THE ROLE OF INTERPRETERS IN HEALTHCARE IN AUSTRALIA

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ABSTRACT

Interpreters play a pivotal role in facilitating communication between healthcare professionals and their patients when there is a lack of a common language which inhibits direct communication. This thesis examines the roles and practices of interpreters in healthcare settings in tertiary teaching hospitals with a high proportion of patients from culturally and linguistically diverse backgrounds in Melbourne, Australia. On the surface, the process of interpreter-mediated communication may seem straightforward, and the interpreter's role is characteristically presented as being that of a neutral 'language conduit', seamlessly transferring meaning between two languages. However, this research explores the argument that conceptualising and understanding the role in this way is too simplistic, and devalues a range of contributions expected and made by interpreters in facilitating patient--health professional communication in Australian hospitals.

The study was designed to investigate qualitatively the expectations and experiences of each group of participants in interpreter-mediated health communication concerning the role/s of the interpreter and factors that impact these role/s. To provide a complementary lens, the qualitative investigation of interpreters' practices includes analysis of recordings of actual interpreted health encounters. Thirty-one individuals across three groups of participants (i.e. health professionals, patients and interpreters), across two large hospitals participated in semi-structured in-depth interviews. For the contrasting perspective, three interpreter-mediated outpatient healthcare interactions (in Dari, Arabic and Italian) were recorded and analysed enabling examination of similarities and differences between reported experiences and interpreter practice.

The overall findings highlighted the interpreters' awareness of the code of ethics and code of conduct that AUSIT (Australian Institute of Interpreters and Translators) promotes as professional standards. Interpreters seek to adhere to the neutral language conduit role as best they can. However, factors impacted the effectiveness of interpreters in relation to this role in the hospital interpreting setting, in particular, patients' limited educational level and understanding of health terminology, dialect and gender compatibility between patient and interpreter, and institutional constraints, such as time and scheduling of consultations.

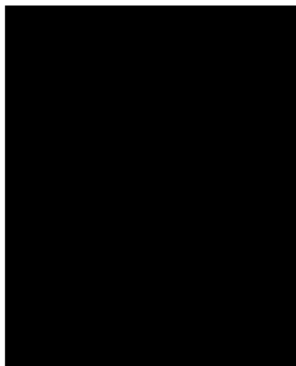
On average interpreters engaged solely in direct message transfer in about 60% of their interpretations. However, they demonstrated a willingness and ability to move beyond their direct language conduit role when required, to facilitate more meaningful and expeditious HP--patient exchange. Three core non-conduit roles (conversational facilitator, cultural facilitator, and experience facilitator) were also identified. Each of these roles is discussed in detail.

Most importantly, whilst interpreters adopted these three non-conduit roles on an 'as needs basis', they felt in control and able to manage their professional boundaries when challenged.

To conclude, recommendations about enhancing communication and training for health professionals, interpreters and patients were presented.

DECLARATION

I, Mojdeh Mahdavi, declare that the Doctor of Philosophy thesis entitled 'The Role of Interpreters in Healthcare in Australia' is no more than 100,000 words in length including quotes and exclusive of tables, figures, appendices, bibliography, references and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

Signature:  Date: 30/6/2020

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I would like to acknowledge and thank the two Melbourne public hospitals for their participation in my research, their ethics committee members, the heads of the interpreters offices who initially welcomed and supported my research, the healthcare staff who participated in my research, and the interpreters and patients whom, by their participation, made this research possible. The names of the hospitals will remain undisclosed as part of de-identification of the data collection.

As a part time student with many personal challenges along the way completing this PhD has involved me in confronting and overcoming many obstacles. I could not have achieved this without the emotional support and encouragement of my extended family. I thank them for their patience, understanding, and for believing in me every step of the way.

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LIST OF ACRONYMS

AUSIT	Australian Institute for Interpreters and Translators
CALDB	Culturally and Linguistically Diverse Background
CCHCP	Cross Cultural Health Care Program
CHIA	California Healthcare Interpreting Association
DRCC	Dublin Rape Crisis Centre
IFT	International Federation of Translators
LEP	Limited English Proficiency
LOTE	Language Other Than English
NAATI	National Accreditation Authority for Translators and Interpreters
NCIHC	National Council on Interpreting in Health Care
NHMRC	National Health and Medical Research Council
TIS	Translating and Interpreting Services
UK	The United Kingdom
US	The United States of America

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Chapter One – Introduction

1.1 Background

1.1.1 Personal context

My motivation and interest in researching interpreting practice has arisen from both personal experiences as a migrant and child of migrant parents, and professional experiences as an accredited interpreter practising in Melbourne. Both experiences caused me to reflect on what makes the process of communication facilitated by an interpreter work well in the absence of a common shared language. Ideally, the process of interpreter-mediated communication leads to satisfaction and clarity of mutual understanding for those concerned, but the ideal and reality of the experience do not always align. I begin by sharing some reflections that influenced my thinking in making sense of the process of interpreter-mediated communication—both personal and professional.

When my family arrived from Iran in 1994, my mother's English proficiency was low. She required interpreters to assist her in understanding the language. Initially we did not even know there was an interpreting service available for migrants who required it. In the early days, it was not mentioned usually to us by the organisations that we attended that my mother could request an interpreter if she needed one. Only once did an employee at the government employment services offer to call a telephone interpreting service (TIS), because Mum had said that she did not want to use family members. By having support from TIS, I could see that my mother felt empowered to narrate her employment experiences and talents, even those we told her not to mention because they were not important, such as her short-term singing career, and her diploma in hairdressing obtained while she was on a three-month holiday. She excitedly reported to us after her session finished that the staff had told her she may be able to work in a radio station broadcasting Iranian programs, as a reporter or newsreader, as she had had a singing career in the past, so therefore she must have a good voice! It made her heart fill with joy that she had managed to have direct communication via the interpreter, despite it not necessarily generating feasible outcomes.

The next time she required an interpreter was when she sat for the VicRoads theoretical test to obtain her driver's licence. She was told that an interpreter had been booked for her in four weeks and she could not sit for the test before then, regardless of her being ready. On the day of the appointment, feeling stressed about sitting for the test and worrying whether she would pass with all the different rules to learn, she arrived at VicRoads and waited for a long time before she was told that the interpreter was no longer available and she needed to re-book her appointment. This was quite a frustrating moment, not only for her, but also for family. She had had to skip her English class and prepare herself for the test, only to learn that her time and effort was being disrupted due to a third party who, for some unexplained reason, did not arrive. The next appointment was made some weeks later to allow administration to find an interpreter in her language. Before the arrival of the interpreter, we were not certain there would be one there and it felt like her plans and aspirations were in the hands of the unpredictable arrival of a third person—the interpreter.

When I started working as a professional interpreter in 2000, I observed that the clients, either patients of culturally and linguistically diverse backgrounds (CALDB) or health professionals (HPs) seemed to know a few Persian interpreters by their first names and spoke of them as being good interpreters. One particular name that kept popping up was Zoya (pseudonym). I was intrigued and curious to understand why some professional interpreters seemed to be viewed more positively than others—what the criteria were among service users for labeling some interpreters better than others.

I noticed that at times the CALDB or the HP mentioned the name Zoya, and that I had been booked only because she was not available. I kept searching for Zoya in order to understand why so many clients liked her. One day I was interpreting for an old lady with whom I had to sit for some time, waiting for her doctor to call her. It was the second time I had interpreted for her in that clinic. I had also interpreted for her when she had her regular meeting with public-housing staff. She felt comfortable seeing my familiar and friendly face on that day, telling me that she was happy that I had come along to her appointment because she had seen me before. She then talked to me about

Zoya and how she usually attends her appointments and sometimes picks her up in her car and takes her to do her grocery shopping. She said that Zoya had told her not to mention to anyone that she was helping her, because she is old and does not have anyone to help her with shopping. It was then that I realised the possible answer to my question as to why many CALDB clients requested Zoya: her willingness to provide extra assistance beyond her role as an interpreter—assistance that was undoubtedly needed and welcomed by many Limited English Proficiency (LEP) older migrants and refugees.

Some years passed. My mother had another appointment at the hospital. When I asked her afterwards about her appointment she said she had an interpreter named Zoya, who acted a bit differently from her other interpreters. She said that Zoya arrived early, sat next to her and reported that she had asked the staff to see her as soon as possible, because both interpreter and patient were present. She then asked Mum all about herself: What year she came to Australia? With whom? What was her occupation in Iran? What was she doing here? What was her husband doing? How many children did she have? Where in Melbourne did she live? And then she said she was surprised that this was the first time she had seen Mum, given her years of residency in Australia and the need for interpreters. And without being asked by Mum, Zoya spoke about her own educational background, her family, and their length of stay in Melbourne.

According to my mother's perception, during the consultation Zoya interpreted everything precisely. When she was required to make her next appointment, Zoya was proactive in asking the receptionist to book her for the next appointment, informing Mum that she had already asked the receptionist to book her for her next appointment.

My mother was not too impressed by a few things that happened in her encounter with Zoya. Without any prompting by me, Mum volunteered that she found it unprofessional that Zoya claimed she had done her a favour by asking the receptionist to advance her file, so she could be seen as soon as possible. She felt that by doing so the interpreter had assumed power and made my mother feel indebted to her. As a patient, Mum felt it was not necessary to request such a favour anyway, because she should wait her turn

to see the doctor. The interpreter's assumption of control was further reinforced at the end of the consultation when Zoya presumed that the patient would not contest her request to attend her next appointment with her. Furthermore, as a patient, Mum did not like being questioned about her life by the interpreter and she had no interest in knowing the life story of the interpreter. Having been given personal information she had not asked for, my mother felt sorry for the interpreter. Despite holding a postgraduate degree in another discipline, the interpreter had related how she had not been able to find employment in her primary field in Australia, and relied on interpreting as her main source of income. The attempt to build a personal relationship through encouraging the sharing of personal information had not engendered professional regard and respect on my mother's part.

Despite my mother having been satisfied with the accuracy of Zoya's interpreting, she felt uncomfortable with what she perceived as inappropriate manipulation by the interpreter to advance her own interests. Subsequently, my mother asked me to call the hospital and re-schedule her appointment, so she could have a different interpreter.

My mother's story highlighted, for me, how there can be a range of reasons as to why some interpreters are more popular, not all of which reflect well on the interpreter's adherence to ethical and professional expectations of their role in practice. Whilst proactively volunteering to attend the next meeting with the client could be seen to be supportive in providing continuity and familiarity with their interpreter, the exercise of subtle control over the organisation and scheduling of a patient's consultations removes an element of patient autonomy—implicitly advantaging the interpreter materially and personally in terms of their access to further employment. In the case of my mother, the blurring of professional and personal boundaries in the interpreter's approach to being 'helpful' to her clients created a dynamic in the patient-interpreter relationship that was open to dependency and manipulation, particularly when clients are vulnerable due to their age and LEP.

1.1.2 Australian context

Since European invasion and settlement over 200 years ago, Australia has become a

nation relying heavily on immigration for its population growth and national development. In the second half of the 20th century the pace of migration to Australia increased and source countries diversified, with an increasing proportion of migrants from Asian and Middle Eastern countries. Whilst recent government policy has favoured migrants with good levels of proficiency in English, nevertheless there are many older and refugee/humanitarian migrants with limited proficiency in English. Many first generation migrant settlers are dependent on the assistance of an interpreter for communicating with mainstream services across the linguistic and cultural divide.

According to the 2016 Australian Bureau of Statistics census, the number of people self-reporting that they spoke English "not well" or "not at all" was 820,000. Without the linguistic means to address a myriad of needs, including those related to education (Kong, Hamsworth, Rajaeian, Parkes, Bishop, Almansouri & Lawrence, 2016), employment (Guven & Islam, 2015), and social and legal services (Mikkelson, 2016), these people can be denied access to services that are the right of all citizens.

Health, in particular, is an area where access to services requires well developed English language skills. The scale of the problem can be seen in hospitals in Melbourne. For example, in St Vincent's Hospital, which in 2017--2018 had 151,000 clinical appointments and 60,000 inpatient admissions, approximately 46% of patients for these appointments and admissions were CALDB with approximately 20% requiring an interpreter's assistance to facilitate their communication regarding the hospital's services. So, in just one of Melbourne's hospital networks in a single year, approximately 19,400 patients needed interpreter support services. And St Vincent's is far from being an isolated case. Another Melbourne provider, Western Health, stated in their 2015/16 annual report that their language services had to accommodate 110 languages and dialects, and that on a typical day 150 patients would require an interpreter (equating to more than 54,000 consultations requiring interpreter support annually).

Access to essential health care services depends on the ability of service users and seekers to communicate their health needs using the language spoken in the host

country. Communication breakdown presents service users with challenges ranging from minor inconveniences, such as a short delay in doing a lab test, through to grave consequences associated with inaccurate diagnoses and subsequent treatments. As SBS and *The Conversation* reported in multiple articles in 2016, poor language skills increase the likelihood of ill health among migrants and refugees (Armstrong, 2016; Narchal, 2016; Waters, 2016).

International research shows a strong relationship between a patient's level of proficiency in the language of their host country and quality of care in medical settings (Al-Sharifi, Frederiksen, Rossau, Norredam, & Zwisler, 2019; Angelelli, 2008; Bowen, 2001; Edwards, Temple, & Alexander, 2005; Haralambous, Tinney, LoGiudice, Lee, & Lin, 2018; Henderson & Kendall, 2011; Verrept, 2008; Watt, Hu, Magin, & Abbott, 2018). Yet, to learn a second language or improve language proficiency to a desired level takes time, compounded by numerous Limited English Proficiency (LEP) permanent residents simply not being able to learn English well. In this situation, interpreting becomes an important and often necessary service for medical consultations, where highly developed language skills are of critical and immediate significance.

The absence of interpreters to help LEP patients negotiate their health care when visiting hospitals has been reported to bring about undesirable situations, including less satisfactory medical outcomes (Morales, Cunningham, Brown, Liu, & Hays 1999; Weech-Maldonado, Morales, Elliott, Spritzer, Marshall, & Hays (2003), patients' inaccurate understanding of their diagnosis (Gany et al., 2013), patients receiving inadequate care (Devore & Koskela, 1980; Garg et al., 2017; Patriksson, Berg, Nilsson, & Wigert, 2017; Todd, Samaroo, & Hoffman, 1993; Watt et al., 2018), and patients staying longer in hospital (John-Baptiste et al., 2004 (Canada)). Many of these outcomes could have been avoided with the presence of a well-trained medical interpreter (Crezee, 2013 (New Zealand)).

1.2 Community interpreting: Codification and the interpreter's role

Until about 30 years ago employing interpreters, especially in health care settings, was

not a common practice, despite the need for interpreting being recognised by HPs as they strove to gain an adequate understanding of their LEP patients' health issues. Pöchhacker (2004) (Austria) has identified the initial development of community-based interpreting in countries with proactive immigration policies, for example Australia and Sweden around 1970. In his account of how interpreting provision and its codification developed, he then named North America and Europe as following in their adoption of the concept of community interpreting. He defines community interpreting as "professional interpreting in a community based setting" (2008: 24). Distinctive features of community interpreting are that it usually takes place consecutively, and is directed to facilitating the communication of a community member with a service provider in a host country setting where there is an imbalance of knowledge and understanding of institutional process and practices.

As a result of this demand for interpreters in different countries and regions with large numbers of new migrants, agencies in the relevant countries, such as in Australasia, New Zealand, North America and Europe, have attempted to define the professional role/s that interpreters in health and other community contexts are expected to fulfill. As a result, professional standards and codes of practice have been developed and adopted as the basis of training, including by the Australian Institute for Interpreters and Translators (AUSIT), the International Federation of Translators (IFT), the California Health Care Interpreting Association (CHIA), and the Dublin Rape Crisis Centre (DRCC), amongst others. Hale (2007a) has emphasised when comparing codes of ethics and practice for interpreting internationally, that interpreting is a complex task, involving the "process of comprehension, conversion and delivery" (2007:15), with the professionals working with interpreters rarely understanding the complexity of rendering an accurate message from one language into another. However, as Hale (2007a) has argued, certification and the existence of a code do not guarantee that all interpreters are willing and able to follow the high standards of that code.

Those who are not language experts tend to view the process of interpreting as straightforward and uncontentious. Those who appreciate how human languages segment and express concepts differently, and subtly reflect cultural values and life

contexts, understand that accurate translation between languages is difficult, and sometimes, impossible. In specialist fields, such as health and the law, interpreting is further complicated by the need to translate specialist terminologies and registers. Furthermore, in her international comparison, Hale (2007a) found that by examining 16 selected codes of ethics from nine countries there was a lack of in-depth discussion of the meaning of codes, or explanation of abstract notions they adopted, such as concepts of impartiality or confidentiality. As a consequence, in order to assist interpreting practitioners to make their best judgments, a code is best considered as a guide. In reviewing ethical standards in different countries, Ozolins (2015), drawing on Baker and Maier (2011), Hale (2007a) and Tebble (2012), concludes that a code of ethics can only go so far to assist in establishing the righteous conduct for interpreters, as well as in making service users understand the role of the interpreter. He advocates that further attention needs to be given to educating and awareness of the interpreter's professionalism. Wang (2016) reiterated Ozolins' conclusion that internationally there is no single universally understood interpreter role, but highlights "that codes of ethics help establish the interpreting habitus and promote the understanding of the interpreter role by other participants" (2016:112).

Pöchhacker (2004) considered Australia to be in a unique position given its national accreditation system (NAATI), which provides testing in language proficiency as well as being grounded in AUSIT's national code of ethics and conduct for those who practise interpreting and translating. Furthermore, acceptance of community interpreting as a field distinct from translation and conference/simultaneous interpreting, has been more strongly recognised recently in Australia with the major overhaul of NAATI's (2018) approach to interpreter accreditation, leading to the introduction of new certification levels for interpreters. The new certification framework clearly delineates the different areas of professional practice that are linked to employment as an interpreter or translator, including recognising the specialist nature of health and legal interpreting.

The AUSIT Code of Ethics and Code of Conduct was first developed and disseminated in 1990s and expanded from the members' annual meeting in 1995 (as cited in AUSIT

2012:2). Following a broad community and organisational consultation process, initiated by a joint proposal from Monash University and AUSIT for a review of the codes, it was rewritten and republished in 2012 to reflect changes in the translation and interpreting industry. The current Australian Code (2012) contains general ethical principles as well as a code of conduct for practitioners. It highlights nine major ethical principles to guide interpreters in their practice. Each ethical principle is supported with more specific guidance through a code of conduct that aligns with each ethical principle.

1. professional conduct
2. confidentiality
3. competence
4. impartiality
5. accuracy
6. clarity of role boundaries
7. maintaining professional relationships
8. professional development
9. professional solidarity

The AUSIT code provides a theoretical definition and outlines expectations of an interpreter as a professional, importantly not only in terms of their role in the application of their knowledge and skills across the two languages, but also in terms of their conduct as a professional in relation to others. The transference of a message from one language to another necessarily involves the interpreter's judgment, culturally and linguistically, in order to achieve a transfer of content to the other party. Although training materials and guides include concrete examples of what is ethically expected of interpreters, the broader point to highlight here is that it is impossible to cover all potential scenarios requiring the interpreter's cultural, linguistic, and content knowledge. The exercise of judgment necessarily required highlights why interpreting is increasingly recognised as a field requiring professional training and knowledge. Much recent work in Australia has focused on increasing professional recognition and lobbying for improved employment conditions for professional interpreters, such as through industrial advocacy (e.g. formation of Translators and Interpreters Australia –

https://tia.professionalsaustralia.org.au), as well as documenting risks of not using credentialed interpreters and making the case for their increased usage in health care (Foundation House, 2013). However, there has been less focus on the nuances of what constitutes the interpreter's role in the dynamic environment in which community interpreting takes place.

The main role of an interpreter is what I have chosen to refer to and define as 'the conduit role', that is, to transfer a message spoken in one language accurately into the language understood and spoken by the other person party to the interaction. The attributes of competency and accuracy in the AUSIT code both directly relate to this role expectation. As 5.1 states "interpreters and translators are able to provide an accurate and complete rendition of source message using skills and understanding they have acquired through training and education". However, as Hale (2007a) has emphasised, while "the AUSIT code advises interpreters to explain their role to those who are unaccustomed to working with interpreters, but it does not define it" (p.124), although "it is implicit in the entries for accuracy and impartiality" (p.125).

A 'conduit' is a metaphor that is based on the function of connecting two points or places. In its most common everyday usage in engineering it refers to "a pipe or passage for water or electrical wires"(Cambridge Dictionary of English online). In the case of interpreting, it connotes the process of shifting a message automatically between two parties who do not share a common language. As with some other commonly adopted mechanistic metaphors to describe this role, such as 'invisible pipe' or 'robot', it portrays what Hsieh (2009: 135) has referred to as a "non-thinking role, the voice -- to establish direct communication between provider and patient, robot or machine" and importantly, implying the interpreter "not to be controlling the situation". It is important to reiterate the negative impact of this metaphorical allusion—it effectively devalues the role and dehumanises the interpreter as a person, as it presents the interpreting process as something that can occur automatically, providing the mechanical means is in place (i.e. in this case, the brain of the interpreter). Such a mechanistic, dehumanised lay understanding of the role as being that of a 'conduit' is further reinforced by how simplistically recent developments in computer-mediated translation through web

interfaces, such as Google translator, present the exercise of transference from one language to another.

In addition to the ‘conduit’ role, there are other roles that have been identified in research to date globally, such as cultural broker or patient advocate, that interpreters may assume or be expected or required to take on, depending on the circumstances of their practice. In Australia, the AUSIT code and associated guidance to practitioners de-emphasise the practice of these other roles by focusing on the importance of the clarity of boundaries between roles, rather than the scope for benefits to clients (HPs and patients) of incorporating other roles into the interpreter’s practice. However, it is important to explore how well this official delineation of the interpreter’s role is understood by those who are involved in the use of interpreting services and, also, to what extent the ‘conduit’ role is practised in relation to other role expectations in the day-to-day professional practice of interpreters. Additionally, in terms of quality of cross-cultural health communication, it is important to consider how the restriction of the interpreter’s role to that of ‘conduit’ affects overall satisfaction and quality of the health professional–patient interaction and resulting health outcomes, given that the gap between health professional and patient is mediated by a range of influences, including non-linguistic ones, such as cultural and educational differences.

Perhaps one of the best known examples of where cultural differences between a migrant’s background and their host country may impede treatment is that of Lia, a child from Hmong background, discussed by Fadiman (1997). Born in central California, Lia, who had at one time been a bouncy toddler, became neurologically unresponsive and increasingly suffered epilepsy and a seizure disorder. Lack of access to someone who was competent in English and Hmong and, equally importantly, familiar with Hmong culture resulted in a highly ineffective process of communication between Lia’s parents and physicians and nurses and, consequently, an inefficient and ineffective treatment of the child. While her parents resisted physicians’ diagnosis and interventions, thinking that Lia’s condition was caused by a bad spirit which led to her soul fleeing her body, the physicians failed to acknowledge the parents’ culturally embedded understanding of Lia’s condition and what they thought would cure her. The

story ends with Lia's very sad death. In contrast, Pidgeon (2015) reports how communication between health professionals and patients where cultural beliefs are acknowledged may help with the process of medication. Pidgeon reports the case of a child in a remote indigenous community in Australia whose parents attributed pitted scarring across the legs and torso of the child (following meningococcal infection) to the child's 'crocodile dreaming'. Therapists making an explicit effort in understanding and acknowledging this cultural belief resulted in the parents' increased willingness to engage in the medication protocol proposed by the doctors. Such experiences highlight the importance of cultural understanding to achieving successful health treatment, but also raise the question of how such cultural understanding can be achieved. The two cases outlined above point to the benefit of health professionals having access to one or more cultural informants or intermediaries to assist in the treatment process. A professional interpreter with the same or similar cultural background to the patient, is one such person who may have the capacity to act as a cultural informant, despite this not being part of the primary interpreting role.

1.3 Research gaps

Studies on interpreters' roles in medical consultations reflect that in some contexts of community interpreting, different understandings and expectations of the interpreter's responsibilities and roles may exist (Angelelli, 2004; Butow et al., 2012; Estrada, 2014). The AUSIT code explicitly discourages interpreter's engaging in other than direct accurate transfer of messages from one language to the other, and advocates for clarity and limitation of boundaries in the interpreter's role. Yet, in other international contexts (e.g. in NCIHC and CHIA), a community language interpreter may be expected to take on additional roles, as pointed out by Ozolins, such as "cultural clarifier, and patient advocate" (2015: 322). These additional roles have been adopted internationally in cases where the institution has neglected the patient or been racist towards the patient, aiming at the overall goal of maximising the quality of communication and cross-cultural understanding between mainstream service providers and LEP members of the immigrant ethnic community.

Whilst there is an increasing body of research into community interpreting and its practice in health settings, there remains much to be further investigated and understood. Firstly, the qualitative and small-scale nature of most studies mean that it is not possible to achieve saturation, let alone to enable generalisability from findings of research to date. Rowland's (2008) study, for instance, involved only three professional interpreter participants working in two languages in dental clinics, from which he concluded that the major role of interpreters was that of a language conduit. Studies involving greater numbers of participants—such as Rosenberg, Richard, Lussier, & Shuldiner (2011) with 22 recorded patient--interpreter--doctor consultations, Hsieh, Bruscella, Zanin, & Kramer (2016) using 44 oncologist--patient interactions, and Krupic et al. (2016) with 26 patient participants in four focus group interviews—provide a more comprehensive picture of patients' perceptions of interpreters' roles. However, a limitation of their research is that they have employed only one method of data collection, such as the recordings of the actual interactions or focus group interviewing the participants, not a combination of methods to enable data triangulation.

A second issue identified as a limitation of most research to date is the lack of triangulation of differing experiences of the three parties participating in a three-way (triadic) interpreter-mediated interaction: the health professional, patient and interpreter. Researchers have mostly interviewed either one or two groups of participants in triadic interpreted health encounters, usually only interpreters themselves (e.g. Butow, 2012; Rowland, 2008), or health professionals (Fatahi, Hellstro€m, Skott, & Mattsson 2008; Leanza, 2005).

A further identified gap in research conducted relates to the specific place and context of study, that is, community interpreting in the delivery of health care in Australian public hospitals. Studies of the expectations and experiences of the interpreter's role/s and practices in this context are quite limited in Australia, compared to studies in other countries with similarly large numbers of migrants (e.g. Butow et al., 2012; Riggs et al., 2012). In relation to the context of study, the majority of interpreting studies either explicitly focus on the interpreter's role/s within the consultation (e.g. Rowland, 2008),

or in a broader context, such as cultural differences in using the health system in the host country (Sweden) for patients (e.g. Krupic, Hellstro€m, Biscevic, Sadic, & Fatahi 2016).

To address these research gaps and make a new contribution to the understanding of the role of the interpreter in community interpreting in Australian hospital settings, I have designed this research study.

1.4 Research aims and questions

In investigating the role of the interpreter in Australian hospital settings my overarching argument is that conceptualising and understanding the role of the interpreter in health care settings, as a neutral language, 'conduit' is too simplistic, and devalues the range of contributions expected and made by interpreters in facilitating patient--health professional communication in Australian hospitals.

In undertaking the investigation my research aims to explore the perceptions and experiences of all three groups of participants (i.e. interpreters, health care professionals and patients) in interpreter-mediated health consultations in hospital settings. Specifically, it investigates qualitatively the expectations and experiences of each group concerning the role/s of the interpreter and the factors that impact on their role/s. To provide a complementary lens, the qualitative investigation of interpreters' practices includes analysis of some recordings of actual interpreted health encounters in the hospital setting. The study is underpinned by two groups of research questions:

1. Interpreting as message transfer
    - 1.1. How do health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters?
    - 1.2. What factors affect the effectiveness of message transfer?
    - 1.3. What are the respective outcomes of effective and ineffective message transfer?
2. Interpreting beyond message transfer

2.1. What roles do interpreters fulfill beyond message transfer to facilitate health professional--health service user communication?

2.2. What are the attitudes of interpreters, health professionals, and health service users toward interpreters serving roles beyond message transfer?

To address these research questions, for which the ethics approval was received (HRETH07-271), semi-structured in-depth interviews and some discourse analysis techniques have been adopted to analyse individual experiences and behaviour in three groups of participants in interpreter-mediated health encounters: interpreters, health professionals and patients. Thirty-one participants drawn from three participant groups participated in interviews. Within the health professionals' group, the interviewees represented a variety of specialties, across two hospitals, which differed in their areas of medical focus. Both in-house and agency employed professional interpreters were interviewed to enable identification of meaningful differences in terms of their perceived roles and challenges in fulfilling their roles. The participating patients reflected also a diversity of migration backgrounds and they were native speakers of three languages (Persian/Dari, Arabic and Italian).

1.5 Overview of the thesis

This thesis consists of nine chapters. In this chapter, I have presented brief background and introduced the study. Chapter 2 reviews the literature related to interpreters in bilingual consultations, providing historical background, briefly focusing on models for interpreting, and reviewing relevant research studies on the roles of interpreters. Chapter 3 presents the study's methodological underpinning and methods. Chapters 4 to 6 present thematic analyses of interviews with the three groups of participants: interpreters, health professionals, and patients. Chapter 7 reports findings from the analysis of interpreter practices, focusing in detail on three interpreter-mediated health consultations. Findings from Chapters 4 to 7 are brought together in Chapter 8 and relate to findings from other research. Finally, in Chapter 9, I present the conclusions and discuss the implications and applications of the findings, as well as acknowledging the limitations of the study, and making recommendations for future research.

Chapter Two – Literature Review

In the Introduction I highlighted that the role of the interpreter in healthcare in countries with a significant number of migrants is an evolving one that has been comparatively underresearched, particularly in Australian healthcare practice. This chapter aims to provide a review of key debates and empirical research conducted in the field of community health interpreting to elucidate current understandings about service users' and interpreters' expectations of how the role of the interpreter is and should be practised when facilitating communication. In particular, it considers in-depth research concerning the need for and definition of community health interpreting, as well as its conceptualisation. It then reviews and critically analyses research on the range of roles, including the message transfer 'conduit' role, that have been identified internationally as being practised by community interpreters. Research related to other important factors such as impartiality, trust, power and time constraints, are also reviewed to contextualise the chosen areas of focus for the research. Following the review of the literature, the chapter will conclude with a consideration of the limitations of previous research and the issues which need to be further explored.

