment. Typical appropriate distances for Southern Europe and South America will be closer – and will be perceived as much too close for the British.

> The British are notoriously poor 'touchers' compared with other cultures. One study by Nancy Henley ('Body Politics') counted the number of touches between pairs chatting in cafes during a one hour sitting. The results: in Puerto Rico there were on average 180 instances of touch, in London, none. [11]

[11] http://www.globalideasbank.org/TouchHealth.html

• ***Diffuse/Specific***

Space can also be perceived as psychological (Trompenaars and Hampden-Turner 1997:73-76). The degree to which individuals let others into their life (psychological space) tends to change with culture. Americans tend to the specific. New acquaintances become intimate friends over a relatively short period of time. However, this relationship (including both entitlements and obligations) is specific to a particular activity or sector.

A diffuse life space orientation, on the other hand, has a relatively guarded approach to acquaintances. However, once a relationship has been formed (whether business or personal), entry, including entitlements and obligations is expected to all areas of private space. Germany is a prime example of this system, and Italy also tends towards this system. The meaning of the word "friend" and the expected reciprocal rights and the duties will vary according to cultural orientation. The word itself should not be translated but mediated. Trompenaars and Hampden-Turner (1997:83) write about a personal experience in the U.S.A:

> **...the British author had been introduced at a reception following a graduation ceremony as Dr. Hampden-Turner, but at a party for much the same people a few hours later as Charles Hampden-Turner. He had also been introduced as "I want you to meet my very good friend Charles... (what's your surname?).**

• ***Power***

Brake et al.	*Hofstede*	*Trompenaars*
Hierarchy	High Power Distance	¦ Ascription
Equality	Low Power Distance	¦ Achievement

In all societies there is power. It can be distributed evenly, with an attempt to reduce the degree of visible status. Alternatively, hierarchy and visible status can be emphasized. Italy is a relatively high power distance country, while Northern Europe, Britain and the States in particular tend to emphasize low power distance. South America, Asia, and (to a lesser extent) Southern Europe tend to respect high power distance. The importance of 'respect' when addressing a person, address rituals, and the degree of HAP or LAP type language most of the citizens have, are indications of a culture's power distance orientation.

In a similar way, Trompenaars and Hampden-Turner distinguish between cultures that tend to accord status according to 'who' someone is (according to family, background or title) and those cultures oriented towards awarding status to proven results (achievement) regardless of background. Clearly a professional's obligations are also culture-bound here: to the people who employ you (ascription) or to the task (achievement), as Trompenaars and Hampden-Turner (1997:109-10) explain:

> **...it often becomes clear that the translator from an ascriptive culture behaves "unprofessionally" according to the standards of achieving cultures. According to British, German, North American, Scandinavian and Dutch values, the translator is an achiever like any other participant and the height of his or her achievement should be to give an accurate, unbiased account of what was said in one language to those speaking the other language. The translator is supposed to be neutral, a black box serving the interests of modern language comprehension, not the interests of either party who may seek to distort meanings for their own ends.**
>
> **In other cultures, however, the translator is doing something else. A Japanese translator, for example, will often take a minute or two more to "translate" an English sentence 15 seconds long. And there is often extensive colloquy between the translator and the team he or she serves about what the opposite team just said. The translator on the Japanese side is an interpreter, not simply of language but of gesture, meaning and context. His role is to support his own team and possibly even to protect them from confrontational conduct by the western negotiators.**

• *Individualism*

Brake et al.	*NLP*
Individualism	(tend to) Internal + Independent/Proximity
Collectivism	(tend to) External + Co-operative

Japan is the most well-known "we", collective, oriented culture. However, Southern European (such as Turkey and Greece), Central and South American countries are even more collective, relying on tight social networks for most communication. America leads the "I", "do your own thing" cultures on all individualism indexes, while Northern Europe (such as Italy and France) are also heavily individualist. Differences between these countries occur most on the universalistic/particularist orientations.

•*Particularism*

Trompenaars	*Hofstede*
Universalism	Truth
Particularism	Virtue

Universalist codes are universally applicable. There is a tendency to generalize laws and procedures, and to apply them universally. American mass-production, McDonald's, sneakers (as we have seen in Chapter 4.1) and Henry Ford's "You can have any colour you like as long as it's black" symbolize the desire for universalism. Particularist cultures, such as those on the Russian subcontinent, Asia, Central and

South America, and Southern Europe plus France and Italy, do not reduce situations to simplistic rules. These cultures emphasize difference, uniqueness and exceptions, from food and restaurants to the application of parking fines and queuing. We have already mentioned the universalist American difficulty in understanding the particularist Mexican approach to speeding offences in Chapter 2.3.

George Orwell noted how it is possible to be particularist in a politically collectivist society in his political satire *Animal Farm*: "All animals are equal, but some animals are more equal than others" (see also Hofstede 1991:161). This orientation nurtures the patronage system, which can work for the good of the collective society as in Japan, or for a particular group or family as in Italy (see also Mead 1994:111-37 and Gannon 2001:126). This means that the translation of the term 'democracy', for example, needs to be contextualized (see also Lewis 2000:131). Francesco Rossi does so in his 1963 film *Le Mani Sulla Città*/'Hands Over the City', an investigation into the collapse of a block of flats. Jones, in his *The Dark Heart of Italy* describes the plot to explain Italy today, perceived, understandably enough from a universalist orientation, as corrupt:

> **[The Christian Democratic] party get rich by assigning building contracts to *Mafiosi*, who in return guarantee the politicians their votes ... As far as the law goes, *tutto è in regola*, everything is 'by the book'. The [illegal construction of the flats] has been legalized. The commission of enquiry can reach no conclusion. Politics is reduced to the buying and selling of votes made possible by the vast amounts of money slashing around by the construction business. Besieged by angry women, the mayor unfolds huge notes and passes them around. Looking over his shoulder he smiles and says 'Consigliere, see how democracy works?'**

• *Competitiveness*

Brake et al.	*Hofstede*	*NLP*
Competitive	Masculine	Proactive + Independent + Self Sorting style: (material) things
Cooperative	Feminine	(Reactive) + Co-operative + Others Sorting Style: people

Competitive cultures privilege the more masculine character. There are winners and losers, people "live to work", workaholics are respected, and material success is a high motivator. Cooperative cultures, on the other hand, work together as interdependent teams, "work to live" and place a higher value on the quality of life. Japan, Germany, Italy and the Anglo-American countries are all competitive cultures. High-cooperative cultures include the Scandinavian countries, Spain and a number of South American countries. As Hofstede (1991:90, emphasis in the original) explains, this orientation affects the interpretation and evaluation of terms such as 'average' and 'best':

> Experience in teaching abroad and discussions with teachers from different countries have led me to conclude that in [...] the more masculine cultures like the U.S.A. the *best* students are the norm. Parents in these countries expect their children to try and match the best. The 'best boy in class' in the Netherlands is a somewhat ridiculous figure.

• *Structure*

Brake et al.	*Hofstede*	*NLP*
Order	Strong Uncertainty Avoidance	Procedures
Flexibility	Weak Uncertainty Avoidance	Options

The future is an unknown factor for all cultures, and day-to-day life can also present people with the unknown. The degree to which a culture feels threatened or uncomfortable with ambiguity, uncertainty or change, is an indication of its orientation towards order or flexibility. Japan, Greece, Italy and Germany have a strong orientation towards order, and tend to avoid ambiguity or change in all things. Hence change tends to come about through destabilization and revolution. In Italy, though the appearance of structure is highly valued, its particularist orientation ensures that the orientation towards order is never fully achieved.

The Anglo-American countries have a relatively high toleration for uncertainty and change. According to Hofstede (1991:113), Great Britain is the most unperturbed of that group, and rates forty-eighth out of the fifty-three countries surveyed in terms of "the extent to which members of a culture feel threatened by uncertain or unknown situations". Singapore, at number fifty-three, has the highest toleration. These cultures have less need for detailed rules which attempt to define all situations. Flexibility (except for time itself), choice and options are valued. To a certain extent this orientation explains the reasons why the Italian equivalents of "No Smoking" or "Thank you for not smoking" notices are the more detailed and legally structured:

> ***DIVIETO DI FUMARE***
> ***Ai sensi della Legge n. 584 del 11.11.1975 è severamente vietato fumare; i trasgressori sono soggetti all'applicazione delle previste Sanzioni Amministrative.***
>
> **SMOKING IS FORBIDDEN**
> **Pursuant to regulation no. 584, 11/11/1975, smoking is severely forbidden. Those in breach will be subject to the relevant Administrative Sanctions**

• *Thinking*

Brake et al.	*NLP*	*Hall*	*Trompenaars*
Deductive	Match / Similarities / Large Chunks	HCC	
Inductive	Mismatch / Differences / Small Chunks	LCC	
Linear	Specific	Monochronic	Specific
Systemic	General	Polychronic	Diffuse

• *Deductive/Inductive*

Alternative labelling for deductive/inductive has already been given at the beginning of the chapter. Deductive thinking orientations focus on theories, logic and principles. This is very true of Germany and France, and to a lesser extent Italy. Situations are classified according to already existing theories. Inductive cultures are more pragmatic and specific, starting from empirical observation. Facts and statistics are highly valued. The United States and Britain are particularly inductive.

• *Linear/Systemic*

Linear-oriented cultures will dissect problems into logical and precise sequences, look for detail, precision and minute cause and effect, such as the McDonald's itemization of the service counter routine. Systemic, on the other hand is holistic, and tends to look at the full picture, the background and relationships with other parts of even bigger pictures. Explanations will be less in terms of statistics and logic; but rather in connections, feelings and similes. Italy tends towards the systemic, while Japan is a clear example of the most systemically oriented culture.

Many have already noted how communication patterns between men and women differ. Any popular book on the subject will tell you that it is not necessary to go abroad to encounter difference: men tend to be linear while women tend be systemic – and the results of these different orientations to reality are known to us all.

> **Even today we still need translators. Men and women seldom mean the same things when they use the same words. For example, when a woman says "I feel like you *never* listen", she does not expect the word *never* to be taken literally. Using the word *never* is just a way of expressing the frustration she is feeling at the moment. It is not to be taken as factual information.**
>
> **To fully express their feelings, women assume poetic license and use various superlatives, metaphors and generalizations. Men mistakenly take these expressions literally. (Gray 1993:60)**
>
> **A woman's superior sensory equipment picks up and analyses [verbal and non-verbal] information and her brain's ability to rapidly transfer between hemispheres makes her more proficient at integrating and deciphering ... This is why most men have difficulty lying to a woman face-to-face. But as most women know, lying to a man face-to-face is comparatively easy, as he does not have the necessary sensitivity ... most men, if they're going to lie to a woman, would be far better off doing it over the phone, or with the lights off, and a blanket over their heads. (Pease and Pease 2001:29)**

Chapter 10. Contexting

The aim of this chapter is to:

- introduce Edward T. Hall's Theory of Contexting in communication
- discuss the links between contexting and left/right brain distinctions
- illustrate a number of the language behaviour differences as a result of contexting differences
- show the relevance of contexting for a cultural interpreter/mediator involved in translation and interpreting transactional situations

10.1 High and Low Context

Communication			Possible cultural priorities	
Hall	*Trompenaars*	*Simons et al.*		
• HCC	Diffuse	loosely knit	Relationship	what is understood the context of the message the meta-message
• LCC	Specific	tightly woven	Task	what is said the text of the message

One of the guiding orientations, which perhaps could be termed a meta-orientation, is 'contexting'. This term was coined by Hall in 1976 (1989:85-128) and further discussed in 1983 (59-77). The basic concept is that individuals, groups, and cultures (and at different times) have differing priorities with regard to how much information (text) needs to be made explicit for communication to take place.

The words 'text' and 'context' have particular meanings here. Context is "stored information", and as such is very close to Halliday's (Halliday and Hasan 1989:47) "non-verbal environment of a text" which is made up of "the context of situation and the wider context of culture". In terms of communication, according to Hall (1983:61), it is "the amount of information the other person can be expected to possess on a given subject", while the text is "transmitted information".

Both Halliday and Hall, among many others, agree that communication entails both text and context. Gregory Bateson's comment (as cited by Ting-Toomey 1985:83) is clear and to the point: "All communication necessitates context and ... without context there is no meaning".

Halliday suggests that the context of situation is "the total environment in which a text unfolds" (Halliday and Hasan 1989:5, 36) but then goes on to say: "In the normal course of life, all day and every day, when we are interacting with others through language ... we are making inferences from the situation to the text, and from the text to the situation". It seems that here Halliday is concentrating on the immediate context of the text within a single frame of culture. Hall's context though, is explicitly both the context of situation and the context of culture, i.e. it includes the beliefs and values that determine the behaviour to be interpreted.

Clearly, also, in any communication, the speaker and listener will have their own perception of the context. The more these perceptions are shared the more possible it will be, as Halliday suggests (Halliday and Hasan 1989:5), to use them as a framework for hypothesizing what is going to be said. Sperber and Wilson (1995:15) also understand 'context' in terms of perception rather than reality. They suggest that it is "the set of premises used in interpreting an utterance" and that it is "a psychological construct, a subset of the hearer's assumptions about the world. It is these assumptions, of course, rather than the actual state of the world, that affect the interpretation of an utterance".

Halliday (Halliday and Hasan 1989:12-14; also Taylor Torsello 1992), on the other hand, sees context of situation as a tangible construct (visible and audible). The description is in terms of a simple conceptual framework of three headings:

the field	what is happening
the tenor	who are taking part
the mode	what part the language is playing

Problems in understanding, through translation or otherwise, arise from the fact that assumptions about the world differ. Widdowson (1979:138) shows the importance of sharing mutual assumptions in successful communication with this well-known conversation exchange:

A: doorbell!!
B: I'm in the bath.
A: Ok.

Both parties 'know' that "I'm in the bath" did not mean what was textually said. As a result, the meta-message is successfully communicated through what is already shared. In another situation, between two other people who do not know each other, less can be assumed to be understood; and the conversation might be as follows:[1]

(phone rings)
A: George?
B: Yes?
A: Look, I'm a little tied up at the moment – do you think you could answer it and ask them to phone back in 10 minutes?
B: Sure. Where is it?
(phone stops ringing)
A: Never mind.

[1] See also Scollon and Scollon (2001:76-82) and their discussion on meta-communication and unclear reference.

Interlocutors in each communication event will, usually out-of-awareness, arrange themselves and others along the context scale. We tend to believe we know how much needs to be said and explained to have our message understood the way we meant. Whether or not this is true, as we cannot mind read, is usually difficult to objectively judge. In cross-cultural communication, the scope for error is even larger.

There are, then, two aspects to communication (text and context), each represented by a triangle:

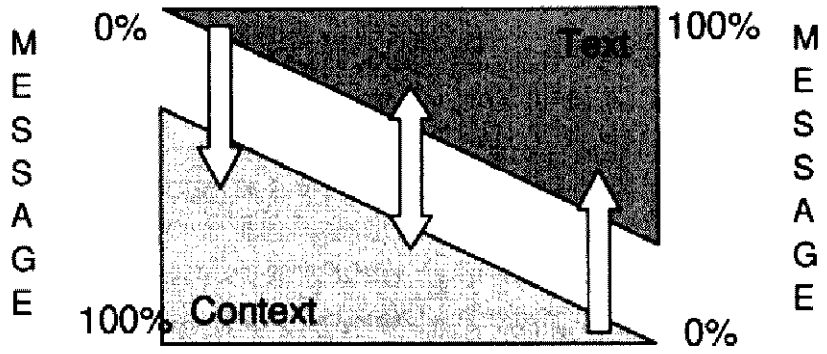

Figure 40. Hall's Triangles

At one theoretical extreme, all the information that is to be conveyed is made visible, or explicit, in the 'text' triangle. While at the other extreme, no text is necessary as all the information is implicit, i.e. it is contained in the 'context' triangle. The diagram, adapted from Hall (1983:61), shows how both triangles operate together in a cline to form the message. He explains that, "as context is lost, information must be added if meaning is to remain constant".

Hall suggests that contexting is a fundamental aspect of culture; and also that members of a culture will have a shared bias, either towards communication through the text or the context. This will be their guiding principle in all decisions to be made. However, as we have already noted in the introduction, orientations *can* change according to situation. Following other authors, we will refer to a High Context Communication orientation as 'HCC' and a preference for text as a Low Context Communication orientation or 'LCC'.

Hall's contexting theory is "begging to be connected" (Vincent-Marrelli 1989:473) to a language based theory of communication. In her paper is a clear indication of how the theory can prove fruitful in understanding Anglo-Italian cross-cultural miscommunication.[2] George Simons *et al.* (1993) have also made extensive

[2] See also Katan (1994).

use of this HCC/LCC polarity in their volume on cross-cultural business management. They also suggest that all cultural orientations depend on this meta-orientation, which they relate to two principle types of culture: 'loosely knit' and 'tightly woven'. The metaphors relate to the adaptability of a loosely knit fabric, which has yet to take on a final form and can be stretched without damage. This is compared with a dense, interwoven, more solid fabric – and more resistant to change. We begin to see parallels here with the uncertainty avoidance orientation: either towards structure or flexibility.

How much written information is available for the foreign visitor, and how much will need to be obtained from a local informer is a possible indication of how high or low context a culture is. In New York, there are helpful signs indicating the best time and angle from which a photograph should be taken at every tourist site. In Cairo there are no signs telling you which pyramid is which – but there is no shortage of guides.

On American Forces radio,[3] there are a variety of public service adverts giving advice that would strike higher context communication cultures as 'obvious', i.e. the sort of advice that would be passed on informally (out-of-awareness) and through observation:

- **It's a dog's life, so please don't stroke us while we are eating, or chase us around the garden.**
- **Remember, those nice exotic house plants could be poisonous for your little ones.**
- **Eating too fast is not only bad for your diet; it is also bad for your digestion.**
- **Oil and grease on linoleum floors can be dangerous. It's just an accident waiting to happen.**
- **Spend quality time with your family. You can make a difference.**
- **When it comes to choosing a life-mate, be sure to check with your best friend.**

Universities vary their welcome to new students according to how text-based they are. The British and the American have "Freshers' Week"[4] and "Orientation" respectively. During this time, administrative, academic and student organizations battle for the time to formally and technically explain and entertain. In Italy, and other Mediterranean countries, the explaining and the entertaining is very much more informal and unplanned. Students are informed through the grapevine.

Some British universities, being older, are more 'tightly woven', and therefore less explicit in their dissemination of information. Two Americans, Bill Bryson and Stuart Franklin noted the inaccessibility of the culture for an outsider at one of the Oxford colleges:

[3] Heard on ZFM, American forces Radio (1995-6)

[4] The term "fresher" is British English; "freshman" is the less PC American term.

> **Waiting for a professor one day, I passed the time by glancing through [the bulletin board announcements]. 'Master's Handshaking will take place in the Dining Room of the Master's Lodgings. Please wait in the passage outside,' said one. Another, more cryptically, announced: 'Lagrangian Mechanics – Saturday 11 a.m'. A third stated: 'RFC 1st and 2nd XV practice Thurs. 2 p.m'. Perhaps 50 such notices were pinned to the board, all dealing with some important component of college life, and it occurred to me, as I stood there idly looking them over, that I couldn't truly understand a single one. It is a feeling you soon grow used to in Oxford.** ***National Geographic*** **(November 1995:120)**

Other universities, in higher context communication cultures, do not even use bulletin boards; and students are expected 'to know' through the informal network of personal contact where and when lessons are, and in particular when and where changes have been made. In an HCC, tightly woven culture, the participants are expected to share more of the larger context – whether or not this is actually the case.

Identity, in tightly woven cultures, is closely related to social position. People take their place within a pre-formed, stable and interwoven network where change is unusual. Japan would be a case in point. Trompenaars (1997:102-119) uses the term 'achievement' and 'ascription' orientations to explain cultures' options in according status. An LCC culture will tend to accord status to the person who merits the position through proven capability in the field and through election. Particularly important is a written CV. In an HCC culture you already need to be known for who you are. Long-term contacts and networking become increasingly important – paper qualifications less so.

So, HCC cultures are not immediately oriented to the newcomer (though the guest will be very well looked after). The United States, on the other hand, is a prime example of a 'loosely knit' society, accepting newcomers into its social fabric. The successful newcomers will also have an orientation to low uncertainty avoidance and the ability to change identity. They quickly become, for example, ethnic Black, Afro- or Chinese- American. In this melting pot there is space (both physical and mental) for change.

Many authors have also likened the LCC and HCC differences in terms of rooting systems. Some cultures have more solid and interwoven roots, while others, with a shallow root system can be uprooted without creating great disturbance. Remarks made (reported below) by two ministers (one British and one Italian) on the problem of unemployment reflect this presence or lack of a deep root system.

In each case the ministers' reaction to unemployment is totally 'natural'. In Britain, in the aftermath of the 1981 Brixton riots, Norman Tebbit, the then Secretary of State for Employment, made the "infamous assertion that 'My father didn't riot but got on his bike to look for work. 'Get on your bike' became the moral imperative of conservatism":[5]

[5] Quoted from "The Silent Takeover Global Capitalism and the Death of Democracy" in www.thirdworldtraveler.com/Global_Economy/ Silent_Takeover%20_Part1.html

SOME CONSIDERATIONS ON POLITICAL IDEOLOGY AND THE BRITISH SEARCH FOR PROSPERITY FOR ALL ITS CITIZENS

4.4 Labour market flexibility. The Conservative government believed that insecurity in the workplace motivates the workforce. The government resisted all measures to give part-timers the same rights as full timers or to introduce a minimum wage in the belief that these measures would cost jobs. The argument used is 'low pay or no pay'. If work is not available you should simply 'Get on your bike' to find it. There is no such thing as 'a job for life'. [6]

Not only is this idea firmly accepted by the Conservative party (and to a large extent by the general populace) but the expression "get on your bike" has now come into the language, and into recent dictionaries (e.g. *Longman* 1992).

Tiziano Treu, the Italian Employment minister in Berlusconi's centre-right government (1995), had a very different point of view when talking about the chronic unemployment situation in Southern Italy:

[...] è naturale che i ragazzi, specie se diplomati o laureati, piuttosto che spostarsi preferiscono attendere qualche opportunità nella zona in cui hanno le loro radici. *Corriere della Sera* (3/5/95)	It's natural that young people, particularly those with college or university qualifications, would prefer to wait for an opportunity in their own area where they have roots, rather than move.

The fact that a culture is more HCC or LCC will also mean, according to Hall, that there will also be other related text/context orientations. Victor (1992) and Simons *et al.* (1993) have produced lists of typical (and simplified rather than actual) features of these two different orientations. With some adaptations, they are outlined below:

Low context operating mode	**High context operating mode**
More loosely knit	More tightly woven
shallow rooted	deep rooted
Emphasis placed on:	*Emphasis placed on:*
• text	context
• facts	relationship/feelings
• directness	indirectness
• consistency	flexibility (in meaning)
• substance	(social/personal) appearance
• rules	circumstances
• monochronic	polychronic

[6] John Baillie of Park Lane College, Leeds, United Kingdom, 1997. Contribution to the EDUVINET "Living Conditions of EU Citizen", http://www.eduvinet.de/eduvinet/uk005.htm

If we take two different cultures, such as Italy and Britain, and compare them on the above lists, it is clear that they can be associated more with one list than with another. Italy would tend to operate on a more tightly woven, high context basis, while the British would tend to operate on a more loosely-knit, low context basis. Comparing Britain and the United States, it would seem that the US is even further down the cline towards low context. We should also remember that the operating mode favoured will, as we have already mentioned, depend on many variables: culture, sub-culture, gender, class, age, situation, and, of course, individual personality.

That being said, there are some useful generalizations that can be made (always couched in the positive, to reflect prioritized cultural values). If we think about the way the British and the Italians regard fashion, food and furniture, it is clear that the British are lower context, attaching more value to functionality, whereas Italy places a higher value on design, taste and aesthetics.

With regard to appearance, we have already mentioned the English city without mirrors: "The girls in their cheap and flimsy finery ... How the Italians would despise and laugh at them". Another article, published a year earlier, echoes the same thoughts. The article (*The Sunday Times* 18/12/94, 6:5) has an LCC title "Face Facts" and discusses the case of a woman who had been described as "ugly" by a policeman. The verbalization of 'ugly' flouts PC norms (discussed in Chapter 5.3). The article, in fact, begins by discussing the public outcry which resulted from the police officer's ill-advised description. The article then moves on to look at Britain as a whole (emphasis in original):

> **Britain *does* look a mess, particularly compared to our EC neighbours. The average Italian waiter would not dream of working in anything other than starched white coat and bow tie. The average Italian banker is kitted out in immaculate tweed and has perfectly manicured fingernails – as does the local fruit seller and probably newsagent too. I've lived in Milan. I remember feeling obliged to look neat and tidy for the plumber/telephone man/cleaner.**

Using the Meta-Model we can immediately note the use of the modal necessity: 'to feel obliged'. The values that lie behind that statement are steeped in a culture which values individual freedom (an orientation towards self). An Italian would tend to value in-group norms. It would, therefore, be 'normal' to dress neatly and tidily in public groups (an orientation towards others).

The culture-bound aspects of the normality are hidden in the deletion of the performatives of words such as *rispetto* / "respect" or *normale* / "normal", and in the nominalization of *in ordine* / "neat and tidy". The full representation (hidden to most speakers) would be as shown in figure 41.

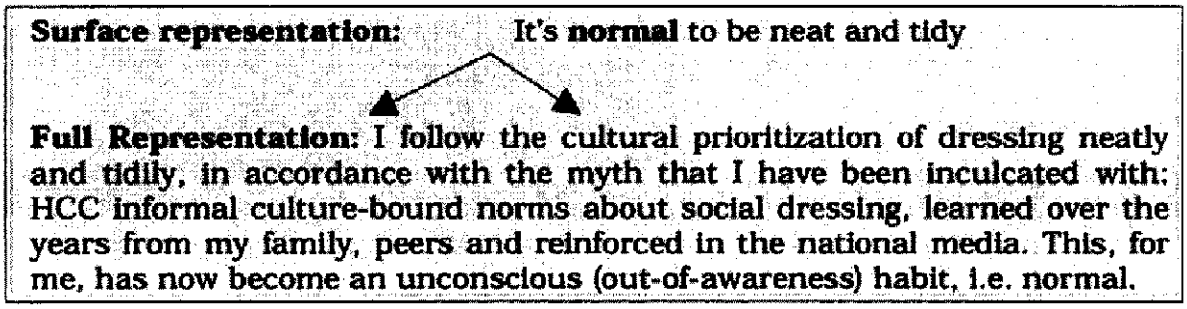

Figure 41. Full Representation of Italian "normal"

What is hidden in the English remark is as follows:

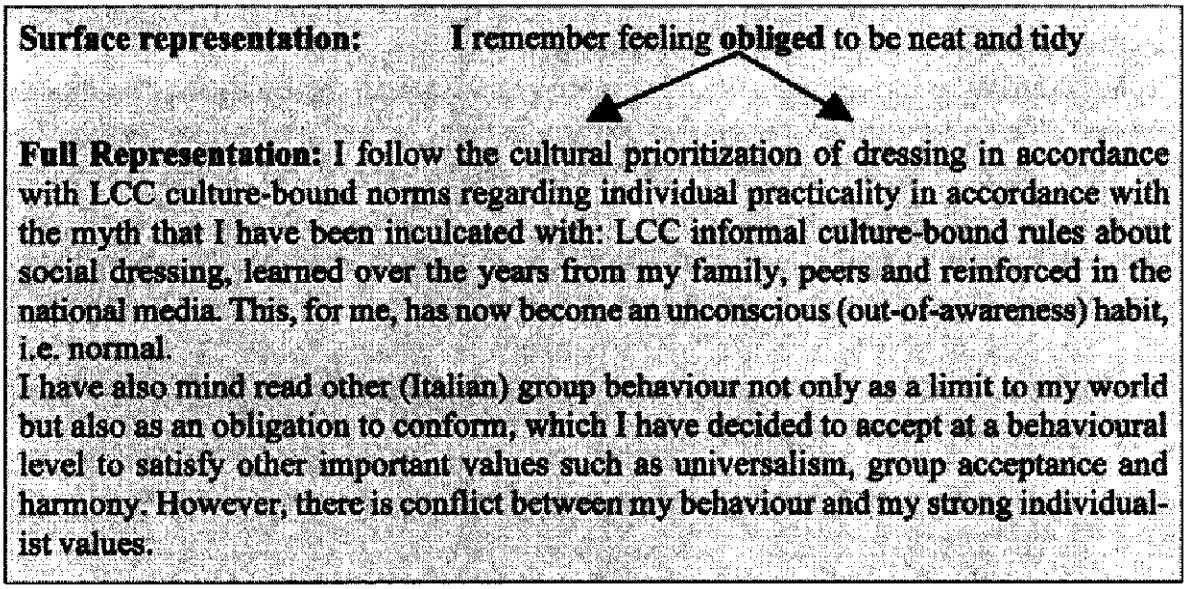

Figure 42. Full Representation of English "obliged"

The two cultures, British and Italian, not only disagree on the importance or cultural prioritization of being "neat and tidy", but there is also disagreement over the criterial equivalence, i.e. what has to happen for the neat and tidiness value to be met. We have already seen how 'casual clothes' need to be contextualized before we can fully understand what is being talked about. Also, what is 'tidy' for one culture (and, of course, generation) will not necessarily meet the criterial equivalence of another. Hofstede (1991:118) notes a related culture-bound concept, that of 'dirt', or as he calls it "matter out-of-place". He points out that what is dirty or clean is also an extremely relative concept: "The Italian *mammas* and nannies see dirt and danger in the piazza where the American grandparents see none".

However, the Americans, British and Italians are in complete agreement that the Japanese have an exaggerated sense of dirt. The Italian fruit seller and newsagent may have "perfectly manicured nails", but the Japanese train, taxi and bus drivers, for example, wear starched white gloves. Their gloves, in harmony with the rest of their immaculate uniforms, are expected to remain clean all day.

What counts as neat and tidy in Singapore is also very different generally from accepted Western 'civilized' attitudes. Fines for litter dropping in Singapore are

taken seriously, and laws requiring houses to be repainted are also a sign of the culture's perception, interpretation and evaluation of dirt. As a result, both the Japanese and the Singaporeans tend to perceive the West in much the same way as the West sees a developing country, i.e. as a dirty place. Dirt, as we have said, is a relative concept, and each culture is happy with its own understanding of the concept. There will always be cultures that exaggerate, and cultures that do not come up to our standard. And so every culture positions itself on a cline, convinced that its position is the correct one. This is the heart of the belief that the map or myth is reality.

The following contexting cline comes from a business article adapted by Victor (1992:143). Hall's theory, in fact, has been developed, like much anthropological theory more in the very pragmatic field of business management than in any other field. It should also be pointed out that unlike the other orientations mentioned in the previous chapter, this particular cline is not based on any published statistics:

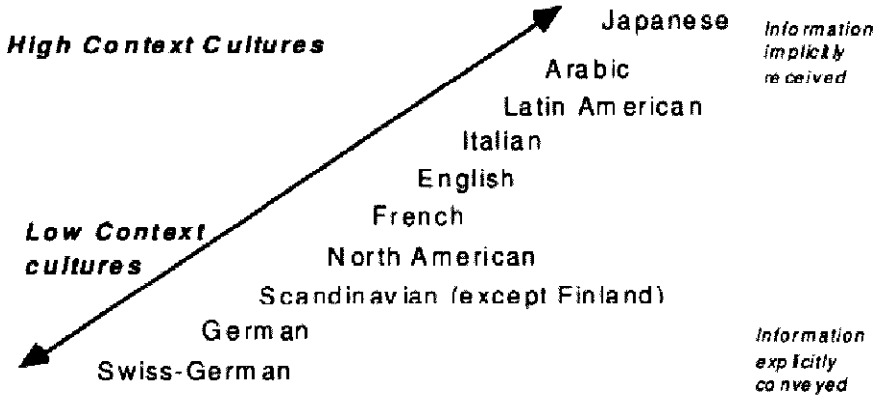

Figure 43. Context Ranking of Cultures

The highest context communication culture is the Japanese, which fits our stereotype of their inscrutable culture, where silence is more valued than the word. At the other end of the cline is the Swiss-German where the stereotype of exacting precision and detailed information fits their LCC position.

An extreme example of a low context character comes from Charles Dickens' *Hard Times* (1987). The schoolmaster, Thomas Gradgrind is presented to the reader with these words:

> **Now what I want is Facts. Teach these boys and girls nothing but facts. Facts alone are wanted in life. Plant nothing else, and root out everything else. You can only form the minds of reasoning animals upon Facts: nothing else will ever be of any service to them. Thomas Gradgrind, sir. A man of realities. A man of fact and calculations. A man who proceeds upon the principle that two plus two are four, and nothing over, and who is not to be talked into allowing anything else.**

Thomas Gradgrind, as we can see from the cline, will be appreciated by cultures lower down the ranking scale. In fact, he has problems enough in England, and with

this orientation should not be sent to a teaching post in Japan.

Returning now to an earlier discussion on language and culture, we can now look at the relationship between the use of the lexico-grammar and the contexting theory. We will look first at the English language, and then at British and American differences in the use of English.

10.2 English – The Language of Strangers

The English language itself, as a lexico-grammatical system, is decidedly LCC in comparison with many other languages. The language is well-adapted to explication, and less suitable for the signalling of pre-established social relationships, as Mühlhäusler and Harré (1990:32-33) note. They point out that in Japanese, the language itself obliges speakers to pronounce themselves on one of the four levels of relationship with others. Membershipping the relationship itself is an essential part of Japanese discourse: "To speak at all some choice must be made among the four. Whatever word one selects expresses a particular relationship". English, on the other hand "does not facilitate the expression of social relations between speakers and audience at all".

Halliday (1992:75) notes exactly the same point, and explains the LCC nature of the English language itself (as used by the middle-class): "the ways of meaning of the listener are precisely not taken for granted. This kind of discourse can be spoken to a stranger". Hasan (1984:131, 151) notes that cultures select from 'implicit' and 'explicit' options (without ever mentioning Hall or the contexting theory). In her study, contrasting Urdu and English, she notes that an English person:

> could not speak as implicitly as the Urdu speaker, even if he tried – the system of his language will not permit him to do so ... We can claim without hesitation that the dominant semantic style in Urdu is the implicit one ...

Urdu, spoken by eighty-five million people in Pakistan, North and central India and Bangladesh is an example of a language spoken by a tightly woven group. According to both Halliday and Hasan, speakers of this language will tend to select the implicit option, not only for lexico-grammatical reasons, but also because the context of situation will not have changed in time and there are strong relations between events.

Concluding her research on the high level of assumptions made by Urdu speakers, and the expectation that the addressee (whether total stranger or not) will implicitly know, Hasan (1984:153) makes a strong case for the tightly woven/loosely structured hypothesis: "the Urdu speaker's world must be a fairly-well regulated place in which persons, objects and processes have well-defined positions with reference to each other, and the speakers know the details".

• *American and British English*

We now turn to differences in standard usage of the same lexico-grammatical sys-

6. according to court interpreters the dignity and status of a recognized professional.

There are, of course, obstacles which stand in the way of a new role prescription, but they should not prove to be insurmountable. One is the question of whether the interpreter's knowledge and skill represent "expertise" in the way the courts have become accustomed to act on and what scope this expertise might have. Traditionally, it has been accepted that expertise must be held within a recognized area of science, however, it has not been necessary for the expertise to have been acquired professionally (Cross, 1989). As of today, "there are no agreed criteria for resolving the problem" (Cross, 1989: 433) which leaves the door wide open for discussion and development.

The same goes for the appointment of the interpreter as an expert witness. Whereas interpreters under their present role prescription are in the court at the discretion of the judge, expert witnesses are not appointed by the judge. In the adversarial courtroom, the judge holds the balance between the disputing parties and stands above the appointment of witnesses. But here again, in criminal cases the judge may choose to do so and "as a matter of practice, calling expert linguistic evidence is unlikely to generate controversy" (Laster and Taylor, 1994: 178). This situation too leaves room for discussion and renewed assessment.

This paper is offered to generate discussion in order to bring about a shift in the thinking about the work of interpreters in the adversarial courtroom. If interpreters continue to qualify themselves and raise their standards and the legal profession seeks to understand the real demands and the true nature of interpreting, then perhaps we can look forward to what one magistrate called "the day when the interpreter is seen by *all* who work within the legal system as having full membership of the court team" (Colin, 1993: 189).

RECYCLED INFORMATION AS A QUESTIONING STRATEGY
PITFALLS IN INTERPRETER-MEDIATED TALK

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Introduction

The present analysis explores an authentic case of an interpreter-mediated police interrogation.[1] More precisely, it focuses on the police-officer's strategies for eliciting from the suspect her spontaneous story about the case of minor theft that is under investigation. The analysis suggests that the functions of the questioning strategies, which are of types that are usually found in interrogations, can be affected substantially by the dynamics of the interpreter-mediated conversation. The conclusion to be drawn from this is that interpreter-mediated interrogations must be explored and understood in their own right as a particular kind of three-party communication. The analysis makes an important theoretical distinction between talk represented as text and talk seen as activity.

Interpreters in Society – Service and Control

According to a Swedish law in force since 1975, a person who does not speak Swedish or who is hard of hearing has the right to have an interpreter present not only during court trials but also in other legal situations as well as in contexts involving health services and social welfare. (One million out of the nine million people living in Sweden do not have Swedish as their first

language). The law states that an interpreter should be called upon if needed, and the responsibility for calling in an interpreter lies with the officials of the various public bodies. The law is there to protect the rights of the non-Swedish-speaking party.

In practice, of course, representatives of the majority, that is to say court officials, the police, health workers, and people working in social service organizations are mostly no less dependent on the assistance of interpreters than are their clients and patients. This law, therefore, protects the social and legal systems.[2]

Interpreters are actors within the *service system* of society, and at the same time within the public *system of control*. Civil rights and civil responsibilities are two sides of the same coin. This paper will cast some light on how this duality appears in real life activity; and what possibilities and constraints this can mean for the interaction between monolingual parties in actual encounters.

Popular Images of Interpreters

Interpreters are seldom depicted as *providers of service* and *agents of control*. A more common image is that of *producers of text*. Even more common perhaps is the image of interpreters not as actors but as passive *tools*, to be used or handled by the primary interactants. We are all well aware of the idealistic image of the interpreter serving merely as an instrument or a *channel*, transmitting messages back and forth between two languages. Ruth Morris in her thesis (Morris, 1993) eloquently describes the legal theory of what she calls "language switching" (meaning the activity carried out by interpreters in court), showing that there is a predominant "legal fiction, that L2 = L1, and that the instrument of this equation uses no discretion or freedom of will whatsoever in achieving the goal set by the law" (1993:136).

Another image frequently used, and also brought forward by Morris, is the interpreter as "a necessary evil" (cf. Herbert, 1952:4); that is, the interpreter as a remedy to an abnormal situation. In a sense, this metaphor reflects an underlying mistrust and fear of the alien or the deviant, a problem that legal systems apparently are not sufficiently prepared to handle. The underlying assumption is that the monolingual situation is the normal case by which the abnormal, bilingual case should be measured. Yet, as we all know, the bilingual situation is far from unusual, both in private and public life in most countries today. This view of normality, I would argue, is also the basic logic

behind studies of interpreting which concentrate on omissions and distortions, asking such questions as: What gets lost? and, What gets added? Whereas, from another perspective, the interpreter-mediated encounter implies its own conditions and organizational principles. Another way to explore it might be by asking: What is so specific about this mode of communication?

The first approach implies a focus on issues that can be explored and evaluated as one would *texts*. This implies that people's talk as well as the interpreter's interpretation is basically explored as *text production*. The second approach implies an alternative look on talking as *activity*. This means that the interpreter's job must be explored and evaluated on the basis of the *multiple functions that people ascribe to talk in actual interaction*. These are essentially different points of departures, however the one does not exclude the other. If the first is used to impose a textual structure on empirical data, the second can be applied to raise questions about this structure and the dynamics of the activity it represents. Below I present excerpts from an authentic police interrogation. On the basis of the spoken word on a tape, I have produced and structured these texts. The people who were recorded can be understood simply as having been conversing. Their talk made sense and fulfilled functions in the there-and-then situation. As will be demonstrated, the participants did not necessarily share the same understanding of what was being said. We do not know if they even noticed that this was the case, but in retrospect we are able to make sense of what they said in new ways.

The Multifunctionality of Talk in Interaction

In any interpreter-mediated encounter, most utterances by the monolingual parties are routinely designed to have two functions. On the one hand they have the function of a question or a proposition for the other primary interlocutor to react upon appropriately, by answering, confirming, disclaiming etc. On the other hand, most utterances are designed also to function as preliminary questions or propositions for the interpreter to react upon adequately by repeating them in another language.

Given the framework of a police-interrogation, we may predict more specifically some of the central functions that talk is supposed to have, at least from the point of view of the institution. A police interrogation consists mainly of the police officer's efforts to elicit information on a given topic from a suspect or a witness. What is supposed to come out of the interaction is then a

written report, authored by the officer, and approved by the person interrogated as a true account of what he or she has stated.

In the transcript which follows, we will keep the *encounter* (and not a participant) as our unit of exploration. The verbal interaction to be analysed is seen as the result of joint efforts (cf. Duranti & Brenneis, 1986). Following this idea, we could compare the people taking part in the conversation with a trio of dancers. The three of them coordinate their turns in the common activity. Dancing, as most of us have experienced, can be improved by practising. But the practice you get dancing in pairs will not automatically make you a good performer in a dance for a threesome. The interpreted encounter can be seen as a special kind of a pairs dance with an additional person. The question is how this *pas de trois* is organized and performed.

In an interrogation, the police officer in charge is, according to social and cultural conventions, the one to take the lead. In the interpreter-mediated case, however, the encounter is regulated in part by the person in the middle. The mere presence of interpreters in an interaction provides a certain service and exercises a certain control, as they give voice to others and listen on behalf of others. A central issue then must be: what happens to questioning techniques conventionally used in interrogations, when the questioning is done with the assistance of an interpreter?

The Case

In the following transcript, we will take a look at a single case, an interrogation concerning a minor theft. The interpreter in question is both experienced as an interpreter for the police and well aware of the Code of Ethics for certified interpreters. Certification for Community Interpreters was established in Sweden in 1978. In a short interview, immediately after the half-hour encounter in question, the interrogating officer told me that he too was aware of the Interpreters' Code of Ethics. Moreover, he mentioned that he knew the interpreters' preferred way of working; namely that he should address the suspect directly, and not the interpreter. He meant that he did this most of the time while conducting interpreter-mediated interrogations and, as he remembered it, he had done so on this particular occasion.

The suspect is a young woman. She is one of three Russian-speaking people (one man and two women) who have been caught red-handed shoplifting in a big department store and brought to the police station where they have spent the night in custody in separate cells. Moreover, a quantity of goods, suspected to be stolen, was found in a luggage locker at a railway station, and the key to this locker was found on one of the women, here called Rita. As a result, the Russians, who were travelling together, are also suspected of receiving stolen property.

The recordings were made during a second round of interrogations. The first were conducted immediately after the shoplifters had been caught. The police officer in charge, here called Peter, told me that the first interrogations were conducted in English, without an interpreter, by a colleague of his. Peter now sees the suspect, here called Sasha, for the first time, as does his assistant who is present during the interrogation, primarily to help him with showing the items found in the locker. The assistant is supposed to fetch things from the big plastic bag he has brought with him and put them on the table for the suspect to see. The interpreter, Irina, has been briefed on the case before they all go in to see the suspect and then the interrogation starts.

The excerpts below are drawn from the last third of the encounter. We come in where all the goods from the locker have been shown to Sasha and she has denied all knowledge of them. But Peter has already questioned her friend Rita and has got another impression. Rita had claimed that she had been at the railway station together with her friends, and that they had put a pair of shoes that belonged to her, that is to Rita, in a locker. One way to get at the truth would, therefore, be to compare their stories.

Excerpt 1 (7:11) (cf. transcription conventions below)[3]

->	364	Peter:	men **Rita** säger ju det. att ni gick alla tre, *but Rita says like this. that you went all three,*
	365.	Irina:	а **Рита** так говорит что вы туда все трое пошли. *but Rita so says that all three of you went there.*
	366	Sasha:	а **я** так не говорю. *but **I** don't say so.*
	367.	Irina:	men jag **säjer** inte så. *but I don't **say** so.* (1.0)
	368.	Peter:	men va e:::h va säjer-? då::: (.) ljuger Rita? *but what e:::h what says-? then::: (.) is Rita lying?*
	369.	Irina:	но::: что тогда сказать что кто-то из вас, е::: лжёт? *but::: what then [one can] say that one of you e:::h is lying?*

370. Sasha: наверно.
perhaps.
(1.5)
371. Irina: °kan hända.°
°might be.°
-> 372. Peter: kan hända?
might be?
373. Irina: наверно?
perhaps?
(2.0)
374. Peter: **ljuger** hon?
*is she **lying**?*
375. Irina: она лжёт?
*is **she** lying?*
(1.5)
375. Sasha: наверно. я говорю что я про этот бокс ничего не знаю.
perhaps. I say that I about this locker don't know anything .

The excerpt above includes four turns by the police officer. The three which are indicated by arrows (364, 368, and 372) each illustrates a different type of questioning strategy. They are different, but based on a common principle—the recycling of information for the purpose of eliciting confirmation or further details. These questioning strategies are used routinely in police interrogations. We will here explore how, in the interpreter-mediated case, they can come to function in non-standard ways.

Recycled information as a questioning strategy

In the following, I will identify three types of questioning strategies. Instances of these found in the first excerpt will be analysed subsequently. Then to illustrate further the specific dynamics of these questioning techniques in the interpreter-mediated encounter, we will also explore a second excerpt. To begin with, let us distinguish between:

— (i) quotes from documents or absent persons (NN says that...).

— (ii) 'formulations' (Heritage & Watson, 1979). In this paper, the definition of a 'formulation' is more restricted, and is similar to that of Adelswärd (1988:106), namely an account of the gist of the preceding turn or turns which is offered to the counterpart for approval (You say that...).

— (iii) quotes from the immediately preceding utterance, often with a questioning intonation, 'format tying' (Goodwin & Goodwin, 1987) or, to use a common expression, 'latching on to somebody's words' (What do you mean by...?).

Quotes from an Absent Person

Police officers are taught in general to conduct interrogations in a way that stimulates an atmosphere of mutual confidence. They should see to it that the suspect or the witness does not feel threatened, but opens up and becomes willing to speak. One of the ways in which an interrogator can appear less threatening is by presenting himself as a mediator, merely forwarding what others have said (cf. Clayman, 1992). The first utterance in the previous excerpt, "but Rita says like this. that you went all three" (364) is an example of this. As we see, however, Sasha does not take this as an invitation to tell her version of the event. Instead she refers back to the position she has just stated: "but *I* don't say so" (366). The topic therefore is shifted away from the question about who had been doing what at the railway station to who is claiming what right now.

Peter has actually, for some time, been mentioning parts of Rita's version of an event which, from his perspective, did indeed take place and all his efforts now are directed towards eliciting Sasha's own account of it. We can note, however, that Sasha, instead of providing an account of her presumed doings at the railway station, continues questioning the relevance of the police officer's inquiries. He is alone in providing more information about the goods found in the locker, and in framing the talk as a discourse about the suspect's involvement in a case of minor theft and receiving stolen property. There are many examples here of this recycling of information technique for eliciting information and it is continuously upgraded, as it were. The following excerpt is taken from a short while later in the interview. Peter claims, based on what Rita told him, that among those things he has listed, only one pair of shoes belongs to her. In other words, to whom do the rest belong? There is one

second of silence before Peter comes back to steer Sasha more firmly into his line of thought.

Excerpt 2 (7:13)

->	439. Peter:	hon säger, (.) indirekt, (.) att dom andra sakerna tillhör ju er. *she says, (.) indirectly, (.) that the other things belong to you.*
	440. Irina:	и::: опосредственно, она говорит что все другие вещи вам принадлежат. *and::: and indirectly, she says that all the other things belong to you.*
	441. Peter:	och inte henne. *and not her.*
	442. Irina:	а не ей. *and not her.* (0.5)
	443. Sasha:	я могу сказать что из всех вот этих вещей мне не принадлежит ничего. *I can say that of all these things nothing belongs to me.*
	444. Irina:	jag kan säga att bland alla dom här sakerna som finns här, hör till mig ingenting. *I can say that among all these things that are here, belongs to me nothing.*
->	445. Peter:	vad säger du om att Rita e::h (.) påstår att du har varit med in och köpt ett par skor och att du och den här karln var borta och låste in dom härа. (1.5) dom andra sakerna i en box. vad tycker du om det? *what do you say about that Rita e::h (.) claims that you have been in with [her] and bought a pair of shoes and that you and this guy went away and locked these things up. (1.5) these other things in a locker. what do you think about that?*
	446. Irina:	а что вы думаете о том что вот Рита утверждает что вы были с ней в магазине купили туфли. что вы с этим мужчиной закрывали вещи в бокс. что вы об этом думаете? *and what do you think about this that like Rita claims that you were with her in a shop [and] bought shoes. that you and this man locked up things in a locker. what do you think about this?*
->	447. Peter:	du är misstänkt för stöld, alternativt häleri, *you are suspected of theft, alternatively of receiving stolen property,*
	448. Irina:	вы *you*
	449. Sasha:	я думаю это ситуация e::: мм. (1.0) когда (2.0) кто-то пытается выгородить себя. *I think this is a situation e::: mm. (1.0) when (2.0) someone is trying to get away.* (1.0)
	450. Irina:	°mhm° det är någon eh försöker faktiskt e:::h (1.0) e:::h m::: (.) komma undan. *°mhm° it's someone eh is trying actually e:::h (1.0) e:::h m::: (.) to get away.*
->	451. Peter:	någon? vilken någon? *someone? which someone?*
	452. Irina:	а кто? (0.5) кого вы имеете в виду? *and who? (0.5) who do you have in mind?*
	453. Sasha:	я не знаю. *I don't know.*

In Excerpt 2, it can be seen how the questioning technique we pointed out earlier (in 364) subsequently gets upgraded. For instance, Peter (in 439 and 441) refers to what the absent companion claims and explains what conclusion he draws from this, namely that the goods in front of them must belong to Sasha and/or the third person. This too is not taken as an invitation to confirm or to specify. Sasha insists (in 443) that nothing found in the locker belongs to her, hence that the conclusion drawn by the police officer is wrong.

It should be mentioned here that the pronouns used conventionally for addressing a person are different in Russian and in Swedish. In Swedish, the *singular* form of 'you' (*du* in Swedish) is used broadly, between strangers of different status as well as between friends, in contrast to the corresponding Russian singular (*ТЫ*), which functions exclusively as a familiar (or non-polite) form. In this encounter, the *plural* form of 'you' (*ni* in Swedish), is systematically translated by *ВЫ*, i.e. the Russian plural form, which in Russian is also the polite form. The Russian polite/plural form (*ВЫ*) thus comes to be used in this encounter to designate Sasha. The possibilities for making the distinction between 'you' in the plural and 'you' in the singular, which the police officer's statement in 439 is based on, is at this point not readily available to the interpreter. And, as was confirmed later, Sasha is left with the impression that the police want her to believe Rita has blamed her for hiding stolen goods at the railway station together with the young man.

In utterances 445 and 447, there is a new upgrading of the quoting technique. Peter again takes Rita's story as a starting point and then he adds - as an explanation of why it is important for Sasha to tell the truth - the charges that are being laid formally against her: "you are suspected of theft, alternatively of receiving stolen property" (447). Again the recycling of information fails to achieve the expected result. The illocutionary force of the question is somewhat counteracted by the organizational principles of the interpreter-mediated talk. As we see in 448 and 449, Sasha starts talking at the same time as Irina begins her interpretation of Peter's added clarification (447). The initiative remains with the suspect. She has her answer ready to the first part of Peter's question. As a result, the latter, crucial part ends up, as it were, off the record. Irina in her next turn picks up again from the immediately preceding utterance, Sasha's answer. Sasha is, thus, not reminded of the seriousness of the situation. From her point of view, the talk is still about the truth of Rita's allegations.

Formulations

Peter's utterance in excerpt 1, "but what e:::h what says-? then::: (.) is Rita lying?" (368), is perhaps not the best example of a 'formulation' as defined above. What is interesting here, however, is that Irina apparently makes sense of it as such. The officer's utterance is characterized by the typical redundancy of spontaneous speech. The first part of it stands apart as what is called a 'false start' (but what e:::h what says-? then:::). This feature is normally not attended to specifically by participants in spoken interaction. But once such parts of an utterance *are* attended to, as they tend to be when they are reproduced in print, it takes an extra effort to disregard them and hear or see the utterance as if it began after the end of the false start, in this case with: "is Rita lying?" (368). Nevertheless, attentive listening to the tape while transcribing leaves me with the impression that this yes-no question is cued prosodically as the edited, or final, version of the utterance.

The interpreter's mode of listening is different from that of ordinary interactants in a conversation. Unlike the monolingual parties, she is supposed to listen in order to be able to repeat. This means that, in the interpreter's listening mode, everything said by the primary interactants tends to be given an equal status, the status of being constituents of the original utterance, all of which, according to the interpreting norm, should be relayed in the other language. As empirical research has shown, however, there are cognitive

constraints involved in memorizing fragmented speech exactly , and probably social constraints against repeating other people's false starts (Wadensjö, 1992).

We may note therefore, that Peter's initially somewhat unclear, but in the end straightforward request for a yes or a no (368), in the interpreter's version (369) becomes wrapped up differently. Irina relays Peter's utterance as something of a 'formulation.'

Another indication that Irina takes it as such can be seen in the fact that she uses the Russian verb сказать for 'say',"but::: what then [one can] say that one of you e:::h is lying?" (369), and not the word that Sasha just used, "говорить: а *я* так не говорю" ("but *I* don't say so") (366). In Russian, there are two different words for 'say.' The one, сказать, indicates a finished action, while the other, говорить, implies an ongoing activity.

Format Tying

The officer's utterance "but what e:::h what says-? then::: (.) is Rita lying?" (368) could be said also to have an element of the third questioning technique, referred to earlier as 'format tying' (Goodwin & Goodwin, 1987). The suspect has resisted the invitation to tell *her* version of what is presented as her friend's story. Instead, as was previously mentioned, Sasha positions herself in opposition to the information recycled by the officer: "but *I* don't say so " (366). This is then rendered in Swedish by the interpreter. Irina's version (367) includes a non-standard emphasis on the word *säger* ('says'), which potentially increases Peter's attention to it. Although the pronoun is stressed in the suspect's Russian version (as "Rita" was in the preceding two turns 364 and 365) it is the verb which is stressed in the translation. The police officer subsequently (368) picks up *säger* from the immediately preceding utterance (367), but because Irina takes the function of his utterance (368) to be a 'formulation,' this latching-onto-a-word type of action gets completely replaced in the Russian version (369). A function of this formulation which is worth mentioning is that it cuts off what appears as an argumentative twist in the conversation. Sasha, when answering "but *I* don't say so" (366) has in turn picked "say" from the preceding utterance "but Rita says like this..." (365).

The Russian word for "say" is here the same: говорить. But by taking Peter's utterance as a 'formulation,' Irina smoothes over the latent quarrel aspect of the sequence in progress, and thereby influences the exchange of information.

We will now look at two other examples of 'format tying' found in the police officer's contributions, and clearly belonging to his repertoire of questioning techniques. One occurs further on in Excerpt 1. Peter repeats the exact wording of a preceding utterance, only with a questioning intonation: *kan hända* ?("might be?") (372). Irina most probably has a feeling for what the officer's question is designed to do. When interpreting this utterance back to Sasha, she reuses the suspect's word from a moment ago: "НАВЕРНО" ("perhaps.") (370) - "НАВЕРНО?" ("perhaps?") (373). And then come two seconds of silence. In spoken interaction, such a short period of time can be experienced as quite long. Peter, as we see, is the first one to break the silence. This may be explained perhaps by the fact that the format tying technique relies to a large extent on timing and immediacy. Peter inserts a new question when his question "might be?"(372) does not provoke an immediate response. In monolingual conversation, a major function of this would be to reduce the time available for the antagonist to think twice about how to reply. What the police officer needs is spontaneous answers. The interpreter-mediated conversation has a potential impact on interlocutors' spontaneity.

Peter's next move is therefore to rephrase the yes-no question from a moment ago (in 368), now saying more straightforwardly: "is she **lying**?" (374). But apparently Sasha does not feel obligated to explain what she meant to say. There are probably complex reasons for this. What we have pointed out so far is part of this complex picture. Another detail worth mentioning concerns prosody. As can be observed, the first three turns at talk (364, 365, and 366) all contain stressed nouns or pronouns. The emphasis on the "I " in the suspect's answer (366) makes it stand in contrast to "Rita" in the officer's question (364). But the interpreter's non-standard stress on *säger* ("says") pointed out above (in 367), indicates opposition not to an actor but to an action. The verb in the officer's initial utterance (364) is "went." Consequently, the officer could get the impression here that the suspect has not ruled out that she went to the railway station, but she is determined to say nothing about it. If we add to this what we can observe by comparing the officer's question "is she **lying**?" (374) and Irina's version of it "is **she** lying?" (375), we get the picture of two somewhat different ways of understanding the aim of the questions. The difference is visible to us from our distant perspective but most probably is not noticed at the time by those involved in the interaction. To the interpreter, the inquiry at this point is not about whether or not Rita is lying, but about which of the suspects is doing so. This in turn may be explained partly by her being biased because of what she has heard from the police officer and his assistant

before the interview (when we were all standing in the corridor). Irina knows that it is obvious to Peter and his colleague that one or both of the girls is lying, and apparently this forms a general framework for her understanding of the officer's questions during the encounter.

Let us move on to a third example of the format tying type of question. At the end of the second excerpt, the police officer repeatedly echoes a word from the previous utterance: "someone? which someone?" (451). Irina's preceding translation of Sasha's utterance, like the original, includes a "someone," and Peter in this way presses the suspect to be clearer about who she means is trying to get away. Irina's rendition of the officer's utterance, "and who? (0.5) who do you have in mind?" (452), does indeed look like a request to be specific on this point. But it fails because the suspect refuses again to specify and once more provides an answer which puts her under no obligation to explain further: *Я не знаю*. ("I don't know.") (453).

Direct and indirect address

At this point I wish to come back to the issue of modes of addressing, brought up at the beginning of this paper. Throughout the two excerpts the officer addresses the monolingual counterpart directly. But in other parts of the encounter it apparently feels natural for him to address the interpreter, and to speak to the suspect only indirectly. From the recording it is clear that Peter moves freely between addressing the suspect and addressing the interpreter in different parts of the encounter. The interpreter in turn, as well as the suspect, is more consistent in the manner of addressing.

As was mentioned earlier, the police officer said in a short interview after the encounter that he was familiar with the interpreters' preferred way of working, including the principle that the monolingual parties should address each other directly. Moreover, he thought that he had been adhering to this mode of communicating most of the time. Listening through and transcribing the tape however, gave quite another impression. I will not go into details here about when one and the other way of addressing occurs. This is a phenomenom that is quite obvious intuitively but should be further explored. It is sufficient to note that the officer shifts between addressing the suspect and the interpreter directly and indirectly, and that this tends to coincide with shifts in related physical activities, including handling the list of stolen goods, dealing with the goods themselves, and reading and writing the interrogation protocol. The

presence of the assistant adds to the complexity of the interaction. Every now and then Peter checks that his assistant is following him and asks if he has any comments or questions to add. Their common activity (going through the list of stolen goods, and showing these to the suspect) is coordinated through islands of short verbal exchanges, exchanges that do not preempt the attention of the two women.