In this chapter I will review studies from a range of countries and it is important to recognise the national and local regulatory context in each country differs. This means that interpreters in the various studies reported may not have been subject to equivalent methods of testing their linguistic and medical knowledge through training and/or formal tertiary education, or be subject to explicit ethical codes of conduct for their professional practice. As explained in 1.2, whilst some countries with a large number of migrants have attempted to define the professional role/s that interpreters in healthcare are expected to fulfill, others have not adopted such a regulated national approach. As a result compared to countries such as Australia and New Zealand studies may have taken place in countries where the codes of ethics and professionalism as well as approaches to training for interpreters may not have existed or have been relatively weak (Hale, 2007a). Therefore, I will indicate the country context on first mention of a study, and allude to the context elsewhere as required to appreciate its findings.

2.1 Need for interpreting

Language barriers can and do present numerous challenges in healthcare provision to immigrants. Research worldwide shows a direct correlation between quality care in medical settings and patients' level of English proficiency. While many migrant patients are native speakers or proficient users of English, there are patients who have low levels of English proficiency, including those who may not be able to attend English classes due to work and/or family commitments or who have been unable to learn English successfully as a result of age and/or educational barriers (Edwards, Temple, & Alexander, 2005 (UK)).

Limited English Proficiency (LEP) patients are reported to achieve less satisfactory healthcare outcomes (e.g. Carrasquillo, Oray, Brennan, & Burstin 1999 (US); Hyatt et al., 2017 (Australia); Morales, Cunningham, Brown, Liu, & Hays, 1999 (US); Weech-Maldonado et al., 2003 (US)). Additionally, they may not be able to develop an adequate understanding of the healthcare system in their country of residency (Bowen & Kaufert, 2003 (Canada); Crezee, 2003 (New Zealand); Hyatt et al., 2017 (Australia)). Specifically, studies have reported that these patients are more likely to be admitted to hospital (Lee, Rosenberg, Sixsmith, Pang, & Abularrage, 1998 (US)) and have longer in-hospital stays (John-Baptiste et al., 2004 (Canada)). Furthermore, they may feel helpless and, therefore, leave all the decision making to health professionals (Lim et al., 2019 (Australia)). When admitted to hospital they may also receive insufficient anesthesia (Carnie & Perks, 1984 (UK); Devore & Koskela, 1980 (US); Todd, Samaroo, & Hoffman, 1993 (US)). LEP patients have also been reported to not access preventive healthcare, such as dental or eye examination (Solis, Marks, Garcia, & Shelton, 1990 (US), or treatments like cardiac rehabilitation (Alsharifi et al., 2019 (Denmark)). They also tend to be at greater risk of going through unnecessary diagnostic testing (Wardin, 1996 (US)) and suffering medical errors (Flores, Laws, Mayo, Zuckerman, Abreu, Medina, & Hardt, 2003 (US); Ghandi, Burstin, Cook, Puopolo, Haas, Brennan, & Bates, 2000 (US)) and physical harm (Divi, 2007 (US)). LEP parents of sick and premature newborns may feel anxious and frustrated as a result of misunderstanding, and may not have adequate involvement in and influence on the care of their child (Patriksson, Nilsson, & Wigert, 2019 (Sweden)).

To avoid the negative impact on healthcare for migrant patients with limited second language proficiency (like English proficiency), an interpreter, who has knowledge of the patient's language (i.e. their mother tongue) and the main language spoken in their country of residency (e.g. English in Australia), can play a critical role in making communication between the patient and healthcare provider parties possible. It is important to recognise also that for effective healthcare interpreting, interpreters need to have sufficient medical knowledge as well. Presently, in Australia, the need for knowledge in various medical areas, such as anatomy, physiology and pathology, in order to understand HPs' communication (Crezee, 2013), is formally recognised and reflected in the training offered for interpreter accreditation.

As researchers have noted, prior to its recognition as a profession, interpreting was regularly performed by children, bilingual family members, bilingual staff, or orderlies as well as by some interpreters (Pöchhacker & Shlesinger, 2005). Although interpreting performed by non-professional interpreters has been characterised as containing omissions (Price, 1975 (Australia)), additions (Lang, 1978 (Papua New Guinea)), and instances of third parties taking over consultations (Launer, 1978 (Nigeria)), until very recently using non-professional interpreters was the prevailing practice globally (Aranguri, Davidson, & Ramirez, 2006 (US); Edwards et al., 2005 (UK); Moreno, Tarn, & Morales, 2009 (US); Raval & Smith, 2003 (UK)).

In England (Bauer, 2016; Hall & Guery, 2010) and the United States (Katz, 2014; Weisskirch, 2010), where the provision of language services for migrant communities is less advanced than in Australia, children of migrant families are still often used as 'language brokers' to assist with interpreting for their family members in the healthcare system, as well as on other occasions. As pointed out by Frey, Roberts-Smith, De Pieri Tentori, & Bessell-Browne (1990), Galanti (2004), and Hall & Robinson (1999) in Australia, however, although interpreting provision is still evolving as a set of understandings and practice standards, it started to emerge over three decades ago. Increased online publications have encouraged professionals in various disciplines to only use the service of professional interpreters in situations like family violence (AUSIT, 2012; Victorian Department of Human Services, 2017; Victorian Foundation

House, 2013; Queensland government webpage, 2017).

There is a considerable body of evidence (Ali & Watson, 2017 (UK); Attard, McArthur, Riitano, Aromataris, Bollen, & Pearson, 2015 (Australia); Hale, Goodman-Delahunty, & Martschuk, 2019 (Australia)) that using professional interpreters in healthcare consultations and police interviews (see for example Hale et al., 2019 (Australia)) generally results in a better experience of care. For example, Moreno & Morales' (2010) survey of 1,590 Spanish-speaking Latino adults in eight sites across the United States showed that those who needed and could use interpreters reported more positive experiences with care than those who did not have access to interpreters. Specifically, the former had better ratings of doctor communication, office staff helpfulness, and satisfaction with ambulatory care. Similarly, Hadziabdic & Hjelm (2014) reported that Arabic-speaking migrants in Sweden considered their experience with interpreters in healthcare encounters generally positively. They believed that professional interpreters were able to facilitate their verbal communication with healthcare staff, through translating their descriptions of their concerns, feelings and pain into the target language (2014: 40).

2.2 History of the development of community interpreting

Among European countries, Sweden was at the forefront of what became known as community interpreting, a type of consecutive interpreting, and thus different from conference interpreting, which involves simultaneous interpreting. The qualifier 'community' points to how this type of interpreting is used to facilitate interaction between the cultural and linguistic sub-groups within a society (Pöchhacker, 1999). By the early 1980s, the term had gained currency in Europe, first used in Australia around 1970 (Chesher, 1997), and later became the acceptable alternative to 'ad-hoc interpreting' and 'cultural interpreting' worldwide (Roberts, 1997).

Growing recognition of community interpreting as a profession and a research area in sociology, linguistics, and health science culminated in the establishment of the Critical Link, as a network aimed at supporting community interpreting. In Canada in 1992 the first international conference on community interpreting was organised and generated

more research on community interpreting, particularly in medical and legal settings (Pöchhacker, 2004). Since then Critical Link has evolved to be Critical Link International, a not-for-profit organisation "committed to the advancement of the field of community interpreting" and continues to organise conferences and publications to promote the dissemination of research on community interpreting.

Debates continued as to whether community interpreting is a profession, especially given that conference or delegate interpreting had been recognised as a comparatively more prestigious profession (Harrington & Turner, 2000 (UK)). With this contested status, community interpreting has been underdeveloped, underpaid, and has suffered from lack of unity as a profession (Garber, 2000 (Canada); Ozolins, 2000 (Australia); Pöchhaker, 2000 (Austria)). A spectrum of definitions ranging from an "amateur and ad hoc" practice to a "formal profession with training" (Dueñas González, Vásquez, & Mikkelson, 1991, p. 29 (US)) reflect the contested status of community interpreting. As Pöchhacker (1999) has observed,

> communication and interpreting needs arise in a broad range of situations in the personal lives of migrants or deaf persons, it is practically unavoidable that 'natural interpreting' by family members or friends will persist at least in a number of less formal circumstances. (p. 135)

Pöchhacker (2004) argues that since 'natural interpreting' is likely to persist it will continue to impede the progress of community interpreting towards gaining a truly professional status. Pöchhacker specifies a range of factors acting against community interpreting emerging as a profession. He also argues that the dominance of economic considerations as a factor may result in clients opting for amateur interpreting. Economic factors are less personally constrained in Australian healthcare, as individuals usually are not required to pay for health interpreting services, although economic considerations impact indirectly as healthcare providers often have a limited budget available for interpreting services.

Pöchhacker (2004) advocates for the development of a uniform code of conduct, and pre-service training for community interpreters to facilitate in developing the field into a recognised profession. Australian developments provide a representative exemplar of how such a shift can be effected with the development of national standards (AUSIT

Code) (originated in 1995, rewritten in 2014) and an interpreter accreditation system (through NAATI) since 1977. More recent developments include the formation in 2018 of a division of Professionals Australia, Translators and Interpreters Australia, to advocate industrially for improved recognition, professional development and remuneration for interpreters (professionalsaustralia.org.au), and a new NAATI certification system for accrediting interpreters. NAATI initially recognised accreditation at four levels but without identifying community interpreting in terms of its specialist complexities. Its new (NAATI, 2018) system better recognises the diversity and differences of interpreting and translating practice, including the specialist nature of community interpreting in areas such as health and the law. A greater emphasis is now also being placed on ongoing professional development for interpreters (NAATI, 2018).

As the levels of certification are not the main focus of this thesis, they are not discussed in detail here. Rather, in light of this brief account of the historical development of community interpreting, we proceed with a focus on major models of interpreting that underpin interpreting practice in different contexts.

2.3 Theoretical models of interpreting

Whilst a number of models of interpreting have been presented, with each focusing on interpreting within a specific profession, such as medical interpreting (Angelelli, 2004 (US)), court interpreting (Hale, 2007a (Australia)), and sign language interpreting (Swabey & Mickelson, 2008 (US)), some broader theoretical perspectives on interpreting have emerged. An overview of these models is important to considering how the interpreter's role is conceptualised. Pöchhacker (2004) goes beyond how interpreting is conceptualised and practised within specific contexts and presents two overarching models, namely a cognitive processing model, which focuses on mental and cognitive dimensions of the process of interpreting, and an interaction model focused on sociocultural and communicative aspects. These two major models are briefly discussed here.

2.3.1 Cognitive processing model

The cognitive processing model has its origins in theories of simultaneous interpreting. The focus of this model is on the process of encoding and decoding utterances by the simultaneous interpreter, who may work in contexts ranging from conferences (e.g. Gile, 1988) to TV programs (e.g. Chiaro, 2002; Kirchhoff, 2002). This model is characterised by the construction of interpreters as "*invisible*" or "*unseen*" participants (Angelelli, 2000; Hall & Robinson, 1999; Wadensjö, 1998). Influenced by this conceptualisation, Wadensjö (1998) regards interpreting as a service provided for the society in which the interpreter is a vital, but invisible part, drawing on Goffman's (1981) notion of their role as a 'non-person'. The role of the interpreter in a conversation is considered as similar to that of a servant whose presence is expected on certain occasions, but who is regarded "*as someone who is not there"* (Wadensjö, 1998, p. 66).

2.3.2 Interaction model

While a cognitive processing view of interpreting may still be dominant and reflected in how the interpreter's role is described (e.g. as an invisible conduit) even in consecutive interpreting contexts, the interaction model of interpreting has increasingly acknowledged interpreting as a process which goes beyond data processing through encoding and decoding, and is, rather, a "*community* activity performed by a human being in a particular interaction" (Pöchhacker, 2004, p. 53, emphasis added). From this viewpoint, which has its origins in community interpreting, interpreters may be regarded as linguistic and cultural mediators whose presence influences the interaction between two parties (Muller, 2001). Interpreters, conceptualised as such, need to focus on the speaker's "*intended meaning*" which is to be communicated to the listener. Such a focus which some have taken for granted in their theorising, elevates interpreting to the level of mediation in discourse (Pöchhacker, 2004), and the status of the interpreter to one of active participant rather than an automated switch between two languages (Erasmus, 1999; Gentile et al., 1997; Knapp-Potthoff & Knapp, 1986). Looking at interpreting as a process of active interaction, research in medical interpreting has increasingly focused on interpreters as active participants in the interaction (Bolden, 2000; Bot, 2005). An interpreter is regarded as an influential party who takes control

of the communication (Wadensjö, 1998), and the process of interpreting is considered to be visible, multidimensional and multileveled (Angelelli, 2004).

In enunciating the multileveled nature of interpreting, Angelelli (2004) has discussed three levels. The first level is interpreting as interaction, which acknowledges the important distinction between simultaneous (e.g. Conference) and consecutive (e.g. medical and educational) interpreting. Whilst simultaneous interpreting is considered to be interaction, it has a strong monologic orientation (Angelelli, 2004). In this type of interpreting, the interpreter interprets from one speaker to one listener, mainly in the context of a conference where there is one person is talking and others listen. In contrast, consecutive interpreting is a dialogic interaction in which both parties engage in communication with each other with the assistance of an interpreter. Therefore, this type of interpreting also has been called dialogue interpreting (Hale, 2007a; Pöchhacker, 2004). It has been argued that in simultaneous interpreting, the interpreter has more of the status of a non-person conduit, merely serving as a translation machine (Bolden, 2000; Bot, 2005; Leanza, 2005), whereas consecutive interpreting gives the interpreter more existence and the opportunity to contribute participation value in an interaction (Wadensjö, 1998), and to participate in the co-construction of meaning (Angelelli, 2004).

Angelelli (2004) characterises a second level of interpreting as being institutional. At this level, the focus is on interpreting what is happening in interactions occurring not in a social vacuum, but within an institution, where there are forces to affect it, such as hierarchical rules in a hospital or in a government agency as an institution. Thus, the interpreter becomes an integral part of the institution and her/his behaviour (e.g. omissions and additions) may be explicable in terms of the institutional context and types of interaction and relations between participants in the interaction (Davidson, 2000 (US)). In the case of a hospital, for example, doctors, patients and interpreters are considered as different groups, each bringing specific characteristics to the role they have (Angelelli, 2004).

Interpreting can also be discussed at a third level, the societal level (Angelelli, 2004). While interpreter mediated interaction is situated within an institution like a hospital, the institution itself is situated within society and the culture/s that is/are governing it; hence this wider structure has significant impacts on how an interpreter approaches her/his role and how this role is approached by the other parties (e.g. doctors and patients), including in the context of patient rights to equitable care, equity of access to support services and privacy.

2.4 Roles of interpreters

Chronologically speaking, as previously mentioned, until about 30 years ago using interpreters, especially in healthcare settings, was not a common practice and the need for interpreting was strongly felt where HPs' adequate understanding of patients' health issues was critically important. As a result of this demand and shift towards professional community interpreting, attempts were made to establish the roles that interpreters are expected to fulfill professionally in serving their LEP populations.

The ways in which the interpreter's role/s has been defined across different countries differ, thus reflecting differences in expectations from interpreters internationally. Studies across different nations, such as Canada (Garber, 2000), Austria (Pöchhacker, 2000), and Sweden (Roberts, 1997; Wadensjö, 1992), have reported interpreter's duties in healthcare settings to be vague and defined differently, which suggests that even after years of the profession's existence in different communities, healthcare providers may not be clear about interpreters' roles and responsibilities. One example, contrasting to the current code in Australia, is that of Switzerland, where the professional code of ethics for interpreters in healthcare settings holds that interpreters should serve as brokers of patients' interests and mediators between HPs and patients, helping them understand cultural differences (INTERPRET Schweizerische Interessengemeinschaft für interkulturelles Uebersetzen und Vermitteln, 2011). Sleptsova, Hofer, Morina, & Langewitz (2014) argue that such an approach takes the interpreter's role beyond the assumed primary role of a conduit that transmits information without change and distortion, and supports their contention that there is no universally accepted understanding of the interpreter's role. As they argue, "because healthcare interpreting

is not yet a universally licensed … field, the definition of a *healthcare interpreter* and his/her training varies widely in the published literature" (2014:170). Significantly, in their systematic review of 34 empirical studies published between 1984 and 2011 that considered the role of interpreter in healthcare internationally, Sleptsova et al. (2014) found that only in two studies was there "strict adherence to the conduit model" (p.167). In the remaining 32 studies, broader roles were expected and/or accepted with other commonly documented ones including "a cultural broker, manager or clarifier, mediator" (p. 179). Research from the perspective of interpreter service users also highlights the diversity of their expectations of the interpreter's role (e.g. Pöckhacker, 2004, Kaufert, Putsch, & Lavallee, 1999).

What further complicates the understanding of interpreters' roles is that they have been observed to practise their roles differently and form strategies of their own in order to perform them in healthcare settings, in this case, specifically in the United States (Hsieh, 2008). Furthermore, there are roles which the literature has shown to be applicable to all settings of interpreting such as medical, legal, and education, although approached and practised rather differently. This next section focuses on interpreters' roles which are relevant to the present study, and which have received attention in the research literature.

2.4.1 Interpreters as language conduits

The main role interpreters are commonly expected to fulfill is successful transfer of information between professionals and clients. Therefore, sometimes interpreters are referred to as 'language conduits' (Shannon & Weaver, 1964). Adopting this conceptualisation, many healthcare providers and interpreters simplistically assume that such transfer can be made in a straightforward and unproblematic manner from one language to another, and see interpreters as invisible and entirely neutral language transmission vehicles (Angelelli, 2004; Hale, 2007a). Angelelli (2004) referred to Reddy's (1979) conduit model in describing interpreters in communication. Rowland (2008) (US), for example, reports on his interpreter participants' perceptions of benefits of accurate and thorough transfer of information in dental clinics, where specific questions are asked by dentists and specific answers are expected. The interviews of Fatahi et al. (2008) (Sweden) with a group of general practitioners show that their

participants believe an interpreter should serve as "a stable neutral information bridge" (p. 40). And most Cognitive Dementia and Memory Service (CDAMS) clinicians interviewed by Haralambous et al. (2018) (Australia) considered interpreters who assisted them in their patients' cognitive assessment as a "mouthpiece" facilitating assessments.

Several studies have been conducted on how well interpreters fulfill this expected neutral information transfer role. While many report interpreters' effective transfer of information; there are studies that show there are omissions and additions in interpreters' performance, sometimes resulting in communication breakdown. Although interpreters who have received training interpret more accurately than those who are untrained (Flores, 2005), formal education does not necessarily prevent errors. Flores et al. (2003), for example, report that in paediatric emergency department visits, Spanish-language interpreters made 31 errors on average per patient encounter, with 63% of the errors being judged to have potential impacts on diagnosis and/or treatment. Regardless of formal education, Ebden, Carey, Bhatt, & Harrison (1988) (UK) found that the most common type of error their interpreter participants made was omission of information, with up to 50% of physicians' questions not being interpreted.

Interpreting inaccuracies and distortions have been found to be attributable to different factors. One such factor is the inherent challenge of achieving linguistic equivalence in translating between certain languages. The interviewed interpreters in Hudelson's (2005) (Switzerland) study indicated that translating some medical concepts and terms is highly difficult and some of these concepts are unknown to patients, but also may not be directly translatable. The solution they proposed was to use less technical language in their translations and for physicians not to expect literal translation from them. In mental health settings, Tabassum, Macaskill, & Ahmad (2000) (UK) observed that in diagnostic interviewing some basic clinical questions may necessitate reformulation for such languages as Urdu which do not have direct English equivalents for words like "anxiety" and "depression". This linguistic disparity seems to present interpreters with greater challenges when they need to concurrently translate the content of psychological tests during the assessment session. Their unintended additions,

omissions, and substitutions may significantly alter test content and, as a result, validity. Lopez, Lamar, & Scully-Demartini (1997), therefore, strongly recommend that bilingual examiners replace interpreter aided testing.

The interpreter's language proficiency may also result in interpreting inaccuracies. Moreno, Otero-Sabogal, & Newman (US) (2007) report that after a number of omissions were observed in the performance of staff interpreters of Spanish, Chinese and Russian; their proficiency in these languages was tested and the results indicated that most of them did not have enough competency in both languages to work as interpreters in medical encounters. In their study of Australian dentists' experience with interpreters, Goldsmith, Slack-Smith, & Davies (2005) also reported that their participants were concerned about interpreters' limited knowledge of the specific terminology in their area. Whilst the AUSIT Code of Ethics and Code of Conduct's general principle of Competence requires interpreters to "only undertake work they are competent to perform in the languages for which they are professionally qualified through training and credentials" (p. 5), despite their credentials, the participants in Moreno et al.'s (2007) study did not seem to have the level of language competence they needed in order to transfer information successfully. Their low competence may have been a result of inadequate ongoing professional development on the part of these interpreters.[1]

As pointed out by Goldsmith et al. (2005), many interpreters have limited knowledge in healthcare terminology. Crezee (2013) has highlighted the importance of obtaining medical knowledge for healthcare interpreters to be recognised as competent interpreters. To this end Crezee (2013) has been re-published with co-authors who have included health related terminology in a number of languages other than English to address this issue (see also Crezee, Gailani, & Gailani, 2016 (Arabic); Crezee, Mikkelson, & Monzon-Storey, 2015 (Spanish), Crezee & Ng, 2016 (Chinese)). The issue of competency of interpreters has also been emphasised in Hale et al. (2012),

[1] AUSIT Code of Ethics and Code of Conduct has a guideline in this regard too. Under the principle of "Professional Development", it requires interpreters to "continually upgrade their language and transfer skills" (p. 6).

leading to proposed changes in the NAATI certification system and recognition of the need for specialisation and specialised testing in healthcare interpreting as well as ongoing professional development and recertification.

The issue of interpreters' language competence is sometimes more complex than knowledge of a given language. When it comes to different dialects within a language, different interpreters may have varying levels of dialectal command, which affect the effectiveness of their interpreting. The following excerpt from a Bangladeshi male participant reported in Edwards et al.'s (2005) (UK) study clearly shows the importance of interpreters' knowledge of dialects within a language:

> I think most people who do interpreting speak Dhaka dialect. This can cause problems for a Sylheti-speaking person. I think Sylheti-speaking interpreters should be provided for Sylheti people. Another example, say a person is from the Chittagong area. If you have a Sylheti-speaking interpreter then this person won't understand the Sylheti dialect. For them, there should be someone from Chittagong doing the interpreting. (p. 84)

The pressure that hospitals put on interpreters to participate in a large number of consultations within limited time has also been identified as leading to lower quality performance. In Davidson's (2000) study, for example, one of the reasons the Spanish interpreters did not translate some parts of patient--doctor conversations and held off information based on their perceived relevance was the necessity to keep doctors' appointments on schedule. Interpreters feeling pressured to translate with less rigour originates also from the institutional power structure within hospitals with there being certain expectations from interpreters who, as their employees, have to abide by those expectations (Angelelli, 2006; Bell, 2019; Davidson, 2000; Hsieh, 2006). Research on time constraints and their impact is discussed further in section 2.7 below.

2.4.2 Interpreters as more than language conduits

Despite the major focus on the language conduit role of interpreters on the part of some stakeholders, as reported in Rowland (2008) (US) and Fatahi et al. (2008) (Sweden), many other studies have reported that interpreters may fulfill various other roles. Kaufert et al. (1999), for example, observed that interpreters who translate for Aboriginal Canadian patients in urban hospitals have received training to undertake additional roles, such as visiting hospitalised patients, assistance with crisis,

intervention, and social services support and record keeping. As Kaufert et al. (1999) explain:

> These roles often involve interpreters in cultural need assessment; interpreters are allowed to review and add relevant cultural information to patient records. This protocol allows the interpreter to inform monolingual staff of patient concerns when the interpreter becomes aware of additional information which was not discussed in direct interaction with the provider. (pp. 31-32)

Interpreters who assume multiple roles is not always a matter of the system 'allowing' them to do so, as Kaufert et al. (1999) have put it. Rather, it might be an inevitable situation, such as in the process of end-of-life decision making for terminally ill patients from Aboriginal Canadian backgrounds (Kaufert et al., 1999). In her in-depth qualitative study, Angelelli (2004) uncovered a number of previously unrecognised roles that health interpreters in a hospital setting adopted as part of their daily practice, describing these metaphorically as detective, multi-purpose bridge, miner, and diamond connoisseur. Interpreters participating in Hilfinger-Messias, McDowell, & Estrada's (2009) (US) study, similarly conclude that remaining committed to the impartial and invisible role of a language conduit was impractical and even sometimes impossible:

> Participants encountered LEP [Limited English Proficiency] patients who viewed them as a composite of language interpreter, advocate, systems navigator, and even healthcare provider. Patients and providers alike had expectations that interpreters would provide information and practical or logistic support in areas beyond language assistance, such as "walking the patient into the next appointment or to the X-rays" or the provision of emotional comfort or counselling.

Similarly in recent years well-trained, experienced and highly medically informed interpreters have been employed to perform in a distinct role as a bilingual patient navigators in selected US hospitals (Crezee & Roat, 2019). This role has been recognised specifically as assisting in unpacking the complexity of medical language for families and patients who would struggle otherwise to understand the system and treatments.

Sleptsova et al.'s (2014) review of 34 studies conclude that while information transfer remains the interpreters' main role, they may also be required or expected to fulfill

additional roles, such as cultural broker, mediator, manager/clarifier, or patient advocate. Key studies of these additional roles are discussed in the following sections.

Interpreters as cultural brokers

Interactions that happen in healthcare settings between patients and healthcare staff are underpinned by cultural knowledge and expectations. However, many health professionals working in these settings may lack awareness of how fundamental culture is in shaping people's engagement in and responses to healthcare and prevention (Luntz, 1998; O'Sullivan, 1998) including Australian studies (Armstrong, 2016; Attard et al., 2015). Even those who appreciate the significance of culture do not usually receive any form of training to improve their cultural competency (Cho & Solis, 2001 (US)), and, if proposed, they may resist it (Betancourt, Green, Carrillo, & Park, 2005 (US)), hence the increasing emphasis on the importance of this training (Betancourt, Green, Carrillo, & Ananeh-Firempong 2003; Bhugra 2004 (UK); Goldsmith et al., 2005 (Australia)). Lack of such understanding and training may hinder intercultural health communication (Kar, Alcalay, & Alex, 2001) and adversely affect the treatments patients receive (Novak-Zezula, Schulze, Karl-Trummer, Krajic, & Pelikan, 2005).
Numerous examples of adverse events or suboptimal diagnosis and/or care due to lack of intercultural understanding on the part of healthcare professionals are evident from the research literature. Betancourt (2004) (US) reports that the way a patient may describe the symptoms of their disease may differ from conventional ways that healthcare textbooks present symptoms to healthcare professionals. Therefore, professionals' lack of familiarity with patients' description may prolong the process of disease identification. For example, Waite & Calamaro (2009) (US) report on a young male African patient suffering from depression who did not ask for help, because in his community depression was associated with femininity which involved sensitivity and being in touch with emotions. The mental health professionals' lack of awareness resulted in their failure to detect this patient's health issue until it became severe. On the whole, lack of adequate knowledge about patients' culture may result in hesitancy, anxiety, and stress on the part of health professionals, as also experienced by participants in Kai, Beavan, Faull, Dodson, Gill, & Beighton (2007) (UK).

What further complicates this situation is that often intercultural communication happens between patients who are not native speakers or proficient users of the dominant language spoken in their communities. These are the situations where cultural competency training for these professionals does not usually guarantee effective communication with patients with limited target language proficiency (Penn, Watermeyer, Koole, Picciotto, Ogilvy, & Fisch, 2010 (South Africa)). Therefore, interpreters who usually serve as language conduits may take on the additional role of cultural brokers/advocates, as their cultural insight and assistance may help health professionals identify patients' health issues and come up with a suitable medical solution (Zimanyi, 2009 (Ireland)). Several studies have shown that many interpreters welcome this role or believe it is an inevitable responsibility as part of their job. In Australia, Ra & Napier (2013) reported that interpreters consider culture-related terms and expressions and differences in cultural customs and rituals impact the process of interpreting and, therefore, they should take them into account. Similarly reporting from Australia, Butow et al. (2012), for example, found that their participants believed their role was beyond mere translation and encompassed "cultural advocacy and sensitivity" (p. 238). Their analysis of focus group discussions among 30 interpreters yielded many cases of participants taking note of cultural issues that would impact the process of communication between doctors and patients. For instance, they noted that a tradition of passivity in medical consultations and a deep respect for physicians and specialists in some cultures prevent patients from asking questions they may have to better understand their situation. Therefore, serving as a cultural advocate, the interpreter would encourage patients to ask questions. Another cultural issue in Butow et al.'s (2012) study that interpreters mentioned was that while in their home countries non-Western patients may be simply told by doctors what to do, in a Western context they would be asked to make treatment decisions, which confused them.

Cultural brokering by the interpreter through a pre-consultation meeting with physicians has been proposed as an approach to cultural mediation that can be effective, for example, Hudelson's (2005) study in Switzerland. Through interviews with interpreters Hudelson showed that interpreters believed pre-consultation meetings with a cultural focus would help physicians develop a better understanding of their patients'

style of communication and therefore interact with them more effectively. However, they were reluctant to proactively assume the role of providing cultural information to physicians, which Hudelson (2005) argues may be a result of inherent power relations existing between interpreters and physicians. In contrast, the interpreters in Hilfinger-Messias et al.'s (2009) study refused to comply with health professionals' requests and expectations around culture, and were sometimes considered to be uncooperative as a result.

Clearly, the involvement of the interpreter in cultural mediation is not without difficulties or constraints. Leanza (2005) (Switzerland) reported that interpreters were faced with certain constraints when trying to fulfill their cultural roles, as well as their own perceived role, as accepted officially. For example, they could serve as cultural informants from physician to patient but not the other way around, since they considered it difficult to influence physicians' discourse. While some paediatricians Leanza surveyed did not welcome a patient-to-physician approach in interpreters' cultural information transfer, the rest considered and valued interpreters as two-way cultural informants. They believed that "the contact with interpreters provided an opportunity to modify their representations of child rearing. They had tried to adapt their discourse to the reality and customs of the parents" (p. 176). Leanza similarly reported shared perceptions by paediatricians and interpreters regarding interpreters' other culturally-oriented roles outside the consultation room and hospital. For example, both groups acknowledged the interpreters' cultural role of support for families, which they fulfilled through informal follow-ups in the community (e.g. by explaining prescriptions to the parents again). Finally, the interpreter participants referred to some other tasks they may fulfill, that involve them mediating or supporting differences in cultural rituals and practices, such as welcoming patients to the hospital and assisting with performing greeting rituals at the beginning of the consultation. Such mediation by the interpreter appears to be generally accepted by both physicians and patients, but is not necessarily explicitly recognised as requiring the interpreter to move beyond their usual language conduit role. In Leanza's (2005) study the paediatricians believed that the interpreter helping with these apparently minor interactional rituals gave patients

and parents confidence to navigate through the unfamiliar context and dynamics of the hospital.

Studies reported in this section show that interpreters may take on a cultural broker role, which manifests in different ways, ranging from explaining the cultural aspect of a patient's response to a question posed by a HP to greeting rituals with patients at the beginning of a consultation. As HPs are often unfamiliar with service users' cultural backgrounds, depending on the degree of unfamiliarity, interpreters may find it helpful and/or expected that they will assist as cultural mediators rather than just language conduits. Whilst there are HPs who proactively seek an interpreter's cultural advice, others may not welcome cultural mediation, given their perception that such input from the interpreter potentially results in their own loss of control over the consultation.

In the Australian context, the Australian code of ethics and conduct for interpreters (AUSIT, 2012) discourages adoption of advice or advocacy roles by the interpreter, emphasising the importance of clarity of role boundaries: "interpreters and translators do not, in the course of their interpreting and translation duties, assume other roles such as offering advocacy, guidance or advice" (AUSIT, 2012).

Interpreters as patient advocates

Another role which has been discussed as fulfilled by interpreters beyond their language conduit role, and in line with a critical humanistic perspective to interpreted medical consultations, is serving as advocates of patients' interests and rights (Greenhalgh et al., 2006 (UK)). The Cross Cultural HealthCare Program (CCHCP), which is a leading American training program, define the interpreters' advocacy role as "any action an interpreter takes on behalf of the patient *outside* [emphasis added] the bounds of an interpreted interview" (Roat, Putsch, & Lucero, 1997, pp. 17-18) to deal with problematic situations, such as cases of injustice and inequality in healthcare services. Beyond this conception, some interpreters, such as those studied by Hsieh (2008) in the United States, consider their advocacy capacity as a role which they could adopt on behalf of the patient, both inside the provider--patient interaction and outside the bounds of interpreted interviews, to clarify situations that are problematic in health

professional–patient communications in the medical context (Hsieh, 2008). Acting as an advocacy role aims "to empower a patient when they cannot obtain fair and equal healthcare services" (Hsieh, 2008, p. 1372).

Greenhalgh et al. (2006) (UK) observes two ways in which interpreters empower patients. As overt advocates, they act on behalf of patients, and as covert advocates, they provide means for patients' self-advocacy. Through making the interpreters' presence strongly felt in the triadic consultation, the overt advocacy role makes maintaining a neutral and invisible position difficult for interpreters, and may threaten patients' authority and autonomy as a likely consequence. Covert advocacy of patients, which fosters their self-advocacy through, for example, providing suggestions or hints, increases their access to existing resources, such as relevant medical information. Therefore, covert advocacy may improve their health literacy and, by extension, their independence.

On the whole, in addition to interpreters themselves who have shown a willingness to serve as patients' advocates (Greenhalgh et al., 2006), patients also have often been reported to expect interpreters to serve as their advocates, rather than just translators (Hillfinger-Messisas et al., 2009 (US)). Some health professionals have also been observed to welcome interpreters taking on an advocacy role. The pharmacists in Watermeyer's (2011) South African study, for example, considered it legitimate for interpreters to have the freedom to navigate between such roles as cultural broker, patient advocate, and conduit depending on what the situation necessitates.

Interpreters sometimes actively avoid assuming an advocacy role. Greenhalgh et al. (2006), for example, reported that some interpreter participants

> assumed that non-western perspectives on health and illness had been deemed 'off limits' by the GP. They saw their role not as helping to expose these influences but as concealing any dissonance from the doctor and conveying the western biomedical perspective to the patient. Such examples illustrated how in many situations of potential conflict, the interpreter tended to abandon the role of patient advocate in favour of strategic collusion with the doctor around the latter's agenda. (p. 1180)

Greenhalgh interpreted this in terms of an equivocal system-lifeworld situation in

which interpreters work. As an advocate and possibly a member of the minority ethnic community that the patient belongs to, an interpreter is 'of the lifeworld'. As a professional interpreter who represents the healthcare system he/she works in and is paid by, the interpreter is 'of the system'.

The advocacy role of interpreters is not approached favourably by some other stakeholders either. A director of an interpreting agency interviewed by Hsieh (2008), for instance, considered interpreters serving as patients' advocates more harmful than helpful. Some health professionals interviewed by Greenhalgh et al. (2006) did not consider advocacy of patients as a role for interpreters, and exclusively focused on working towards the expected outcome and conveying their (health professionals') agenda to the patient as interpreters' major responsibilities. In addition to these traditional role constraints, lack of relevant training for interpreters and health professionals impose limitations on interpreters fulfilling an advocacy role (Hillfinger-Messias et al., 2009).

Interpreters as co-diagnosticians

A role that explicitly puts interpreters in a position similar to that of health professionals is them serving as co-diagnosticians. This term was first coined by Davidson (2000) (US) who noted that interpreters actively, but covertly examine information for its medical value and interpret according to their evaluations. Angelelli (2004) (US), similarly, reported instances of interpreters obtaining medical history or giving medical-related advice without any prompting by the physician. While Angelelli (2004) considers these behaviours conducive to successful provider–patient communication, Hsieh (2007) (US) highlights the importance of conscious attention to the potential risks involved in interpreters' problematic behaviours.

Despite the potential significance of the co-diagnostician role of interpreters, few studies have focused on this role. Hsieh (2007), for example, conducted an ethnographic study on two Mandarin Chinese interpreters, four patients, and 12 healthcare providers. Analysis of observation and audio-recording of interactions, interviews, and field notes revealed that the interpreters fulfilled this role through

deploying five strategies. First, they assumed the healthcare provider's communicative goals through independently evaluating whether they had been achieved and, if not, accomplishing them. Second, they vetted information for medical emphases as they recognised its medical value. Third, they initiated information-seeking behaviours based on their personal judgment about what information was necessary in a medical consultation. Fourth, they took part in diagnostic tasks through collaborating with the provider to examine symptoms and identifying the illness. Finally, they volunteered medical information to patients to save the providers' time and make the healthcare services culturally appropriate. Although these strategies could be attributed to interpreter's efforts to save providers' time and to bridge the cultural differences, they may also put patients' privacy at risk by seeking information from the patient without the HP's knowledge and consent, jeopardise the HP--patient relationship and may ignore the HP's actual value and purpose in terms of his/her medical communicative goals. There is also inherent risk in an interpreter becoming proactive in diagnosis given their non-professional level of medical/health, and also the HP not being aware of or able to monitor the interaction/advice given their lack of knowledge of the other language.

The degree to which and ways interpreters fulfill the roles discussed in section 2.4 within consultations are affected by a number of factors. Some of these factors are different stakeholders' perceptions of how impartial and knowledgeable interpreters are in completing their tasks, issues relating to patients' and health professionals' trust in interpreters, time limitations imposed on interpreted consultations, and dynamics of power which affect triadic interactions between health professional, patient, and interpreter in a consultation. Each of these important topics is discussed in the following sections.

2.5 Impartiality

Interpreters are bound by professional codes of conduct which enshrine particular notions of the interpreter and their neutrality, and oblige interpreters, at the risk of serious professional (and potentially personal) consequences, to observe often vaguely formulated articulations of how they should interact within the institution/client relationship as they go about their professional duties (Maltby, 2010 (Australia)).

A commonly mentioned attribute to be assumed by interpreters is remaining impartial, neutral, and objective. This attribute has been emphasised by several official interpreting and translation associations such as NAATI and AUSIT in Australia and CHIA (California Healthcare Interpreting Association). The codes of practice adhered to by these associations encourage interpreters to “control their subjectivity” (Hale, 2007a, p. 121), rule against them expressing emotions and personal opinions, and also adopting any type of advocacy role regarding their clients (Norma & Garcia-Caro, 2016 (Australia)).

For example, in an early document produced by NAATI, “proper performance of one’s professional work and duty” is considered as influenced neither by “personal opinions or involvements about politics nor [sic] anything else” (Frey et al., 1990, p. 71). This desired state is sometimes conceptualised in terms of dignity. AUSIT (1995, as cited in Hale, 2007a:4) requires practitioners to “be unobtrusive, but firm and dignified, at all times”. “Dignified” conveys a sense of disengagement and detachment from the wider socio-political context surrounding the profession (Norma & Garcia-Caro, 2016). In Spencer’s (2016) article published by NAATI (2016), a similar emphasis on the conception of interpreters remaining dignified is evident. Addressing the definition and practice of impartiality the current AUSIT code (2012) states:

> Interpreters remain unbiased throughout the communication exchanged between the participants in any interpreted encounter …. They do not allow bias to influence their performance; likewise they do not soften, strengthen or alter the messages being conveyed.

In addition to translation and interpreting professional bodies, some other organisations also promote interpreters’ social disengagement. For example, the Dublin Rape Crisis Centre (DRCC, 2008) discourages interpreters from socialising with their clients outside what their professional relationship dictates, even when a client desires social interaction. Discouraging adopting a support or advocacy role, the instruction notes, “the interpreter does not become involved in providing emotional or other support” (p. 20) and proceeds to require the interpreter “to feel able to sit with a very distraught person and to resist the impulse to push the boundaries in order to console them” (p. 21). In legal settings, similar expectations have been expressed of court interpreters. In

the Code of Conduct for Court Interpreters published by the International Federation of Translators (FIT), Article 5 reads "The court interpreter shall at all times be neutral and impartial and shall not allow his/her personal attitudes or opinions to impinge upon the performance of his/her duties". In this regard, Morris (1999) observes, "fiction or not, the legal professionals in the courtroom consider the interpreter to be "a reluctantly accepted practical necessity" who should fade into the background and allow the parties to conduct their business undisturbed" (Morris, 1999, p. 84).

In recent revisions of professional codes, there seems to have been some consideration of interpreters as human beings, typically unable to entirely ignore their emotions and personal beliefs when undertaking their professional tasks (Norma & Garcia-Caro, 2016). For example, NAATI (2013) acknowledges the practitioners' right to withdraw from assignments that include any discussion of a termination of pregnancy (abortion). However, the "myth of the neutral interpreter" (Torresi, 2005, p. 1), together with the static status it assigns to the dynamic process of interpreting (Brisset, Leanza, & Laforest, 2013), still dominates how the profession is described and how interpreters are encouraged to fulfill their roles. Norma & Garcia-Caro (2016) (Australia) argue that interpreters working with migrant women in emergency domestic violence situations should advocate, moving away from simplistic notions of the role as being objective, to a notion better aligned with what their clients actually need. Regarding why this need is real and cannot be ignored, Bahadir's (2010) reasoning in her conceptual piece is worth considering:

> As there can be no neutral part in mis/communication and as there is no objective way of perceiving, analysing, and processing information and emotions (see Vermeer 1996, 2006), the professional interpreter has to position herself. Open and courageous positioning is vital because interpreters mostly suffer from burnout or "helper syndrome" when they do not reflect critically and honestly on their involvement as "participant observers" with human(e) qualities in these contexts. (p. 128)

Bahadir (2010) proceeds to argue that since the interpreter exists physically, therefore features such as being "impartial", "neutral", or "non-disturbing" are a "myth" (p. 131). She has likened the existence of an interpreter to the existence of a soldier from an occupying army; both are undeniably physical, she believes, which leads to her concluding that features such as being "impartial", "neutral" and "invisible" are a

"myth" (p.131). Likening an interpreter, who supposedly belongs to the same community as the person needing assistance seems to be far-fetched to a soldier belonging to an occupying army, in terms of the potential feelings of hatred and fear that exist towards such soldiers from people of the occupied land. Therefore, such a likening would not transfer similar feelings towards interpreters because the interpreter and the person in need are not in a war-zone.

Mikkelson (2016) similarly argued that while we should not actively seek biased interpreting in a legal setting, interpreters' establishing rapport with their clients may result in more or less biased translations. Rapport and other elements that take interpreting beyond neutral practice have led Zimanyi (2009) (Ireland) to reconceptualise neutrality in interpreting as a matter of degrees, ranging from most neutral to most involved. She argues that the interpreter usually stays somewhere near the middle of this abstract line. As Angelelli (2006, p. 189) has argued, how neutral or involved an interpreter is depends on "the situational reality of their work environment".

Further, Maltby (2010) argues that "interpreter behaviour is as much shaped by the habitual institutional routines in which the interpreted exchanges take place as by codes of conduct" (p. 210). Indeed many empirical studies suggest and highlight how interpreters approach the practice of interpreting in a situationally sensitive manner. An interpreter in Hsieh's (2008) study admitted that she did not interpret neutrally when interpreting for her mother, as in that situation she had considered herself a daughter and not an interpreter. In her survey of professional interpreters, Hale (2011) (Australia) reported "*I love helping others*" (p. 242) was the second most frequently nominated reason for current job satisfaction. Hsieh (2008) observed interpreters moving between a range of roles as they encounter different dilemmas and challenges in their everyday professional activities and maintain a sense of responsibility towards patients. These roles entailed clarification, cultural mediation, and advocacy according to the specifics of the context. Advocacy and serving as professional team members were among the responsibilities mentioned by interpreters in Tribe & Morrissey's (2003) study, and

participants in Mason's (1999) study highlighted coordinating others' talk as one of their tasks.

Although promoted by codes of conduct, impartiality is not necessarily advocated by other parties involved in an interpreted communication either (Maltby, 2010). Exploring the issue from a group migrant perspective, Edwards et al. (2005) highlighted the perceived importance of interpreters' personal characteristics and attitudes and advocates the case being more proactive on behalf of their clients.

The observations in the abovementioned studies do not necessarily mean that interpreter's subjectivity is always to be supported. There have been cases where interpreters' personally decided courses of action in their professional practice have had negative consequences. In a case observed by Baraldi & Gavioli (2012) (Italy), the interpreter delayed interpreting in court with the intention of providing extra time for the defendant to respond to what the judge said. However, this involved some risks. The relevancy of the contribution made by the defendant was not clear. Also, the interpreter's approach to giving more space to one party meant less space for other parties involved in the conversation, hence "*unequal interaction*" (p. 225). In another case described by Davidson (2000), to keep the appointments for the doctor on track, the interpreter held off on information exchanged between the doctor and the patient and screened it for relevancy. Specifically, the interpreter did not interpret all questions that the patient and the doctor were asking from each other.

The interpreter's subjectivity should be acknowledged, and it needs to be recognised that there are specific interpreting situations where maintaining impartiality and objectivity are difficult. Nevertheless, the impartiality of the interpreter is desirable and respectful of the interests of both parties who they are acting for. Furthermore, interpreters should receive appropriate training to handle and utilise their subjectivity effectively. For example, Bahadir (2010) emphasises that interpreters should "be made aware and trained for the consequences of their in-between position and their status as third party to a communication" (p.128). Edwards et al. (2005) stress the importance of interpreter training being "refocused to include the crucial issue of developing a

personal and trusting relationship with the users they [i.e. the interpreters] are aiding to access services" (p. 92).

2.6 Trust

Trust is considered a key element of interpersonal relationships between a health professional and a patient in healthcare settings (Hsieh, Ju, & Kong, 2010; Pearson & Raeke, 2000; Robb & Greenhalgh, 2006). Patients should be able to trust health professionals' ability to deal with their health issues and improve their health (Mechanic & Schlesinger, 1996), and health professionals' knowledge and interpersonal skills affect patients' trust in them (Pearson & Raeke, 2000). In fact, insufficient trust in health professionals' knowledge and capabilities may threaten the health of a patient (Pearson & Raeke, 2000).

Further complexity is added to the dynamics of building and maintaining trust in a medical encounter when there is three-way communication with an interpreter facilitating communication between the health professional (HP) and the patient. The patient needs to trust both the interpreter and the HP and vice versa. In other words, patients and health professionals are put in the vulnerable position of needing to trust that the communication and information transfer will happen efficiently, with appropriate sensitivity being exercised in this dynamic exchange, and the integrity of all parties being acknowledged (Norris, Wenrich, Nielsen, Treece, Jackson, & Curtis, 2005 (US)).

Several groups of factors have been found to affect the degree of trust service users and health professionals put in interpreters. A set of these factors are related to interpreters' professional backgrounds and skills. One such factor is the interpreter's ability to transfer information effectively. Most of the service user participants in Hadziabdic, Heikkilä, Albin, & Hjelm's (2009) study reported that their trust in interpreters' translation ability increased when they observed that interpreters could adapt to their use of language and speak their native dialect. Service users interviewed by Edwards, Temple, & Alexander (2005), however, related several negative experiences with the interpreters they had used who, they believed, lacked adequate proficiency. The

interpreters' perceived lack of proficiency had led the participants to feel that these interpreters ignored their interests and were, instead, concerned with their own and service providers' interests, hence generating a sense of distrust. Regarding health professionals' perceptions of interpreters' language and translation abilities, some reported being concerned about their own lack of language skills necessary to evaluate the interpreter's competence. Therefore, they tend to assess their competence based on what they know about the interpreter's training and credentials. Some also count on and trust the medical expertise of interpreters who previously worked as nurses or physicians (Hsieh et al., 2010). The service user participants in Hadziabdic et al. (2009) also referred to what they knew about the interpreter's knowledge of medical terminology and educational background as affecting their degree of trust in them. In addition to an interpreter's professional background and technical knowledge, their translation experience as perceived by health professionals and service users also affects the amount of trust placed in them (Greenhalgh, Robb, & Scambler, 2006; Hadziabdic et al., 2009; Hsieh et al., 2010).

Other factors affecting the degree of trust are related to professional conduct. The most frequently mentioned aspect of interpreters' professional conduct, emphasised by both health professionals and service user patients, is confidentiality. Some studies have shown that patients may be concerned about whether interpreters maintain confidentiality of information exchanged in medical consultations about their health issues. Their concerns result from the fact that their interpreters usually belong to the local communities of which they are members. Some of the participants in Hadziabdic et al. (2009) recalled a few cases in which their friends had become informed about their health issues through interpreters not maintaining confidentiality. This had resulted in them avoiding sharing some information with health professionals when an interpreter was present. This feeling of avoidance and inhibition was also observed by some clinicians in Greenhalgh et al. (2006), who attributed it to their patients' lack of trust in the interpreter, especially when discussing a personal issue or a serious and, thus, stigmatising health condition such as cancer or HIV. Similarly, health professionals and community representatives interviewed by Nithianandan et al. (2016) (Australia) identified concerns around interpreters breaking confidentiality as

preventing women from disclosing symptoms of mental health issues. Trust in the interpreter's professionalism, however, can alleviate confidentiality concerns. Gartley & Due's (2017) (Australia) interviews with psychologists and other mental health practitioners showed that concerns related to confidentiality, often leading patients to avoid interpreted consultations that would sometimes result in a preference for telephone interpreting. In highly sensitive contexts, like prisons, the issue of confidentiality in medical consultations becomes particularly significant. Watt et al. (2018) (Australia) reported that one reason why female inmates prefer to be served by formal interpreters rather than peer interpreters was the higher likelihood of loss of confidentiality when the latter were utilised.

Aware of these concerns on the part of service user patients, interpreters interviewed by Hadziabdic et al. (2009) reported that they try to gain patients' trust in their commitment to confidentiality through creating a safe atmosphere for the patient in consultations. Those participating in Rosenberg, Seller, & Leanza's (2008) (Canada) study said they do so through clearly explaining their professional role to service users and emphasising its precedence over their social connections as members of the same community.

Some other aspects of interpreters' professional conduct which health professionals believe impacts their trust in interpreters are their impartiality (see section 2.5), lack of emotional involvement, punctuality, and maintaining their professional boundaries (e.g. refraining from casual conversations with patients who have mental illnesses) (Greenhalgh et al., 2006; Hsieh et al., 2010). Finally, the fact that interpreters and health professionals work toward common goals as a healthcare team increases health professionals' willingness to trust interpreters (Hsieh et al., 2010). The idea of health professionals and interpreters working together as a team, though an interesting proposition, is sometimes in conflict with the expectation that interpreters maintain their professional boundaries. Some health professionals in Hsieh et al. (2010) showed so much trust in interpreters as to express their willingness to be interrupted by them if, for instance, any clarification is needed or they find the professionals' care culturally inappropriate. Yet, these health professionals were also concerned that they may lose

control of their voice and progress in consultations, which would compromise their trust.

Since trust takes time to build, having the same interpreter over a number of consultations provides the patient and health professional with the opportunity to get to know them and ideally trust them. The importance of repeated encounters in trust building was acknowledged by both service users (Edwards et al., 2005) and health professionals (Gartley & Due, 2017; Hsieh et al., 2010). In the case of the latter, the participants in Hsieh et al. (2010) discussed three ways in which working with the same interpreter helped them establish patterns of collaboration and facilitate communication: anticipating each other's communicative needs more efficiently, appreciating and adapting to each other's style of communication, and interpreters gaining familiarity with clinic procedures. Utilising the same interpreters in multiple consultations was reported by health professionals interviewed by Gartley & Due (2017) as being extremely important, resulting in patients' increased comfort with disclosing sensitive information, and also avoiding disruption to treatment:

> Using the same interpreter was considered to be so important that where a new interpreter was used in the middle of a series of sessions, participants reported that clients' discomfort was sometimes so extreme that they did not continue therapy sessions. (Gartley & Due, 2017, p. 36)

Finally, emotion-related factors, such as interpreters showing empathy and kindness, giving patients a secure and calm impression, and even their physical appearance (e.g. clothing) are reported by service users to positively influence their trust in interpreters (Hadziabdic et al., 2009; Haralambous, et al., 2018; Rosenberg et al., 2008).

Some of the challenges mentioned in connection with working with professional interpreters may lead service user patients to prefer to use their family members or friends as their interpreters. The reasons behind this preference reported in the literature are emotional support and sense of comfort, helping with practical issues, adequate knowledge of the patients' health issues due to having lived together, and loyalty (Hadziabdic et al., 2009; MacFarlane, Dzebisova, Karapish, Kovacevic, Ogbebor, & Okonkwo, 2009). Yet, patients have indicated that they cannot always trust other people's commitment to confidentiality, especially if they belong to small

communities, where news travels quite fast (Edwards et al., 2005; Greenhalgh et al., 2006; Rosenberg et al., 2008). The major concerns that health professionals have regarding interpreting by patients' friends or family is their lack of medical knowledge and a professional relationship with health professionals. In contrast, professional interpreters have or develop specialist medical knowledge and health professionals have the opportunity to build a mutually beneficial professional relationship with them (Hsieh et al., 2010).

2.7 Time and its effect on interpreted medical consultations

One of the issues affecting the efficiency of communication in interpreted medical consultations is time limitation. Availability of time for patient service users to ask questions important to them and understand healthcare providers' responses has been shown to have a great influence on their satisfaction with the service they receive (Riggs et al., 2012 (Australia)). In busy hospitals with a large number of patients seen on a daily basis, healthcare staff are usually allocated a specific amount of time for every patient. They are expected to start and finish each consultation, as scheduled, to avoid lagging behind. This requirement may not be overly difficult to meet in consultations where health professionals and patients share the same language. However, it becomes a real challenge in interpreted consultations where a third party is added and the process of interpreting necessarily prolongs the medical encounter, making on-time completion of consultations difficult (Lee, Lansbury, & Sullivan, 2005 (Australia)). A second reason why interpreted consultations may take longer than expected is the limited possibility of translating some culture-bound expressions and the consequent necessity of interpreters explaining them (Hsieh et al., 2010). In addition, there are situations where interpreters arrive at consultations having been delayed or do not show up at all for different reasons (Krupic et al., 2016 (Sweden)). As a result, some patients may not be seen at all (Lee et al., 2005).

Health professionals and patients seem to approach the time constraints within which interpreters work differently. Lee et al.'s (2005) survey of physiotherapists in New South Wales revealed different reactions health professionals may have to interpreter-related delays. Some participants show understanding towards an interpreter's late

arrival since they themselves sometimes keep interpreters longer than planned in their own consultations, thereby contributing to the delay at another health professional's consultation. Some, however, feel stressed and anxious if interpreters are late, as this may result in inadequate time to finish a consultation. Moreover, they may perceive delays as the interpreter's lack of punctuality (Lee et al., 2005). In contrast, Krupic et al.'s (2016) survey of patient service users shows a generally negative attitude on their part toward interpreters cancelling appointments or not appearing at the scheduled time. The patient participants reported experiencing stress, anxiety, disappointment, frustration, and anger at interpreters' absence in consultations. They felt that interpreters who did not attend scheduled appointments did not care about them.

Different solutions to the issue of interpreter delays and not turning up are reported to have been adopted by health professionals and interpreters themselves, each presenting certain challenges. For example, interpreters sometimes attempt to leave consultations when the scheduled time finishes so they can arrive at subsequent consultations on time. This course of action, as presented in the Australian study by Lee et al. (2005), tended to be judged by health professionals as the interpreter's lack of commitment to fulfilling their role well, even though it could be due to time limitations which are out of the interpreter's control. A further possible consequence of this judgment is some health professionals' reduced collaboration with the interpreting service (Lee et al., 2005). A common course of action taken by service providers when interpreters do not show up is to use hospital staff as interpreters. While this may help resolve the problem of the interpreter's absence, it is considered sub-optimal from the perspective of professional service delivery, since bilingual staff usually lack the skills and training needed to act effectively as interpreters (Fatahi, Mattsson, Lundgren, & Hellstro€m, 2010). Furthermore, patient service users sometimes have a negative emotional reaction, since interpreting staff members tend to look at their watches during consultations as they are mindful of their own patients who might be waiting for them (Krupic et al., 2016).

Finally, in some contexts, health professionals have been reported to modify their consultation schedule, by allocating extra time to interpreted consultations. However, the extra time given to some consultations may negatively impact subsequent

consultations, to the point where some service users are disadvantaged and not attended to (Riggs et al., 2012).

2.8 Dynamics of power in interpreted consultations

Power exists in any type of communication where the parties involved interact, drawing upon their beliefs, goals, and perceptions of each other and the nature of the interaction (Foucault, 1982; Leezenberg, 2002). In medical settings, the interactions which occur between health professionals and patients are inherently power structured. These interactions have been described as characterised by "inequality between doctor and patient" (Fatahi, Mattsson, Hasanpoor, & Skott, 2005: 162) and, depending on the nature of the interaction, the HPs may behave in a controlling manner (Ong, Dehaes, Hoos, & Lammes, 1995). Generally, they "maintain high control in which they initiate questions as well as interrupt patients" (Waitzkin, 1984, p. 344) and "ultimately [HPs] control the discourse due to being professionally knowledgeable with having care responsibility towards their patients" (Cordella, 2004, p. 188).

The presence of an interpreter brings an additional power differential into the HP--patient interaction. Interpreters can change the outcome of an interaction by controlling access to information, and the degree to which the patient and health professional can negotiate their communication goals (Davidson, 2000 cited in Watermeyer, 2011; Haralambous et al., 2018). At the same time, the interpreter's space to manoeuvre in the consultation is limited by a number of factors such as their outsider status and the pressure to conserve health professionals' time (Hsieh, 2006). Several studies (e.g. Bischoff, Kurth, & Henley, 2012 (Switzerland); Watermeyer, 2011 (South Africa)) have explored the dynamic power relations generated by and impacting the triadic communication in interpreted consultations. Insightful examples will be discussed further.

Interpreters have been reported to be able to empower patients and health professionals. In Switzerland, for example, Bischoff et al. (2012) observed that interpreters can enhance health professionals' understanding of immigrant patients, but concomitantly empower patients by facilitating their active participation in their own healthcare.

Furthermore, Watermeyer (2011) reported that side conversations between interpreters and patients have the potential to highlight misunderstandings or concerns that health professionals may not identify. By extending interpreters' contributions beyond consultations the healthcare system is able to adapt to its increasingly diverse clientele (Bischoff et al., 2012; Watermeyer, 2011), and contribute to them not being disadvantaged by the culture and language barriers.

In contrast, the interpreter's impact on existing power differentials within a medical consultation is not always perceived as positive. In South African communities, for example, interpreters have reported that the high status given to English as a tool which facilitates access to different resources gives them power over patients due to their higher language proficiency (Fisch, 2001). Similarly, the patient participants in Hadziabdic et al.'s (2009) study considered using interpreters as a "disability" (p. 465) as it creates a sense of dependency on the part of the patients. Regarding telephone interpretation, the participants in Hadziabdic et al. (2009) reported a feeling of powerlessness and insecurity because visual information was lacking in this situation and patients could not identify interpreters as well as they wanted to. Another factor resulting in patients' perceived lack of power (Hadziabdic et al., 2009) was the fact that they could not choose interpreters, and if they were not comfortable with an interpreter, they were not entitled to ask for another one. The patients participating in Watermeyer's (2011) study believed that having an interpreter in a pharmacist consultation detracts from making the session patient-centred, as it made their involvement more passive.

When it comes to the relationship between health professionals and interpreters in triadic consultations, a number of findings from the literature need to be acknowledged. First, health professionals generally seem to exercise more power than interpreters, who tend to follow their interactional style. This is particularly true in the case of interpreters directly employed by hospitals. These interpreters have a higher tendency to align themselves with the institutional context of the hospital and, thus, health professionals (Angelelli, 2006). Kaufert et al. (1999) reported a situation highlighting the inherent power structure in which the interpreter had informed the treating doctor about the wishes of an older patient to discontinue further treatment due to her tribal cultural

beliefs. Despite the interpreter communicating the patient's readiness to face death, the doctor, exercising his power as a health expert, decided to continue with the treatment. The patient wishes, as communicated by the interpreter, were in this case not respected.

Health practitioners' interest in remaining in charge of interpreter-mediated interactions has been documented in a number of studies. In cases where HPs acknowledge the interpreter's roles beyond language transfer, they tend to remain in the position of determining the boundaries. Regarding the cultural informant role of interpreters, for example, HPs have been reported to want interpreters to fulfill this role but only from HPs to patients (Leanza, 2005). Hsieh et al. (2010), for example, quote one of their participants as saying, "I consider [interpreters] colleagues, but ancillary services to mine. I welcome [interpreters' input]. But I still get to call it. [laugh] I'm still the leader" (p.178). No matter how successful health practitioners are in maintaining control, it remains an inherent challenge to have full control due to the interpreter's inevitable role of representing the HP's voice and resultant blending of voices (Hsieh & Kramer, 2012). It is also worth mentioning Pauwels' (1995) (Australia) finding that sometimes practitioners' concerns about interpreters' interventions and their own loss of control may be due to perceived pauses and differences between the sequencing in an interpreter-mediated dialogue and a natural conversation.