Four Categories of Address

To provide a structure to the interrogation which could elucidate the issue of addressing, all turns at talk in the 37-minutes-long recording were counted and sorted into four categories. In total, the recording consists of 586 turns. The definition of a turn is a sequence in which one person is speaking without interruption. It commences when this person starts talking and ends when speech stops. Hence, when two people speak at the same time, two turns occur simultaneously (or partly simultaneously). In the interrogation described here, turns are distributed between the participants as follows: Peter 178, Sasha 118, Assistant 12, and Irina 278. Table 1 shows these turns categorized according to the pronouns they contain and, consequently, by how they are designed to address the monolingual counterpart, namely:

- indirectly (he, she, they, one)
- simultaneously indirectly and directly; i.e. when including the speaker (we)
- directly (you, Swedish *du*, *ni*; Russian ВЫ, ТЫ)
- no address, i.e. utterances containing no pronouns.

Table 1. Categories of address in police interrogation

Address	P (n=178)	I (v P) (n=149)	S (n=118)	I (v S) (n=123)	I (v I) (n=4)
indirect	**45**	**0**	0	0	0
"we"	6	4	1	2	0
direct	36	**82**	6	7	0
none	90	63	111	114	4

Figures in parentheses = total number of turns. P = Peter, I(vP) = Irina voicing Peter, etc. For the sake of simplicity, the assistant's turns are not included.

There are three figures in the above schema that should be commented upon in this context. First of all, we may note that the officer talks in 45 of his contributions *about* the suspect. The interpreter, in contrast, never talks about

the suspect even if she is speaking on behalf of the police officer. The question is then, what happens to these utterances of his? From the transcript it is clear that Irina relays most of them with the suspect as a direct, explicitly mentioned addressee - "you." Moreover, the same thing happens with turns from all the different categories in the police officer's column. The figure 82, in the Irina-voicing-Peter column supports the hypothesis that direct address is one of the most powerful means by which an interpreter can entertain and strengthen a common focus of interaction, and the illusion of a direct exchange between the monolingual parties. There might be dissimilarities between different language combinations in this regard, but it seems to be the case at least in exchanges involving Russian and Swedish, judging from my two corpora totalling 30 encounters collected in various institutional settings.

The Case Revisited

If we look again at the last sequence we pointed to at the end of Excerpt 2, we can see that direct address as the interpreter's means of coordinating talk is exactly what is brought into play. The officer's "someone? which someone?" (451) is designed as a format tying type of question, urging the suspect to specify what she meant to say by what is relayed as "°mhm° it's someone eh is trying actually e:::h (1) e:::h m::: (.) to get away" (450). In the interpreter's rendition, the latching-on-to-a-word function is downplayed substantially. She says: "and who?" (in 452) and there is a silence of 0.5 seconds, a silence which she breaks herself, making the question more specific by saying: "who do you have in mind?" (452). By addressing the monolingual counterpart explicitly, Irina makes it clear that the suspect (and nobody else) is expected to account for what the latter meant. She urges Sasha to talk, and she does this in a manner which is understood conventionally as less face-threatening than repeating someone else's words. Simultaneously, Irina protects her own detached middle position.

Concluding Remarks

One likes to think that a good interpreter should ensure a successful interrogation. In practice, however, criteria for quality in interpreting remain to be defined. First of all, quality is a matter of perspective. Good or bad must be seen in relation to one or a number of well-defined goals. As interpreters

and/or as teachers of interpreting, we may sense intuitively bad or good quality, but our theoretical instruments to evaluate it are still quite blunt. For many reasons, most of them are oriented towards treating talk as texts. It becomes convenient, therefore, simply to compare texts, i.e. primary interlocutors' originals and interpreters' renditions. Such comparisons do give information about crucial factors like the interpreter's memorizing capacity and vocabulary in the two languages. Indeed, the more detail we discover in the textual structure of the interpreter-mediated encounter, the more knowledge it should be possible to generate from text-oriented analyses. We know intuitively however, that quality in interpretation is also dependent on factors that do not lend themselves to evaluation through comparisons between originals and renditions, and that generally speaking are represented in text. For example, how do we evaluate timing? What about the interpreter's ability to mediate, to create and sustain a common focus of interaction, to keep alive the primary parties' illusion of taking part in a non-mediated interaction? Moreover, are these always equally desirable capacities, or must they be evaluated differently according to the type of context, or constellation of speakers?

This paper contributes to the exploration of the interactive conventions followed in real-life interpreter-mediated encounters. Most of the time these conventions are, not surprisingly, the same as those applied in monolingual conversations. But it appears that what is considered convention in the one situation is not automatically understood and does not function in the same way in the other. The present single case of a police interrogation suggests that when the professional interlocutor asks questions in the same ways as in monolingual dyadic proceedings, the questions tend to function in a non-standard fashion. The paper has identified three types of questioning techniques based on the recycling of information, and has analysed instances where they were brought into action. We have observed that in three-party interpreter-mediated interaction there is an inherent possibility that they may be counteracted. When the interpreter works on creating and strengthening a common focus of interaction, and on keeping alive the illusion of a direct exchange between the monolingual parties, it can sometimes have substantial implications for the effectiveness of this questioning strategy.

This has both theoretical and practical corollaries. Courses in community interpreting, as well as courses in interrogation techniques, are today modelled basically on the dyad, and not just any dyad. It is the monolingual dyad which is generally viewed as the norm. 'Normal' in the

sense of 'usual' gives us little difficulty. In the sense of 'how it should be' it poses more substantial problems if we consider the fact that interrogations are conducted quite frequently with the assistance of interpreters. As has been shown here, the constellation of three participants and their various linguistic proficiencies can make a significant difference.

When interpreting is explored as interaction (Wadensjö, 1992), it becomes evident that the interpreter-mediated talk forms a particular type of encounter, with its own specific organizational principles. From the interaction perspective, the role of interpreter can be seen as a combination of two central functions; on the one hand, translating and on the other hand, coordinating others' talk. The translating function is obvious for those taking part in the interaction. The coordinating function is obvious to the extent that the interpreter is expected to take every second turn at talk. Yet, the coordinating work of the interpreter's contributions can be more or less explicit and can have a stronger or weaker effect on the progress and the substance of the interaction. Drawing on a single case of an interpreter-mediated police interrogation, it has been demonstrated how two-language talk as a social activity implies conditions that potentially affect the conventional function of a common questioning strategy, namely recycling of information. This, in turn, may help fuel the discussion on how to define the professional ethics of community interpreters.

To develop community interpreting as a profession, and consequently to guarantee equal legal rights to language minorities, these questions must be taken seriously. The interpreter-mediated situation must be seen as normal on its own terms.

Notes

1. This article draws on a research project supported by the Swedish Council for Research in the Humanities and Social Sciences (F 402:87) and the Swedish Ministry of Labour (DEIFO 34/89). I wish to thank the local police organizations for giving me time to record and interview people at work. Thanks also to Per Linell and to Brian Harris for valuable comments on earlier drafts of this paper.
2. Here is an anecdotal illustration: In the Swedish North, there was a Lappish man who appeared in court to be heard in a criminal case. The judge, who was very experienced and conscious about the language problems started by asking if the accused could manage without an interpreter. The answer was yes, and so the trial begian. The prosecutor read the charges and directed the first question to the accused. The reply came rapidly, but nobody understood what he was saying. He was speaking Lappish. "Hey! You said you didn't need an interpreter!" said the judge. "No," said the suspect, "I don't need an interpreter. Do you?"

3. Transcription conventions:
   underlining = two people talking at once.
   , = 'continuing intonation' (a prosody-shift after a unit of talk indicating that it is not completed and/or that the speaker does not want to relinquish the turn).
   . = 'terminating intonation' (indicating that the speaker is prepared to relinquish the turn, or, at least, that a complete unit of talk information has been uttered).
   ? = 'questioning intonation.'
   - = sudden cut-off of the current sound.
   ... = 'open-ended intonation' (utterance fading out with an ambiguous intonation terminal).
   : = the sound just before has been noticeably lengthened.
   (n) = a pause, where n is the length of the silence in seconds.
   (.) = a very short silence (micro-pause).
   boldface = emphasis, which may be signalled by increases in pitch and/or amplitude.
   ° ° (framing part of an utterance) = pronounced *sotto voce.*
   italics = the author's English translation of talk in Swedish and Russian.

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Volume 19

Silvana E. Carr, Roda Roberts, Aideen Dufour and Dini Steyn (ed.)

The Critical Link: Interpreters in the community

THE CRITICAL LINK: INTERPRETERS IN THE COMMUNITY

PAPERS FROM THE FIRST INTERNATIONAL CONFERENCE ON INTERPRETING IN LEGAL, HEALTH, AND SOCIAL SERVICE SETTINGS

(Geneva Park, Canada, June 1-4, 1995)

HQ 1465 09/01

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AMSTERDAM/PHILADELPHIA

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences — Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Library of Congress Cataloging-in-Publication Data

International Conference on Interpreting in Legal, Health, and Social Service Settings (1st : 1995 : Geneva Park, Ont.)
The critical link : interpreters in the community ; papers from the First International Conference on Interpreting in Legal, Health, and Social Service Settings (Geneva Park, Canada, June 1-4, 1995) / edited by Silvana E. Carr ... [et al.].
p. cm. -- (Benjamins translation library, ISSN 0929-7316 ; v. 19)
Selected rev. papers from the conference.
Includes bibliographical references and index.
1. Translating and interpreting--Social aspects--Congresses. 2. Translating services--Congresses. 3. Human services--Translating--Congresses. I. Carr, Silvana E. (Silvana Ester), 1943- . II. Title. III. Series.
P306.2.I55 1995
418'.02--dc21 96-6510
ISBN 90 272 1620 7 (Eur.) / 1-55619-701-2 (US) (alk. paper) CIP

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John Benjamins Publishing Co. • P.O.Box 75577 • 1070 AN Amsterdam • The Netherlands
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The Community Interpreter's Task:
Self-Perception and Provider Views

Franz Pöchhacker
University of Vienna

Abstract

Defining the role and task of interpreters in community settings is an issue of prime concern and controversy in the drive for professionalization of interpreter service delivery. In an effort to fuel this debate with empirical data from a context of very limited institutionalization of community interpreting, the views of over 600 service providers (doctors, nurses, therapists and social workers) in Vienna hospitals and family affairs centers as well as the views of 16 spoken language and 16 sign language interpreters were collected on the question of what is or is not part of the interpreter's task. The responses to nine selected task demands above and beyond the norm of faithful relaying show that service providers expect interpreters within their institutional settings to do much more than "just translate." Interpreters themselves were found to share a rather expansive conception of their role, though there is considerable heterogeneity within the different sub-groups of persons serving as interpreters without task-specific training.

Introduction

The provision of interpreting services in community settings such as health care and social service institutions is somewhat of a novelty in some countries and a well-established tradition in others. Chief among the latter is Australia, which boasts decades of experience in this field (Ozolins 1991; Chesher 1997), while Austria is a small but perhaps typical example of the former group (Pöchhacker 1997a). Strikingly, though, the nature and limits of the community interpreter's task seem to be an issue of prime concern and even controversy at any stage of

institutionalization. Gentile *et al.* (1996), in their *Handbook* designed to aid the professionalization of community interpreting after nearly a quarter century of its existence, devote an entire chapter to "The Role of the Interpreter," and Wadensjö's (1992) research on dialogue interpreting in Sweden provides ample evidence that, even for trained professionals cognizant of their code of practice, the issue of task demands in the role of interpreter in community settings is by no means cut and dried. Consequently, Roberts (1997: 20) stresses the importance of "providing a better understanding of the role(s) of the community interpreter" as a prerequisite for successful professionalization.

If clarifying the interpreter's role and task is challenging enough in countries with at least some level of institutionalized and professionalized community interpreting services, it is an even more fundamental issue in a country like Austria, where the need for professional interpreters in health care and public service settings is only beginning to gain some recognition, and untrained bilinguals are doing the job as best they can. In the absence of any code of practice or professional authority, these untrained community interpreters presumably shape their task according to some implicit norms of translational behavior (Harris 1990) as well as expectations on the part of their (professional) clients (Gentile *et al.* 1996, ch. 3). As part of a survey on community interpreting needs and standards in hospitals and social service centers of the Austrian capital, the author therefore attempted to ascertain both providers' views of the interpreter's task and the self-perception of those serving in the role of interpreter, in an effort to further the debate on the professionalization of community interpreting services with empirical data. This paper presents quantitative findings from over 600 service providers and a total of 32 interpreters on the issue of the interpreter's task(s) in hospital and social service settings.

The Interpreter's Role(s) and Task(s)

As pointed out by Gentile *et al.* (1996: 37), "the work of liaison interpreters covers such a variety of situations, and is often performed in such an *ad hoc* manner by untrained and sometimes unwilling practitioners, that it is difficult to specify behaviour requirements." In the absence of commonly accepted standards of practice, the interpreter's task definition may be situated anywhere along the spectrum between those who would limit the interpreter's role to that of a linguistic conduit or "language converter" and those who regard cultural

brokering or advocacy as an integral component of the interpreter's role. Putsch (1985: 3345) observed for the health care setting that "Interpreters may act as ombudsmen or counselors," and providers have voiced the demand that "The interpreter should not merely act as translator, but as a cultural bridge between therapist and client" (McIvor 1994: 268). Similarly, Barsky (1996: 61) concludes from his analysis of mediated communication in refugee hearings that "Interpreters ... have to be allowed to work as intercultural agents rather than translation devices."

Such demands and expectations on the part of observers and service providers are often close to the aspirations of interpreters themselves, who are aware from experience that "just translating" is little more than a simplistic fiction in an interaction marked by the interlocutors' unequal status and different educational, social and cultural backgrounds. Consequently, the notion of "cultural interpreter" as described by Cairncross (1989: 7) comprises the roles of "faithful mouthpiece" and cultural mediator as well as client "representative and advocate." A similarly broad view is embodied in the hospital interpreting initiative which was launched in Vienna in 1989 with the official designation of "native-language counseling" (*Muttersprachliche Beratung*) for Turkish patients. Describing the role of these "mediators between patients, nursing staff and doctors," Kloimüller and Wimmer (1995: 269) conclude: "The area of activity of the native-language counselors therefore goes far beyond linguistic translation as such. They are also and particularly 'translators of cultures'." [my translation]

Just what is meant by such labels as cultural mediator, broker or agent, though, to describe the way in which interpreters carry out their task, is not always clear. In fact, as early as the mid-70s, Anderson (1976) observed from a sociological point of view that

> the interpreter's role is always partially undefined—that is, the role prescriptions are objectively inadequate.... The interpreter's position is also characterized by role overload. Not only is it seldom entirely clear what he is to do, he is also frequently expected to do more than is objectively possible. (Anderson 1976: 216f.)

Deploring the the problem of "role overload" in the field of community interpreting, Roberts (1997: 20f.) calls for research on "the question of when the interpreter should step out of his specific role."

In an effort to contribute towards this goal, albeit on a more elementary level, service providers and interpreters in Austrian health care and social service institutions were asked, as part of a more comprehensive survey by questionnaire, whether they considered a set of selected aspects of interpreter behavior as belonging to the community interpreter's task or not. Rather than using abstract labels, like conduit, clarifier, culture broker, helpmate, agent or advocate, respondents were confronted with a range of selected tasks pertaining to and going beyond the interpreter's relaying and co-ordinating functions in mediated talk (Wadensjö 1992). The actual question items, which were gleaned from the literature on professional ethics (e.g. Schweda Nicholson 1994) and interpreters' standards of practice, are presented in detail in the following section.

Material and Method

Questionnaire

The issue of the interpreter's task in health care and social service settings was raised on the last page of a questionnaire on community interpreting needs and standards distributed among the staff of hospitals and family affairs centers in Vienna (Pöchhacker 1997b). The question: "Does the TASK of interpreters in communication with non-German-speaking clients ALSO include..." was followed by nine items to be answered with "yes" or "no." (Note that "client" is used here and throughout this paper to refer only to the minority-language speaker.) The normative ideal of the accurate and faithful rendition of a speaker's utterances (Harris 1990: 118) was not made an issue; rather, the question focused explicitly on tasks over and above the interpreter's basic relaying function. Two items referred to the task of improving the comprehensibility of the provider's utterances for the client by means of simplification and explanation, whereas another two dealt with editing the client's utterances to enhance the efficiency of the interaction. A fifth item was the interpreter's task (or not) of explaining cultural references and meanings for the provider, i.e. "assisting the social service personnel's understanding of the beliefs and practices of the client's culture" (Cairncross 1989: 7). The interpreter's role in "co-ordinating talk" (Wadensjö 1992) was represented by the issues of self-initiated clarification with the client and alerting the parties to any misunderstanding in their conversation. The list of items was completed by two

rather autonomous types of action: as an "agent" of the provider, interpreters might directly formulate questions and (routine) explanations at the provider's request, while they may also serve clients by helping them fill in forms and questionnaires.

The nine items mentioned above were presented in the questionnaire in scrambled order. Two dotted lines (labeled "Other:") with answer boxes were offered to respondents for any task demands they would wish to add; with a few exceptions, though, this space was left blank.

Apart from its inclusion as a question in the seven-page provider questionnaire, the list of potential interpreter tasks was also used in a questionnaire addressed to individuals serving as interpreters in the settings in question. Preceded by the sentence: "In your view, does your TASK as interpreter ALSO include...," the nine question items were presented in identical form. The list of task demands, in a close English translation, is given below:

- simplifying technical language for the clients;
- explaining technical terms for the clients;
- summarizing clumsy long utterances of the client;
- omitting utterances which are not to the point to avoid losing time;
- explaining foreign cultural references and meanings;
- clarifying indeterminate statements by immediate follow-up questions to the client;
- alerting parties to any misunderstanding in the conversation;
- asking questions and giving information at the request of the provider
- filling in forms with the clients.

Needless to say, these question items neither amount to a checklist for community interpreters' task specification nor do they give comprehensive coverage to role-related issues such as clarifying/explaining, helping and acting as an agency. Within the constraints of space in a comprehensive questionnaire, and given the limited time and attention one can reasonably expect from busy service providers for an issue to which they have hardly ever given particular thought, the question(s) needed to be concise, yet explicit, and both easy to relate to and relevant. The fact that all the items included in the question had to be meaningful to both providers and interpreters in the health care as well as in

the social service setting was another factor constraining the selection of task demands for this study.

Respondents

Of the 765 questionnaires distributed to doctors, nurses and therapists in the departments of internal medicine, surgery, gynecology/obstetrics, pediatrics, ENT and psychiatry of 12 Vienna hospitals, and the 151 distributed to social workers and childcare nurses/counselors in the seventeen District Offices for Youth and Family Affairs of the City of Vienna, 629 questionnaires were returned. This amounts to an overall response rate of 68.7% (66.4% in the hospitals and 80% in the family affairs offices).

The study population in the provider survey is comprised of 184 doctors (male/female ratio 2 : 1), 204 (mostly female) nurses, 120 (mostly female) therapists, 95 social workers (male/female ratio 1 : 5) and 26 childcare nurses/counselors. The average age of respondents is 35 to 40 years, with an average of 12 to 13 years of experience on the job.

The interpreter questionnaire was administered in individual interviews or group sessions to a total of 16 persons providing spoken language interpreting in the institutions covered by the provider survey. This group consisted of 6 "native-language counselors" (interpreters) for Turkish patients, 5 interpreters assigned full-time to family affairs offices and 5 bilingual hospital staff serving *ad hoc* as in-house interpreters. None of these interpreters, all but two of whom are female, had received any training in interpreting at the time of the study (early 1996).

In addition to this data from the "Vienna Community Interpreting Survey" (Pöchhacker 1997b) completed in September 1996, a group of 16 sign language interpreters (13 women, 3 men) from all over Austria with work experience in health care settings was asked to fill in the interpreter questionnaire during a seminar at the University of Graz in early 1997.

Results

Provider Views

The views of service providers regarding the scope and limits of the interpreter's task, expressed in percent approval of the nine selected task demands, are shown

in Figure 1. (For technical reasons, the question items are labeled only in abbreviated form in the diagram. They are given in full *in italics* in the text below.)

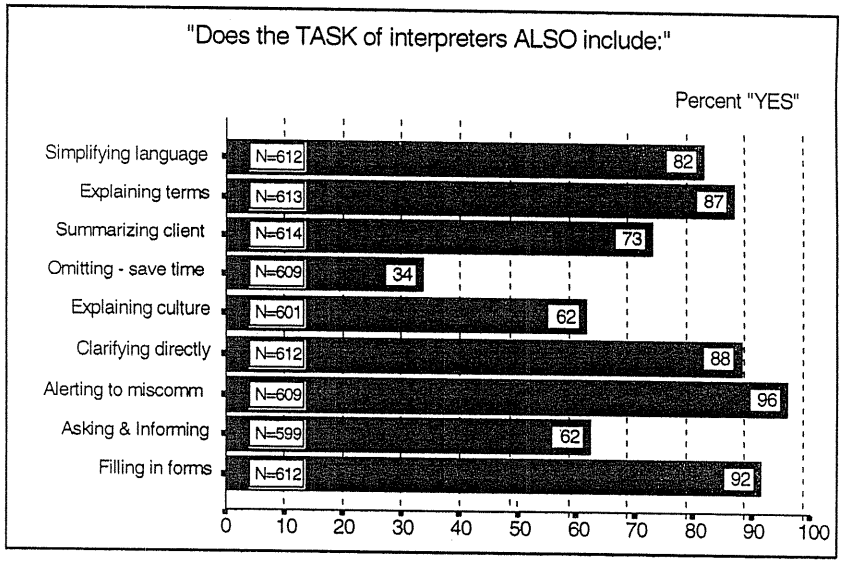

Figure 1: Provider views on the scope and limits of the interpreter's task

All but one of the "tasks" of interpreters in communication with non-German-speaking clients are approved by a clear majority of the service providers questioned. The highest level of acceptance (more than 90%) is found for two items which do not relate to the transfer or relaying function as such: the interaction-managing function of *Alerting parties to any misunderstanding in the conversation* (96%) and the helping function as manifested in the task of *Filling in forms with the clients* (92%). The discourse co-ordinating task of *Clarifying indeterminate statements by immediate follow-up questions to the client* is regarded as part of the interpreter's task by 88% of the respondents. Majority approval is clearly given also to editing tasks in conveying the provider's utterance to the client (*Simplifying technical language for the clients* - 82%, *Explaining technical terms for the clients* - 87%, *Summarizing clumsy long utterances of the client* - 73%). A lower level of approval (62%) is found for two

tasks which imply a higher degree of autonomy of the interpreter's output (*Explaining foreign cultural references and meanings* and *Asking questions and giving information at the request of the provider*). The suggestion that *Omitting utterances which are not to the point to avoid losing time* is part of the interpreter's task is rejected by two thirds of the respondents.

If the data is broken down by the four main types of service providers in the study (doctors, nurses, therapists and social workers), a rather clear pattern of differentiation emerges (see Figures 2a-b). Only the percentages for the two most highly approved tasks mentioned above show very little variation (no more than 3 to 5 %). (For the sake of clarity of presentation, these two items—"Alerting to miscommunication" and "Filling in forms"—are not shown in the diagrams.)

For all the four editing tasks shown in Figure 2a, the percentages of doctors and nurses exhibit the most pronounced differences, with the values for therapists falling consistently between the two. For three of the items, the results for the social workers closely mirror the low percentages of the doctors while exceeding those of the three other groups for the task of *Explaining technical terms for the clients*. The differences among the three types of providers in the hospital sample are highly significant: "Simplifying language" - c^2=14,85157 (DF=2), p =0,00060 (Pearson's); "Explaining terms" - c^2=22,63266 (DF=2), p = 0,00001; "Summarizing" - c^2=21,00680 (DF=2), p = 0,00003; "Omitting - save time" - c^2=13,13499 (DF=2), p = 0,00141.

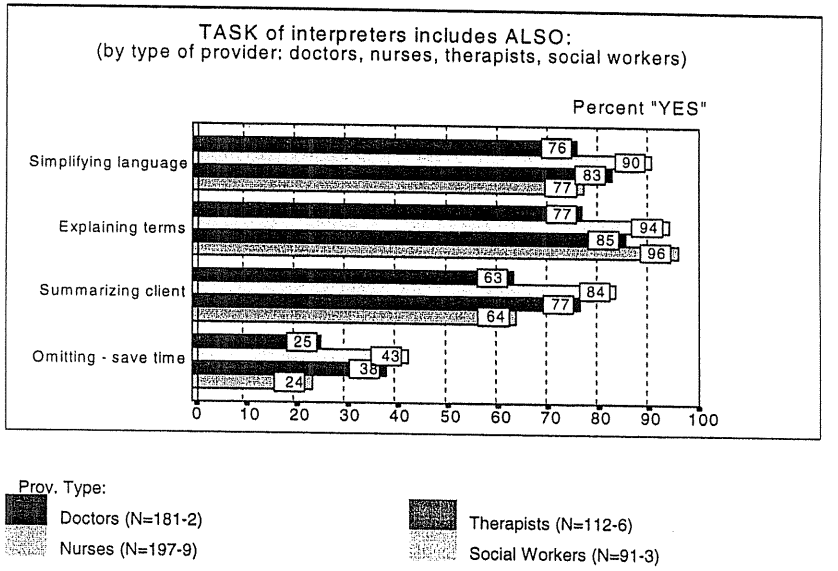

Figure 2a: Views by type of provider (editing tasks)

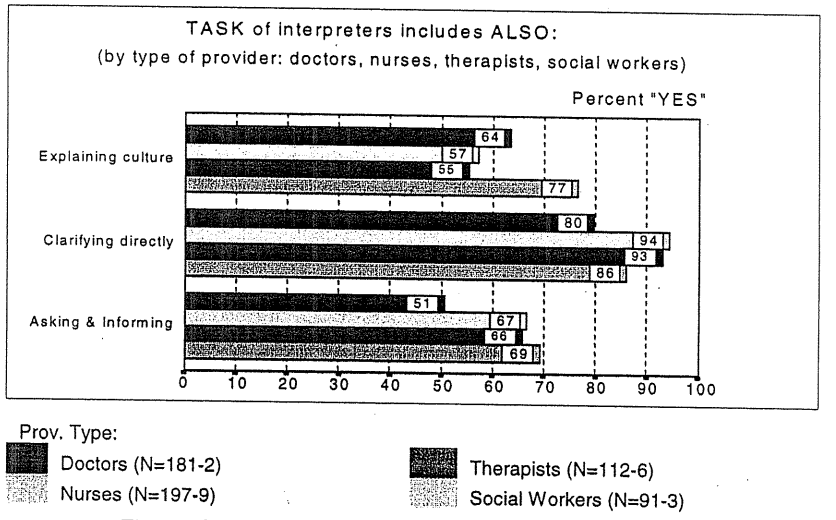

Figure 2b: Views by type of provider (tasks beyond relaying)

Among the tasks beyond the interpreter's relaying function (Figure 2b) a clear departure from the pattern noted for "editing tasks" above is found for *Explaining foreign cultural references and meanings*. Whereas the nurses and therapists are least inclined to regard this as part of the interpreter's task, social workers are clearly in favor (77%), far more so than physicians. Social workers also give the highest approval, albeit by a slim margin, to the interpreter *Asking questions and giving information at the request of the provider*, while the results for the co-ordinating task of *Clarifying indeterminate statements by immediate follow-up questions to the client* follow the pattern observed for the tasks shown in Figure 2a (c^2=22,82875, DF=2, p = 0,00001).

Interpreters' Views

Even though the two groups of 16 (spoken language and sign language) interpreters questioned on the issue of their role and task(s) are not too dissimilar with regard to possible variables such as the number of men in the group (2 vs. 3), average age (38 ± 9 vs. 32 ± 9) and level of education (only 1 vs. 4 without secondary school-leaving certificate), it seems appropriate to treat them side by side, given the different time and local/institutional context of their participation in the study, if not the basic difference in working language modality. Figure 3 shows the percentages of approval for the nine question items suggested as part of their task as interpreters.

Both spoken language and sign language interpreters see it as part of their task to adapt the provider's utterances to the communicative needs of the client by *Simplifying technical language* (75%) and *Explaining technical terms for the clients* (75% and 81%, resp.). Similarly close agreement (81%/80%) is found for the task of *Explaining foreign cultural references and meanings*. In contrast, the percentage figures are strikingly different for editing tasks to be performed on the utterances of the client. While 94% of the spoken language interpreters accept *Summarizing clumsy long utterances of the client* as part of their task, only 38% of the sign language interpreters share this view. By the same token, 44% of the spoken language interpreters approve of *Omitting utterances which are not to the point to avoid losing time*, as opposed to only 7% of the sign language interpreters. The two co-ordinating tasks—*Clarifying indeterminate statements by immediate follow-up questions to the client* and *Alerting parties to any misunderstanding in the conversation*—meet with high levels of approval in both groups, with spoken language interpreters showing higher percentages by 12% and 21%, respectively. The more autonomous task

of *Asking questions and giving information at the request of the provider* is considered part of the interpreter's role by 44% of spoken language interpreters (7 out of 16) and 56% of sign language interpreters (9 out of 16). *Filling in forms with the clients* is accepted as a responsibility of interpreters by slightly less than two-thirds of the spoken language interpreters whereas all but two of the sign language interpreters (88%) agree with this proposition. This level of approval, given by the latter group, is matched only by the equally clear acceptance of putting direct clarification questions to the clients. Overall, the interpreters' views on the limits of their task are most different with regard to *Omitting utterances which are not to the point to avoid losing time* and *Summarizing clumsy long utterances of the client*.

Given these discrepancies between the two groups of 16, it seems appropriate to further analyze the findings for spoken language interpreters for any differences between the three sub-groups, namely "native-language counselors" (i.e. hospital interpreters) for Turkish, hospital staff serving as *ad hoc* interpreters (for Serbian/Croatian, Turkish, Kurdish, Polish and Farsi), and interpreters (for Serbian/Croatian and Turkish) assigned full time to the District Offices for Youth and Family Affairs. The results of this breakdown of data from spoken language interpreters are shown in Figures 4a and 4b (which do not include the item of "Clarifying directly," for which there was unanimous approval).

With only five or six respondents making up the three sub-groups, the percentages shown in Figures 4a and 4b are necessarily approximate and must be interpreted with care. Nevertheless, one may clearly note an overall pattern of differentiation in which the family center interpreters adopt the most comprehensive ("all-inclusive") view of their task, giving unanimous approval to five out of the eight items shown in Figures 4a and 4b. Conversely, the hospital interpreters for Turkish ("native-language counselors") impose the greatest limits on the interpreter's task. *Ad hoc* hospital staff interpreters appear to fall in between and are particularly more inclined to accept autonomous tasks such as *Asking questions and giving information at the request of the provider* and *Filling in forms with the clients*.

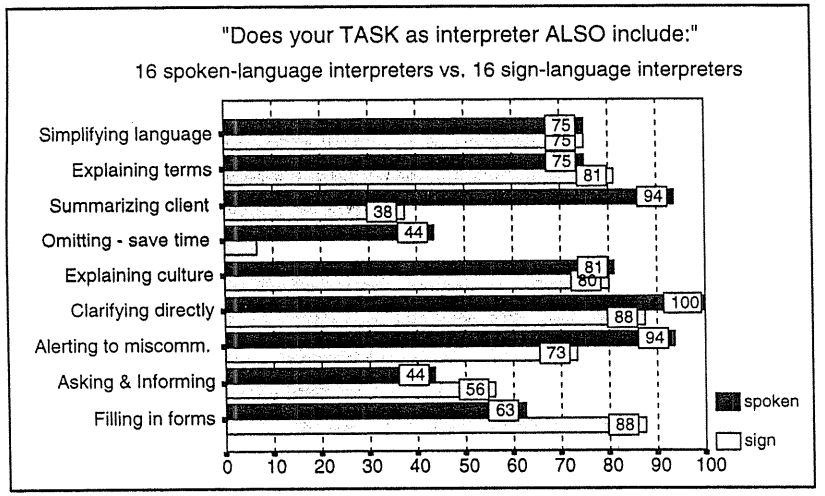

Figure 3: Interpreters' views on the scope and limits of their task

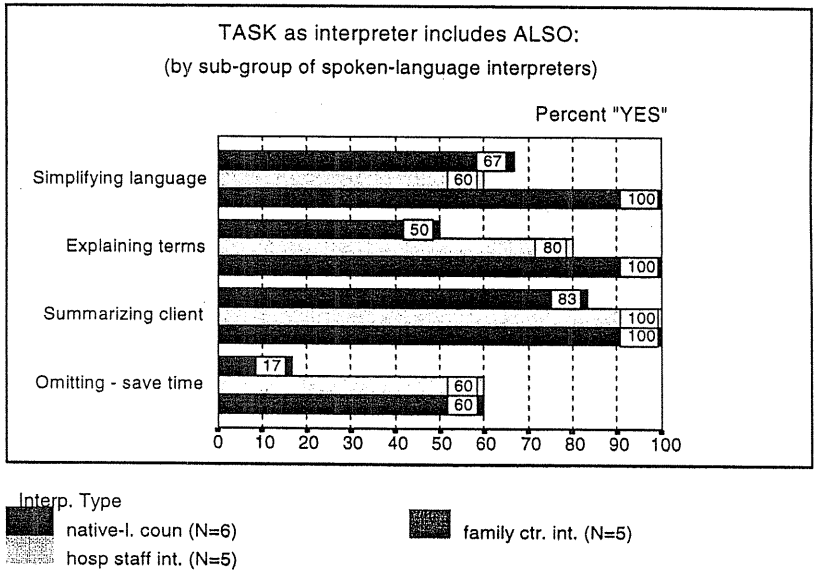

Figure 4a: Views of spoken language interpreters by sub-group (editing tasks)

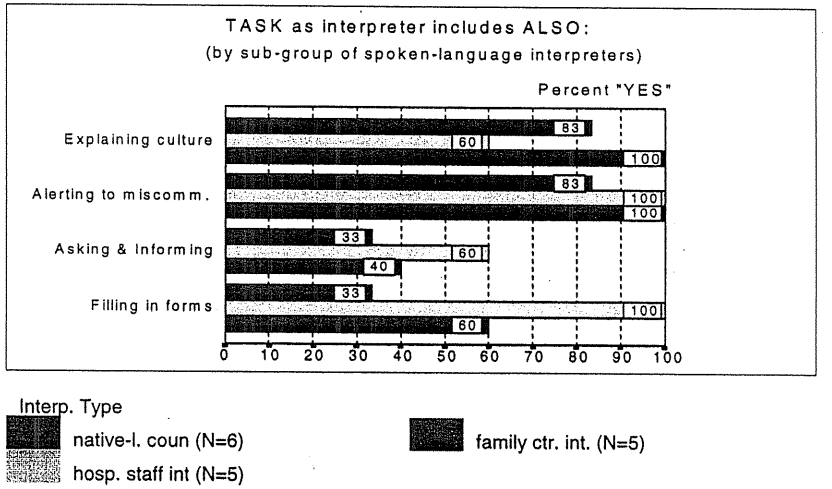

Figure 4b: Views of spoken language interpreters by sub-group (tasks beyond relaying)

Discussion

The statement by Roberts (1997: 20) that "the role of the community interpreter today is ill-defined or, more commonly, too vast" is an appropriate point of departure for an investigation of the interpreter's role and task in a particular socio-cultural and institutional context. In the health care and social service facilities of the Austrian capital, where patent needs for community interpreting services have been met by very limited institutionalization and professionalization of service delivery, the issue of what an interpreter is or should be expected to do requires as much clarification as the question of how the scope and limits of the interpreter's task are defined by those—untrained—mediators who have come to serve in that capacity. The quantitative findings of this study, while containing some tentative answers, essentially provide a first set of empirical data for a discussion which is by no means clear-cut.

User expectations

The views of more than 600 service providers in Austrian health care and social service settings clearly indicate that actual and potential users of community interpreting services expect interpreters to do much more than "just translate." With the exception of the standard of completeness, which most respondents would not want to see violated at the interpreter's discretion, health care professionals and social workers give the interpreters broad licence and thus expect them to perform editing tasks such as adapting their utterances to clients' communicative needs (by simplifying technical language and explaining technical terms) and abridging circumlocutory utterances by clients. The same holds true for discourse co-ordinating tasks like putting direct questions to the client to clarify indeterminate statements and alerting parties to any misunderstandings. Service providers would also like to rely on the interpreter to fill in forms with non-German-speaking clients and, albeit to a more limited extent, to explain foreign cultural references and meanings as well as to formulate (presumably routine) questions and information. There is thus considerable evidence that, in the context of hospital and family affairs services in Vienna, the interpreter's task is construed rather broadly so as to include

aspects of role designations such as "clarifier," "explainer," "cultural mediator," "helpmate" and "agent." Whether providers would give the interpreter license to act as a representative or "advocate" of the client's needs or rights cannot be concluded from the data and will probably depend on how interpreters actually handle the "task" of alerting parties to any (apparent or potential) misunderstandings.

To what extent the user expectations documented in the survey are "too high" and amount to "role overload" for the interpreter remains unclear in the absence of any normative pronouncements or standards of practice for the Austrian context. Nevertheless, one can attempt to give a relative answer by comparing provider expectations to the way interpreters themselves conceive of their role and task.

Self-Perception and Provider Views

It is obviously difficult to establish how interpreters in Vienna's community settings perceive the scope and limits of their task since only a very limited number of individuals are actually engaged in this capacity. The sample of 16 spoken language interpreters, including eleven people who work as interpreters more or less full-time, is indeed very small. Considering, though, that there were only 14 persons employed as interpreters in hospitals and family affairs offices at the time of the study, the group of respondents represents a considerable share (11 out of 14) of the total population. It is less obvious to what extent the group of 16 sign language interpreters from all over Austria with working experience in health care settings constitutes a representative sample. At any rate, the fact that the group includes many of Austria's most active and professionally committed interpreters for the deaf community (Grbic 1994) should be sufficient justification for attributing significance to their responses.

The findings for both the spoken language and the sign language interpreters indicate a rather broad conception of the community interpreter's task, not unlike the providers' profile of the interpreter's task. Respondents largely accept responsibility for facilitating comprehension on the part of the client (by simplifying technical language and explaining technical terms), for enhancing the provider's understanding of the foreign cultural background, and for ensuring an efficient flow of interaction by taking charge of clarification and

pointing out misunderstandings. The latter two aspects of discourse management rank high on the list of tasks of both interpreters and providers, though sign language interpreters have noticeably more reservations about alerting the interacting parties to miscommunication. Interestingly, providers expect interpreters to simplify and explicate their utterances for clients more decidedly than interpreters view this editing function as part of their task. Conversely, interpreters are much more willing to act as cultural mediators by *Explaining foreign cultural references and meanings* than most providers would expect them to. Provider views and interpreters' own role definitions are significantly congruent with regard to the lack of approval for *Omitting utterances which are not to the point to avoid losing time*, with sign language interpreters being much less inclined to summarize and omit information.

Given the heterogeneity within the group of spoken language interpreters as well as among the four main types of service providers in the study, the comparison of aggregate percentages needs to be related to results by setting and group (cf. Figures 2a-b and 4a-b). For the hospital setting, there is a clear pattern of convergence of the results for service providers (doctors, nurses, therapists) and staff members acting as *ad hoc* interpreters, while the "native-language counselors" adopt a more restricted view of their task as interpreters than care-giving and interpreting hospital staff.

Finally, in the social service setting, the comparison between the provider and interpreter perspectives once again highlights the family center interpreters' broad perception of their task. Not only do they give unanimous approval to six out of the nine task demands, including *Summarizing clumsy long utterances of the client*, but they also favor (by three against two) *Omitting utterances which are not to the point to avoid losing time*. On the other hand, they do not concur with social workers' clear expectations regarding the autonomous formulation of questions and information at their request and *Filling in forms with the clients*. (For both of these items, the interpreters' percentages fall short of social workers' expectation levels by 30 points.)

Conclusion

On the basis of data from a comprehensive survey on community interpreting needs and standards in Vienna, this paper has suggested some tentative answers

to the question of user expectations and interpreters' self-perception of the community interpreter's task in an environment with little institutionalization and even less, if any, professionalization of interpreter service delivery. With reference to selected potential task demands relating to role labels such as "clarifier," "explainer," "cultural mediator," "helpmate" or "agent," service providers were found to view interpreting within their institutional settings as a multi-faceted task beyond "mere translation," and interpreters themselves were shown, on the whole, to share a rather expansive view of their role. However, given the lack of sensitization to and reflection on issues of community interpreting in the institutions under study, and bearing in mind the methodological limitations of quantitative data elicited by questionnaire, the findings presented here are best seen as an exploratory attempt to provide descriptive empirical data in the interest of encouraging further discussion and promoting consensus-building and professionalization.

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Volume 31

Roda P. Roberts, Silvana E. Carr, Diana Abraham and Aideen Dufour (eds.)

The Critical Link 2: Interpreters in the Community.
Selected papers from the Second International Conference on Interpreting in legal, health and social service settings, Vancouver, BC, Canada, 19-23 May 1998.

THE CRITICAL LINK 2: INTERPRETERS IN THE COMMUNITY

SELECTED PAPERS FROM THE SECOND INTERNATIONAL CONFERENCE ON INTERPRETING IN LEGAL, HEALTH AND SOCIAL SERVICE SETTINGS, VANCOUVER, BC, CANADA, 19–23 MAY 1998

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AMSTERDAM/PHILADELPHIA

TM

The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences — Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Library of Congress Cataloging-in-Publication Data

International Conference on Interpreting in Legal, Health, and Social Service Settings (2nd : 1999 : Vancouver, B.C.)
The critical link 2 : interpreters in the community : selected papers from the Second International Conference on Interpreting in Legal, Health, and Social Service Settings, Vancouver, BX, Canada, 19-23 May 1998 / edited by Roda P. Roberts ... [et al].
p. cm. -- (Benjamins translation library, ISSN 0929-7316 ; v. 31)
Includes bibliographical references and index.
1. Translating and interpreting--Social aspects--Congress. 2. Translating services--Congresses. 3 Human services--Translating--Congress. I. Title: Critical link two. II. Roberts, Roda P. III. Title. IV. Series.
P306.2 .I55 1999
418.02--dc21 00-058578
ISBN 90 272 1636 3 (Eur.) / 1 55619 790 X (US) (alk. paper)

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John Benjamins Publishing Co. • P.O.Box 75577 • 1070 AN Amsterdam • The Netherlands
John Benjamins North America • P.O.Box 27519 • Philadelphia PA 19118-0519 • USA

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DIALOGUE INTERPRETING AND SHARED KNOWLEDGE

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1. The dialogue interpreter

The present paper will discuss the issue of attaining shared knowledge in and by interpreter-mediated interaction, with particular focus on the role of the dialogue interpreter in this process. The dialogue interpreter (Sw: *dialogtolk* or *kontakttolk*) acts within the Swedish social welfare system. Since the end of the sixties there have been dialogue interpreters working at institutions such as police stations, social welfare centers, hospitals and courts. They provide an interpreting service for laymen and officials speaking in different languages.[1]

The professional skill of an interpreter is in everyday practice often thought of as a warrant for the avoidance of misunderstanding. Accordingly, lack of shared understanding is often attributed to the interpreter's failure to carry out her professional task. Yet an interpreter does not necessarily acknowledge any blame in such cases. When is miscommunication the interpreter's fault, or, to what extent is the primary parties' achievement of shared understanding and knowledge the responsibility of the interpreter?

As is well known, translation as practice and theory is very much a chronicle about rights and wrongs, about correctness versus error. Consequently, literature on oral interpreting is often biased by this historical heritage of largely concentrating on translation accuracy. At the

Department of Communication Studies, University of Linköping, two research projects on dialogue interpreting[2], suggest a less rigid way of looking at this mode of communication. *Interpreting* is investigated *as interaction*.

Thus, a point of departure is that whatever is accomplished or fails in communication, should be seen as a *collective* activity; what comes out of talk derives from the efforts interlocutors make in social interaction. The questions related to knowledge are then not the classical ones within philosophy: "What is knowledge?" or "What is true knowledge?" but "How does knowledge get communicated?" and "How is something established as shared, or common knowledge?".

This paper will discuss three actors' attainment, and lack of attainment, of shared knowledge in common interaction. The method applied is discourse analysis of recordings and transcriptions of an interpreter-mediated encounter.

2. Communication and miscommunication - two sides of the same coin

There is always an aspect of unpredictability in human interaction. Conversation, perhaps even more than monological speech, could be perceived of as a chain of possibilities to get on a track, which could turn out to be either *wrong* or *right*. When people have a common wish to interact, they run the risk of getting into different directions of association, onto different discoursal paths; of misunderstanding each other. And, yet, possible and actual sources of miscommunication, if seen from another perspective, may stand out as factors *promoting* dialogical communication. Rather than breaking off a verbal exchange, interlocutors will compensate for felt or feared lack of shared understanding. Given that miscommunication or difficulties are detected and parties are prepared to take remedial measures, interaction will continue.

Co-actors in conversation have conventionalized means to check the existence of intersubjectivity between them. Instances where they make use of such routines, e.g. meta-comments, salient silences within topics, explicit negotiations of meaning, signs of uncertainty or irritation etc., reveal that they have experienced a lack of fit between understandings. In instances where interlocutors' remedial measures are manifested in discourse itself, a retrospect analyst can locate a *miscommunication event* (Linell 1992). The present analysis of authentic talk will start at an instance where a lack of fit between interlocutors' contributions to discourse is sensed, identified and/or dealt with by the actors themselves, in and by their contributions to talk.

Simmel (1964) argues that a two-party and a three-party constellation imply fundamentally different conditions for human interaction (see also Goffman 1982). A third party may be either included or excluded in a union established between two individuals. This individual is a potential ally and a potential antagonist. The one ascribed/taking on an allied's role in interaction will carry out a *mediating function* between the others.

In an *ordinary* (i.e. non-institutional) one-language conversation between three or more persons, in principle anyone can take on/be given a mediator's role, in other words, be the one who sees to it that a (potential) speaker is attended to; is included or excluded in commonly focused interaction. Moreover, in the process of conversation, this function may be carried out by different people.

As regards institutional conversation, the responsibility for including (and excluding) participants often lies with articular role incumbent. An obvious example is the therapist in the family therapy session. And, in a two-language institutional talk, there is a mediating function inherent in the dialogue interpreter's (activity) role (cf. Wadensjö 1992). She has, by definition, a certain pregiven responsibility for the primary parties' attaining of shared knowledge. She is, self-evidently, a factor promoting the primary parties' communication, or even substantiating it. Perhaps less self-evidently, this holds true whether or not shared knowledge is mutually held as a communicative goal by all persons involved.

To shed light on the complexity of components in the genesis and the development of miscommunication events one may seek to distinguish the origins of them. Possible and/or potential factors could be divided into *local* and *global* ones. Discourse contributions can be, on the one hand, locally conditioned by what is contributed in the immediately preceding turns (Sacks, Schegloff & Jefferson 1974). Moreover, as suggested by Bergmann (1990), the local management of talk is also conditioned by 'matters outside of the verbal flow itself - objects at hand and situated events - which can be perceived by the actors and which in themselves constitute a separate local context for next action' (*ibid.*: 206).

What people say in interaction is, on the other hand, conditioned by what, in contrast, could be termed global factors, i.e. cultural and social background knowledge, deeply embedded in language use, tied to interlocutors' expectations about places, time, activities and co-actors' activity roles, gender etc.

3. At the immigration division

The analysis which follows will be based on some extracts of talk recorded in a regular, interpreter-mediated interview at the immigration division of a local Swedish police station. The talk was subsequently transcribed at a considerable level of detail.[3] The languages spoken were Swedish and Russian (here transliterated). A rough English translation of the original utterances is presented in italics.

The actors were: Pia, a young female police-interrogator, Alex, a young man applying for prolongation of his residence permit in Sweden, and Iza, the dialogue interpreter. Where we come in, Iza is reading the report which Pia has been typing while interviewing. More precisely, she is translating into Russian what is written in Swedish. Alex is thus confronted with a text which he is expected to either confirm or disconfirm as correct. At a certain point the applicant interrupts:

Extract (1) (G 26:12[4])

Alex:123[5].	a eto- izvinjajus'. eto tjto, v mnozjestvennom? tjisle tam napisanno. ((light laughter)) *but this - excuse me. what is this. in the plural? written there. ((light laughter))*
Iza:124.	tjto zdes' napisanno. **de** har inte rest runt i regionen i sommar. e::: **oni** ne razre- ne razezjalis- po- e::: v oblasti letom. *what is written here. **they** did not travel around in the area this summer. e::: **they** did not tra- travel around **in**- e::: in the surroundings during summer.*
Alex:125.	ja ponimaju no ona zadala voprosy **mne** ili **nam**? ja... *I understand but she put the questions to **me** or **us**?I...*
Iza:126.	e::: har du ställt frågan beträffande **mig** eller beträffande **oss**? *e::: did you put the question concerning **me** or concerning **us**?*

When Alex comes up with 'but this- excuse me. what is this, in plural? written there.' (1:123), he focuses on a possible mistake in the report. One may note that he moderates this potentially daring suggestion by excusing himself, and by means of the light laughter. Iza replicates, first in Russian: 'what is written here' (1:124). Subsequently, she animates the already translated sentence. She reads aloud first in Swedish, then repeats in Russian what was written on the issue on which the applicant had fastened. Emphasizing the personal pronouns *de* ('they') and *oni* ('they') (1:124) the interpreter confirms Alex's inquiry about whether it is correct to understand the text as referring to a plural. At this point, a lack of shared understanding is sensed and topicalized.

Alex replies a bit irritated: 'I understand but she put the questions to me or us? I... ' (1:125). Iza relays by substituting the original 'she' with 'you', thus addressing Pia in the name of Alex: 'e::: did you put the question concerning *me* or concerning *us*?' (1:126). By then, it seems, the primary parties both know that miscommunication is at hand. After a short silence Pia replies:

Extract (2) (G 26:12)

Pia:127.	e::: (1) ja i allmänhet tror jag att jag fråg- när jag fråga **ni** så menar jag... alltså både **du** och din fru.

e::: (1) yes in general I think that I as- when I ask(ed) you [pl.-form] so I mean... that is both you and your wife.

Iza:128. no esli ja sprasjivaju vas to ja normal'no e::: imeju v vidu vas oboich. znatjit vas vmeste. vas i- s zjenoj.
but if I ask you [pl.-form] then I normally e::: have in mind you both. that is you together. you and- and (your) wife.

Alex:129. da ja eto ponimaju no togda ja tozje znaju tjto ona sejtjas tozje projdet e::: ((telephone signal)) interview ((telephone signal)) tak tjto ((Pia lifts the receiver, turns away from Alex and Iza)) ja dumal eto kasaetsja mne, vse.
yes I understand this but then I also know that she also goes through now e:::: ((telephone signal)) the interview. ((telephone signal)) so that's ((Pia lifts the receiver, turns away from Alex and Iza)) I thought this concerns me, all.

The routine of checking the report implies an additional possibility of tracing miscommunication otherwise possibly hard to distinguish in discourse. This holds true for the actual readers of it, as well as for the distanced analyst of miscommunication events. Yet it might be worth noting a difference between the first and the latter - the actors taking part in the encounter are not necessarily interested in tracing possible sources of miscommunication, even if instances of such are sensed and dealt with. Actually, had it not been for the report, the particular miscommunication event focused here would scarcely have been attended to in interaction.

In search of the source of the miscommunication, the analysis will now go backwards in the encounter, to where information on which the piece of the report protested against was gathered. At a particular point during the interview, the officer brought up a new topic:

Extract (3) (G 26:7)

Pia:1. har ni gjort nånting? speciellt i sommar?
have you done something? special this summer?

(1s)

Pia: rest eller?
travelled or?

->Iza: 2. vy ne zanimalis' tjem-to::: (.) interesnym? letom.
you did'nt do something:::: (.) interesting? this summer.

Alex: 3. net. nitjem.
no. nothing.

Iza: 4. nej. ingenting.

no nothing.

Pia: 5. ni har- ni har int rest runt här i området?
you did- did you not travel around here in the region?

Iza: 6. putesjestvovali vokrug... (.) po rajonu?
travelled around... (.) in the region?

->Alex: 7. net. ja byl tol'ko vgorode.
no. I was/have been only in town.

->Iza: 8. nej. jag har varit bara i sta'n.
no. I have been only in town.

When Pia brings up the issue of travelling during the summer she uses *ni* ('you' in pl.) (3:1) as a pronoun of address. This is indeed relayed as *vy* ('you' in pl.) (3:2). Alex answers: 'no, nothing' (3:3) and 'no. I was only in town' (3:7). Alex' use of a non-emphasized 'I' suggests that he understands the referential meaning of *vy* (in 3:2), in the preceding question, to be himself as an individual.

However, the non-emphasized *jag* ('I'), (in 3:8) provided by Iza, apparently opens up, at least it does not prevent, an understanding of Alex as the spokesman of a couple. As one could see from the text in the report, this is how it was heard by Pia, or, if you wish, misheard. She might alternatively have assumed Iza to be mistakingly picking the wrong pronoun. In any case, for the officer, the *ni* ('you' in pl.), self-evidently refers to the couple. This is shown in her utterance, following immediately after Iza's rendition (in 3:8). Pia first types for 28 seconds and then brings up a new topic:

Extract (4) (G26:7)

Pia: 9.m. (2s) ((types for 28 s)) (2s) har **du** några släktingar eller vänner som bor i sta'n som du kände **innan** du flyttade hit?
*m. (2s) ((types for 28 s.)) (2s) do you have any relatives or friends who live in the town whom you knew **before** you moved here?*

Iza: 10. u vas imejutsja ili rodnye ili druz'ja s kotorymi vy byli znakomy **do** togo, kogda vy pereselilis' sjuda?
*do you have either relatives or friends with whom you were acquainted **before**, when you moved here?*

In retrospect, Pia's emphasis on *du* (sg. form of 'you') (4:9) stands out as a marker of contrast to the referential meaning she takes as established for

ni, (pl. form of 'you') in the preceding question. In other words, bringing up the next issue she puts a stress on this *du* ('you'), thus here focusing on Alex as an individual, in contrast to Alex as one in a couple, referred to earlier.

One may note that Pia's emphazis on 'you' when asking ' do *you* have any relatives') (4:9) confronts Iza, at least theoretically, with the problem of how to relay the thereby given differentiation of references between *du* and *ni* (the Swedish *tu-* form and *vous*-form). It is evident that for the dialogue interpreter to mark such a differentiation at this point would demand other means of expression than what was used in the original (emphatic pronunciation). For Iza to use an emphasized *ty* (*tu*-form of 'you') would at this stage hardly have given the effect of differentiation between the two actualized, possible understandings of *ni* and *vy* (*vous*-form of 'you').

The discrepant referential meanings are further consolidated when the interrogator shortly afterwards takes up yet another new issue. The fact that Pia and Alex for a long period of time talked on different discoursal paths was revealed to them only in the checking phase of their encounter. In the process of their exchange, the interlocutors, to a certain extent, managed to compensate for miscommunication. They continued the conversation. Yet the shared knowledge achieved by the primary participants did not include knowledge about the discrepant discoursal paths developed and sustained during a long part of their interaction.

4. On the local level of discourse

Summarizing the analysis above as far as the local, turn-by-turn level of discourse is concerned, and relating sources of miscommunication to the mediating aspect of the dialogue interpreter's role, gives an opportunity also to point at their potential opposite functions. In this particular case, what led listeners and speakers on to different tracks, could from another perspective be seen as sources *promoting* their communication. The interpreter's contributions to discourse indeed conditioned the continuation of communication.

First, one may point at a potential source of miscommunication in the dialogue interpreter's very mode of working on-line. To a considerable extent, the dialogue interpreter must conceive of *fragments of interaction as de-contextualized wholes*. When she listens to another's talk for the purpose of memorizing it, and being able to relay it as closely as possible, her understanding has a turn-by-turn basis. She has limited possibilities to bring in extra context for a subsequent rendition. Thus, utterances, the interactional and referential meanings of which are on their way to being established, may be taken as a ground for premature decisions.

Secondly, in this particular case, the institutional goal of putting together a report brings about another characteristic feature of interaction which, occasionally, determines the local organization of talk. The very activity of writing is bound to distract the writer's concentration from the joint discourse. The effect of this is possibly accentuated in two-language exchanges, because of the relative delay between questions, answers and, not least important, feed-back items. The interrogating officer in the above example was actively taking notes for the report while the applicant was talking. In other words, the two of them did not always attend to each other (This is what regularly in conversation gives guidance about whether or not people are on the same track).

Thirdly, in police-interrogations, as well as in interviews, the interviewer might use a specific vagueness as a technique of putting questions. This serves to elicit spontaneous answers from the interrogated person. Their spontaneous delivery would then count as someting of a warrant for their truthfulness. This method, it seems, is somewhat counteracted in and by interpreter-mediated talk. There seems to be an inherent resistence against vagueness, since the dialogue interpreter has a tendency to, in and by renditions, specify vague originals. The particular *Grad der Differentierung* ('degree of differentiation') (Hönig & Kußmaul, 1982, 58ff), accomplished by her contributions is, more or less deliberately, adjusted to prevent, suppress or counteract primary parties' miscommunication, and simultaneously, to promote continued interaction.

5. On the global level of discourse

The miscommunication event discussed above actualized, on the global level of discourse, *cultural differences in addressing conventions* between Russian and Swedish. While the *tu*-form in Russian is used only between friends, it is in Swedish the conventionalized, spread form. The Russian *tu*-form could on the contrary, if used between non-acquainted adults, be a marker of disrespect. As opposed to this, the Swedish *vous*-form could in some cases mark exaggerated respect and be taken as irony. Iza was very alive to the applicant's (possible) expectations. She consistently used the *vous*-form and, when the confusion related to pronouns of address was revealed at the end of the encounter, she explicitly commented on the general need of doing this in Russian, to avoid being impolite.

Moreover, one could point at the inherent *differences between lay and institutional goals* in an interrogation. The officer was to write a report, a kind of document which is designed to play a role in another situation, for another audience, who are to evaluate it from their point of view. The layman tried to do his best as an applicant. Through the checking routine he got tied to the jointly compiled document in a specific way. One should particularly note that this checking was not carried out for the sake of establishing or securing interlocutors' mutual confidence, but to make sure that what the document said was held as correct by the applicant, that he subscribed to being responsible for its content.

It is an open question if, and if so to what extent, shared knowledge is at all a mutually held goal in this kind of institutional talk. However, whether it is or not, the dialogue interpreter has a certain pre-given responsibility for the primary participants' achievement of shared knowledge. In interpreted conversations, an interlocutor's explicit focus on mutual misunderstanding does not necessarily turn the very lack of shared understanding into shared knowledge. And, if interlocutors do not share understanding of what has been understood and misunderstood respectively, they will have obvious difficulties in collaborating on compensating for misunderstandings, regardless of a general willingness to do so.

Understanding the nature of (mis-)understanding presupposes a distanced view. As Linell (1992) points out, the dialogical nature of mis-communication events, revealed through close reading of transcripts and repeated listening to tapes may never be immediately visible to the interlocutors-in-action. In the interpreted conversation, the dialogue interpreter, regardless of a high level of professional competence and skill, does not share the predicament of a distanced analyst. She is a participant in the interaction, and her possibilities of analysing how people collaborate in (mis-)understanding, let alone how she herself plays a part in this, are limited.

Notes

1 In a functional sense the dialogue interpreter could be compared to what is in English called "community interpreter" (e.g. Shackman, 1984). Yet, in contrast to some of her collegues in other countries, the Swedish dialogue interpreter enjoys a professional status, with trade unions and state authorization. In contrast to what is sometimes termed "liaison interpreter" (e.g. Hatim & Mason, 1990) she is expected to always translate in two directions, from Swedish into a foreign language and vice versa, consecutively, answering to the primary, one-language participants' contributions.

2 In Swedish *Kontakt genom tolk* ("In touch through interpreters"), sponsored by The Bank of Sweden Tercentenary Foundation (89/44) and *Rätten och invandrarna* ("Immigrants and justice"), supported by grants from The Swedish Research Council of Humanities and Social Sciences (F 402:87) and The Ministry of Work (DEIFO 34/89).

3 *Key to transcription*:
In the transcription conventions applied here speech is generally normalized to conventional orthography. Note, however, that punctuation symbols are used to mark intonation terminals, rather than grammatical boundaries as in conventional writing.
Underlinings in the extracts indicate simultaneous talk.
, = continuing intonation. (prosody, possibly also a short pause, indicating that the speaker does not want to drop the turn).
. = terminating intonation. (a pause, indicating that the speaker is prepared to

relinquish the turn, or, at least, that an informationally completed unit of talk has been issued).
? = rising intonation.
- = sudden cut-off of the current sound.
... = open-ended intonation, utterance fading out without an unambiguous intonational terminal.
: = the sound just before has been noticeably lengthened.
(.) = a short silence (micro-pause).
(1s) = one second silence.
((looks up)) = gives a description of a person's nonverbal activity.
boldface = emphasis, which may be signaled by increases in pitch and/or amplitude.
* *(framing part of an utterance)= the framed part is pronounced in *sotto voce*
(xxx) = transcriber heard talk but the words could not be identified.
(something) = transcriber thought she heard a certain word (here: "something") being uttered, but is not completely sure.
italics = the author's translation of utterances into English.
[ ] (framing part of an utterance) = marks words added in the English translation.
-> = a righthand arrow marks an utterance to which the author refers in the text.

4 Indicates page in original transcription.

5 Figures indicate the internal relation of utterances in this particular example.

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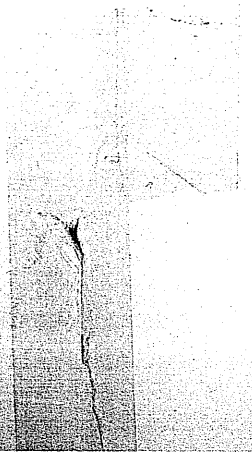

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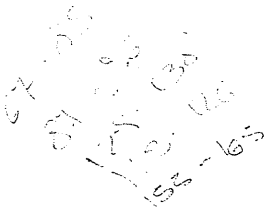

TRANSLATION AND KNOWLEDGE

SSOTT IV

SCANDINAVIAN SYMPOSIUM ON TRANSLATION THEORY

TURKU, 4. - 6. 6. 1992

ISBN 951 - 880 - 951 - 8

Grafia Oy, Turku
Kansikuva: Maria Käld, Turku

UNIVERSITÀ DEGLI STUDI DI TRIESTE
SCUOLA SUPERIORE DI LINGUE MODERNE
BIBLIOTECA

FOREWORD

Turku University was the host of the Fourth Scandinavian Symposium on Translation Theory (SSOTT IV) on 2-4 June, 1992. Despite its being called a *Scandinavian* conference, the meeting also attracted a large number of representatives from outside the Nordic area. The participants numbered about one hundred and represented altogether sixteen countries. The organizers recall with pleasure the active, friendly and tolerant contribution of every one of our guests.

The proceedings at hand include the texts of the three plenary lectures as well as twenty-six papers read in the six parallel sessions. The texts are presented largely as supplied by the authors, with only minor corrections and alterations, particularly in the bibliographies.

The topic of the meeting, 'Translation and Knowledge', allowed a multiplicity of approaches. Consequently the papers reflect a variety of traditions and individual research programmes. We hope the thematic groups we have established partition this variety in a sufficiently meaningful way.

We would like to express our thanks to the student members of the organizing committee: Tuula Huttunen, Annikka Larkiomaa, Kristiina Oksman, Heli Reinikainen and Heli Törmänen. We are also particularly grateful to Erkki Satopää for his help in desktop publishing. The Symposium received financial support from the Ministry of Education, the Academy of Finland, the Turku University Foundation, and the University of Turku.

The publisher of this volume is the newly established Centre for Translation and Interpreting at the University of Turku. The Centre coordinates training and research in the field of international communication.

Turku, 31 March 1993

Yves Gambier

Jorma Tommola

The International Journal for Translation & Interpreting Research
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Ethical implications in situations where the language of interpretation shifts: The AUSIT Code of Ethics.

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Abstract. In bilingual or diglossic situations, shifting or switching between languages can be a common phenomenon amongst groups or individuals. In interpreting situations, a shift in the constellation of languages, i.e. from language *a* and language *x* to language *a* and language *y,* is perhaps not so common. It can only occur in interactions between multilingual clients and multilingual interpreters, typically when clients wish to shift to their dominant language and interpreters also have proficiency in this language. Twenty Australian-based interpreters, out of a sample of sixty, reported engaging in shifting in the course of interpreting. Responses to hypothetical shifts in the language of interpretation are discussed, in which interpreter informants provide acceptability judgements of courses of action and justifications for accepting – or refusing to accept – a shift in the language of interpretation. Ethical considerations relevant to interpreters in these situations are discussed and the AUSIT Code of Ethics is examined to see which guidelines relate to this phenomenon.

Keywords: ethics, AUSIT Code of Ethics, shifting, multilingualism, code-switching, proficiency, dominance

1. Introduction

Moving between languages is axiomatic to interpreting. Moving between languages is also commonplace for bi- or multilingual individuals and groups. In Interpreting Studies the prototypical model of the interpreting situation is that of two parties speaking monolingual varieties of two different languages, with the interpreter functioning as a linguistic intermediary. This seems to disregard the profile of many interpreters who have proficiency and accreditation in more than two languages. Multilingualism (i.e. the use of three or more languages) may find its way into interpreting situations that are usually perceived as being bilingual. This paper examines a situational intersection of multilingualism, interpreting and ethics. A negotiated shift in the language of interpretation and perceived ethical implications for interpreters as reported by them is examined and then related to the AUSIT Code of Ethics (hereafter: AUSIT CoE).

Within the literature on shifting languages or code-switching, attention typically focuses on features that are thought to account for why a change in language occurs, such as change of interlocutor, topic, mode of communication or discourse-conversational features such as asides, emphasis or reiteration. The type of code-switching or language shifting that is the focus of this paper is motivated by different reasons. It usually derives from a self-perceived level of proficiency and to a lesser extent the perceived level of proficiency of the interpreter, based on whatever information is available to a client about that interpreter. Language shifting also assumes that clients normally wish to speak the language variety in which they have greater proficiency, in the interpreting situations that they find themselves in.

Most bi- and multilinguals have a sense of which language/s they are more highly proficient or 'dominant' in. Notwithstanding the persistent myth that bi- or multilinguals can or should be multiple monolinguals in the same person (cf. Grosjean, 2008) or the idealised notion of 'equilingualism' as an

attainable goal, bi- and multilinguals are usually able to specify which language/s they are dominant in, taking into account the situation, topic or interlocutor. This is related to the contexts in which each language was acquired or is regularly used. A detailed discussion of linguistic dominance goes beyond the focus of this paper (see Genesee et al. 1995; McNamara, 1997). This paper relates 'dominance' to the linguistic performance of an individual based on his/her own declaration or on the evaluation of a language specialist. This latter point is of course problematic but axiomatic to *all* interpreting situations. As language specialists who are required to recognise and comprehend varying dialects, registers, genres and pragmatic patterns, interpreters make automatic and involuntary judgements about other interlocutors' proficiency levels as well as suppositions about which languages they are likely to know.

The second feature which may determine the likelihood of shifting is a client's (and to a lesser extent an interpreter's) re-negotiation of personal, ethnic, educational and socio-economic attributes, which may be initiated by the client as a direct request, or which may be signalled through "inferences" (Mason, 2006, p.363). The term "take-up" is also used for interpreters in the "sense [that]… they make of others' talk and how they respond to it" (Mason, 2006, p.365). While these processes usually relate to discourse-internal and content features of text, the inferences can also relate to other attributes, such as ethnic allegiance, educational level or previous place of residence, all of them possible predictors of the preferred language variety.

A client's re-negotiation or re-positioning of key attributes indexed through linguistic forms is largely based on 'linguistic monitoring'. Some studies of interpreting interactions in which the proficiency level of either client or interpreter is examined (e.g. Müller, 1989; Pym, 1999; Davidson, 2002; Baker, 2006) point to an overt level of 'linguistic monitoring'. 'Monitoring' here refers to activation of receptive, i.e. listening, skills which focus not only on the referential content of a text but on the linguistic forms that a speaker employs to convey such text. Within such text there may be overt, metalinguistic features that indicate the speaker's consciousness of forms chosen, such as side-comments, retrieval difficulties, hedges, filled pauses and so on. While linguistic monitoring and assessments of proficiency level are key notions in the fields of second language acquisition and language testing, they rarely figure in studies of mediated interactions or interpreting. The present paper seeks to address the specific issue of desired or negotiated one-way shifts in the language of interpretation.

My interest in clients who change their selected choice of language is based on my own interpreting experience and my observation of other interpreters.

This paper has eight main sections. Section 2 briefly describes some examples of shifting that I have been a part of or that I have witnessed amongst interpreter colleagues. Section 3 outlines ethical considerations relevant to a discussion on shifting in general. In section 4, I present the method and details of data collection which was gained through a sample of sixty interpreters. Further, I present examples and circumstances of shifting reported amongst a sample of sixty interpreters. This is followed in section 6 by responses from the same sample of interpreters to hypothetical scenarios presented to them. Lastly, interpreter informants' responses are collated and I re-visit the AUSIT CoE and examine relevant sections and contextualise and apply them to the phenomenon of shifting.

2. Examples involving shifts in the language of interpretation

I am an Australian-based interpreter with accreditation as a Croatian-English and German-English interpreter. I have experience as a freelance interpreter and translator in Croatia, Austria and Germany. I have also worked as an ESL instructor in Australia and have been both teacher and interpreter for large numbers of Croatian-speaking students who have settled in Melbourne. Most of these students had left their country of birth in 1991 and 1992 and had spent five to ten years in Germany or Austria, and had acquired proficiency in German.

Chronologically, the first language of these students was Croatian. In terms of proficiency, many of them reported that German had become their dominant language. Interactions, both in the classroom and interpreted ones, would often begin in Croatian but students often shifted to German, in which they "felt more at home". I also usually shifted to German after they had done so. This type of shifting by students from language *x* to language *y* is motivated by their self-reported dominance in language *y* and by knowing that the interpreter was also proficient in that language.

In other educational situations where interpreting services were provided for recently-arrived migrants, I have witnessed shifting from Ukrainian, via a compromise variety, Surzhyk, to Russian. In another situation I witnessed some Assyrian-speaking clients abandon en masse their Assyrian-English interpreter to hear the interpretation of an Arabic-English interpreter colleague. In the second instance, the client's dominant language was Russian. In the third instance, due to language shift already occurring amongst Assyrians in Iraq, Arabic was becoming the dominant language amongst younger, tertiary-educated and urban Iraqi Assyrians.

In all three of these examples, the shift was initiated by the clients, for their own benefit, through a direct request, a re-selection of interpreter and language where two or more were available, or a compromise variety. The desired shifts appear as the preferred choice of the client.

There need not be a synonymous or axiomatic relationship between a person's (chronologically) first language, ethnicity, citizenship, place of residence and their dominant language. Table 1 presents profiles of three other clients known to the author in which a bi-cultural background or previous migration have led to a preference for a specific language for interpreting purposes.

Table 1. Demographic and linguistic profiles of some bi- and multilingual clients

Ethnicity	Chinese	Ashkali	Lebanese/Arab
Citizenship	Indonesian	Serbian	Lebanese
Place/s of residence	Indonesia	Kosovo, Germany	Lebanon
First language/s	Hakka, Indonesian	Albanian, Serbian	Arabic, French
Dominant language/s	Indonesian	German	Arabic/French
Preferred language for interpreting	Indonesian	German	French

Allocation of interpreting services is frequently initiated not by clients but by government services, healthcare providers and educational institutions that determine the choice of language based on information about a client's citizenship, country of origin or ethnicity (cf. Chesher et al., 2003, p. 282),

and not necessarily on the client's preferred language. Further, some clients select a non-dominant language, often due to their own notions of identity which may not encompass linguistic dominance. Sometimes, due to a sense of duty or loyalty as nationals of a particular country, they select that country's national language. Some clients may specify a non-dominant language, as they do not believe that interpreting services are available in their dominant language. Due to legal and privacy restrictions it is hard to systematically gather data on people's linguistic biographies, documentation of their 'declared' first language (and other languages) and the actual T&I services provided to them or sought by them. As an interpreter and as an ESL teacher working in programs that provide interpreting services for newly-arrived adult students, I have witnessed dozens of instances of 'mismatched' interpreting services such as those described above.

3. Ethical considerations

Guidelines that set out desirable standards of conduct have been part of the formalisation and professionalisation of the interpreting profession. Mikkelson (2000/2001, p.49) even notes that a formal code of conduct distinguishes a profession from an occupation. Of course, ethical, i.e. moral assumptions or principles about human behaviour are axiomatic to interpreting situations as they are to all forms of human interaction. In the last ten years, focus on ethical considerations and the categorisation of types of behaviour as desirable, neutral or undesirable for interpreters has reflected a formalisation of ethics within Interpreting Studies research and training. Legal, medical and sign language interpreting were amongst the first to formally address moral dilemmas and ethical considerations (e.g. Morris, 1995; Kaufert and Putsch, 1997; Mikkelson, 2000/2001; Chun et al., 2002; Leneham and Napier, 2003). Now, all branches including not only community and conference interpreting but also talk show (Katan and Straniero-Sergio, 2001) emergency relief (Bulut and Kurultay, 2001) and military interpreting (Monacelli and Punzo, 2001) now engage in discussions on codes of conduct. Some (e.g. Rudvin, 2007, pp.48, 55) are cautious about the need and validity to mandate particular types of behaviour and whether such behaviours can be universal or inevitably remain culturally-specific. Many of these discussions follow general debates in the social sciences about characteristics of universalist versus particularist cultural settings and the norms of interpreter behaviour that hold in either group (Tompenaars and Hampden-Turner, 2002; Rudvin, 2007). Nonetheless, codes of conduct are now a characteristic attribute of professional associations that seek to provide sets of principles informing their members' behaviour. Questions on ethics and professional conduct are also a compulsory part of testing for accreditation in Australia.

In Australia the AUSIT CoE, redeveloped and revised in 1999, is the guiding code for practitioners in Australia, superseding the nine codes (e.g. Queensland Association of Translators and Interpreters: Code of Ethics; The Western Australian Institute of Translators and Interpreters: Code of Ethics) that had existed in different states in Australia or for particular state departments (NAATI, 1989). A comprehensive description and analysis of the AUSIT CoE is provided by Hale (2007, pp.101-136) with discussion of comparable codes from other countries. Contemporary research in Interpreting Studies in Australia now frequently includes reference to the AUSIT CoE (e.g. Glass and Dixon, 2007); one recent study tests awareness of the code, not only amongst practitioners but also their clients and third parties (Dragoje and Ellam, 2007). The AUSIT CoE contains eight main

sections: professional conduct, confidentiality, competence, impartiality, accuracy, employment, professional development and professional solidarity. The AUSIT CoE is re-visited in section 8 where relevant parts of the code are examined in relation to shifting.

4. Methodology and informants

Informants who are accredited, recognised and/or practising interpreters were sought to examine the frequency of shifting. Potential informants were contacted through the Australian Institute of Interpreters and Translators (AUSIT), a professional association of interpreters and translators, and through a training session conducted by the National Accreditation Authority for Translators and Interpreters (NAATI) in Melbourne.[1] The total number of potential informants invited to participate through AUSIT's electronic newsflashes was approximately 1000. Participation was voluntary and consisted of the completion of an anonymous electronic or paper questionnaire. Sixty-seven responses were obtained. Seven participants were excluded from the final sample due to incomplete or missing data. The sample thus consists of responses from sixty informants. Responses were collected in August and September 2008.[2]

All sixty informants are Australian-based, at least tri-lingual and forty-four of them possess formal accreditation or recognition. Interpreters with two languages only, English and one other language, were not included in the sample. Thus, the sample and the number of reported instances of shifting cannot be considered representative of the experiences of interpreters in general. However, a sample size of sixty multilingual interpreters does allow for some generalisation about the likely experiences of this (large) sub-group and gives some indication of the frequency or incidence of shifting in this sub-group.

Non-personal information was elicited about the settings in which informants acquired their languages. Informants were invited to report on whether they had ever experienced a situation in which a client had shifted the language of interpretation or had sought to do this. Those who had experienced this were asked to provide details of the languages in question and the situation. Further, the second and main part of the questionnaire consisted of descriptions of hypothetical situations involving shifts in a language of interpretation. All informants, regardless of whether they had experienced a shift of language in an interpreting situation or not, were invited to provide judgements of acceptability in hypothetical situations. Comments were invited and provided by many. Summaries of comments are provided after the responses for each hypothetical situation.

The data presented below is collected from interpreters only. The study does not include data from clients, agencies or others. Thus, discussion of shifting is based on responses from one party only and includes the reported but not self-reported circumstances and motivations of clients.

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[1] I am grateful to Annamaria Arnall from AUSIT for distribution of information and the questionnaire link to AUSIT members, and to Cynthia Toffoli-Zupan and David Deck from NAATI (Victoria) for allowing me to contact potential informants.

[2] Approval to contact potential informants and collect data was granted by the Standing Committee on Ethics in Research Involving Humans (SCERH), Monash University. Project Number 2007002093. Project Title: Bilingual clients and multilingual interpreters. Chief Investigator: Dr Jim Hlavac. Approved from 13 Nov. 2007 to 13 Nov. 2012.

5. Incidence of shifting amongst the informant sample

Twenty (33%) of the sixty informants reported experiencing shifts in the language of interpretation while working as interpreters. They fell into seven categories, depending on the status of the languages involved or on the motivation for shifting and the direction of the shift. Patterns of shift are summarised below in Table 2.

Table 2: Type and details of shifting recorded amongst informants

Pattern of shifting: languages involved, directions or motivations	Number
Language of country of previous migration → Language of country of birth Spanish → Italian Oromo → Somali Spanish (→ Italian) → Sicilian Japanese → Mandarin German → Hungarian	5
National language → Regional language[3] Mandarin → Cantonese Mandarin → Shanghainese Urdu → Punjabi Amharic → Oromo Urdu → Pushto	5
Minority language [3] **→ National language** Karen → Burmese Karen → Thai Nuer → (Sudanese) Arabic	3
National language 1 → National language 2 Dari → Pushto Croatian → Bosnian Bosnian → Croatian	3
National language → Minority language Indonesian → Hokkien Serbian → Hungarian	2
Language of country of birth → Language of country of previous migration Dinka → Swahili	1
Desire to avoid contact with interpreter from L1 community French → Arabic → French	1

[3] The terms 'regional' and 'minority' refer to languages that do not have an official status as national languages of an independent political state. 'Regional languages' are those languages with an official status in a specified area of a state whose speakers usually co-identify ethnically with the (majority) national ethnicity. Examples of regional languages are Galician in Spain, Sicilian in Italy or Shanghainese in China. 'Minority languages' are those languages whose speakers usually do not co-identify ethnically with their nation state's (majority) national ethnicity and who are usually domiciled in a specific area of a national state. Examples of minority languages are 'indigenous' languages such as Sorbian in Germany or Cantonese in Vietnam and also recently transposed 'immigrant' languages such as Arabic in France or Berber in The Netherlands (cf. Arzoz 2008). The status of the same language can differ from state to state. For example, Pushto is a regional language in Pakistan but one of the two national languages in Afghanistan.

The reported number of instances of shifting presented above in Table 2 reflects those instances of shifting experienced by twenty of the sixty informants. A full presentation of informants' experiences and circumstances of shifts in the language of interpretation is provided in Hlavac (2010). In regard to the person who initiated shifts presented in Table 2 above, twelve of the twenty examples presented above were shifts that were initiated by the client, in all cases for the client's own benefit. In five cases it is not clear who initiated the shift or whether it was negotiated and enacted jointly by both parties. In three instances, interpreters took the initiative of offering or suggesting a shift to the client which, in all cases, was accepted. Informants' responses indicate that shifting is usually initiated by the client, and invariably meant to be of benefit to the client. The following section contains informants' responses to hypothetical situations involving the possibility of shifting.

6. Ethical considerations about interpreter behaviour in relation to shifts in the language of interpretation

Shifting occurs among 33% of informants and, as section 5 above reports, the interpreters themselves usually shift to accede to a client's preferences. In this section, I examine how interpreters judge situations, their role and its obligations and how these are negotiated with other parties. This section presents informants' responses to hypothetical situations in order to examine the following: client-initiated vs. interpreter-initiated shifts; shifting for the client's benefit vs. the interpreter's benefit; the interpreter's judgements of the client's proficiency vs. client's judgements of the interpreter's proficiency; the need to inform or gain permission from other party. Responses in this section are from all sixty informants, not only from the twenty informants who reported experiencing shifting. The experiences of the twenty informants who had experienced shifting are likely to influence their responses to the hypothetical situations presented below. However, their responses to hypothetical situations need not be reflective of how they responded in real-life situations and their responses are not otherwise distinguished from those of the other forty informants.

Informants were asked to grade the interpreter's behaviour in the hypothetical situations as acceptable, borderline or not acceptable. Some informants did not choose any response and gave no verbal answer. Summaries of informants' comments are provided following the statistical break-up of responses to each question.

In the questions below, language *x* is the language in which interpreter and client commence communication. Language *y* is the language into which they may shift. Language *x* may be a client's L1, L2, 'native' or 'non-native' language, 'mother' or 'adopted' tongue. The same constellation may apply to language *y* and to the interpreter for whom languages *x* and *y* may be a working language (whether active or only passive). The only characteristic that distinguishes *x* from *y* is the (client's) self-reported or (interpreter's) assumed dominance.

6.1 Informant judgements about the ethical status of various types of shifts

6.1.1 Client-initiated, for client's benefit

Question 1. The client is speaking language *x* and the interpreter is interpreting from and into language *x*. The client says: "You also speak

language *y*. I'll talk to you in *y* because it's easier for me." Both client and interpreter shift to language *y*.

Acceptable: 35 Borderline: 7 Not acceptable: 10 No answer: 8

Responses above show that informants consider it acceptable for both a client and an interpreter to shift languages where this is initiated by the client and the client will benefit from the shift, i.e. will be able to communicate more easily. Responses which consider this acceptable refer to the need to facilitate communication and the importance of flexibility. Those who consider this example borderline cite the need to consult the other party, while those who consider it unacceptable give (in)consistency of performance as a reason.

Question 2. The client says: "You also speak language *y*. I'll talk to you in *y* because it's easier for me." You as the interpreter do not switch to language *y* and continue to speak language *x*.

Acceptable: 19 Borderline: 10 Not acceptable: 23 No answer: 8

The responses above to question 2 are evenly distributed. Roughly the same number of informants deem it acceptable and not acceptable for the interpreter to refuse a client's request to shift. Most informants in the former group cite the primacy of facilitating communication between client and interpreter as justification, and it appears that many interpreters believe clients appreciate or expect a proactive and accommodating approach that includes openness to shifting. These kinds of responses are also recorded by Rudvin (2007, p.66) who reports that an "independent, impartial or even detached approach to an interaction involving a fellow member of the same speech community is, for many users or clients, divergent to behavioural patterns that they typically expect from them [interpreters]". Borderline responses refer to concerns over the lack of preparation or practice. Those claiming that it is acceptable not to shift, cite doubts about proficiency and/or a lack of accreditation.

6.1.2 Client-initiated, for interpreter's benefit

Question 3. The client says: "You also speak language *y*. If it's easier for you we can speak *y*." Both client and interpreter switch to language *y*.

Acceptable: 25 Borderline: 10 Not acceptable: 13 No answer: 12

Responses to this question are comparable to those given in the previous section. Question 3 refers to a situation in which a client offers to shift for the interpreter's benefit. It is seldom that clients or others offer to change a constellation for an interpreter's benefit. Interpreters do not expect this either.

The primacy of ease of communication, even if the interpreter is the primary beneficiary, appears to motivate most informants' responses about the acceptability of this alternative. Responses which consider this borderline or unacceptable voice concern that the client should be the primary beneficiary.

Question 4. The client says: "You also speak language *y*. If it's easier for you we can speak *y*". You as the interpreter do not switch to language *y*, but remain speaking language *x*.

Acceptable: 28 Borderline: 11 Not acceptable: 10 No answer: 11

Informants' responses to question 4 above show that most consider it acceptable to refuse a client's offer to shift, when this is for the interpreter's benefit. Twenty-eight responses of acceptance appear to represent a divergent position from the twenty-five responses of acceptance to question 3. This need not be the case. Both courses of action appear to be acceptable to many respondents.

Familiar arguments are put forward that expand on these responses above. The 'safer' option of staying in the booked language contrasts with many interpreters' sense of duty to suit clients' wishes. One informant pointed out that declining to shift to language *y* would be unusual if the interpreter had divulged that s/he speaks *y*. This is reminiscent of the notion of consistency or uniformity of performance. Borderline comments repeat the concern about a lack of preparation while responses which view this as unacceptable posit that a refusal to shift when invited to do so is offensive in terms of a client's cultural expectations.

6.1.3 Interpreter-initiated, for client's benefit

Question 5. The client is having problems expressing him/herself in language *x*. You say to the client, "Feel free to speak language *y* if you want. I also speak it".

Acceptable: 36 Borderline: 5 Not acceptable: 9 No answer: 10

Informants' responses show that a majority consider this course of action to be acceptable.

The responses which list this behaviour as acceptable cite facilitation of communication, to the client's benefit. Borderline responses again refer to this as dependent on the other party's knowledge and approval. Responses that consider this unacceptable reject the status of the interpreter as an adjudicator of the client's proficiency in language *x*. An interpreter-initiated offer to shift languages carries with it an implicit evaluation of the client's greater ease in language *y*. As language specialists who are required to readily recognise and comprehend varying dialects, registers, genres and pragmatic patterns, interpreters make judgements about the linguistic repertoires of other interlocutors as an automatic and involuntary process. Although they are not requested or obliged to do so, they are still well-placed to make suggestions such as that in question 3.

Nonetheless, in the context of community interpreting, judgements about proficiency can have wider consequences: clients may not appreciate an offer which casts doubt on their language skills in language *x* (cf. Luoma, 2004). Interpreters are themselves rightfully sensitive to others' judgements of their own proficiency level and ability to interpret successfully. And yet the circumstance that "the relationship between client and interpreter extends beyond the interpreting situation" (Gentile et al. 1996, p.32) means that interpreters may feel compelled to offer suggestions, where such suggestions "facilitate rather than hinder communication" (AUSIT CoE, 1998, p.3). But are such suggestions demonstrations of "power or influence over clients" (AUSIT, CoE, 1998, p.1), against which the same code warns? This is further investigated in the following question.

6.1.4 Interpreter-initiated, for client's benefit (based on interpreter's judgement of client's proficiency)

Question 6. The client is having problems expressing him/herself in language *x*. You say to the client, "I can see that you are having problems speaking *x*. Why don't we switch to language *y*."

Acceptable: 28 Borderline: 10 Not acceptable: 11 No answer: 11

Question 5 above contained an offer. Question 6 above is a suggestion or even a recommendation. While question 5 does not contain an obvious face-threat, question 6 could, depending on how it is conveyed, threaten the client with a loss of face. As presented in question 6, such a recommendation is still seen by most informants as acceptable. Pragmatism appears to be their main explanation while those who do not support this view cite its tactlessness and the potential negative effect on client–interpreter relations.

6.2 Attitudes towards informing and obtaining permission to shift from other parties

Question 7. When a situation occurs where an interpreter could change from language *x* to language *y*, should the interpreter first inform the other party?

Yes: 31 Maybe: 5 No: 1 No answer: 24

Question 7 is a leading question and unsurprisingly, most informants believe that the other party should be informed and their permission sought:

> It is likely that in many situations where shifting could occur interpreters would already have conveyed this, through interpretation, to the third party, relating to them what clients have stated. This reminds us that, particularly in legal settings, all utterances produced by interlocutors, are interpreted. In community interpreting, there can be many situations when client and interpreter are alone and conversation is dyadic and where this type of exchange occurs without the presence of the third party (Gentile et al. 1996, pp.32-33).

7. Conclusions and implications

The judgements about the acceptability of shifting the language of interpretation described above indicate that, by and large, shifting is a condoned practice where the accompanying conditions of accreditation and awareness of shift by other parties are given. Unsurprisingly, it is generally judged acceptable for clients to initiate a shift in the language of interpretation and for interpreters to follow their lead. It is generally less acceptable for interpreters to refrain from shifting to another language where this shift is to the benefit of the client. At the same time, it is also acceptable for interpreters not to shift where a client appears to do this for the interpreter's benefit rather than his/her own.

Surprisingly, client-initiated shifting for the interpreter's benefit meets with widespread approval, as does an interpreter's refusal to shift in these circumstances. Offering to shift for a client's benefit is acceptable to a clear majority of informants. At the same time, a relative majority of informants, twenty-eight out of sixty, believe that a stronger inducement, namely a recommendation to shift, is also acceptable.

Informants' justifications for shifting to take place are based primarily on the desire to facilitate communication between themselves and their clients and to seek optimal conditions for the interpreting interaction to take place. The ethos of being flexible and the ability to respond to unexpected situations are mentioned repeatedly in many informants' responses.

The main justification given for a refusal to shift is a lack of obligation on the part of the interpreter. Fear of a lack of preparedness or practice in another language is also listed as justification, in line with ethical guidelines which recommend that practitioners decline work that is beyond their level of competence. Further, some maintain that personal information including proficiency and accreditation in other languages should not be divulged.

The hypothetical situations presented above to informants do not contain information that may be present, and of relevance, in real interpreting situations that informants have found themselves in or are likely to. For example, the hypothetical situations contain no reference to any specific language, no formal diagnosis of proficiency levels, no reference to the status of languages in clients' homelands or elsewhere and there is no information about the relationships between declared ethnicity, citizenship, nationality or religion and language use. These factors co-determine whether clients or interpreters are likely to shift and the means through which this is negotiated.

Examples of overt justifications (questions 1 and 2), offers (questions 3, 4 and 5) and a recommendation (question 6) reflect how these speech acts are performed in Australian English. These are appropriate speech acts in an interpreting situation for a speaker of Australian English. However, these same speech acts may be inappropriate for the same functions to be performed in other languages. The pragmatic and politeness norms of other languages may require different formulations and different choices of responses for the functions of justifying, offering or recommending. Face-saving strategies and offer-response conventions may mean that in some cases a client (or interpreter) is unable to provide an unambiguous response in the following turn. Cultural and pragmatic norms co-determine conversational parameters and how individual acts within these parameters are enacted (Bowe and Martin, 2007). Examples of informants' individual comments are presented and discussed in Hlavac (2010, pp.201-209). These examples reveal interpreters' and clients' cues, negotiation strategies and the language choice outcomes but not (translations of) the actual linguistic forms that were used to enact these. A detailed, ethnographical investigation into individual client's situations goes beyond the scope of this paper which seeks to present responses quantitatively and to re-visit relevant sections of the AUSIT CoE, contained in the following section.

8. Proposed guidelines for shifting

Like many guidelines, the AUSIT CoE seeks to be both brief and prescriptive and to articulate in clear words desirable or undesirable forms of conduct. Below is a list of excerpts from the AUSIT CoE which are relevant to situations in which the possibility of shifting is likely to or does occur. Excerpts are given in the chronological order of expected interactions and guidelines are presented that pertain to shifting. Following each excerpt I attempt to interpret the intention of the guidelines and apply them to the possible occurrence of shifting. These interpretations and applications of the AUSIT CoE are my own and have not been drawn on the basis of discussion with AUSIT members or with those AUSIT office-bearers who were responsible for the code's composition and publication in 1998.

8.1 Initial contact

> **5. ACCURACY**
> c) Clear Transmission
> ii. A short general conversation with clients prior to an assignment may be necessary to ensure interpreter and clients clearly understand each other's speech. (AUSIT CoE, 1998, p.3)

Confirmation from all parties should be gained that the language pair for which interpreting services were booked is the language pair that all parties wish to use. After establishing for whom interpretation is to be performed, initial contact is the opportunity for the interpreter to 'acclimatise' him- or herself to other interlocutors.

Initially, an interpreter should wait for a client to inform the interpreter of alternate language preferences or to suggest a different language if the language booked for is not their dominant language. However, an interpreter can consider initiating such a shift where effective communication is jeopardised.

> **1. PROFESSIONAL CONDUCT (extra notes)**
>
> To determine the appropriateness or otherwise of a proposed course of action, consider whether or not it might impede or jeopardise effective communication. (AUSIT CoE, 1998, p.8)

The phase of all parties introducing themselves to each other and ascertaining their roles to each other is instrumental in the notion of a "contract" (Tebble, 1999, p.185) or formal understanding of the aims, purposes and logistics of the interpreting interaction. If non-dominant competence of a client in the booked language becomes apparent this is the point in the interaction at which a requested or offered shift should occur.

8.2 Initiating a shift to another language

> **1. PROFESSIONAL CONDUCT**
> a) Standards of Conduct and Decorum
> iv. It is the responsibility of interpreters and translators to ensure that the conditions under which they work facilitate rather than hinder communication.
> b) Honesty, Integrity and Dignity
> iii. Interpreters and translators shall not exercise power or influence over their clients. (AUSIT CoE, 1998, p.3)

Sub-section 1. a) iv. above within the section on professional conduct states that interpreters have a "responsibility" to facilitate communication. This suggests that if a client wishes to shift languages to be able to communicate in a less hindered way, the interpreter has a responsibility to accommodate to this where s/he is able to.

Sub-section 1. b) iii. above warns against exercising power or influence over clients. A *recommendation* to choose a different language to speak is an example of an interpreter exercising influence over a client. Therefore, where a shift is a possibility, it should be initiated by the client for the client's benefit or it should be initiated by the interpreter as an *offer* to the client for the client's benefit.

8.3 Proficiency and accreditation

> **3. COMPETENCE**
> a) Qualifications and Accreditation
> i. Interpreters and translators shall accept only interpreting and translation assignments which they are competent to perform.
> iii. Interpreters and translators shall clearly specify to their clients the NAATI level and direction in the languages for which they are accredited or recognised. (AUSIT CoE, 1998, p.4)

The sub-section above advises that an interpreter may shift if s/he is able to competently perform in the other language and only if s/he has accreditation or recognition at the same level (or higher) than that level required for the interpreting interaction s/he was assigned to.

> **3. COMPETENCE**
> b) Level of Expertise
> In the course of an assignment, if it becomes apparent to interpreters and translators that expertise beyond their competence is required, they shall inform the clients immediately and offer to withdraw from the assignment. (AUSIT CoE, 1998, p.4)

It is incumbent on interpreters, regardless of which language they are working in, to inform others of proficiency or other limitations and to offer to withdraw. If an interpreter is aware of a lack of proficiency in the language to which s/he and the client have already shifted, s/he should request to return to the original choice of language for which the interpreting interaction was assigned.

8.4 Mid-assignment shifting

> **5. ACCURACY**
> b) Uncertainties in Transmission and Comprehension
> ii. If anything is unclear, interpreters and translators shall ask for repetition, rephrasing or explanation. (AUSIT CoE, 1998, p.5)

The above recommendation sanctions enquiry where characteristics of a client's language indicate that it is not his/her dominant one. An offer to shift may be made where the prerequisites of competency and accreditation pertain.

> **5. ACCURACY**
> a) Truth and Completeness
> i. In order to ensure the same access to all that is said by all parties involved in a meeting, interpreters shall relay accurately and completely everything that is said. (AUSIT CoE, 1998, p.5)

Where this is not already interpreted, the other party must be informed of proposed shift and acknowledgement gained.

8.5 Responsibility to other parties /agencies

> **ENCROACHMENT**
> Interpreters should guard against encroaching on the work of co-members. (AUSIT CoE, 1998, p.1)

Where a shift of language has taken place, the interpreter should subsequently inform the relevant agency or contracting body of the language used for interpretation. It is possible that if an interpreting interaction had been booked for the language into which both client and interpreter shifted and not for the language for which it was originally booked then that booked interaction may have been awarded to another interpreter for various reasons (i.e. level of experience, area of expertise, higher level of accreditation). Practitioners should otherwise inform relevant contracting bodies if they anticipate that an interpreting interaction is likely to be conducted in a language different from which it is booked.

Acknowledgement

I would like to thank Helen Tebble and the anonymous referees for valuable comments and criticisms to previous drafts of this paper.

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Medical interpreting

Some salient features*

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Introduction

The aim of this paper is to present some preliminary findings of ongoing research within the project "Interpreting in Hospitals", which has recently been established at the Research Centre on Multilingualism in Hamburg. Within the project we compare monolingual and multilingual interactions in hospitals to investigate the differences between interpreted and non-interpreted doctor-patient communication. The languages under study are German, Turkish and Portuguese.

We would like to draw attention to two features of interpreted doctor-patient communication which at first glance seem to be rather subtle, but which, as they appear frequently in our data, may also be considered 'salient'. First, the communicative function of modal verbs in briefings for informed consent will be discussed. Then, we will take a look at switches between monolingual and multilingual modes of interaction. It will be argued that an analysis of these features within the framework of Discourse Analysis and Functional Pragmatics[1] may help us understand the communicative demands of these specific institutional settings and may also contribute to the discussion concerning professional community interpreting.

1. Preliminary remarks

The web page of the Monterey Institute of International Studies provides us with some remarks about medical interpreting. There it is stated that:

> the task of interpreting between patient and health care provider is very difficult, not just because of the specialised terminology involved and the already complex nature of the patient-provider relationship, but also because of the linguistic and cultural barriers that must be bridged (www.miis.edu/iirc/iirc9.html).

This quote raises four issues which are important in multilingual doctor-patient communication: the problem of medical terms, the doctor-patient relationship, problems stemming from differences between languages in general and from possible cultural differences between people who do not speak the same language. Each of these issues is in some way independent from the others and they all seem to constitute separate problems. In what follows we will take a closer look at two of these dimensions: the issue of medical terms and the doctor-patient relationship. The aim is to show that language is not just one problem among others, but rather the crucial point.

1.1 Medical interpreting in Germany

Usually, social, political and medical institutions in Germany are not considered to be multilingual. Disregarding some local exceptions, multilingualism is not perceived as the norm in German society, although the percentage of migrant population in urban areas sometimes reaches 20 percent. According to their different needs, these non-native speakers of German differ widely in their linguistic skills. Not all of them speak German well enough to talk to physicians, but almost all have access to medical services (McGroarty 1996). So far, only rarely have "professional" interpreting services been offered in hospitals. The interpreters are often bilingual staff members or relatives of the patient, who are drafted in on an unpaid, *ad hoc* basis. One might argue that the lack of payment, as well as the lack of training, makes it impossible to call these persons 'interpreters' in the professional sense. However, it cannot be denied that a lesson can be learnt from the experience gained in this kind of activity, which can provide useful insights if in the future professional interpreting services are to be offered — as seems it would be advisable — in a medical setting, all the more so since to date professional experience in this field has been so scanty.
It is clear that only more extensive study of problems related to interpreting in this sector will ensure a full needs analysis, with a view to recruitment of professional language mediators.

1.2 Focus and data

In our research we focus on language as a tool for communication. We believe that common language forms fulfil specific communicative functions within medical discourse, though these are not always self-evident. Our aim is to find out how linguistic forms and institutional demands fit together and how the former are shaped by the latter. We presume that the interpreters' lack of familiarity with the institutional background will be one major difficulty in interpreted interaction between doctor and patient.

We are collecting data in a unit for internal medicine at a German general hospital, and in a clinic in Turkey. To date, our sample comprises 78 monolingual and multilingual interactions. The interactions last on average 13 minutes. We collect not only interpreted but also monolingual discourse, to compare the two and identify any cultural interferences. We investigate mainly two types of discourse: medical interviews and briefings for informed consent.

The audiotaped data are transcribed and translated following the HIAT-conventions (Ehlich and Rehbein 1976; Ehlich 1993; Meyer 1998).[2]

2. Medical discourse in hospitals — The case of briefings for informed consent

Hospitals as providers of medical care for large populations serve two purposes: care and research, i.e. reproducing the individual capacity for labour and investigating illnesses and medical methods (Foucault 1988). Doctor-patient communication takes place mainly within the sphere of care, in which two interrelated complex procedures are carried out: diagnosis and therapy.

For each illness, specific types of treatment have been developed. Strauss et al. (1985: 20) put forward the notion of "illness trajectory" to account for the fact that the course of events is based each time on a trajectory scheme, which comprises potential events and predictable actions. Although the normal course of events may differ for specific illnesses, a repetitive structure can be identified. One potential action within the normal course of events is the briefing for informed consent.

Figure 1 provides a general trajectory scheme and shows where briefings for informed consent are located (see also Bührig, Durlanik and Meyer 2000).

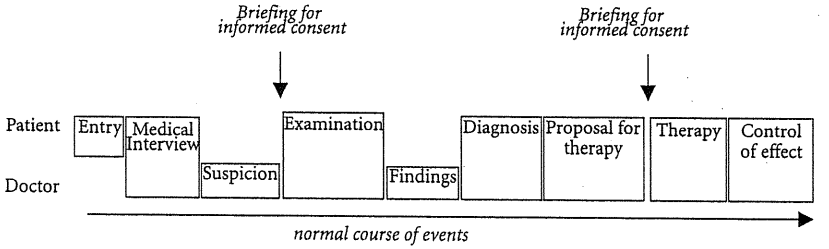

Figure 1. Trajectory scheme and location of briefings for informed consent.

Each box in this figure represents a complex of predictable (inter-) actions. Some of them are interactions between doctor and patient. Briefings for informed consent are only potential events, as they are not necessarily carried out. They

necessarily occur only before certain invasive methods of examination (gastroscopy, colonscopy, bronchoscopy, bone marrow puncture) or before certain operations. A third variant are briefings to prepare the patient for general or local anaesthesia. They may be carried out before examinations and operations and show specific features.

2.1 The institutional purpose(s) of briefings for informed consent

All types of briefings (pre-diagnostic, pre-operative and pre-anaesthetic) are obligatory by law, but serve institutional purposes as well. The patients are informed about the type of intervention and the course it will follow, as well as the possible risks and complications that it might entail. On the basis of knowledge imparted by the doctor, the patients decide whether to consent to the operation or method. This is the juridical background, the intention being to guarantee the patients' self-determination. The patients' decision should be based on an appraisal that takes into consideration the purpose of the operation and possible risks. Usually, the patient will have little or no knowledge of either of these. S/he is thus completely dependent on information from the medical staff. Moreover, the patient often does not realise that s/he can actually reject the planned operation, or that an appraisal on his or her behalf is called for. In most cases the patient will consent to the decision made by the doctor. The consent will be documented through a signature at the bottom of a form, which proves that the patient has been informed.

In our data, we deal mostly with briefings which occurred within the diagnostic phase of the trajectory scheme.

Due to their specific purpose, these briefings are subject to a particular structure. In Meyer (2000), I have retraced their constitutive elements by analyzing 22 authentic interactions. Figure 2 contains the constitutive speech actions of the doctor in pre-diagnostic briefings for informed consent.

The doctor's scheme or plan of action for the briefing is divided into two parts. First, the medical intervention is announced and described. To clarify why this particular method needs to be applied, the announcement and description may be combined with information about findings with previously applied methods. In the second part of the briefing, the doctor refers to possible risks and complications, which will be illustrated. After a rough estimation of their frequency, the doctor will ascertain the patient's further need for information and finally get the patient to sign the form.

By announcing and describing the method, the doctor orients the patient towards the institutionally determined plan of action, thus ensuring future co-operation during the medical intervention. On the other hand, the reference to risks is done for legal purposes.

Both of these institutional demands (i.e. orienting the patient and appraising the method) determine the course of verbal interaction in these briefings. They

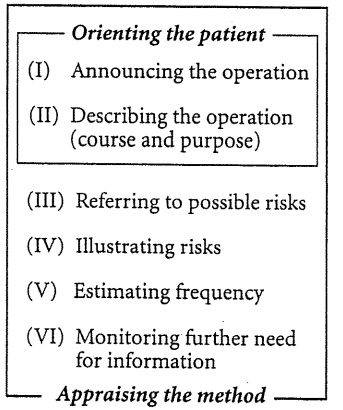

Figure 2. Institutional demands and constitutive speech actions in briefings for informed consent.

entail a particular sequence of speech action patterns to be performed by the doctor, and they influence lexical choices. This does not imply that the course of the briefing is fixed and inflexible. Indeed, patients as well as interpreters may influence 1the course of interaction. Nevertheless, doctors on the whole stick quite predictably to the sequence shown in Figure 2.

2.2 Modality in announcements

One constitutive speech action pattern that needs to be performed at the beginning of pre-diagnostic and pre-operative briefings is the announcement of the planned action, the method the medical staff has opted for. As Rehbein (1981) shows, annnouncements usually contain an indication of future time, for example, a modal and/or a deictic temporal expression like 'tomorrow'. Within the framework adopted here, modality is the mental representation of a relationship between actor, action and reality. Within this perspective, modals refer to stages of action processes (Redder 1984, 1992).[3] Doctors tend to refer to the institutional pre-history of the planned action by saying that they "wish to", "would like to" or "want to" apply a certain method. By doing so, the doctors conceptualise the constellation between doctor and patient as a decision-making process in which the patient can intervene. Interpreters tend to use forms like "will", thus referring to the carrying-out stage of an action. They convey the doctor's speech action as if it were the announcement of an action which undoubtedly will take place. The patient thus appears as a purely passive participant. Let me illustrate this by taking an example from our data. In this briefing the doctor (referred to in the transcription as "DOC") informs the

patient ("PAT") about a gastroscopy and a specific type of ultrasound. The patient is a retired Portuguese worker who has lived in Germany for 35 years and has only a poor command of German. The interpreter ("INT") is his 28-year old niece, who is bilingual and grew up in Germany.

Excerpt 1

(1) DOC Gut • •äähm, Herr Gomes, wir wollen • bei Ihnen zwei Untersuchungen noch • durchführen.
Well • •uuhm, Mister Gomes, we want • to do two more check-ups in your case.

(2) DOC Und zwar einmal eine Magenspiegelung und einmal • ein Ultraschall des Herzens durch die Speiseröhre.
One is a gastroscopy and one • an ultrasound of the heart performed through the throat.

(3) DOC ((2s)) Hm

(4) INT O tio percebeu?
Did you understand that, uncle?

(5) INT Ou...
Or...

(6) PAT Percebi.
I understood.

(7) INT Ach so, soll ich jetzt immer alles übersetzen • direkt, oder?
Oh, shall I translate everything directly, or...

(8) PAT Disse que eu/ que...
She said that I...

(9) INT Oder wenn er jetzt verstanden hat ähm • •wie...
If he understood this now, how...

(10) PAT Não, não.
No, no.

(11) PAT Eu/ eu/ eu percebi.
I/ I/ I understood.

(12) INT Oder wenn er jetzt verstanden hat ähm • •wie...
If he understood this now, how...

(13) PAT Disse/ disse que já me fizeram...
She said/ she said that they have already done...

(14) DOC Übersetzen, würd ich sagen.
I would suggest you translate.

(15) INT Ja?
Yes?

(16) PAT Disse que äh äh...
She said, that uh uh...

(17) DOC Das ist am einfachsten.
That would be the easiest.

(18) INT Okay.

(19) PAT Disse que já me fizeram do/ do/ do/ do/ do(is) Spiegelungs.
She said that they have already done two/ two/ two/ two/ two (two) scopies to me.

(20) INT Não, não fizeram.
No, they have not done that.

(21) INT Vai/ vão fazer.
She will/ they will do that.

(22) INT •Ainda mais dois exames.
Two more examinations.

The modality shift between doctor's utterance (1) and the interpreter's (21) is a subtle, but nevertheless frequent feature within our data, as the following table shows.

Table 1. The different use of modals in announcements: number of occurrences

	Doctors	Interpreters
'want', 'would like to', etc.	*12*	*1*
'will', 'going to', etc.	*4*	*12*
No interpretation		*3*

In 16 bilingual briefings, the doctors used a German modal similar to 'want' 12 times, and a modal construction like 'will' or 'going to' only 4 times. Of these 4 occurrences, 3 were in pre-operative briefings. In 12 cases the interpreters rendered the announcements with a Portuguese or Turkish form similar to 'will'. Only once did an interpreter use the Portuguese *querem* ('they want'), which leaves the carrying-out of the action unspecified. In three cases the announcement was not translated into the target language.

The contrast between source and target languages does not stem from a grammatical constraint. Both Turkish and Portuguese provide means to express modality. Although modal expressions are specific to each of these languages and not always easily transferable to German, the difference between referring to planning ('we *want* to do x') and referring to carrying out ('we *will* do x') is expressable in both. The most convincing explanation for the switch of modality is that interpreters are not familiar with the institutional presuppositions of the doctor's talk.

3. Partial transparence as a feature of medical interpreting

Müller (1989) analyses translation as only one option in bilingual conversation. His data, based on interviews with Italian migrants living in Germany, show that, in bilingual constellations, linguistic repertoires may be mutually exclusive only to

an extent. In communicating with migrants, several choices are possible. Most of the doctor-patient interactions we have taped so far are, in Müller's terms, characterised by a certain degree of transparency: the patients understand German to some extent. The participants in our data (doctors, patients, and interpreters) frequently use this factor to switch between different modes of interaction. In Excerpt 1, the patient uses the German term *Spiegelung* ('scopy') in utterance (19). He then insists on direct interaction with the doctor in utterances (6) ('I understood') and (11). This may be viewed as his reaction to a partially transparent constellation. Similarly, the constellation forces the interpreter in (8) into explicitly asking whether interpretation is necessary — as her uncle apparently understands at least part of the doctor's talk, she is unsure whether and when she should interpret. This prompts the doctor's suggestion in (14) ('I would suggest you translate').

Müller (*ibid.*:736) perceives the option of switching between different modes of interaction in partially transparent bilingual conversation as a resource which actors use creatively, for instance to modify their alignment to the interaction.[4] For example, bystanders may adopt the role of interpreter to get involved in the conversation of others. However, it seems that in our data the partially transparent constellation is more a hindrance than a help. This will be shown in the analysis of Excerpt 2. As the numbering indicates, Excerpt 2 (below) is the continuation of Excerpt 1.

Excerpt 2

(23)	INT	É umaaa, uma
		It is aaa, a
(24)	PAT	Spiegelung.
		Scopy.
(25)	INT	uma Magenspiegelung, genau.
		a gastroscopy, exactly.
(26)	INT	Äähm • •ee • vão lhe tirar/ vão lhe fazer Ultraschall ((1s)) ao coração.
		Uhm, and they will remove/ they will do an ultrasound of your heart.
(27)	PAT	Hm
(28)	INT	Ultraschall, sabe o que é?
		Ultrasound, do you know what that is?
(29)	PAT	Sim.
		Yes.
(30)	PAT	Não sei.
		I don't know.
(31)	INT	Oh Gott!
		Oh my God!

After correcting her uncle, the niece proceeds in (23) with an attempt to name the examinations that the medical staff want to carry out. She lengthens the indefinite article and indicates a kind of 'search for the right word' ('It's aaa, a'). Her uncle helps her by offering the word *Spiegelung* (scopy), which he obviously had heard before.

This word as such is inappropriate, but allows her to introduce the correct German compound *Magenspiegelung* (gastroscopy) into her Portuguese utterance (25). She then adds the second announcement and relies on the same strategy, using the German term instead of a Portuguese one (26). The patient's reaction is a hearer signal with level stress, which in German serves to indicate processing problems (Ehlich 1979). This leads to a clarifying question by the interpreter in (28), again with the German term as part of the Portuguese construction. The patient responds 'Yes' and 'I don't know' in (29) and (30), which in turn leads the niece to exclaim in German: 'Oh, my God!'

This cry for divine intervention is not astonishing if we consider the communicative function of the term *Ultraschall* (ultrasound) in this section of discourse. As has been pointed out in Section 2, the doctor at the beginning of such briefings usually initiates the speech action pattern of 'announcing'. The underlying constellation of 'announcing' is determined by a joint process of action, in which the hearer is unprepared for the "planned occurrence" of a specific type of action (Rehbein 1981:221). Hence, the speaker verbalises knowledge about a "plan for future action" in order to prepare the hearer (Rehbein *ibid.*:219). If the character of the planned action is unknown to the hearer, the speaker has to reveal it more explicitly by propositional elements. Thus, the propositional content of the announcement may vary according to the hearer's knowledge.

In the particular case of announcements at the beginning of briefings for informed consent, the hearer (the patient) usually has little or no knowledge about the planned action. Therefore, the doctor has to explicitly describe elements of the plan for future action. This explicit description, required by law, enables the patient to co-operate within the procedure. The medical terms used in announcements at the beginning of briefings for informed consent are therefore important anchoring elements for the following discourse sections. Here, the niece feels intuitively that something important is missing.

It would be tempting to analyse the interpreter's difficulties merely as a problem of terminology — if she had known the Portuguese word for 'ultrasound' she would not have had any trouble. This view would be correct if Excerpt 2 would were just an isolated case. However, our attempt was to highlight the partially transparent bilingual constellation as a subtle, but salient feature of medical interpreting in Germany. This feature has an impact on interpreted medical interaction in various ways, and one of them has been discussed in this section. The primary interlocutor's option for native–non-native interaction in German causes difficulties for all participants. Interpreters have to step continuously into and out of their role, doctors are unclear about whether patients have understood, and patients themselves may have the mistaken impression that they have understood the message conveyed to them by the doctor.

4. Conclusions

Two features of medical interpreting have been discussed in this article: the use of modals and the impact of the partially transparent bilingual constellation. With regard to modals, it has been shown that interpreters tend to shift modality: whereas doctors announce planned medical procedures without specifying whether the procedure will actually be carried out, the interpreter's version of these announcements treats the procedure as an action which undoubtedly will take place.

The specific bilingual constellation and the option for native–non-native discourse can be perceived as a communicative condition which influences the interaction process in various ways, but it is not precisely quantifiable. Unlike the case of modality shift, it is not restricted to specific types of action but appears in many interactions. Thus, the constant change in the interpreter's alignment towards the interaction is a more general feature, which still needs to be studied in detail.

From the specific format of the bilingual constellation, one may conclude that specific skills are required to cope with the communicative dynamism triggered by this format in a medical setting. That all types of liaison and dialogue interpreting require different communicative skills from those of conference interpreting (Keith 1984, Mason 1999b) is a view that is gradually gaining ground. These skills, however, still need to be defined more precisely for medical settings.

Concerning the use of modals, another conclusion can be drawn. As has been pointed out above, what the shift in modality indicates is not that the interpreter lacks linguistic competence, but that she is unfamiliar with the institutional presuppositions of the doctor's talk. Doctors' use of modals like 'want' or 'would like to' is not random, but stems from the fact that the patient's approval is called for. Therefore, the carrying out of the medical procedure cannot be taken for granted. Although patients are not always aware of this institutional demand and usually agree to the doctor's proposal, the announcement must leave room for doubt whether the procedure will actually be carried out.[5]

Furthermore, we can deduce that briefings differ according to whether the patient's agreement is needed. Announcements in briefings that refer to anaesthesia usually contain an expression similar to 'will' or 'going to', as they are carried out only if the patient has already opted for an operation or diagnostic method. In preoperative briefings the constellation between doctor and patient is even more complex, as these talks are influenced by different kinds of institutional prehistories of the interaction (see Biel 1983, Jung forthcoming). Sometimes the patient has already opted for the operation before s/he came to the hospital. In other cases, the physical state of the patient may not allow a true decision-making process, even where this is required.

The influence of institutional demands on doctor-patient communication in (monolingual or multilingual) briefings for informed consent is not a unique case.

The same holds for medical interviews, counselling, or explanatory talks (Bührig 1996; Hartog 1996; Rehbein 1985b, 1993). If we want to overcome "commonly held perceptions (...) of the interpreter as a kind of 'translating machine'" (Mason 1999a: 149), we need to investigate and to verify the complexity of interpreting in ordinary types of discourse in hospitals and other public service institutions.[6] This would be more fruitful than further discussion of spectacular, but rather isolated and anecdotal evidence of misinterpreting and culture clashes. Anecdotes may serve to highlight the need for interpreting services, but they tell us hardly anything about features of ordinary interpreted doctor-patient communication.

Notes

* This work was funded by the Deutsche Forschungsgemeinschaft (DFG), within SFB 538 'Mehrsprachigkeit' (Research Centre on Multilingualism). The author is entirely responsible for any flaws in the work or its presentation. I wish to thank Kristin Bührig for comments and Tessa Say for help with the English version.

1. Functional Pragmatics is a variant of Discourse Analysis, inspired by the work of John L. Austin (1962) and Karl Bühler (1934/1982). It reconstructs features of interaction between speakers and hearers (writers and readers) in terms of linguistic action theory ('Theorie des sprachlichen Handelns': Rehbein 1977). Rehbein 1994 applies it to medical discourse, Koole and ten Thije 1994 to multicultural team discussions.

2. Due to limited space, the data is presented in LIST form in this article.

3. Tebble (1999: 186–188) analyses modals as means to express the interpersonal metafunction in interpreted doctor-patient interaction.

4. The term "alignment" is from Goffman (1981). It refers to the relationship between a participant and an utterance. Wadensjö (1998, Ch. VII) applies it to dialogue interpreting.

5. In terms of the MIIS, this might be perceived as one aspect of the 'doctor-patient relationship'.

6. E.g. in Pöchhacker and Kadric (1999), who reveal subtle mismatches between source and target discourse in a speech therapy session.

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Volume 43

Interpreting in the 21st Century: Challenges and opportunities
Edited by Giuliana Garzone and Maurizio Viezzi

Interpreting in the 21st Century

Challenges and opportunities

Selected papers from the 1st Forlì Conference on Interpreting Studies, 9–11 November 2000

Edited by

Giuliana Garzone
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John Benjamins Publishing Company
Amsterdam/Philadelphia

™ The paper used in this publication meets the minimum requirements of American National Standard for Information Sciences – Permanence of Paper for Printed Library Materials, ANSI Z39.48-1984.

Library of Congress Cataloging-in-Publication Data

Interpreting in the 21st Century : Challenges and opportunities: Selected papers from the 1st Forlì Conference on Interpreting Studies, 9–11 November 2000 / edited by Giuliana Garzone and Maurizio Viezzi.

p. cm. (Benjamins Translations Library, ISSN 0929–7316 ; v. 43)

Includes bibliographical references and indexes.

1. Translating and interpreting--Congresses. I. Title: Interpreting in the twenty-first century. II. Garzone, G. (Giuliana) II. Viezzi, Maurizio. IV. Title. V. Series.

P306 .F64 2002

418'.02-dc21 2002074684

ISBN 90 272 1649 5 (Eur.) / 1 58811 281 0 (US) (Hb; alk. paper)

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The Translator
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rtrn20

Replies and Response Cries

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Published online: 21 Feb 2014.

To cite this article: Melanie Metzger (1999) Replies and Response Cries, The Translator, 5:2, 327-332, DOI: 10.1080/13556509.1999.10799047

To link to this article: http://dx.doi.org/10.1080/13556509.1999.10799047

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The Translator. Volume 5, Number 2 (1999), 327-332 ISBN 1-900650-21-5

Revisiting the Classics

Replies and Response Cries

Interaction and Dialogue Interpreting

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Forms of Talk. Erving Goffman. Oxford: Basil Blackwell and Philadelphia: University of Pennsylvania Press, 1981. 335pp. ISBN 0-631-12788-7 (Blackwell) / ISBN 0-812-21112-X (Pennsylvania).