Challenges, such as those documented in the literature, relating to the power-structured nature of interpreted consultations show the significance of well- designed training for both interpreters and health professionals in relation to their respective roles. Hsieh (2006) problematises the discrepancies between the kind of training interpreters receive and the reality they encounter in medical settings. Thus, it seems necessary for their training to incorporate this reality and prepare them for it, especially in the case of young professionals, who, as Leanza (2005) noted, "have to negotiate the complexity and uncertainty of working with interpreters with their efforts to acquire basic skills and expertise" (2005:30).

2.9 Gender

In addition to the issue of power imbalance, gender is another key variable which can affect an interpreter's performance and triadic communication in an interpreted

consultation (Torresi, 2005). Yet, it is one of the most neglected interpreter-related factors in the available literature, despite all the arguments thus far promoting the view of the interpreter as a person ‘present’ in an interpreted consultation. One of the earliest attempts to foreground the issue of gender in interpreting was the research reports of the “Interpreting for Women Project” funded by the Australian Government (McRobbie & Jupp 1993; Pardy 1995), which shed light on the importance of giving migrant women the right to choose the gender of their interpreters. Pardy’s (1995) report recommended hiring more female interpreters to cater for the gender requirements of the interpreting service users. Another example of an early focus on sex concordance between interpreters and patients comes from South Africa, where Drennan (1999) reported that Cape Town's Valkenberg psychiatric hospital hired a female interpreter for the female ward and a male interpreter for the male ward.

From the late 1990s, the literature reflects an increased emphasis on the issue of gender in interpreting. For example, Cronin called for a cultural turn in research on interpreting to address “issues such as class, gender, race in interpreting situations” (2002, p. 387). Later, Angelelli (2004) argued that interpreter characteristics, like gender, are an integral part of his or her presence in medical consultations and must be taken into account in discussions and research on interpreting. Drawing on empirical research, Nithianandan et al. (2016) concluded that HPs and community representatives believed that having a female interpreter serve women with mental illness would give the conversation more cultural appropriateness, especially in the case of women who have traumatic histories. Arguing for strong connections between Interpreting Studies, Feminist Translation Studies, Gender Studies, Sociology, and Sociolinguistics, Weber, Singy, & Guex (2005) explored how patients, health professionals, and interpreters perceive sex difference or concordance between these three groups of stakeholders using focus groups. Important psychological and cultural aspects emerged and many considered female interpreters to be more suitable in areas such as paediatrics and gynaecology, which are part of ‘women's world’, or in dealing with taboo topics, such as violence and sexuality. Another significant finding though was that experienced interpreters were concerned that attaching considerable importance to issues related to

gender may give health professionals and hospitals an excuse to exclude interpreters from medical consultations on the grounds of sex difference with the patient.

Given the relative neglect in the literature on gender as a factor in health interpreting, studies in other areas of interpreting are useful for providing a more comprehensive picture of the relevance of gender to interpreting in the health setting. For example, studies in courtroom settings show that interpreters' visibility is reinforced through their gender. Berk-Seligson (2002) (Australia) found that Spanish-speaking witnesses address interpreters rather than attorneys. In an anecdotal piece, Cocchi (2005), an Italian professional police interpreter, explained how she bridged the cultural gap between Italian police officers and Nigerian women by moving beyond the expected conduit role, to ensure that women's responses were presented in a way that was easily understandable to a police officer, who otherwise tended to characterise women as being inconsistent. Focusing on the particular situation of the Domestic Violence Court System in Ontario, Canada, Oda & Joyette (2003) reported that while interpreters were used to mediate for female witnesses or victims, they needed training to be able to work with male perpetrators. This training needed to involve developing interpreters' assertiveness and their ability to deal with challenges related to their psychological and physical safety.

As this review of the literature on gender in community interpreting shows, while there has been some focus on this topic in courtroom settings, limited published research exists that examines how gender impacts interpreted consultations in medical settings.

To reiterate the main insights from existing research informing this thesis, what stands out is that community interpreting is a complex process involving cognitive, ethical, institutional and social dimensions. Fundamentally, community interpreting involves a cognitive process dealing with decoding and encoding shared information to render a message as accurately as possible from one language to another, and from one party to the other in an interpreter-mediated encounter. But, most importantly, to effectively and accurately interpret requires sophisticated, but under-appreciated by non-linguists, linguistic and cultural understandings of two languages and their associated dialects

and registers. Second, community interpreting takes place in a context of great sensitivity and vulnerability. In the case of healthcare in triadic interactions, the community interpreter is the only person who has access to both technical and medical (from HPs) and highly personal information (from CALD patients) and responsibility for the transfer between the two parties not sharing a common language or culture. Hence, the importance of ethical principles and understanding and adoption of principles of professional interpreting conduct to ensure the integrity and quality of communication between the two parties. Third, community interpreting in health takes place in an institutional context, in this case, hospitals, as large highly structured organisations that impose ways of organising and engaging that influence and mediate the nature of interactions and outcomes.

2.10 Limitations and gaps in the research

The literature highlights the many problems that need to be addressed to make interpreted health communication work effectively. The poorer outcomes for those with LEP are clearly documented, and exacerbated without the assistance of a professional interpreter. The barriers to effective transfer of meaning are not purely linguistic. Given the cultural, institutional, educational, and social dimensions that impact an LEP migrant patient's understanding of health and institutional contexts (medical/health), and both their own and their treating HP's cultural and linguistic backgrounds, their equitable participation in the hospital system is fraught.

Whilst the 'conduit' role of the interpreter in effecting information transfer is widely accepted, and in most cases in Australia portrayed officially as the only or main role of the community interpreter, as a number of international studies have highlighted, the community interpreter has access to knowledge and capabilities that raise the possibility of their undertaking additional roles. Indeed, in some countries and contexts, roles such as cultural mediator or patient advocate, are assumed or expected of the interpreter, given that person's unique capacity to act as a bridge or support to the culturally different and vulnerable LEP patient in negotiating the health system. The motivation for this research project is to contribute to how the community interpreter's role is both understood, and practised in Australian hospital settings. Importantly, given

the differences in views and expectations documented to date, it is important to consider the perspectives and experiences of all three parties to triadic health consultations, the patient, the health professional and the interpreter.

Whilst evidence from Australia to date suggests that the community interpreter's role continues to be primarily conceived as that of a conduit, an invisible 'pipe' transferring a message through a straightforward cognitive process from language A to language B, this conceptualisation is extremely limited. It is also not strongly empirically based as it denies fundamental aspects of the dynamics of the interaction that necessarily take place in delivering consecutive interpreting in a community context. The interaction model of interpreting (see section 2.3.2) better reflects community interpreting. It recognises that the interpreting process is community based, bringing together two linguistically and culturally different participants to engage with each other. In such contexts, the interpreter has the potential to be a more active participant and has the capacity to adopt a more active role in assisting with the co-construction of meanings between the two parties being supported. Furthermore, in positioning this research as being informed by the interaction model, the juxtaposition of the construction of the health interpreter, as being invisible versus a more active and visible co-constructor of meaning in Angelelli (2004), is particularly pertinent. Her characterisation of the role as being potentially multidimensional as well as taking place in a complex multileveled social space also has informed my thinking about the nature and range of roles that health interpreters in hospitals may practise or be asked to practise.

Much of the research reviewed in this chapter is taken from peer-reviewed journals, which, despite their generally high quality and rigour, have a number of limitations that need to be acknowledged here. First, some of the research, like Bahadir (2010) and Maltby (2010), is conceptual and involves document and policy analysis rather than drawing on data from those involved in the process of health interpreting. As such, they have limited applicability for further development of the actual practices of professional interpreting.

Empirically based research is mostly qualitative. Given the depth of data and phenomenological nuancing, such research provides important insights into community interpreting. However, given the small sample sizes and discrete contexts in such studies, their generalisability is limited. Rowland's (2008) (US) study, for instance, involved only three professional interpreter participants in two languages in dental clinics, and the 'conduit' role was found to be dominant. Other qualitative research with greater numbers of participants across a range of health contexts have offered a broader view of interpreters' perceived roles (Dysart-Gale, 2007; Greenhalgh et al., 2006; Leanza, 2005). For example, Hsieh (2008), who collected data from 26 professional interpreters, 12 health professionals and 4 patients, reported that the participants referred to roles they considered necessary for interpreters to fulfill beyond that of language conduits, such as advocate, cultural broker, and moderator. This research project seeks to add to the understanding of the interpreters' role/s by including the views and experiences of three groups of participants directly involved in interpreter-mediated consultation as well as analysis of the actual recordings of healthcare interpreting.

Another limitation identified in the literature is that of limited participant triangulation. Researchers have mostly interviewed representatives of either one or two groups of participants of triadic interpreted encounters. For example, Rowland (2008) and Butow et al. (2012) interviewed interpreters only, and Hadziabdic et al. (2009) interviewed only patients. Exclusively focusing on health professionals, Fatahi et al. (2008), Lee et al. (2005) and Leanza (2005) interviewed general practitioners, physiotherapists, and paediatricians respectively. Watermeyer (2011) and Rosenberg et al. (2007) involved two groups of participants: HPs and patients. A few studies have collected data from all three parties involved in triadic medical consultations—patients, health professionals and interpreters. Weber, Singy, & Guex (2005), for example, conducted focus group discussions with the three parties involved in interpreted consultations. White and Laws (2009) and Rosenberg et al. (2008) collected data from all three groups of participants, though not through interviewing them, but rather by analysing audio-taped triadic consultations. This research will add further to what we know by including the viewpoints and experiences of all three participant groups in the medical

consultation as well as exploring how the actual dynamics of the interaction may impact on the role that interpreters are assigned to undertake. By taking this approach, it is intended to contribute perspectives that can assist in demonstrating how the conceptualisation and understanding of the role of interpreter as a language 'conduit' is overly simplistic.

Finally, the research has been designed to contribute new knowledge by focusing on community health interpreting in Australia. While important Australian studies have focused on interpreters' roles and the factors which affect their fulfillment (see for example Butow et al., 2012; De Jongh, 1991; Lee et al., 2005; Norma & Garcia-Caro, 2016, Riggs et al., 2012), most have suffered from the limitations mentioned above (i.e. small numbers of participants and limited participant triangulation). Australia has been proactive internationally in defining and codifying interpreting as a profession, and structuring the approach to professional recognition; however, evidence from the available studies suggests a need for better understanding how the interpreter's role/s play/s out in practice in the complex and pressured institutional context of medical settings, such as hospitals.

As the following chapter describes, I have addressed the limitations outlined above by designing a project that has enabled collection of data from two Australian hospital settings, including the perspectives of a relatively large number of participants (31), representing all three groups—health professionals, interpreters and patients—with direct experience in triadic interpreter-mediated consultations. Furthermore, the methodology and associated research methods have supported the collection of a broad range of complementary data, interviews, observations, and recording of triadic interactions. The methodology and methods adopted in the research design contributes new understandings about how the community health interpreters' role/s are understood and practiced. They are described in detail in the next chapter (Chapter 3).

Chapter Three – Research Methodology and Methods

In this thesis I am arguing that conceptualising and understanding the role of the interpreter in the healthcare setting as neutral language 'conduit' is too simplistic. As a result of my argument the methodology and methods for the research are designed to enable a more in-depth and nuanced understanding of the nature of the contributions made by interpreters in facilitating patient--health professional communication in Australian hospitals. A major gap in the research literature has been identified (see Chapter 2, section 2.10) as being the limited number of qualitative studies on interpreters' roles within Australia, especially those which explore contrasting perspectives of the three key groups of participants who take part in interpreted triadic medical consultations, namely interpreters, HPs, and patients. To address this gap, the present study has been designed to investigate experiences and expectations of those from the three distinctive groups of consultation participants concerning the role/s of interpreters in medical consultations. Factors that may impact on the role/s of interpreters will be considered as well. In addition to exploring interpreters' perceived roles, this research is designed to complement participants' views by analysing how interpreters fulfill their role/s in action within conversations conducted in interpreted medical consultations. The study was directed by two sets of research questions:

1. Interpreting as message transfer
   - 1.1. How do health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters?
   - 1.2. What factors affect the effectiveness of message transfer?
   - 1.3. What are the outcomes of effective and ineffective message transfer?
2. Interpreting beyond message transfer
   - 2.1. What roles do interpreters fulfill beyond message transfer to facilitate health professional--health service user communication?
   - 2.2. What are interpreters', health professionals', and health service users' attitudes toward interpreters serving roles beyond message transfer?

3.1 Qualitative research

To answer the research questions, I chose to adopt the constructivist paradigm for its comprehensiveness and appropriateness. Constructivists believe that reality is not a universal entity and is not pre-existing; rather, it is negotiated and constructed by individuals engaged in social interactions. In such interactions, as Staller (2012) and Willis (2007) discussed, individuals are understood as developing, sharing, and revisiting their subjective understandings of the world.

Research within healthcare settings is said to benefit from qualitative methods that provide a "rich description of complex phenomena" and "illuminate the experience and interpretation of events by actors with widely differing stakes and roles" (Sofaer 1999, p. 1101). Furthermore, as researchers such as Bourgeault Dingwall & De Vries (2010) and Hoff & Witt (2000) have argued, qualitative research in healthcare can bridge the gaps in research on stakeholders' beliefs and practices that cannot be answered with quantitative techniques. For the purpose of this research, a qualitative approach has also been adopted as it aligns well with a constructivist worldview. As Denzin & Lincoln (2000) have pointed out, qualitative research is an appropriate tool to study personal experiences and life stories which can be communicated through data collection instruments such as interviews, observations, and life narratives.

In this study, interviews and interpreted conversations serve as primary data sources as they provide complementary perspectives of patients, health professionals and interpreters towards gaining understanding of the interpreter's role in discourse and in practice respectively. My observations of actual triadic consultations added further value about the dynamics of how things occur with the presence of interpreter. Specifically, interviewing helped me to explore the multiplicity of perceptions of interpreters' roles in interpreted medical consultations, while analysis of interpreted interactions provided direct insight about the roles interpreters actually fulfill in consultations. Furthermore, the selected qualitative, constructivist approach has enabled me to understand and then integrate the range of qualitative data with my own subjective perspective and, by doing so, develop an intersubjective understanding

(Anderson, 2008; Denzin & Lincoln, 2000) of the interpreters' role/s in health consultations.

Table 3.1: Research questions and data collection methods

Data collection method	Research question addressed
Interviewing	How do health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters? (1.1) What factors affect the effectiveness of message transfer? (1.2) What are the outcomes of effective and ineffective message transfer? (1.3) What are interpreters', health professionals', and health service users' attitudes toward interpreters serving roles beyond message transfer? (2.2) What roles do interpreters fulfill beyond message transfer to facilitate health professional--health service user communication? (2.1)
Recording of interpreted consultations	What roles do interpreters fulfill beyond message transfer to facilitate health professional--health service user communication? (2.1)

3.2 My positioning as the researcher

In addition to being the researcher in this study, I am also a woman, a migrant and interpreter. These three integrated aspects of my identity inform my positioning in relation to my research in a number of facilitative, as well as potentially limiting ways. Given the importance of researcher positioning in qualitative research (Berger, 2015; Liamputtong, 2013; Pitard, 2017), in this section I reflect on the benefits and limitations that my migrant and professional background as an interpreter present me with in undertaking this research.

As a migrant, member of a migrant family and child of an LEP migrant mother who required interpreting assistance at the hospital, I have been able to understand and

personally relate to patient participants' language related challenges. My migrant background made it easy, to differing degrees, for both patients and interpreters to open up and present me with genuine answers to interview questions.

As a woman I was able to relate to my female interviewees, both HPs and interpreters, and I believe they were able to open up to discussing issues experienced with their female patients more freely, as we were the same gender. At the same time my female patient interviewees seemed to be at ease discussing their experiences and concerns with me, because we were both females. Male HPs and interpreters were accustomed to dealing with female interpreters and researchers, so my gender did not appear to influence their willingness to participate and respond to my questions. In the case of male patients, I presented myself as having a background as interpreter and researcher.

Being an interpreter, I shared many of my colleagues' experiences, perceptions, and analyses. Likewise, I understood my interpreter participants' lived experiences beyond the data I collected in the study. I had experienced, firsthand, most of the issues they reported having encountered as a result of dealing with patients or health professionals who expected them to fulfill roles they did not consider to be their responsibility. In particular, I could deeply understand the cultural challenges that my Iranian interpreter interviewees discussed as having to deal with when working with patients from the same background, such as being confided in with information that, while potentially significant, should not be disclosed to health professionals. As an agency interpreter and having served hundreds of clients in varied contexts, including medical settings, I was able to relate to my patient participants and understand issues they were dealing with due to their non-English speaking language background. Before I recruited my patient participants I had already been informed by my own patient clients about a myriad of positive and negative experiences they had with interpreters and their sense of satisfaction with many of my colleagues' interpreting services, but also some frustrations they experienced when served by other, perceived as unhelpful, interpreters.

Another way in which my professional background facilitated the process of data collection was my previous experience of interpreting in both hospitals where I conducted interviews and recorded medical consultations. Having worked in those hospitals had given me familiarity with some members of staff in the language unit, and some in-house interpreters who proved to be receptive of me and my research agenda. Given that one of the settings was a women's hospital, being a female interpreter also proved to be beneficial to the process of recruiting interviewees for all three groups. Having served a few Iranian background patients in these two hospitals in the past, I found it easy to recruit patients as interviewees as they appeared to have had positive experiences of medical consultations with me.

There were limitations in undertaking the research that related to my position as a Persian speaker and interpreter. Due to my ability to speak Persian, I was only able to interact directly with Afghan and Iranian patients for the purpose of recruitment. This limited me in interacting with patients from other language groups (i.e. Arabic and Italian) as I needed to rely on other interpreters when trying to recruit patients from these languages. In addition, the awareness of my status as an interpreter and researcher meant that some fellow interpreters were concerned about me observing the consultation with them or participating in an interview, apparently apprehensive about being judged on their interpreting practice.

3.3 Context of the study

This study is situated in two Melbourne public hospitals, which I refer to as Rose Hospital and Smith's Hospital. In these hospitals, culturally and linguistically diverse background (CALDB) patients are treated for a range of health conditions with the assistance of interpreters for communication. Both are teaching hospitals accommodating patients from a diverse range of cultural, linguistic, and socio-economic backgrounds, including many for whom English is not their first language. Both hospitals have in-house interpreters for some languages with large numbers of patients from that background. Rose Hospital provides in-house interpreters for six languages, including Arabic, and Smith's Hospital provides in-house interpreting in

five languages, including Arabic and Italian. For other interpreting support, both hospitals book interpreters through an interpreting agency on an as needs basis.

The hospitals also differ in their specialties and size. Rose Hospital includes a focus specifically on women's health, including fertility and childbirth, while Smith's Hospital is larger (almost twice the number of patients) and caters for a broader range of specialties, including infectious diseases, brain and spinal injuries, as well as providing emergency and critical care, aged care, diagnostics, rehabilitation, allied health, and mental health. Fieldwork data collection took place over a six month period in Rose Hospital from September to December 2009 and in Smith's Hospital from February to March 2010.
As highlighted in data from the Australian Bureau of Statistics (ABS, 2016) (see Table 3.2), the proportion of women who do not speak English well or not at all is higher, indicating that migrant women require interpreters more often than their male counterparts. This was the rationale for including a hospital, such as Rose Hospital, which focused on interpreting in the context of women's health.

Table 3.2: Victorian data on proficiency in spoken English of LOTE speaking permanent migrants (ABS, 2016)

Speaks a LOTE* + speaks English	Male	Female
Very well or well	192,972	201,835
Not well	25,597	36,835
Not at all	7,369	11,965
TOTAL speaking English Not Well + Not at All	**32,966**	**48,800**

3.4 Ethical considerations

The process of ethics approval was complex and multifaceted. There was initial consultation with both hospitals to understand the parameters of what might be ethically and practically acceptable and feasible in the hospital context, whilst also being consistent with project aims. A hospital staff member and expert on interpreting

services acted as associate supervisor and mentor through the process of finalising the project design for ethical approval and data collection.

An ethics application was first considered and approved through Victoria University and then through the respective hospitals' ethics committees. The research was categorised as non-adverse and low risk, as no patients' files were to be accessed and no clinical interventions required. I approached three hospitals initially and two hospitals agreed, in principle, to participate and, subsequently, granted ethics approval.

The research involved conducting interviews with three different groups of people involved in the healthcare setting—patients, health professionals and interpreters. A consent form was signed by those who were willing to participate. Recording of consultations similarly involved informed consent of all participants. The consent form included information about the research, any risks involved, and my commitment to maintaining confidentiality and anonymity. It was also clearly stated that the participants were free to withdraw from the study or refuse to answer any question at any stage of the study. For the patients, there was an option to receive the project information in their home language, and there was time provided for the patient to take the information home to discuss with family members prior to providing consent. (see Participant Information and Consent Forms (PICF) in Appendix 1.)

In line with the National Health and Medical Research Council (NHMRC) guidelines in Australia, payment was not offered to participants. However, as their time was considered to be equivalent to employment, the agency interpreters were paid at the hourly rate payable to interpreters for their time taken for interviews. The health professionals and in-house interpreters were interviewed voluntarily during their work hours and patients were interviewed in their own time (most commonly while they were waiting to be seen by a health professional). The health professionals and in-house interpreters were given the choice of either a $20 gift card or two movie vouchers and patients were given a $20 gift card in recognition of their out-of-pocket expenses and inconvenience associated with participating in the research.

Across the two hospitals it was proposed to collect data from a maximum of 12 participants in every participant group (interpreters, HPs, and patients). Working within the constraints of each hospital, ultimately influenced the final dataset that was able to be collected. For the group of HPs across both hospitals I was able to recruit 12 participants, but for the group of interpreters I was able only to collect 10. Some potential participants in the case of interpreters either did not hold a professional level of interpreter accreditation (a key criterion for participation), or were not willing to participate. For patients, I was able to interview nine in total, including one who was a patient support person. The potential patient participants for the Italian language were reluctant to accept my face-to-face invitation to participate, and therefore none consented. As a result, I stopped my data collection with the number participants who consented. In addition, I was able to record three actual interactions of the interpreter-mediated consultations across three languages (Arabic, Persian/Dari, Italian) with the consent of the HPs, interpreters and patients in each consultation. To supplement this, I was permitted to sit in as an observer for a number of additional consultations, and took extensive notes of these observations.

3.5 Recruitment of participants

Even though my migrant and interpreter background benefitted my research in many positive ways and enriched my capacity to observe and reflect on the participants' experiences, nevertheless some institutional and practical limitations in the process of recruitment of participants were experienced. First, since my supervisor and I had not asked to access the patients' hospital files due to ethical constraints, I was only able to recruit from the pool of patients who attended their appointments during my data collection visits. Second, it was necessary to limit the language backgrounds of potential patient participants to those speaking four specific languages: Dari/Persian, Arabic, and Italian.

The participants in this research reflected a range of views and experiences of those representative of the three different groups of people who participated in the interpreted health consultations, that is, health professionals, patients and interpreters. To recruit

them, a combination of sampling procedures, namely purposive, convenience, and snowball, were used.

Initially, my choice of hospitals was informed by both convenience (Saumure & Given, 2012) and purposive sampling (Palys, 2012). I chose hospitals purposefully, as my objective was to collect data in hospitals with different kinds of specialties and a comparatively high proportion of CALDB patients requiring assistance from interpreters. I approached hospitals which not only met these criteria, but also were assumed to be open to supporting research. The way I decided on the convenience of data collection was based on prior familiarity with the settings. As explained earlier (section 3.2.), I had worked at both hospital sites, and was familiar with some staff members in the language services unit; therefore, it was convenient for me to approach these two potential sites for data collection, as I thought I was likely to be able to gain access to HPs and interpreters who were willing to participate in my study, both as interviewees and for audio-recording conversations.

To assist with on-the-ground recruitment of participants, I first approached the heads of interpreting services at both hospitals to assist me in approaching potential participants. With their assistance I was able to recruit my HP participants through approaching outpatient clinics, explaining my research either directly to the health professionals or to the supervisors, and requesting them to introduce my study to the staff. The other recruitment procedure was introducing my research to health staff in allied health meetings. All potential participants were given the chance to read the information form and decide whether they wanted to participate.

To avail myself of more participants, I used snowball sampling (Morgan, 2012). At the close of interviews with HPs, early in the process of data collection, I asked them to direct me to their colleagues who they thought would be interested in participating in my research. This method helped me recruit HPs from a range of specialties. I also asked them if they had non-English speaking patients (from the selected languages) whom they would meet in interpreted consultations in the following weeks.

I approached the in-house interpreters by initially being introduced by the head of interpreters in their staff room. Then, I introduced my research and asked if they would like to participate. Only professional level interpreters were approached. The time and date were set for interviews conducted in an empty staffroom so they could talk freely.

Targeting only four groups of patients was informed by the need to be able to work across the languages of the chosen patient groups (including providing the information sheet in their language, and having access to interpreting assistance for the languages I did not know personally). Selecting four groups enabled in-depth understanding of the views and issues these patients experienced through their preferred language of communication, whilst also representing patients from a range of language backgrounds with different migration histories and community profiles, in terms of important attributes such as age and education levels. Patients also were recruited using a combination of convenience, purposive and snowball sampling. Convenience meant that I approached patients based on their ease of availability, and Persian-speaking patients constituted definite candidates since Persian was my native language and, therefore, I could interview the speakers in their mother tongue. Dari speaking patients were also able to understand Persian because they had lived in Iran prior to migrating to Australia; therefore, I was able to interview them without the requirement of an interpreter.

Purposively, I selected Arabic and Italian as the two other targeted patient languages based on the advice of the heads of language service units at both hospitals, who reported that the hospitals served a larger number of patients from these two language backgrounds. Also, both hospitals had Arabic and Italian in-house interpreters to assist me with interviewing. Finally, through the assistance of HPs and snowball sampling I was able to identify and recruit two additional patients.

Recruiting patients was organised by checking ahead the list of the languages of the patients who were going to attend the hospital in a few days' time. If they belonged to the languages selected (Arabic, Italian, and Persian/Dari), I would go to the hospital when the patients had their appointments and approach them while they were in the

waiting room. I then introduced myself and my research and asked if they were willing to participate while they were waiting to be seen by the doctor. Since the patients had limited English understanding, I had the consent form translated by professional translators through a translating agency in Melbourne into Italian, Arabic and Persian/Dari languages. While I interviewed the Persian and Dari-speaking patients; when interacting with and, where agreed, subsequent interviewing with patient participants who spoke Arabic and Italian, I was assisted by in-house interpreters.

Having made the decision about the selected language, however, when I approached Italian patients via the Italian in-house interpreters, all refused to be interviewed. The Italian interpreters explained that Italian patients were concerned that what they would say could be used against them. This same concern would sometimes also lead them to not having an interpreter in the consultation room, instead preferring to communicate with health professionals using their own limited English. Similar remarks by an Italian agency interpreter who participated in the study confirmed this lack of trust of older generation Italians in interpreters. Despite such reservations, I was able to gain the consent of an Italian background patient for the recording of an interpreted interaction with their interpreter and HP.

3.5.1 Health professionals

Most of the HP participants from Rose Hospital were highly experienced nurses and midwives with none being medical specialists, while the HP participants from Smith's Hospital were more diverse, with the majority being doctors and medical specialists in acute disease areas, with two working in allied health. This difference in focus largely reflects the different priorities and services in the two hospitals, especially those of outpatient services in each hospital. Whilst just over half of the HPs were comparatively less experienced, having practiced for 10 or fewer years, the others (5/12) were extremely experienced, having practiced for 25 or more years. This diversity in experience reflects the nature of practice in large teaching hospitals, where highly experienced staff are often engaged in training and mentoring more junior colleagues. Table 3.3 provides an overview of each of the 12 participating health professionals, using pseudonyms.

Table 3.3: Overview of HP participants

Name	Gender	Speciality	Years of practice (range)
Alice	Female	Health educator nurse	30-40
Fiona	Female	Physiotherapist	1-5
Frank	Male	Senior GP	6-10
Georgia	Female	Physician	1-5
Jack	Male	Surgeon	6-10
Janet	Female	Physician	6-10
Linda	Female	Nurse/midwife	36-40
Matthew	Male	Overseas medical graduate	1-5
Nancy	Female	Nurse/midwife	26-30
Patrick	Male	Surgeon	26-30
Sarah	Female	Nurse/midwife	36-40
Tina	Female	Dietician	1-5

3.5.2 Interpreters

The 10 participating interpreters practised as either in-house interpreters at Rose Hospital or Smith's Hospital or agency interpreters hired by the respective hospitals for a specific patient. They were all professional level interpreters who had obtained their NAATI level 3 accreditation. All had more than five years of experience, and most at least 10 years of experience, working as professional interpreters. Prior to becoming interpreters, most participants had completed university degrees in Australia or overseas. The participant interpreters were working either as in-house or agency interpreters. The in-house interpreters worked on a full-day basis; some worked five days a week on a full-time basis, and some worked fewer days per week on a part-time basis at the hospital and were freelance interpreters on other days of the week. The pattern of their employment was based on language and interpreter demand at each hospital. For example, the Chinese interpreter worked three days a week in Rose Hospital, but in Smith's Hospital the Chinese interpreter worked five days a week. Some interpreters in less demanded languages were occupied in other professional activities, such as teaching LOTE (language other than English). Table 3.4 presents

further details about the interpreters' gender, language spoken, years of experience in the profession, and their workplace. All names are pseudonyms, and all were interviewed in English.

Table 3.4: Overview of interpreters' backgrounds

Name	Gender	Language/s spoken	Years of experience (range)	Location of work and other positions
Akbar	Male	Dari	11-15	Agency interpreter
Anja	Female	Macedonian	16-20	Agency interpreter
Eliza	Female	Greek	11-15	In-house and freelance
Hiba	Female	Arabic	6-10	In-house and freelance
Hilda	Female	Chinese	11-15	In-house
Jafar	Male	Persian	6-10	Agency interpreter
Mary	Female	Chinese	11-15	In-house
Parvaneh	Female	Persian	16-20	Agency interpreter
Silvia	Female	Italian	6-10	In-house and freelance
Sophia	Female	Italian	15-20	Agency interpreter

3.5.3 Patients

The patients' background in terms of language spoken, their experience of having lived in other foreign countries, work, and educational background is presented in Table 3.5 below.