Erving Goffman has made many classic contributions to our understanding of human interaction. *Forms of Talk* (1981) is, in fact, itself a collection of classics, since it includes the re-printing of three previously published journal articles, followed by two original papers that apply the theories regarding behaviour and communication that were developed in the previous three. By focusing on the study of human behaviour as it pertains to language, Goffman's *Forms of Talk* provides useful information that makes clear a distinction between dialogue interpreting and conference interpreting, and that has provided the basis for a new approach to the study of interpreting in general.

In *Forms of Talk,* Goffman focuses on three themes: ritualization, participation status, and embedding. By ritualization, he refers to the learned and rule-governed but unconscious behaviours discussed by those who study conversational interaction. These can include gestural information, such as glances and postural shifts, as well as oral information such as the intonation, pausing, and restarting of utterances by a single speaker. Goffman proposes that these features of interactive discourse are important to both speaker and addressees, and are frequently used, for example, during retellings of prior events and experiences, to create what Tannen (1989) refers to as involvement strategies, using the language in a theatrical manner to involve the addressees and assist them in inferring those things left inexplicit.

Goffman's first theme, ritualization, while discussed as part of non-interpreted interactive discourse, clearly has implications for dialogue interpreters. If a speaker, in one language, uses gestural and prosodic strategies to involve addressees and hint at implicit meanings in their own discourse, then clearly

ISSN 1355-6509 *© St Jerome Publishing, Manchester*

the dialogue interpreter must have a means to similarly convey the imagery of a retelling and the hinted-at allusions within a rendered interpretation. Whether or not, or how, a dialogue interpreter might do this is beyond the scope of Goffman's work here. But as those in the field of translation and interpreting began to turn their attention to what sociology and sociolinguistics has to offer the field (see Hatim and Mason 1990), Goffman has provided a foundation for researchers to begin to examine the ritualized interactive features of interpreted encounters (cf. Roy 1989, Wadensjö 1992, Metzger 1995, forthcoming).

Participation framework is Goffman's second theme. By this he refers to the fact that all individuals, regardless of their status within an event, have a status with regard to the discourse. That is, one person might be designated as a speaker, another might be designated as a primary addressee, as when a speaker calls someone by name: "Dawson, what do you think of that?". Even those individuals who are not in the room have a designated status. For example, if they are within earshot of a spoken conversation they might be considered overhearers, and as such, have an avenue for taking a turn within the conversation, perhaps answering the question despite being 'unratified' and maybe receiving a reply such as "Are you Dawson?".

Like the ritualization theme, this notion of participation framework also has important implications for dialogue interpreters. Interpreters are often expected to be neutral with regard to the people and discourse that they interpret. However, as individuals present during the interaction, Goffman's notion implies that interpreters do have a participation status within the communicative event. Some theorists have speculated on the interpreter's role within this participation framework, often presuming the interpreter's status to be neutral. For example, Edmondson (1986) proposes that, while interpreters do have some participant responsibilities, such as formulating and producing utterances, they are not responsible for the content of the utterances, and therefore, interpreters have a unique status as neither hearers nor speakers within the participation framework. However, more recently, research based on Goffman's work (e.g. Wadensjö 1992) has begun to demonstrate that the interpreter's status is not nearly so neutral and uninvolved as was once thought to be the case.

The third theme, embedding, refers to the fact that speakers can produce utterances that reflect the words of other people, as well as their own. For example, speakers can construct the dialogue of other people from other times and places (see Tannen 1989). This raises an interesting issue for dialogue interpreters, who relay the dialogue of others at the same time and in the same place (see Metzger forthcoming).

Goffman weaves these three themes throughout the five chapters of *Forms of Talk.* Each chapter contains a wealth of information about the nuances of interactive discourse in dyadic or multiparty encounters. Goffman's insights, and his application of previous findings regarding the structure of interactive

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discourse, provide a foundation on which interpreted interaction can be discussed in a new light. After years, even centuries, of discussion regarding the nature of translation and interpreting, Goffman's attention to the details and ritual constraints underlying interactive discourse has already sparked innovative approaches to theories of and research in dialogue interpreting.

The implications of Goffman's work can be seen merely by examining one chapter of *Forms of Talk.* In the very first chapter, 'Replies and Responses', Goffman builds a case that both supports and extends the basic units of interaction, namely adjacency pairs. Adjacency pairs are those two-part units of discourse that provide evidence of the sequential nature of interactive discourse. That is, dyadic interaction is not simply two people engaging in monologues while taking turns at talk (though possibly some interactions feel like this!). Turns at talk are related to one another, each turn providing the opportunity for interlocutors to respond to what has previously been said as well as to make a connection to which the addressee can respond in subsequent turns. Greetings provide evidence of these adjacency pairs and the sequential structure they imply, as they generally include a first-part (in English perhaps a "Hello, how are you?") and a second-part response (such as "Fine"). Closings, question-answer pairs and so forth all represent examples of adjacency pairs.

In keeping with prior research, Goffman points out that adjacency pairs provide further evidence of the sequential nature of interaction by 'chaining'. He cites Merritt's (1976) findings regarding the chains in service encounters:

A: "Have you got coffee to go?"
B: "Milk and sugar?"
A: "Just milk." (quoted in Goffman 1981:8)

In this example, Goffman points out that two two-part adjacency pairs have been condensed into three turns at talk, because one part of the first pair (the answer to the first question, "Yes") can be understood without actually being uttered.

While all of this is not new to discourse analysts, Goffman's contribution is to suggest that the units of interaction are not nearly as precise and identifiable as once thought. In interaction, people do not speak in sentences when, pragmatically speaking, partial utterances are sufficient for mutual understanding. Conversational discourse analysts have tried various ways of approaching the study of interaction, to identify the basic unit of talk in interactive discourse. Goffman suggests that the *sentence,* the *utterance,* and the *turn* are all insufficient measurements. He suggests, instead, that the basic unit of interactive discourse is the *move.* A *move* can be a sentence, utterance, or turn, but need not be. A move can even be accomplished by silence, since pauses are as capable of conveying meaning as is discourse (cf. Tannen 1986, 1989).

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The notion of moves as a basic unit of interaction can be very useful to the dialogue interpreter (as well as to the interpreter educator and researcher). This notion clarifies an issue that has plagued the field for some time, namely equivalence. It is sometimes assumed that the only true measure of an interpreter's success at their work is to know that they have conveyed an equivalent message in their rendition of the source into the target language. However, it has long been clear that the notion of equivalence is not straightforward. Moreover, where a translator of written discourse deals with the lexical, syntactic, pragmatic and discourse levels of text, the dialogue interpreter must cope with the additional dimensions that live, real-time participants offer in particular contexts (see Hatim and Mason 1990).

In the case of Goffman's description of interactional moves, a question for the dialogue interpreter might be this: has the move that was intended by the originator of an utterance been conveyed appropriately? And if so, what has this done to the various levels of linguistic equivalence? Or if not, how can the interaction continue, when interactive discourse, as Goffman points out in this classic, is built by participants move by move? While it might be argued that moves can also occur in written discourse, the dialogue interpreter does not have the luxury of a text that has been completed from beginning to end. Interactive discourse is a jointly negotiated process that participants engage in, and though many professional codes of ethics for dialogue interpreters suggest otherwise, dialogue interpreters are, as Wadensjö (1992) points out, centrally involved in this negotiation process (see, for example, Roy (1989) for a study of an interpreter's role in turn exchange).

The fact that dialogue interpreters have a unique participant status is also indirectly addressed in Goffman's chapter entitled 'Footing'. In this chapter (chapter 3), he describes the relationship between participants in interaction. By examining the role of all individuals present in interactions, he makes it clear that even unaddressed bystanders can have an impact on the unfolding of interactive discourse.

In his discussion of participant roles in interactive discourse, Goffman extends the notion of 'speaker-hearer', once presumed to represent the status of interlocutors in interaction. And although it would be easiest to develop a relatively simple structure (such as speaker-hearer) to describe interaction, he attempts, instead, to characterize the dynamic and ever-changing relationships between interactants and the discourse itself. He does this by focusing on the production and reception of utterances. With regard to production, he proposes that the term 'speaker' implies that an individual is animating their own words, ideas, and positions, whereas this might not be the case. For example, when an individual reads a paper at a conference presentation for a colleague who is unable to attend, the reader is animating words but the ideas and positions are not their own. Goffman provides numerous examples of the ways in which a 'speaker' can fulfill one or another, rather than each, of these roles.

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This clearly has relevance for interpreters, whose professional responsibility it is to animate in a second language the ideas and positions of others. Hence, a dialogue interpreter is constantly shifting back and forth between these three aspects of being a 'speaker', sometimes animating the words of one participant, sometimes those of another, and still at other times giving voice to ideas and positions of their own (for example when explaining something about the interpreting process to other participants).

This is the basis for Goffman's production format, in which he divides the notion of speaker into three roles, based on distinguishable characteristics. An *animator* is a speaker who functions essentially as a "talking machine" (p. 144). An *author* is responsible for originating the content as well as the form of an utterance. The individual who is responsible for or committed to what is being said is the *principal.* It is clearly possible for a dialogue interpreter to animate the words of another. Nevertheless, when an interpreter is not the originator of the content of an utterance (a rendition), they are still responsible for the form of the utterance, since they render it into a different language. Moreover, it is also possible for them to behave as *principal*, uttering words of their own. The implication for research into dialogue interpreting is that we can use Goffman's taxonomy of speaker roles to examine in greater detail how interpreters function in various types of interactive settings (see Wadensjö 1992, Metzger 1995, forthcoming).

Erving Goffman's *Forms of Talk* provides important insights regarding the structure of interactional discourse. In addition, by adopting a sociological point of view, it deepens our understanding of the nature of such encounters. Ultimately, these are the reasons why Goffman's work is still considered to be a classic today. And perhaps even more importantly for the purposes of this volume, these are the reasons that Goffman's work is so critical to both the theoretical and the empirical foundation of dialogue interpreting.

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Interpreters in Emergency Wards

An Empirical Study of Doctor-Interpreter-Patient Interaction

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Abstract. *This paper explores interpreting practice in the field of emergency medicine. The analysis is conducted on a corpus of tape-recorded interpreter-mediated encounters between the medical staff of an Italian hospital and English-speaking tourists. The specificity of the setting – an Accident & Emergency Ward – where patients are not members of a minority community, but feel nonetheless vulnerable because the emergency has occurred away from home, as well as the unusual profile of the interpreters who are employed on a seasonal basis as "administrative assistants", make this study an atypical investigation into public service interpreting. Through the use of different theoretical approaches – from Fairclough's distinction between powerful and non-powerful participants, to ten Have's notion of phase-specific conversational patterns, to Hall's theory of contexting – it is demonstrated that asymmetry in medical encounters is the product of a complex set of factors. More specifically, it is a shifting variable which is locally and interactionally determined through successive turns at talk by all interlocutors, doctor, patient and interpreter alike. The latter, in particular, is seen to behave as a fully-fledged social actor who makes independent choices on the basis of his or her assessment of the goals and requirements of the ongoing activity.*[1]

1. Introduction

This study is part of a wider research project designed to build a corpus of audio-recorded dialogue interpreting sessions taking place in a variety of professional fields – from healthcare to immigration services and business negotiations – which can serve as an empirical basis for investigation of real-life interpreting practices. Given the confidential nature of most of these face-to-face encounters and the consequent difficulty in obtaining authorization to record them, to date, relatively few analyses have been conducted

[1] I am indebted to Diana Unfer for the time and energy she spent in collecting the data. Without her enthusiastic commitment, this study would not have been possible.

on transcribed interpreted interactions.[2] In an attempt to contribute to this area of research, the present discussion explores the behaviour of participants in medical encounters from the point of view of their contribution to and control over the ongoing activity. Taking as a starting point the by now largely accepted and documented view of the dialogue interpreter as an active participant in the interaction,[3] the following analysis will show how the interlocutors' moment-by-moment decisions concur to shape the structure of discourse at the various stages of the communicative event.

2. The setting and the data

The data for this study were collected over a one-month period – July 2004 – by a student interpreter who worked under my supervision, Ms. Diana Unfer.[4] Since ensuring the anonymity of both the facility and the staff involved in the encounters was a *sine qua non* condition to obtain the authorization to record, it will only be said here that the setting is a National Health Service hospital, located in a popular tourist destination, a seaside resort in Northern Italy, which, every summer, attracts large numbers of holidaymakers from the United Kingdom, as well as from other countries of northern, central and eastern Europe. Given this seasonal inflow of foreign visitors, the local health authorities operate every year, from May to September, an additional Accident & Emergency Ward specifically reserved for tourists (*Ambulatorio di Medicina Turistica*) within the Casualty Department of the general hospital.

Posts for "Administrative Assistants-Interpreters" are usually advertised every two years, following an assessment of the previous years' needs in terms of number of staff and languages required.[5] The job title is deliberately

[2] For a review of past studies on recorded interaction in the field of medical interpreting, see Bolden (2000). More recently, three full-length monographs have appeared – namely Angelelli (2004); Meyer (2004) and Bot (2005) – which draw on extensive corpora of recorded data.

[3] See Wadensjö's (1998) seminal work on the multi-faceted nature of interpreters' conduct in face-to-face interaction.

[4] Her unpublished dissertation (Unfer 2003-2004) offers a detailed, first-hand description of both the professional setting and the recorded data.

[5] The hospital in question has been operating the interpreting service for more than 15 years and is currently participating in an EU-wide research programme, which focuses on enhancing communication between medical staff and foreign patients. At the end of each consultation, the latter are routinely asked to fill in a questionnaire to evaluate the quality of the information they received through the interpreter. The results of the survey will be used to critically assess and improve the interpreting service.

chosen to indicate that successful applicants will be asked to perform a series of administrative tasks alongside the interpreting one, such as hospital reception work, filing patients' details, providing information on services, procedures and payments, etc. Requirements for the post make no specific mention of academic qualifications in either translation or interpreting. The selection is carried out through an interview which is designed to test the applicants' knowledge of the foreign language(s). The successful candidates are then recruited on a seasonal basis for a period of 5 months. On-the-job training is provided, but only in the administrative field.

From a practical point of view, it is interesting to note that interpreters wear the same white uniform as the medical staff and could easily be mistaken for bilingual nurses by foreign patients, and all the more so because they prepare the patients' case notes, inquiring about the nature of the complaint, and sometimes even about the symptoms, before ushering them into the doctor's room. At the end of the consultation with the doctor, interpreters are once again left to deal on their own with the patients, to give them technical instructions, or simply direct them to another hospital facility or to the closest chemist. We will see that this perception of the interpreter as a member of the medical staff has an impact on the interaction.

The recorded sessions involved the following participants. The interpreters were two young women with a degree in foreign languages; they have been renamed here Tina and Teresa (i.e. names beginning with T for tourism). Out of the 9 encounters, Tina interpreted 6 (T.1, T.2, T.3, T.6, T.7, T.8) and Teresa 3 (T.4, T.5 and T.9). The doctors were all male. The patients, or at least one of the parents in the case of children, spoke English, although only in 4 cases were they British nationals and native speakers of the language. The remaining patients came from Poland (2), Denmark (2) and the Netherlands (1).

Table 1 offers a schematic illustration of the encounters. Sessions 1 to 5, highlighted by means of shaded cells in the table, will provide the exemplification for the present discussion. All the complaints reported by the patients were either minor injuries or minor ailments. Aside from the requirement of anonymity, this was the only limitation imposed on the observer, who was not allowed in the room when more serious cases were being dealt with.

Place	A&E Ward for Tourists, Italian NHS Hospital		
	Transcript 1 (T. 1)	Transcript 2 (T. 2)	Transcript 3 (T. 3)
Date	14 July 2004	14 July 2004	22 July 2004
Duration	10' 49"	6' 31"	14' 27"
Interpreter	Tina	Tina	Tina
Patient	Polish baby girl with her parents	English woman	English woman
Complaint	High temperature and red dots	Eye problems	Swollen ankles
	Transcript 4 (T. 4)	Transcript 5 (T. 5)	Recording 6
Date	27 July 2004	27 July 2004	19 July 2004
Duration	6'	11'	6' 22"
Interpreter	Teresa	Teresa	Tina
Patient	English girl with her parents	Polish baby boy with his parents	Young Dutch woman accompanied by her employer
Complaint	Ear pain	High temperature	Sore knee
	Recording 7	Recording 8	Recording 9
Date	22 July 2004	22 July 2004	27 July 2004
Duration	9' 10"	14'	4' 35"
Interpreter	Tina	Tina	Teresa
Patient	Danish boy with his parents	Young Danish woman	Young English man
Complaint	Nasal herpes	Stiff neck	Sore throat

Table 1: The recorded sessions

3. The medical encounter in an Accident & Emergency (A&E) Ward

Following the literature on doctor-patient interaction (see, e.g., Byrne and Long 1976; Heath 1986; Waitzkin 1991) the typical phase-by-phase structure of a medical encounter can be represented as follows:

1. opening
2. complaint presentation
3. verbal and physical examination
4. delivery of diagnosis

5. prescription of treatment and/or advice
6. closing

Within this conventional framework, ten Have (1991:151) suggests classifying sequences of talk, which he calls "episodes", according to their higher vs. lower "conversational quality", i.e.:

- type 1 episodes, in which non-medical topics are discussed;
- type 2 episodes, which have to do with medical topics that are relatively marginal to the main agenda of the consultation;
- type 3 episodes, in which the main medical agenda is explicitly developed.

In the opening phase of an encounter, parties usually engage in small talk (type 1 episodes) to establish a relationship. Type 1 and type 2 sequences may also occur whilst a predominantly non-verbal activity is being performed, such as the physical examination. Type 2 episodes tend to concentrate mainly towards the closing of the encounter (stages 5 and 6 above), as the patients may want to "clarify any residual matters" following the physician's "exposition" of the diagnosis (Tebble 1999:185), or "elicit some minor medical advice or submit some medical idea of their own, even if it is not related to the major agenda" (ten Have 1991:151). Type 3 sequences, on the other hand, are usually characteristic not only of the announcement of the diagnosis, but, prior to this, of the verbal stage of the data-gathering activity, otherwise known as history taking (or, in medical jargon, differential diagnosis).[6] This phase, which is the least "conversational" in nature, normally entails a question-answer pattern tightly controlled by the doctor, where patient-initiated topics are largely dispreferred.

Before discussing the notion of asymmetry in the questioning format, let us briefly consider the features which differentiate consultations concerning minor injuries and ailments in an A&E Ward, in particular those involving foreign patients, from similar events occurring in other healthcare settings. Unlike in the case of the "informing interview" (see Maynard 1991, 1992), when doctors meet again with patients, after the latter have gone through a series of examinations, to present the findings and deliver a final diagnosis, the doctor-patient encounter in an A&E Ward is by definition an emergency consultation. When the complaint is a minor one and the condition of the

[6] For extensive bibliographical references on the process of differential diagnosis, see Bolden (2000:393).

patient enables him[7] to interact with the medical staff, the encounter will typically proceed from stage 2 through to stage 6, unless the physician requires specific tests – for instance, an x-ray – and refers the patient to the relevant department, thus stopping at stage 3. In either case, the core activity being performed in this context, prior to the emergency treatment (which may be either prescribed or delivered), is the gathering of information through questioning and physical examination.

The emphasis on this phase of the interaction is further reinforced by the fact that patients and doctors are unknown to each other. This means that there is no medical history on which the doctor can base his assessment of the patient's problem, and that the production of a focused historical account becomes fundamental to the forming of an accurate diagnosis.

The urgent nature of the medical condition on the one hand, and on the other the large number of requests which must be handled especially in the summer season impose a fast pace on the encounter, where the occasion for small talk is drastically reduced, introductions are brisk and rapport-building is considered non essential. To go back to ten Have's classification, this means that type 1 episodes are either totally absent or, much less frequently, confined to the physical examination.

If we now consider the case of foreign tourists who do not speak the language of the country they are in, who, whilst on holiday, are faced with a health problem affecting either themselves or their children, who are far away from home and are unable to consult the family doctor, we can easily understand how much more vulnerable these patients must feel in a situation which is naturally stressful. Although this interactional scenario is hardly comparable to the conventional image of a community interpreting framework, where the hierarchical configuration of the participants' roles, naturally stemming from their unequal knowledge, is heightened by a marked status differential (the service users are in this case immigrants and refugees), the psychological dependence on the interpreter can be assumed as a typical trait of this kind of interaction too.

4. Asymmetry vs. symmetry in medical interviews

As ten Have observes (1991:140), when set against the benchmark of ordinary conversation among peers, doctor-patient communication exhibits

[7] In the remaining discussion, doctors and patients will be conventionally referred to as 'he' and interpreters as 'she'.

at least two kinds of asymmetries. First, there is an asymmetry of topic, given that it is the patient's condition that is under examination and not the doctor's. Second, there is an asymmetry of knowledge and therefore of tasks, whereby the patient reports the complaint, answers questions and accepts the doctor's decisions, while the doctor listens to complaints, elicits specific information, makes a diagnosis, and prescribes treatment. This means that, apart from the initial decision to consult a physician and request treatment, the patient loses the initiative early on in the encounter, and the doctor takes over as the dominant party, by controlling the question-answer format.

Investigating interactional behaviour in terms of turn-taking and topic development, researchers have found that moves such as questions, which establish a conditional relevance for specific kinds of actions (i.e. answers), are mostly taken by doctors and seem to be dispreferred when taken by patients. Fairclough (1992:153) argues that this interactional dominance by the doctor results from an asymmetrical and institutionally determined distribution of "talking rights and obligations"[8] between "powerful" (P) and "non-powerful" (N-P) participants, whereby: "(i) P may select N-P, but not vice-versa; (ii) P may self-select, but N-P may not; [...] (iii) P's turn may be extended across any number of points of possible completion". What this means in practice is that the patient usually takes the floor when the doctor offers it by asking him a question. The doctor, on the other hand, is not given the floor but takes it when the patient has finished answering the question, or when he decides that the patient's response has become "irrelevant" to a strictly medical assessment of his problem. In the latter case, overlaps may be used by the doctor as a device to cut short the patient's turn. A corollary of this organization is to do with topic control. It is the doctor who introduces new topics through his questions, "polices the agenda" – the expression is again Fairclough's (*ibid.*:155) – by simply acknowledging the patient's answer without commenting on or assessing it, changes topic abruptly, or else stays on topic by reformulating a question which he thinks has not been satisfactorily answered.

This asymmetrical model is contrasted by Mishler (1984) with a more

[8] Drew and Heritage (1992:22) clarify that, in institutional interaction, acceptance of, or rather, adherence to "special and particular constraints on what one or both of the participants will treat as allowable contributions to the business at hand" depends on their orientation to the goals, tasks and identity of the institution in question.

symmetrical interactional format – which the author sees as morally superior and professionally more effective – where the doctor swaps the normative "Voice of Medicine", with its assertiveness, scientific objectivity and affective neutrality, for the "Voice of the Lifeworld", thus displaying a high degree of attentiveness to the patient's understanding of his problem and to his communicative needs. The effect of this alternative conversational style is that turn-taking is more collaboratively managed and topic development more extensively negotiated by the two participants. Although both Mishler and Fairclough explore the possibility of analyzing the same interaction in terms of conflict and struggle between the two voices, with the VoL intruding on the doctor's agenda, they nonetheless seem to imply that the shift in conversational models is made possible primarily by the doctor's willingness to make the floor available to the patient. Fairclough's words (1992:146) are unequivocal:

> Notice that the initiative for yielding a measure of control to the patient in medical interviews of this sort invariably comes from the doctor, which suggests that doctors do still exercise control at some level, even if in the paradoxical form of ceding control.

Looking at doctor-patient interaction from a different angle and explicitly rejecting the notion that asymmetry is simply an effect of institutionalized power relationships, ten Have (1991) suggests considering interactional control as a variable of the specific phase in the interaction. Whereas the patient has limited possibilities for requesting information during the questioning sequences of history taking, his interventions appear to be more acceptable in other phases, for instance during or after the discussion of treatment (see section 3 above).

Whilst accepting both perspectives as promising analytical tools, we would contend that equal attention needs to be devoted to the patient's conduct as a crucial factor in deciding the extent of the doctor's domination on the interaction. Building on the above-mentioned notion of a conflict of voices, what is suggested here is that the selection of a more assertive style by the patient – which may be due to personality, medical knowledge or cultural models – may act as a powerful counterweight to institutionally determined or even phase-specific asymmetries. For the purposes of the present study, let us consider in particular the impact that cultural patterns may have on interactional behaviour. Hall's theory of contexting (1976, 1983) offers an interesting paradigm to assess an individual's communicative

style in terms of his or her reliance on explicit information (text) versus implicit information (context), as dictated by the conventional orientations of the culture he or she belongs to. The author's basic distinction between high- and low-context cultures has since been expanded to include other sets of related dichotomies – i.e. direct vs. indirect, and egalitarian vs. hierarchic. Figure 1 below, which is a slightly modified version of the contexting cline suggested by Victor (1992:143), shows the positioning of the three cultures, namely Italian, British and Polish, involved in the encounters discussed in this paper.

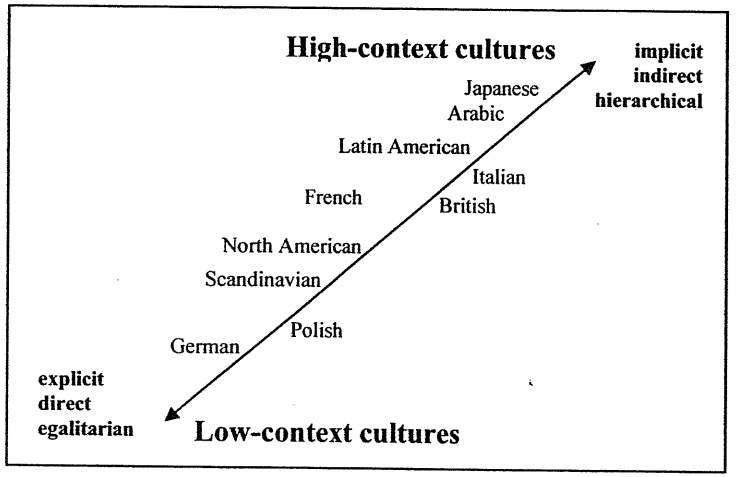

Figure 1: Contexting cline

Whilst the Italian and British cultures are somewhat closer to the Japanese end of verbal restraint and hierarchic positioning, than to the German preference for explicitness and egalitarianism, the Polish culture – which has been added to the cline following Goddard and Wierzbicka's (1997) description of Polish discourse style – endorses extreme frankness and directness. Given the marked distance between these culture-specific interactional models, a third line of investigation will thus be pursued in the analysis of the recorded sessions. This will be done in full awareness that the limited number of cases under examination cannot obviously be taken as supporting evidence for the validity of theoretical assumptions about culturally divergent patterns of interaction. Cultural modelling will be used here as a supplementary

tool, to offer possible explanations of the patients' interactional behaviour, besides personal inclinations and preferences.

If one moves from monolingual settings – either culturally homogeneous or heterogeneous – to linguistically mediated encounters, the picture becomes even more complex, given that the interpreter, who is usually the sole bilingual, is in a somewhat unique position to control the content, direction and organization of the verbal exchange. Depending on her reproduction or modification of the participants' normative orientations or interactional styles,[9] the encounter can be expected to develop along different pathways and produce more or less symmetrical configurations.

5. Analysis of the data: who leads?

In the following analysis, examples will be organized into three sections according to the party who is monopolizing the initiative at that moment. We will start from sequences where the doctor controls the question-answer cycles, the patient refrains from formulating requests and gives very short and factual answers, and the interpreter confines herself to translation acts. We will then move on to more marked interactional forms, where first the interpreter and then the patients (or their parents) are seen to deviate from their conventional roles.

5.1. The doctor leads

In T1 a Polish baby girl is taken to the emergency ward by her parents because she has had a high temperature for two days and some red dots have appeared on her body. In the following sequence the doctor is clearly seen to proceed through a pre-set agenda. He interrupts the interpreter, before she has finished translating the father's answer, to state his intention to examine the baby (line 128). He then disregards the father's attempt to explain that although the baby did not cry the night before, they as parents know that she is not feeling well (line 130), and asks the mother to hold the baby's head still, thus forcing the interpreter to translate his instruction instead of the father's comment. Lastly, he announces the diagnosis, i.e. an inflammation of the nose.

[9] See also Merlini and Favaron (2005).

[1] T. 1(121-133) [10]

121 D: **allora la bambina ha pianto durante la notte↑**
now did the girl cry during the night

122 I: did she cry during the night↑ ((the question is first addressed to the mother
123 who does not speak English then to the father)) did she cry during the night↑=
124 F: =no not at all=
125 I: =no not at all
126 F: she is rather silent because=
127 I: =è abbastanza silenziosa la bambina ┌>°non ha pianto°<
the girl is rather quiet │ *she did not cry*
128 D: └**va bene vorrei vedere un attimo questo**
alright I would like to examine this
129 I: ┌°she[11] wants to°
130 F: └we know that she's ill
131 D: **le tiene ferma la testa**
can you keep her head still
132 I: °could you keep please the head°
133 D: **va bene comunque la bambina ha in atto una una rinite**
okay in any case the girl has an inflammation of the nose

T2 presents the case of an English woman complaining of cloudy vision. The doctor, after asking a series of questions aimed at ascertaining the symptoms she is experiencing, changes topic abruptly, cutting short the interpreter's last sentence (line 55) in what had been a long-winded and laborious translation, where the lack of an English word ("shadow") had required the joint efforts of the doctor, who kept offering synonyms for the Italian word ("ombra"), and of the patient, who kept repeating the same concept over and over. Once order is restored, an unmarked sequence follows which sees the doctor regaining total control of the question-answer mechanism (line 57). As reported in the literature on medical interviews,[12] the doctor refrains from utterances indicating his information processing. He simply acknowledges the patient's answers through discourse markers such as *yes, mhm, okay*, and proceeds to check the patient's blood pressure, without any explanation (line 64).

[10] Examples are numbered progressively. The acronyms T. 1, T. 2, T. 3, etc. identify the transcript from which a given excerpt has been taken, whilst the numbers in parentheses refer to the place of the reported lines in the transcript. For easier reference, the latter also appear beside each line. Idiomatic translations into English of the Italian utterances are shown in italics. Features of interest are shown in bold. For the transcription key, see appendix 1.

[11] Here, the interpreter's use of "she" instead of "he" to refer to the male doctor is simply a slip of the tongue.

[12] For a review of studies on the physicians' uses of third turns, see ten Have (1991).

[2] T. 2 (50-67)

50 I: └insomma┘ lei vede una forma ner ┌a:=
so she sees a black shape
51 D: └sì
yes
52 I: =rotonda::
round
53 D: mhm
54 I: a black shape ┌round
55 D: └**okay okay**
56 P: yes round
57 D: **la signora soffre di ipertensione la signora↑**
does the lady suffer from hypertension
58 I: do you suffer from hypertension hypertension↑
59 P: no
60 I: no
61 D: **no ha preso qualche trauma al capo↑**
has she had any head trauma
62 I: have you got any:: any: trauma↑
63 P: ((shakes her head))
64 D. **no va be' intanto le misuro la pressione eventualmente**
no okay in any case I'll check her blood pressure
65 I: we check your pressure=
66 P: =okay=
67 I: =blood pressure

5.2 The interpreter leads

Let us now look at sequences where the translation mechanism – i.e., the conversion of each original utterance into an equivalent utterance in the target language – is dropped, and the interpreter is seen either to respond to a primary interlocutor or to take the initiative by introducing new topics. As was previously said, the first person foreign patients meet when coming to the emergency ward is the interpreter, who takes down their names and inquires about the nature of the complaints. It is, therefore, not surprising to see the interpreter introducing the patient and her problem at the beginning of the session, as shown in the following example:

[3] T. 3 (1-7)

1 D: sì
yes

2 I: **le si è gonfiato un po' le caviglie↑**
her ankles are a little bit swollen

3 D: come si chiama la signora ↑
what's the lady's name

4 I: **S. ((spells the surname))**
5 D: sì (.)la signora soffre di ipertensione ↑
yes does the lady suffer from hypertension

6 I: umm suffer do you suffer hypertension↑
7 P: no

Equally natural is the interpreter's attempt to engage the 7-year old British girl in T4, whom she has already met in the waiting room, in a brief conversation so as to make her feel a bit more relaxed while the doctor is examining her ear:

[4] T. 4 (16-21)

16 D: si siede qua un attimo↑
would she come and sit here

17 ((the doctor starts examining the girl))
18 I: **°how old are you C.↑°**
19 P: °seven°
20 I: °seven°
21 D: è la prima volta che le capita ┌ questo problema↑ ┐
is it the first time that she has had *this problem*

Whilst autonomous initiatives of these kinds are almost negligible when occurring in type 1 episodes, which are characterized by a marked conversational quality, in type 2 and type 3 episodes, the interpreter's attempt at controlling the interaction may have more serious repercussions. Going back to T3, as the doctor examines the British woman's ankles, Tina, the interpreter, first addresses the latter to comment on her symptoms (line 53), then re-expresses her opinion in Italian (line 55), thus inviting the doctor to respond by selecting him as next speaker:

[5] T.3 (53-56)

53 I: °do you think they are very swollen or (.) they don't seem to be very swollen ( )°
54 P: ┌yeah o-on ( )
55 I: └non sembrano tanto gonfie=
they don't look so swollen

56 D:=un pochino qua mi sembra un po' gonfie qua
a little bit here I think they are a bit swollen here

In sequence [6], the doctor's later remark, i.e. that the swelling of the left ankle is visibly due to an insect bite, is mistranslated by Tina as a diagnosis for the overall problem (line 96), to which the patient understandably asks whether the puncture on the left ankle can be the cause of the swelling in

both ankles. Instead of translating back the patient's question, Tina self-selects as primary interlocutor and reiterates the diagnosis; interestingly enough, at this point she switches from reported speech ("in his opinion he says…") to the first person plural to associate herself with the diagnosis, thus projecting the idea that she is part of the medical staff (lines 98-99). The hesitations in her utterance are, however, an indicator that she sees the point the woman is trying to make. In her next turn, she therefore checks again with the doctor whether he thinks that the swelling might be caused by the insect bite. Unfortunately, she then sticks to the same statement (lines 106-107) instead of translating the doctor's intention to check the patient's pulse. It will take many more turns before the woman is explicitly told that the problem might derive from her high blood pressure.

[6] T.3 (94-107)

94 D: └qua si è gonfia:ta > perché la signora < è stata punta da un
here it is swollen because the lady was bitten by an

95 insetto sicuramente
insect for sure

96 I: **in his opinion he says you have been bitten by an insect**

97 P: and would that make both ankles to swell↑

98 I: **yes we-w- yes we suppose >this is the< the reason why you are why your**

99 **ankles are so swollen**

100 P: right

101 I: tu pensi che sia così gon┌fio↑=
do you think it is so swollen

102 D: └è molto probabile
it's very likely

103 I: ┌il polso↑
her pulse
└=per una puntura
because of the puncture

104 d'INSETTO↑
of an insect

105 D: perché il problema circolatorio adesso le misuro anche la pressione ┌però il polso
because the circulation problem now I'll also take her blood pressure *yet her pulse*

106 I: └**yes he**

107 **probably says you have been bitten by an insect**

In T2, the interpreter's behaviour is potentially dangerous for the patient's health.[13] The interaction has reached the stage in which the doctor is formulating a possible diagnosis, a detached retina, and decides to refer the patient to an eye specialist (lines 68-69). In subsequent sequences, and up

[13] For an in-depth discussion of this session, see Merlini (2007).

to the very end of the encounter, this diagnosis is never once translated into English for the patient, who is only told that she needs to see some specialist (lines 82 and 84). Tina is repeatedly found to shift topics and use her translation slots to interact as a powerful primary interlocutor with either the patient, as in [7], or the doctor, as in [8] and [9]:

[7] T. 2(68-84)

68 D: eventualmente la mandiamo a fare una visita urgente specialistica da un oculista
possibly we should make an urgent appointment for her to see an eye specialist

69 perché potrebbe essere un distacco della retina °per cui° adesso vediamo
because it could well be a detached retina so now

70 I: **so please sit here (.) how long are you** ┌**staying↑**
71 D: └>dove la mandiamo↑<=
where shall we send her

72 P: ┌( )
73 D: └>dove la mandiamo a XX ┌X[14]<↑
where shall we send her to XX │*X*
74 P: └back home on Saturday °go home on
75 Saturday°
76 D: può stare seduta
you can sit down

77 I: you can sit
78 D. >sit down<
79 I: yes sit down here yes just-just NOW sit può star seduta vero:↑ (.) **relax yourself**
she can sit down can't she

80 **don't worry**
81 P: ((smiles))
82 I: maybe you need a specialist to visit you
83 P: all right
84 I: you need you need to be visited by a specialist ( )

An interesting feature, aside from the patient's submissiveness (lines 81 and 83), is Tina's attempt to reassure her ("relax yourself don't worry", lines 79-80), which may indicate that the non-translation of the diagnosis is a deliberate choice on her part not to frighten the woman. This interpretation is further supported by a reiteration of the reassuring utterance a few exchanges later, as shown in excerpt [8], line 107. The sequence also contains an aside initiated by Tina, who asks the doctor to comment on the

[14] The 3 X's stand for the name of a nearby hospital.

blood pressure reading she has just translated into English (line 97), without then conveying his answer to the patient, who is left with a meaningless string of numbers:

[8] T. 2 (95-107)

95 ((the doctor checks the patient's blood pressure))
96 D: (novanta) centoquarantanove
ninety one-hundred and fortynine

97 I: ninety one-hundred and fortynine **e com'è quindi**↑
how high is this then

98 D: leggermente altina quanti anni ha la signora↑
slightly high how old is the lady

99 I: what how old are you↑
100 P: fiftythree
101 I: fiftythree ((smiles)) cinquantatré
fiftythree
102 D: cinquantatré
fiftythree
103 I: yes
104 D: >sentiamo un attimo il cuore<
let's listen to the heart
105 I: °he wants to check to check your heart° (.) deve togliersi la [maglietta↑=
does she have to take off her T-shirt
106 D: [°sì°
yes

107 I: = YES >you have to ( )< **°don't worry°**

In [9], as the consultation is coming to a close, Tina is seen to interrupt a primary speaker and shift topics, thus exhibiting once again the behaviour of a powerful participant in Furlough's (1992) terms. Instead of translating the doctor's reiterated indication that there might be some problem with the woman's retina requiring urgent attention, she asks him to confirm the hospital facility where the patient is to be sent (line 123), and then concentrates on practical details as to the way in which the latter can reach it.

[9] T.2 (120-131)

120 D: l-l'iride è normale il riflesso della pupilla è normale però e:videntemente
the iris is normal the pupil reflex is normal but clearly

121 potrebbe esserci qualcosa a livello della retina personalmente: io la mando a fare
there might be something wrong with the retina personally I would have her

122 una visita [specialistica=
examined by a specialist
123 I: [**°allora la mandiamo a XXX:↑°**
so shall we send her to XXX

124 D: =urge:nte: da un oculista
an eye specialist through an urgent appointment

125 I: **okay (.) you have two choices (.) first possibility you're going to drive to XXX**
126 **have you got a car↑**
127 P: no
128 I: °no niente macchina okay° so you can't go to XXX because we are
no car okay

129 all together the same hospital and we don't have the the: specialist here you have
130 to go to you have to drive to XXX OR you can go to private o può andare da
or she can see a

131 un privato
private doctor

Sequences [6] to [9] are clearly more of an example of how the interpreter can actually mislead rather than lead the conversation. In the following section, we will see how this incomplete and highly incoherent set of instructions spurs the British woman to change tack.

5.3 The patient leads

The sequence discussed above continues with a series of questions posed by the woman who is clearly concerned about her health and probably scared by what she perceives as a reticence to break bad news:

[10] T.2 (132-157)

132 P: **is it urgent is it urgent↑**
133 I: yes the doctor says it's urgent=
134 P: =urgent ((she turns to the doctor for confirmation))
135 D: sì ((whispered))
yes

136 P: [[**where's**] **X-=**
137 I: [facciamo:]
let's

138 P: **=where's X- where's this place X-↑**
139 I: >XXX< but come here sit down here
140 P. **(my pressure)**
141 I: it's light high than usual è un po' dico lievemente [più elevata
shall I say it is a bit higher
142 D: [sì::
yes

143 I: just a little bit
144 D: =centoquarantanove su novanta diciamo [>dunque< considerando l'età:↑
one-hundred and forty-nine over ninety so considering her age
145 I: [one-hundred and forty-nine over

146 ninety
147 P: **my heart is okay↑>my heart is okay<↑**
148 I: il suo cuore è a posto↑
is her heart okay

149 D: sì il cuore è a posto però il solito [problema:] che può essere correlato ( )=
yes her heart is okay but this *problem* *is usually related*
150 I: [°it's okay°]
151 D: =al momento >comunque< la pressione non è preoccupante=
at the moment however her blood pressure is not worrying

152 I: =mhm=
153 D: =certo è che:: sarà meglio che insomma che sia vista da un medico °perché°
in any case she'd better be examined by a specialist because
154 deve esserci un problema all'interno dell'occhio ehm un problema vascolare
there must be a problem inside the eye a vascular problem
155 °(all'interno dell'occhio)°
inside the eye

156 ((interpreter and patient exit the room; the interpreter makes the appointment
157 with the eye specialist and explains to the patient how to reach the other hospital))

Although, as stated earlier on, patient-initiated questions are more common in the closing stages of a medical encounter, here this typically unassertive British woman is driven to take the initiative not so much by the delivery of diagnostic news – since almost none has so far been given – as by the interpreter's behaviour. Tina's preoccupation not to alarm the patient has in fact had the opposite effect. Despite her questions, however, the patient will still leave the ward unaware that her eye problems might be due to as serious a condition as a detached retina (lines 156-157).[15]

Let us end this analysis with sequences where the parents of both the

[15] Investigating Spanish-speaking patients' knowledge of their discharge diagnosis at a public hospital emergency department in Los Angeles, Baker *et al.* (1996) found markedly lower subjective ratings of understanding for patients who communicated with the English-speaking healthcare personnel through an interpreter compared with those who thought an interpreter was unnecessary and did not have one. More specifically, 16% of patients for whom an interpreter was not needed and not used stated that the physician "did not say the diagnosis", compared with 29% for whom an interpreter was not used although the patient thought one should have been used, and 32% for whom an interpreter was used. In their attempt to explain the reasons why the assistance of interpreters did not improve the patients' understanding of their diagnoses, the authors point to suboptimal interpreting performances, resulting from the use of untrained interpreters, such as other hospital personnel or family members and friends. Although no such *ad-hoc* interpreters are involved in the present study, the lack of formal training in interpreting, particularly in professional ethics, is an underlying concern in our case too.

Polish baby girl (T.1) and the Polish baby boy (T.5) are seen to consistently introduce new topics throughout the two encounters. Only a few exchanges into the data-gathering phase (type 3 episodes), the father of the baby girl offers unasked-for information, as in the following example, where he self-selects as next speaker and starts producing a full account of the previous day, even though the doctor was still inquiring about the dose of Ibuprofen that had been administered to the girl to bring the temperature down:

[11] T. 1 (30-44)
30 D: e gli ha dato quanti millilitri↑
and how may millilitres did you give her

31 F: [[two point two point five]
32 I: [due punto cinque] ogni sei ore ha detto due virgola cinque
two point five *every six hours he said twopoint five*

33 °milligrammi° ogni sei ore
milligrams every six hours
34 ((background noise))
35 F: **and in the night in the night=**
36 I: =yes=
37 F: =we were on the beach after uh afternoon because he we asked if we can go=
38 I: =°mhm°=
39 F: =outside ( ) so we were afternoon on the beach=
40 I: mhm
41 P: =there were no: higher [temperatures
42 I: [ah so you-you-you went to the beach with the
43 child↑
44 P: yes

A few exchanges later, as the doctor is asking to examine the red dots on the baby's body, the father intervenes again to inform him that his child has an allergy:

[12] T. 1(85-91)
85 D: [[va be' vediamola un attimo
okay let's have a look at her
86 I: [°e un'altra sulla schiena°
and another one on the back

87 F: **she's she's an allergician but umm**
88 I: s-she's a↑
89 F: al-aller she has a-an allergy=
90 I: =which one↑=
91 F: =of the milk

Similar instances of interactional control are also found during the doctor's prescription of the therapy at the end of the physical examination.

In [13], seeing that only the temperature problem has been addressed (lines 150-151), the father brings the discussion back to the red dots, thus inviting the doctor to have a closer look at the baby:

[13] T. 1(150-157)

150 D: allora umm per il momento l'unica cosa da fare >se vuol tener la bambina< è
now for the time being the only thing you can do can you hold the baby still is

151 quella di fare una terapia antifebbrile dandogli l'ibuprofene
to treat her with Ibuprofen for fever relief

152 I: what we can do now is a therapy against ┌ the fever and=
153 F: └against the fever
154 I: =that's all
155 F: **mhm mhm and the dots↑**
156 I: e queste macchioline che dice perché è venuto principalmente per quello
and what about the dots because he says that he's come here mainly for them

157 D: sì sì eh le macchioline vediamole meglio un attimo alla luce
yes yes the dots let's have a better look at them by the light

The father's direct and explicit questioning goes on right to the end of the encounter, when the interpreter has already started dealing with the paper-work formalities, as the sequence 14 shows:

[14] T. 1(243-248)

243 I: devo stampare↑ venticique e ottantadue nòn hanno titolo
shall I stamp twenty-five eighty-two they have no title

244 F: **air conditioned can we use in the room↑ air conditioned can**
245 **┌we use (in the room)**
246 I: └possono usare l'aria condizionata
can they use air conditioning
247 D: [nella stanza↑
in the room
[ecco meglio evitare
no better not

248 I: it's better to avoid it (.) for the moment all right↑

(257-259)

257 F: **and vitamin vitamin C**
258 D: vitamina se vuole
if he wants to give her the vitamin
259 I: [gliela può dare
he can
[yes these vitamins you can

The same interactional style is displayed in T5 by the mother of the Polish boy. Our last example is taken once again from the closing phase of the consultation:

[15] T. 5(168-184)

168 D: il modello centoundici
the one-hundred-eleven form

169 I: you have any copy of the: e one-hundred-eleven module so coz I left it in the
170 office
171 M: mhm
172 I: °just to see the ( ) thank you°
173 M: **and his throat is is is infected his throat↑**
174 D: è infiammata è infiammata
it is inflamed it is inflamed

175 I: it's inflamated inflamated
176 M: **inflamated and kind of angina or so↑**
177 I: °angina°
178 D: be' è angina ma per il momento non c'è non ci sono placche digli non ci sono
well it is angina but for the moment there are no plaques tell her that there are no

179 placche
plaques

180 I: there's not plaques inside the throat it's not plaques
181 M: **so it's not s-serious↑**
182 I: dice se è
she asks whether

183 D: no: [al] momento no
no [*for*] *the moment no*
184 I: [no]

Observation of sessions T.1 and T.5 would seem to reveal the above-mentioned orientation of Polish culture towards text-based, equal-to-equal communication (see section 4). This behaviour stands in stark contrast to the extremely low level of interactivity displayed not only by the two English women, but also by the English parents in T4. Throughout the latter encounter, which cannot be further exemplified owing to constraints of length, the couple never once take the initiative, and mostly confine their interventions to yes/no answers to the doctor's questions, clearly not out of inadequate knowledge of English. The fact that out of a 600-word interaction only 30 are uttered by the English parents (their seven-year-old child speaks only once to answer the interpreter's question about her age, as shown in [4] above) is particularly revealing.

6. Conclusions

The main theoretical concern of this paper was with the identification of those factors which can determine a higher or lower degree of interactional

control by any one of the participants in the medical encounter. We will therefore attempt to summarize the findings of our analysis by answering a series of questions.

Firstly, is asymmetry a function of the doctor's adherence to an institutionally determined distribution of talking rights and obligations? If in a monolingual encounter the doctor may decide to monopolize or else share his/her interactional power with the patient on the basis of his/her personal inclination towards a more or less empathic conversational style, in linguistically mediated communication his/her moves are necessarily dependent, at least in part, on the interpreter's translation choices and management of turns. Evidence of this was found in our sessions, where throughout the same encounter (see, for instance, excerpts from T.1 and T.2), the same doctor displays varying degrees of interactional dominance, as rapid and restrictive questioning alternates with more informally and cooperatively negotiated topic development.

Secondly, is asymmetry a function of a given phase in the medical consultation? As previously mentioned, the literature on medical communication indicates that patient-initiated questions are most strongly dispreferred in the data-gathering phase (type 3 episodes), whilst they are more acceptable after diagnosis and treatment have been announced (type 2 episodes). The analysis of our sessions has not produced unequivocal evidence of phase-specificity. Whilst in T.2 and T.5 patient-initiated questions did tend to appear towards the end of the encounter, in T.1 they were a constant feature throughout all the stages of the consultation, including history-taking.

Thirdly, is asymmetry a function of the patient's preference for directness vs. indirectness, possibly dictated by reference to prevailing cultural paradigms? A significantly higher concentration of patient-initiated questions and hence a less marked asymmetry were indeed observed in the encounters involving the Polish parents (T.1 and T.5), as compared with the generally passive interactional behaviour of the English participants. Although this may depend on an individual's disposition and character, rather than on adherence to a given cultural orientation, the latter hypothesis was thought to offer an interesting enough explanation, bar mere coincidence, for the recurrence of similar communicative styles in the two nationally diverse groups of patients, albeit in the restricted and statistically irrelevant confines of our sessions. At the same time, however, we have also seen a submissive British woman become progressively more assertive, as a consequence of information gaps in the interpreter's – not the doctor's – delivery of the diagnosis.

Fourthly and lastly, is asymmetry a function of the interpreter's independent assessment of the goals and requirements of the ongoing activity? Here, two different trends have been observed. On the one hand, a more empathic and less asymmetrical conversational model clearly emerged when the interpreter engaged in small talk with the patients, in particular during the physical examination. On the other hand, in less informal phases of the encounter the interpreter's attempts to exert interactional control often resulted in an increased asymmetry, as she topicalized the practical aspects of the doctor's utterances whilst leaving out more medically relevant information in the translations for the patient. This behaviour, which put the patient in a position of even greater knowledge inferiority, eventually led to a redressing of the imbalance, as the latter shifted to more assertive patterns. It is worth noting that this kind of asymmetry was recurrently found only in the encounters interpreted by Tina. This would further suggest that interpreters are fully-fledged social actors, who may have different perceptions of their roles and different views on how to organize their participation in a mediated encounter. Our study has shown that this may entail independent analyses and decisions as to what the patients should or should not be told. However, as Bolden (2000:415) warns, "given interpreters' lack of medical expertise, their interventions may have negative consequences on the quality of medical care received by patients".

To conclude, what seems to emerge from the preceding analysis is a complex interplay of different factors, which explains why symmetrical and asymmetrical configurations are in a state of constant flux within any communicative event, and are only partially determined by institutional norms or individual preference. In this view, interactional control is to be seen as a shifting variable, or rather as a "micro-political achievement, produced in and through actual turns at talk" (Frankel, in West 1984:95-96) by all interlocutors, doctor, patient and interpreter alike. The polymorphic nature of medical encounters, especially when occurring across linguistic and cultural barriers, is vividly depicted in the following quotation, which aptly summarizes the present discussion:

> Consultations are sometimes almost like conversations. At other times, they resemble interrogation. But mostly they are somewhere in between, zigzagging between the two poles in a way that is negotiated on a turn-by-turn basis by the participants themselves. (ten Have 1991:162)

APPENDIX: Transcription key

Symbols		Meaning
A	[[well I said	utterances starting simultaneously
B	[[Yes	
A	she's [right]	overlapping utterances
B	[huh mm]	
A	I agree=	latched utterances
B	=me too	
	(.)	untimed pause within a turn
	((pause))	untimed pause between turns
	↑	rising intonation
	wo:::rd	lengthened vowel or consonant sound
	word – word	abrupt cut-off in the flow of speech
	word	emphasis
	WORD	increased volume
	°word°	decreased volume
	>word<	quicker pace
	((word))	relevant contextual information; characterisations of the talk; vocalisations that cannot be spelled recognisably
	(word)	transcriber's guess
	( )	unrecoverable speech

Fillers		Meaning
English	*Italian*	
umm	umm	doubt
mhm	mhm	expression or request of agreement
ah	ah; eh	emphasis
eh	eh	query
uh	ehm	staller
oh	oh	surprise

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Role Models in Mental Health Interpreting

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Abstract. *In this paper, two frequently used models of interpreter and user cooperation are described: the translation machine model and the interactive model of interpreting. The paper provides a summary of observations made on the basis of some empirical data (extracted from videotaped interpreter-mediated psychotherapeutic sessions) with regard to the adherence of participants in the communication to these models. It concludes that the translation machine model is, in essence, an ideology, but that translation machine techniques are used in practice. It also concludes that the translation machine ideology denies the interactional realities of interpreter-mediated talk, which leads to the unwarranted assumption that interpreters actually make equivalent renditions that do not need any repair strategies. The interactional approach, however, leads to the questioning of the concept of equivalence and to the use of repair strategies in the practice of interpreter-mediated talk. This ultimately leads to the mutual understanding at which this type of talk aims.*

1. Introduction

In the Netherlands, most interpreters working in the social sector are engaged through the *Dutch Interpreter and Translator Centre* (TVcN). TVcN provides interpreters, i.e. professionals whose task is to translate the words uttered by the primary speakers – mainly healthcare providers, police personnel, lawyers, judges, and their clients – and who do not consider advocacy or cultural mediation to be part of their job. Interviewing some of these interpreters, the professionals using their services and some patients about "what aspects define the quality of interpreter-mediated dialogue" as part of my PhD research (Bot 2005), I observed, however, that within this paradigm – the interpreter as a performer of language transfer – people have different ideas about the actual involvement of the interpreter in the interaction.

I described the interpreter's roles according to two "*Ideal typische*" models: the interpreter as a "translation machine" and the "interactive

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Interpreting and Translating in Public Service Settings

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UNIVERSITÀ DEGLI STUDI DI TRIESTE
BIBLIOTECA SCUOLA SUPERIORE DI LINGUE MODERNE
S.B.A.

Edited by

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St. Jerome Publishing
Manchester, UK & Kinderhook (NY), USA

Published by
St. Jerome Publishing
2 Maple Road West, Brooklands
Manchester, M23 9HH, United Kingdom
Telephone +44 (0)161 973 9856
Fax +44 (0)161 905 3498
ken@stjeromepublishing.com
http://www.stjerome.co.uk

InTrans Publications
P. O. Box 467
Kinderhook, NY 12106, USA
Telephone (518) 758-1755
Fax (518) 758-6702

ISBN 978-1-905763-16-0 (pbk)

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Printed and bound in Great Britain by
TJI Digital, Padstow, Cornwall

Typeset by
Delta Typesetters, Cairo, Egypt
Email: hilali1945@yahoo.co.uk

British Library Cataloguing in Publication Data
A catalogue record of this book is available from the British Library

Library of Congress Cataloging-in-Publication Data
Interpreting and translating in public service settings : policy, practice, pedagogy / edited by Raquel de Pedro Ricoy, Isabelle A. Perez, Christine W.L. Wilson.
p. cm.
Includes bibliographical references and index.
ISBN 978-1-905763-16-0 (pbk. : alk. paper)
1. Public service interpreting. I. De Pedro Ricoy, Raquel. II. Perez, Isabelle, 1962-
P306.947.I58 2009
418'.02--dc22

2009011524

UNIVERSITÀ DEGLI STUDI DI TRIESTE
BIBLIOTECA SCUOLA SUPERIORE DI LINGUE MODERNE
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Interpreting and Translating in Public Service Settings

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Translation, interpreting and other forms of communication support within public sector settings constitute a field which deals, quite literally, with matters of life and death. Overshadowed for many years by interpreting and translating in other domains, public sector interpreting and translating (PSIT) has received growing attention in recent years, with increasingly mobile populations and human rights, diversity and equality legislation shining the spotlight on the need for quality provision across an increasing range and volume of activities.

Interpreting and Translating in Public Service Settings offers a collection of analytically-grounded essays by researchers and practitioners in both translating and interpreting and in the public sector. Against a backdrop of breaking down barriers in PSIT, it aims at providing new insights into the reality of the interaction in public sector settings and into the roles and positioning of the participants by challenging existing models and paradigms. Issues of local need, but with global resonance, are addressed, and current reality is set against plans for the future. The triad of participants (interpreter/translator, public sector professional and client) is investigated, as are aspects of pedagogy, policy and practice. Empirical data supports the study of topics related to written, spoken and signed activities in a variety of professional settings. The studies presented here point to a clear need for cooperation, as well as scope for collaborative developments, across professional boundaries and international borders. Indeed, new directions in research and practice will only be fruitful if all three groups of participants come together, as decisions regarding practice should be based on theoretical tenets underpinned by empirical research.

Bringing together academics and practitioners from different countries in order to explore the multidisciplinary dimension of the subject, this collection should serve as a valuable reference tool, not only for academics and students of public sector interpreting and translating, but also for practising linguists, providers of language services and policy makers.

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Healthcare Interpreter Policy: Policy determinants and current issues in the Australian context

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Abstract. Healthcare interpreter policy comprises both the written and the unwritten actions that affect the interpreter service, its structure, funding and service provision arrangements. A model of interpreter service policy is proposed which identifies the interactive policy determinants as being: interpreter provider factors, non-English-speaking (NES) patient factors, managerial factors. health system factors, stakeholder factors, factors associated with non-health sectors and evidence and research. Interpreter policy is viewed as being nested within multicultural and mainstream healthcare policy. Using this model, the article canvasses the range of factors currently influencing healthcare interpreter policy, discusses the evidence and research related to the effectiveness of current policy, and makes suggestions for future policy directions. Key policy directions suggested include: clarification of interpreter roles and responsibilities; taking action to maximise the service reach, scope and effectiveness; developing the cultural competency of healthcare providers; and improving the health literacy of patients with limited English proficiency. It is argued that these changes must be made with an overall healthcare interpreter policy context that defines the central concern as patient safety.

Keywords: interpreting; health care; health policy; immigration; welfare.

Interpreter Policy and the Policy Process

Policy and the policy process are highly contested terms. In the health context, Buse et al (2005) see policy as embracing

> 'courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system…. including policies made in the public and private sector.....and the actions external to the health system which have an impact on health.' (Buse et al 2005 p6)

Dye argues that policy is anything that governments choose to do or not do (Dye 2001), that is, that policy may be explicit or implicit (Folz 1995), written or unwritten.

Health policy also includes actions outside of the healthcare system that impact on health or health status (Palmer & Short 2000). For instance immigration policy changes supporting the immigration of people from sub-Saharan Africa, or small village communities from south-east Asia, has significant implications for the organisation, delivery and budgets of healthcare interpreter services, as the range and demand for cross-linguistic encounters increases and diversifies.

Policy can be seen as one of the key dimensions of the health system; others are resources, organisational structure, management and support systems, and service delivery (Janovsky & Cassels 1995 p12). Fundamental to policy analysis is the way power and influence are exercised and the way

societies and governments function (Buse et al 2005; Walt 1994). Thus, this model of interpreter policy highlights the important role of key stakeholders.

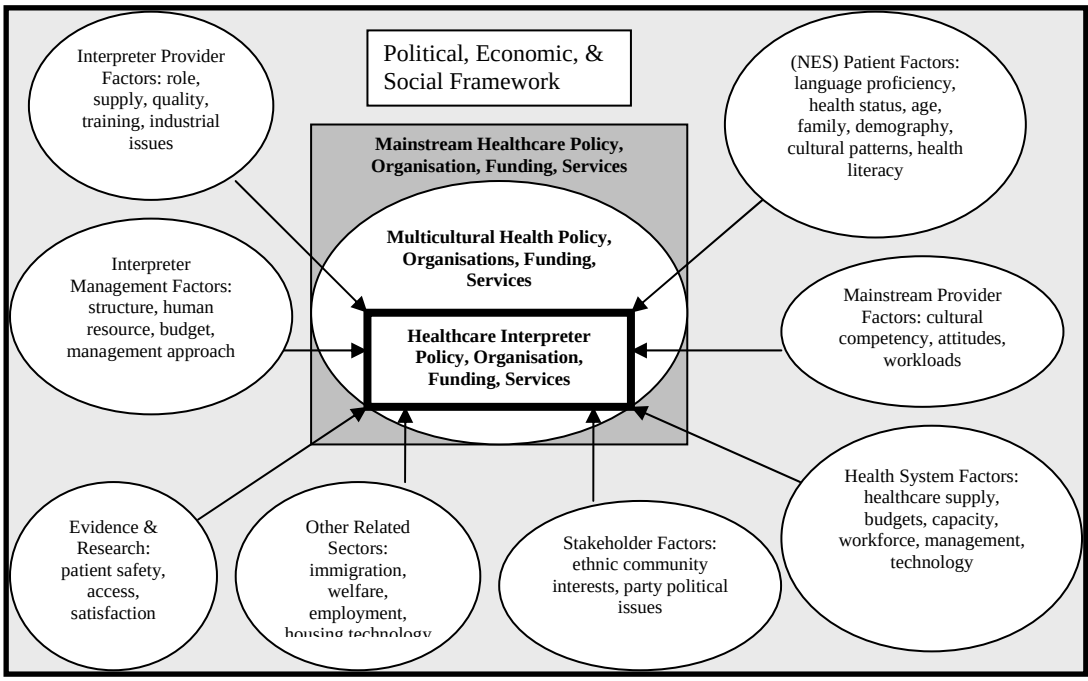

Figure 1: Model of Interpreter Policy in Healthcare

The Model of Interpreter Policy within Healthcare

The complex and dynamic nature of the interpreter health policy process is modelled in Figure 1. Interpreter policy operates within a context that is both defined and influenced by the broader political and social context. Thus attitudes towards immigration, immigrants, health and welfare social provision all (explicitly or implicitly) frame, mediate and influence interpreter service policy and provision. Healthcare interpreter policy is intertwined and nested within multicultural and mainstream healthcare policy. The interpreter service is a key multicultural service which promotes access to health services for people with limited English proficiency.

Many more direct factors may interactively influence or determine interpreter policy and service delivery. These include factors associated with the patients with limited English (including their language proficiency, beliefs, socio-cultural background, age, health status, family relationships), factors associated with interpreters (including their personal and socio-cultural background, interpreter supply, quality, accreditation and training), factors associated with the interpreter service management (budget, structure, management culture), factors associated with healthcare providers (such as their cultural competency, attitudes and workloads), healthcare system factors (such as budgetary constraint, service capacity, workforce supply, institutional culture), the advocacy and interests of key stakeholder groups (including ethnic community groups and party political groups), and the available evidence and research.

At the operational level, interpreting in healthcare is a complex communicative interaction between provider, interpreter and patients; parties which have unequal power relations and each of which has their own socially and institutionally mediated values, demands, beliefs, expectations and goals.

These factors consciously and unconsciously shape each encounter. Thus, as Angelelli notes:

> '..interlocutors bring their own set of beliefs, attitudes and deeply held views on interpersonal factors, such as gender, race, ethnicity, and socio-economic status, all of these get enacted. The interpreter…. also brings her own set of beliefs, attitudes and deeply held views that are constructed, co-constructed and re-enacted within the interaction.' (Angelelli 2008, p 149)

Contextual Policy Determinants in the Australian context

Mainstream Healthcare Policy, Budgets and Systemic Factors

In the period since the 1970s when multicultural policy was proclaimed by the Australian federal government, the mainstream healthcare context has undergone a series of shifts which in turn have impacted upon multicultural health and interpreter policy.

The early seventies was a time when policy was concerned with distributional goals seeking to redress social disadvantage, extend the rights of minority groups and improve participatory democracy. Migrant rights groups and community lobby groups advocated for mainstream health service changes to improve equity and access (Garrett & Lin 1990). The introduction of universal health insurance and the development of the community health program were arguably the two most significant health care changes. It was during this period of mainstream healthcare upheaval, that multicultural and interpreter policies and services were conceived and developed (Garrett & Lin 1990). In many respects they developed in response to advocacy rather than evidence (Kelaher & Manderson 2000). Policy was generally enshrined in service guidelines and protocols rather than regulation or legislation.

In the 1980s the mainstream policy focus shifted to a concern with equity and efficiency (Eagar et al 2001). Policy focused on de-institutionalisation and on means of improving coordination and integration.

By the 1990s the accelerated efficiency drive led to a concern about the quality and effectiveness of health interventions (Eagar et al 2001). Fiscal availability in health services had tightened, in response to the rising costs associated with increased demand, population ageing, wage increases and increasing costs of technology (Sax 1990). As health care budgets tightened, so too did the budgets of interpreter services, affecting the reach, scope, flexibility and effectiveness of the service. Some interpreter services responded by introducing operational policies such as fee charging for selected services or facilities or capping of particular service types. Others limited their service provision to the public hospital sector and carefully prioritised interpreter calls in terms of their perceived urgency or complexity. The relative priority of interpreter provision in community health or outpatient settings versus acute hospital care was debated with priority inevitably being given to Emergency Department requests for interpreters. Distance technologies such as telephone and tel- and video- conferencing were sometimes employed to improve efficiency and reach. However, the supply of interpreters remains outstripped by the demand (Garrett et al 2008b).

In this most recent decade, health care policy has promoted effectiveness, health outcomes, performance monitoring, quality and patient safety (Lazarus

1998; Lapsley 2000). Patient safety has been the most prominent policy concern and evidence has been required as the basis for investment.

However, in the healthcare interpreter and multicultural health field, evidence has been limited and uneven (NHMRC 2005). The important relationship between language services and patient safety remains unstudied in the Australian context. The impact of interpreter services in preventing disparity based on race or ethnicity has not been examined. Thus, in the last decade, a disjuncture has arguably emerged between the driving policy ideals of the mainstream (patient safety) and the goals and ideals of interpreter policy (access and equity).

Stakeholder Policy Determinants in the Australian context

The NES Patient Factors Influencing Interpreter Policy

Over half a million people in Australia (561,413) or 2.8% of the total population speak English not well or not at all, according to the most recent population census (ABS 2006). Being unable to proficiently speak English is associated with a range of social factors which may be critical in a highly structured hospital environment. Aside from being unable to negotiate complex institutions such as hospitals alone, the non-English-speaking patient is likely to have a lower income and to experience poorer health status (Kliewer & Jones 1997). It has also been suggested that non-English-speaking patients have poorer health outcomes (Smedley et al 2003), although this has not been tested in the Australian context.

The Australian non-English-speaking population is highly diverse in terms of their countries of origin, languages spoken, proficiency in English, religions, length of residence, and education levels. The health status of immigrants can vary as a function of age, socioeconomic status, language proficiency, and settlement issues (Kliewer & Jones 1997). For example, poor English proficiency has been associated with poorer health and greater use of medical services (Kliewer & Jones 1997).

Many studies report that language barriers decrease equity in healthcare by reducing access to healthcare services including primary care and emergency department care. Further language barriers have been reported as reducing patient understanding and involvement in decision-making, and decreasing adherence to treatment, including medications (Derose & Baker 2000; Ferguson & Candib 2002; Fiscella et al. 2002).

A fundamental policy concern must be improving the health literacy (within the Australian context) of patients with limited English proficiency. Improving health literacy needs to be carefully targeted, ongoing and employ a large variety of educational and information methods.

Mainstream Provider Factors

Mainstream providers in ‘western’ healthcare services undoubtedly operate within a paradigm which has been termed ‘biomedicine’. Good argues that ‘clinical narratives’ or ‘therapeutic plots for patients’ are created and shaped through assumptions about the role, obligations and conceptions and responses of both patient and provider (Good 1995, p. 464). Clinicians learn to ‘read the unfolding medical plot determined by disease and patient response’ (Good 1995, p. 464). That is, that mainstream providers construct and then represent the patient’s condition and this is then enacted within the patient-provider-interpreter interaction.

Where an encounter is inter-cultural, encounters are inherently more complex. Much has been written about the great potential for miscommunication with patients with limited English proficiency, derived from diverse beliefs and behaviours, language barriers and cultural differences (Parsons 1990; Stuart et al 1996), problems in understanding medical language (Bourhis et al 1989), differences in gender, class and power (Kaufert & Putsch 1997), racism, bias and stereotyping (Ferguson & Candib 2002; Johnstone & Kanitsaki 2008), and divergent consumer and provider roles, preferences and expectations (Cortis 2000). Language barriers and the approach to facilitating communication are arguably the most fundamental of these issues in the case of the non-English-speaking patient (Flores 2005; Karliner et al 2007). The negative consequences of poor inter-cultural communication may include inappropriate use of health services, incorrect diagnosis, non-compliance, dissatisfaction, poor rapport, and the patient feeling fearful and desperate (Ferguson & Candib 2002; Meeuwesen et al 2006).

A literature review on intercultural doctor-patient communication found that doctors showed lower levels of positive affect when interacting with ethnic minority patients and that ethnic minority patients were less verbal, assertive and affective in intercultural communication (Schouten & Meeuwesen 2006). A study in the Netherlands, found that the interview time spent with Dutch patients was longer compared with immigrant patients, that immigrant patients showed greater compliance and agreeability with their General Practitioner, that doctors gave more medical advice to immigrants, yet were more empathic towards Dutch patients, and that doctors were less affective towards immigrants (Meeuwesen et al 2006). In another study, minority patients were found to be less likely to engender empathy, establish rapport, receive adequate information, or participate in decision-making (Ferguson & Candib 2002). Intercultural medical consultations resulted in more misunderstanding, less compliance, less participation and less satisfaction than in intra-cultural consultations, although most reviewed studies did not directly assess the relationship between communication and outcomes (Schouten & Meeuwesen 2006). Studies of this type have not been conducted in the Australian setting so the degree of transferability of these findings is uncertain.

Cultural similarities between provider and patient, particularly in terms of language and physical appearance have often been cited as facilitating the clinical relationship and improving agreement, accessibility and outcomes (Powe 2004; Chen et al 2005). The importance of bilingual professionals has been cited in studies (Johnson et al 1998). However, the poor match between the languages represented in the bilingual workforce and the languages of patients has also been a consistent finding.

The factor that can significantly affect the patient-provider relationship is the cultural competency of the provider, service and organisation (Garrett et al 2008a). Culturally competent care relates to behaviours, attitudes and policies that support a negotiated process of appropriately caring for people across languages and cultures (Cross et al. 1989). The cultural competency of providers must be a formative element in any healthcare interpreter policy.

Interpreter Provider Factors Influencing Interpreter Policy

Language facilitators, whether they be professional interpreters, family or bilingual staff, provide a necessary and empowering communication bridge for the patient with limited English. However, healthcare language service

provision is fraught with vexing issues such as the accuracy of interpretation or of cultural interpretation, issues associated with confidentiality and trust, the potential for bias related to cultural, political or familial affiliation, queries about the appropriate roles and responsibilities of interpreters and concerns regarding both the healthcare provider's and the interpreter's legal and ethical duty of care (Vasquez & Javier 1991; Ozolins 1993; Angelelli 2008).

The diverse and increasingly complex roles of professional interpreters in the health care setting has been noted. This complexity is in part derived from the range of interpretation modes, including face-to-face, remote, telephone and tele- or video-conference linkage; further, interpretation may be simultaneous or consecutive. A large literature exists on possible interpreter roles, ranging from a neutral conveyor or renderer of the spoken word, cultural and linguistic broker, gatekeeper or powerful mediator between the parties, advocate for the healthcare provider, and advocate for the powerless non-English-speaking patient (Martin & Valero- Garcés 2008; Hale 2008). Such roles are inevitably mediated by individual interpreter preferences and professional standards, and, as outlined in the model of interpreter policy, by the social and institutional factors influencing other aspects of interpreter policy.

The roles and responsibilities of interpreters may be referred to in policy documents, for example, the NSW Standard Procedures for the Use of Health Care Interpreters (NSWHealth 2006). This policy defines interpreters as responsible for 'the oral transmission of speech from one language to another'. However, this conception of the interpreter role as a 'communication conduit', what Davidson terms 'neutral machines of semantic conversion' (Davidson 2002, p379) and Angelelli terms 'language converter' (Angelelli 2004) has been vigorously contested in the recent literature (Valero Garcés & Martin 2008). Several studies have demonstrated through methods such as sociolinguistic and discourse analysis that interpreters, both consciously and unconsciously, exercise considerable agency and influence in the process of constructing and facilitating communication between provider and patient (Davidson 2000; Davidson 2002; Angelelli 2008). Thus, interpreters have the capacity to influence, or at least shape, the outcome of interpreted interactions in the medical setting. Clearly, interpreters, as the mediator in the interaction, comprehend the interactive discourse through their own perceptual and cognitive lenses, thus resulting in a representation, which is influenced by a complex myriad of personal, professional, contextual and socio-cultural factors. Values, attitudes, experiences and expectations may all, for example influence the perception, construction and representation of communication.

Both professional and non-professional interpreters have been found to participate in keeping interviews moving and in constructing an outcome, which matches their own understanding of the institutional goals and expectations (Wadensjo 1998). One study found that interpreters had an overall tendency to reduce what is being said, by omitting, revising or reducing the content in the interaction. Further it has been found that there was very little social talk or small talk when an interpreter was involved (Aranguri et al 2005). Some US studies have questioned the correctness of interpretation in the medical setting (Baker et al 1996; Karliner et al 2007).

Yet, distinctions must surely be made between the professional interpreter, in Angelelli's terms, 'bringing the self' to the encounter (Angelelli 2004), interpreters working to professional norms and expectations, interpreters

facilitating information provision and, on the other hand, interpretation that is clearly inaccurate or widely divergent from the patient or provider's communicative intent or where the interpreter even takes over the provider's role. While recognising that all communication is subjectively constructed, it is important that relativistic perspectives do not prevail to such an extent as to render the professional interpreter's role as irrelevant.

Addressing this complexity of issues requires self-aware, professionally accredited, highly trained and accountable healthcare interpreters who transparently and purposefully discuss and agree upon the interpreting approach with both provider and client. At the institutional and professional level, the expectations need to be clarified in interpreter policy. Leading commentators in the translating and interpreting field have noted this gap between such research findings and the policy documents in respect of the role of interpreters (Angelelli 2008).

Effectiveness of Interpreter Services – The Evidence and Research

There have been very few published Australian studies discussing interpreter services or the usage of healthcare interpreters. In general the sample sizes in such studies are very small, and in two studies the usage of interpreters is assessed by surveying staff (Heaney & Moreham 2002; Giacomelli 1997), a method which may not elicit reliable results as it relies on staff identifying the need for an interpreter. Kazzi and Cooper (2003) in a cross-sectional study of interpreter usage in paediatric emergency cases mailed translated questionnaires to non-English-speaking parents, with non-respondents being followed up by a telephone survey undertaken by an interpreter. They found that of 131 respondents who identified themselves as requiring an interpreter, 47 (36%) received a trained interpreter and 55 (42%) an 'adhoc' interpreter (family or friends). Less than half of these respondents were identified by Emergency Department (ED) staff as needing an interpreter.

Garrett et al (2008b) in a study using a patient survey and medical record review, with 258 respondents, similarly found that only about a third of patients with limited English had actually used an interpreter in hospital and that only about half of those who spoke limited English reported that they were offered an interpreter in hospital. They found that usage of interpreters was particularly limited in the ED, with only 13% of ED patients using a professional interpreter. The study found that about 60% of those patients who were admitted to the hospital had used an interpreter. Most patients, whether they were admitted or emergency department patients, saw an interpreter only once during their hospital stay. However, the likelihood of receiving an interpreter increased significantly with the increased clinical complexity of patients. For many patients, interpreters sorted out problems at some point in their hospital stay (Garrett et al 2008c).

The high rate of usage of family and friends as interpreters has been a consistent finding in research studies (Garrett et al 2008a; Kazzi & Cooper 2003; CEH 2006). Forty eight percent of the patients in one study advised that they would prefer to use family and friends to interpret (Garrett et al 2008b).

An unpublished literature review undertaken by the Centre for Multicultural Health, UNSW, reports a number of operational and managerial challenges in providing interpreter services. Inefficient booking systems, inadequate interpreter availability, provider perceptions that interpreters are difficult to attain, the patient's inability to directly book an interpreter, patient preferences for family or friends as their interpreter, and the lack of flexibility of the interpreter service were factors cited as potentially

mitigating against optimal usage or monitoring of interpreter services (Centre for Multicultural Health 2003). Such systemic issues need to be addressed in operational policies.

Although quality Australian studies in interpreter effectiveness are sparse, a number of recent seminal international studies have associated professional interpreter usage with increased patient satisfaction, improved patient understanding, greater patient participation in decision-making, high levels of compliance by patients with recommended treatments, improved access by patients to services, and fewer medical errors (Karliner et al 2007; Timmins 2002; Jacobs et al 2001; Flores 2003). Thus, the overall significance and effectiveness of the professional interpreter service is not at issue.

Rather, a key question in relation to interpreter service effectiveness in the Australian context is the service reach and availability and the extent to which policy is meeting the basic requirements of key stakeholders.

Conclusion

Understanding the diverse perspectives of each of the major stakeholders is clearly fundamental for effective healthcare interpreter policy. For the patient, policy needs to broach issues associated with health literacy, the role of the family in brokering language barriers, service access and their healthcare safety. For the provider, cultural competency, particularly enhancing skills in inter-cultural communication, is fundamental. For the interpreter, clarification of role expectations is essential.

The review of evidence related to interpreter service effectiveness indicates that systemic changes may be needed at an operational level to maximise the reach and availability of the service. This might include extended usage of technology, selectively changing the mode of communication (e.g. less face-to-face interpreting and more telephone interpreting) or improving interpreter budgets.

The further development of interpreter services may be hampered by a lack of substantiating research and evidence. Improving the (Australian) evidential base for interpreting services would place interpreter policy on a firmer footing within mainstream healthcare. Further, effective interpreter policy might wisely base its discourse and purpose firmly within the mainstream discourse on patient safety. This would improve the opportunities for interpreter service developments within the current tight fiscal environment.

In summary, there is a complex array of determinants in the interpreter policy arena. The Model of Interpreter Policy (Figure 1) provides a useful means of conceptualising these policy determinants. The model highlights the interactive impact of diverse stakeholders, including the non-English-speaking patient, the provider and the interpreter, interwoven with healthcare institutional and broader social factors.

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The Translator
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rtrn20

The Hospital Cleaner as Healthcare Interpreter

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Published online: 21 Feb 2014.

To cite this article: Franz Pöchhacker & Mira Kadric (1999) The Hospital Cleaner as Healthcare Interpreter, The Translator, 5:2, 161-178, DOI: 10.1080/13556509.1999.10799039

To link to this article: http://dx.doi.org/10.1080/13556509.1999.10799039

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The Translator. Volume 5, Number 2 (1999), 161-178 ISBN 1-900650-21-5

The Hospital Cleaner as Healthcare Interpreter
A Case Study

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Abstract. *Against the background of current hospital interpreting practices in Vienna, the authors present a case study of an authentic therapeutic interaction in which a Serbian-speaking hospital cleaner serves as interpreter in a 47-minute voice therapy and briefing session. Communication between the two speech therapists and the ten-year-old voice patient and his parents from the former Yugoslavia (Bosnia) is described and analysed on the basis of twelve excerpts from the full transcript of the videotaped interaction. The findings show that the untrained ('natural') interpreter clearly fails to maintain a consistent focus on her translatorial role and task and introduces significant shifts in the form as well as the substance of communication. Unaware of the cleaner-interpreter's impact on the interaction, the therapists ultimately lose control over the quality and effectiveness of their professional work.*

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Dialogue interpreting in healthcare settings has increasingly become a focus of attention as a significant speciality of translatorial practice. Despite a growing number of professionalization initiatives in Anglo-American as well as other countries however, the provision of interpreting services in healthcare settings remains characterized by *ad hoc* arrangements involving the use of untrained bilinguals, most commonly family members and hospital staff, as interpreters.

A recent survey carried out in a total of 71 departments of twelve hospitals in Vienna (Pöchhacker 1997) confirmed the present state of medical interpreter service delivery. Out of 464 doctors, nurses and therapists responding to the question of what kind of hospital staff served as interpreters, 61% indicated that it was frequently or nearly always "cleaning staff" – as opposed to nurses (44%) or doctors (10%). (Migrants from the former Yugoslavia represent the most numerous non-German language group in Vienna, and many women from this community have traditionally found employment as housekeeping staff.) Given their pivotal role in enabling communication between Austrian healthcare providers and non-German-speaking patients, Serbocroat-speaking hospital cleaners are a prime target group for any study

of current healthcare interpreting practice in Austria.

While the use of untrained bilingual hospital staff, let alone cleaners, as interpreters may be flatly rejected by professional linguists (e.g. Scouller 1988: 66, Burley 1990:150), there are very few well-documented studies to date which investigate what actually transpires in an authentic provider-patient interaction involving "natural translation", i.e. "[t]he translating done in everyday circumstances by people who have had no special training for it" (Harris and Sherwood 1978:155)

Against this background of current interpreting practice in Austrian hospitals on the one hand and theoretical interest in the performance of 'natural interpreters' on the other, the present study investigates the translatorial behaviour of a hospital cleaner in a therapeutic setting. From a descriptive rather than a normative perspective, the nature of the interpreter's renditions as well as her behaviour in the role of interpreter will be analysed for their impact on the dynamics of the communicative exchange and on the functional quality of the professional interaction as a whole.

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1. Material and method

The material analysed in this case study is derived from the Ear, Nose and Throat Department of a teaching hospital in Vienna, where speech therapists can and routinely do use a video camera to document patient encounters for subsequent reference and analysis. In the context of a survey project carried out by the first author, the head and staff of the department in question were requested – and agreed – to make recordings of sessions with non-German-speaking patients available for a study of translation practice. This arrangement obviated the need for participant observation and allowed for routine patient (parent) consent to the use of recordings for scientific purposes.

The recording used for this study was made in August 1995. It documents the initial voice therapy session of a ten-year-old boy of Bosnian descent and the subsequent briefing session with his parents. The session is conducted jointly by two (monolingual) speech therapists and a Serbian-speaking hospital cleaner who serves as interpreter.

The German-language portions of the interaction were transcribed by the first author and checked by the second author, who contributed the transcription of the Bosnian/Serbian utterances (which were in turn checked by a fellow sworn court interpreter for the respective languages). The working translations into English, which were made as readable as an interlinear approximation of the original would allow, are by the first author in cooperation with a native-Serbian professional interpreter in California.

The transcription system follows the basic approach of Ehlich and Rehbein (1976) and is largely congenial with Wadensjö (1992). The excerpts drawn from the full transcript of the interaction are referenced to the time on tape

(from MIN.SEC to MIN.SEC), with the individual utterances numbered consecutively within each excerpt.

Given the explorative nature of this case study, which essentially aims at describing the behaviour of a hospital cleaner acting as interpreter, the analysis is focused neither on *a priori* categories or typologies nor on particular issues or problems. Rather than using isolated examples for illustration, the data are presented in such a way as to reflect the chronological development of the interaction (in so far as this is possible on the basis of a dozen excerpts). This descriptive approach is intended to provide the reader with a richly contextualized understanding of the interaction. In the discussion, these empirical data will then be summarized with regard to the interpreter's role and performance, ultimately leading to an assessment of the cleaner-interpreter's impact on the functional quality of the therapeutic interaction.

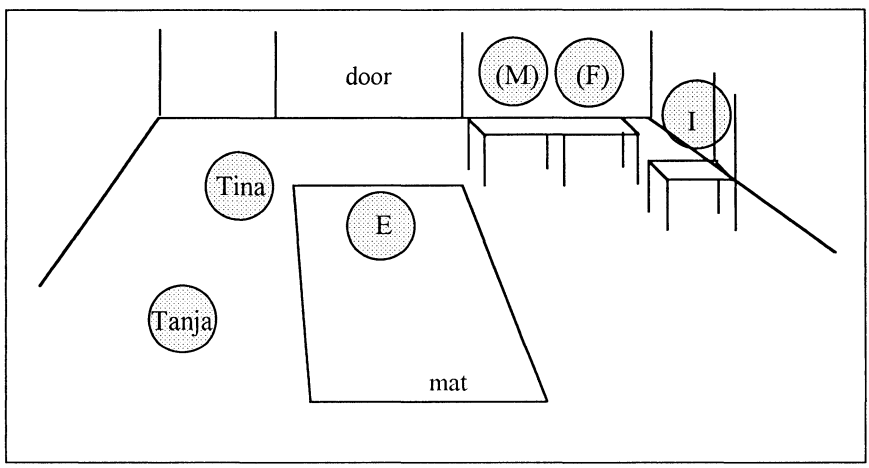

Figure 1: Constellation of Interactants

2. Setting the scene

The voice therapy session with ten-year-old Emir (approx. 39 minutes) is conducted jointly by two young speech therapists (under 30), Tanja and Tina. The latter does most of the actual 'hands-on' exercises while Tanja appears to act in a supervisory capacity and takes charge of the subsequent briefing with the boy's parents (approx. 8 minutes). The Interpreter is a middle-aged woman who speaks a Wallachian dialect of Serbian. The basic constellation of the interactants as seen through the camera is sketched in Figure 1. During most of the therapy session, Emir is lying on the mat, on his back with his head pointing to the door, while Tina is kneeling or sitting beside him. Tanja

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mostly adopts a more distant position, closer to the camera. The Interpreter (I) is sitting on a chair on the opposite side of the mat, often bending forward towards Emir.

The content structure of the therapy session may be described as follows. After several minutes of introductory exchanges and preparatory moves, such as getting Emir to lie down on the mat, Tanja performs a relaxation massage (approx. 5 minutes). Tina then takes over and guides the boy through a number of exercises – awareness of breathing (2 minutes), exhaling (5 minutes), humming and voicing (8 minutes) – before concluding her physical work with a demonstration of breathing movements and how to monitor them (3 minutes). The rest of the time is spent on preparing for the (breathing) exercises at home.

When Tina brings Emir into the room, the interpreter is already sitting in her chair. As is evident from Tanja's introduction (Excerpt 1:1), the woman had been present in a previous encounter with the boy.

Excerpt 1 (00.06 – 00.15)

1	Tanja	Servus! Schau mal, kannst du dich an die Dame erinnern? *Hello! Look, do you remember this lady?*
2	I	(to Emir) HALLO. *Hello.*
3	Tanja	DIE ÜBERSETZT EIN BISSCHEN, WAS WIR MACHEN MIT DIR HEUTE, OKAY? *She'll translate a little what we're doing with you today, okay?*
4	Emir	(hoarse) OKAY.

Paradoxically, Tanja addresses Emir in German, and the Interpreter provides neither a translation nor an introduction of her own (2). While Emir's response by taking up the tag question (4) appears to signal understanding, his insufficient command of German becomes evident a few seconds later (in Excerpt 2).

Excerpt 2 (00.21 – 00.42)

1	Tina	PASS AUF, HEUTE WERDN MA UNS NICHT HINSETZEN, HEUTE WERDN MA UNS HINLEGEN, SO WIE BEIM SCHLAFEN. *Now look, today we won't sit down, today we'll lie down, like in sleeping.*
2	I	TIĆEŠ OVDE DA LEGNEŠ. *You will lie down here.*
3	Tina	HM? .. . MACHT DIR DAS WAS AUS? *Hm? .. . Do you mind that?*
4	Emir	(definite) JA. *Yes.*
5	Tina	MACH MA DAS? *Shall we do that?*

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6	Emir	JA. *Yes.*
7	Tina	JA, GUT. VERSTEHST DU MICH? (to I) SAGEN SIE IHM, ER SO/ *Yes, good. Do you understand me? Tell him to/*
8	I	JE L' RAZUMEŠ? TETA KAŽE DA LEGNEŠ. TU DOLEĆEŠ DA LEGNEŠ, TU DOLE *Do you understand? The lady says you should lie down. Down there you should lie down, down there.*

In her first rendition (Excerpt 2:2) the interpreter addresses Emir using direct speech and reduces Tina's gentle instruction to a statement of what Emir will (have to) do. With his attention focused on Tina and his back turned on the interpreter, however, Emir does not react to either utterance and Tina soon realizes from his obliging affirmative answers that she needs to communicate through the interpreter. (Some 50 seconds later, a similar exchange prompts her to instruct the interpreter to "try and always translate right away" since she believes that Emir does not understand). Again, the interpreter renders the therapist's instruction in a much more command-like and rather insistent tone. In fact she cuts off Tina's utterance and produces her own as a mix of direct and reported speech.

3. Therapy session

Before Tina begins with her breathing and voice exercises, Tanja performs a relaxation massage, which she introduces as follows (Excerpt 3):

Excerpt 3 (04.45 – 05.05)

1	Tanja	SAGEN SIE IHM, DASS ICH SO EINE ART MASSAGE JETZT MACH, UND ER BRAUCHT GAR NIX TUN, ER KANN RUHIG DIE AUGEN ZUMACHEN, *Tell him that I'll now do a kind of massage, and he doesn't need to do anything, he can close his eyes,*
2	I	TETA KAŽE DA ĆE DA TE MALO MASIRA, TI SE OPUSTI, ZATVORI OČI. NEĆE TI NIŠTA BUDE, NEMOJ DA SE BOJIŠ, ZATVORI OČI, AKO HOĆEŠ, SKROZ ZATVORI. *The lady says she will massage you a little, you relax, close your eyes. Nothing will happen to you, don't be afraid. Close your eyes, if you want, close them tight.*
3	Tina	(Emir closes his eyes) ABER ER MUSS SIE NICHT ZUMACHEN, WENN ER NICHT WILL. *But he doesn't have to close them, if he doesn't want to.*
4	I	JA, ICH RED NUR WENN ER WILL. *Yes, I says only if he wants.*

The interpreter clearly expands on Tanja's explanation by explicitly telling

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Emir to relax, close his eyes and, most strikingly, not to worry (Excerpt 3:2). When Tina notes Emir's obliging reaction and emphasizes that he does not have to close his eyes (3), the interpreter, changing her footing (cf. Wadensjö 1992:117f), replies that this is what she has said (which she did, but with considerably more illocutionary force), thus opting for a face-saving remark rather than a rendition of Tina's utterance for Emir.

Another case of face-work (cf. Wadensjö 1992:151) on the interpreter's part can be observed when Tanja has finished her massage (Excerpt 4):

Excerpt 4 (07.10 – 07.26)

1	Tanja	FRAGEN SIE IHN, OB DAS ANGENEHM WAR ODER UNANGENEHM. *Ask him whether that was pleasant or unpleasant.*
2	I	PITA TETA, JE L' TI BILO PRIJATNO IL TI NIJE BILO PRIJATNO, KAKO SE OSEĆAŠ. .. . KAD TE TAKO MASIRA. JEL' TI BILO LEPO? *The lady asks if it was pleasant or not pleasant. How do you feel when she massages you like that? Was it nice?*
3	Emir	LEPO. *Nice.*
4	I	ER SAGT ES/ ANGENEHM. (Tanja: MHM.) ES TUT IHM GUT. *He says it/ Pleasant. It feels good for him.*

As a result of the alternative phrasing in her rendition (2), the interpreter elicits an answer that does not quite fit the original question (3). As if to correct this mismatch, she drops her plan for a rendition in reported speech and gives the answer in terms of Tanja's question (4), subsequently adding another utterance, the nature of which (rendition or comment) remains unclear.

During the exercise which will ultimately become the focus of Emir's practice assignment, the translation is again worded in such a way as to elicit a verbal response (Excerpt 5).

Excerpt 5 (11.04 – 11.58)

1	Tina	GENAU. .. .. SEHR GUT. DER BAUCH WIRD GRÖSSER, UND WIEDER KLEINER. .. .. . (turns to I) *Exactly. .. .. Very good. The belly gets bigger, and smaller again.*
2	I	JE L' OSEĆAŠ KAKO STOMAK GORE-DOLE? *Do you feel the belly go up-down?*
3	Tanja	STE/ SAGEN SIE IHM, ER SOLL SICH VORSTELLEN, ER HAT EINEN LUFTBALLON IM BAUCH, UND WENN ER EINATMET, BLÄST SICH DER LUFTBALLON AUF. *Ima/ Tell him to imagine that he has a balloon in his belly, and when he inhales, the balloon is inflated.*
4	I	JA. TETA KAŽE DA ZAMISLIŠ DA IMAŠ BALON U STOMAKU I KAD TI DIŠEŠ ON VEĆI PA SE SMANJI, PA VEĆI PA SE SMANJI. MOŽE TO?

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Yes. The lady says, imagine that you have a balloon in your belly, and when you breathe it is bigger, then it gets smaller, and bigger and smaller. Can you?

5 Tanja UND WENN ER AUSATMET, DANN GEHT DIE LUFT SO PFFFHHHHHH AUS DEM LUFTBALLON, =[UND DER BAUCH WIRD KLEIN.]=
And when he exhales, the air goes like pfffffhhhhhh out of the balloon, =[and the belly becomes small.]=

6 I =[I KAD IZDAHNEŠÔ= ONDA VAZDUH IZADJE I STOMAK SE SMANJI, U{Z}DAHNEŠ – SVE VEĆI. MOŽE TO?
=[*And when you exhale*]= *the air comes out and the belly becomes smaller, inhale (sigh) – bigger again. Can you?*

7 Emir (nods, turns from I to Tina)

8 Tina MHM. KANNST DU DAS SPÜREN. SEHR GUT.
Mhm. So you can feel that. Very good.

Whereas the therapists merely provide descriptions to accompany and facilitate the exercises, the interpreter tends to use (tag) questions, implying the need for some response (Excerpts 5:2, 4, 6). While the therapist, unaware of the eliciting tags, appreciates Emir's affirmative response (7-8), the latter may in part be induced by the translation. The fact that the interpreter preempts the second part of Tanja's illustration (5) and incorporates it in her rendition of part one (3-4) is glossed over by a similar duplication in (6), and Tanja's simile arguably loses some of its clarity in the process.

The following excerpt marks the end of the exercises and introduces the next phase of the interaction (Excerpt 6:1):

Excerpt 6 (24.38 – 25.03)

1 Tanja (to Tina) SOLL MA DEN ELTERN, DAS ZEIGN, DASS SIE DAS ZUHAUSE MIT IHM MACHEN ODER ERST / .. .. .. (to I) KANN SICH SCHON AUFSETZEN.
Should we show the parents, show them that they do this with him at home or first / .. .. .. He can sit up now.

2 I USTANI AKO HOĆEŠ.
Stand up, if you want.

3 Tanja .. .. . (to Tina) ABER S'HAT IHM EINDEUTIG GFALLN.
But he clearly liked it.

4 I (to Emir) JE L' TI BILO DOBRO?
Was it good for you?

5 Emir (smiles, nods, to I) JA.
Yes.

6 I (to Tanja, Tina) JA, ES HAT IHM GEFALLEN. (Tanja: MHM.) .. ..
Yes, he liked it.
(to Emir) TO SU SAMO VEŽBE BILE.
That was just exercises.

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As in many other instances throughout the session, the therapists, who are kneeling on the floor, talk to one another about how to proceed (Excerpt 6:1). When Tanja interrupts this consultational mode by suggesting that Emir sit (!) up, the interpreter takes her subsequent remark to Tina (3) as a prompt to formulate a direct question for feedback (4). Her rendition of Emir's affirmative response (5) – without a prior question by the therapists – is followed by a strikingly autonomous act of reassurance.

4. Homework preparations

Preparations for home exercises are initiated by Tina, who lies down on the mat herself to give a demonstration of diaphragmatic breathing, with Emir's hand on her belly.

Excerpt 7 (26.31 – 27.00)

1	Tina	GELL, DAS HAST DU VORHER AUCH BEI DEINEM BAUCH GESPÜRT. DER IS HINEINGEGANGEN UND WIEDER HINAUSGEGANGEN, HINEINGEGANGEN UND WIEDER HINAUSGEGANGEN DER BAUCH, GELL? *This is what you also felt on your belly a little while ago, isn't it? It went in and out again, in and out again, your belly, right?*
2	Tanja	FRAGEN SIE IHN, OB ER DAS AUCH GESPÜRT HAT. *Ask him whether he felt this too.*
3	I	JESI LI OSEĆ'O KOD TEBE ISTO TAKO KAO KOD TETE DA SE STOMAK DIZO GORE-DOLE? *Did you feel this on your belly like on the lady, that the belly was moving up and down?*
4	Emir	(shakes his head)
5	I	JESI OSEĆO? NISI? KAKO NISI KAD SI DRŽO RUKU. JESI OSEĆO KAKO SE STOMAK DIŽE, JESI? *Did you feel it? No? Why not? But you did put your hand there. Did you feel how the belly was rising, did you?*
6	Emir	JA. *Yes.*

As in a number of other passages, Tanja needs to prompt the interpreter for a rendition of Tina's question (Excerpt 7:1-2). When Emir shakes his head to signal a negative answer (4), the interpreter presses him to reconsider his reply with a series of direct follow-up questions and subsequently renders the boy's "yes" for the therapists. Similar 'questioning' by the interpreter occurs some three and again six minutes later. When Emir responds affirmatively to Tanja's question as to whether he has a room of his own, the interpreter probes further with "You sleep alone in the room? Neither, neither child, nor Mummy nor Daddy nor little brother?" (30.59 – 31.40) before rendering it into German for the therapists. Emir's preference for doing the

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exercises without his parents draws two follow-up questions from the interpreter ("You want to do it alone?" "And you'll be sure to do it?"), the latter preempting Tina's own words to that effect (32.37 – 33.22).

Another type of follow-up by the interpreter, with potential implications for therapeutic procedure, appears in Excerpt 8, when Tanja asks Emir about school:

Excerpt 8 (32.19 – 32.33)

1	Tanja	UND WAS MACHT ER AM LIEBSTEN IN DER SCHULE? *And what does he most like to do at school?*
2	I	ŠTA NAJVIŠE VOLIŠ DA RADIŠ U ŠKOLI? .... DA PIŠEŠ, DA ČITAŠ, FIZIČKO, ŠTA NAJVIŠE VOLIŠ, MUZIČKO, DA PEVAŠ, DA CRTAŠ? ŠTA NAJVIŠE VOLIŠ? *What do you most like to do at school? .. .. Writing, reading, gym, what do you most like to do? Music, singing, drawing? What do you most like to do?*
3	Emir	DA .. PISEM. *.. Writing.*

When Emir does not reply to the question regarding his favourite subject at school, the interpreter expands her rendition by suggesting a total of six options, whereupon Emir chooses the one first mentioned. Shortly after that, the therapists decide to make use of this preference for the procedure of documenting the home exercise: "If he likes writing, we can have him write a list for next time" (33.23). Tanja draws a grid on a sheet of paper and writes down the German name for every day of the week. As she is presenting the sheet to Emir, the interpreter volunteers an unprompted explanation, which immediately precedes – and preempts – an exchange between the therapists (Excerpt 9):

Excerpt 9 (37.28 – 38.26)

1	I	TU PIŠEŠ KAD SI RADIO VEŽBE. *Here you write down when you have done the exercises.*
2	Tina	.. .. .. UND WAS/ ER SOLL DIE ÜBUNGEN EINTRAGEN. *.. .. .. And what/ He is supposed to fill in the exercises.*
3	Tanja	NA, ER SOLL HINEINSCHREIBEN / *No, he's supposed to write in /*
4	Tina	WAS ER GEMACHT HAT. *what he has done.*
5	Tanja	(thinking) .. . NEIN, NUR DIE BAUCHATMUNG SOLL ER ÜBEN, JA? *... No, only diaphragm breathing is what he should practice, right?*
6	Tina	JA. *Yes.*
7	Tanja	(hesitating) .. OB ER / *.. Whether he /*

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8 Tina .. .. OB ER DRAN =[GEDACHT HAT.]=
.. .. *Whether he =[remembered it.]=*

9 Tanja =[Ob er dran]= gedacht hat, mhm. (to I) JA, ER SOLL, AH, HINEINSCHREIBEN, OB ER AH, AM ABEND ODER IN DER RÜH, JA, ODER UNTER/ UNTERTAGS EINMAL DARAN GEDACHT HAT, SICH HINZULEGEN, HAND AUF DEN BAUCH UND SO DIESE ATEMÜBUNG ZU MACHEN.
=[*Whether he*]= *remembered it, mhm. (to I) Yes, he should, uhm, write in whether, uhm, in the evening or in the morning, right, or during/ some time during the day, he remembered to lie down, hand on his belly and do this breathing exercise.*

10 I ONA JE REKLA, SLUŠAJ, OVDE, OVDE, I TU UVEK DA NAPIŠEŠ KAD SI PRAVIO VEŽBE, UJUTRO - MORGEN, MITTAG ODER NACHMITTAG, TAKO ISTO SONNTAG, TAKO ISTO MONTAG SVE DO FREITAG DOK NE DODJEŠ OPET OVDE. JE L' ZNAŠ? JE L' ZNAŠ SINE? JESI RAZUMEO?
She said, listen up, here, here you always write down when you have done the exercises, in the morning - morning, midday or afternoon, the same for Sunday, also Monday to Friday, until you come here again. Y'know? You know, my son? Did you understand?

11 Emir Ja.
Yes.

In formulating her own instruction (9:1), the interpreter uses a dialect form of the temporal pronoun 'when', which could mean anything within the semantic range from 'when' to 'whether'. As it turns out, though, the therapists are only beginning to work out what Emir is actually supposed to do (2-9). When Tanja finally formulates the instruction to be passed on to Emir, the interpreter not only repeats her non-standard usage of 'when' but also structures her rendition in such a way as to favour the temporal interpretation ('when') over the meaning intended by the therapists ('whether'; cf. the syntactic position of the German words for 'morning', 'midday' and 'afternoon'). Moreover, the interpreter expands on Tanja's instruction and seeks explicit confirmation of Emir's understanding. Emir once again replies to a question the therapist has not asked, and when Tanja does ask it a few seconds later, it has become superfluous and is answered directly by the interpreter.

When Tanja subsequently suggests that Emir may simply put a check mark or an asterisk on the sheet, the boy's sense of understanding is clearly shaken. His confusion about the instruction is not only reflected in subsequent turns, when Tina reacts laughingly to Emir's uneasiness and hesitation, but also becomes the subject of a lengthy exchange during the parents' briefing.

5. Parents' briefing

Emir's therapeutic regimen is explained to his parents as follows (Excerpt 10):

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Excerpt 10 (41.32 – 42.27)

1	Tanja	Sagen sie, dass, ahm, wir Übungen gemacht haben, ah, für die Atmung, damit er nicht so verspannt ist, ja. *Say that, uhm, we have done exercises, uh, for his breathing, so that he isn't so tense, alright?*
2	I	PRAVILI SMO OVDE VEŽBE DA ON DIŠE POLAKO, LAGANO, DA NIJE ONAKO NAŠPANOVAN, ONO ZNAŠ OVAKO, POLAAAKO, SVE POLAAKO, DA POLAKO DIŠE. *We have done exercises here, so that he breathes slowly, easily, so that he isn't so tense, you know like, slooowly, always slowly, so that he breathes slowly.*
3	Tanja	UND DASS ER HALT JEDEN TAG ALLEINE VO/ DAS MACHEN SOLL, ... JA? *And well that every day he on his own, [bef]/ should do that, ... yes?*
4	I	SVAKI DAN MORA MALO DA VEŽBA, KAD, KAD LEGNE , STAVI RUKU NA STOMAK. *Every day he has to practice a little, when he goes to bed, put his hand on his belly.*
5	Tanja:	(to Tina) SOLLN IHN DIE ELTERN ERINNERN? *Should the parents remind him?*
6	Tina	JA. JA, SCHON. *Yes, yes, they should.*
7	Tanja	SIE KÖNNEN IHN SCHON ÄH ERINNERN, DASS SIE SAGEN: HAST DU HEUTE SCHON DIE ÜBUNG GEMACHT? DASS SIE IHN ERINNERN, JA? *You can, uh, remind him, that you say: Have you done the exercise today? that you remind him, alright?*
8	I	DA GA PODSETITE, DA L' JE RADIO TE VEŽBE. UVEČE NAJBOLJE KAD LEGNE, KAD SE SMIRI, DA, NAJBOLJE. *That you remind him, if he has done these exercises. In the evening it's best, when he goes to bed, when he is already calmed down, yes, best.*

At least two substantial shifts are introduced by the interpreter in this significant part of the briefing session. Whereas Tanja speaks about breathing exercises for relaxation (10:1) without further describing their nature (3), the interpreter puts the emphasis on "breathing slowly, easily" (2) and mentions not only what Emir is to do but also when he is to do it. One might speculate that Tanja was about to utter something like "before he goes to bed" (as Tina did, once, thirteen minutes earlier). Nevertheless, the fact that Tanja deliberately cuts herself short (3) is in accordance with her instruction (Excerpt 9:9) to do the exercise at any time during the day. In contrast, the interpreter not only introduces an explicit focus on bedtime (4) but also reaffirms it, even supplying her own rationale (8).

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When someone at the door asks Tanja and Tina respectively to suggest a date for an appointment and attend to a patient in another room, that interruption paves the way for a lively discussion between Emir, his parents and the interpreter on how to use the exercise sheet. While both parents attempt to address Emir's concerns about whether and what to write on the sheet, the interpreter clearly serves as the main source of authoritative advice until the therapists are ready to continue the briefing with further instructions on the home exercise (Excerpt 11).

Excerpt 11 (43.44 – 43.57)

1	Tanja	WENN ER, WENN ER'S VERGESSEN HAT, IST ES OKAY, JA. ES IS NICHT SCHLIMM, =[WENN ER EINMAL VERGISST.]=
		If he, if he has forgotten it, it is okay, alright? It's no problem,
		=[if he happens to forget.]=
2	I	=[NICHT SCHLIMM, JA.]=
		=[No problem, yes.]=
3	Tanja	DANN SOLL ER HALT NICHTS HINMALEN.
		Then he just doesn't mark anything down.
4	I	(to parents) AKO ZABORAVI, DOBRO, ALI DA GLEDA DA SVAKI DAN UVEČE, NAJBOLJE UVEČE, NE?
		If he forgets it, okay, but he should try every day in the evening, best in the evening, right?
5	Father	MHM.

Rather than provide a rendition for the parents, the interpreter reacts to Tanja's first utterance (11:1) by giving confirming feedback to her. When the interpreter does address the parents after Tanja's instruction (3), she relays only the former statement and reaffirms her advice that the exercise be done at bedtime (4).

When Tanja concludes the briefing by asking if there are any questions, the father declines whereas the mother asks, via the interpreter, just what the exercises are for. Given the scope of this incomprehension, Tanja launches into an explanation of the relationship between breathing and the voice, squarely addressing the interpreter rather than the parents.

Excerpt 12 (45.45 – 46.46)

1	Tanja	DIE ATMUNG, JA, DIE ATMUNG IST DIE, ÄH, EINE RICHTIGE ÄH BAUCHATMUNG /
		Breathing, yes, breathing is the, uh, correct uh diaphragm breathing /
2	Father	(questioningly to I) PRAVILNO DISANJE?
		Correct breathing?
3	I	PRAVILNO DISANJE.
		Correct breathing.

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4	Tanja	IST DIE VORAUSSETZUNG, IST DIE VORAUSSETZUNG FÜR EINE GUTE STIMME, JA, UND ER IST SEHR =[VERKRAMPFT UND VERSPANNT, JA, AUCH WENN ER STEHT.]=
		is the prerequisite, is the prerequisite for a good voice, you know, and he is very =[cramped and tense, you know, also when he stands.]=
5	Father	(questioningly) =[GLASNE ŽICE (XXX)
		=[*vocal cords (xxx)*
6	I	[XXX] ON STEGNE, PLASI SE.]=
		(*xxx*) *he tightens up, is afraid.*]=
7	Tanja	AUCH WENN ER STEHT / SCHAUN SIE MAL, MAN SIEHT ER STEHT **SO** UND HAT DIE SCHULTERN IN DIE HÖHE GEZOGEN, JA, ER IST SEHR VERSPANNT.
		Also when he stands / Take a look, you see he stands like ***that*** *and has his shoulders pulled up, right, he is very tense.*
8	Father	JA, NORMALNO, NORMALNO.
		Yes, sure, sure.
9	I	ON JE STEGNUT, KO DA SE BOJI. TREBA DA SE OPUSTI (XXX).
		He tightens up, as if he were afraid. He has to relax (xxx).
10	Tanja	MAN KANN ES, AUCH WENN MAN'S IHM SAGT, ER SPÜRT DAS NOCH NICHT SO SEHR, UND DESWEGEN MACHEN WIR DIE ATEMÜBUNG, DAS IST EINE ENTSPANNUNGSÜBUNG, UND AUCH GLEICHZEITIG ÄH FÜR DIE STIMME.
		One cannot, even though one tells him, he does not yet feel that very well, and therefore we do the breathing exercise, that is a relaxation exercise, and also at the same time uh for the voice.
11	I	ON DA SE OPUSTI, DA PRAVILNO GLAS, MISLIM DA DIŠE PRAVILNO I DA LAKŠE GLAS DODJE, KAD PRIČA, DA NE GALAMI, DISANJE, KAŽE MNOGO STEGNE.
		He is supposed to relax, so that the right voice, I mean that he breathes right, so that the voice comes easier, when he talks, that he does not shout, his breathing, she says, he tightens up very much.
12	Mother	(to Emir) JE L' SE BOJIŠ. BOJIŠ SE?
		Are you frightened? Are you afraid?
13	I	NEMA ŠTA DA SE BOJIŠ. (to Mother) ONI SU SUPER OVDE S NJIM.
		You don't need to be afraid. They are really great with him here.

Trying to follow Tanja's explanation in German, the father seeks clarification from the interpreter for individual concepts he believes he has picked up (Excerpt 12:2, 5), which results in a considerable overlap of talk (4-6). Apart from confirming the father's guess at what Tanja is talking about (2-3), the interpreter limits her rendition of Tanja's explanation to an attempt at expressing the meaning of the technical keyword 'tense' (VERSPANNT). By

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associating it twice with 'fear' (6, 9) rather than physical posture, the interpreter gives the briefing a final undetected twist. Tanja's effort to clarify the relationship between posture, relaxation, breathing and voice (1, 4, 10) ends up rather garbled in the Serbian version (11) and evidently fails to command the attention of the mother, who had asked the question in the first place. Following the interpreter's two reduced renditions (6, 9), the mother's concern shifts to her son's fear (12), whereupon the interpreter, who has introduced that notion, moves to reassure both the boy and his mother (13). As Tanja brings the briefing to a close, the therapists remain blissfully unaware of both the preceding exchange about their patient's emotional state and the mediator's flattering comment on their treatment of the boy.

6. Discussion

The 47-minute therapy and briefing session, documented above on the basis of excerpts from the full transcript, represents a routine case of mediated interaction with a patient of non-German-speaking background in a large hospital in Vienna. From the therapists' point of view, nothing in the encounter was noticed as particularly problematic, either from immediate recollection or upon subsequent reviewing of the videotape. Nevertheless, close inspection from a translational perspective yields a number of striking findings for the intermediary's behaviour in the role of interpreter and her translational output as well as her impact on the dynamics of the communicative interaction.

6.1 Interpreter role

Since the ten-year-old patient's command of German is found to be all too limited, the cleaning woman is explicitly assigned the role of interpreter (Excerpt 1:3). Despite the instruction to "always translate right away", the interpreter often fails to provide a Serbian rendition of German utterances unless requested to do so (e.g. Excerpt 7:1-3). Apart from numerous gaps affecting the exchange in the boy's primary language (or some variant of it), this passive attitude of the interpreter, which is also reflected in her physical position on the sideline, as it were, of the therapeutic interaction, exacerbates the indirectness of communication in both the verbal and the nonverbal dimension (i.e. Emir having to turn his head back and forth). In order to ensure translation for the patient, the therapists need to preface their utterances by an explicit request (ask him, tell him), which in turn leads the interpreter to formulate her rendition in indirect speech (the lady asks, she says), as in Excerpts 2 (7-8), 3 (1-2), 4 (1-2), 5 (3-4), etc.

In many instances, the cleaner is thus less than actively fulfilling her role as interpreter. At the same time, however, she is often prepared to go beyond

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providing "renditions on request" and makes direct contributions to the communicative content of the interaction. In some instances, the two role orientations become manifest within a single turn, as in Excerpt 3 (2), when the interpreter combines her (indirect) rendition of Tanja's instruction with a reassuring comment of her own. Apart from taking the initiative to calm the boy down (cf. also Excerpt 13:5), the interpreter also assumes responsibility for the boy's answers and actions. In Excerpt 7 (5), she dismisses the boy's negative answer and prevails on him until he says 'yes', and in Excerpt 8 (2) she moves to elicit an answer by suggesting a number of alternatives. In other passages not documented in the excerpts, the interpreter even asks two consecutive follow-up questions before relaying the patient's utterance to the therapist.

The most consequential case of a substantive contribution by the interpreter is her specification that the exercises ought to be done at bedtime. Without any such indication on the part of the therapist in charge of the briefing, or even despite her deliberate move not to link the exercises to a particular time of day (Excerpt 10:3), the interpreter introduces her explicit preference in several of her mediating turns and even supplies her own reasoning and justification (Excerpt 10:4, 8; Excerpt 11:4). Other examples of the interpreter taking charge in a covertly co-therapeutic role include her preemptive explanations in Excerpt 5 (4) and Excerpt 9 (1) and her autonomous move to verify the therapists' impression that their patient had enjoyed the exercise (Excerpt 6:4). However, the interpreter's co-therapeutic attitude, which is never apparent to the therapists, is anything but consistent during the interaction. While her poorly phrased comment in Excerpt 6 (6) ('That was just exercises') may have been intended once again to reassure the boy, the interpreter actually sends the patient a message which strangely belittles the preceding 25 minutes of therapeutic work. Towards the end of the briefing, the interpreter again distances herself from the therapists with her comment on their treatment of the boy (Excerpt 12:13).

6.2 Translational output

As discussed above, the interpreter in many instances steps out of her role as an "honest spokesperson" (Harris 1990:118), either by not rendering utterances of the primary parties or by introducing substantive contributions of her own. In addition to such 'lack of rendition' and 'non-renditions', to use Wadensjö's (1992) terms, the interpreter's renditions as such also exhibit numerous deviations from the ideal of complete and accurate re-expression. Apart from 'reduced renditions', as exemplified in Excerpt 2 (2), some of the paraphrases making up the 'expanded renditions' of key technical terms introduce significant conceptual shifts, e.g. from 'not being tense' to 'breathing slowly' (Excerpt 10:1-2) and from being 'cramped and tense' to 'being afraid'

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(Excerpt 12:6). A particularly salient and systematic shift results from the interpreter's dialectal Serbian usage of the pronoun 'when' (Excerpt 9:1, 10). The interpreter's fuzzy rendition, suggesting that the boy 'write down when' rather than 'mark down whether' he has done the exercise, creates considerable confusion about how the home exercise is to be recorded.

Apart from shifts in semantic content, the interpreter's renditions often alter the illocutionary force of the therapists' utterances. In Excerpt 5, several descriptive statements explaining what the patient is to become aware of are tagged with questions designed to elicit an affirmative response (1-2, 3-4, 5-6). Thus, whereas the therapists state *what* they want their patient to feel, the interpreter in addition asks *whether* he can feel it. To the therapist unaware of the interpreter's prompting, the boy's responsiveness understandably seems rather pleasing (8; cf. also Excerpt 9:10). In a similar vein, gently phrased indirect requests by the therapists are invested by the interpreter with considerably more directive force, as evident in Excerpts 2 (8), 3 (2) and 10 (8).

Given the interpreter's undeniable impact on the form as well as the content of the communicative interaction under study, it may well be asked whether she is more of a help or a hindrance in the therapists' professional interaction with their patient and his parents.

6.3 Interactional function

In all fairness, the cleaner-interpreter must be credited with enabling communication between providers and clients in a session lasting three quarters of an hour; without her help, the boy's voice problems could or would not have been attended to in this particular healthcare institution. From the professional point of view of the two speech therapists, the interpreter appears to have done her job well enough, and she is actually 'booked' again for Emir's appointment the following week. From the perspective of both the patient and the providers, then, the interpreting arrangement has fulfilled its purpose. Or has it?

As only a discourse-based translational analysis can bring to light, the interpreter in many ways leaves the clients with both much less and much more than the therapists intended them to understand. The boy's confusion about how to use the exercise sheet, which is cleared up only after a lengthy exchange among all the interacting parties, and the instruction to the parents that the exercise is to be done at bedtime, stand out as clear examples of the interpreter's undesired impact on the effectiveness of communication. Similarly, the fact that at the very end of the briefing neither parent is sure about the purpose of the exercise can be traced back to the interpreter's change of focus in expressing the patient's key physical symptom.

Following a review of the interaction on the basis of the transcript, the therapist in charge (Tanja) found the interpreter's initiatives to reassure, ques-

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tion and advise the client(s) totally unacceptable and was greatly disconcerted by the way in which the interpreter's renditions often blunted the points she had meant to bring across. From her informed professional perspective, the mediated interaction is judged as embarrasingly dysfunctional, even in the absence of an obvious breakdown of communication. With the cleaner-interpreter covertly shaping the content and form of their discourse, the therapists have in fact lost control of their professional (inter)action to such an extent that they can no longer ensure the quality and effectiveness of their work.

7. Conclusion

The mediated therapeutic interaction described and analysed in this authentic case study represents a routine and possibly typical example of current healthcare interpreting practices in Austria. Though unprecedented within its geographic and institutional context, the study corroborates many of the concerns voiced in the literature about the *ad hoc* use of bilingual staff for the function of interpreting. The untrained ('natural') interpreter clearly fails to maintain a consistent focus on her translatorial role and task and introduces significant shifts in the form and substance of communication. Naively unaware of the cleaner-interpreter's ignorance of translatorial standards of practice, the therapists, who are equally untrained as regards the management of non-German-speaking clients with the help of an interpreter, thus venture into an interaction, the professional quality of which they no longer control.

While the findings presented above are hardly controversial in highlighting the various inadequacies in the performance of a 'natural' interpreter, more far-reaching conclusions must be drawn for the mediated encounter as a whole. From a functional perspective, the case reported here ultimately bears not on the cleaner's lack of translation competence but on the failure of the healthcare institution and its staff to appreciate the complexities of mediated communication across cultures. It would be a great compliment to the emerging discipline of interpreting studies if case studies such as this one could help healthcare managers and providers recognize and remedy a serious gap in their quality assurance for professional services.

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On: 07 September 2015, At: 03:18
Publisher: Routledge
Informa Ltd Registered in England and Wales Registered Number: 1072954
Registered office: 5 Howick Place, London, SW1P 1WG

The Translator
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/rtrn20

Information Loss in Bilingual Medical Interviews through an Untrained Interpreter

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Published online: 21 Feb 2014.