Table 3.5: Overview of patient participants

Patient	Gender	Language spoken	Highest level of education	Work experience	Country of birth	Countries lived in
Ahmad	Male	Dari, Persian	No formal education in Afghanistan mentioned *	Fruit picking in Australia	Afghanistan	Afghanistan, Iran
Elmira	Female	Dari, Persian	Grade 5 primary school in Iran	Home duties in Australia	Afghanistan	Afghanistan, Iran
Hassan	Male	Dari	No formal education in Afghanistan mentioned *	Cleaner in Australia	Afghanistan	Afghanistan, Iran

Kiana	Female	Persian	Year 12 Diploma in Iran, Admin staff in Iran	Home duties in Australia, Admin staff in Iran	Iran	Iran
Kourosh, patient's company	Male	Dari, English, Persian	University graduate in Australia	Program analyst in Australia	Afghanistan	Afghanistan, Iran
Maryam	Female	Arabic (Sudanese)	Year 12 Diploma – overseas	New arrival in Australia	Sudan	Sudan, Egypt
Mona	Female	Persian	Teacher training diploma in Iran	Casual childcare worker in Australia, Teacher in Iran	Iran	Iran
Neda	Female	Arabic (Iraqi), Persian	Grade 5 primary school in Iran	Home duties in Australia	Iraq	Iraq, Iran
Salma	Female	Arabic (Lebanese)	Year 12 Diploma in Lebanon	Factory worker in Australia, Sports teacher in Lebanon	Lebanon	Lebanon

(*) Despite probing by the researcher, two male participants did not disclose the level of education in their home country.

The interviewed patients had different levels of English proficiency across different skills, such as comprehension, speaking, and knowledge of medical terminology. Some, like Mona, Salma, Neda, and Hassan, could understand parts of what HPs said to them. However, they were still unsure about medical terms and could not make themselves understood effectively. The rest of the patients explained that they could hardly understand what HPs said to them. Some of the words they used to describe their level of understanding were "About 5%" (Ahmad), "very little" (Elmira), and "a little bit" (Maryam). It should be mentioned, however, that Ahmad, Elmira, and Maryam were attending English classes in Australia as part of their migration entitlements.

When I visited Smith's Hospital to interview patients, I encountered a couple. The patient was the wife, Elmira, who was accompanied by her husband, Kourosh. Elmira had a very limited understanding of English while her husband stated that he would understand conversations "*100%*", and, therefore, he would accompany her to the

consultations to ensure transfer of information between HPs and his wife was successful. After hearing their story, I decided to interview the couple as two separate research participants, responding to questions separately, to enable me to develop a more complete picture and additional patient-focused perspective of how interpreters contribute to patient--HP communication from the perspective of a bilingual patient's companion. Due to his high English level, Kourosh was given the choice of being interviewed in either Persian/Farsi or English, and he chose the latter.

3.6 Data collection

3.6.1 Semi-structured in-depth interviews

In general, interviewing is one of the most common tools for understanding human beings (Fontana & Frey, 1994). Interviewing comes in different forms, the most common being interviewing individuals face-to-face in a verbal exchange (Fontana & Frey, 2000). I conducted face-to-face interviews in this research so as to document and make sense of events and experiences from participants' perspectives (Bogdan & Biklen, 2007; Mertens, 2010). The aim was to understand the lived experience of individuals and the understandings they develop of their experience (Gubrium & Holstein, 2001; Richards, 2014; Seidman, 2013).

Semi-structured, as opposed to tightly structured, interviews were used in order to provide more flexibility in questioning and answering as the conversation flowed, while allowing standardisation of interviews in terms of the broad content areas covered (Richards, 2014). This method was important given the aim of triangulating contrasting views of the role and input of interpreters to cover the same broad themes. Investigating individual's experiences holistically and in a completely unstructured way (Kelly, 2010; Minichiello et al., 2008) would not have been appropriate for this investigation, as it would limit capacity to compare and contrast perspectives of the three participant groups.

Based on the research questions and reading of the literature, I developed the interview questions with the assistance of my supervisor and in line with the hospitals' ethics' application guidelines. The hospitals' ethics committees reviewed the interview

questions as part of the application and made comments. I made minor changes in a few questions based on these comments. The focus of the questions was on the following three areas:

- the educational background and work experience of the participant;
- their experience and expectation of working with interpreters (for HPs and patients) or their experience of working with patients and HPs (for interpreters); and
- their reflection on their experience of a good day and a bad day of working with interpreters (for HPs and patients), or for interpreters working with HPs and patients (see Appendix 1.b for the interview proforma).

As detailed in Table 3.1, interviews were conducted with the aim of exploring ways in which health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters, and perceptions of HPs, patients, and interpreters regarding factors affecting the effectiveness of message transfer, outcomes of effective and ineffective message transfer, and the roles interpreters fulfill beyond message transfer.

Interviews with HPs and interpreters were all conducted in English. Persian/Dari patients were interviewed in Persian and those with Arabic patients were facilitated by the interpreter present in consultation sessions who provided immediate interpretation.

Interviews with health professionals were conducted in their own consultation rooms. In-house interpreters were interviewed in the interpreter's room at the hospital, and agency interpreters were interviewed in the agency interpreter's waiting area at the hospital. Interviews with Arabic patients were conducted in a vacant consult room at the hospital in the presence of the in-house interpreter, and those with Persian/Dari speaking patients were conducted in waiting rooms.

The interviews were all tape-recorded using a digital recorder and fully transcribed in an English version. In both hospitals the duration of the interviews was between 30 and 50 minutes. Persian and Dari interviews were transcribed and translated into English by me, whereas those with Arabic speaking patients were transcribed based on the

interpretation of the Arabic interpreter present. The excerpts reported in Chapter 4 and 5 from interpreters and HPs are the participants' original utterances and have remained intact, whereas patients' utterances are based on their translation into English by either me or the Arabic interpreter.

3.6.2 Interpreted medical consultations

While interviewing was valuable in helping to explore interpreters', HPs', and patients' experiences and perceptions of the role/s fulfilled by interpreters in triadic medical consultations, recording interpreted interactions was a complementary method of data collection, which enables examination of medical consultations as they naturally occur. Therefore, it provides a space for a closer and more direct analysis of how interactions take place and are facilitated by interpreters (Bolden, 2000; Estrada, 2014; Li, 2013, Maynard & Heritage, 2005).

Toerian (2014) has argued that even though actual interactions occur in real life, they cannot give us access to speakers' intentions or emotions. Therefore, in this study, I used recordings of interactions in combination with interviewing to explore adequate answers to the research question: "What roles do interpreters fulfill beyond message transfer to facilitate health professional–health service user communication?"

Gaining consent and making arrangements necessary for actual recording of consultations proved difficult. In total, three triadic medical consultations involving a doctor, interpreter, and patient were permitted to be audio- recorded in outpatient clinics at Smith's Hospital. The patients had Dari, Italian, and Arabic language backgrounds. Of the interpreters supporting them, two (Arabic and Italian) were in-house interpreters, whereas the Dari interpreter was from an agency. These recorded interactions were fully transcribed, including glossing of utterances not in English, and could then be analysed in detail to examine, in each case, how the interpreter fulfilled their role in practice. The transcripts and glossing for Arabic and Italian were checked and revised for accuracy by independent bilingual tertiary-educated native speakers. The transcription did not involve the extremely detailed conversational dynamics as would be required for a full conversational analysis (see Ten Have (2007) and Wooffitt

(2011)), as the focus of the analysis of recordings was narrower than that involved in a full conversational analysis. Specifically, the focus was planned to be on what the interpreter does in facilitating the conversation between HP and LEP patient, including the strategies and roles adopted by the interpreter within the interactions.

3.7 Data analysis procedures

The interview and interpreted interaction data were analysed using thematic analysis. There were a number of reasons why I chose thematic analysis as my data analysis tool compared to grounded theory, ethnography, or phenomenology. Due to its "theoretical freedom" (Nowell et al., 2017:2), thematic analysis is highly flexible and, therefore, can be modified to meet the needs of many studies. Another advantage, related to the first one, as discussed by Braun & Clarke (2006) and King (2004), is that it provides an accessible method of analysis suitable for different contexts, including health research.

The often cited steps proposed by Braun and Clarke (2006: 87) were followed in this study. These steps were:

1) Familiarising yourself with your data, by reading the transcribed data several times to become familiar with the contents
2) Generalising initial codes, by coding every sentence in the interview transcripts based on the topic it was discussing
3) Searching for themes, by finding commonalities across the codes which were then put together to form the themes
4) Reviewing themes, by reviewing the developed theme, the researcher ensured the data were sufficient in supporting a theme. In some instances, a theme was broken into sub-themes
5) Defining and naming themes, by naming the theme according to what best described them in relation to the data included
6) Producing the report, by having the final opportunity to support the selected themes being enriched with scripts from data, and relate them to research question and literature review to present a scholarly based analysis.

The results of the analysis of each of the three sets of interviews and conversations are presented in four separate chapters (Chapters 4 to 7).

3.8 Triangulation of the data

In line with Hasting's (2012) recommendations, multiple sources of data collection and approaches to analysing data have been used to enhance the credibility of findings. As mentioned in section 3.1, this research is conducted within the constructivist paradigm where attempts are made to capture multiple realities. Triangulation helps researchers achieve this goal. There are several methods of triangulation, namely: investigator triangulation, which involves using several people in the data gathering and data analysis processes; theory triangulation, which is approaching the data with multiple theories in mind; data triangulation, where the researcher uses different sources of data, including different places and different people to collect data; and methodological triangulation, which uses more than one method to gather data (Wilson, 2014).

In this study I adopted both data and methodological triangulation. I collected data from multiple groups of participants in two separate hospitals. Within group interviews, I attempted to collect data from people from a variety of backgrounds. The health professionals included specialists, nurses/midwives, and allied health professionals. The interpreters were both in-house and agency, serving patients from Persian, Dari, Macedonian, Chinese, Arabic, Greek, and Italian backgrounds. Finally, the patients were from Arabic, Iranian, and Afghani backgrounds. The methodological triangulation was achieved by collecting data from two sources, namely interviews and interpreter-mediated conversations. The integrative discussion of all of the findings in Chapter 8 reflects the outcomes of these approaches to triangulation, as it effectively integrates the findings from the separate data sources and groups of informants.

Chapter Four – Interpreters' Experiences in Healthcare Consultations

The interpreter as sole participant in an interpreter-mediated health consultation has the linguistic knowledge of the patient's and the HP's primary languages, as well as having understanding of cultural and institutional influences on how healthcare functions in Australia and the patient's host country. The interpreter's bilingual and bicultural positioning raises questions about how this positioning impacts on how interpreters engage in their practice and undertake a neutral 'conduit' role and exercise other potential roles in the process of facilitating HP-patient communication. This chapter presents the findings of the thematic analysis of the interpreters' perspectives of the roles they fulfill, or are asked or expected to fulfill by HPs or patients in consultations. Presenting and analysing interpreters' experiences will give their specific perspectives on the contributions they are expected to make as community interpreters. The analysis starts by considering the interpreters' attitudes and experiences of message transfer, the language 'conduit' role. Then it proceeds to identify and discuss other roles that emerge from their experiences, such as in accommodating patients' dialect, educational backgrounds, drawing on their cultural understandings and capacity for cultural mediation, as well as in supporting patients emotionally and improving the atmosphere of consultations. The chapter also will examine an important emerging additional theme that impacts on the way they carry out their roles: how time affects interpreters' practice.

4.1 Interpreter as language 'conduit'

Analysis of interviews with interpreters showed that they primarily conceptualise their role as professionals who transfer information between HPs and patients as language 'conduits'. When describing her role, Sophia, for example, simply said, "I'm just an interpreter" highlighting the core of her role, that is, language transfer. Using the metaphor of 'linguistic pipe', Eliza explained: "You're just there as a linguistic pipe and that's it, nothing more. You're just facilitating for the language barrier, and you give it from language A to language B, and that is where you stop as an interpreter". Akbar communicated a similar view by expressing his active avoidance of addition or

exaggeration: “Not exaggerating, just word by word interpreting, and not adding anything to what is being said”. Emphatic expressions like ‘just’ in Sophia’s and Eliza’s words and ‘stop’ in Eliza’s response show that these interpreters saw their role as solely that of a neutral language ‘conduit’. The main observation from how these interpreters describe their role is their commitment to transferring the exact message from HP to patient and vice versa. However, their presentation of the role in this way also minimises and devalues the complexity of the task of transferring information accurately between two distinct languages. It also potentially ignores other contributions they make in facilitating HP--patient communication.

In conceptualising their role as one of direct message transference, interpreters drew upon a range of metaphors, and valued having clarity in their role. Akbar likened his role to that of ‘a messenger’. Others, giving their role an explicitly mechanistic status, used metaphors like ‘a pipe’ (Eliza), ‘an instrument’ (Parvaneh), and ‘a channel’ (Hilda). Such evocative metaphors also appeared to help the interpreters define the boundaries of their professional role. Eliza focused on the importance of having such a clear boundary. Her experience has been that patients would ask her to serve in other roles, such as a support person or to advocate for them:

> You’ve got days that your patients don’t know your role or they want to ignore your role and use you like a little puppet, like, ‘I want to be seen quicker’ or ‘can I see this doctor? because I like her, she was a nice doctor’.

Having a clear professional boundary enabled Eliza to feel authorised professionally to reject such requests.

Emphasising neutral message transfer as their core role, some other interpreter interviewees highlighted that part of their attempt to fulfill this role was to maintain the level of linguistic complexity and HPs, or patients, communicate:

> You interpret what they are saying …you interpret it in the same level as your client is speaking whether that’s high register, whether that’s low register, that is the level that you’re staying, whether that’s the professional term whether that’s the medical term. (Anja)

> As interpreter we are not supposed to downgrade the languages to make the other party understand…. (Hilda)

> It’s not up to me if they [patients] don’t understand. They have to tell me they don’t understand. If they don’t understand, I refer back to the doctor… (Silvia)

From the perspective of all interpreters there is intrinsic value in them functioning as a language ‘conduit’ by directly, and as accurately as possible, interpreting the words of one party to the other. They valued transparency in the quality of communication taking place between the HP and the patient. Transferring the message, even when it was irrelevant to what HPs expected, was mentioned by a few interpreters as a sign to the HP that the patient had not understood the message as expected. For example:

> …In consultation the doctors will ask you for some follow-up questions and … from the answers the doctor will know the patient actually didn't understand what he or she said. (Hilda)

Hilda’s reflection implies the significance of the conduit role in enabling the HP to accurately gauge the level of that patient’s (mis)understanding of them. Parvaneh and Mary express, similarly, an obligation to interpret what is actually said accurately, regardless of its truth:

> Even though sometimes you see things that are not true, but again you are an interpreter, so you pass it on to the professional…. but again my role is just to pass it on. (Parvaneh)

> To make the information known to the patient but not compensate about the accuracy and the context. (Mary)

Finally, committing to a message transfer role meant avoiding giving or asking for additional explanations. Anja, for instance, said, “I don’t offer an explanation; it is not my role to ask questions of clarification”, and Parvaneh said, “They want direct [communication], without adding or deleting any information”.

Even though interpreters’ excerpts presented here demonstrate their level of commitment to remain in the language conduit role; in the next section interpreters demonstrate inevitable cases where they moved beyond the conduit role to provide a meaningful communication.

4.2 Moving beyond the conduit role -- linguistically

For the purpose of patients’ comprehension of the medical issues interpreters described moving beyond the conduit role linguistically. This occurred in some circumstances

when accommodating patients' dialects and/or registering that that suited their comparatively low level of formal education.

4.2.1 Dialect accommodation

Whilst adding further complexity to the 'conduit' role, interpreters often were required to accommodate the patient's dialect when the language was pluricentric, such as varieties of Arabic or different derivations of Farsi language in the form of Persian and Dari. To assist their patients, some interpreters, whose language is spoken in different dialects, report modifying their own original dialect to accommodate the patient's dialect in order to improve their understanding. Chinese, Farsi, and Arabic interpreters had experienced dialect accommodation due to seeing patients from different parts of the world. These interpreters reported using the vocabulary or imitating the accent of the patient's dialect. Parvaneh expressed her views as:

> The dialect is a bit different … but if you have studied you know there are differences in the words so you'd be able to help them [patients] as well. (Parvaneh)

Hiba, an Arabic interpreter, was generally expected to interpret for patients from many different Arabic speaking countries. Although she reported that some patients (in this case Sudanese) only accepted interpreters from their own country. As Hiba explained:

> We speak so many dialects and when paged we have to sort out the right dialect in the consultation. Some Sudanese patients speak Dinka and when there is no interpreter we try to help and ask if they speak Arabic and if they do we interpret; however, patients from southern Sudan hold pride and only ask to have the interpreter in their language. The best service to the patient is respecting the patient. (Hiba)

As Hiba emphasised the hospital aims to provide interpreting services that best satisfy patients, even though this is not always possible.

Dealing with dialectal differences was not explicitly mentioned by any of the interpreters as an insurmountable barrier to them carrying out their interpreting role. They tended to see modifying their dialect, or variety, as part of the care and speech accommodation that interpreters were willing to provide for patients. At the same time, the patient was ultimately in control of accepting an interpreter, and could express a

preference for an alternative interpreter if mutual communication was difficult as a result of varietal or dialect differences.

4.2.2 Accommodating the patient's educational background

Almost all interpreters interviewed in this study described having dealt with patients coming from different educational backgrounds, and discussed how this affected how consultations would go and how they would fulfill their role as interpreters. In the case of some interpreters, such as Eliza, Silvia, and Sophia, their patients had come from rural areas to work in Australia at a young age, not having developed a good level of literacy in their own language or English. Consequently, these patients would struggle to understand what was interpreted into their languages in transferring the HPs messages in the HP's register. Regarding elderly Italian patients, Sophia explained:

> The majority of my clients only went to school the equivalent of, if they're lucky, grade 4 or 5, so you're talking about 9 or 10 years of age if they were lucky. If they were very unlucky, they were just tossed in[to] the farms and working at 5 or 6 years of age. So not only are they are illiterate in English, they are illiterate in Italian also. …so that makes it hard for concepts and to understand just basics, taking medicines, when not to take them and all those sorts of things, …when it comes to signing documents at the banks, signing authority forms, understanding procedures, understanding operations, that's when they need assistance, and that's when an interpreter should be called.

Other interviewed interpreters also had to deal with patients who had a poor level of education and which they experienced as negatively affecting HP--patient communication. More precisely, the low educational level of these patients would make it difficult for them to understand the medical terminology and jargon HPs tend to use. Silvia and Eliza shared related experiences:

> They don't have the educational levels to understand what's going on, so the doctor might say something and would be very clear and then I'll explain it in a very clear way as well but the patient still does not understand. (Silvia)
>
> They are mostly illiterate or they have just finished, if they have finished the primary school, then they will be most specific terms like the doctor will be speaking about bladder but because they have never heard the bladder before, they think, '*aah they're talking about blood'*, and…they think they can hear what they think they wanna hear. (Eliza)

When encountering patients from low educational backgrounds, most interpreters report adopting either of two distinct and contrasting approaches: 1) maintaining the technical level adopted by HPs, assuming they are not responsible for suggesting changes in HPs' discourse, or 2) trying to convince the HPs to simplify their language. However, no one suggested that they would simplify HPs' discourse in their own translation without seeking the HPs' agreement. Regarding the first course of action, Anja said,

> The way we have been instructed, and as a professional, you interpret it in the same level as your client is speaking, whether that's high register, whether that's low register, that is the level that you're staying, whether that's the professional term whether that's the medical term… I don't offer an explanation; it is not my role to ask questions of clarifications.

This excerpt shows Anja's strict adherence to translation of the register of the HPs' input as it is in the source language as her sole role. Neither does she offer simpler explanations nor does she ask the HP for further explanations.

Some interpreters' exposure to different communities within their language group has given them insight about how to accommodate patients according to their language needs. Two examples were reported by Parvaneh and Mary. Parvaneh distinguished between her clients' backgrounds in relation to the level of assistance they required by saying, "Afghani people, for any reason, they need more help". Mary showed a lack of interest in taking the initiative to ask the HP to simplify their input, although she admits this is sometimes necessary:

> I found the education [level] from Hakka [speakers] is very low so you really have to negotiate and bargain with the professional before interpreting, say, 'the background is as such, would you mind when you explain say it in simple phrases and themes?'… I would …, leave it to them [HPs] to do.

The difference between their positioning in these two quotes is that one interpreter (Parvaneh) is proactively volunteering her help and assistance to people from Afghanistan, whereas the other (Mary) is proactively and progressively moving forward by focusing on setting up the HP to be aware of the low level of education in Hakka speakers, and requesting simplification in HP communication style.

While Eliza, like Mary, would "keep the register as it is", she also reports adopting the second approach by trying to convince the HP to simplify their discourse first through interpreting the patients' puzzled remarks and then explaining the situation to the HP.

> I want the doctor to understand that she [the patient] not understanding is not through me. She [the patient] would say 'Uhhh I didn't understand what she [the doctor]'s saying', and I say [to the doctor], 'Sorry I didn't understand what you're saying', and that's how it goes; otherwise, I never ever lower the register in any case…

Eliza also talked about her other strategy in how to ask the doctor for simplification by having a direct conversation about the patient not understanding the message,

> If you mention something … and she [the patient] talk about something else … you ask … the doctor, 'Excuse me can you please simplify a little bit so I can give it to that patient?' Otherwise I don't want to lower the register…

Hilda and Sophia describe adopting a similar approach to rectifying this type of situation by actively engaging HPs about the patient's response.

> When I find that there is some miscommunication or misconception in either of the parties, usually I will raise the issue and explain to the professional 'probably the patient may not understand what you really mean.' (Hilda)

> If I interpreted something and I get the impression or by the answer that they didn't understand, I say to the professional. I obviously interpret what was said and then I say 'Do you want me to ask it in another way?' or 'I don't know if it answered your question'. But I always ask the professional if I should interpret in another way, change my language perhaps. Yeah, that's what I do, when either myself or sometimes the professional gets the impression the client didn't understand. (Sophia)

Akbar also alerted the doctor that the patient has not understood the message as he said, "I ask him [the patient], 'Did you understand?', if not then I ask the doctor to rephrase the question again and then the professional turns it around for explanation".

Some other interpreters, like Mary and Anja, describe how they more often deal with highly educated patients; therefore, the transfer of HPs' messages to them was less challenging. Mary, for example, considered Mandarin speaking patients as coming from a higher educational background than her other patients: "In the Mandarin group the education is much higher. They (patients) are aware of very high level of terminology … because the register… is the same [as that of HPs]".

Anja reports having noticed an increase in the educational level of Yugoslavian immigrants to Australia after the recent conflicts compared to those who had immigrated to Australia in the past. This had made her job of interpreting in medical consultations easier:

> In my situation, there was a war in the former Yugoslavia, so people were coming and I've noticed that the level of interpreting, linguistically for me has changed since that time. People are very highly educated so you have engineers, lawyers, doctors who come, who use incredibly different terminology to the terminology [Yugoslav background] people used to use.

Most interpreters also shared positive experiences of having dealt with patients who did not have difficulty understanding the translations of HPs' questions, because they had received good education in their home countries. As a strategy to deal with educated patients, a few interpreters reported needing to educate themselves in order to be able to facilitate HP--patient conversation using the same high register through which these patients would communicate their medical problems to HPs. Anja explicitly mentioned her need for self-improvement to deal with highly-educated patients, "In fact, I had to improve in order to do just as what they say because you interpret what they are saying. The way we have been instructed and as a professional, you interpret it in the same level as your client is speaking".

Consistently, the interpreters criticised extra roles assigned to them by HPs or assumed by patients, and claimed to prefer to remain in the neutral language 'conduit' position. However, this expressed preference was not always reflected in their subsequent actions. Despite the strong and clear focus on message transfer as their core or even sole role, interviewed interpreters talked about roles beyond that of conduit they were sometimes expected to fulfill or the dynamics of the consultation led them to shoulder, mostly unwillingly.

4.3 Moving beyond a conduit role -- cultural facilitator

Interviews with interpreters revealed that their cultural knowledge and background has assisted them to shape and maintain their professional performance in varied cultural dimensions of how they engaged with patients and HPs. These dimensions related to implementing culturally respectful professional practices, interventions focused on

their relationship with patients, and HP--patient communication. For example, some interpreters described their different personal presentation strategies when dealing with difficult patients (self-management). The interpreters explained their strategies and clues about when to intervene and in the HP--patient consultation.

4.3.1 Implementing culturally respectful professional practice

Some interpreters' involvement in rather difficult consultations required them to engage with managing the situation, drawing on their cultural awareness and understandings. In such situations, their focus was on how to manage their image of professionalism, as well as developing and implementing tactics, to be accepted and respected as professionals. Some interpreters discussed these strategies as enabling them to act professionally, but supportively, around CALDB patients in three main ways: by respecting the patients' cultural beliefs, establishing boundaries without giving offence, and also being tolerant of patients' behaviours.

Awareness of and respect for cultural beliefs was considered important in how interpreters self-managed in their interpersonal interactions with a patient/client. For those interpreters who were interpreting for patients practising different religions, demonstrating respect for each patient's belief and values, this was evident in the way they interacted. For example, Arabic-speaking but non-Muslim Hiba reported accommodating her appearance and assimilating her personal habits (e.g. drinking water) to her patient's assumed expectations of religious observance:

> It is our culture. Interpreters from Eastern culture [are] reserve[ed] in dressing and can't be exposed, [sic] be indirect regarding religion, for example, during the month of Ramadan, drink water before you attend the appointment if I am thirsty. It is no good for the outcome of the session if you don't consider these matters. (Hiba)

Establishing boundaries in their relationships with patients was important for the interpreters, but they discussed the need for awareness of cultural expectations in managing the interpreter–patient relationship respectfully. The interpreters strategised tactics to maintain personal distance from their patients in order to retain a sense of professional detachment and neutrality. One way to achieve this was by deliberately avoiding conversing with the patient before the consultation. As Hiba explained, "I

have no interaction before consultation with the patient. When you break [sic] familiarity it breaks the content”. In some contexts, the interpreter may be required to sit with the patient while waiting for the appointment. Hiba reports adopting some specific, culturally respectful tactics to avoid conversational engagement with the patients in these circumstances:

> I always take a book to read when I need to wait to see the health professional so that I don't talk to the patient. I don’t read magazines because the husbands look at the pictures in the magazines that I am looking at and there are advertising women's underwear in magazines so I take a book to read, something that does not indicate any religion or anything else form the cover and I say that I need to finish translating this book tonight. This way they can see that I am busy and I don't answer the questions they ask me such as when did you come to Australia? Do you have husband?

Interpreter--patient boundaries may also be challenged or transgressed through an expectation that the interpreter will run errands for patients. Both Hiba and Eliza reported confronting this expectation and developing tactics to deal with it. As Hiba explained, “It's not my role to take the patient to places. My role is to interpret”. Similarly, Eliza shared her experience as,

> You only act as a linguistic pipe … otherwise they [patients] think that you would step and … do something else like, … ‘can you please see where I am or if the doctor will see me next?’ or ‘can you do something because I’ve been waiting?’

As part of the tactics they used, they both tried to keep their boundaries by not involving themselves further than interpreting. Eliza further added that she reminded her patients about her role:

> You facilitate for the language barrier … and there is where you stop as an interpreter… you’ve got days that your patients don’t know your role or they want to ignore your role … you say ‘no sorry it’s not my role’… if you are worried you can go to the clerks and ask, we can then go to the nurse and ask together…

Hiba further reports the importance of explaining how the hospital may be able to assist with the patient’s non-interpreting needs, by indicating “there are hospital facilities such as volunteers who are assigned to do these things, to show directions”.

Poor behaviour of the patients was sometimes reported as being experienced by interpreters and they appreciated, based on their cultural understanding, that the root of these difficulties was the traumatic experiences people from some nations had been

through. In this regard a few of the interpreters had encountered patients who acted impolitely towards them. In encountering such patients, Akbar, for example, said, "Some patients are very hard to deal with, they are aggressive, and you have to cope. Some patients are abusive", but expressed his tolerance and understanding of their background experience and living conditions, drawing on his cultural awareness. Other interpreters, such as Hiba, Silvia and Eliza, also described situations they had experienced that required them to tolerate some less than respectful reactions of patients, as Silvia said, "they [some patients] don't understand how their body works, quite ignorant about lots of things so because they're old, they can be quite difficult. Sometimes they can be a bit aggressive; they get a bit angry". Sophia described tolerating a patient's husband's refusal of her assistance as an interpreter in a psychiatric setting while she had to remain in the session, listening (calmly) to his rude remarks to the doctors:

> The husband was called in because the wife had mental health issues ... to see a psychiatrist and myself, … he said, 'I don't need an interpreter' and I said, 'well I'm sorry, I'm here and I'm staying, I've been booked'… he spoke in English made all accusations against doctors… I was embarrassed … to be an Italian … because he was very rude and judgemental … The interview was over in 10 minutes … I went home but I felt pretty bad…

4.3.2 Implementing patient-focused cultural interventions

Interpreters also describe practices that draw on their cultural knowledge and insights in engaging in some patient-focused interventions. They describe actions they engage in to facilitate and manage successful interactions, specifically through facilitating patient responsiveness as well as understanding and awareness of female patients' gender issues.

Facilitating patient responsiveness

Some interpreters reported situations where they facilitated culturally bound patients' responses for HPs. This type of facilitating involved the interpreter in compensating for patient characteristics perceived as being culturally bound (e.g. culturally reserved patients). Specifically, the interpreters sometimes reported needing to be proactive in facilitating the transfer of HP messages. From the interpreters' experience, cultural issues that related to the health and hospital context may cause patients to feel inhibited

and therefore reluctant to speak up. The interpreters' awareness and sensitivity to presumed causes of such patient behaviour have resulted in strategising around their patients and the interpreter acting according to their interpretation of the patient's cultural values and beliefs. The variety of responses, highlighted in the examples below, are indicative of the range of possible approaches to facilitation. For example, in communicating bad news, Parvaneh explains that:

> Many years ago if one of your relatives is dying, normally the professionals [are] not saying it in the face of [sic] the patient that you have a terminal illness and you won't live more than six months, but… this is a cultural issue and I know this happens here as well that some from Anglo background, they try to discuss those cases with the relatives [rather] than with the patient directly. As an interpreter, … you are living in another society which is different, … but probably you don't put it in a very blunt way using very harsh word[s] … you have to choose a phrase which makes the same meaning and the exact message.

In this case, Parvaneh is describing a situation in which the HP has given a direct, harsh message to be interpreted, but the interpreter feels the need to subtly modify, so as to not give the same message so harshly to the patient, due to her background knowledge of the patient and inappropriateness of giving such messages bluntly from a cultural perspective.

Referring to her background knowledge, which leads her to judge some clients as being too shy to ask for further assistance, Parvaneh describes how she tries to find other ways to assist the patient in understanding everything clearly in the consultation:

> ...Culturally we are too polite sometimes. I am assertive so I ask my question. Even though they may say 'yes' you can read from their faces. At the end when the professional say[s] any more question[s] on the same topic, I repeat it again so they have the chance a few times to ask their question. If they don't, sometimes I ask for pen and paper from the professional and I write it down and hand it to the patient so it makes it easier for them and I'll be happier to leave the room.