To cite this article: Jan Cambridge (1999) Information Loss in Bilingual Medical Interviews through an Untrained Interpreter, The Translator, 5:2, 201-219, DOI: 10.1080/13556509.1999.10799041

To link to this article: http://dx.doi.org/10.1080/13556509.1999.10799041

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The Translator. Volume 5, Number 2 (1999), 201-219 ISBN 1-900650-21-5

Information Loss in Bilingual Medical Interviews through an Untrained Interpreter

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Abstract. *This paper presents research based on discourse analysis of seven extempore simulated consultations between practising General Medical Practitioners and non-English speaking volunteer patients, with language-switching provided by educated but professionally untrained native speakers of the foreign language. The research set out to examine how information is lost to both doctor and patient in the language-switching process. The results highlight the importance of appropriate interlocutor roles being occupied by all parties, as well as the dangers inherent in a lack of common ground within the transaction. The language pair used in the data is English-Spanish, but the results are discussed as applicable by extrapolation to any language pair. The findings highlight the risks to all parties of dysfunctional communications across language and culture. Cross-language communication is shown to be complex, and highly trained doctors' skills blunted by malfunctions in language-switching. Information is lost in such malfunctioning encounters, to the detriment of effective medical practice.*

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The purpose of this study was to look not simply at medical encounters but in particular at the effects on medical encounters across language and culture of using untrained language switchers. A medical interview is a very specific type of encounter, with constraints of time and many other factors placed upon it. The patient may well present symptoms unrelated to the real problems, and the diagnostic skill of the doctor relies heavily on skilful questioning. Where doctor and patient do not have an adequate command of a shared language, someone must act as a language switcher. This may be an untrained mediator. I use the term 'mediator' to indicate the difference between a trained interpreter and an untrained language switcher, after the work of Knapp and Knapp-Potthoff (1987). I will not address the many reasons for avoiding the use of family members or children in this situation, but will look instead at the use of bilinguals who are unknown to the patient, who appear to the other participants in the encounter to have a good command of both languages, but who have no relevant professional training.

ISSN 1355-6509 *© St Jerome Publishing, Manchester*

1. The type of encounter

Interactions have many governing factors, which determine how they are carried out. They are influenced by goals, by the sex and status of the speakers, the existence or not of common ground between the speakers, the social distance between them, and their role within the conversation.

Cheepen and Monaghan (1990) borrow the terms 'transactional' and 'interactional' from Brown and Yule (1983:1-3). I shall be using Cheepen and Monaghan's definition of the terms, in which there are three principal features of a transaction. The first feature is asymmetry of power. One interlocutor has knowledge or some other commodity in his or her gift, which puts the other in a position of relative powerlessness. Solidarity, unity of interests or sympathies among members of any social group, is a function of power and social distance. In transaction there is asymmetry of power and there is social distance, even though there may be no social distance between the two individuals when they meet in other spheres. Maximum solidarity is the point at which there is minimum social distance and minimum asymmetry of power, as shown in Figure 1.

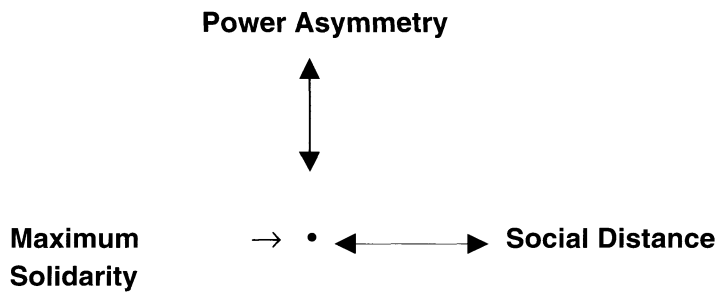

Figure 1 Power, Distance and Solidarity

The second feature, particularly in an institutional context, is an external goal. The goal of the encounter, such as the exchange of goods or services for money, is external to the encounter itself. The third feature is a sequence of topics, determined by the goals; and that one person has control of turn-taking. The person in 'client' role will often guide the conversation by asking for a sequential set of information regarding the goods and culminating with an offer of payment. The doctor-patient transaction, however, is supplier-(i.e. doctor-) led. In other words transactional roles that apply in most settings are changed in the doctor-patient setting. Instead of the service provider (doctor) waiting to be asked for information in an ordered sequence of utterances controlled by the client (patient), the doctor's expert knowledge leads him or her to take charge and control the flow of information. In a medical

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interview, it is the doctor who knows what the probabilities are, the various permutations of symptoms, possible treatments and likely side effects. The goal, external to the encounter itself, is the enhanced wellbeing of the patient who has requested an appointment. In interpreted medical encounters, the interpreter is "implicitly co-ordinating the conversation as a common activity simply by providing renditions" (Wadensjö 1992:73).

For my purposes, this transaction has the added factor that the patient does not necessarily know the 'rules'. Topic change and turn taking are governed by the doctor. However, there are occasions when the doctor appears to assign power to control both these elements to the patient within certain parameters. For example probing or open questions like "what do you think these symptoms mean?" or "is there anything you would like to ask me?" seem to invite the patient to take control briefly and offer an opinion. The doctor is in fact still in charge of both elements, since it is he or she who decides when this part of the transaction will take place, how long it will last, and what sort of contributions are admissible. A patient from another cultural and linguistic background may not be competent to pick such signals up or confident enough to offer any contribution anyway.

1.1 Face, equity and politeness

When a third party to an encounter is used to perform language-switching functions, potential loss of face becomes an issue if this person perceives him/herself as being personally accountable for the words being uttered by others, or as identified with the ideas expressed by them (Knapp *et al* 1987: 184-85). Brown and Levinson (1987) define positive and negative types of both face and politeness and discuss the severity of Face Threatening Acts (FTAs). Face is defined as the public self-image that everyone wants to preserve for themselves. The term has two related aspects. One is negative face, which is the basic right to freedom of action and freedom from imposition. The second is positive face, which is essentially self-esteem and the positive regard of others. The question of face, and identifying with one or other of the parties, is particularly relevant in a clinical setting, where the danger is that an untrained linguistic mediator may 'filter out' utterances seen as showing the ethnic minority group in a bad light. Western medicine, for example, is distanced from traditional forms of healing in other cultures such as curanderismo, voodoo, or shamanism. If a patient were to refer to having consulted a shaman before visiting the doctor, a mediator who is identifying strongly with his or her home culture and feeling protective of it may not relay this information. Such filtering may protect the bilingual intermediary from the fear of ridicule, but it also deprives the clinician of potentially vital information. Apart from the loss of clues to the patient's perceptions of illness, 'wellness' and healthcare, it is quite possible that a doctor may pursue a

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diagnostic course or system of treatment while completely unaware that the patient has been, or is still, taking some preparation recommended by the traditional practitioner, and which has a pharmacological effect.

People engaged in talk change their footing within the encounter constantly. That is to say that there is an altered relationship between the interlocutors, in terms of the presentation and reception of utterances (Goffman 1979:5). Wadensjö (1992:118) describes this framework as accounting for "speakers' distribution of responsibility for the spoken words". These shifts are subtle and often paralinguistic, and are designed to preserve equity and face. The maintenance of equity within an encounter demands that speech acts which threaten the hearer's face be mitigated by some threat-reducing strategy. This includes negative politeness and positive politeness. Negative politeness uses strategies such as indirectness, questions and hedges, impersonal and passive constructions, among many others, all designed to acknowledge the hearer's wants. Essentially it is "respect behaviour ... [and] performs the function of minimizing the particular imposition that the FTA unavoidably effects" (Brown and Levinson 1987:134). Positive politeness offers redress in a wider sense, acknowledging the other's wants, asserting reciprocity of wants, offering gifts (of praise, or help, etc.) and is typified by joking or familiar behaviour. Both seek to soften the impact of an FTA such as criticism or complaint.

It is expected of the parties to an encounter not only that each will display self-respect but also that they will respect the other parties' own face. When this is not adhered to, the dominant party is thought to be behaving 'unfeelingly' or 'rudely'. This happens in clinical settings where the clinician fails to attend to patients' views of themselves and, for example, uses euphemism inappropriately, either thoughtlessly or in order to serve his or her own needs in preference to the patient's. Where the glib use of 'baby talk' is a superficial gesture towards establishing solidarity, as in "slip your pants off dear and pop onto the couch", the patient will lose face and feel belittled. Where a doctor feels unequal to delivering bad news, a euphemism can sound unfeeling. 'Cyst' as a substitute for 'tumour' or a phrase such as "try not to mope" following a terminal diagnosis may serve a need and save face for the doctor but does not preserve equity or face for the patient. Brown and Levinson (cited in Clark 1996:295) consider that politeness strategies for maintaining and restoring equity are universal, or almost so, across the world's languages. Nevertheless, the actual practicalities of those strategies are culturally bound and therefore an issue in establishing cross-cultural common ground as the basis for joint action.

1.2 Common ground

Clark (1996:12) defines common ground as "a great mass of knowledge, beliefs, and suppositions [people] believe they share". There is common

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ground that the cultural group shares: that the earth is round, that 707s are capable of flight, that the potato is edible. This is communal common ground. Personal common ground draws on mutual experience, either perceptual or linguistic. This means that two people can have communal common ground in that they belong to the same theatre club, for instance, but no personal common ground when they meet for the first time. If they then both attend the same performance of a play, they have personal, perceptual common ground. If only one of them sees the show but afterwards describes it to the other, they have linguistic common ground based on reporting an experience. The concept of communal common ground, as opposed to personal common ground, is reflected in the lexicon that identifies a speech community. Words which appear in the lexicon of one group may have another meaning for a different group. In common parlance the word *contagious* is used loosely to mean that an illness is easily caught from other people, making it synonymous in that lexicon with the words *infectious* and *catching*. Doctors, on the other hand, use it to mean that the disease is transferred from one person to another by physical contact. Successful communication between doctor and patient will rely on first establishing which lexicon is being drawn on.

Where no communal common ground exists, patients can be alienated and even disempowered by the inappropriate use of a lexicon which belongs to a particular speech community. What Holmes (1992:276) has described as 'occupational style' is often experienced by the patient as impenetrable jargon and is caused by the doctor's mistaken assumption that there is communal common ground, which causes him or her to use an inappropriate lexicon. Where the hearer is not empowered, as in a medical interview, this can be intimidating. West (1984:112) remarks: "Patients do not like medical jargon, and physicians do not know what constitutes it".

When an interpreter is added to the encounter the situation is even more open to complications. The interpreter may share communal common ground with the doctor, for example an understanding of how such interviews are conducted in this culture; but he or she may not share the medical lexicon, may not understand a medical concept or the purpose behind a particular line or form of questioning. Questions which may pose a threat to face are unlikely to be answered truthfully, and are therefore often prefaced with some kind of hedge or non-judgemental statement like "Would you mind telling me your age?" or "It's common for people to find themselves comfort-eating when they're very stressed. Do you think that might be happening to you?". An interpreter who is unaware of the strategy involved in this may put the questions baldly: "How old are you?", or "Are you overeating?".

1.3 Interlocutor roles

Clark (1996:20) draws on Goffman's (1981) model of interlocutor roles and

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describes speaking as being composed of three levels of action: meaning, formulating and vocalizing.[1] The Vocalizer utters the sounds which represent a message. This message may have been composed by another person, the 'Formulator', who actually scripted the content of the message. The 'Principal', on the other hand, is the agent who means what is contained in the message. In extempore face-to-face conversation a speaker will usually fill all three roles. A police officer reading a person their rights prior to arrest is vocalizing a message, but will not have formulated what he or she is saying. When a lawyer reads a statement on behalf of a client, the lawyer is vocalizing a message, but it is the client's meaning that is represented and quite possibly a clerk who formulated it.

At the same time there are Listener roles: Attender, Identifier and Respondent. When speaking to the class, a lecturer may ask a question of the listeners. They may or may not be attending to what is said. If they are attending they will be identifying words and phrases, and then perhaps responding. In this framework (Clark 1996:20-21), the Attender pays attention, the Identifier identifies the words and the Respondent understands what is meant by them and answers the question. The two activities which most actively engage the personality and judgmental faculties of an individual are those of Principal and Respondent. It is the Respondent who glosses the content of a message in terms of an individual's own life experience, opinions and beliefs; and the Principal inserts meaning, on the same basis, into a message that the Vocalizer sends. In a monolingual encounter between doctor and patient, one speaks and conveys information and the other responds. The first speaker is therefore able to assess whether or not the message he or she sent was accurately received. If it was not, then they can take immediate corrective action.

This is the basis of the diagnostic skill involved in medical interviewing. Underlying symptoms are rarely offered directly by the patient. A doctor in general practice in England told me that when a patient comes to consult her "the presenting sign may be false, so it must be checked out, which involves probing by questioning" (Dr C. Brace, personal communication, September 1997). This probing by questioning is skilful and relies as much on unconscious clues in the patient's replies as it does on the phrasing of the questions themselves. In a monolingual encounter each interlocutor is able to operate all three of the functions involved in each activity for themselves and exercise their own judgement and choices. When an interpreter is interposed between the primary interlocutors, that feedback is broken. The patient speaks, but the next turn goes to the interpreter, so the patient cannot know if his or her intentions were properly recognized. The doctor meanwhile has been attending, but unable to identify or respond. He or she must wait until the interpreter takes a turn, and will then attribute the meaning of what the interpreter says to the patient. The doctor has no choice in this, since he or she has

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no way to check. If the interpreter should change the content of the message during this process, and act in the role of Principal, creating his or her own message, it will be four 'turns' before the patient can take corrective action, if the doctor's reply should seem not to match expectations. When Pablo, speaking Spanish, describes his headaches through an interpreter, Dr Jones may attend to Pablo's utterances without identifying or understanding them. Although she attends to, identifies and understands the interpreter's English, she attributes to Pablo the meaning expressed. This decoupling can be seen in the data transcripts discussed later in this paper and is the cause of some misunderstandings.

The fundamental problem of communicating through an interpreter is that, in Clark's model, it is not a joint action between interpreter and interlocutor or between two interlocutors directly. As can be seen in the data, both listener and speaker roles are decoupled in an interpreted encounter. The interpreter is both Vocalizer and Formulator in the sense that he or she composes the actual words, though not the meaning, of the message. The interpreter also delivers the message. When he or she identifies too strongly with one party or the other, the tendency is for the interpreter to take over the role of Principal as well, which creates the potential for misunderstanding, since listener roles have also become decoupled. When the interpreter adopts the role of Principal, it is his or her meaning that is being relayed and not the original speaker's. Wadensjö (1992:118) points out that "if someone speaks/ is heard as speaking as if not referring to anyone else as "principal" of her utterance, this would imply that she takes a personal stand and is responsible for what she says herself". Because the interpreter tends to take over the role of Principal covertly – and probably inadvertently – either doctor or patient remains in the roles of Attender and Identifier but will attribute the role of Principal inappropriately. Thus Pablo may remark that his headaches cause him to vomit and suffer visual disturbance, in that he sees rainbows round lights. An interpreter who is listening in all the listener roles may make the judgement that the final part of the message is fanciful, therefore irrelevant, and relay only the first two symptoms. He or she therefore responds to the doctor in Principal role and says that Pablo suffers from vomiting and loss of sight, omitting the rainbows. The doctor attributes this meaning to Pablo, treats him for migraine and thus fails to check for acute glaucoma.

2. Collecting the data

The data consist of seven extempore conversations between practising GPs (General Practitioners) and non-English speaking 'patients', using volunteer interpreters. These conversations were unscripted role-plays; the scenarios were provided by the doctors. None of the doctors was aware however of what the 'patient' would present with since each prepared a scenario for one

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of the others. The filming was done at the training suite of the Robert Darbyshire Medical Practice in Rusholme, Manchester. This is part of the Faculty of Medicine's Department of General Practice and is a training practice, operating as a normal city health centre in a multi-ethnic area, serving a multilingual population. The practice as a whole is experiencing communications problems. The training suite offers a mocked-up consulting room with video link to an adjacent room, so that participants were able to carry out their conversations in conditions as close to reality as possible.

The doctors concerned gave up time during their normal surgery hours to hold a consultation with the volunteers. All the doctors were well used to working in this way and were perfectly comfortable with the video camera. Four doctors did seven consultations with four patients, using two interpreters. The interpreters were both women, which reflects the fact that the majority of people working in the field of public service interpreting are women. For this reason, I will refer to mediators and interpreters in general as 'she' throughout. Both were in their thirties and married. Interpreter A was Mexican, and had lived in England for 15 years. She had some teacher training, but did not practice. She was married to an English nurse and had in the past been called on to interpret for patients at hospitals near to her home. Interpreter B, who came from the north of Spain, had lived in England for 10 years and was married to an Englishman. Both she and her husband were teachers of Spanish. The two women had quite different styles as interpreters but neither had any relevant formal training. Interpreter B doubled as a 'patient' in the final interview, as the other volunteer 'patients' were all men. There were three volunteer 'patients'. Patient C came from the Canary Islands and was studying music at the Royal Northern College of Music. He was in his early twenties. Patient D and Patient E were from Alicante, both in their mid-twenties, had university degrees – one in law and the other in economics – and were in England to improve their English. They were working in a hotel in an English tourist resort, and had been in the country for about three months. Of the doctors, one said that she was accustomed to working with non-English speakers, without the benefit of interpreters, having spent some time in Australia working with Aboriginal people. Another said that at the age of 16 he had spent about three months in Colombia. He could not speak Spanish, he said, but could understand it.

3. Discussion

It should be remembered that there are particular constraints on interpreters, some of which are specific to public service interpreters. Common to all types of interpreting are the problems of speed; lack of access to, or time to use reference materials during the assignment; accent; jargon; and the likelihood that no advance briefing has been given. Specific to the difficulties facing

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public service interpreters are poor acoustics (especially in Britain's older hospitals), loud background noise and surrounding conversations, the possibility that extra time will not have been allowed for an interpreted interview, and the five features described by Nathan Garber (1998), which distinguish public-service from other groups of interpreter:

- The setting involves an interview between a service provider and someone who needs or wants the services (a 'client').
- The interview arises out of some sort of crisis in the life of the client.
- There is a significant level of risk inherent in the situation.
- Cultural differences between provider (doctor) and client increase the risk.
- There is a power imbalance between provider (doctor) and client.

These factors do not affect the work of conference or diplomatic interpreters, nor those working in industry. Furthermore the public service interpreter may not offer one language as active and another as passive. She must work both into and out of all her languages.

By far the commonest cause of miscommunication is the mediator's occupying inappropriate interlocutor roles. There are three main types of malfunction attributed to inappropriate interlocutor role: loss of content, addition to content, and alteration of meaning. These will be discussed below. There are also two less frequent but more obvious malfunctions which demand repetition of the original message, namely failure to identify a word or phrase, and failure to attend adequately, which results in getting the time wrong or forgetting a list.

On many occasions information is lost due to the Attender role failing. Either the mediator (M) has simply forgotten the content of a long preceding utterance, since she took no notes, or else she has judged some part of the utterance to be irrelevant and omitted it, as in the following extract. The patient (P) complains of diarrhoea and the doctor (D) has asked if he knows of anyone else with the same symptoms.

Extract 1

P Pues la verdad que no caigo ahora. Hombre hay alguien que me ha dicho alguna vez ¿no? Porque comemos todos en el mismo sitio, que está un poquito mal de estómago o algo así pero [no realme/ No, no]
Well, at the moment I can't think ... Oh there is someone who told me once, you know? Because we all eat in the same place, that they had a bit of an upset stomach or something but not really. No, no.

M [No significa] No, he has heard of some other people that have had the same upset but he's not sure that it's the same thing. The same condition.
It doesn't mean .. No, he has heard, ...

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The mediator appears to be going to say something of her own in response but stops herself. The fact that all the students eat in the same place is not relayed, with obvious public health measures therefore ruled out as an option open to the doctor. During consultations in which the doctor could understand some Spanish, he corrected these omissions once or twice. Ironically though, a little knowledge of the other language involved can cause its own problems: the mediator actually failed to correct a misinterpretation by the doctor in one interview.

On other occasions the mediator is speaking in Principal role, relaying her own meaning and giving information that is additional to the primary interlocutor's meaning:

Extract 2

D Okay (.) Um, I think it might be helpful if I had a look at you to check for any physical reason for the weight loss, but it sounds most likely that it's related to the worry. Change. Coming here. Um, and I would like to look at, look at you and, and then we can talk again.

M → Sí, va a examinarte un poco para ver si va a encontrar una causa física con presión de la sangre para examinarte de manera que se asegure de que no hay nada específico fisicamente que te está afectando. El piensa
→ que fácilmente sea el cambio de, estar viviendo en un entorno diferente,
→ el cambio de alimentación y las preocupaciones, exámenes, familia, lo normal. Pero va de todas maneras a examinarte.
Yes, he's going to examine you a bit to see if he can find a physical cause with blood pressure to examine you so as to be sure there's nothing specific, physical that's affecting you. He thinks it could easily be the change of, living in a different environment, the change of food and the worries, exams, family, the usual. But he's going to examine you anyway.

Alternatively, still in Principal role, she subtly alters the primary interlocutor's meaning in potentially very dangerous ways, as in Extract 3 below.

Extract 3

D So, you said about exams soon
M ¿Tienes exámenes ahora?
Do you have exams now?
P Yeah. Uhuh.
M ¿Ahora, en junio?
Now, in June?
P Yeah.
M Now, in June, so they're about to happen.
D Quite soon? Okay. How do you think you will feel after the exams?
M ¿Cómo crees que vas a encontrarte después de los exámenes?
How do you think you'll feel after the exams?

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P Pues eso (.) Si las apruebo, bien.
Oh, that. If I pass, fine.

M ¿Y si no, será una desgracia? (laughs)
And if not, will it be *a disgrace?*

P Bueno, si no, ya veré
Well, if not, I'll find out

M Uh, he thinks he's going to feel much better if he pass exams of course. Otherwise he will have to reorganize his life and think over what he is going to do.

D I feel that you are quite worried, but I don't sense that you're unhappy or depressed. Do you, d'you feel like crying?

M Em, eh, entiende, cree que estás preocupado pero mmm, de momento no ve que estás infeliz o que estás deprimido, que mm si a veces lloras o que haya una sensación en ti mismo de angustia o depresión. ¿Tú crees, eso te pasa?
Um, er, he understands, he thinks you're worried, but mmm, at the moment he doesn't see you as unhappy or depressed, mmm do you cry sometimes or do you feel inside yourself that you're anxious or depressed. Do you think that happens?

P Que me/ mmn hombre de eso me dan gana ¿no? Porque lo típico de eso es saber ¿por qué me tiene que pasar a mí?
I Mm, oh I do feel like it, you know? Because the thing is I think why does this have to happen to me?

M → He sometimes, he doesn't reckon it's too serious, he feels depressed because he feels how, why this has to happen to me? And when things are difficult around and when it's a bad moment to be suffering ehhm, but/

D Right.

M → Only occasionally. He is not unhappy continuously.

I interviewed the doctor who appears in this part of the film. I offered him the transcript of his consultation to read. We discussed the exchange about depression, and I asked him if he would have proceeded otherwise, had the patient's full, actual replies been clear to him at the time. He replied that the mediator "may have understated" the severity of the problem:

> If I had felt the severity of the mood disorder was consistent I might have talked about anti-depressive drugs or recalled him after the exams or probed a bit further ... I might have agreed to sleeping pills, but I would have explored his feelings about anti-depressive drugs. So I might possibly have missed a more serious depression because I thought it was not a persistent mood disorder. (Dr Perry, personal communication, August 1997)

The transcript shows that the mediator adds two statements of her own opinion to the patient's replies, i.e. "he doesn't reckon it's too serious" and "Only

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occasionally. He is not unhappy continuously". If the patient had really been suffering from depression, all the parties would have been at risk.

Finally, subtle linguistic changes, such as reversing the polarity of a question, as in Extract 4 below, may alter meaning in a potentially significant way.

Extract 4

D Okay. Does he vomit with the headache?

M ¿No tienes vómitos?
You don't vomit?

P No.
No.

The mediator's negative question in Spanish prompts for a negative reply, in contrast to the doctor's phrasing, which allows for a positive or a negative response (Cruttenden 1986:97).

3.1 Distance

It is noticeable throughout the data that the mediators both use the third person style of interpreting. No discussion had taken place beforehand about how they would proceed, and so this was a free choice. It may have been influenced by the doctors' use of the third person. Only one of the doctors makes any attempt to address the patient directly, using the second person. This does not seem to have any effect on the malfunction figures, which may be due to the fact that the mediator does not use the second person when relaying from patient to doctor. Both mediators tend to use the second person when relaying from doctor to patient, though, which continually changes the focus regarding 'principal addressee', and keeps the mediator firmly in Principal role throughout. On several occasions, the doctors speak to the mediator as though she were the responsible adult in charge of the patient:

Extract 5

D Is he tending to eat regular meals? Because as a waiter or working in a restaurant it is often difficult to eat regularly, is he eating properly, looking after himself?

and

D Ask her to tell me again where the pain is.

Another aspect of the distancing effect of the third person style is that the doctor's supportive comments tend not to be relayed. It is not apparent whether this is because the mediator thinks them irrelevant, or whether she thinks

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they were addressed to her and not to the patient, or why they are left out. However, the following examples illustrate the point.

Extract 6

D In the meantime I'm also going to give him some tablets to try and help
→ this pain get better quickly so that hopefully he will not miss time off
→ work because I hear what he's saying about not wanting to lose his job.
M Ahora, para que no pierdas tus horas de trabajo te va a dar por lo mientras unas tabletas para que te alivien un poco el dolor para que puedas seguir trabajando, solamente mientras esperas el análisis de sangre.
Now, so you don't lose your hours of work she's going to give you some tablets in the meantime to relieve the pain a bit so you can go on working, just while you wait for the blood tests.

The doctor has offered the information that she has taken note of the patient's concern about losing his job and is trying to help him, specifically, to address that. The phrase "I hear what he's saying" is omitted in the mediator's version, and the result could be taken to mean that the treatment is to prevent idleness.

To the suggestion that he may be suffering from headaches as a reaction to the stress of moving to live overseas, the patient replies:

Extract 7

P No creo. Yo estoy acostumbrado a viajar. Estoy acostumbrado a salir.
I don't think so. I'm used to travelling. I'm used to being abroad.
M He is/ he doesn't think so because he is used to travel around and go out and about.
D That's fine. Well that's something for him to think about, because he's in a strange country. Students sometimes have work problems or money problems, so just for something for him to think about. What I would like to do is to arrange to meet him again in a couple of months time just to see his progress and to see how he's getting on ...
M Would you be able to come back in a couple of months time/ eh, podrás venir dentro de dos meses a, para revisar la situación o/ sí
Would you be able to come back in a couple of months time, eh, could you come in a couple of months to review the situation or, yes
P Sí
Yes

The offer of understanding and support implied in the doctor's remarks about possible work or money problems is not relayed, nor is the suggestion of a friendly visit being made to "see how he's getting on", and the patient is left with the idea that his headaches are being attributed to stress caused by not being used to being away from home and that he is being offered a further,

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purely clinical, check-up in the future.

The doctor's continuous use of the third person, which identifies the mediator rather than the patient as principal addressee, causes both patient and mediator to take responsive action. The patient, where he has enough English to recognize what is happening, responds on his own behalf and puts in a few English words. The mediator, where she is being treated as responsible adult, i.e. in charge of the patient – *in loco parentis,* as it were – responds by changing her transactional role altogether and replying to questions on the patient's behalf without relaying them first. The fact that the mediators are in Principal role throughout leads them to build up a solidary relationship with the patients on the basis of common ground (common language and cultural background) and of a symmetrical power and social distance structure. This causes the mediator to step out of role completely and offer advice and personal opinions. In extract 8 below, the structural change has not been signalled in any way and the covert nature of the mediator's interventions is the cause of a misunderstanding about 'vitamins' (and the reason for the problem with the 'depression' conversation in extract 3 above).

All the above types of malfunction are hidden from the primary interlocutors, whose Attender may be working perfectly but who are denied the use of their Identifier or Respondent by the nature of the encounter. They will therefore attribute the meaning they hear from the mediator to the wrong interlocutor (i.e. to the other primary interlocutor instead of to the mediator). This is very clearly seen in the depression interview (Extract 3), quoted above. The doctor suspects that the patient's mood swings may indicate a serious depression. The mediator puts words into the patient's mouth, which the doctor naturally responds to as though they were genuinely the patient's, having no danger signal to guide him. There are occasions when the mediator steps out of the mediation role altogether, becoming a primary interlocutor in her own right, and sending messages entirely of her own. Extract 8 provides a good illustration of this.

Extract 8

D In someone of yo/ a young person with the change that you've described, it's very likely to be related to worry, the weight loss. I wonder if we should check your weight again, and talk again, after the exams ... How does that sound?

M El mm piensa que sería bien pasar los exámenes porque a esta edad con la presión de los exámenes, el trabajo y presiones exteriores y personales, puede ser un síntoma todo ese peso, perder. Entonces le gustaría volverte a ver una vez que se relajen ciertas partes de las preocupaciones, y volver a ver el tema. ¿Bien?

He mm thinks that it would be good to finish the exams because at your age with the pressure of exams, the work and outside and personal pressures, all that weight that you lost could be a symptom. Then he

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would like to see you once some of your worries are over, and look at the matter again. Alright?

D If that sounds alright to you?

M → ¿Qué te parece? ¿Quieres hacer algo más, o (.) esperar un poco mas
→ hasta que pase la situación. Quieres algún tipo de vitamina quieres/
How does it seem to you? Do you want to do something more, or (.) wait a bit until the situation's over. Do you want some kind of vitamin, do you want/

P Yo creo, no sé. Si él ve que, que está bien, que, que no hay ningún problema pues de acuerdo. Si me manda algún vitamina y funciona pues no sé ... se lo agradezco.
I think, I don't know. If he thinks that, that it's okay, that, that there's no problem, well I agree. If he orders some vitamin and it works well I don't know ... I'll be grateful.

M He thinks what you decide is right unless you want to give him some vitamins or something you reckon is going to help, he will be happy to wait for a while and come back to you.

D Right. I don't think vitamins will help. I think that there are some simple things you could do about the sleep at night that might help.

We can see here that the issue of vitamins has come directly from the mediator, who appears to be acting in Principal role, as the student's mentor and protector. This is a hidden role change as far as the other two interlocutors are concerned. Inadvertently, she poses a real threat to the patient's face, since he would not have risked rejection by the doctor's refusal had it not been for the mediator. These incidents show the mediator's failure to realize that she holds a very specific and specialized place within this transaction, and that the other participants cannot know that she has changed her status within it, unless she herself is aware of it and signals the change clearly.

3.2 Word order and structure

The next largest reason for the common ground problem is that the mediator does not understand the reason for a particular question being framed in the specific way the doctor has asked it. For instance, in Extract 9, the doctor prefaces his potentially face-threatening enquiry with a carefully phrased acceptance of the use of alcohol as a soporific.

Extract 9

D Right, yes. Sometimes when we don't sleep, sometimes when people don't sleep very well they tend to drink more. I just wondered, d'you, are you having any more alcohol?

M Eh, el/ eh, tienes un/ ¿Bebes más de lo normal? porque a veces cuando se está un poco desequilibrado para coger más fuerzas o ánimos eh, la gente bebe más de lo normal. ¿Crees que estas tomando más alcohol del que deberías?

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Er, he/ er, do you have a/ Do you drink more than usual because sometimes when one's a little off balance people drink more than usual to give them more courage or strength ... Do you think you're drinking more alcohol than you should?

The mediator fails to realize that there is a purpose behind this preamble and turns the utterance round. Her re-phrasing and omissions mean that the doctor's attempts to probe for underlying psychosocial influences are potentially frustrated.

There are many instances of the mediator taking on a full interlocutor role. In Extract 10, she does this, unsignalled, of her own accord (as mentioned above) and replies to a question from the doctor without reference to the patient.

Extract 10

D She said she wasn't sleeping well. I wondered why that was? Is it the stomach or something else?

M No, it's not the pain that wakes her up.

At other points, she puts words into the patient's mouth, asks a question of her own or offers an opinion of her own. But both doctor and patient occasionally change the transactional structure themselves. The patient, because he understands some English, replies directly to the doctor but does so in a mixture of Spanish and English, partly usurping the mediator's role.

Extract 11

D Two years. And did he have problems with headaches when he was living in Spain at all?

P Pues no, no he tenido problema. Posiblemente, yo creo que puede ser influencia de tiempo. Weather influence.
No, I haven't had a problem. Possibly, I think it could be the influence of the weather. Weather influence.

3.3 Face threats

The doctors who took part in the study appear to be well aware of both face threats and gender issues, and very practised at minimizing or avoiding them. The patient seems to feel that he is not free from imposition, since he understands some English and needs to assert himself, as for example in the "weather influence" quote (Extract 11). In Extract 12, the sequence shows him to be unwilling to admit that he may have self-prescribed.

Extract 12

M ¿Tomas pastillas o algo?
Do you take pills or anything?

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P No, es la primera vez, que consulto al médico
No, this is the first time I've been to the doctor
M ¿O sea que no has tomado aspirina o una cosa así por ejemplo, em, por tu cuenta?
I mean have you taken aspirin or something like that for example, um, off your own bat?
P Paracetamoles.
Paracetamol.

Later in the interview, his face is threatened by the suggestion that he may be under stress simply by being away from home. The repeat of the question may be attributable to other causes, of course, such as a belief that *pastillas* referred to medication available over the counter as distinct from prescribed medicines. On the other hand, in Spain, the home country of this patient, antibiotics, including those for intravenous administration, are still available over the counter on a self-prescribed basis. The most outstanding examples are the face-threats offered by taboo words. In Extract 13, the patient describes his problem thus:

Extract 13

P Cuando me levanto por las mañanas, la primera orinar, normalmente suele ser (.) fuerte y me escuece, ¿se dice escuece?
When I get up in the mornings, the first time I urinate, is usually ... strong and it stings me, do you say stings?
M Sí.
Yes
P Me escuece orinar, se escuece el pene al orinar.
It stings me to urinate, my penis stings when I urinate.
M He has got a problem. When, the first time he goes to the toilet in the morning he usually feels some pain and, and it um, and um, it's hard to pass the water. So
(...)
D He doesn't, no. Okay. Has he noticed er anything else such as a discharge from, from the penis, when he's not passing urine?
M ¿Has notado, em, has sentido algún otro síntoma en, en el pene cuando no estás orinando, no sé, que puede (haber) algo?
Have you noticed, um, have you felt any other symptom in, in your penis when you're not urinating, I don't know, there could be something there?
P ¿Como cuál?
Like what?
M No sé, algún tipo de/
I don't know, some kind of /
P No
No
M No, he doesn't have any symptoms, really.

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It is the mediator's face that is threatened by the use of taboo words, and probably also by the personal nature of the information. If she were not 'owning' all the words she is relaying but had closed off her Principal and Respondent roles, the words *penis* and *discharge* would not be so embarrassing. If she were to relay directly, the position of the patient as Principal would be maintained. In fact she fails to find a word for *discharge* and so asks rather vaguely about other symptoms, leaving the doctor with the false impression that his question was asked and answered.

4. Conclusion

Miscommunication occurs throughout the data for a variety of reasons. To a certain extent this is due to a lack of awareness in the doctors, in that their use of the third person style of address has a distancing effect and tends to sideline the patient, and cause all the participants to change role within some encounters. The majority of miscommunications are initiated by the untrained mediators and are due to several causes. Unfamiliarity with the routines and procedures of medical consultations leads to uncomfortable moments. Insufficient command of the appropriate lexicon leads to difficulty in describing pain, and confusion in the use of technical terms. Occupying an inappropriate interlocutor role causes the mediator to over-identify with one party to the encounter (in this case the patient), which lays her open to threats to her own face. This use of inappropriate interlocutor roles also causes relay of meaning to suffer from omission, addition and alteration. Among the additions are the mediator's own, unsignalled, opinions and advice.

Overall, what is lost is an element of available diagnostic resources, and the doctor's skill in developing a satisfactory relationship with the patient. So, while a mismatch of messages may be occurring in a discursive sense, 'data bits' of hard information are also being lost – usually to the physician – and it is precisely this loss which most damages the patient's interests.

This piece of research suffered from several drawbacks. The interviews were simulated, and no post-simulation interviews were done. The data produced, however, are rich and have only been 'unpacked' here to a limited extent. Interesting further work could be done on studying the output of untrained interpreters, who are the principal linguistic resource in most healthcare settings (see Pöchhacker and Kadric, this volume). This may shed light on training issues. Changes to clinical practice, however, are unlikely to result from anything less than a comparative study under clinical conditions.

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Notes

1. Clark uses the terms 'Vocalizer' and 'Formulator' to replace Goffman's 'animator' and 'author'.

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Interpreter-mediated interaction in healthcare and legal settings

Talk organization, context and the achievement of intercultural communication

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Studies of dialogue interpreting have shown that interpreters are active participants in interpreter-mediated interaction and that their contributions are not simply a gloss of the interlocutors' turns. Wadensjö (1998), in particular, has underlined the coordinating and mediating functions of dialogue interpreters. In this paper we analyse the activity of interpreters in the interaction by looking at different ways of organizing sequences of turn-taking and their effects on intercultural mediation. We analysed a sample of 65 encounters in healthcare and legal settings in Italy, involving (Italian) institutional representatives, (English speaking) patients/defendants from West African regions and an interpreter. We note that different types of interpreter-mediator contributions are promoted or prevented in different ways in the medical and in the legal sets of data, in line with different contextual expectations, and with different results for the involvement of participants, particularly the "laymen".

Keywords: dialogue interpreting, social interaction, intercultural mediation, healthcare, legal settings

1. Introduction

The analysis of the linguistic and communicative functions of interpreter-mediated public service encounters (e.g. Wadensjö 1998, 2006; Mason 1999, 2005, 2006; Davidson 2000; Merlini 2009 and also Angelelli 2004; Hale 2007; Corsellis 2009) has shown that the interpreter's discourse roles, including those of language facilitator and of cultural and social mediator, are highly complex. Interpreter-mediated interactions generally occur in public service settings, such as hospitals

and courts, and may be considered a particular type of institutional talk, in that they involve at least one participant who represents an institution and are related to a task the participants need to achieve (Drew & Heritage 1992: 3). The participation of the interpreter, however, introduces some important differences in the setting. First, interpreters are usually hired by the institution, and are thus seen as performing "institutional roles," but strictly speaking, they are not institutional representatives. Second, while in institutional interaction there are generally two parties, the institutional representative(s) and the layman/men, the interpreter in interpreter-mediated encounters is a third party in the interaction with the task of providing interpreting, rather than giving/receiving the service her/himself. So while negotiating reciprocal understanding is a task characterising interaction in general, in interpreter-mediated interaction, one participant (the interpreter) is there with the sole communicative function of making understanding possible.

Through co-construction of the conversation, the interpreter as well as the other participants orient themselves to both the "local context" (what is actually said in the interaction) and the broader "frame," provided by the setting (hospital, court) in which the interaction takes place and by the respective participants' roles as patients, defendants, doctors or judges (see Cicourel 1992; Baker 2006; Mason 2006: 364). In this paper we look at interpreter-mediated interactions in healthcare and legal settings and analyse the ways in which interpreting is achieved, with reference to the relevant contextual assumptions. We note that the ways in which interpreter-mediation is achieved have interesting implications for the actual participation of interlocutors in the interaction and for the management of intercultural communication.

Given the complexity of interpreter-mediated interaction, our data lend themselves to being studied from a perspective that combines different approaches, integrating research in the field of interpreting studies, interaction research and work on interlinguistic and intercultural communication. Following studies in Conversation Analysis (Sacks et al. 1974), we look at the ways in which participants co-construct understanding through a coordinated system of turn-taking. In particular, we observe the mechanisms by which the participants (all of them) contribute to talk construction (Jefferson &Schenkein 1978; Jefferson 1979; Schegloff 1980; Pomerantz 1984) and project institutional and individual expectations (Mason 2006). Our presupposition is that the interlocutors' responses are very important in explaining how participants take up each other's actions (Schegloff 1995) and that it is interesting to see how this takes place in interpreter-mediated talk, where not all participants speak the same language and direct uptakes show particular configurations (see Mason 2006: 364).

In this paper we also look at interpreter-mediated interaction as mediation (e.g. Bush &Folger 1994; Winslade& Monk 2008) in intercultural settings, with

particular attention to cultural diversity and to its treatment in the interaction (e.g. Carbaugh 2005; Kotthoff& Spencer-Oatey 2009). Our attempt to combine these perspectives is guided by the aim of seeing the potential for cross-fertilization between studies that focus on features of language production and those that focus on features of cultural production — two perspectives that are very closely interrelated in bilingual interpreter-mediated talk, such that each of them can profit from taking the other into account (see also Gavioli 2009).

2. Interpreting, interaction and intercultural mediation

Research on interpreting has recently come to foreground the communicative and social competence of interpreters (see Straniero Sergio 1999, 2007). Studies of dialogue interpreting centering on analyses of naturally occurring data (Wadensjö 1998; Bolden 2000; Davidson 2002; Mason 2005, 2006; Wadensjö et al. 2007; Jacobsen 2008) have shown that interpreters are active participants in interpreter-mediated interactions and do not confine themselves to translating on a mere, automatic, turn-by-turn basis. In particular, Wadensjö (1998: 108–110) has shown that access to both languages allows interpreters to play an important role in "coordinating" the organization of talk, either implicitly, by providing or not providing translation, or explicitly, by projecting the point where translation can be provided or by contributing to the clarification of actions and sequences occurring in the interaction.

Examining interactions in hospital settings, Davidson (2000, 2001) has looked at the function of interpreters as "gatekeepers." In particular, he noted that they tend to prevent some patient-generated questions from reaching doctors if these questions are not strictly connected to medical diagnosis or treatment. By the same token, Bolden (2000) shows that interpreters select the quantity and quality of information as related to the "world of medicine" rather that the "lifeworld"and similar conclusions have been reached by Brennan (1999), Cambridge (1999) Hale and Gibbons (1999), Tebble (1999), Pöchhacker and Kadric (1999), Meyer (2002) and Bührig and Meyer (2004), some of whom discuss the work of non-professional interpreters and warn against the risk of poor coordinating abilities. Davidson (2002), in an attempt to provide a model of turn-structuring for interpreter-mediated conversation, shows that such a structure is unexpectedly complex, reflecting the interpreters' contribution to the (re)construction of contextually relevant meaning.

These studies consistently underline the complexity of analysing the participants' and interpreters' respective contributions to the interaction. In particular, they have noted that concepts such as that of equivalence are far more complex

when studied in an interactional communicative context. Mason (2006: 360) notes that the very notion of "source text" creates problems in talk-in-interaction where the "text" is jointly negotiated among and co-constructed by participants in their ongoing activity. Interpreters cannot limit themselves to turn-by-turn translation, and in their attempt to understand what is meant by participants in talk, and select what is actually to be translated, they contribute to the achievement of talk. What emerges in these studies, then, is that the interpreters' "interpreting" activity is co-constructed so that their contribution does not consist in "mere" repetition in another language but amounts to a complex interactional and intercultural achievement (Wadensjö 1998: 75; Davidson 2000: 381).

Considering the inevitable function of interpreters as interactional mediators, it maybe worth having a look at the interpreters' activity in the broader context of mediation, when seen as an activity aimed at facilitating communication (Bowling & Hoffman 2000; Sahah-Kazemi 2000), and as a form of active interactional participation (Bush &Folger 1994; Mulcahy 2001; Ayoko et al. 2002; Brigg 2003). Mediators actively intervene in conversation distributing opportunities to speak, giving the parties space to introduce and deal with particular issues, reinforcing particular roles and identities and promoting successful outcomes. Mediation is then seen as the active co-ordination of communication, and includes facilitation of participants' contributions as well as the production of shared alternative narratives (Winslade& Monk 2008), helping conversation go on, offering turns to talk and monitoring mutual understanding. The mediator's task is that of empowering other participants, avoiding expressions liable to impede communication, such as status assertions and other forms of dominance behaviour.

Within this frame of reference, interpreters areseen as intercultural mediators: they promote and coordinate linguistic communication and in so doing become coordinators of intercultural relations (Baraldi 2006). Looking at the ways in which interpreters participate in co-constructing the interaction, as they strive to balance their translational and non-translational interventions, has thus become a matter of interest and a key to appreciating interpreters' social and communicative competence in intercultural interactions. A key issue in both interpreting studies and research on intercultural mediation in general is that of observing ways in which interpreters' activity, both translational and non-translational, facilitates participants' active involvement and offers them a space in which to provide their contribution.

In the following paragraphs, we look at the ways in which interpreters provide opportunities for shifting from sequences in which translation is provided "bit by bit" — i.e. on a turn-by-turn basis — to those in which it is suspended or delayed. We will not deal with interactions that take place in one language only, e.g. separate conversations of the interpreter with one of the parties or those in which one of the parties is present but temporarily preoccupied with an unrelated task (for

instance, a doctor who is busy examining records or reviewing tests). This analysis also excludes sequences involving code-switching or code-mixing mechanisms, where the interpreting is shaped by a (partial) knowledge of the "other" language on the part of (one of) the participants. Consequently some interpreters' contributions which may be significant in our data (e.g. interpreter-patient talk about the organization of hospital activities, or lawyer-interpreter talk about defendant assistance, or "zero" rendition when understanding of the "other" language is achieved) will not be discussed in this analysis. It should also be mentioned that the interactions analysed below were produced by interpreting professionals of varying levels of skill, training and experience, working at institutions with different requirements. To some extent, this is a reflection of the policy of some institutions in Italy whereby community interpreters' primary role is that of "cultural mediators" (see Merlini 2009). As a consequence, some of the instances presented below may seem to represent non-professional — or even "unprofessional" — behaviour on the part of experienced interpreters. As we know, however, the interpreter's choices do not necessarily tell the whole story when it comes to her/his proficiency or competence, and as we hope to make clear, these choices may be the result of a range of complex orientations, expectations and requirements enforced by the institutions and the social systems in which they occur. In our analysis, "unskilled" or "skilled" interpreting behaviour may be observed in the work of highly qualified professionals as well as less qualified ones. Our goal here is to look at the consequences of particular sequences of actions, and to suggest in what ways such sequences may favour or inhibit communication in intercultural situations. It is our hope that this research will prove conducive to further reflection on professional standards — a topic which lies beyond the scope of the paper itself.

3. Data

This study is based on the analysis of a sample of 65 interpreter-mediated interactions, of which fifty took place in healthcare settings, and fifteen at a local police centre dealing with residence permits for immigrants.[1] All of the interactions involve institutional representatives (a doctor or a nurse; a judge, a lawyer and a police officer); a patient or a defendant; and an interpreter. In all cases, the interpreter had been hired by the institution for the purpose of making communication possible and facilitating those institutional activities that involve immigrants. Interactions in hospital settings generally involve three or four parties (one or two healthcare providers, a patient and an interpreter). Interactions at the police centre are in fact short trials and involve five participants: a judge, a lawyer, a police officer, a defendant and an interpreter.

The interactions were recorded in Italian institutional settings and all of the institutional participants were Italian native speakers; the patients/defendants were immigrants from central Africa (mainly Ghana and Nigeria) who spoke English. There were three interpreters involved, all of them women in their thirties. The two women working in the medical setting were Nigerian and spoke a West-African variety of English (see e.g. Christophersen 1999), while the interpreter at the police centre was an Italian native speaker and a competent speaker of English. As explained by Merlini (2009: 57–62), Italy does not have a system of national, regional or public service interpreter registration. Thus, the three interpreters were employed on the basis of the current criteria adopted in Italian healthcare and legal institutions. With respect to their training and experience, the two Nigerian interpreters had an educational background in nursing and belonged to an association that had provided them with training in communication as well as intercultural and conflict mediation. At the time of recording, one had worked at the institution for approximately five years and the other for approximately two years. The interpreter in the legal setting had a Masters degree from a prestigious university program in interpreting/translation studies and had worked at the institution for three years. The three were selected as representing the highest possible standards in each of the two settings and were described by their employees as very good and experienced.

The two institutions concerned applied different requirements with respect to their interpreters. While interpreters in the legal setting were primarily required to "translate carefully" and training in translation and interpreting was appreciated, the primary requirement of the interpreters in the medical setting was that they facilitate contact between doctors and patients. Their training focused on cultural and intercultural competence with less emphasis on translation proper. In healthcare services, there is an acknowledged preference for working with interpreters from the immigrant community rather than the host one, and the interpreters are trained *ad hoc* for the requirements of the particular setting. In the legal sphere, interpreters with bilingual expertise are hired irrespective of their nationality or ethnicity. The labels used by the two institutional frameworks differ as well, with the legal institutions referring to the interpreters as "interpreters", the healthcare institution referring to them as "mediators." In this study, we will use the expression "interpreter-mediator" (IM) to reflect the two types of discourse and the implicit complexity of the task.

The healthcare settings involve clinics in or out of the main hospital building, most of which deal with the prevention or treatment of gynaecological conditions or with pre- or post-natal monitoring of patients (all of them female.) Some of the healthcare providers were male, some were female. Interactions recorded at the

police centre dealt with individuals (both male and female) who had been apprehended by the police for not possessing a legal residence permit.

The data used in this study had been audio- rather than video-recorded. This was due to Italian legal restrictions on recording in general and on video-recording in particular, and to a strong reluctance on the part of the institutional representatives to accept the possibly intrusive presence of a video-camera. For this reason, participants' posture, gaze and gestures could not be included in the data.

The samples of data used here have been fully checked for transcription accuracy by at least three researchers, applying the transcription conventions commonly used in Conversation Analysis (developed by Jefferson 1978, see also Psathas& Anderson 1990). All personal details have been altered in the transcription to protect participants' anonymity.

4. IMs' interventions in mediated talk

In interpreter-mediated talk, the interpreter is the only participant who is assumed to fully understand both languages. As a result, it is the interpreter who provides responses to most turns — both those of the institutional representatives and those of the laymen. The IMs in our data respond to other participants' turns either by providing a rendition of the previous turn or by other actions, such as asking for clarification or providing the interlocutors with acknowledgment tokens and continuers. While the IMs' own interventions were invariably oriented towards the potential translatability of the previous turn, the actual interpretation could either be provided immediately or suspended until a later stage. A case of immediate rendition is shown in extract 1, in which a judge asks about the defendant's nationality, then we have the IM's rendition and the defendant's response.

Extract 1.[2]
((J: Judge, IMF: Interpreter-mediator Francesca; D: Defendant))

1	J	nazionalità nigeriana?
		Nigerian nationality?
2	IMF	are you from Nigeria?
3	D	yes

In extracts 2 and 3 we observe two different types of suspended rendition. In extract 2, rendition is suspended by a clarification sequence, with the judge's question about the defendant's date of birth (turn 1) being rendered immediately by the IM and answered by the defendant providing his place rather than date of birth, whereupon the IM repeats the question (turn 4) and initiates clarification.

The question is then repeated by the judge in Italian (turn 6), rendered by the interpreter in English (turns 7, 9) and answered by the defendant (turn 10).

Extract 2.
((J: Judge, IMF: Interpreter-mediator Francesca; D: Defendant))

```
1 J       ((typing)) quand'è na:to?
          when was he born?
          (.)
2 IMF     whe:n were you bor:n=uh?
          (0.6)
3 D       (Gha:na)
          (.)
4 IMF     whe:n
          (0.2)
5 IMF     Gha:na
6 J       Ghana [i:l uh?
          Ghana [o:n uh?
7 IMF     a da:te uh?
8 D       mptu[h
9 IMF         [theda:te
10 D      (fourty oh) four seventy fi:ve
```

A second type of suspension occurs when the IM provides feedback to the interlocutor in the form of continuers and acknowledgment tokens (Schegloff 1982; Jefferson 1985; Gardner 2001). In extract 3 the IM provides continuers and acknowledgment tokens as the doctor explains the complex procedure of inducing labour. This activity provides a space for the doctor to negotiate what should be explained to the patient. An abridged rendition of the IM-doctor sequence follows (data not shown here).

Extract 3.
((Doc: Doctor, IMH: interpreter-mediator Heather, Pt: patient))

```
1 Doc  In base alla densità quindi come comincia: il riscontro con
       la visita nel collo uterino, si decide di mettere un gel a
       livello vaginale oppure l'ossitocina a livello (venoso) più
       avanti. Però (.) eh: sicuramente bisogna dirle (.) che non
       è tutto scontato cioè non è che siccome lei ha partorito una
       volta in un attimo si sbriga.
       On the basis of the density so as the check-up sta:rts with
       an examination of her cervix, we decide whether we use a
       vaginal gel or intravenal oxytocin later on. But (.) erm: we
```

certainly need to tell her (.) that she cannot take it for granted that is even if she has already given birth once it doesn't mean this will be quick

-> 2 IMH Sì infa[tti.
Yes ri[ght

3 Doc [Ogni donna è dive[rsa.
[each woman is differ[ent

-> 4 IMH [Sì certo
[yes sure

5 Doc e' una storia a sé.
e*ach one is a different story*

6 IMH [E poi il bambino-
[and then the baby-

7 Doc [Quindi non si deve demora- (??) tempi diversi dipende (??) un certo orario (??) eccetera. Non si deve demoralizzare nè deprimere se vede che- i miei colleghi le metteranno prima un gel, poi di nuovo un'altra ossitazione dopo sei otto o:re=
[So she shouldn't get discour- (??) different reactions it depends (??) particular timing (??) and so on. She shouldn't lose heart or feel depressed if she sees that my colleagues will place gel first, and then again a new oxytocin induction after six eight hou:rs=

-> 8 IMH Sì.
Yes.

9 Doc =poi valuteranno loro.
Then they will make their assessment.

-> 10 IMH Sì.
Yes.

11 IMH Anche il fatto che la rivisitano e le rimettono un gel e la reinducono non vuol dire che- è fallita l'induzione=
Also the fact that she is checked again and that they place gel again doesn't mean that- the induction has failed=

-> 12 IMH Sì.
Yes.

13 Doc =vuol dire che ci vuole un po' di te- E' raro che dopo il primo gel [parte e inizia il travaglio ok?
=it means that it takes a bit longer- It is rare that labour [starts after the first gel induction ok?

14 IMH [Parte, sì.
[it starts, yes.

Extracts 1–3 above show what are probably the main types of interpreting sequences found in our data. They also show that different types of intervention may figure in interpreter-mediated interactions — some of which involve immediate renditions and some require other types of intervention (such as requests for clarification, displays of understanding or acknowledgment tokens.) Thus, it appears that both types of intervention are sometimes necessary to achieve understanding, with different interactional consequences following each. When providing an immediate rendition, the IM passes the turn to the next interlocutor, treating the sequence as non-problematic, understandable and immediately translatable. On the other hand, in the case of suspended interventions of the types shown above, the interpreter treats the turn as problematic and proceeds to solve the trouble or to negotiate the comprehensibility and translatability of the previous utterance. This type of interactional work, however complex it may be, seems necessary to achieve understanding. In the following section we focus on the interactional consequences of suspended renderings.

5. Consequences of suspended contributions

There are several mechanisms for negotiating the suspension of rendition in interpreter-mediated talk, including the code-switching mechanism by which interlocutors show that they speak and (partly) understand their interlocutor's language and may not need rendition at local points (see Angermeyer forthcoming; Anderson 2009; Baraldi & Gavioli 2010). Here we focus on two types of suspending mechanisms initiated by the IM. Both seem quite frequent in our data (see also Englund Dimitrova 1997): 1. IM's initiation of a repair or clarification (e.g. to pursue a particular response, as in extract 2 above); 2. IM's minimal responses, such as continuers or acknowledgment tokens (as in extract 3 above) prompting the interlocutor to continue.

The initiation of a repair treats the interlocutor's response as non-relevant; the IM may then intervene for the sake of clarification and may pursue a contribution that responds to the content that had been made relevant in the previous sequence of turns. Thus, for example, in extract 2 above, the IM intervened to pursue the defendant's answer concerning his date rather than place of birth. Another example is provided in extract 4 below, taken from the medical set of data. Here the doctor's question ("Does she know if she's allergic to any drug?") is rendered by the IM and then answered by the patient with "mm" in turn 3, and "yeah" in turn 5. These minimal responses are treated as non-relevant, and the IM reformulates the question in turn 6, thus opening a side sequence in which clarification is negotiated. In line with the side sequence mechanism described by Jefferson (1972),

these clarification sequences end when the answer that was required is provided. The relevance of the answer is confirmed by the IM rendering it and resuming the immediate, turn-by-turn rendition mechanism.

Extract 4.
((Doc: Doctor, IMH: interpreter-mediator Heather, Pt: patient))

1 Doc Mh. Va bene. Sa di essere allergica a qualche farmaco?
Mh. Alright. Does she know if she's allergic to any drug?
2 IMH Did you allergic to any medicine?
3 Pt (.) Mmm
4 IMH Is there any medicine you take (??) that caused you problem?
5 Pt Yeah.
6 IMH Which one?
7 Pt Clorochina in Ghana.
8 IMH Clorochina.
9 Doc Clorochina. Eh.
10 IMH E:: Sempre quella.
E:: that one always.
11 Doc Ok. Trasfusione di sangue ne ha mai avu[te?
Ok. Blood transfusions, did she have [any?
12 IMH [You don't have blood
before. They don't give you blood before?

Sequences similar to those shown in extracts 2 and 4 are observable in both the medical and the legal data.

The second mechanism conducive to the suspension of interpretation is seen when the IM provides minimal responses, as in extract 3 above. Extract 5 below shows a similar case from the legal setting, with the IM "listening" to the defendant. In turn 1, the judge asks the defendant a question, which is translated by the IM in turns 2 and 4. In turn 5 the defendant asks for clarification and the IM responds in turn 6. In turn 7 the defendant describes the problems he has encountered in attempting to have his passport validated and the IM, in turn 9, provides a continuer and a possible completion of the defendant's turn. The IM then initiates a rendering in turn 11, but the defendant continues recounting his story to the IM, who eventually reports it to the judge in turns 15 and 17.

Extract 5.
((J: Judge, IMF: Interpreter-mediator Francesca, D: Defendant, L: Lawyer, P: Policeman))

```
1 J    = PERCHé NON SI è RIVOLTO AL CONsola:[to per avere il  [rinnovo
       del::docume:ento?
       = WHY DIDN?T HE ASK THE CONsula: te to get the document
       [validation?
2 IMF                                      [co:nsula:te, WHy [ di:dn't
       you: (0.2)
       didn't your: =
3 L?                                                         [((
       coughs))
4 IMF  = why didn't you ask to the co:nsulate or to the e:mbassy mm
       uh:: for ne:w docume:nts=uh, >°.hh°< the embassy of you:r
       country¿
5 D    for der:: pa- >for der pa-<pa:sspo[:rt
6 IMF                                    [<ye:s[:>
7 D                                           [>be-be-<becau:se:
       be- befo:re: >de- dey< do: it in he:re but now we have to send
       money to: (.) a:frica. <an' i do:n't 'ave mo:ney to do it.
       (.)
8 D    <so i ha[:ve to-       ] [<i ha:ve [to
9 IMF          [>you have to-<] [you:     [NOW You ha:ve to se:nd
       so:meo:n: [:e
10 D             [ye::s <bu:(t) nu:-
11 IMF [perchè n-
       [because n-
12 D   [nu- now is alrea:dy- is co:ming.
       (0.4)
13 D   no::w i have finished will have to find a jo:b.
       (.)
14 D   an' i can ge:t, (0.2) a proof on (s:ome). (.) [k-
15 IMF                                              [<eh::: dice che
       [pri:ma si pote]:va: fare: dall'ita:lia<me:ntre ade:sso: =
       [<eh::: he says that [be:fore you cou:ld do: it from
       Ita:ly<whi:leno:w: =
16 D   [(a- a: dito:) ]
17 IMF = si deve fare dall'a:fri:ca e:: >non ave:va i so:ldi< °per
       poterlo fa:re°
       = it has to be done in A:frica a::nd > he didnt' ha:ve the
       mo:ney< °to do it°
```

When the IMs produce minimal responses, they position themselves as listeners and encourage the speaker-in-turn to continue speaking, which leads to the production of a long turn on the part of this participant. This long turn generally ends with a rendition in the form of a formulation (Heritage 1985: 100–4) reporting the gist of the preceding sequence. The opening of this (often summarised) rendition is generally signalled by the IM with a marker for drawing attention, such as "so", "well", "erm" or throat clearing, followed by a reporting verb and speaker attribution ("he said", "the doctor said")

It is worth noting that suspending mechanisms may function to solve interactional problems such as the need for clarification or taking/giving a longer turn in the case of an interlocutor who needs more time in which to provide, e.g., explanations of complex procedures, as in extract 3, or personal trouble's telling (Jefferson 1988) as in extract 5. Unlike immediate renditions, in which the IM treats the turn as non-problematic and as not being directed at her/him, suspended interventions treat the turn as not immediately translatable and as being directed at the interpreter. Thus, while immediate rendition projects a response by the third party and involves the third party in the interaction immediately, suspended contributions project a monolingual interaction involving an interactional problem.

In this respect both requests for clarification and continuers or other displays of listening activity are necessary if the participants are to identify shared meanings and to achieve understanding. However, renditions may sometimes be suspended for several turns. In order to construct understanding, involve the participants in the interaction and give them space to contribute to talk in interpreter-mediated interaction, it is therefore necessary to strike a balance between immediate rendition and suspended interventions (Baraldi & Gavioli 2007, 2010).

6. Participants' co-construction of translation relevance in the legal and the medical data

The interactional mechanisms described above are recurrent ones in both the legal and the medical data sets, and seem to be in line with more general conversational mechanisms described in the literature on conversation analysis. Interestingly, however, the IMs' contributions are treated differently in the two settings, with immediate renditions and suspended interventions being promoted or prevented in different ways in each of the two.

In the legal set, immediate rendition is generally provided at the participants' first turn completion point. Feedback by the IM occurs in just a few cases. When the IM does not provide a rendition, the judge invites her to do so, as in extract 6 below, in which the judge starts her turn by saying that the defendant has been

ordered to move out of Italy, then stops and asks the IM to interpret ("traduca pure"/"please translate", turn 1), which the IM accepts ("okay", turn 2) and does (turn 2).

Extract 6.
((J: Judge, IMF: Interpreter-mediator Francesca, P: Policeman, L: Lawyer))

```
-> 1   J  è stato e:spu:lso tra:duca pure con decre:to della
       prefettura lo sa già perché[:: (gli è stato notificato [ieri)
       he was expe:lle:d please translate under an order by the
       council he knows that already because[:: (he got a notice
       [yesterday)
-> 2 IMF                          [okay                      [the[::
   3 P                                                          [c'è:
       c'è un provvedimento di espulsione regolare notifica:[to a lui::
       [there's: there's a regular expulsion order notifie:[d to him::
   4 J                                                    [Quattro
       dodici duemila tre:,
                                                          [Four twelve
       two thousand three:,
       (.)
       ((J, L e P talk and type documents in overlap with IMF's
       translation))
   5 IMF  on the=uh::: (.) f:ourtee:nth of dece:mber you were- (.)
       order:ed (0.2) from:: (.) the la:w, (.) from the- offi-
       officials here: in Padova .hhh to:: leave italy? because (.)
       you a:re here without do:cume:nts
```

In the legal set the IM's suspending contributions occur mainly in the form of side clarification sequences and are rapidly re-directed to the predominant immediate rendition mechanism of turn organization; e.g. in extract 2 above, where the IM reformulates the judge's question several times (turns 4, 7 and 9) in an effort to elicit a relevant response. The relevance of the response is then confirmed by the IM interpreting it to the judge and then resuming the immediate rendition mechanism. In extract 2, the judge contributes to maintaining the immediate rendition mechanism by asking a precise question concerning the date of birth, as initially requested. In other cases, the judge seeks to end the clarification sequence by overtly re-directing the IM's attention to her interpreting task.

Extract 7 is very explicit in this respect. In turn 2 the defendant asks for clarification about what is meant by "drugs", which the IM had mentioned in turn 1. As the IM and the lawyer then engage in an attempt to solve the problem, the judge intervenes (turn 10) by questioning the interaction order that is being established

with this clarification sequence and affirming his role as the one who addresses questions to the defendant : "(chiedo io gli) faccio io le domande./(I ask) I am the one who asks the questions." The judge's contribution then stops the IM–defendant sequence, as the IM abides by the judge's request to establish a different interactional order ("ye:s," turn 11), and the immediate rendition mechanism is taken up again in turns 12–13.

Extract 7.
((IMF: Interpreter-mediator Francesca, D: Defendant, J: Judge, L: Lawyer))

```
1 IMF      and for drugs in pa:dova.
           (0.6)
2 D        (what was it)
           (.)
3 IMF      dru:gs=uh¿
           (.)
4 D        wha:t is drugsen
5 IMF      dru:gs,
           (0.6)
6 IMF      uh:::::: hhhh uh::[:
7 L                          [(dice dru:g non lo so)
                             [(she says dru:g I don't know)
           (0.6)
8 IMF      you don't know drug=uh?
           (0.3)
9 D        drug to say s[omething to me
-> 10 J                 [(chiedo io gli) facc[io io le domande. =
                        [(I ask) I am the one who asks [the questions.=
11 IMF                                         [ye:s.
12 J    = a:llora. si chia:ma Norda Dominic na:to Accra, (.) il no:ve
        o:tto sessanta ci:n[que
        = n:ow. Your name i:s Norda Dominic you were bo:rn in Accra,
        (.) on ni:nthei:ght sixty fi:[ve
13 IMF                        [you we.re born in Accra on the:: ni.nth of
        augu:st sixty five
```

It may be noted that the clarification sequence in extract 7 above is initiated by the defendant, who first asks for clarification and initiates a side sequence. Even in those cases where it is the judge who initiates a clarification sequence, the interaction is rapidly restored to the immediate rendition mechanism. Extract 8 below provides a clear example of this. Here the judge in turn 2 asks the IM to confirm whether the defendant's first arrival in Italy was in the South of Italy

("meridione?"/"southern regions?"). The IM confirms this in turn 3 ("sì"/"yes") and the judge asks for further clarification in turn 4 ("giù giù sicuramente in Sicilia"/"down down surely in Sicily"). Once again, the IM offers confirmation, in turn 5, then reports back to the defendant and interprets the judge's request in turn 6 ("Sicily, was it an island or was it the mainland"); after further clarification in turns 8–10, the defendant's answer is rendered (turn 11: "era sì su un'isola"/"he was yes on an island")

Extract 8.
((IMF: Interpreter-mediator Francesca, J: Judge, D: Defendant))

```
1 IMF  nn::: non sa- non conosce:va nie:nte dell'ita:lia allo:ra
       qui:ndi:
       nn:: he didn't kno:w any:thing about ita:ly at the ti:me so
2 J    =meridio:ne?
       =southe:rn regions?
       (.)
3 IMF  [s:ì.
       [ye:s.
4 J    [giù  giù s[:icuramente in sici:lia?
       [down down s[u:rely in sicily?
5 IMF             [sì
                  [yes
6 IMF  si:ci:ly:, was it an i:sla::nd =uh or was i:t the mai:nland=
7 D    =(sì.)
       =(yes.)
       (0.4)
8 IMF  an isla:n[d?
9 D        [sì
           [yes
       (.)
10 D   sì.
       Yes.
11 IMF era:: sì, su un isola
       he wa:s yes, on an island
```

These extracts from the legal set of data indicate that the rendition is made relevant by the participants (including the IM) at the first possible turn completion point; when other actions (such as requests for clarification) are introduced in the sequence they are treated as "asides," are rapidly responded to and are terminated by returning to what seems to be an immediate rendition mechanism. Interpreting then is overwhelmingly provided immediately after participants' turns, with

occasional side clarification sequences, which may be initiated by any one of the three participants. In all cases the clarification sequences end rapidly (even when the problem has not been solved, as in extract 8) and the participants return to the immediate rendition organization.

In the healthcare set of data, interpreting activity is organized differently and the rendition is made relevant at different points. Particularly at possible turn completion points, IMs provide minimal responses to one interlocutor (most often the doctor), which encourage her/him to proceed, and interpretation is generally provided in a long turn, summarizing what has been said previously, as in extract 3 above. Extract 9 below provides a further example of this type of turn organization. In turn 1 the doctor explains that the patient is infected with the hepatitis B virus and that her newborn was given a vaccination which needs to be repeated several times. The IM, in turns 2, 4, 6 and 8, provides acknowledgment tokens and minimal responses and the doctor continues with a lengthy explanation. In turn 10 the IM provides a summary, in English, for the patient.

Extract 9
((Doc: Doctor, IMA: Interpreter-mediator Alice))

1 Doc Le cure particolari per il bimbo sono queste, mhm ecco. La mamma ha questo virus dell'epatite B, quindi al bambino abbiamo fatto la vaccinazione per l'epatite B. La prima dose l'abbiamo fatta q[ui
The particular treatments for the baby are these ones, mhm here. Mummy has this hepatitis B virus, so we have given the baby a vaccination against hepatitis B. The first dose was given to the baby here.
2 IMA [uh uh
3 Doc La vaccinazione dovrà fare le altre dosi. E' una vaccinazione che in Italia è obbligatoria, quella per l'epatite B. Noi l'abbiamo anticipata senno la faceva entro il terzo me[se
The vaccination she will get more doses. It is a vaccination that is compulsory in Italy, that for the hepatitis B. We have anticipated it for her, otherwise she should have done that before the age of three months
4 IMA [uh mhm ok
5 Doc Il laboratorio vaccinazioni, se è qua di ((ci[ttà))
The vaccination lab, if she lives here in ((city))
6 IMA [ah si in via Nova[ra
[ah yes in Novara street

```
7  Doc     [andrà a ((città 2)) a farle. La chiamerà per fare le altre
       dosi della vaccinazio[ne
           [She will go to ((city2)) to get that. She will be called
       to get the other doses of the vaccination
8  IMA                      [mhm
9  Doc Ok
->10 IMA   Ok, you know. They say you have the epatite B that they
       say your baby, they did the-the anticorpi, the-the vaccin. But
       later, they say that you come for the vaccination mhm they say
       they did this to baby of mhm three months but it will be too
       late for your baby to do the vaccination then
```

While this type of suspending contribution may be observed in the legal data too in some cases (see e.g. extract 5 above), it applies to most of the encounters in the medical set. Conversely, while the immediate rendition organization is observed also in the medical data, it is probably not the predominant type (but see extract 4 above). The IMs' responsive actions, such as acknowledgment tokens or minimal responses, are accepted by participants in the medical data, and rendition is provided in the form of lengthy reports. This difference may be connected to the different types of professionals involved in the two sets of data, but may also relate to particular features of legal and medical institutions. Legal institutions require certainty regarding normative conversational processes, so accuracy in interpreting each utterance is considered essential. In medical institutions, the emphasis is on monitoring the patient's condition and adapting her/his behaviour to clinical requirements. Interpreting techniques will thus be oriented primarily toward this goal.

7. Translation organization and the promotion of participants' involvement in talk

The analysis above highlights two of the main organizational patterns regarding sequences of turns in our data. In the one case, the interpretation is provided as an immediate rendition, interspersed with side clarification sequences where problems of hearing or understanding are being managed or where a particular response is negotiated and pursued. In the other case, the IM exhibits a more proactive response, providing acknowledgment tokens and minimal responses, and summarised renditions for the third participant.

While, as suggested above, the nature of the interpreter's intervention may be related to the setting (medical or legal), it may also be related to the purposes of the service required. As mentioned in Section 3, the IM's primary requirement in

the legal setting is that of getting accurate renditions whereas in the medical setting IMs are also required to act as intercultural mediators (see Section 2 above); i.e. to facilitate contact between healthcare providers and patients and to direct attention to patients' needs. Analyses of data collected in different healthcare settings (Amato 2006; Amato & Gavioli 2007) suggest that when the IMs are not explicitly required to work as facilitators of contact, i.e. as mediators, they may use practices other than the ones we have observed above, and may make more frequent recourse to immediate rendition.

Two points seem worth considering here: first, alignment to the one type of sequence or the other is not the sole responsibility of the IM; second, alignment to one type of sequence or the other fosters different types of involvement on the part of the participants. In the hospital setting, where the IMs are required to work as intercultural mediators, they respond to the participants directly and provide helpful feedback. In the legal setting, the turn organization assumes a different pattern: since the IM's primary requirement is to render the participants' contributions, interpretation is overwhelmingly provided at participants' first turn completion point and the IM's self-positioning as a listener is a rare exception to the rule. For example, in extract 10 below, the IM interprets what the judge has said ("it's not a good enough reason for you not to renew the residence permit", turn 3) and in turns 4–6 the defendant replies to the judge's decision by saying that he was in the process of having his permit validated when he was apprehended. In turn 8 the judge replies directly to the defendant, and his reply is rendered by the IM in turns 9 and 11. In turns 15–17 the defendant complains that he needed to get his passport validated first and that it takes time to do this.

Extract 10.
((J: judge, IMF: interpreter-mediator Francesca, D: defendant))

```
1 J    p- (.) non è: una ragio:nesufficie:nte pe:r uh per uh::
       [per non aver rinnovato il perme:s[so di soggiorno.
       f- (.) this is no:t a sufficie:ntreaso:nfo:r uh for uh::
       [for not having renewed the reside:n[ce permit
2 IMF  [per no:nave:rrinnova:to          [sì
       [for no:t havi:ng renewe:d        [yes
3 IMF  fo:r a:- (0.5) it's not a good enough rea:son for you: not to
       rene- ne:w the: re:sidencepe:rmit
       (1.4)
4 D    because of wha:t
5 IMF  sorry?
       (1.0)
```

```
6 D    (wha:t i decided to do) is for- is for me i i: (0.2) i'm- i'll
       make it
       (0.8)
7 IMF  .hhh eh[:
8 J           [avrebbe dovu:to rinnova:re i docume[::nti e:
              [he should ha:ve renewed his pape[::rs and:
9 IMF                                          [you: shou:ld
10 J   =  rifa:re
       =  do it a:gain
11 IMF = 'ave do:ne i:t be:fo:re [er:: you should 'ave do:ne
12 J                            [rifa:re: la:
                                [do: a:gain the:
13 IMF = i:t befo:re
14 J   = segui:re la procedu:ra per ave:re di nuo:vo [il permesso
       = follo:w the procedu:re to ge:t agai:n [the residence permit
15 D                                           [(    ) but i-
16 J   = (di soggiorno)
17 D   = i do:n't have er that i do:n't ha:ve th- the way to do de
       pa:sspo:rt (0.4) so i 'a:ve to fi:nd a way to do the pa:ssport
       da- da:t's [(   )
```

In this example, by translating the judge's turns in sequence, the IM allows the defendant to react to what is being said. In other words, the interpreter's organization of the interaction provides the defendant with an opportunity to participate by offering a reply to the judge's turn, mediated by the IM. Thus, while postponing interpretation with minimal responses and acknowledgment tokens, IMs allow the speakers to describe their problems and viewpoints, they risk reducing the relevance of third participants' contributions. This type of tension is characteristic of interpreter-mediated interaction and accounts for much of its complexity.

8. Interpreter-mediated interactions and intercultural mediation

The different organizations of translation sequences that we have shown and the IM's positioning as a listener (e.g. providing "mhm"s and other types of feedback) or as a turn-rendition provider (e.g. in immediate renditions) have different interactional consequences for the participants' co-construction of talk. It also seems that such different co-constructions have, in their turn, consequences for the activity of intercultural mediation.

The first and probably main consequence is that when the IM positions herself as a listener, she actually "takes the place" of the participant she is supposed

to give voice to. This, paradoxically, risks the exclusion from the interaction of precisely that participant whom the IM aims to serve, in that the interpreter may literally "take that voice." Taking the voice of one of the participants may also lead to the IM's siding with the participant she has been speaking with. In this way, the distribution of active participation in the interaction is unequal and this in turn prevents effective intercultural mediation, including the process of facilitating participants' contributions, producing shared alternative narratives, helping the conversation proceed, offering turns to speak, checking reciprocal understanding — in a word, empowering participants (as discussed in Section 2 above).

IM's provision of feedback thus gives space to the participant-in-turn but risks reducing the space of the other participant(s). A careful and balanced shift to a rendition-oriented activity may then be essential in the organization of interpreter-mediated interaction as a way of promoting participation and contact between the institutional participant and the layman, favouring effective intercultural mediation. This is a major problem in interpreter-mediated interactions. Summarized renditions, provided after long stretches of talk between the IM and one interlocutor only, seem in fact to have negative consequences for intercultural mediation. In extract 11 below, the IM renders a lengthy explanation by the doctor in English, for the patient. The concern is about the patient's behaviour before and after kidney transplant. The doctor, as well as the IM in her rendition, highlight the importance of the patient's being maximally informed and in contact with the institution before and after his surgery. In the (quite evident) attempt to reassure the patient, the IM introduces distinctions between the doctors ("the doctors are ready to answer", turn 4, "the doctors are here for you and they are very careful", turn 11) and "we", the patients-laymen ("we are not animals we are men", turn 6) and misses a more personal direct contact that seemed to be introduced by the doctor in turns 1–3 ("se lui non sa o vuole qualche informazione il mio consiglio è di chiederetutto" / "If he doesn't know or if he wants any information my advice is that of asking everything").

Extract 11.
((Doc: Doctor, IMA: Interpreter-mediator Alice, Pt: Patient

1 Doc volevo chiedere se lui sa qualco[sa. Se lui non sa o vuole qualche informazione il mio
I wanted to ask if he knows someth[ing. If he doesn't know or if he wants any information my
2 IMA [mhm
3 Doc consiglio è chiedere tutto, anche le domande più banali.
advice is that of asking everything, even the most banal questions

```
4 IMA  You can ask them all the questions. If you want, they are
       there. Before the operation.
       If it doesn't come to you when you are there with the doctor and
       it comes to you when you go home, then write it down. So ask
       the questions, there are no problem. If you remember, you can
       come or you can call me (??) Any question and the doctors are
       ready to answer the questi[on
5 ?Pt                            [because, if (?) want to know
       everything ab[out
6 IMA                   [you understand, eh? Because we are not
       animals, we are [men
7 Pt                   [men
8 IMA  (h) So, ask, ask any question, don't be afraid. Every time it
       comes, you can ask question
       (.)
9 IMA  And after the operation you have to be very very careful
10 Doc Noi siamo qui per aiutarlo.
       We are here to help him
11 IMA the doctors are here for [you and they are very careful
12 Pt                          [mhm
```

This interactional organization of translation sequences and a delayed shift to the actual rendition leads participants to accept being excluded and leaves it up to the IM to "give voice" to them in her own terms, replacing them in the process of contributing to the interaction. These terms may not correspond to those used by the participant and may indeed give space to what the IM views as appropriate to interactions between institution and laymen or between host culture and guest culture, impeding any direct contact between the two. Thus participants' acceptance to be excluded from the interaction does not necessarily provide them with an advocate and their "voice" fades, not only in conversational terms, but also from the point of view of intercultural participation.By positioning herself as the patient's co-participant (summarizing what the doctor has said), the IM, in effect, reinforces the institutional cultural system and the gatekeeping role of the IM (see Davidson 2000). This is observable in extract 11, where the IM uses her own terms to insist on the reliability and high quality of the medical staff and inhibits direct reassurances from the doctor.

Delayed renderings may be connected to a lack of interest in the IM's activity as an interpreter and may lead the institutional representatives to blindly trust the IM's understanding of the situation and decline to take responsibility for it. This, in turn, leads the IMs to de-emphasize the importance of interpreting and to take the responsibility of the institution upon themselves, so that they may be regarded

as its "representatives" in talk and, in assuming the role of gatekeepers, may lose not only the role of "interpreter," but also that of "mediator."

The consequences of different organisations of interpreting for intercultural mediation are controversial. Above, we suggested that when participants adopt a mechanism of turn organization in which immediate rendition is made relevant, this organization seems to favour more direct contact between the institutional representative and the layman as the IM's action makes participation by the third interlocutor relevant after each previous participant's turn. Direct contact (e.g. in extract 10 above) promotes the perspective of the patient/defendant who sometimes participates actively in the interaction. This, at least, gives the patients/defendants the possibility of complaining or of rejecting the institutional norms and promotes a space in which they may express themselves. Immediate renditions, however, treat turns as non-problematic and easily translatable, allowing little space for the participants to say what may be difficult for them to say; e.g. to tell about their problems, worries or to describe complex procedures. Moreover, direct contact promotes the institutional cultural perspective, which, in the legal context for instance, emerges in its normative character ("(chiedo io gli) faccio<u>io</u> le domande/(I ask) <u>I</u> am the one who asks the questions").

By listening to one interlocutor the IM is able to perform what are considered empowering actions in mediation and to achieve effective intercultural communication (Gudykunst 1994; Kim 2001), by facilitating the interlocutors' contributions, offering them turns to speak, checking their perceptions and understanding, actively listening to them, particularly in those cases where the interlocutor who is given space is the layman, e.g. the migrant patient. Thus, while on the one hand immediate renditions put the interlocutors in close contact, suspending contributions allow the IM to give the participants space to talk, to deal with problematic issues, and to understand in greater depth what is to be translated. The management of these "spaces" is risky and may involve a very complex balancing activity on the part of the IM, but can actually be the space through which dialogic mediation is coordinated and achieved in intercultural communication (Baraldi & Gavioli 2007, 2010; Baraldi 2009).

9. Conclusion

The analysis above leads us to a series of conclusions regarding the IM's function in talk organization and the effects of her/his activity on the process of intercultural mediation. In particular, this concerns the dynamics of interpreting as a *pas de trois* (Wadensjö 1998: 10), a triadic interaction in which the interpreter is quite central. In this respect, it may be interesting to note that "third parties" in this

triadic interaction change constantly, causing considerable attention to be devoted to the interpreter's coordination of talk.

Second, there seems to be a relationship between the organization of interaction and the types of contributions provided by the IMs. In particular, after a participant's turn at talk, IMs may intervene either with a rendition of that turn or with a suspended intervention, such as the initiation of a clarification or acknowledgment tokens and continuers. Immediate rendition works as a "pass" in the terms of Jefferson and Schenkein (1978), a signal that the interlocutor-in-turn is not the main addressee of the previous interlocutor, and avoids any delay in involving the third interlocutor (the "relevant" one) in the interaction; through suspending contributions, on the other hand, the IM assumes the position of interlocutor of the first participant, delaying the rendition but providing space for the participants to express what cannot be said quickly and easily.

Third, there seems to be a difference between the two sets of data with regard to the actions pursued in each of them. In the legal set, suspended contributions are systematically resisted, and in the (rare) event of acknowledgment tokens or clarification sequences, the immediate rendition mechanism is quickly re-established. In the healthcare set, suspended contributions, particularly through indicators of listening activity, such as continuers or acknowledgment tokens, are frequent and are favoured by participants. While this talk organization may have to do with differences between the types of professionals involved — "mediators" in the healthcare settings vs. "interpreters" in the legal one —, it seems unlikely that this mechanism would be so systematically favoured by the participants in the interaction if it were not in line with participants' wider expectations. Parallel analyses of healthcare data involving different types of IMs (Ciliberti 2009), moreover, indicate that this mechanism also prevails in the case of highly qualified professional interpreters working in Italian public healthcare settings. It seems then that while immediate rendition promotes immediate responses and balanced space for the participants, it also limits the space allotted to individual interlocutors. In all probability, therefore, the rendition activity must be suspended when space for single interlocutors is more overtly needed, as may be the case in healthcare settings, e.g., when dealing with patients' reluctance to speak.

Fourth, different interactional structures have different consequences for inclusion/exclusion of participants in/from talk and seem to be associated with different types of mediation. An interesting point here is that when the IM "takes the part" (talks on behalf) of one of the interlocutors, she excludes that interlocutor, depriving her/him of a voice. This is particularly relevant in the asymmetric role structures of legal or hospital settings: indeed, as Davidson shows (2000, 2001), by assuming the part of one participant the IM excludes the weaker party (the migrant patient, in the present case) from the interaction and reinforces the asym-

metry of the relationship. When rendition is suspended, it is a delicate and complex interactional work for the IM to re-involve all participants in talk and give them a voice. Participants' inclusion/exclusion in mediated talk, then, is not only a matter of information selection, as the literature seems to suggest, but is closely connected to the structure of the interaction. In this way, the analysis contributes to clarifying the connection between interlingual (translational) and intercultural aspects of interpreter-mediated interactions.

Finally, we believe that this type of research may contribute to the study of interpreting and other mediating practices. There are different approaches to the training of interpreters and mediators and these have often been kept apart — leading to a separation between "interpreters" proper, as professionals with knowledge and skills in translation, and "mediators," as professionals with special cultural knowledge and skills. This, in its turn, is reflected in some contradictory disciplinary approaches (linguistic vs. pedagogical and sociological). Our analysis suggests that there may be different ways of achieving the task of interpreting, that these may be strictly connected to contextual expectations and that they affect intercultural mediation.

In this article, we have looked at interactions involving different types of professionals and at the consequences of their actions in talk as interpreting *and* as mediation. We suggest that an analysis of these different actions and interactions contributes to improved understanding of intercultural communicative competence in different settings and under different requirements.

Notes

1. The medical interactions are part of a larger corpus of over 200 conversations in healthcare settings including more institutions, more IMs and more languages (Arabic, Chinese). The set used here has been selected for the languages and the participants involved, which are comparable to those in the legal set.

2. An English approximate gloss of the Italian utterances is provided in italics below each Italian turn. Following Wadensjö (1998), prosodic symbols are inserted in the translation to give an approximate representation of the sounds.

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About the authors

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Malattie delle coronarie

Che cosa sono le coronarie?
Le arterie coronarie sono i due vasi sanguigni destinati all'irrorazione del cuore. Originano separatamente dall'aorta, e prendono il nome di coronaria destra e coronaria sinistra. Dalla superficie del cuore penetrano all'interno del miocardio, ramificandosi ampiamente.
Che cosa sono le coronaropatie?
Tutti quei disturbi delle coronarie che pregiudicano l'irrorazione del muscolo cardiaco. Tenuto conto che il cuore è in continua attività e che questo costante lavoro comporta un enorme consumo di energia, si comprende come il miocardio necessiti di una buona irrorazione sanguigna e come questa gli possa essere assicurata soltanto dall'adeguato funzionamento delle coronarie.
Qual è la causa più comune delle coronaropatie?
L'aterosclerosi.
Che cos'è l'insufficienza coronarica?
Con tale termine si definisce quella particolare condizione per cui le coronarie, in seguito a un processo di restringimento (stenosi), non sono più in grado di assicurare una sufficiente irrorazione sanguigna del miocardio, che di conseguenza non può lavorare con l'energia necessaria. In simile eventualità, il cuore emette, per così dire, un segnale d'allarme, che può manifestarsi come un dolore acuto, improvviso, o un senso di costrizione al petto, generalmente sotto lo sterno. Il dolore può irradiarsi anche in altre parti del corpo, per esempio nella schiena, nelle braccia, nel collo, nelle mascelle e nella regione sopra-ombelicale (epigastrio), e in molti casi può comparire anche in conseguenza di sovraffaticamento. Questa sintomatologia, che scompare se il paziente osserva un periodo di riposo ed evita qualsiasi sforzo fisico, è di solito chiamata angina pectoris (vedi oltre).
Che cosa si intende per occlusione delle coronarie e infarto del miocardio (o infarto cardiaco)?
Occlusione delle coronarie viene definita la completa interruzione del flusso sanguigno in un ramo delle coronarie stesse; in conseguenza di ciò, una porzione più o meno estesa del miocardio non riceve più sangue e finisce per necrotizzare, cioè per perdere ogni funzione vitale: in simile eventualità, si parla di infarto del miocardio. Se l'occlusione interessa un grosso ramo delle coronarie, ne rimane danneggiata una porzione piuttosto estesa del muscolo cardiaco; se l'interruzione si produce invece in un piccolo ramo secondario, il danno rimane ovviamente circoscritto a una piccola porzione del miocardio. Questa successione di eventi viene definita, nel linguaggio comune, «attacco cardiaco».
Da che cosa è provocata l'occlusione delle coronarie?
Generalmente da un coagulo di sangue (trombo), che si forma di norma in un punto della parete dell'arteria già alterato dall'aterosclerosi: in tal caso si parla di trombosi coronarica.
Quali fattori determinano la sorte di un individuo colpito da infarto cardiaco?
a) L'età e le condizioni generali di salute del soggetto;
b) la presenza o meno di una preesistente lesione cardiaca;
e) l'estensione della porzione di miocardio rimasta danneggiata;
d) l'estensione della porzione di miocardio rimasta funzionante;
e) la comparsa di un'aritmia cardiaca;
f) la formazione di trombi nelle cavità cardiache, che potrebbero staccarsi dalla parete e essere trasportati in altre parti del corpo;
g) l'eventuale lacerazione della parete cardiaca indebolita; h) la rottura di valvole cardiache;
i) la possibilità che la stessa malattia che ha causato l'infarto possa colpire altri rami coronarici.
In che misura l'insufficienza coronarica o l'«angina pectoris» risultano pregiudizievoli per le condizioni generali del paziente?
Come si è accennato in precedenza, con il termine «angina pectoris» si indica quel complesso sintomatologico che di solito compare in presenza di un'insufficienza coronarica. Questi disturbi possono manifestarsi con gravita diversa da caso a caso, gravita che dipende fondamentalmente dall'estensione della malattia coronarica, cioè da quanti rami sono interessati dalle stenosi e in che misura. Nei casi più lievi i dolori al petto compaiono solo dopo pesanti sforzi , mentre in quelli più gravi anche a riposo. In tutti i casi è comunque necessario uno stretto controllo medico, e l'assunzione regolare di una terapia.
Le persone affette da angina pectoris sono necessariamente destinate a essere colpite da occlusione delle coronarie?
No, anche se sono comunque decisamente più esposte al rischio di un infarto.
È possibile prevenire gli attacchi di angina pectoris?
Fino a un certo grado, sì. Conducendo una vita regolata, il più possibile priva di stress psichici o fisici, evitando il fumo di sigaretta e assumendo opportuni medicinali.
Le coronaropatie possono essere curate chirurgicamente?
Sì. Quando le medicine non sono sufficienti a prevenire gli attacchi di angina pectoris, si rende necessario intervenire chirurgicamente. L'intervento, detto by-pass aorto-coronarico, consente attualmente a una gran parte di coronaropatici di poter riprendere a condurre una vita pressoché normale.
Come si cura l'infarto cardiaco?
Innanzitutto tutti gli individui colpiti da infarto miocardico devono essere ricoverati in appositi reparti ospedalieri, detti «Unità di cure intensive coronariche», perché possano essere tenuti sotto stretta sorveglianza, e si impedisca così l'insorgere di gravi complicanze. I soggetti devono poi osservare nella fase iniziale della malattia un assoluto riposo a letto, ed evitare il più possibile tensioni psichiche. I farmaci che vengono somministrati nelle prime fasi dell'infarto sono diversi: in primo luogo analgesici per calmare il dolore, medicinali che dilatino le coronarie, vasodilatatori come i nitrati, o che riducano il lavoro del cuore, come i beta-bloccanti, e farmaci anticoagulanti (vedi oltre). Nel caso insorgessero poi delle aritmie gravi si somministreranno anche degli antiaritmi-ci, o addirittura potrà rendersi utile l'uso del defibrillatore.
Esistono rimedi che possono evitare lo svilupparsi di un infarto una volta che l'attacco è già iniziato?
Sì, ed è frutto dei recenti progressi della medicina. Attualmente esiste infatti la possibilità di iniettare in vena, o addirittura direttamente nelle coronarie, una sostanza in grado, nella maggior parte dei casi, di sciogliere il trombo formato-si. Questa sostanza, l'urochinasi, può però essere somministrata solo se l'attacco è iniziato da poche ore. Esiste poi anche la possibilità di sottoporre l'individuo colpito da infarto a un by-pass immediato.
Per quale ragione il riposo a letto e la limitazione dell'attività fisica sono così importanti?
Perché una limitata attività significa un minor lavoro del cuore per far circolare la corrente sanguigna; la differenza tra la quantità di energia consumata dal cuore in condizioni di riposo

e durante un'attività normale è talmente forte da apparire quasi incredibile.

In caso di infarto, per quanto tempo bisogna rimanere a letto?

Secondo le più moderne teorie, l'immobilizzazione a letto è necessaria solo per una settimana; quindi bisognerà riprendere gradatamente l'attività fisica iniziando, per esempio, con il rimanere seduti in poltrona per qualche ora, e così via.

Dopo un infarto, per quanto tempo è necessario non lavorare?

Di solito è possibile riprendere il lavoro due mesi dopo l'attacco, intensificando però gradualmente l'attività; qualora si esercitino professioni molto stressanti, è consigliabile modificare opportunamente le proprie funzioni. La maggioranza delle persone *può* e addirittura *deve* riprendere il lavoro dopo un infarto, però evitando nel modo più assoluto gli sforzi e le tensioni, sia psicologici sia fisici.

Che cosa sono gli anticoagulanti?

Composti chimici che inibiscono la normale capacità di coagulazione del sangue (i più usati sono l'eparina e la dicumarina, o dicumarolo).

Per quali ragioni la trombosi coronarica viene curata anche con anticoagulanti?

a) Per evitare che il trombo formatosi in un'arteria coronaria si diffonda in altri vasi sanguigni e, di conseguenza, che l'irrorazione sanguigna delle coronarie venga ulteriormente pregiudicata;

b) per evitare la formazione di un trombo nell'endocardio e nelle vene delle gambe. Questi trombi, infatti, potrebbero staccarsi e verrebbero allora trasportati con la corrente sanguigna in altri vasi (embolia).

È possibile prevedere gli attacchi cardiaci?

Non sempre. In molti casi ne vengono infatti colpite all'improvviso persone apparentemente sane e il cui elettrocardiogramma appariva del tutto normale immediatamente prima dell'attacco. Vi sono tuttavia anche casi in cui settimane o mesi prima di un attacco acuto compaiono segnali d'allarme, quali dolori al petto.

Gli esami elettrocardiografici eseguiti perìodicamente possono mettere in evidenza il possibile perìcolo di infarto?

Solo in rari casi.

A quale età si è maggiormente soggetti all'infarto?

Tra i 40 e i 60 anni.

Dopo un infarto cardiaco, si può vivere ancora per molti anni?

Sì; fondamentale è comunque osservare un adeguato stile di vita, mantenersi sotto controllo medico e assumere le terapie prescritte. A queste condizioni, se il danno cardiaco non è stato particolarmente grave, le previsioni di vita sono buone.

Gli uomini sono più inclini delle donne all'infarto?

Sì; la tendenza alle coronaropatie è negli uomini di tre volte superiore rispetto alle donne. Dopo i cinquant'anni, tuttavia, l'incidenza di trombosi coronariche nelle donne aumenta sensibilmente.

Esiste una predisposizione ereditaria alle coronaropatie?

In taluni casi, sembra esservi una tendenza ereditaria, che non va però considerata come unica ed esclusiva causa della malattia.

Quale ruolo rivestono gli stress emotivi nella comparsa di un infarto?

Gli stress emotivi possono contribuire all'insorgere di un attacco cardiaco, ma di norma non ne sono né l'unica né la principale causa.

Gli sforzi fisici hanno un'influenza sulla comparsa di coronaropatie?

In linea generale, gli sforzi fisici non costituiscono un fattore determinante nell'insorgenza di attacchi cardiaci. In alcuni casi, però, questi si verificano durante o poco dopo violenti sforzi fisici: in simile eventualità, vi era probabilmente una coronaropatia preesistente, non individuata, e di conseguenza una certa predisposizione a un attacco cardiaco.

Quali fattori stimolano la predisposizione alle coronaropatie?

Diabete, pressione sanguigna elevata, un alto tasso di colesterolo, obesità e abitudine a fumare molto. (Il colesterolo è un componente del metabolismo lipidico dell'organismo, presente in tutti i tessuti animali.)

Che influenza ha l'alimentazione sulle coronaropatie?

La comparsa di coronaropatie è stata collegata a varie abitudini alimentari, per esempio una dieta ricca di acidi grassi saturi, o di alimenti ad alto contenuto di colesterolo. Per ora mancano dati certi dell'esistenza di queste relazioni.

Che influenza ha il fumo sulle coronaropatie?

Oggi è opinione comune che, a parità di ogni altra condizione, le probabilità di essere colpiti da queste malattie siano tanto maggiori quanto più si fuma. È comunque accertato che in presenza di una coronaropatia si deve rinunciare completamente al fumo.

Quali sono le operazioni più idonee per correggere le coronaropatie?

Il by-pass aorto-coronarico. L'intervento consiste nel creare una sorta di ponte che, partendo dall'aorta, si colleghi alla coronaria malata, al di là del restringimento che in essa è presente. Il ponte generalmente è costituito da una vena superficiale presa dalla gamba dell'individuo stesso, o dalla sua arteria mammaria interna (un'arteria che corre lungo lo sterno). Tramite questo intervento si riesce a ripristinare una normale irrorazione del muscolo cardiaco scavalcando, o by-passando, appunto, i restringimenti presenti sulle coronarie. È possibile applicare più di un by-pass nello stesso intervento, anzi questa è l'evenienza che accade più frequentemente. Il numero dei by-pass dipenderà dal numero dei rami coronarici ristretti.

La terapia chirurgica delle coronaropatie contempla altre tecniche d'intervento?

Sì; esiste un'altra possibilità di correggere i restringimenti delle coronarie: l'angioplastica. È una tecnica entrata in uso solo molto recentemente, ma ormai già ben collaudata. È molto meno traumatizzante in quanto non consiste in un intervento a cuore aperto; si esegue infatti come il cateterismo cardiaco, inserendo cioè un sottile catetere in un'arteria dell'inguine e facendolo risalire fino alle coronarie. Il catetere ha sulla punta un palloncino che, una volta arrivato al restringimento, viene gonfiato in modo da allargarlo. L'intervento non è doloroso e viene eseguito senza anestesia generale. Purtroppo può essere utilizzato solo per una piccola percentuale di casi, pur essendo molto efficace.

I risultati degli interventi chirurgici alle coronarie sono soddisfacenti?

Sì; la mortalità di questi interventi è molto bassa, mentre la percentuale di successo elevata. In una minoranza di casi è però possibile che i by-pass
si occludano anch'essi per fenomeni trombotici. In questi casi è però possibile anche intervenire una seconda volta.

Che tipo di anestesia viene praticata per le operazioni al cuore?

La narcosi per inalazione (metodo con intubazione).

Dove viene praticata l'incisione?

In mezzo al torace, lungo lo sterno.

Che cosa si intende in cardiochirurgia con il termine «ipotermia»?

Durante la maggior parte degli interventi cardiochirurgici il cuore viene fermato e irrorato con una soluzione ipotermica per raffreddarlo, in modo da produrre un forte rallentamento del

suo metabolismo. Così il cuore, pur non ricevendo sangue, non viene danneggiato durante il tempo dell'operazione.

Vi sono attualmente metodi che consentono di escludere il cuore dalla circolazione per la durata dell'intervento chirurgico?

Sì; sono state infatti costruite pompe cardiache che, durante l'operazione, sostituiscono efficacemente il cuore nel compito di mantenere in costante movimento il sangue circolante. Ciò consente al chirurgo di operare direttamente a cuore aperto e in una zona priva di irrorazione sanguigna.

Nel corso dell'operazione, il chirurgo provoca talvolta intenzionalmente l'arresto del cuore?

Sì; in taluni casi si ricorre temporaneamente a questo accorgimento per poter correggere con maggior cura e rapidità il difetto cardiaco. Ovviamente, ciò comporta la necessità di collegare il paziente con la macchina cuore-polmoni, per mantenere in funzione la circolazione sanguigna.

In quali casi il medico consiglia un intervento chirurgico al cuore?

a) Quando ha l'impressione che, sottoponendosi all'operazione, il paziente abbia maggiori probabilità di sopravvivere;

b) nel caso il malato sia condannato a un'infermità cronica e a un'inattività permanente, per cui l'intervento chirurgico potrebbe dargli la possibilità di condurre una vita più normale;

c) quando l'operazione offre buone probabilità di guarigione o almeno di miglioramento, e il paziente o la sua famiglia sono perfettamente consapevoli dei rischi insiti nell'operazione stessa.

Gli interventi al cuore sono molto lunghi?

Sì; alcuni durano parecchie ore.

Le operazioni al cuore sono dolorose?

No; durante la convalescenza postoperatoria, di solito i pazienti si sentono abbastanza bene.

Se operate con successo, le affezioni cardiache sono suscettibili di ricadute?

No; nella maggioranza dei casi, il risultato è positivo e duraturo.

È possibile compiere un secondo intervento al cuore?

Sì; molti pazienti, che erano stati operati alla valvola mitrale per un vizio di origine reumatica e hanno in seguito avuto una ricaduta, possono essere sottoposti con successo a un nuovo intervento, eseguito a cuore aperto, di correzione o sostituzione della valvola danneggiata.

Morbo di Crohn

Che cos'è l'enterite regionale, o segmentaria, o morbo di Crohn?

È un'infiammazione a decorso prevalentemente cronico, che colpisce tratti ' localizzati dell'intestino (da cui il nome di segmentaria). Tale malattia può interessare qualsiasi parte del canale alimentare, dall'esofago all'ano, ma la localizzazione più frequente è l'ileo, in prossimità della valvola ileo-cecale.

Da che cosa è provocata?

Non se ne conosce la causa precisa; si pensa all'azione combinata di fattori diversi: congeniti, ambientali, psichici (stress), infettivi, immunitari.

Questa malattia viene definita anche in altro modo?

Sì; se la sintomatologia è circoscritta all'ileo, viene chiamata anche ileite terminale.

Quali sono i suoi sintomi?

Dolori alla parte centro-inferiore dell'addome; ripetute evacuazioni quotidiane, con feci semiliquide; inappetenza; leggera febbre. Questi sintomi spesso scompaiono dopo un paio di giorni, per ricomparire a intervalli dopo alcune settimane. La malattia può portare all'occlusione intestinale.

L'enterite regionale è frequente?

No, ha un'incidenza di 1-4 casi su 100.000 persone. La si riscontra soprattutto nelle persone fra i 20 e i 30 anni, anche se tutte le età possono essere colpite.

Come viene diagnosticata?

Essenzialmente con l'esame radiologico.

Che decorso ha?

Il decorso è assai diverso a seconda della gravita della forma. Nella forma « leggera, può verificarsi un solo attacco che termina dopo alcuni giorni e non si I ripresenta più; nella forma più grave, si hanno ripetuti attacchi di febbre, dolori addominali ed evacuazioni di feci semiliquide.

Il morbo di Crohn può avere complicazioni?

Sì; queste sono costituite da: a) formazione di fistole, cioè comunicazioni patologiche di un'ansa intestinale ammalata con un'ansa adiacente, oppure con una porzione dell'intestino crasso, oppure con la vescica, o addirittura con la cute dell'addome; b) ascessi intestinali; c) occlusione intestinale.

Come si cura l'enterite regionale?

a) Nelle forme leggere, con riposo a letto, dieta blanda che escluda spezie e alcolici; uso di preparati steroidei (cortisone), esclusione delle tensioni emotive;

b) se la malattia è avanzata, si può intervenire chirurgicamente con: 1. asportazione della porzione intestinale infiammata e successiva anastomosi della porzione sana con il colon trasverso (colostomia ileo-trasversa); 2. semplice anastomosi del tratto intestinale sano con il colon, in modo da escludere il tratto infiammato (fig. 10). Attualmente, la tendenza è di rimandare quanto più possibile l'intervento chirurgico e di riservarlo ai casi che non rispondono alla terapia medica o che abbiano dato delle complicanze. Infatti l'intervento non previene le recidive e può esso stesso causare complicanze, soprattutto la formazione di fistole.

Vi sono persone maggiormente inclini a questo disturbo?

Si presume che ne siano colpiti con maggiore facilità gli individui sovraffaticati ed esposti a violente tensioni nervose, ma lo si riscontra anche in persone perfettamente equilibrate.

Una volta scomparsa, l'enterite regionale è suscettibile di ricadute?

Sì.

È possibile condurre una vita normale dopo l'intervento chirurgico?

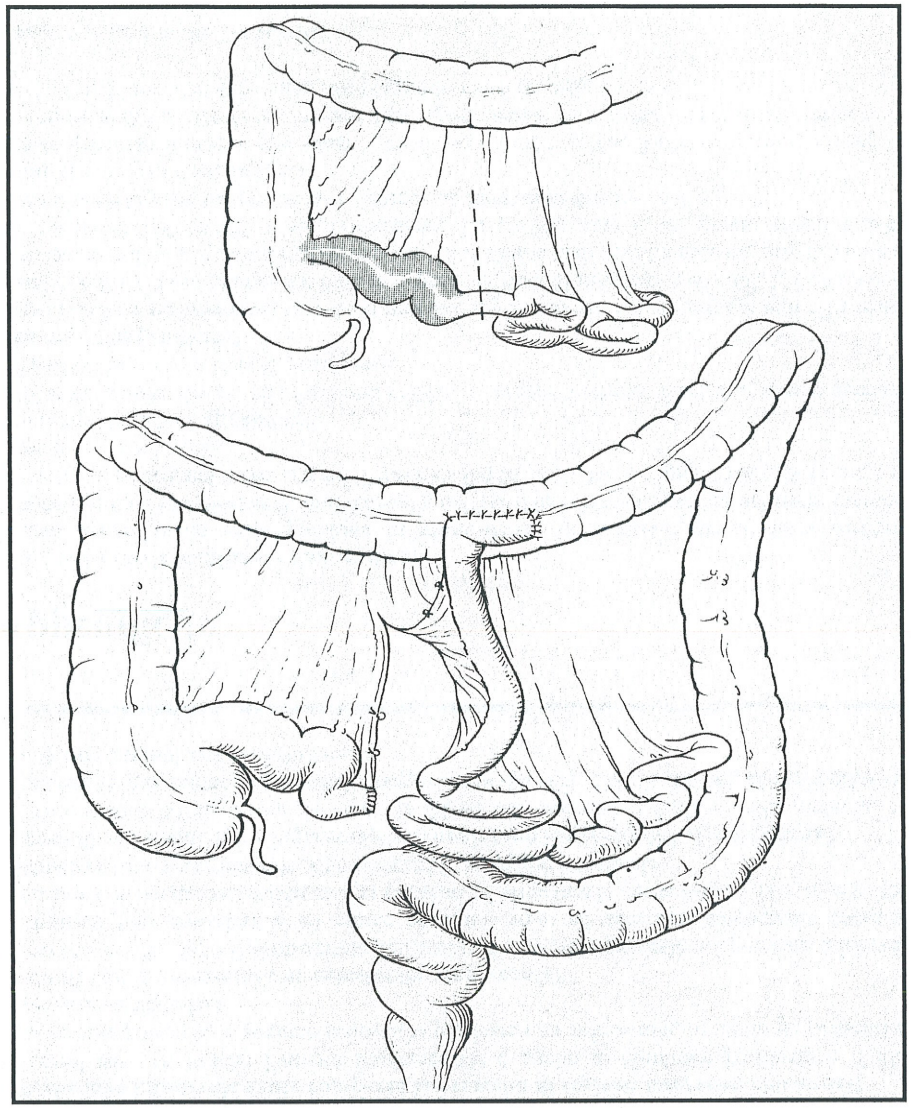
Sì, l'intestino tenue è lungo circa sei metri; ne basta meno della metà per assicurare la normale funzionalità intestinale.

L'enterite regionale è ereditaria o ricorrente nell'ambito familiare?

No.

Una volta superata questa malattia, è necessario osservare una dieta particolare?

Sì, per alcuni mesi, se non addirittura per anni, occorre seguire una dieta blanda, priva di sostanze irritanti.



Intervento chirurgico in caso di enterite regionale: L'intestino tenue viene reciso al di sopra dell'area infiammata, e mentre la porzione inferiore viene sturata e termina a fondo cieco, la restante porzione sana viene collegata direttamente con il colon. Con questa anastomosi (definita tecnicamente <<termino-laterale>>, in quanto l'estremità aperta del tenue viene abboccata <<di lato>> nel colon), la porzione infiammata viene esclusa, il che porta nella maggioranza dei casi alla regressione del processo morboso.

Occlusione intestinale

Che cos'è l'occlusione intestinale acuta?
L'occlusione intestinale, definita anche ileo, è una sindrome provocata dall'arresto del contenuto liquido, solido, gassoso nell'intestino.

Quali sono le cause che possono provocare un'occlusione intestinale?
Si possono distinguere due tipi di cause: a) meccaniche (ilei meccanici); b) dinamiche (ilei dinamici).
Gli ilei meccanici sono dovuti alla presenza di un ostacolo anatomico: tumori vegetanti, calcoli biliari, ammassi di peli (bezoari), stenosi di natura infiammatoria o neoplastica o malformativa, compressione da parte di tumori estrinseci, formazione di «angolature» per effetto di aderenze infiammatorie che fissano le anse fra loro o ad altri visceri o alla parete addominale, strangolamenti di anse, come i volvoli (torsione dell'intestino sul proprio asse), invaginazione intestinale, ernia irriducibile.
Gli ilei dinamici sono dovuti a condizioni di insufficienza funzionale, per cui l'intestino diventa incapace di peristalsi e le sue pareti, avendo perduto il tono muscolare, si rilasciano.
Tra le condizioni che più frequentemente sono causa di ileo paralitico possiamo ricordare: peritoniti, traumi addominali (anche in assenza di perforazioni o rotture viscerali), interventi laparotomici, coliche biliari o pieloureterali, torsioni di cisti ovariche o di testicolo, traumi del midollo spinale, pleurite diaframmatica o pleuropolmonite del lobo polmonare inferiore, farmaci (alcaloidi dell'oppio, miorilassanti, neuroplegici).

Quali sono i sintomi dell'occlusione intestinale?
a) Gonfiore dell'addome; b) assenza di evacuazioni; c) ripetuti attacchi di vomito; d) dolori di tipo colico, cioè violenti e accessuali, localizzati alla regione addominale. Tipicamente, la presenza di occlusione intestinale viene evidenziata dall'esame radiologico.

L'occlusione è sempre totale?
Dipende dalla causa: nel volvolo, l'occlusione è totale e immediata. Nelle altre cause, inizialmente è parziale e si manifesta con stitichezza, che nell'arco di alcuni giorni si accentua e viene accompagnata da gonfiore dell'addome e comparsa di dolori addominali.

Che cosa accade se l'occlusione non viene eliminata?
L'addome diviene fortemente rigonfio e insorgono progressivi attacchi di vomito; l'equilibrio minerale viene alterato dalla perdita di succhi gastrici e dal ristagno di liquidi nell'intestino; nella composizione del sangue si producono mutamenti gravi. In altri casi l'intestino, rigonfio in modo abnorme, può perforarsi, con conseguente peritonite.

L'occlusione intestinale può regredire senza intervento chirurgico?
In singoli casi, sì, qualora sia stata causata da volvolo, invaginazione o colite; questi stati patologici, infatti, regrediscono talvolta spontaneamente, e con essi l'occlusione.

Come si cura l'occlusione intestinale parziale?
Introducendo una sonda nell'intestino tenue (attraverso il naso, il faringe, l'esofago e lo stomaco); la sonda, collegata con un aspiratore, rimuove gran parte dei liquidi e dei gas ristagnanti. Per migliorarne lo stato generale, al paziente vengono praticate fleboclisi, con cui gli si fornisce il necessario apporto di liquidi, zuccheri e minerali. Infine, si procede, laddove esistano, alla rimozione delle cause.

Come si fa la diagnosi di occlusione intestinale?
In base alla sintomatologia e ai referti di esami radiologici. L'eventuale presenza di una cicatrice lasciata da una precedente laparatomia porta a sospettare che l'occlusione abbia

un'origine meccanica e sia stata probabilmente causata dallo strozzamento di un'ansa intestinale in seguito alla formazione di un'aderenza.

Che tipo di operazione comporta questa malattia?
Se l'occlusione intestinale si è sviluppata in seguito a uno strozzamento o alla formazione di un'aderenza, si provvede a recidere il tessuto strozzato; se è invece la conseguenza di un tumore, è necessario asportare la porzione di intestino malata.

L'occlusione intestinale acuta comporta la necessità di ripetuti interventi chirurgici?
In taluni casi, sì. Poiché l'intento fondamentale è quello di eliminare l'occlusione il più rapidamente possibile, è sovente necessario praticare una colostomia, in modo da consentire l'evacuazione delle feci.

In simili casi, è necessaria una colostomia permanente?
Di norma, no. Se dopo l'eliminazione dell'occlusione lo stato generale del paziente migliora, il chirurgo può procedere a un esame accurato, volto ad accertare esattamente causa e posizione dell'occlusione stessa; ciò gli consente di eliminare la causa originaria e, in seguito, di chiudere l'ano preternaturale, ripristinando il passaggio intestinale.

In caso di occlusione intestinale completa, quali sono le probabilità di guarigione?
Se l'operazione viene compiuta entro le 24-48 ore successive l'inizio della malattia, si raggiunge la guarigione nella grande maggioranza dei casi; oltre le 48 ore, le probabilità di guarigione diminuiscono sensibilmente.

Appendicite

Che cos'è e dov'è localizzata l'appendice?
Situata generalmente nella porzione inferiore destra dell'addome (fossa iliaca destra), l'appendice è un'estroflessione, o diverticolo, dell'intestino crasso (o meglio del tratto iniziale di questo, il cieco), nel quale si apre. Termina a fondo cieco, ha una lunghezza di 8-14 cm e il diametro di una matita.

Quale funzione ha l'appendice?
Nell'uomo attuale riveste una funzione residua di organo linfoide, mentre in specie animali più antiche la sua importanza è maggiore.

Che cos'è l'appendicite?
L'appendicite è un'infiammazione della mucosa appendicolare, che si propaga agli altri strati parietali e finisce per interessare l'intero organo. In caso di infiammazione acuta, l'appendice può riempirsi di pus; qualora l'infiammazione si diffonda al di là della mucosa, può provocare la distruzione dei tessuti e la perforazione. La perforazione è un evento molto grave: determina l'infezione del peritoneo e richiede un intervento chirurgico d'urgenza.

Come si sviluppa l'appendicite?
Questo processo morboso può essere provocato da un'infezione batterica, oppure essere la conseguenza di un'alterata irrorazione sanguigna, causata da ristagno di contenuto intestinale che blocca il lume dell'appendice comprimendo i vasi sanguigni vicini.

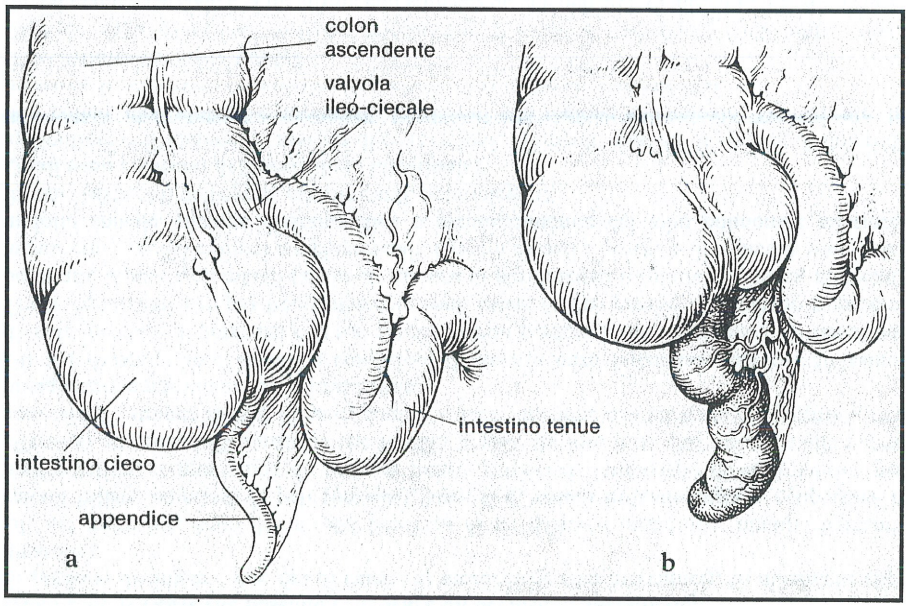
L'appendicite è molto frequente?
È tra le più comuni malattie addominali che necessitano di intervento chirurgico e può colpire individui di ogni età, pur essendo particolarmente frequente durante l'infanzia e la vecchiaia.

I casi di appendicite vanno diminuendo?
Sì; per ragioni tuttora ignote, l'appendicite è oggi meno frequente di 20 o 30 anni or sono.

L'appendicite può essere provocata da corpi estranei, quali noccioli di frutta, gomma da masticare ecc., che siano stati inghiottiti per errore?
No, anche se un'alimentazione ricca di piccole scorie solide e di cibi tendenti alla fermentazione (frutta secca) può favorirne la manifestazione.

All'origine dell'appendicite vi è una predisposizione ereditaria o una tendenza familiare alla malattia?
Non è sicuro, ma in alcune famiglie si manifesta la tendenza ad ammalarsi, presentando inoltre gli stessi sintomi.

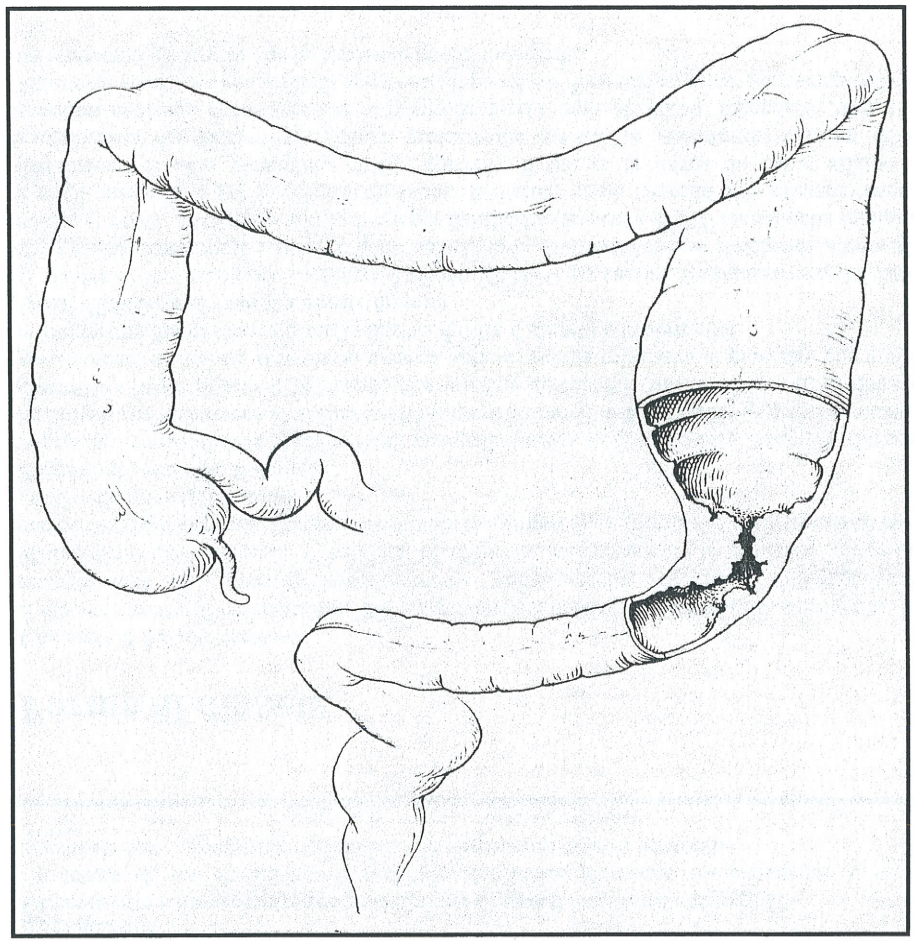
In quali forme si può presentare un'appendicite?
a) Appendicite acuta, che di solito inizia con dolori addominali, nausea, vomito e successiva localizzazione del dolore nella fossa iliaca destra; queste manifestazioni morbose si succedono normalmente nell'arco di alcune ore;
b) appendicite cronica, caratterizzata da ripetuti attacchi di infiammazione appendicolare, che regredisce spontaneamente per poi svilupparsi di nuovo a distanza di alcuni mesi o anni con sintomi più gravi.



a) L'appendice normale è grossa all'incirca quanto una matita, lunga 8-14 cm, ha una colorazione grigio-rosastra pallida ed è rivestita dal peritoneo.
b) L'appendice infiammata può gonfiarsi in misura abnorme, assume una colorazione più pallida, presenta i vasi sanguigni fortemente dilatati e contiene sovente pus. Se i processo infiammatorio raggiunge uno stadio troppo avanzato, l'appendice può perforarsi e far defluire il pus nella cavità addominale (peritonite).