Sophia gives the example below in relation to her patient's cultural characteristics:

> In our community when a client doesn't have an interpreter they'll just say 'yes everything is good everything is fine'; they make a general statement but then when there is an interpreter there then they can express themselves, they tend to ask more questions, probably [they] feel a bit more confident.

Compared with Parvaneh's experience, that patients may not ask questions even in the presence of an interpreter, Sophia's experience is that the clients may not communicate

their concerns without the presence of an interpreter. Such subtle differences in how interpreters are involved in interventions to facilitate patient responsiveness result from the interpreter's knowledge and judgement of people in that respective community and the likely effective ways to maximise their engagement with the HP's communication. These interventions based on their personal judgement of the dynamics of the communicative exchange in context, take their role well beyond that of neutral language 'conduit'.

Awareness of patient gender issues

Culturally based understanding and knowledge of gender relationships also causes interpreters to move beyond their neutral language 'conduit' role. A range of contexts all related to the gender of patients, including the positioning of women and men in the community they have come from—such as gendered conventions in various socio-cultural situations, and/or the patriarchal social context of the patient—impact on how interpreters engage and behave. Their knowledge in this regard is reported to have enabled them to resolve gender-related situations when they arise, specifically in relation to gender expectations and preferences, providing encouragement to a female patient, and dealing with the presence of a dominant male companion.

Interpreters express the view that they have cultural understanding that provides them with the tools to act appropriately in dealing with gender issues. For example, awareness of gender preference prompted Akbar to realise his female CALDB client was feeling uncomfortable, so therefore he opted to leave these consultations because the nature of the assignment was related to female issues:

> Having female patients is challenging, cultural barrier stops the male interpreter to explain the terminology to female patient. If you don't interpret, it is not a good thing because you are bound to do it, you have to interpret but sometimes you can't, because if you do, the patient feels uncomfortable, specially in giving birth and related issues.

Jafar, another male interpreter who did not make as many comments overall as the other interpreters, nevertheless expressed similar concerns about interpreting for female patients on female specific problems: "Also some people are shy to mention some of their problems to a male interpreter".

In another example, Parvaneh expresses her consciousness of the need to respect sensitivity to undressing for male patients when they are being examined by the doctor:

> You see if a male [patient] just wants to undress in front of the specialist… you know what to do as an interpreter…we go behind the curtain, even the professional doesn't care but you look after that area and try to go by cultural aspect …of you and … a patient, female and male.

And Sophia talked about her experience with some of her older female patients:

> Their doctor might be male or might be English speaking so because it's seen as a female personal thing they [female patients] sort of suffer for quite a few years until perhaps they see a female doctor, or there's an interpreter there or there are [sic] some sort of trust and they say, 'look this has happened' and that has occurred a few times… .

These examples indicate the extent to which interpreters understand the sensitivity of gender-specific issues that their patients may be facing and accommodate their behaviour within the consultation to the patient's level of comfort with their involvement.

The preceding discussion presented examples where interpreters observed shyness in their patients and accounted for that in their interpreting practices. Another contribution that Eliza was passionate about was her role in encouraging older female patients. She discussed situations where patients who came from traditional cultural backgrounds were challenged and uncomfortable as a result of gender disparities. Eliza recounted how she was able to encourage her older female patients to see a male doctor and to support another patient to discuss her issues directly in her own English with the doctor. The interpreter had socio-cultural understanding of the backgrounds of her patients. She was able to assist them by supporting them and encouraging them not to be afraid and to try what was available to them medically. As she reflected:

> When I first started I remember more women wanted to be examined by woman. I remember this clearly but now although they're embarrassed, they keep saying to me, 'I am embarrassed' but I politely say to them, 'the doctor, he will try to be as quick and as gentle as possible' and they [doctors] do, … the doctors are very nice and [you] smile to[wards] them and say, 'don't worry it'll be a few minutes'. I see that they understand where they are coming from and they try to pacify their worries as well… .

At times when a male companion was present with the female patient, one interpreter reported experiencing different dynamics within the consultation. Hiba explained that when a patient comes from a male-dominated society in Arabic speaking culture and a female HP is not available, the male companion may create problems: “When the woman goes by herself, it goes smoothly. But in a male dominated society, they ask for female doctor and if a female doctor [is] not available, he [the male companion of the female patient] creates a bad atmosphere”. Hiba further described how she would arrange the seating in the consultation room, drawing on her cultural knowledge, with the aim of facilitating smooth communication irrespective of the presence of a male companion:

> When men come to consultation room I set it up by three chairs in a position that I situate the chairs in three-point position. I am the professional too so there are two professional[s] in the room creating a three-point set up like. If he interferes, the professional, then I have established my seat so that I interpret to the patient. For more lengthy discussions the health professional needs to learn to develop strategies and make shortcuts.

Due to her cultural understanding of the patients’ background, by the seating arrangement, to shape like a basic triangle where the main three participants of HP, patient and interpreter would be sitting in one corner of this assumed triangle, the Arabic interpreter was able to bring the focus back towards the female patient.

4.4 Moving beyond a conduit role – cultural mediator

Cultural understanding appeared to influence the interpreter’s practice in such a way that some interpreters mediated the HP--patient communication to clarify cases of cultural barriers in patients’ understanding of the message. In this regard, the interpreters may engage HPs in different ways in order to enhance cultural understanding, thereby acting as a cultural mediator.

Interviews with interpreters showed that patients’ cultural background had effects on the efficacy of their interpreter-mediated conversation with HPs in more than one way, and this sometimes entailed interpreters adopting roles beyond mere message transfer. In the next section, I initially focus on the interpreters’ reported mediation of patients’ cultural understanding within the consultation, and then on how interpreters themselves

made attempts to foster improved cross-cultural communication between HPs and patients.

4.4.1 Mediating for cultural clarification

Interpreters at times reported feeling the need to simplify medical concepts discussed in the consultation, so the patient could understand it. Interpreters reported that most often they shared with HPs the patients' cultural conceptualisation of specific types of disease prior to entering into the act of simplifying the concepts. Silvia, Eliza, and Mary each reported having faced the challenge of facilitating HP--patient communication due to patients' culturally constructed conceptualisations of medical concepts. One example is Eliza's experience of what it means for the patient to have a benign versus malignant tumour and to make the HP understand where the concern of the patient originated from. In this patient's Greek culture, gender roles are assigned to malignant and benign cancer cells, considering malignant cells to be female and benign ones to be male. As Eliza describes:

> When we're talking about cancer, malignant is the female; that's how they know it. Malignant is a female and benign is a male. So when the doctor would say, 'aah, you've got a malignant tumour' and I'll say your tumour is malignant, they would look at me and go 'Is there a boy or is there a girl? Is it a male or female'? And I'll say back to the doctor, she asked me 'is that female'? and I told them malignant. … 'no no no you tell them it's malignant, it's bad for example, bad'. And I just say it's bad. 'Yes but you haven't told me as yet is it a bad? Is it a boy or a girl'? So tumour comes as a boy or a girl in their culture. It doesn't have [to] but because it has been introduced to them since little kid, since they're kids and now they are in their seventies, no matter what you're going to say, whether it's good or it's bad, they know it as a boy or as a girl and no matter what you're going to do, no matter what you're going to say, they could be like, like having malignant and you have to tell them it's a bad one, still you haven't explained to me [whether] it's a boy or if it's a girl. I said to doctor 'Sorry, can I say if it's a boy or if it's a girl? Okay go ahead'. I say it's a girl, for example, if it's malignant.

Some patients were reported to be traditionally attributing certain symptoms to certain medical conditions, which made it difficult for interpreters to convince them that the cause was different from what they thought. Mary recalled interpreting for a Chinese patient who considered purple nails to be a symptom of a heart condition, while, in fact, the change in the colour of nails was due to chemotherapy. In the quote below, Mary

highlights how challenging it can be to convince patients they have an inaccurate interpretation:

> The treatment they [HPs] proved for the patient also needs the patient to have a sound heart in order to receive certain therapy. This can really create some kind of hurdle because when a patient has this perception that I might have a heart attack soon, when you interpret it, she constantly avoids [listening and following] the information. She [the patient] just focuses her mindset that I'm having this [therapy], so it really makes the information hard to properly digest.

Silvia had found it difficult to elicit information from an Italian patient about how much pain she was going through since she did not rate pain; rather, she looked at it in a black and white way:

> Italians tend … when they're sick, they really say that they're sick. Like, you know, in general, not that they exaggerate, but you know, pain is pain; they don't understand the pain scale. For example, when you ask them the question, "what's your pain from 1 to 10?", it makes no sense in Italian because you either have pain or you don't…., we don't grade pain. You either have pain or you don't, you have a lot of pain or you have pain. One to 10 doesn't really have much sense.

Some interpreters were able to distinguish through their cultural knowledge that some medical concepts in the patient's cultural background do not exist in the target language culture, and recognised that clarification may be required for their patient's better understanding. However, it was not possible to gain full insight about what they do with such cultural knowledge within the interactions, as none of the interpreters explicitly mentioned intervening to resolve such misunderstandings, despite their stories suggesting they sometimes did intervene. Reluctance to discuss their exercise of cultural mediation in such situations appears to be mainly due to their claimed adherence to their primary role as being a language 'conduit'. Therefore, whilst the interpreters were able to recognise such cultural issues in how illness and medical problems are conceptualised and understood the confusion between patient and HP, they usually did not claim to do anything proactive to resolve these misunderstandings. Three only ever reported intervening to assist as cultural mediators in a medical related cultural misunderstanding, and reported doing this when it was clearly causing a significant breakdown in communication between the HP and the patient, such as in Eliza and Mary's examples above.

Interpreters' cultural awareness positions them uniquely to be able to distinguish whether cultural stigma is preventing a patient from showing distress or accepting treatment. For example, a few interpreters discussed that due to their knowledge of the importance of cultural factors or stigma attached to some diseases, they were aware that the patient's behaviour towards treatment related to how the disease was understood culturally. Despite their cultural understanding, these interpreters did not attempt to intervene to resolve cross-cultural differences.

Mary shared her experience of interpreting for some Chinese patients who would not agree to have their gall bladders removed, because in traditional Chinese medicine a gall bladder determines one's degree of courage:

> We know the gall bladder operation is very common. These days many people had their gall bladder taken out but the truth of the matter [is that] the Chinese take it very seriously and it always sounds a very scary thing to do because [the] gall bladder, unfortunately in the old days, they think that's the origin of your strength and your courage. So when the doctor says I've got to take out your gall bladder they just freak out, saying 'my goodness I'm going to be sort of zombie now' and they really reject it and that happened.

The concept of gall bladder and its metaphoric meaning has been discussed by Yu (2009) as an internal organ that originates in traditional Chinese medicine for determining the person's courage. It is believed that the gall bladder contains energy, courage and decision-making properties as a cultural concept and its removal would mean that the person is without courage. This cultural conception of gall bladder was in conflict with the treatment the HP suggested to the patient, as discussed by Mary. However, she did not mediate culturally in her role as an interpreter in this case. It is the understanding of the researcher that Mary chose not to try and mediate culturally to persuade the Chinese patients to change their decision, although from the researcher's non-Chinese cultural perspective, this could precisely be a situation where cultural mediation might be helpful. Mary's appreciation of the patient's valuing of the gall bladder to their life and awareness of her official role as the interpreter appears to have made her reluctant to get involved in addressing this cross-cultural dilemma.

Another example comes from Sophia who pointed out how the issue of mental health is considered a cultural stigma and a source of embarrassment among her Italian clients:

> There is still a stigma in Italian society, in Italian culture that if you go to a mental hospital you are mad. There still seems to be stigma and they don't want people to know. They probably say, 'oh he went to a hospital for two weeks' but they won't say what hospital [e]specially, if it is a mental hospital because they just categorise it as mental[ly] insane. There is no distinction between an anxiety attack or mild depression or severe depression. It's all categorised as mad, so if there is someone in the family who has been hospitalised, especially in a psychiatric setting, it tends to be hush hush.

In the abovementioned situations neither interpreter attempted to mediate culturally due to their insights into the value and cultural sensitivity toward medical issues involved for the patients.

While the above examples are related to patients' cultural beliefs and traditions, Hilda observed how differences in organisational structures and respective cultures of healthcare in China and Australia may present the process of consultation with challenges:

> Sometimes they [patients] don't understand very well the concept of what the doctor means even though a word like bank or hospital or the health system in Australia; we can translate this word into our language, but what it means to the patients may be different to what they expect. The concept of the service is very different. Those who are from China, when they're sick they go directly to a hospital. They don't have that GP system but here when they see a professional here, they say, 'aah if you have any problem first of all you have to go to the GP and get a referral to see a specialist'. So they don't understand 'why should we do that? We're sick we just go to the hospital, we don't even need to make an appointment, we just queue up to wait for our turn'. So [it is] very different and then it takes time for them to understand, okay, this is Australia, it's different.

In response to challenges presented by the cultural beliefs and previous health practices of patients, the majority of interpreters reported being expected by HPs to go beyond the role of message transfer and mediate consultations culturally. Specifically, the interpreters explained that, due to the impact of culture on patients' way of thinking about their health, some HPs expected them to serve as cultural informants or encourage patients to accept the proposed treatment, using their insights about the patients' cultural background, beliefs, and values. Hilda, for example, said:

> Sometimes they expect us to act like a channel, like a cultural channel or linguistic channel for them to communicate the ideas or some concepts that are not familiar in the patient's background so sometimes after the consultations they would ask us some questions about whether the patient understands what we are talking

> about or they would ask us some ideas [about] what we think, like not really expert but they sort of consult us as a person who is more familiar with the culture of the patient.

In this excerpt, Hilda suggests that HPs may be interested in knowing “what [interpreters] think” and their “ideas”. This choice of wording clearly suggests that interpreters may be asked by HPs to contribute to the content of the consultation as cultural informants.

Mary explained another aspect of the interpreters’ cultural role:

> Sometimes they [HPs] expect you [interpreter] to take sides: ‘Try to’, for example, ‘convince this patient to accept this, this and that’. That's not our role. I'm sure even though in the in-house area but in other areas it happens as well. But often when doctors are frustrated that certain things can't be done in a way of certain procedure, certain therapy and treatment, if not done it can cause potential harm to patient, they sometimes expect you [interpreter] to achieve that task. They [HPs] should be the ones to do it.

In this excerpt, Mary focuses on HPs expecting interpreters to draw upon their shared cultural background with patients in order to serve as persuaders and help frustrated HPs “achieve that task”. On two occasions, she makes it clear that this is the HPs’ rather than the interpreter’s role, thereby expressing her unwillingness to shoulder this responsibility. She went on to show her lack of willingness by saying, “Our role is still mainly the facilitator of language, not really the cultural expert professional”.

In contrast, some of the interpreters were not against taking on a role of cultural mediation. In this regard, Anja said, “I assist if it’s something relating to the culture”. The above excerpts by Mary and Anja indicated that sometimes HPs request interpreters to persuade patients if the HP perceives the matter to be cultural or perhaps a linguistic barrier to acceptance of treatment. Other times interpreters would initiate mediation due to their awareness of the culture, and knowing that the matter is culturally related. Interpreters seem to be monitoring the interactions and communication in relation to culture related barriers, and are selective in their choices to intervene by being proactive in trying to mediate the cultural divide.

4.4.2 Mediating to improve the atmosphere of the consultation

As part of acting as cultural mediators, some interpreters reported the positive consequence of their mediation in creating a pleasant atmosphere for both patients and HPs. This role some interpreters reported fulfilling was to improve the dynamics of communication between HPs and patients, by consciously intervening to assist in creating a more relaxed atmosphere. Compared to the previous roles discussed, more interpreters expressed their willingness to take this on. Mary and Sophia, for example, said that they would try to calm stressed patients through slowing down the conversation and assuring them that things would be okay:

> If I have a patient who is very anxious, if I speak like a machine, she would not understand. Quite often I slow it down. I still put the information across but slow down the process. By doing so mentally you also affected the calm because when the interpreter slows, they have to slow as well, so does the [health] professional. (Mary)

> Sometimes when you go into people's homes with elderly they think that you're there to put them away in a nursing home. So as soon as they see a nurse and interpreter or doctor, they think that they have to sign everything away to a nursing home so sometimes when that's explained at the very beginning of the interview that if they desire to stay at home … then all the support and service to try and help them stay at home and once you get over that, then the client is more relaxed and the communication moves more smoothly and the client feels well. (Sophia)

As a female interpreter, Eliza was faced with the situation where female patients would share their concern about being seen by male HPs with her, putting her in a welcome position of sympathising with and soothing them:

> When I first started, I remember more women wanted to be examined by women. They keep saying to me 'I am embarrassed' but I politely say to them 'the doctor he will try to be as quick and as gentle as possible'. (Eliza)

While Eliza's experience sheds light on how an interpreter starts to impact on a consultation even before it starts, Mary's experience shows that interpreters can exercise control over the process of communication by somehow determining the speed at which it happens and thereby alleviating patients' anxiety.

Emotional relaxation in the consultation was not limited to patients. Interpreters like Parvaneh, for example, expressed how emotionally relieved she was to be the

interpreter in the consultation: "There are lots of cases that you feel so relieved that you are explaining". The interpreters were well attuned to the level of stress and discomfort in some patients, and realising how their presence could assist in creating a sense of support and calmness in distressed patients, they proactively adopted strategies to improve the atmosphere of the consultation for the patient.

4.5 Interpreter as patient supporter

Another role that some interpreters reported being asked to fulfill, specifically by patients, was serving as their support person. The expectation of the patients was that they would act like a family member or a friend by giving emotional and practical support. Most interpreters disliked being asked or expected to take such a position and were only interested in remaining as a language facilitator. Some of the interpreters, such as Eliza, explained how she would deal with such expectations by reminding her patients what her role is and advising them where to go at the hospital for further information and support. Other interpreters did not elaborate further, despite being given the opportunity to explain how they dealt with such situations.

> Sometimes they [patients] expect me, as interpreters I think in general, to be like social workers or advocates… the client [needs] to understand we are there as their interpreters; we are not there as their social worker or sons or daughters or there to advocate for them. (Sophia)

> Sometimes they will have this misconception about the interpreters, they think you speak our language so that you are our people…. 'You speak our language,' … they [patients] think … 'you may understand me more or sometimes you speak on my behalf.' (Hilda)

> They expect a lot, that you're their friend, you know, that you give them sympathy; … they don't see you as a professional, they see you more as like a helper, … you're like their daughter. (Silvia)

> Because they see a person from their home country or the same language they expect you to just listen to extra information here and there. (Parvaneh)

> You've got days that your patients don't know your role … and use you like … 'I wanna be seen quicker' or 'can I see this doctor because I like her she was a nice doctor before' … and you say 'no sorry it's not my role I can't'… 'If you are worried you can go to the clerks and ask' … and that is when if they know you very well they tend to [say] … 'you remember me, you remember my history, you remember my tablets I'm taking'… they think I remember all their tablets … and they go to [the] doctor [and say] 'she knows she can tell you' … (Eliza)

Hilda questions the legitimacy of patients' expectations of her to serve as their support person by using the word 'misconception'. Silvia draws a clear demarcation line between being a 'professional', by which she means an interpreter responsible for information transfer, and serving as a 'helper' as typically fulfilled by a 'social worker', 'daughter' or 'friend'.

Hiba and Eliza also objected to assuming a support person role, which they see as involving facilitating patients' navigation of the hospital system and site. Hiba said,

> It's not my role to take the patient to places. My role is to interpret…we hear questions such as 'Can you take her [patient] there?', asking the interpreter to take the patient to places, whereas there are hospital facilities such as volunteers who are assigned to do these things, to show directions.

Insisting that her role is to interpret, Hiba makes it clear in the above excerpt that the other roles patients expect her to fulfill, are to be assumed by others. Hiba's observation indicated that not only patients, but also hospital personnel, sometimes ask interpreters to act in roles other than language facilitator.

Sharing similar concerns, Eliza said,

> They [patients] think that you would step in and do something else. For example, 'please see where I am [in the queue] or if the doctor will see me next or can you do something because I've been waiting?' You're just there as a linguistic pipe [sic] and nothing more. (Eliza)

Use of the phrase 'something else' to refer to any roles other than information transfer and insistence on being "just there as a linguistic pipe and nothing more" clearly show Eliza's conceptualisation of her role exclusively as a language conduit. In this quote, Eliza is also sharing her concern that if she moves outside the strict information transfer role, the boundary may blur and patients may ask for further assistance, which goes beyond her main language 'conduit' role.

Another way in which Eliza believed patients expected her to go beyond her information transfer role and serve as their advocate was through asking her to check and guarantee the accuracy of information provided by the HPs. In the following

excerpt, Eliza recalls a situation where she was held accountable by a patient for the inaccurate initial diagnosis made by the HP:

> The doctor said to her, 'you don't have a polyp and it was a fibroid'. And she goes to me, 'Excuse me, you told me it was a polyp. And I said 'I might have told you because that's what the doctor said' and the doctor looked and said, 'Yes… we told you it was a polyp, but after … the examination it was a fibroid'. In a way I was the bad one that I didn't interpret but at the end it was correct interpreting … You see I was the one to blame that I didn't interpret to her what I was supposed to…. That was pretty sad for me because … she believed that I misinterpreted something… [the] doctor did clarify it but in a way she was angry with me and not with the doctor, because she heard it from my mouth.

This experience sheds light on how the dynamics of interaction in an interpreted consultation change depending on each party's (here, the patient's) perceptions and expectations of another party's (here, the interpreter's) role. While the doctor directly addresses the patient in their explanation about the alternative diagnosis, in her response the patient addresses Eliza using the pronoun 'you', putting her in the position of being seen as the person to blame for the earlier inaccurate diagnosis. This is despite the fact that all Eliza did was, using her own wording, "correct interpreting". But it is likely, according to her, that the patient may have negatively judged the accuracy of her translation, making her the target of the patient's anger. This experience of the interpreter highlights that when miscommunication happens the blame is often attributed to the interpreter by the patient, regardless of what caused the inaccurate information provided.

4.6 Impact of time constraints on the role of interpreters

The impact of time constraints in a hospital, as a large institution, may show itself in interpreter-mediated consultations in two major ways, as reported by the interpreters. Firstly, due to time constraints, the doctor may ask questions in a rush and some important information may be omitted. Second, due to the lengthy time the interpreter may have been required to wait prior to a patient's appointment commencing, the interpreter's scheduled time may be up before the patient has seen or completed their consultation with the HPs, leaving the patient without an interpreter for all or part of the consultation.

Parvaneh, Hilda, and Sophia focused on the issue of time as affecting interpreted consultations. Parvaneh talked about how some HPs' tight schedules negatively impact the quality of interpreted consultations in that the HPs may conduct consultations without having gone through patients' medical background or diagnosis may not happen as rigorously as it should have. Parvaneh said,

> It has happened that we go there and the professional has to rush through or even ask the patient the questions and has no idea about the medical background of the patient. So time-wise it would be pressure on both sides, me and [the] professional. From the point of diagnosis, thorough investigation, they are not doing it as they should do. There are other cases when I am there as the third person; standing aside and looking at the whole picture I see that even if the patient didn't see the consultant, didn't seem to be a matter that day, because nothing had changed because nothing new had been told or heard.

Hilda similarly focused on the negative impact of time limitations in the busy context of the hospital on thoroughness of consultations and said,

> In [the] hospital setting everyone is busy and then maybe the professionals or the patients don't have enough time for consultations and when sometimes everyone is in a hurry, some crucial information may be omitted unintentionally and then I think that's how the miscommunication happens.

In their remarks Parvaneh, Hilda, and Sophia talked similarly about how limited time available for consultations results in low rigour and comprehensiveness in interpreted consultations. Sophia discussed her experience with the administrative side of the hospital, which contributed to not having enough time to finish the interpreting fully, as she explained,

> When I go to hospital, the reception staff don't have an understanding that you're only there for an hour and a half and you've got to go, that you have other appointments … we, as interpreters, get more frustrated with going up to reception than actually doing the interpreting because you have to make the receptionist aware that you are there for one hour and a half. The client might have to see an optometrist then the doctor, … and then it has happened that we have left the client not because you wanted to or [it] wasn't very professional but you'd had to leave because you have told staff that you're only there for one hour and a half and they sort of tend to ignore you and that is so frustrating because you feel a bit anxious because you don't think you're giving a good service, specially when you're leaving the client half way … I find that really really frustrating … from our point of view we obviously committed ourselves to various jobs during a day and there is no way I could stay half hour extra if I got another job to get to.

The examples above showed how the time constraints impacted on the interpreters' capacity and satisfaction with undertaking their work in the structured and inflexible hospital environment. Ironically, for agency interpreters, it was the clash between the hospital's work environment and approach to scheduling and their own employment environment's casualised and tightly structured time allocations per job, that led to frustrations with not being able to fulfill their professional obligations in an optimal way. Whilst in-house interpreters did not have the same time restrictions as those from agencies, they faced similar challenges in terms of fulfilling their various allocated assignments within the hospital where time delays or changes caused clashes in their working days.

4.7 Summary

The contribution of this chapter is through its discussion of views and experiences of the interpreters, who are key players in interpreter-mediated health consultations as the only participant who can directly comprehend what is said by the other two parties (i.e. HPs and patients). The findings have shown that interpreters' overwhelmingly described their role in the healthcare setting as being that of language 'conduit', and expressed a strong preference for their role as interpreter to be tightly constrained to language transfer. However, through the experiences they shared, it became evident that they sometimes went beyond the message transfer language 'conduit' role, and adopted other roles, when in their assessment of the situation, remaining a conduit would have impaired meaningful communication for the HP or the patient.

The interpreters discussed their experiences of the expectations and pressures placed upon them within the hospital setting and which highlighted that the interpreter's professionally designated role is not universally well understood among health professionals and patients. As a result of the lack of many service users' awareness of their role and its boundaries, and with the pressures of the busy time-constrained institutional context of a hospital, other demands and requests were made for their assistance. They reported that they were asked to fulfill other roles by HPs and/or patients, including acting as cultural facilitators, explicators or mediators, or the patient's support person. Whilst most of the interviewed interpreters resisted taking on

these additional roles; nevertheless, there were occasions where interpreters reported stepping in with relevant clarifying (cultural or informative) remarks to the patient or HP to facilitate meaningful conversation, according to the dynamics of the consultation as it evolved. Another role that interpreters willingly played in consultations was using simple, but creative strategies to provide a comfortable atmosphere and give the patient confidence when the consultation felt tense or stressed. Finally, they considered time limitations and time management constraints within the hospital setting as affecting the quality and rigour of what was able to be conveyed through their role in interpreting consultations, making their task more challenging, and frustrating.

Having considered in-depth interpreters' experiences and expectations of their role in interpreter-mediated health consultations, the next chapter focuses on the interpreter's role as understood and experienced by health professionals as they interact with their patients.

Chapter Five – Health Professionals' Experiences with Interpreters

Analysis of the experiences of interpreters of their role, highlighted that whilst all prioritised their role as a language 'conduit' in medical settings, in reality their role was never 'static', and changed to some extent according to various parameters within the context of the consultation. This dynamic aspect of interpreting emphasises that the interpreter is not merely 'robotic' (see Hsieh, 2008). The interpreters have described making a range of contributions to assist in facilitating HP--patient communication, suggesting that conceptualising the role of community interpreters in healthcare settings merely as a neutral language 'conduit' is too simplistic. In providing a contrasting lens to that of interpreters', health professionals' (HPs) experiences and expectations of their work with interpreters is the major topic of discussion in this chapter.

In interpreter-mediated health consultations the highly specialised healthcare professionals rely on interpreters, who are linguistically and culturally capable professionals, to facilitate communication with patients. Analyses of the HPs' views and experiences with interpreters have yielded three major sets of themes, namely: the HPs' views of interpreters' roles, their strategies for overcoming communication difficulties, and their experiences of time constraints in working with interpreters.

The HPs' desired experiences of working with interpreters shaped their positive expectation of an ideal interpreter-mediated consultation. The ideal consultation encompassed four roles for interpreters, frequently mentioned as: 1) transferring the information across, 2) reliance on the interpreter's cultural knowledge to make the HP--patient conversation more efficient, 3) maintaining the patient's confidentiality, and 4) creating a relaxed atmosphere for the parties involved.

5.1 HPs' knowledge and experience of interpreters' practice

One of the question areas in HP interviews was about the roles HPs expected interpreters to play in the conversations they had with patients, including how effectively they thought interpreters they were working with fulfill those roles. The

researcher asked them to share their experiences of what they found to be satisfactory as opposed to less than satisfactory help from interpreters.

5.1.1 HPs' awareness of interpreters' professional training

To clarify HPs' knowledge base concerning interpreting practice, they were asked whether they knew about interpreters' different professional levels. Although some of their responses indicated that some HPs differentiated between those interpreters who were more experienced or qualified than others, Alice experienced having the most trouble with the one interpreter who happened to mention having "a Degree in interpreting". Almost all of the HPs were not aware of existing professional levels for interpreters; a few, however, like Alice, Jack and Linda, assumed a tertiary education qualification and special training for interpreters:

> Jack: "… they are some very experienced one and they are some fairly junior ones".
>
> Nancy: "… I imagine some were more qualified than others, but I don't know"
>
> Linda: "I know that they have to do … a degree of training … but … I didn't know about different levels".
>
> Alice: "I know that there is a degree, … And then they must do some extra, …but I don't really know…. The interpreter I had the worst trouble with told me, 'I have a Degree in interpreting. I've been doing this for years and don't you tell, don't you argue with me; like I know'. So he says he's got a Degree, I don't know if he has or not …
>
> Janet: "Well they don't tell me what level they are when they come here; are they supposed to?"
>
> Frank: "I have no idea".
>
> Patrick: "I don't know".
>
> Fiona: "No".

Some of the HPs admitted that they did not have the knowledge needed to evaluate interpreters in terms of languages they were known to have a command of. Nevertheless, they considered some interpreters to be more skilled than others, based on their personal observations regarding how well they thought the consultation went, especially judged by how relevant the patients' answers were to their questions.

5.1.2 Positive experiences with interpreters in the language conduit role

The interviewed HPs mostly considered interpreters as effective facilitators of communication in transferring their messages. The basis of their evaluation of the interpreters' competence was their perceptions of how well the interpreters could transfer messages between the HP and the patient, finish the consultation on time, interpret any input from the patient, which was not necessarily prompted by the HPs' questions, and identify and report to the HP the patient's failure to understand their questions. Two HPs reported they were always happy with their interpreters' performance. Matthew, for instance, said, "I was always happy. There was no particular occasion where I was not happy". Jack said, "Most of the time, nine out of 10 times, I am quite happy with the interpreter".