Tumori dell'intestino tenue e del colon

Dove sono localizzati di solito i tumori intestinali?
In prevalenza nel colon; quelli dell'intestino tenue sono, al confronto, abbastanza rari.
Quali elementi consentono di stabilire se si è affetti da tumore all'intestino?
I due «segnali d'allarme» più attendibili sono l'emissione di sangue dal rette e il cambiamento del ritmo abituale dell'evacuazione.
È possibile prevenire l'insorgere di un tumore?
No, ma qualora si avvertano disturbi è opportuno sottoporsi a periodici controlli medici, con esame endoscopico del colon sigmoideo e del retto.
Quali tumori benigni si sviluppano con maggior frequenza nell'intestino?
Miomi e polipi; questi ultimi sono la forma benigna più diffusa di tumori intestinali.
Questi tumori benigni possono degenerare in cancro?
I polipi possono degenerare ed è questo uno dei principali motivi per cui la comparsa di disturbi addominali o intestinali rende opportuna una visita medica.
In base a quali elementi è possibile stabilire se una persona è affetta da un polipo?
Il sintomo più caratteristico di questa formazione tumorale è l'emorragia indolore dal retto. I polipi di notevoli dimensioni e localizzati nella porzione superiore del colon, inoltre, possono causare ricorrenti dolori di tipo colico, o temporanei episodi di occlusione intestinale. La diagnosi di sicurezza però si può fare soltanto con la radiografia e l'endoscopia.
Come vengono curati i polipi?
Se sono localizzati in un punto non molto distante dall'ano, possono essere asportati semplicemente con un sigmoidoscopio (uno strumento lungo oltre 30 cm, di solito usato per l'esame endoscopico del colon sigmoideo); se sono invece maggiormente spostati verso la porzione superiore, viene praticata una laparatomia, con apertura del colon ed escissione del polipo.
Qual è l'incidenza del cancro intestinale?
Un'incidenza notevole. Il cancro intestinale è una delle neoplasie più diffuse e frequenti.
Il cancro intestinale colpisce con maggior frequenza gli uomini?
No, la sua incidenza è all'incirca uguale in entrambi i sessi.
A quale età si è maggiormente inclini a questa formazione tumorale?
Tra i 60 e gli 80 anni.
La predisposizione al cancro intestinale è ereditaria o ricorrente nell'ambito familiare?
No, ma può ricorrere nella cerchia familiare la tendenza alla formazione di polipi e di altre alterazioni citologiche che vengono considerate lo stadio preliminare del cancro.
L'esame radiologico consente di diagnosticare con sicurezza il cancro intestinale?
Sì, in quanto pone in evidenza la deformazione prodottasi nella continuità della parete intestinale in corrispondenza del punto in cui è localizzato il tumore.
Come devono essere curati i tumori intestinali?
Chirurgicamente, non appena è stata fatta la diagnosi definitiva.
Quali tipi di interventi chirurgici si praticano in questi casi?
a) Se si tratta di un tumore benigno, ci si limita ad asportare il tumore stesso; b) se la formazione è invece maligna, si provvede, se possibile, ad asportare sia la porzione di intestino malata sia un ampio tratto delle porzioni sane, che vengono poi suturate l'una all'altra; nel caso non sia possibile ripristinare il passaggio intestinale, viene praticata una colostomia. Scopo principale del chirurgo è infatti l'escissione radicale della formazione maligna, anche se in taluni casi ciò comporta la creazione di un ano preternaturale.
L'escissione di un tumore intestinale è un intervento chirurgico molto complesso?
Sì, senz'altro, ma viene superato ottimamente in oltre il 90% dei casi.
In quale misura una simile operazione ottiene risultati positivi e permanenti?
Secondo i dati più recenti, oltre il 50% delle persone operate con successo di cancro all'intestino sono ancora in vita dopo 5 o più anni dall'intervento. Non bisogna dimenticare, comunque, che diversi fattori possono influenzare la maggiore o minore sopravvivenza; tra questi il più importante è la precocità della diagnosi.



Cancro del colon: Il disegno riproduce una formazione neoplastica che, partendo dalla parete, occupa spazio e tende a chiudere il lume intestinale.

Il cancro all'intestino può riformarsi?
Una volta asportato, di solito no, ma in un numero di casi variabile dal 5 al 10% si sviluppa un nuovo tumore in un altro punto dell'intestino.
Dopo l'operazione, con quale frequenza è opportuno sottoporsi a visite ed esami di controllo?
Almeno una volta all'anno, e quando insorgono nuovi sintomi.
In base a quali elementi il chirurgo decide se creare o meno un ano preternaturale?
Ogni volta che ne riscontri la possibilità, il chirurgo ripristina la continuità dell'intestino; suo scopo è tuttavia di non lasciare mai in loco tessuti malati.
L'ano preternaturale è necessariamente permanente?
No; in taluni casi viene creato al solo scopo di eliminare un'occlusione intestinale causata dalla presenza di un tumore; la canalizzazione normale dell'intestino viene ripristinata successivamente.
In quali casi il chirurgo decide di chiudere l'ano preternaturale?
Quando ha la certezza di poter ripristinare il normale passaggio intestinale, il che può avvenire alcune settimane o mesi dopo la prima operazione.
È possibile condurre una vita normale con una colostomia permanente?
Sì; la maggioranza dei pazienti impara a tener sotto controllo l'ano preternaturale in modo che la regolarità dell'evacuazione non subisce pressoché alcuna alterazione rispetto al passato.
Le persone con ano preternaturale emanano un odore sgradevole?
No; non solo perché imparano a tenerlo il più possibile pulito, ma anche perché sull'apertura viene applicato un sacchetto, di tipo particolare e fabbricato appositamente, che impedisce il diffondersi di odori sgradevoli quando si verifica un'evacuazione mentre si è fuori casa o al lavoro.
Le altre persone possono accorgersi che si ha un ano preternaturale?
No: vi sono migliaia di persone in simili condizioni, che pur tuttavia svolgono le diverse attività con assoluta libertà di movimenti, senza fastidi per sé e per quanti le avvicinano.
L'asportazione di larga parte dell'intestino pregiudica la possibilità di condurre una vita normale?
No. L'alimentazione e la digestione possono avvenire normalmente anche quando è stato asportato l'intero colon; anche l'escissione di circa la metà dell'intestino tenue non pregiudica affatto la possibilità di avere un'alimentazione normale. Naturalmente tale escissione comporta però una diminuzione della superficie di assorbimento.
Come distingue il chirurgo un tumore maligno da uno benigno?
Anzitutto in base all'aspetto della formazione tumorale, in secondo luogo mediante biopsia, manovra che consente di sottoporre il tessuto prelevato a esame microscopico e di accertare con precisione la vera natura della malattia.
L'esame dell'addome consente al chirurgo di capire se il paziente è affetto da tumore intestinale?
No; appunto per questo è estremamente importante sottoporsi a esame radiologico del tratto intestinale quando si avvertono disturbi all'intestino.
I tumori intestinali possono svilupparsi anche in persone giovani?
Sì; in singoli casi li si riscontra anche in individui di 20 o 30 anni.
In caso di operazione al colon, quanto tempo bisogna rimanere in ospedale?
Questi interventi sono complessi e possono comportare una degenza di più settimane; inoltre richiedono misure terapeutiche pre- e postoperatorie del tutto particolari, tra cui la preparazione dell'intestino con frequenti clisteri depurativi e la somministrazione di antibiotici e chemioterapici; quest'ultima misura serve a prevenire l'insorgere di una peritonite postoperatoria.
La peritonite è una complicazione frequente di questi interventi chirurgici?
Un tempo sì, ma attualmente è possibile sterilizzare pressoché completamente il lume intestinale con sulfamidici e antibiotici. Ciò elimina il rischio di peritoniti.

Forme di diabete

Che cos'è il diabete mellito?
Il diabete mellito, di solito definito più semplicemente diabete, è una malattia del ricambio (o metabolismo) che consiste essenzialmente nell'incapacità, da parte dell'organismo, generalmente per mancanza di insulina, di utilizzare adeguatamente lo zucchero (glucosio) che deriva dagli alimenti. Questo si accumula nel sangue (iperglicemia) e si riversa attraverso i reni nelle urine (glicosuria).
Esistono diversi tipi di diabete?
A prescindere dal diabete insipido (vedi paragrafo Ipofisi, in questo stesso capitolo), che non ha nulla a che vedere con il diabete mellito, quest'ultimo si differenzia in: a) diabete insulina dipendente (ID) o di tipo I; b) diabete non insuline dipendente (NID) o di tipo II; e) diabete gestazionale; d) diabete secondario a causa nota; e) ridotta tolleranza al glucosio, che non è propriamente diabete ma uno stadio intermedio fra il diabete e la normalità.
Quali differenze ci sono fra queste forme?
Il diabete di tipo i colpisce in genere i giovani (diabete giovanile), è caratterizzato dal fatto che i malati sono magri e insorge dopo un'infezione. Il diabete di tipo il colpisce invece gli adulti, che sono predisposti alla malattia per familiarità (presenza di altri malati nella famiglia e negli antenati), e per l'influenza di fattori favorenti, come l'obesità e la contemporanea disfunzione di altre ghiandole (ipofisi, surreni). È questa la forma da cui è affetta la maggioranza dei pazienti. Il diabete gestazionale insorge in gravidanza, a causa delle superiori necessità di insulina che si hanno in questo stato. Il diabete secondario raccoglie tutti i casi in cui, per una serie di cause note, il pancreas viene danneggiato: per esempio dopo un intervento chirurgico che ha asportato questa ghiandola.

Cause del diabete

Qual è la causa del diabete?
In certi casi la causa è conosciuta (diabete secondario) o verosimile (un virus nel caso del diabete di tipo i). Nel diabete di tipo il la causa è tuttora ignota: può essere in gioco un difetto dei recettori cellulari che non riescono a «riconoscere» l'insulina; sicuramente hanno importanza i già citati fattori predisponenti; ma la vera ragione che determina la malattia è sconosciuta.
Gli eccessivi sforzi fisici e le tensioni di natura psicologica possono causare il diabete?
Non direttamente, ma possono peggiorarlo, se già in atto, o favorirne il manifestarsi.

Bronchite

Che cos'è la bronchite acuta?
Un'infiammazione di origine infettiva della mucosa bronchiale (ma può avere anche come fattori predisponenti il fumo o l'inalazione di sostanze irritanti) che, di solito, insorge come complicazione di un raffreddore o di un'influenza. Nell'organismo debilitato i germi hanno maggiore possibilità di attecchire e provocare il processo infiammatorio. La bronchite acuta ha una durata tuttavia limitata.

Quale decorso assume di solito?
Un decorso parallelo a quello del processo infettivo che ne è all'origine, e scompare poco dopo la conclusione di questo. La bronchite, tuttavia, deve essere curata in maniera specifica.

In quale periodo insorge con maggior frequenza?
Durante i mesi invernali; quando sono più frequenti tutte le infezioni delle Prime vie aeree.

Quali sono le complicazioni più comuni della bronchite acuta?
La polmonite e la trasformazione della forma acuta in cronica.

Che significato hanno ripetuti attacchi di bronchite acuta?
Soggetti particolarmente inclini a recidivanti episodi di bronchite acuta possono essere cronicamente esposti a stimoli di tipo irritante per la mucosa bronchiale, oppure essere portatori di un focolaio infettivo cronico a carico dell'apparato respiratorio.

Qual è il sintomo caratteristico della bronchite?
Una tosse persistente, associata all'espettorazione di variabili quantità di muco.

La tosse causata dalla bronchite deve essere repressa mediante somministrazione di opportuni medicinali?
No; pur risultando indubbiamente fastidioso, questo sintomo ha un lato positivo, in quanto stimola l'espettorazione delle masse di muco accumulatesi nei bronchi.
Può, qualora l'espettorazione risultasse particolarmente difficoltosa, essere utile la somministrazione di farmaci fluidificanti.

In quale caso la bronchite acuta si trasforma in cronica?
Una bronchite acuta non dovrebbe persistere per più di 2-3 settimane; se, tuttavia, non le si attribuisce la dovuta importanza, non curandola opportunamente o non rimuovendo le condizioni favorenti una successiva reinfezione, può assumere un decorso cronico.

Se la bronchite acuta non scompare, quali malattie occorre prendere in considerazione, e quali possibili complicazioni?
Polmonite, tubercolosi, bronchiectasie, asma, presenza di un corpo estraneo o addirittura di un tumore nei polmoni.

Chi soffre di bronchite o di tosse persistenti deve sottoporsi a esame radiografico?
In ogni caso deve sottoporsi a visita medica accurata che può poi essere completata dall'esecuzione di una radiografia del torace.

Quando si è affetti da una malattia delle vie respiratorie superiori (raffreddore, influenza, bronchite) si può continuare a fumare?
No, in quanto il fumo esercita un'azione particolarmente irritante sulla mucosa del naso, della gola e dei bronchi; in tal senso è anche opportuno evitare gli ambienti troppo fumosi.

Che cos'è la «tosse dei fumatori»?
Le persone abituate a fumare eccessivamente sono spesso affette da una tosse persistente, che non ci si dovrebbe tuttavia accontentare di attribuire semplicisticamente all'azione irritante del fumo.
Qualsiasi persona che soffra di un simile disturbo, si tratti o meno di un forte fumatore, dovrebbe sottoporsi a un'accurata visita medica per accertare che all'origine della tosse non vi sia una malattia polmonare o bronchiale.

La quantità e le caratteristiche dell'espettorato sono importanti per valutare la natura e l'estensione della malattia-base?
Sì. In presenza di una semplice bronchite, l'espettorato è di solito scarso; nelle bronchiectasie è più abbondante, più viscoso e può avere una tinta gialla o verdastra; in presenza di un ascesso polmonare è maleodorante e contiene talvolta sangue: una caratteristica, quest'ultima, che si riscontra normalmente nella tubercolosi e spesso anche nel cancro polmonare. L'espettorazione di catarro striato di sangue può dipendere anche dalla rottura di un piccolo vaso, determinato dalla forte tosse. Il fatto, tuttavia, specialmente se si ripete nei giorni successivi, deve sempre essere riferito al medico.

La presenza di sangue nell'espettorato è sempre sintomo di tubercolosi o di cancro polmonare?
No; prima di tutto bisogna essere sicuri che il sangue provenga realmente dalle basse vie aeree (e non, per esempio, dalla lingua, dal faringe, dalle cavità nasali o dall'apparato digerente). In ogni caso, può dipendere da altre malattie polmonari (bronchiti acute, polmoniti, bronchiectasie, ascessi e infarti polmonari, traumatismi) oppure essere legato ad affezioni cardiovascolari o coagulopatie. Comunque sia, il sintomo non deve essere trascurato.

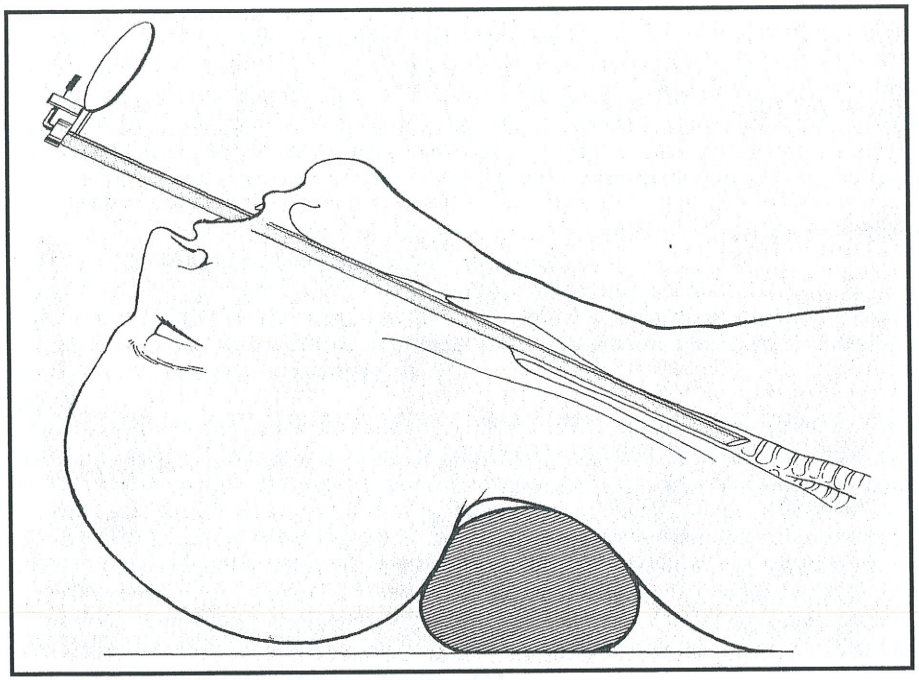
La presenza di sangue nell'espettorato richiede sempre un'ulteriore visita più accurata?
Sì; in simile eventualità, è assolutamente necessario recarsi dal medico, per chiarire la causa di tale fenomeno.

Che cos'è la broncografia?
Una particolare tecnica di esame radiografico, che consiste nell'iniettare preventivamente nei bronchi, per mezzo di sonde, liquidi opachi ai raggi X: in tal modo si ottiene un quadro preciso delle diramazioni bronchiali, anche le più sottili, allo scopo di diagnosticare determinate malattie broncopolmonari.

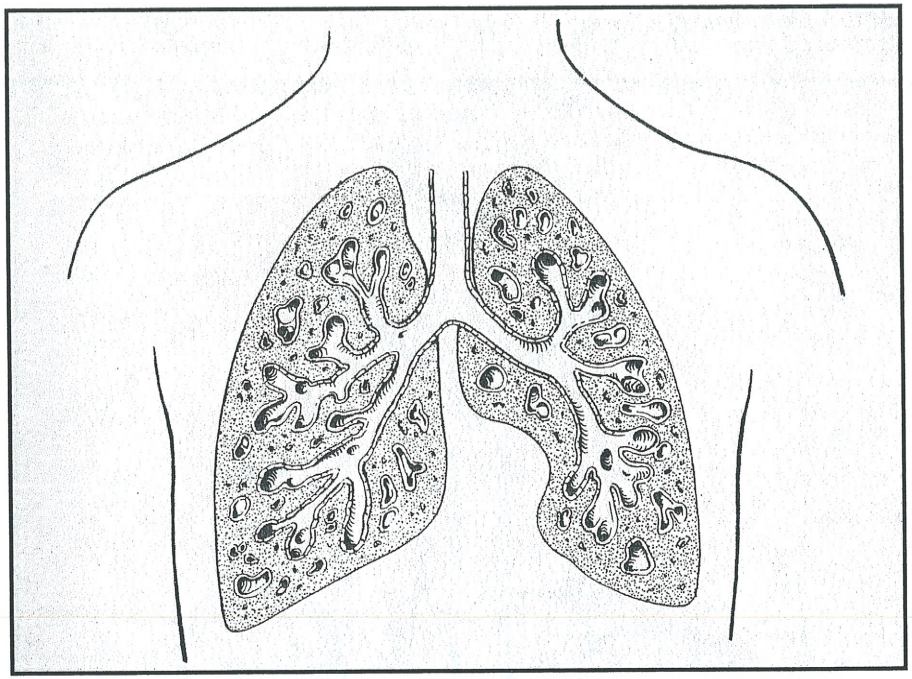
Che cos'è la broncoscopia?
Un esame che consiste nell'introdurre nella trachea e nei bronchi un apposito strumento, chiamato broncoscopie. Questo è costituito da un tubo di metallo, recante a un'estremità una sorgente luminosa e uno specchio, per cui consente di vedere direttamente le pareti della trachea e dei bronchi. I più moderni tra questi strumenti sono i cosiddetti broncoscopi a fibre ottiche, estremamente sottili e flessibili, che consentono la visualizzazione diretta delle vie aeree di calibro più sottile, oltre che risultare molto meno fastidiosi per il paziente.

Che cosa si può rilevare con la broncoscopia?
Questo esame riveste un'importanza enorme per accertare l'esatta natura di malattie polmonari, che né l'esame radiografico né l'analisi dell'espettorato consentono di diagnosticare con sicurezza. Permette infatti di localizzare il punto in cui si è prodotta un'emorragia o un corpo estraneo inspirato nei polmoni; di scoprire la presenza di un tumore bronchiale o di individuare la posizione di una neoformazione polmonare, nonché di vedere il punto in cui si è prodotta un'occlusione bronchiale.

Quali altri aspetti importanti presenta la broncoscopia?
Oltre che come indagine diagnostica ispettiva, la broncoscopia consente anche di operare biopsie mirate su zone dall'apparenza sospetta e di raccogliere selettivamente campioni di



Posizione del broncoscopio nella trache (vista di lato).



Bonchiectasie. La sezione dei polmoni evidenzia una generalizzata dilatazione dei bronchi.

secrezioni che vengono successivamente esaminate sia dal punto di vista batteriologico che citologico.
Trova, inoltre, applicazioni di tipo terapeutico nella rimozione di corpi estranei o accumuli di secrezioni.

Bronchiectasie

Che cosa sono le bronchiectasie?
Dilatazioni, generali o circoscritte, dei bronchi, nelle quali ristagnano delle secrezioni che non possono venire eliminate spontaneamente, causate da alterazioni distruttive delle componenti elastiche e muscolari della parete bronchiale. Tale malattia raramente interessa diffusamente tutto l'albero bronchiale: nella gran parte dei casi è limitata a un singolo segmento o lobo polmonare.
Come possono essere le bronchiectasie?
Controversa è l'esistenza di bronchiectasie congenite. L'origine del processo distruttivo è quasi sempre legata a un'infezione batterica.
A quali sintomi e complicazioni danno origine?
Tosse cronica e persistente, di solito associata ad abbondante espettorazione di muco; difficoltà di respiro; enfisema; emorragie bronchiali; formazione di ascessi polmonari; polmonite.
Un normale esame radiografico del torace è sufficiente per diagnosticare le bronchiectasie?
No; per confermare la diagnosi clinica è in questo caso necessario eseguire sia una broncografia sia una broncoscopia.
Quali principi determinano la terapia delle bronchiectasie?
a) In caso di sovrapposizione batterica, terapia antibiotica il più possibile mirata;
b) in ogni caso allontanamento da ambienti fumosi e irritanti di ogni genere;
c) somministrazione di farmaci mucolitici per favorire l'espettorazione delle secrezioni accumulatesi nei bronchi;
d) drenaggio posturale: tossire finché non si produce più espettorato assumendo una posizione per cui la zona di polmone colpita dalle bronchiectasie sia più in alto rispetto al capo. Tale esercizio va ripetuto 4 volte al giorno.
In presenza di bronchiectasie, è talora consigliabile la terapia chirurgica?
Sì, in presenza di bronchiectasie localizzate (cioè circoscritte a una piccola porzione di polmone) che non rispondano adeguatamente al trattamento medico o che diano luogo a gravi complicanze (emoftoe massiva o polmoniti recidivanti).

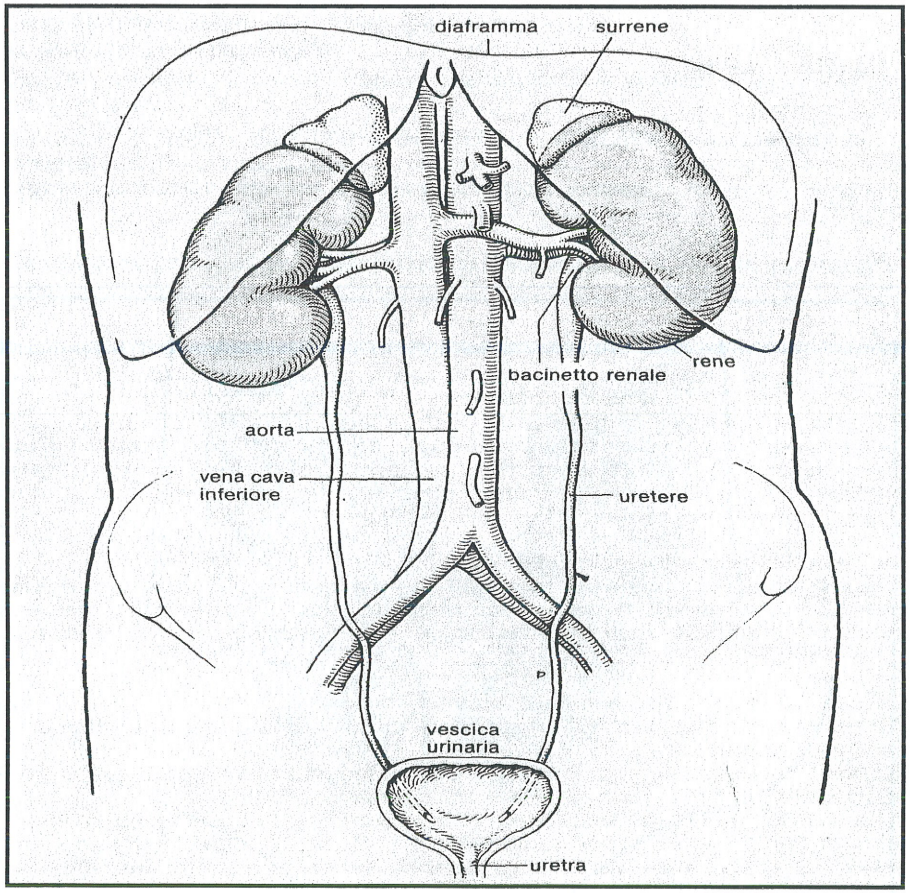
Si tratta di interventi chirurgici pericolosi?
No; grazie al perfezionamento delle tecniche operatorie, attualmente gli interventi di lobectomia e pneumectomia possono essere eseguiti senza alcun rischio da chirurghi specializzati in questo campo.
Quali probabilità di guarigione comportano simili operazioni?
Nel caso vengano asportate tutte le porzioni malate del polmone, si raggiunge la completa guarigione in oltre il 95% dei casi. Prove di funzionalità respiratoria, opportunamente eseguite, consentono di determinare l'estensione della porzione polmonare che può essere asportata senza alcun rischio per il paziente.

Funzioni del rene

Che cos'è e dove è localizzato il rene?
Il rene è un organo pari e simmetrico a forma di fagiolo, di colore bruno-rossiccio, ricoperto da una capsula sottile e lucente, lungo circa 10 cm, largo 5 e spesso da 2 a 4 cm circa. È situato a lato della colonna vertebrale, sotto il diaframma, in zona retroperitoneale.
Come sono strutturati e come funzionano i reni?
I reni sono formati da centinaia di migliaia di minuscole unità funzionali, dette nefroni, che funzionano come piccoli stabilimenti chimici indipendenti, producendo urina man mano che il sangue li attraversa. Più precisamente ogni nefrone è costituito da un glomerulo e da un tubulo. Il glomerulo è formato da un gomitolo di vasi capillari dell'arteria renale avvolti da una capsula; la sua funzione è di filtrare il sangue che lo attraversa, formando così l'urina primaria che passa attraverso il tubulo prossimale e quindi distale raggiungendo la concentrazione e la composizione definitive, tipiche dell'urina. Ogni nefrone riversa l'urina così prodotta in microscopici dotti di raccolta (canali collettori), e quindi nel bacinetto, o pelvi, renale; da qui l'urina passa nella vescica urinaria attraverso un organo tubulare, l'uretere.
Quali sono le principali funzioni dei reni?
Un quarto circa del sangue pompato dal cuore a ogni sistole viene convogliato ai reni che ne eliminano le sostanze chimiche tossiche e di rifiuto, i minerali in eccesso e l'acqua, trattenendo, invece, alcuni prodotti chimici indispensabili e altre sostanze.
Che cosa succede se i reni non funzionano più bene?
a) Si ha un eccessivo accumulo di prodotti chimici di rifiuto e di tossine nella corrente sanguigna;
b) si ha un'eccessiva eliminazione di sostanze chimiche indispensabili, che dalla corrente sanguigna passano nell'urina e vengono eliminate;
c) a causa dell'indebolita funzione renale, il sangue e i liquidi che arrivano ai tessuti del corpo contengono componenti chimici inadatti; se la funzione renale degenera oltre un certo punto, ne deriva uno scompenso chimico talmente grave da provocare la morte.
Si può vivere normalmente e in salute con un solo rene?
Sì, a patto che il rene residuo funzioni in maniera normale.

Esami di funzionalità renale

Come si può stabilire se la funzione dei reni è normale?
a) Con l'esame delle urine;
b) con alcuni esami ematochimici;
c) esaminando i reni e l'apparato urinario con metodiche strumentali; d) con particolari esami di funzionalità renale.
Tra gli esami del sangue quali sono indicativi della funzionalità renale?
Azotemia e creatininemia: un aumento indica deficit della funzione renale.



Reni e vie urinarie, visti anteriormente. L'urina prodotta dai reni viene riversata nel bacinetto renale e, attraverso l'uretere, passa nella vescica, da cui viene espulsa, tramite uretra, fino all'esterno.

Tra gli esami strumentali quali sono i più usati per diagnosticare una malattia renale?
Oggi l'ecografia, innocua e di rapida esecuzione, per la morfologia; l'urografia e il radionefrogramma (o scintigrafia renale sequenziale) per indagare morfologia e funzione di reni e vie escretrici.
È sempre sufficiente l'analisi delle urine per individuare una malattia renale?
No; vi sono casi in cui il campione di urina risulta normale benché il rene sia gravemente danneggiato. Generalmente parlando, comunque, l'analisi delle urine è un esame iniziale utile, di valutazione semplice, rapido e poco costoso.

Segni di patologia renale

Quali sono le cause più comuni che determinano un deterioramento della funzione renale?
a) Anomalie congenite dei reni;
b) qualunque grave infezione o infiammazione generalizzata;
c) un'ostruzione meccanica intrinseca o estrinseca dell'apparato escretore del rene;
d) alcuni farmaci che danneggiano la struttura renale;
e) interferenze nel flusso ematico che arriva ai reni;
f) malattie ormonali o del metabolismo;
g) concentrazioni anormali di minerali nella corrente sanguigna, o disidratazione;
h) tumori renali.
Il gonfiore alle gambe, all'addome e al volto è sempre indizio di una malattia renale?
Non necessariamente; vi sono molte altre malattie che possono causare questo disturbo.
I dolori di schiena sono di solito indizio di una malattia renale?
Nella maggior parte dei casi non hanno alcun rapporto con le malattie renali. Certi dolori di schiena possono indubbiamente essere sintomo di una malattia renale, ma per la diagnosi occorre un esame medico. Caratteristico, nel soggetto magro, è il dolore lombare (di solito a destra) per la presenza di un rene ptosico.
La frequenza della minzione è indizio di malattia cenale?
Talvolta la frequenza della minzione è dovuta semplicemente alla quantità eccessiva di liquidi bevuti, oppure a tensione nervosa. D'altra parte, la frequenza della minzione può essere causata anche da disturbi quali il diabete o l'ingrossamento della prostata. Se la minzione frequente dovesse diventare un fatto ricorrente, è opportuno sottoporsi a un accurato esame medico per individuare eventuali disturbi della funzione renale.
L'enuresi notturna è indizio di malattia renale o di debolezza della vescica?
No; nella maggior parte dei casi, all'origine vi è qualche turba emotiva e non una malattia organica.
La presenza di albumina nelle urine è sempre indizio di malattie renali?
Non necessariamente; la presenza di albumina deve essere comunque considerata un indizio di malattia renale fino a quando ulteriori esami e prove non dimostrino diversamente.
Che significato ha la presenza di sangue nelle urine (ematuria)?
In genere indica la presenza di una malattia delle vie urinarie o del rene e ci si deve recare subito dal medico.
L'ematuria è sempre indizio di una malattia renale?
No; il sangue può provenire dagli ureteri, dalla vescica o dall'uretra che collega la vescica con l'esterno.

Le urine torbide, o una minzione dolorosa, indicano sempre una malattia renale?
Non necessariamente, benché possano indicare la presenza di un disturbo all'interno delle vie urinarie. In presenza di questi sintomi bisognerebbe recarsi subito dal medico.
Che cos'è la nefrite?
Nefrite è un termine generico con cui si indica una qualsiasi malattia infiammatoria del rene.
Il diabete è una malattia renale?
No; il diabete è essenzialmente una malattia del pancreas, che spesso, però, provoca un'alterazione renale. Inoltre, se il glucosio è in eccesso nel sangue passa il filtro renale e si ha una glicosuria utile per la diagnosi di diabete. Solo in questo senso c'è un rapporto fra i reni e il diabete.
Quale rapporto c'è tra ipertensione arteriosa e malattie renali?
Un'ipertensione arteriosa che si protragga per più anni può alla fine provocare una malattia renale, in seguito ad alterata circolazione del distretto interessato. Viceversa, gravi disturbi renali portano spesso all'ipertensione arteriosa. Anche l'arteriosclerosi dell'arteria renale, l'arteria principale del rene, può causare ipertensione arteriosa.
È possibile guarire l'ipertensione arteriosa nefrogena intervenendo chirurgicamente sui vasi sanguigni del rene?
Sì; oggi è possibile stabilire con precisione, mediante speciali tecniche a raggi x, se vi è un restringimento dell'arteria principale del rene. In presenza di una sindrome del genere spesso si può eseguire, con buoni risultati, un'operazione di chirurgia plastica sui vasi sanguigni renali. Se il restringimento è dovuto all'arteriosclerosi, si allarga la parete interna dell'arteria e si pratica un innesto di vaso artificiale in teflon o in dacron: l'intervento permette di aumentare l'apporto ematico al rene e in molti casi di eliminare la causa dell'ipertensione arteriosa.
È necessario bere molta acqua perché i reni funzionino normalmente?
È bene lasciarsi guidare dalla sete; così facendo, di solito i reni ricevono una quantità di liquidi sufficiente alla loro funzione.
Sono utili quei medicinali che, a detta della pubblicità, «depurano i reni»?
No; in condizioni normali i reni provvedono a depurare l'organismo, e in condizioni anormali, cioè quando non funzionano bene, non traggono alcun beneficio da tali medicinali.
È necessario limitare la quantità di sale nella dieta, quando si è affetti da una malattia renale?
Solo in alcuni casi.
Una dieta ricca di carne, uova o sale, può provocare malattie renali?
No.

Uremia

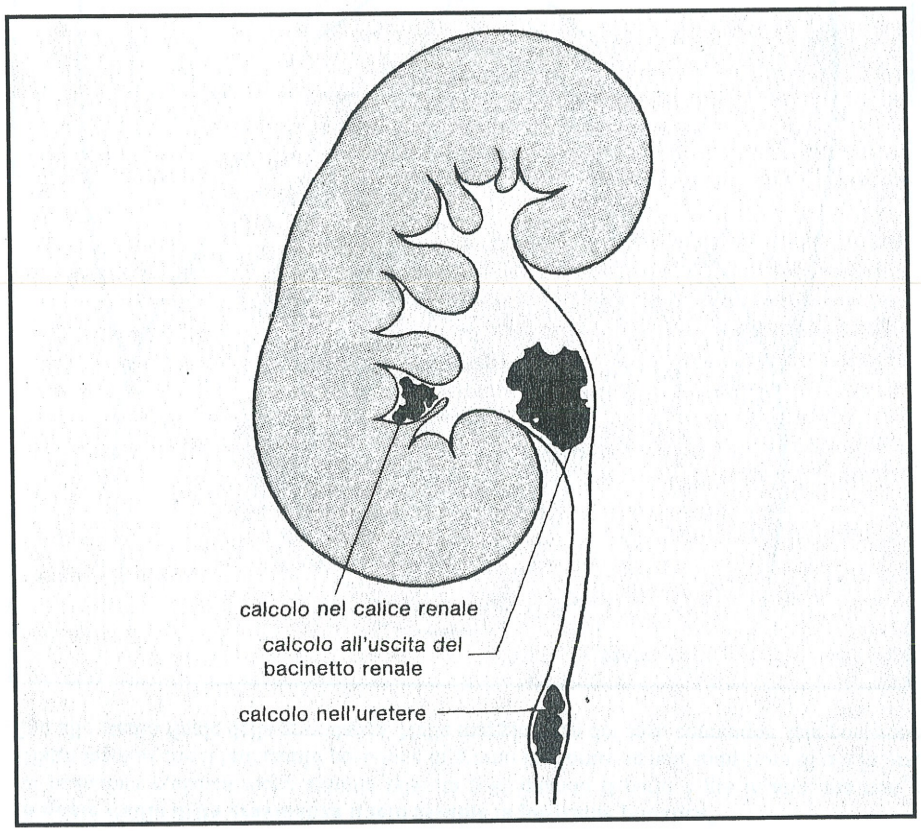
Che cos'è l'uremia?
Questo termine indica le alterazioni chimiche del sangue (e anche i sintomi relativi) che si manifestano negli stadi avanzati di insufficienza renale, quando i reni non riescono a eliminare i prodotti tossici di scarto. Si distingue una forma di insufficienza renale acuta e una cronica.
Quali sintomi dà?
Vomito, sudorazione, colorito pallido, talvolta stato convulsivo e coma oltre ad altri numerosissimi sintomi e segni.

Si può guarire?
Sì, a patto che si individui la causa dell'uremia e si riesca a eliminarla. Per esempio, se l'uremia è provocata da un'ostruzione di un uretere o di un bacinetto renale e si provvede a rimuovere subito l'ostruzione, l'uremia scompare e il paziente guarisce. Al contrario, se per esempio si manifesta negli ultimi stadi della glomerulonefrite cronica, l'uremia rappresenta lo stadio finale di una malattia irreversibile. Oggi, poi, è disponibile la dialisi.
Che cos'è la dialisi?
È una tecnica particolare che permette di depurare il sangue dalle sostanze tossiche che si accumulano in circolo quando il rene non è più in grado di svolgere le sue funzioni catartiche.
Quanti tipi di dialisi ci sono?
Fondamentalmente due: l'emodialisi e la dialisi peritoneale.
Come si fa l'emodialisi?
Prelevando, in un circuito chiuso, il sangue del soggetto, facendolo scorrere su una membrana semipermeabile ove si depura; una volta depurato viene reimmesso nell'organismo.
Come si fa la dialisi peritoneale?
Utilizzando come membrana semimpermeabile il peritoneo cioè la sottile lamina che ricopre all'interno la cavità addominale. Viene immessa, tramite un catetere, una certa quantità di liquido con una concentrazione predisposta delle diverse sostanze nella cavità addominale; il liquido viene lasciato in situ per diverse ore ed estratto successivamente, quando si è arricchito di sostanze tossiche sottratte all'organismo. Questo tipo di dialisi ha il grosso vantaggio di poter essere svolto a domicilio.
Quando va posto un paziente in dialisi?
Quando è presente uno stato di uremia.

Calcoli renali

Da che cosa sono formati i calcoli renali?
Sono una combinazione di sali inorganici come calcio, fosforo, ammonio ecc., oppure possono essere formati da composti organici, come l'acido urico.
Perché si formano?
In alcuni casi si conosce l'esatta causa; per esempio, nella gotta si ha un'alta concentrazione di acido urico nel sangue e conseguentemente nelle secrezioni renali, il che provoca la precipitazione dell'acido urico fino a formare i calcoli. In modo analogo, nei disturbi del metabolismo del calcio, si ha una precipitazione di composti di calcio nell'urina e nei reni a dare i calcoli. Nella maggior parte dei casi, tuttavia, il meccanismo esatto della formazione dei calcoli renali non è conosciuto anche se in proposito esistono varie possibilità teoriche:
a) una dieta inadatta;
b) squilibri nella composizione chimica dell'urina, eventuali perdite idriche;
c) disturbi delle ghiandole endocrine, soprattutto delle paratiroidi;
d) carenze vitaminiche;
e) infezioni renali;
f) scarso drenaggio in una o più parti delle vie urinarie.
I calcoli renali colpiscono con la stessa frequenza sia gli uomini sia le donne?
No; sono leggermente più frequenti negli uomini.
Possono manifestarsi a qualsiasi età?
Sì, ma sono più frequenti negli adulti tra i quaranta e i sessant'anni di età. b raro che un bambino sia affetto da calcoli renali.
I calcoli renali sono tendenzialmente singoli o multipli?
Nella maggior parte dei casi sono singoli, ma possono anche essere multipli; m tal caso è probabile che interessino entrambi i reni.
I calcoli renali variano molto per dimensioni?
Sì; le loro dimensioni sono estremamente variabili: possono andare da minuscoli frammenti non più grossi di granelli di sabbia (l'arenula e la renella) a pietre che formano un calco o uno stampo dei calici renali (calcolo a stampo coralliforme).
Quali sintomi provocano?
In alcuni casi i calcoli sono localizzati, stanno immobili, non danno nessun sintomo e li si può scoprire solo casualmente. Di solito però causano forti dolori (colica renale), presenza di sangue o pus nelle urine con danneggiamento della funzione renale. Frequentemente i calcoli si localizzano nell'uretere, il canale che collega il rene alla vescica, e sono questi a dare i dolori maggiori e a richiedere più spesso l'intervento chirurgico.
Tutti i calcoli devono essere asportati chirurgicamente?
No, molti vengono eliminati spontaneamente; inoltre, come detto, alcuni calcoli non si muovono, non provocano dolori né infezioni e non interferiscono con la funzione renale: in tal caso possono essere lasciati stare. I calcoli da asportare sono quelli troppo grossi per poter essere espulsi, quelli che provocano ostruzione e infezione, quelli che causano dolori costanti o attacchi periodici di dolori acuti, e quelli che, anche solo apparentemente, provocano un danno progressivo alla funzione renale. Oggi inoltre è possibile utilizzare una nuova terapia tramite il litotritore.
Che cos'è il litotritore?
È una macchina che permette di produrre onde d'urto in grado di frantumare calcoli calcifici con caratteristiche particolari.
Esistono medicinali in grado di sciogliere i calcoli?
Soltanto i calcoli formati da urati (sali dell'acido urico) possono essere sciolti con un'opportuna terapia medica. Negli altri casi, vi sono alcuni regimi alimentari, come la dieta a basso contenuto di fosforo, la dieta alcalina o anche una dieta acida, che possono ritardare la crescita di un calcolo o contribuire a prevenire la formazione di nuovi calcoli. Vi sono anche alcuni farmaci che hanno più o meno lo stesso effetto (sali acidi, sali alcalini ecc.) ma non sono in grado di sciogliere i calcoli.
I calcoli renali possono riformarsi dopo essere usciti o essere stati tolti?
Sì. È comunque possibile prevenirne il riformarsi con una dieta appropriata, uso di abbondanti quantità di liquidi, assunzione di determinati farmaci ed eliminazione di infezioni e ostruzioni delle vie urinarie. In una piccola percentuale di casi, i calcoli si riformano comunque, nonostante tutte le precauzioni.
Che cosa sono i calcoli dell'uretere?
È raro che i calcoli si formino originariamente nell'uretere, mentre spesso sono i calcoli renali che scendono nell'uretere e vi si localizzano. I calcoli nell'uretere sono detti calcoli ureterali.
Quali sintomi danno?
Il sintomo principale è il dolore: lancinante, simile ai dolori da colica, può essere così acuto da resistere ai più potenti analgesici. Sintomi comuni sono nausea, vomito e stitichezza; vi può essere anche stimolo e frequenza nella minzione, che è dolorosa; nella maggior parte dei casi le urine contengono sangue e, se il calcolo provoca il blocco del flusso di urina dal rene, si ha febbre.

Come si curano?
Per prima cosa è necessario controllare il dolore; quindi, in caso di infezione, bisogna intervenire con antibiotici o sulfamidici. Se non si può controllare in
maniera adeguata il dolore e l'infezione, è necessario eseguire un drenaggio del rene, che si ottiene introducendo per mezzo di un cistoscopio un catetere nella vescica, spingendolo poi oltre il calcolo. Se non è possibile far passare il catetere oltre il calcolo, s'impone l'asportazione chirurgica.
È sempre necessario ricorrere all'asportazione chirurgica per i calcoli all'uretere?
No; la maggior parte dei calcoli che si insediano in questa posizione passano spontaneamente nella vescica e vengono eliminati. Se non sopravviene un'infezione, se gli accessi di dolore non si ripetono e se il flusso dell'urina non è bloccato, è dunque meglio aspettare che i calcoli



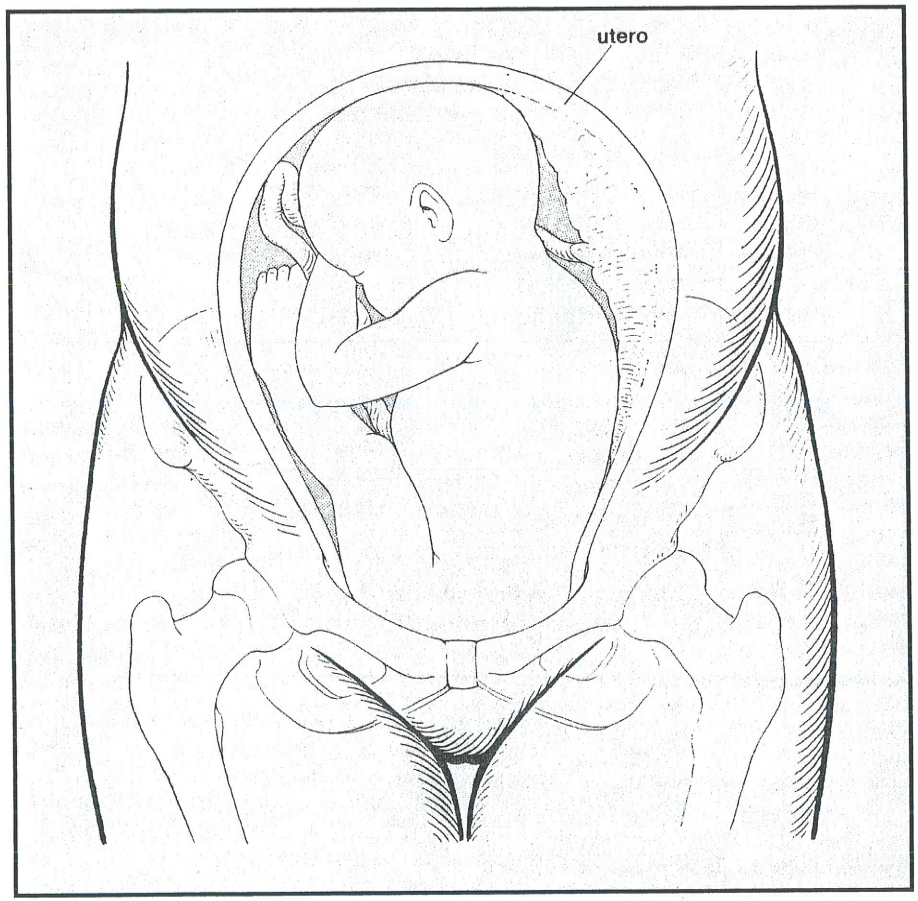
Calcoli renali. La figura mostra, schematicamente, un calcolo localizzato in un calice renale; un altro, più sviluppato, all'uscita del bacinetto renal e un terzo calcolo nell'uretere. I calcoli che occludono i lume delle vie urinarie provocano il ristagno dell'urina.

passino spontaneamente, il che può verificarsi in qualsiasi momento, nello spazio dì più giorni o settimane.
Quando è necessario ricorrere all'intervento chirurgico?
a) Quando il calcolo è chiaramente troppo grosso per passare spontaneamente;
b) quando il blocco dell'urina si prolunga;
c) quando si hanno ripetuti attacchi di dolori acuti;
d) quando l'infezione persiste;
e) quando la funzione renale ne risulta danneggiata.
È possibile afferrare il calcolo con strumenti appositi, introdotti attraverso un cistoscopio?
Sì; esistono strumenti studiati appositamente per afferrare i calcoli e con i quali talvolta si riesce a farli scendere lungo l'uretere. Se questi metodi meccanici falliscono, allora bisogna ricorrere all'asportazione chirurgica.
L'asportazione chirurgica di un calcolo è un'operazione grave?
È un'operazione che non comporta grandi rischi.
Quanto tempo occorre restare in ospedale dopo un'operazione per calcoli all'uretere?
Dieci-quattordici giorni.
Dopo un simile intervento il paziente può condurre una vita normale?
Sì.
Chi ha avuto una volta un calcolo renale dovrebbe sottoporsi a periodiche visite mediche?
Sì; dovrebbe anche attenersi a tutte le prescrizioni prima citate per prevenire il riformarsi dei calcoli.

Presentazione podalica

Che cos'è il parto podalico?
Un parto in cui il bambino si presenta all'ingresso del bacino con le natiche, i piedi oppure le ginocchia.
La presentazione podalica comporta uno svolgimento anomalo del parto?
In un certo senso, tale presentazione rappresenta di per sé un'anomalia; cionondimeno, l'intervento di un ostetrico esperto consente di portare a termine il parto senza alcun pericolo né per la madre né per il bambino.
Qual è l'incidenza di questo tipo di presentazione?
La si riscontra nel 3-5% circa dei parti avvenuti al termine regolare della gestazione.
In quali casi può verificarsi la presentazione podalica?
a) Quando il bacino è anomalo;
b) in caso di malformazione congenita dell'utero;
c) in caso di miomi uterini;
d) quando il cranio del feto presenta un'anomalia strutturale o un tumore;
e) quando la placenta si è disposta nella vagina a una profondità insolita;
f) in caso di parto gemellare;
g) quando il sacco amniotico contiene una quantità eccessiva di liquido.

Se il primo parto è podalico, anche i parti successivi sono destinati ad avvenire nello stesso modo?
Non necessariamente.
In quale stadio della gravidanza il feto assume la posizione podalica?
La posizione podalica viene assunta talvolta solo quando il parto è già in atto, ma non è affatto insolito che il feto cambi posizione di giorno in giorno, se non addirittura di ora in ora, fino allo stadio finale della gravidanza. Nella maggioranza dei casi, comunque, tale posizione



La presentazione podalica si riscontra nel 3-5% dei casi. Con l'assistenza di un ostetrico abile, il parto può di solito avvenire per la via naturale, nonostante la posizione anomala assunta dal bambino; poiché tuttavia la testa ha meno tempo, rispetto alla presentazione cefalica, di adattarsi al canale del parto, in taluni casi in cui il bambino abbia il capo molto sviluppato si rende necessario il taglio cesareo.

si riscontra attorno al settimo mese di gestazione.
Come viene diagnosticata la posizione podalica?
a) Con esame esterno dell'addome, che porta ad accertare come la testa del feto si trovi nella parte superiore dell'utero;
b) con esame vaginale, nel corso del parto;
c) attraverso un esame ecografico.
È possibile correggerla?
Taluni ostetrici sostengono la necessità di correggere la posizione podalica, se scoperta prima che inizi il parto, mediante rotazione dall'esterno del feto; altri ricusano invece tale sistema, in quanto ritengono che così facendo vi siano forti probabilità di danneggiare in qualche modo il nascituro. Una volta riportato nella posizione normale, non è inoltre escluso che il feto riprenda quella podalica.
Come si procede in caso di presentazione podalica?
Le misure da adottare vengono di solito decise quando le doglie sono già iniziate. Se si tratta del primo parto, è necessaria una determinazione esatta delle dimensioni e della forma del bacino materno, in quanto con questo tipo di presentazione il diametro del cranio infantile non riesce ad adattarsi (come invece avviene nella presentazione cefalica) a quello del canale del parto; prima che il travaglio abbia raggiunto uno stadio troppo avanzato, è quindi necessario determinare con precisione i rapporti dimensionali. In seguito, si lascia che il parto segua il suo corso naturale se le doglie sono intense e regolari, l'ampiezza del bacino adeguata e il bambino non troppo grosso, mentre si decide di praticare un taglio cesareo se le doglie sono deboli e irregolari, il bacino troppo stretto o il bambino troppo grosso o se la donna è al primo figlio.
Una volta accertato che il feto ha assunto una posizione podalica, la futura madre deve recarsi in ospedale non appena avverte i primi sintomi del travaglio?
Sì, poiché la decisione riguardante le misure da adottare deve essere presa dall'equipe medica quando il parto è iniziato da poco.

Taglio cesareo

Che cos'è il taglio cesareo?
Un intervento chirurgico che consiste nell'estrarre il feto attraverso un'incisione praticata nella parete sia dell'addome sia dell'utero.
È un intervento chirurgico di notevole portata?
Sì.
Il taglio cesareo comporta pericoli?
No; se praticato a partorienti in buone condizioni fisiche, viene superato ottimamente in circa il 100% dei casi, percentuale che diminuisce leggermente quando in gravidanza insorgono complicazioni. Lo stadio attualmente raggiunto dalle conoscenze scientifiche, l'evoluzione e il miglioramento delle tecniche chirurgiche e dei metodi anestetici, uniti all'uso di trasfusioni di sangue e di antibiotici, inducono a ritenere che il taglio cesareo sia ormai divenuto un intervento chirurgico che comporta ben pochi rischi.
Quando è stato praticato per la prima volta?
Si ritiene che su una donna viva sia stato effettuato per la prima volta nel xv secolo d.C., mentre il parto cesareo della donna morta per salvare il bambino sembra fosse noto già in tempi preistorici. Il nome trae origine dalla leggenda secondo cui Giulio Cesare sarebbe

Appendicite

Che cos'è l'appendicite

L'appendicite è un'infiammazione dell'appendice, un sottile tubulo che parte dall'intestino cieco ed è posizionato nel quadrante inferiore destro dell'addome. L'appendice è parte del sistema immunitario e svolge un'importante funzione protettiva durante il primo anno di vita per poi diventare però un "organo bersaglio" di infezioni.

L'infezione all'appendice può presentarsi in forma acuta o cronica:

l'appendicite acuta si manifesta principalmente tra i 6 e i 20 anni, anche se può presentarsi a tutte le età. Si manifesta quando l'appendice viene riempita da un corpo estraneo che ne causa il rigonfiamento (come ad esempio muco, feci o parassiti) e provoca la moltiplicazione virulenta della flora batterica intestinale.

l'appendicite cronica è un'infiammazione cronica della Appendice che si presenta il più delle volte come conseguenza di un'appendicite acuta non diagnosticata o non sottoposta ad intervento chirurgico. Si manifesta con dolore, inappetenza, nausea e nelle donne - a causa degli estesi collegamenti linfatici tra organi genitali interni ed appendice - è associata spesso a problemi ginecologici.

Cause dell'appendicite

All'interno dell'appendice si trova la flora batterica intestinale: i batteri Escherichia Coli, Streptococchi e Stafilococchi, che normalmente sono innocui, in particolari condizioni possono moltiplicarsi in modo anomalo e causare l'infiammazione dell'organo. La condizione scatenante solitamente è un'occlusione del lume dell'appendice che causa il ristagno dei batteri e provoca l'infezione.

L'occlusione può avere varie cause: muco raggrumato, noccioli, parassiti, una posizione anomala dell'appendice causata dalla sua eccessiva lunghezza. Altre condizioni scatenati sono l'ingestione di cibi molto grassi o ricchi di coloranti e, in particolar modo, il fumo di tabacco.

Segni e sintomi dell'appendicite

L'appendicite si manifesta, nei casi tipici, con un forte ed improvviso dolore addominale, accompagnato da fitte. L'area dolorante varia, estendendosi a tutto l'addome o dall'ombelico in giù, localizzandosi prevalentemente in basso a destra. In casi più rari può interessare la coscia.

Il Dolore può peggiorare con il movimento, con i respiri profondi, con la palpazione, con la tosse o con lo starnutire.

Altri sintomi sono nausea, vomito, febbre, stipsi o diarrea.

In una discreta percentuale di casi la sintomatologia può essere sfumata o presentarsi con sintomi e segni non tipici, soprattutto in età adulta, rendendo a volte difficile la diagnosi.

Diagnosi di appendicite

La diagnosi di Appendicite viene fatta principalmente sulla base dell'esame clinico ma possono essere utili alcuni esami del sangue (valore dei globuli bianchi, della velocità di sedimentazione - VES, della proteina C reattiva), l'ecografia e, in casi selezionati, la TAC che può eventualmente aiutare a distinguere un dolore di origine appendicolare da un dolore che ha altre cause, oppure evidenziare la presenza di ascessi o patologie a partenza da altri organi.

Complicanze dell'appendicite

L'appendice infiammata può rompersi o perforarsi, causando la contaminazione della cavità addominale da parte di materiale infetto e la conseguente produzione di pus: si parla in questi casi di peritonite. È possibile anche l'evoluzione verso l'ascesso appendicolare.

Terapia dell'appendicite

La terapia dell'appendicite consiste nell'asportazione chirurgica dell'appendice (appendicectomia). Il solo trattamento medico ('raffreddare' l'appendicite con antibiotici e borsa di ghiaccio) espone al rischio di ricadute, in forma spesso anche più virulenta, e cronicizzazione.

L'intervento chirurgico si effettua in anestesia generale e può essere eseguito tramite un'incisione di pochi centimetri, oppure in laparoscopia, cioè generalmente con tre accessi di circa 1 cm l'uno. In casi particolari può essere necessario effettuare incisioni un po' più estese. La tecnica laparoscopica è indicata soprattutto nelle donne, in particolar modo quando c'è incertezza sulla diagnosi delle malattie della zona genitale e nei pazienti obesi, nei quali l'incisione dell'intervento chirurgico dovrebbe avere dimensioni maggiori.

Negli altri casi la laparoscopia trova comunque indicazione per i vantaggi che è in grado di fornire, tanto più evidenti quanto maggiore è il grado di infiammazione dell'appendice. Risulta ormai evidente che la percentuale di infezioni delle ferite, di aderenze successive all'intervento chirurgico e di ernie su incisione (laparoceli) sono nettamente inferiori.

Se la causa dei sintomi, inoltre, fosse diversa dall'infiammazione dell'appendice, la laparoscopia offre il vantaggio della diagnosi e dell'eventuale trattamento attraverso le stesse incisioni, non rendendosi necessario l'ampliamento di una eventuale incisione addominale. Non esiste tuttavia in letteratura medica una sicura evidenza di vantaggi significativi rispetto all'incisione tradizionale in termini di dolore postoperatorio, durata della degenza e ripresa delle attività fisiche abituali.

Se l'appendice si è perforata, causando una peritonite, si impone l'intervento chirurgico in urgenza, al termine del quale generalmente viene lasciato un drenaggio, inserendo un tubicino nella cavità addominale per consentire al pus di essere eliminato all'esterno; il tubo drenante viene rimosso dopo pochi giorni, quando non c'è più pericolo di un'infezione addominale.