5.1.3 Concerns of HPs in interpreters' poor information transfer

While many HPs reported receiving a satisfactory service from the interpreters, some reported unpleasant experiences of their exchanges not going well and attributed this to what they perceived to be unskilled interpreters. These HPs reported that such interpreters were often agency interpreters or patients' family or friends. The HPs attributed their negative perception of interpreters' effectiveness to a range of reasons including their poor linguistic knowledge, imbalanced length in interpreted exchanges, and exaggeration of medical concepts. These attributions are worthy of being unpacked further.

Interpreters' being perceived with poor linguistic knowledge

The gap in interpreter's linguistic knowledge was raised by some HPs when on occasion the interpreter was not able to transfer the message across to the patient due to their lack of linguistic knowledge in the field. For example, Fiona, Janet, and Alice all identified this gap. As Janet commented: "Sometimes interpreters themselves have questionable English, you can tell all junior ones that haven't really been around medical language enough to deal with it", and Alice said, "I could see from the looks on the person's [patient's] face that they weren't happy. They could understand enough

English to realise that he wasn't interpreting what they had to say and they lost confidence in him".

Janet required specific terminologies and concepts transferred to her patients despite acknowledging the complexities of these terminologies. She attributed poor transfer to the level of interpreter's accreditation right after she asked the researcher to explain to her the difference between professional and paraprofessional levels in interpreters:

> You can clearly tell the interpreter may be paraprofessional, that they're at a very basic level and the concept is very hard, HIV, Syphilis. Syphilis is a very hard concept to get across to anyone, to a layperson let alone to a patient, so sometimes it's very hard, hard for us and hard for the interpreter and hard for the patient.

What is also attributed consistently to the HPs' perception of interpreter's poor linguistic knowledge was the patients' irrelevant responses to questions. This observation was reported by almost half (40%) of HPs and attributed consistently to poor interpreting, as opposed to other potential causes. Alice and Frank attributed patients' unrelated answers to interpreters' failure to understand patients' responses and accurately transfer their messages back to the HPs. Frank, for instance, said: "The patient sometimes says something different; I'm not sure actually if it's the interpreter telling me the same things". Both interpretations that HPs have of why some consultations do not go as well as they want them to, relate to the interpreters' ability to transfer information accurately, be it from the patient to the HP or the other way around. On a few occasions, the HPs also believed that interpreters may not completely translate the patients' explanations for them. Defining a good interpreter as someone who "will tell you everything that the patient says to them", Linda lamented that "mostly they don't". In all these cases, the HPs did not mention limited clarity of their own questions or patients' limited understanding of the translations, which may have to do with their educational levels or health conditions, as likely causes of communication failure. Instead, they tended to question the efficiency of interpreters.
While Alice and Frank attributed patients' irrelevant answers to interpreters' failure to accurately understand and translate patients' responses, Fiona believed that this could be a result of interpreters' lack of understanding of her utterances:

> …the person is interpreting back what the patient said but they haven't picked up on the fact that their answer has no idea or the answer has no relevance to the question I asked, or they supposedly asked it and so it's helpful but sometimes

> I'm sort of saying 'They didn't answer the question, can you repeat it?' Or I have to put it another way even to help the interpreter to ask the other one; that's frustrating as well.

As for the cause of such frustration, Fiona went on to express her uncertainty about whether some interpreters would transfer her messages to patients the way she expected:

> I guess one big challenge is that with my assessment and with my treatment and my explanations I don't really know how what I am asking the patient is being translated … or whether the questions that are being phrased are exactly what I am wanting to know.

This excerpt shows that Fiona's uncertainty regarding the effectiveness of message transfer arose primarily because the interpreter is the only party in a triadic conversation who knows both languages and, therefore, has a determining role in the success of consultations, while the HP is essentially in the dark as to the content transferred in the language unknown to them. Reasoning that the success of consultations "depends on how the interpreter translates things back to me and then to the patient", Fiona concluded, "So you're kind of at the mercy of the interpreter's skills". Fiona clearly identifies her lack of control over the content of the whole conversation as a major challenge, and is aware of how her own lacking LOTE (Languages Other Than English) knowledge makes her temporary loss of control over the process of communication inevitable, and concerning. This situation puts her in the position of simply hoping that the interpreter is doing a proper job of translating, hence her emphasis on the importance of interpreters' language skills.

The disparity of assigning a male interpreter for a consultation about the patient's female issues concerned some HPs regarding uncertainties. These HPs perceived male interpreters as not having competent knowledge about female issues. The concerned HPs only discussed the matter in relation to assigning male interpreters for female patients, and not the other way.

Linda considered the interpreter's gender as the major cause of inefficient transfer of her message to her female patient on one occasion:

> … when you get somebody on the phone … a man who is talking about women's things and then that's like how much do they actually understand and what are they saying and so I guess sometimes there's a level of not mistrust, but

> uncertainty that how well that interpreter is actually explaining to the patient or talking to the patient about what's going on.

This quote is describing Linda's inevitable reason for concern about the knowledge of the interpreter pertaining to women's issues.

The analysis of the discussed types of experiences by the HPs of poor information transfer reflected ways in which they had experienced interpreters performing their message transfer role ineffectively. An important consequence in each case was the HP feeling a loss of control over the interaction with their patient, and doubting some aspects of the quality of message transfer. These issues of imbalanced in the length of interpreted exchanges and the interpreter's exaggeration of medical concepts prompted concerned HPs to have concerns in interpreters' poor information transfer.

Perceived imbalance in interpreted exchanges

A perceived imbalance in the length of the interpreted message compared to what the HP had said tended to lead the interviewed HPs to conclude that the transfer of messages did not happen efficiently. More precisely, Janet, Linda, and Patrick reported the greater length of interpreter-patient conversations compared to that of conversations they had with interpreters as a cause for concern as to whether the message was transferred accurately. Janet said:

> A bad interpreter will turn around and translate to the patient, but I can tell they're having a big conversation, and then not explain it back to me … why was there such a big conversation, are they trying to clarify something? If there is actually I need to know that and I don't get enough information back from the interpreter because that's the only way that I'm gonna know that the patient doesn't understand. So a bad interpreter would do lots and lots of talking but not give me a good clear answer.

This excerpt shows that Janet does not trust the interpreters' ability to judge what is relevant and important to be transferred to the HP from the patient. Without some explanation from the interpreter concerning the nature and reason for the lengthier than expected interpreter--patient interaction, she assumes she is being excluded from what could be important for her to know.

Linda expressed her dissatisfaction that sometimes interpreters do not translate a comment made by the patient back to her: "… mostly the conversation is between the

two of them … if I make a comment, they [interpreters] say that to the patient but often the patient will make a comment but they won't bring that back to me". Such omission raises concerns about the quality of the interpretation.

The interpreters' silence instead of interpreting, though infrequent, was another perceived manifestation of the interpreters' failing to transfer messages effectively. Fiona, for instance, remembered becoming frustrated when her agency interpreter remained silent instead of interpreting for the patient: "When I said something to the patient and then there's been nothing and so I had to yell from [behind] the curtain 'Can you please interpret?' and I shouldn't have to do that, it should be interpreted automatically". Linda shared a similar experience of interpreters' silence, in this case not interpreting the patient's remark:

> If I make a comment they say that to the patient but often the patient will make a comment but they [interpreters] won't bring that back to me, so I ask, 'What did you say to me?'

<u>Interpreter's exaggeration of medical concepts</u>

Some interpreters reported the interpreter's exaggeration of medical concepts as a less frequent observation. This behaviour caused the HPs to question the interpreters' contribution to enhancing HP--patient communication. Georgia, for example, recalled that a patient was about to change her mind about having surgery due to a telephone interpreter's exaggeration of common surgical procedures:

> I was explaining complications and… I said there is always a risk of bleeding. The interpreter said, 'aah this means you're going to have lots of bleeding, you may die'. The patient of course got very upset and worried. So he was actually not translating what I said. He was sort of embellishing, which wasn't helpful.

If we assume that Georgia's description of the situation accurately reflects what actually happened, then the interpreter she is talking about seems to have failed to transfer her message precisely, leading to a critical misunderstanding. The interpreter seems to have used emphatic and strong words (namely 'lots of' and 'die', unconditionally) which did not accurately reflect the level of nuance in terms of risk Georgia had in her own input. Georgia, therefore, had to repair the situation by reassuring her patient that it was part of the routine and nothing out of the ordinary was going to happen to the patient. This calmed the patient who then agreed to have the surgery. However, the incident resulted in Georgia's avoiding using the telephone interpreting service for future interactions.

5.2 Interpreters as cultural facilitators

A role that HPs reported interpreters adopting beyond message transfer was to facilitate intercultural understanding. Some HPs acknowledged the influence of a patient's cultural background on a consultation and the process of making decisions about the patient's health and treatment. This awareness helped them adopt different approaches to using the interpreters' assistance to facilitate the consultations and bring the patients on board with treatments.

Some HPs explained that they would ask interpreters to use cultural resources at their disposal to bridge the cultural gap. In analysing the HPs' reflections on their expectations of interpreters' assistance in helping bridge the cultural gap, a number of functions were highlighted.

5.2.1 Interpreters providing insight about patients' cultural background

These HPs shared their experience of relying on interpreters' insights into patients' cultural background to understand their patients' culturally influenced behaviours and expectations that impact on their attitudes toward treatment and ways of understanding the healthcare they are being given. For Nancy, for example, interpreters could provide insight about the patient's cultural background by helping to "bridge the gap not just through language but through cultural competency…like my Greek interpreter this morning was able to tell me that methylated spirits is used a lot". This knowledge assisted her in understanding the patient's cultural behaviour, as she further explains:

> …I had one woman this morning that had some pain and in her country they put methylated spirits on the area of pain … my Greek interpreter this morning was able to tell me that methylated spirits is used a lot on that particular Greek island.

Nancy similarly recalled that when she worked in the labour ward she gained valuable understanding of cultural habits through what she learnt from interpreters, explaining "I don't think the Chinese like to get up too early, and wash and all of that too early. I think Indian women tend to like to have more of a lying [in] time."

In reflecting on whether patients themselves would talk to her about their customs or habits, Alice commented:

> They probably wouldn't talk to you about it and you probably don't get enough time with them too to get those things out, so if the interpreter is with you, they might give you some ideas, some insight of what kind of cultural things.

5.2.2 Assisting HPs when culture stands in the way of treatment

A few HPs like Georgia stressed the value of cultural insights provided by interpreters to help her understand the intended meaning of what patients say: "They'll help you with understanding from cultural aspects; … they can read between the lines of what the patient is saying and help to interpret that". Her belief that the interpreter's role goes beyond serving as a language conduit manifests itself in her use of the phrase "read[ing] between the lines", which clearly shows she expects more than transfer of surface meaning.

Some HPs considered interpreters as a support to help them convince patients to accept the selected treatment plan, due to shared culture between the patient and their interpreter. Jack, whose "narrow" specialty involved determining and advising whether his patients would benefit from having surgery, said, "Perhaps with the help of an interpreter and someone who believes in their culture, it might make it simpler for them to understand and accept the surgery".

5.2.3 Not having an interpreter -- on purpose

Few specialised HPs reported that they removed interpreters from their consultations due to their understanding of the significance of cultural role in the patient's life and how cultural stigma was attached to some diseases, as the following excerpts show:

> Researcher: *How often do you need to involve an interpreter?*
>
> Georgia: *Not too often and part of it is not necessary because they don't need interpreters but they don't want interpreters…. there is a lot of misunderstanding and a lot of stigma associated [with the disease] so they often don't want other people to know and they're ashamed of how they contracted it [the disease].*

In another excerpt Linda shared her experience of how the issue of confidentiality impacted on her patient not wanting to be seen physically by the interpreter and further arrangements had to be made. Linda remarked:

> The conception of confidentiality … that's very difficult, … you end up having to get an interpreter and they [interpreters] have to go to another room and use

> the phone, so that the patient doesn't see them and you know you have this, or they [patients] refuse to have any face or anyone physically coming in … and that's really really frustrating.

Once again in the above excerpt lack of clarity around the concept of confidentiality has been raised for patients in question, as to not wanting to be seen face to face by their interpreters; therefore further measures had to be made for the communication between the HP and the patient.

Interestingly, Fiona was the only interviewed HP who was not interested in interpreters' contributions beyond mere transfer of her input to the patient: "[I] *appreciate it when the interpreter just interprets what I'm asking*".

5.2.4 Interpreters resolving ambiguities by probing the patient

In the case of an older Greek background patient involving Alice (a diabetic education nurse), the researcher observed directly that when Alice's questioning through the interpreter failed to establish the cause of high blood sugar in an older Greek patient, the interpreter took the lead in questioning without involving the HP (Alice) to uncover that the high blood sugar may be due to the patient's consumption of special Greek sweets. The patient had not said she had consumed the sweets during the interpreted communication, but when the interpreter continued the conversation further by naming popular Greek sugary sweets and asking the patient if she had been eating them, the consumption was revealed. The interpreter's cultural insight had enabled her to search deeper into the patient's eating habits, proactively asking her if she was eating specific ethnic foods which could affect the level of blood sugar.

Another interpreters' task/role that emerged from the analysis of interviews with HPs that went beyond mere information transfer involved the interpreter fulfilling or being expected to fulfill was as the person in the triad charged with resolving any perceived ambiguity, confusion, or lack of understanding.

When presented with a potentially vague response by patients, Tina believed that interpreters should "tease out" those answers through "simple direct questioning and … really getting the right information from the patient". What Tina desires in an interpreted consultation is for interpreters to probe patients' initial answers through

engaging in direct conversation with the patient and asking effective questions, leaving it in the interpreter's purview to negotiate to get the most accurate information. Tina's quote is a great example as it mirrors the probing and clarifying strategies that will be discussed in the interaction chapter. Clearly, some HPs want the probing, whereas others found it irritating or upsetting (and potentially dangerous) as they lost control of the interaction.

Sarah had been exposed to two other ways in which interpreters had facilitated communication by addressing potentially unclear utterances. One was interpreters helping patients understand HPs' point through proactively providing alternative translations.

> Sometimes an interpreter will have to rephrase what you have said a couple of times before the woman understands… [they] do their own interpreting of what it is I've been saying, and I'm sure the women always gets the right information.

The other analogous strategy Sarah recalled an interpreter using was asking for the HP's further assistance by telling the HP that the patient did not properly understand the input and, therefore, indicating that the HP needed to rephrase it so that the interpreter's translation might make more sense to the patient.

> I remember one, she'd translate the word and then she'd say to me … Sarah, she didn't understand that, you need to put it another way and she'd get me to put it another way and we discussed how I would put it.

The interviewed HPs responded differently to interpreters fulfilling this role. Some did not mind them doing so, although in the case of interpreters' direct communication with patients they were sometimes excluded. Patrick, for example, said: "I don't mind it and that can be quite good because … the directness of communication is important. Sometimes not interrupting the interchange between the patient and the interpreter can be quite good". Patrick's approach to two-way communication between interpreter and patient in his presence was very positive, as reflected in his repeated use of the phrase "quite good" and expressing his lack of interest in interrupting this communication. Linda, however, expressed her confusion as to why conversations between the interpreter and the patient were longer than expected. She said,

> Sometimes a simple question that I might ask might be about 10 words, but it may take almost a couple of minutes of talking and you just wonder whether

> that's because it's so much harder to say it in a particular language or [understand] what's being said.

One reason behind HPs' confusion could be their unfamiliarity with the foreign languages into which their input is translated. This lack of knowledge on the part of HPs puts interpreters in a temporary position of control over the flow of communication and, importantly, without the capacity of the HP to monitor to ensure accuracy of information and questions. Sharing a similar concern, Nancy and Fiona expressed the need to be told by interpreters if their conversation with the patients goes beyond their direct input. Nancy said,

> I like the interpreter to certainly interpret everything I'm saying and I like to know what the interpreter is talking about if she is going out of my guidelines. So if she was to say something else, I would like her to tell me what else she had said.

5.2.5 Interpreters creating a pleasant atmosphere

Some HPs believed that interpreters establish a relaxed atmosphere in the consultation. Nancy, one such HP, considered this to be important due to the climate pervading medical settings. She argued,

> I think we should have a much more holistic model of healthcare, that is, in the areas I work in, maybe. I see women generally in the women's south wing clinics so I like it more rounded, I like it warmer, I like it less clinical

In light of this description of the workplace where she works Nancy concluded: "The interpreter can bring the warmth into a room and a good one helps relax the whole situation". This HP, therefore, believes that an interpreter can be as important a party to a consultation to facilitate implementing a "more holistic" and "less clinical" "model of healthcare".

Patrick expressed a similar view on how the presence of an interpreter can change the dynamics of the consult as he said, "the system of laborious interpreting…relaxes the patient to tell the whole story". Patrick's perspective is one that highlights the interconnection between two interpreter roles: relaxing the patient and, as a result, maximising information transfer. Such remarks indicate that there is perceived sociocultural value in the presence of an interpreter in a consultation, as well as showing

that from the HP's perspective a successful interpreter-mediated consultation was more than a mere successful linguistic transfer.

5.2.6 Maintaining patients' confidentiality

Some HPs assumed, as part of their roles, that interpreters should respect and maintain patient's confidentiality. Janet and Georgia, for example, placed emphasis on interpreters' being responsible for preserving the confidentiality of HP--patient conversations. Since their specialties had to do with infectious diseases, they had observed that CALDB patients may not welcome the idea of talking about their health issues with them in the presence of interpreters, as interpreters were likely to be in contact with the patients' communities. The patients were so sensitive about this issue that many of them chose not to consider interpreters' discretion and to therefore not trust their attempts at protecting the confidentiality of information exchanged in the conversation. Explaining some of her patients' lack of interest in having an interpreter present in medical consultations, Janet, for instance, said, "In [sic] some of my patients, particularly the African ones, their communities are very small, if they have a serious infection like HIV, … he won't ever allow other people from his community to be involved in his care."

Georgia's experience was similar:

> One of the challenges with our patients, particularly with HIV patient[s], is particularly if they've come from a smaller community background. They don't want an interpreter in with them because they're often from the same community as them and they're worried about confidentiality. They often try and struggle through the interview. Because of communication issues, it's hard to give them [patients] the full story and try to communicate all these things, particularly when they're reluctant for the interpreters to be involved.

Janet and Georgia both identified that the feeling of discomfort became particularly serious if the patients belonged to a small community where the spread of information could happen easily. In such instances, the patients' diseases and their identities had to remain confidential due to cultural stigma attached to those diseases within their communities. Therefore, these HPs were willing to agree to not have interpreters facilitate their communication with their patients.

In addition to the size of communities, cultural embarrassment also depended on how different cultures perceived different types of disease. Asian patients suffering from

tuberculosis and cancer from a Greek background were faced with similar challenges, although their communities were quite large as opposed to communities with small number of people. For example, Janet explained that in some cultures tuberculosis was associated with sufferers being dirty, while in another culture it was considered a treatable disease. She said,

> Tuberculosis…is managed very differently by different cultures. In [sic] the African patients, because a lot of them who come here have come from quite privileged backgrounds, it is considered a dirty disease to have something like TB so they're very ashamed whereas patients from China and Vietnam, they understand that it's extremely common and while they're anxious that they have it, they don't have the same reaction as some other cultures.

Being aware of different attitudes across communities, Janet and Georgia would provide the patients with English resources "aimed at low literal readers" and connect them with English speaking support groups with whom they could have limited conversations in English, so their identities would remain confidential. Despite these patients' very limited English, these solutions seemed to be sometimes helpful. However, given the professional interpreting code (AUSIT, 2012) emphasises the importance of practising confidentiality, either this is not well understood as a commitment or not trusted by those using the interpreting services.

Whilst HPs provided detailed descriptions of what roles interpreters should/have fulfilled according to their experiences and expectations, they also named time-related challenges they faced in relation to accessing interpreting services.

5.3 HP strategies to overcome communication difficulties

Whilst HPs regularly reported satisfaction with the quality of message transfer in many of their interpreted interactions with patients, the experiences of poor or unclear message transfer are important to consider. In addition, HPs shared their personal strategies to overcome communication difficulties arising from the need to work through the interpreter. These strategies either involved the interpreter as in encouraging him/her to share the patient's response regardless of its relevance, or conducted by the HPs in a variety of methods such as relying on their own LOTE skills, probing the patient, repeating for the patient, and observing the patient's facial expressions in relation to understanding cues and signals.

HPs such as Linda and Nancy said they would encourage interpreters to share patient's responses regardless of relevance. Linda said,

> Occasionally with a really good interpreter they will tell you everything that the patient says to them as well but mostly they don't. I ask, I say 'what did [a patient's name] say to me?' and sometimes it might be just a little flip [sic] of comment or remark.

In this excerpt, Linda defines "a really good interpreter" as someone who "will tell you everything that the patient says to them", which shows how important it is for her to be informed about the whole content of the communication. Therefore, she does not consider legitimate any conversation between the interpreter and the patient beyond what she determines as relevant to the medical exchange. Sharing Linda's attitude, Nancy explained,

> I like the interpreter to certainly interpret everything I'm saying and I like to know what the interpreter is talking about if she is going out of my guidelines… If there's something else she wants to add, I want to know what she's adding.

Nancy is expressing her expectation of transparency when her interpreter is transferring the content to the patient.

HPs reliance on their own LOTE skills was a strategy used by a few HPs (20%) (e.g. Patrick and Jack) to check the accuracy of the interpreted message. Jack, for example, said, "I speak a few other languages as well and I usually use interpreters and I can check what they say and most of the time they do a pretty good job".

Patrick also said that he would use his LOTE skills to make sure all details were communicated to patients.

> I'm familiar enough with some languages to get the gist of what's being said and there are some times when I'm pretty sure not everything I've said has gone across and I sometimes feel a bit less than happy. Then if I'm not happy I will stop and insist [on] a sort of line-by-line translation of what I say.

By specifically asking interpreters for a line-by-line translation Patrick can draw upon his own LOTE skills to exercise more control over communication.

HPs reported that they probe the patients to make sure the transfer of message is adequate in other ways too such as requesting the patient to give a summary, or

highlights of the consultation or instructions. Fiona, Alice, Linda, and Nancy would ask patients to summarise or repeat what they had been told by the interpreters. Nancy, for example, said,

> I ask them to tell me what they understand about what I've said I suppose. That's probably the best way to do it. Sometimes I might ask if they understand which they can go 'Yes, yes, I understand' but if I had an inkling that it wasn't working, then I would ask them, certainly, what they understood about what I'd said.

Linda similarly explained her approach "I might ask them to…repeat back to me, the key points… I want to make sure that they understood."

Sarah also probes to make sure the patient has understood the main points: "If I tell woman something I get her to tell something back to me, so I'm getting to know that she really does know what I'm talking about."

Linda similarly said,

> I generally depend on what it is. I usually ask them to talk back [sic] to tell me what I've just said. And if I had given them instructions about something and they tell me what and how they understand them to use these instructions so I usually ask them to tell me back [sic] what it is that they've got to do.

To ensure the patient has understood everything correctly, most of HPs said they would repeat for the patients what they have said. As Jack explained, "I say the same thing over and over again so they understand what I say". Alice tells her interpreters, "I want you to say what I've told them, [I] want [you] to repeat this".

On some occasions, however, the HPs' doubts would remain unresolved, leaving them with the inevitable choice of trusting interpreters' language competencies. In this regard, it is worth repeating a quote from Fiona which was partly reported earlier in this chapter:

> I would normally ask the patient if they've understood or I might ask the patient to explain their interpretation of what's happened, you know, what has occurred, but once again that's through an interpreter, so [it] depends on how the interpreter translates things back to me and then to the patient. So you're kind of at the mercy of the interpreter's skills.

Alice and Fiona reported examining and observing the patients' facial expressions as a sign that the patient has understood the content of [the] conversation or not. Fiona said,

> If they look at me with a blank expression on their face, that would also give away that they haven't understood or they're not able to do the exercise properly. That's also another way of seeing that they haven't understood.

Alice said,

> You usually can tell quite quickly when they don't understand you. They look confused. And so usually you can tell, and just by the answers you can get from the interpreter, you can usually work out if they didn't understand you, or maybe the interpreter didn't understand the question.

As the above analyses have highlighted the HPs have developed strategies to address noticeable problems with the work of interpreters. The HPs' knowledge of LOTE, asking/probing patients to summarise or repeat what was said, and HPs' further feedback of what they had said were among the strategies adopted to ensure their message had been understood via the interpreter or when they had concerns about the quality of the interpreter's message transfer. Nevertheless, ultimately have to trust the interpreter's language and translation skills due to their limited scope for direct communication with the patients. HPs also believed that interpreters may contribute to the success of medical consultations, given their knowledge about the patient's cultural background.

5.4 Time constraints and interpreters

Through the analysis of health professionals' responses, time emerged as another major theme that framed their thinking and practices in working with interpreters. By closely examining HPs' reported experiences and how time impacted on the interpreters' performance and, consequently, practice, two major sub-themes emerged relating to time. The first relates to the time involved in communicating when an interpreter serves as an intermediary, here referred to 'interpreters' prolonging consultations'. The second relates to scheduling and availability of both interpreters and health professionals and the issues around gaining access to the interpreter in a way that works for the health professional, the interpreter, and the CALDB patient, referred to as 'institutional time constraints'.

5.4.1 Interpreters prolonging consultations

The HPs shared their perceptions of the impact of interpreters' presence on the length of consultations. The HPs had a set amount of time allocated to spend with every patient, and the presence of an interpreter in the consultation does not make any difference to the length of time allocated for the consultation. While an interpreter contributes to facilitating communication between the HP and the patient, this tends to prolong the session. Some HPs (i.e. Tina, Linda, Fiona, and Patrick) acknowledged the extra time it took to communicate with their patients when interpreters were involved.

> You are relaying the language back and forth and back and forth, so it is time consuming. (Tina)

> Probably one of the biggest problems then, is that when it comes to interpreting it takes time. (Linda)

Therefore, it was important for the HPs to have successful communication within the limited timeframe. In this regard, Frank said, "it's very important in outpatients because time is crucial, we spend like 15-20 minutes with the patient… so it's important [for] the interpreter to be around to communicate". A few HPs mentioned they tried to overcome consultations lasting too long by talking less compared to working with an English-speaking patient so they could save some time for translation. For example, Fiona said, "I'm always very conscious so I try to only speak … in shorter amounts, waiting for the interpreter to interpret".

Also, it seemed evident that it was the individual HPs' choice either to have an interpreter during consultations, like in Sarah's case, or proceed without one by using their own LOTE skills, which Tina and Janet would sometimes do. Tina said, "being a dietician, saying to someone who is Italian 'mangiare' is at least to get them thinking the right thing and then you can sometimes just play around and work it out". Similarly, Janet said, "I do speak a little bit [of] Italian, so when I can, I try to help them out". As helpful as these HPs' LOTE skills are, their wording shows their awareness of the limitations of problem solving. Tina's use of the phrase "at least" and the adverb "sometimes" and Janet's use of the phrase "a little bit" and the clause "when I can" show their attempts to downgrade their claims as to the usefulness of their own LOTE skills.

5.4.2 Institutional time constraints

At an institutional level, scheduling and availability of both the interpreter and the health professional to see a CALDB patient presents some challenges, two of which emerged from the interviews: mismatch of interpreters' and HPs' time, and consultations conducted in the absence of interpreters.

HP--interpreter mismatch of time for consultations

This mismatch of time focuses on the challenges HPs faced when making arrangements for interpreters, mostly in-house, to attend consultations as well as their solutions. Some HPs had experienced situations where they were ready to see a CALDB patient, but the interpreter was not available, although booked, because they had been held up with their previous job on the hospital premises. Linda's description is helpful here: "You call someone into the room, you ring and ask for the interpreter and they've got three or four other people they got [sic] to see first". As the HPs reported, this problem impacted on their work in negative ways. Fiona, for example, had faced situations where the time allocated to a patient would run out, because she had to wait for the interpreter to arrive and, consequently, she had to have a short session with the patient and the interpreter, as another patient was in the queue:

> Sometimes they [interpreters] are held up with other jobs… That of course alters my morning significantly and then often I may not be able to give the patient as much time as what they deserve, because the next person has already arrived.

While Fiona talked about problems with accommodating one patient, Linda explained how the time mismatch with interpreters had affected her commitment to serve all of her patients. For example, she highlighted how challenging it was for her to make sure the interpreting service was available for her to serve as many as six CALDB patients, one after another, in one morning session and still remain on-time.

Another challenge HPs had to tackle due to time constraints was interpreters' leaving consultations before they were finished. This would happen either because in-house interpreters were paged to attend other consultations or because the time agency interpreters had been booked for was over. Regarding in-house interpreters, Nancy said, "The interpreter has to leave early because they've been pulled away somewhere else". This, Nancy observed, would make the interpreters "come in and do the basics and

leave". Some HPs commented on the impact of such disruptions on their work as well as their patients.

> "It can be very frustrating and it's difficult for people at the waiting area as well". (Linda)
>
> "I don't like it when an interpreter asks me can they leave early before I [have] finished". (Nancy)
>
> "…very irritating, it happens quite frequently". (Fiona)

In the case of agency interpreters, Tina had experienced that the time for which the interpreters were booked would run out before the consultation was over:

> The interpreter was very rushed for time and I was having actually quite a serious conversation… I could understand a little bit of what she was saying to the patient and [she] really didn't give enough information and then just left and that was when I was concerned.

Therefore, Tina had to make sure that the next appointment for her patient would be longer. Also since, unlike in-house interpreters, agency interpreters could be asked to be replaced with other more efficient ones, Tina would also request a different interpreter to guard against the perceived inefficient transfer of information having occurred in the first consultation with the patient. She recounted one such event:

> The next time we met with that family, we made sure we had a different interpreter and even though we had organised enough time last time, we made doubly sure that we kept the interpreter for an extended period of time.

Another measure taken by some HPs to save time and resolve the difficulty of making arrangements with interpreters was asking the non-English CALDB patients to leave the consultation and stay in the waiting area until the interpreters arrived while they visited patients who would not need interpreting assistance. As Linda said, "you have to take the patient out of the room again and wait and get another patient in".

This solution, however, would cause another problem. Some HPs reported that it would result in late arriving interpreters' having to wait until they finished seeing the other patient who they had chosen to visit before the non-English-speaking patient. For example, Linda said: "The patient has to go out and wait and you see somebody else, in the meantime the interpreter comes and then the interpreter has to wait until you finish seeing the patient. So that's frustrating on everyone's part".

Despite all these challenges arising from interpreters' availability and hectic schedules, the HPs nevertheless acknowledged their contributions to the efficiency of information transfer between HPs and patients. Linda, for example, asserted "It takes five to 10 minutes to get an interpreter, but it's important for people to understand what's happening to their bodies". Frank and Georgia, who had also talked about time-related challenges regarding using interpreters in consultations, made sure they made positive remarks on interpreters' beneficial roles:

> Interpreter role is very important to relay the message properly and get the patient understands what's happening. (Frank)
>
> When the interpreter is in the room it works fairly well. (Georgia)

Consultations conducted in the absence of interpreters

The impact of institutional limitations on interpreters' availability would sometimes force HPs to run consultations without an interpreter, especially in busy Smith's Hospital where, as Tina said, it was hard to access an interpreter for every CALDB outpatient consultation: "Ideally [it] would be every time if the person obviously doesn't have English as their first language but that's impossible here".

The HPs would sometimes try to resolve this issue by using the family or friends accompanying the patient. Tina, for example, would use family or friends of inpatients, because "I have a longer period of time sometimes in which to see them … and that can help me". In contrast to time constraints, getting help from family or friends does not help maintain confidentiality, which Janet and Sarah referred to:

> In that group [Greek and Italian] however most of the time family members who are very fluent will come with them but because of the cultural issues for both groups of patients… you don't always want the family member to be the one who is interpreting for them. (Janet)
>
> You do not use family members when you're working with, especially with women's health or violence or mental health or anything like that, because it's the language that's being used and understanding but that's also the sensitivity and, I wouldn't talk with my 10-year-old son about my intimate issues so why should I expect somebody from another language and culture to do it? (Sarah)

Some HPs would also rely on their own LOTE skills to either directly communicate with patients, as in Tina and Janet's case (see section 5.3), or check the accuracy of the interpreters/family/friend's interpretations, which Jack and Patrick reported having done. As Jack said, "I speak a few other languages as well … and I can check what they say". Patrick said, "I'm familiar enough with some languages to get the gist of what's being said and sometimes when I'm pretty sure not everything I've said has gone across". Matthew, however, said he would sometimes ask for the help of a bilingual member of staff,

> Here in hospital, because having so many people from all different areas of the world and you also have good staff coming from that area who are very fluent in their mother tongue, it works very well and they're always available if you need them.

Some, like Sarah and Tina, would sometimes avoid using patients' family and, instead, would re-schedule patients' appointments so as to make sure interpreters would be available. To explain, Tina highlighted the importance of the presence of interpreters by saying, "the patient has to come back another day if I can't get an interpreter".

5.5 Summary

By focusing on the experiences of HPs this chapter has explored their views on the roles and responsibilities they expect interpreters to fulfill in consultations, as well as the challenges they face with the interpreting services. The major role the HPs expected or their observations of interpreters was to accurately transfer informational content, but some explicitly expected and appreciated the interpreters to facilitate consultations in others ways, such as using their own insight about patients' cultural beliefs and customs, resolving potential ambiguities in patients' input by probing their initial responses, or in HPs' utterances, by encouraging them to rephrase them, creating a comfortable atmosphere in the consultations, and preserving patient confidentiality.

Most of the observations the HPs shared were positive, indicating an appreciation of the interpreter's involvement. However, they reported situations where interpreters had failed to fulfill their language 'conduit' role, such as having lengthy conversations with the patients, which were perceived to have gone beyond the HP--patient dialogue without informing HPs of the content of those conversations. HPs recalled cases where the interpreters would remain silent when they were supposed to be translating their

input. Finally, perceived inaccurate translations were objected to, as they would lead to patients' unnecessary anxiety and poorly informed decisions as to the next step to take in the process of treatment. To resolve these issues, HPs reported having encouraged interpreters to translate accurately and comprehensively, asking patients to repeat what they had been told by the interpreters to make sure they understood it, repeating their input to patients, and, where possible, using their own LOTE skills to contribute to gauging the quality of message transfer.

HPs reported on the interpreters acting as cultural facilitators in the form of cultural mediation by providing insight about patients' cultural backgrounds. Acting in this role has assisted HPs in situations where the culture of the patient was standing in the way of treatment or understanding the diagnosis. The overall intention in the inclusion of this chapter on the experiences and observations of HPs about interpreters' role/s, and the next chapter is to cross-reference the findings by providing alternative perspectives on how interpreters perform within interpreter-mediated health consultations. Migrant patient participants are the most vulnerable group in such triadic consultations, requiring care for their health and well-being as well as for their limited English language skills. What is common between HPs and patients is that they both use the services of interpreters and have a need to communicate. In the next chapter, I will examine patients' experiences with interpreters in detail.

Chapter Six – Patients' Experiences with Interpreters

In many cases migrant patients require assistance from interpreters in communicating with their healthcare professionals. Such LEP patients are the most vulnerable party in an interpreter-mediated health consultation due to their limited language skills and, perhaps, limited understanding of how the healthcare system works in their host country. In the preceding chapter I discussed the healthcare professionals' views on their experiences working with interpreters. From the HP's perspective whilst interpreters primarily assist in facilitating HP--patient relations as a language 'conduit', a range of other contributions were sometimes expected. With a third lens, that of the patient, this chapter investigates patients' expectations and experiences of the role/s performed by interpreters in hospital based healthcare settings.

6.1 Interpreters as language 'conduits'

Recalling positive experiences of using interpreters to help with their communication with HPs, patients explained that their main expectation of interpreters was that they directly transfer messages from one language to the other between themselves and their HPs. For example, Mona described this as interpreters translating "correctly", and the main criticism Elmira mentioned was that, "some interpreters don't interpret correctly". Hassan expects interpreters "to interpret beautifully for the doctor", and Ahmad emphasised comprehensiveness in translation by saying "my expectation is that any problem that I have I say to the interpreter, and the interpreter must say it to the doctor". Neda communicated the same expectation through sharing her negative experiences with interpreters: "Some interpreters do not listen carefully to what the patient is saying and they say some other things of their own to the doctor."

All patients who participated in my research had attended English classes in Australia so they had various levels of comprehension of English when seeing their HP. Their levels varied from "very little" (Ahmad, Kiana, Elmira), to having a reasonable level of comprehension of non-medical specific English, such as "50%, if he [HP] doesn't use difficult medical terms" (Neda), "understand if vocabulary is familiar" (Mona), and

"there are some specific words with the doctor that makes it difficult for a person to understand" (Hassan).

6.1.1 Patients' reactions to perceived accurate interpretation

As part of language transfer, patients paid attention to how accurately the interpreter transferred their message to the HP. They formed an opinion about accuracy in different ways, based on personal perceptions of how the message transfer was being undertaken. When they were asked to share any positive experiences of consultations going well, some patients provided more specific details as to who they considered to be effective interpreters. Mona, for instance, referred to her ideal, as being an interpreter who is purely a message transferrer, not going beyond the content of the consultation. She shared an example of her own: "It was a session where the interpreter did not talk about anything else with the doctor except about the patient and her problems". Kourosh, favouring rigorous translation based on accurate understanding recalled, "she [the interpreter] explained everything word by word".
Sharing a similar perspective, Elmira judged her interpreter positively "[she] said it correctly and helped me understand what the doctor was saying".

The positive outcome of an interpreter performing their language transfer role well was evident in the patient expressing satisfaction at feeling relaxed and comfortable during the consultation and placing their trust in the interpreter. For example, Ahmad said, "We feel comfortable because whatever I say, the interpreter says it to doctor" and Maryam remarked, "I trust Jasmine [pseudonym for an in-house Arabic interpreter] because she can transfer correct information to me all the time…I am very happy with Jasmine".

6.1.2 Patients' reactions to perceived poor interpretation

In contrast to their positive reactions to perceived accurate interpretation, some patient interviewees recalled situations where they were not able to understand what was going on in the consultation because they felt that the interpreter was not interpreting accurately. For example, Neda reported her experience of inaccurate interpreting and how she came to this conclusion:

> I asked something from the doctor but when they interpret it for doctor, the doctor does not answer the question that I had asked and had said something totally different. So I was surprised and said no my question was like this. Then I knew that the interpreter did not listen to what I asked.

Another patient, Elmira, talked about situations in which she was not able to understand the interpreted message accurately and, therefore, she felt that the interpreter had not done her job well: “Interpreters don’t interpret correctly; therefore, I don’t understand well, that is why it is bad”. Her judgment of how well the interpreter was doing her job was based on her own perceived understanding of the message, as the above excerpt showed.

Inaccurate interpreting was considered a major challenge by some participating patients. Due to negative experiences, they were not willing to work with some potential interpreters and preferred to be regularly served by the interpreter(s) who they regarded as being competent. Kourosh expressed his frustration with “dealing with so many people who don’t have good English”.

Most patients said explicitly in their interviews that they were happy and satisfied with their treating doctors and they attributed problems with their understanding to the interpreter. For example, an unpleasant situation that Kourosh, Elmira’s husband, recalled was the interpreter not translating the HP’s prescription accurately and his picking it up, indicating that sometimes a patient’s assumption (in this case detected by the patient’s partner who said he understood English “100%”) about an interpreting error may be accurate:

> ….the doctor was trying to put across [through the interpreter] that she [Elmira] needs to take medication on a daily basis, three times a day and the way he [the interpreter] translated was [that] she needs to take it on a weekly basis, three times a week, which was not right. I pointed it out straight away…. every time she comes here I’m kind of worried whether she gets the right information because of that one experience…. If I’ve got a day off I’d come, to make sure she is getting the right information. If I’m not here then I put [sic] my hopes up that I’d get the right translator to know what they’re talking about.

This experience highlights the fragility of the bond of rapport and trust with the interpreter – a single, but nevertheless critical, error, can destroy the trust.

An even more unsettling experience Elmira shared with me was when she had been given a scare by her interpreter of the day, who had reportedly told her, in exaggeration, that her health had been seriously undermined. This put her and her family in tears. However, after her husband, Kourosh, had investigated the issue through the doctors, they had reassured them that everything was fine and under control. Kourosh described the situation:

> Last time she [Elmira] was asked to come to the hospital because her blood platelets [had] dropped, they've been giving this information, they [interpreter] pretty much misled [us] and I felt really down with the system; what kind of people out there get their license? Obviously at the time I was at work because I have work commitments, and it was just my parents and my wife who have no English whatsoever and they've been given wrong information through the hospital, you know, anything could happen any time. When I arrived, there was none of that; it was completely a different story, which was just because of lack of English. It's unacceptable.

These experiences, in each case, only identified and resolved through the intervention of the English speaking husband, exemplify the vulnerability of patients like Elmira whose insufficient English makes communication with health professionals particularly challenging, and increases the likelihood of inaccurate messages being transferred between them and doctors, if the quality of the interpreting is not strong. Such communication breakdown or inaccuracy can easily lead patients to develop a negative attitude toward interpreters, whose interpretation skills they stop trusting.

Whilst such a negative attitude or lack of trust may be justified if the interpreter is responsible for an error, the unquestioning trust patients placed in their treating doctors meant that mistakes tended to be always attributed to the interpreter, regardless of whether this was the case or not. For example, Eliza remarks:

> The doctor said to her, "you don't have a polyp and it was a fibroid". And she goes to me "Excuse me, you told me it was a polyp". And I said "I might have told you because that's what the doctor said" and the doctor looked [at the patient] and said, "Yes that's right, we told you it was a polyp, but after all from the examination it was a fibroid". In a way I was the bad one that didn't interpret, but at [sic] the end it was correct interpreting because that's what the doctor had told me at the time and that's what I said. You see I was the one to blame that I didn't interpret to her what I was supposed to, but it was [not my fault]. That was pretty sad for me because I'm thinking she believed that I misinterpreted something and I believed that I did the right job at the time, it was right and the doctor did clarify

> it, but in a way she was angry with me and not with the doctor, because she heard it from my mouth.

This excerpt indicates the high level of patient trust in the treating doctor and their inability to make mistakes, meaning that any mistakes are attributed to the interpreter. Trust in the interpreter tends to be very fragile and easily broken when misunderstandings occur.

An interpreter's request for a remark made by a patient or an HP to be repeated resulted in some patients losing trust and confidence in their interpreter and not wanting to be served by such interpreters, who they considered inefficient. All expected interpreters to understand their HPs' utterances the first time they heard them and translate them immediately. However, there seemed to have been occasions where repetition of the message had been required by an interpreter. For Ahmad and Neda, their interpreters' requests to repeat what the patient had said was synonymous with the interpreter not listening carefully when the patient was talking to them. Ahmad was not convinced that the need for repetition was legitimate because the interpreters who appointed to him had to date been native speakers of Dari, the language spoken in Afghanistan, Ahmad's mother tongue, and he expected them to understand everything immediately. These observations had led Ahmad to conclude that interpreters from Iran were better at understanding him and transferring HPs' messages to him.

Some patients also believed that some interpreters would not listen to them attentively and thus would communicate a different idea to the other party. Expressing her dissatisfaction with this perceived poor performance, Neda said: "some interpreters do not listen carefully to what the patient is saying, they say some other things of their own to the doctor".

Mona, perceiving a problem with how an interpreter had behaved in a previous consultation; she explained that it impacted on her capacity to trust in further sessions, although the patient could not necessarily change the interpreter's attitude or actions:

> As a patient I cannot tell the interpreter you had such and such problems but for my next appointment if I see that I have the same interpreter, I would think to myself 'oh, this interpreter again?' and this is very bad. The patient is supposed

> to be satisfied with the interpreter and be happy when she sees her/him, rather than the other way around.

As is clear from Mona's observation, the patient's satisfaction with a conduit model would escalate to trust and feeling happy and content with her interpreter-mediated medical consultation.

Feelings of contentment and satisfaction were achieved in different ways. For example, for some, like Kourosh and Elmira, continuity in being served by an (agency) interpreter whom they were satisfied with was important, as it provided them with peace of mind and decreased their anxiety. Some participants reported that this anxiety would sometimes lead them to not request interpreters and carry on their consultations with their own basic level of English. Hassan, for instance, said, "Most often I don't have an interpreter, I handle it myself". Mona explained, "A couple of times I was so upset and stressed from previous bad experiences with interpreters that I decided to have the consultation without an interpreter". However, this decision presented its own challenges: "This also made me distressed. I wanted to say things to the doctor but I was not able to due to my English level and so I gave up".

Participants demonstrated the importance of accurate interpreting and when it was not achieved, they felt frustrated and vulnerable. Some attempted to seek alternative solutions, such as not having an interpreter or bringing a family member for support. Accuracy and the development of trust and rapport are key attributes from the patient's perspective to a positive experience of the interpreter's role. Repetition and inaccuracy in interpreting were among causes for patients' negative attitude towards interpreters.

6.1.3 Dialect mismatch

For a number of patients who were interviewed, a key factor in their experience of the effectiveness of interpreting services they received related to how well the dialects spoken by them and their assigned interpreters matched and how familiar their interpreters were with their dialect. This is because dialect mismatch between an interpreter and a patient could result in lack of understanding or inaccurate understanding for some patients. This situation was particularly frustrating for those

using agency interpreters, as in-house interpreters were perceived to be more flexible with accommodating a variety of dialects. Such flexibility was not experienced by patients using agency interpreters.

Patient participants were speakers of one or two languages (Arabic, Dari, or Persian). The official language of Iran is commonly referred to as either Persian or Farsi. One of the official languages spoken in Afghanistan is a language referred to as Dari or Farsi. Both Persian and Dari languages are referred to as Farsi by some speakers of these languages as well as some interpreting agencies. Even though there are contested political views about how these languages are related, linguistically speaking they are in fact separate varieties of one language. There is quite a significant phonological, morphological and lexical difference, but to some extent they are mutually intelligible depending on the level of exposure of the speaker. For example patients who were Dari speakers, who visited Iran for work or living purposes were familiar and understood this language variant. On the other hand, Persian speakers who were not exposed to Dari had problems understanding terminology and sentence structure used by their Dari interpreter.

As an Iranian, Mona believed that Persian and Dari were too different. She said, "when they provide an Afghani interpreter, that's another language. That is very hard and creates problems; an Iranian person needs an Iranian interpreter not an Afghani". She gave an example:

> Once the doctor asked the interpreter to ask me if I have diabetes. We call diabetes *'ghand'* which also means 'a sugar cube', but Afghanis call it "sugar" like the English term for diabetes; so she asked me if I have sugar. I had gone to McDonalds and had a coffee there but without sugar, so I had it in my bag. So I opened my bag to bring out the sugar, then I thought why would she ask me for sugar? Suddenly I realised that she might have been asking me if I have diabetes. But if the interpreter was Iranian, she would have easily said, 'do you have "*ghand*" [diabetes]'? She wouldn't have asked "Do you have sugar"? so I wouldn't have opened my bag. This is the difference between Iranians and Afghanis.

This subtle difference in choice of words resulted in the miscommunication Mona described above, even though she was able to venture a correct guess regarding what the interpreter actually meant.

As unsurprising as it is for Iranian patients to prefer Iranian interpreters, most Afghani patients who participated in this study expressed their preference to be helped by Iranian, rather than Afghani interpreters. Kourosh and Ahmad both had been born in Afghanistan, but preferred to have an interpreter originally from Iran with Persian dialect since they had lived in Iran, and, therefore, could understand the Persian dialect. More important in influencing their preference, they believed, the Afghani interpreters were not as competent in English. Ahmad, for example, said:

> Two or three of my interpreters were Iranian. Iranians understand both our language and English correctly. We feel very comfortable with Iranians because their language is good, they understand quickly but our Afghan interpreters, some of them don't understand. They don't understand doctors' language; they understand our language. Even when they are from our language background, their dialect is different if they are from the countryside or larger cities. Those from the countryside speak in a different way. Those who are from the city speak differently. The interpreters who are from the city understand things better, they are educated. Those from the countryside, those who have come here recently, are those who do not understand the conversations very well.

Clearly, patients may consider the perceived English proficiency of interpreters as a more important factor than how closely their native dialects match. In this example, key factors influencing their preference were perceptions of relative education levels between rural versus urban based Afghanis and how this influences more specialist terminology in English.

Regarding Arabic dialects, Salma and the Arabic in-house interpreter were both from Lebanon, speaking the same dialect. Maryam, who was from Africa and also spoke Arabic, was familiar with a few Arabic dialects because "they [the hospital] also accommodate various dialects, such as Egyptian, Sudanese, etc." and, therefore, "all interactions go well." "Once there was a Coptic Egyptian interpreter and I was happy with him too. Although I am from Sudan, I lived in Egypt, so even that session was good".

These examples show that effectiveness of interpreters may vary based on the patients' familiarity with different language dialects and their tolerance of different dialects and accents. In contrast to Maryam, Neda, who spoke Iraqi Arabic, did not have a positive

experience with the same Arabic in-house interpreters and attributed this to them, because they would be speaking dialects different to hers: "I know the Arabic language because I was born in Iraq. I used to ask for Arabic interpreters, but the interpreters were from other countries and their dialects were totally different from my dialect". This dialect mismatch had led her to ask for Iranian interpreters since, having lived in Iran for many years, she knew Persian: "Then because I know Persian well, I asked for Persian interpreters and now I insist on having Persian interpreters, because Arabic varies across many countries and I couldn't understand it".

Understandably, patients preferred interpreters with whom they had had previously positive experiences in terms of being attentive to the conversation, and speaking a familiar dialect. The patient's familiarity with and tolerance of the dialect of the interpreter was based on their previous experience living in other countries, where they were exposed to languages or dialects spoken there. This exposure definitely extended the patient's options and comfort in selecting and dealing with a greater range of interpreters.

What can be concluded from the above discussion is that participants highly valued accurate interpreting from English to their own language/dialect with the interpreter acting as a language 'conduit'. When they felt that this interpretation had not been achieved, they felt frustrated and vulnerable. Some attempted to find alternative solutions, such as not having an interpreter or bringing a family member for support. Accuracy and the development of trust and rapport were key attributes from the patient's perspective to a positive experience of the interpreter's role. A request for repetition and inaccuracy in interpreting were among various causes for patients' negative attitude towards interpreters.

6.2 Interpreters going beyond a 'conduit' role

Five interviewed patients (55%) made reference to roles that involved the interpreter moving beyond a 'conduit' role. These roles can be described as 'clarifier', 'supporter' and 'repeater'. The patients perceived these roles to provide a better understanding of the message, feeling of support, further satisfaction and meaningful communication. The abovementioned roles will be discussed in the next section.

6.2.1 Clarifier

Some of the patients expected their interpreters to clarify terminology, or a problem by explaining it to them so they were able to understand it. For example, Salma said that one of her expectations from interpreters was “to explain the word or the term that I can't understand from the doctor”. Similarly, Neda said, “we have been told many times that if we have any questions, we should ask them when the interpreter is available”. Hassan also explained that interpreters should “make us understand what the problem is”, which indicates the expectation of the interpreter to do more than merely transfer the message and ensure it is well understood by patients.

6.2.2 Supporter

Some patients explained how they felt supported when having an interpreter present in the consultation who speaks their language and assists them by drawing on their own knowledge. For example, Mona said that the presence of the interpreter makes her feel relaxed because she has support: “When an interpreter is with me, I feel that I have a supporter and this makes me relaxed” and Neda said,

> Most of the interpreters guided me in what I asked them for, things that I didn't know, they told me. For example I might have gone to an office and faced some problems, then I mentioned it to the interpreters and they would resolve the issue for me, telling me that is what I needed to do.

6.2.3 Repeater

Some patients described being satisfied with the interpreter repeating what the doctor had said whilst acknowledging that some interpreters asked the patient if they required repetition. For example, Kourosh talked positively about the interpreter offering to repeat or respond to anything they were still not clear about:

> I had a good experience last time I came in… she [the interpreter] asked at the end, “do you have any question[s]? Do you want me to go through anything again”? So I had a great customer experience, I was really surprised…

Neda liked to be given the opportunity of repetition by the interpreter, saying:

> Because I have some problems with my ears, sometimes I wouldn’t understand what they would say then I would ask them to repeat it. Some interpreters repeat it better than others.

These patients identified the above roles that interpreters undertook, and they all saw such actions on the interpreter's part as helping them feel emotionally supported by the interpreter and achieve a clearer understanding of intended messages. As is evident from how positively the five patients described their experiences, the interpreters adopting these additional roles made an unexpectedly positive impact on their satisfaction with communication.

Reflecting on the discussed roles that patients assigned to their interpreters created a feeling of positivity and relaxation for them. The positive outcome of perceived roles patients assigned to their interpreter was their satisfaction and trust in the interpreter and wanting to have the same interpreter for every consultation. For example, during the interview with Salma, the researcher observed Salma telling the in-house interpreter, "Now I prefer to have you most of the time rather than other interpreters", indicating that she felt comfortable with that interpreter. Kourosh also seemed comfortable with one particular interpreter whom he would trust with his wife's serious health condition. For these two participants, feeling comfortable and trusting the professionalism of the interpreter was more important than merely having an interpreter. When satisfied with an interpreter, patients were likely to form a close emotional connection with them, particularly if regular appointments were required.

It was critical for some patients to feel a personal connection to build a relationship with the interpreter in order to feel relaxed, comfortable, and trusting. This seemed to be particularly true for Arabic speaking patients, who had access to an in-house interpreter, and for some female patients from the other language groups. For example:

> I am very happy, thanks to Jasmine [an interpreter]. (Maryam)
>
> I've had a good experience with her. If she comes on a regular basis, I'd be happy with her. (Kourosh)
>
> It is very good for the patient to be satisfied with the interpreter and become happy when she sees the interpreter. (Mona)

These excerpts show the level of contentment and satisfaction that patients felt with their interpreters.

In addition to interpreters assisting patients to feel relaxed and supported with their presence, there were other characteristics, such as interpreters being punctual and available for consultation, that patients paid attention to, and drew on in determining how well they felt the interpreter had conducted his/her role.

6.3 Impact of professional and institutional constraints on patients

Most patients had encountered situations where professional and institutional constraints impacted on their interpreted medical consultation. Some issues patients experienced related to the hospital as an institution, whereas others related to behavioural conducts, work ethics, and testing of interpreters. Specifically, two themes: interpreters' punctuality and availability, and perceptions of interpreters' unprofessional conduct have impacted patients, shaping their perceptions and attitudes towards the service provided by interpreters.

6.3.1 Interpreters' punctuality and availability

Most patients expressed that availability and punctuality of their interpreters was one of their expectations. Four patients, Kiana, Maryam, Salma, and Elmira, had not experienced any difficulties with availability of interpreters. Kiana and Elmira used agency interpreters and did not report any issues with either their availability or punctuality. However, other patients, such as Mona, Neda, Ahmad, and Hassan, reported challenges caused by their interpreters' rush to leave consultations early (which Neda seemed to have experienced on several occasions), late arrivals (as in Mona's case), or no show (as experienced by Hassan), which had impacted on the effectiveness of communication between them and their HPs. Although the interpreters' unavailability and/or tardiness were mainly a consequence of institutional and agency policies and scheduling practices, patients clearly expressed their expectation of interpreters to arrive on time and stay until the end of the consultation.

In addition to scheduling problems, some interviewed patients had experienced unanticipated situations due to misinformation and mismanagement of interpreter services that affected interpreter availability. Mona, for example, had once visited the

doctor without the interpreter's assistance because the interpreter, having been told that the patient was a man, was outside the HP's office looking for a male patient:

> Once I got very upset because I had finished my appointment when the interpreter showed up and she was only looking to get her assignment slip signed off. She said it wasn't her fault because she had been told that the patient was a man and I was a lady… She said, 'I thought it's a gentleman and I kept sitting down to be called'. I didn't see this lady at all while I was waiting in the same waiting area when the doctor called me.

Such negative experiences affected the patients' attitudes toward using interpreters in different ways. Mona, for example, had consequently chosen to visit doctors without interpreters, which had caused her more inconvenience:

> A couple of times I was so upset and stressed [from previous bad experience with interpreters] that I decided to have the consultation without an interpreter and this also made me distressed… I wanted to say things to the doctor but I was not able to due to my English level and so I gave up.

Giving up, however, was not a solution other patients adopted. Instead they adopted a number of more productive compensatory strategies. Having lived in Australia for seven years, Hassan could handle most of the consultations himself: "Most often I don't have an interpreter, I handle it myself". Other patients reported bringing a family member to act as 'backup' interpreter in case there were serious dialect mismatches or no interpreter was available. These patients' family members certainly had made extra effort to be present at the consultation with them, such as missing work (Neda's husband), or missing school (Ahmad's son). Ahmad would sometimes bring along his son who was more proficient in English than him. Neda would also bring along her husband who could assist in interpreting in case no interpreter showed up. When the researcher was interviewing Neda, she had an appointment at the hospital. When the receptionist told her that the interpreter had arrived, Neda's husband told her he would stay outside and wait for her. The researcher asked Neda about the reasons her husband was there. She explained that she sometimes did not have access to the Persian agency interpreter as the Arabic in-house interpreter was more often available. Thus, she had started to bring her husband to her appointments in case the Persian interpreter was not available. This way, she could ask for the Arabic in-house interpreter as her husband could translate from Arabic into Persian for her. When this three-way interpretation process was required, it would take even longer for the consultation to be conducted as

every statement would be interpreted twice or more, in such a way that initially the doctor's utterance, to be interpreted into Arabic by the Arabic in-house interpreter to be understood by Neda's husband, then her husband would interpret it into Persian for Neda, added to her anxiety about potential communication difficulties.

Some patients experienced not having an interpreter at some consultations they attended. For example Maryam, who was a new arrival and usually required interpreting assistance, did not have an interpreter when she attended the X-ray department: "This morning I had an X-ray and I did not have an interpreter, but the staff were able to understand me". Having appointments for an X-ray or other similar tests, where non-verbal communication can suffice in most cases, may go ahead relatively smoothly without the presence of an interpreter. However, the presence of an interpreter is vital in situations where verbal communication plays a critical role and cannot be substituted in discussing the results of an important test or treatment options in serious health conditions. Whilst the nature of the consultation can affect the necessity for an interpreter, only Maryam explicitly drew this distinction. However, hospital policy mandates the presence of an interpreter when the health professional is having to gain informed consent from a patient, effectively recognising that in certain critical contexts where health and treatment decisions are made, managing without an interpreter is not acceptable.

Other interviewed patients did not report such satisfaction without the presence of an interpreter in consultation, and their planning for attendance incorporated strategies to enable family members to assist, if required. For example, Kourosh had to take leave of absence once every three weeks to accompany his wife, Elmira, to consultations in order to compensate for the possibility of the interpreter's unavailability or inaccurate translations affecting her visits to HPs, adversely. Similarly, Ahmad explained that his son sometimes had to miss school as Ahmad was not sure whether an interpreter would be available to help him communicate with HPs at Smith's Hospital. His previous experiences of not having access to interpreters in regional Victoria had influenced his approach in always bringing a support person from his background who could act as interpreter, if required:

> On that farm in [the] Ballarat region, I went to see a doctor, he gave me tablets. Because there were no interpreters there, I took one of the people from my country, who could understand English, with me to see the doctor. After we saw the doctor, he gave me the tablets.

This excerpt is yet another example that emphasises the extent to which migrant patients prefer to have a support person who speaks English accompany them when attending a medical consultation, due to their concerns about the potential negative impact of lack of availability or punctuality with some interpreters. Another factor that adversely impacted on the perception of patients regarding their interpreters was their judgements of interpreters' unprofessional conduct.

6.3.2 Patients' perceived unprofessional conduct in interpreters

Some interviewed patients reported that on different occasions they had observed interpreters acting in a way they considered unprofessional. A series of 'behavioural patterns' like refusing to listen to the patients' questions, asking personal questions of patients, and finishing the consultation before the patient is properly served were identified by patients who were affected by such unprofessional conduct in their assigned interpreters. Neda and Mona elaborated on interpreter behaviour which they considered unprofessional in more depth and they offered more examples than other interviewees.

One of the behavioural patterns Mona reported observing on a couple of occasions was the interpreters' style of communication with HPs during consultation, asking personal questions of HPs while the consultation was taking place.

> In the middle of consultation, she asks the doctor 'where are you from? How long have you been here?' The interpreter is not supposed to ask such questions from the doctor, especially in the presence of the patient. The interpreter is at the service of the patient and it is not okay for her to ask [the] doctor irrelevant questions.

Emphasising the fact that the major duty of an interpreter is to provide language support to patients, in this excerpt Mona is critical of her interpreter's irrelevant questions to HPs during a consultation. This behaviour on the part of interpreter was inappropriate in Mona's view, particularly because her own legitimate questions would sometimes

be treated as irrelevant by her interpreter, and she would be prevented from asking them.

> Once when I was going to ask a question from the interpreter, she said; 'sshhhh, your voice is being recorded and you are not supposed to talk about things other than the subject'. The interpreter is allowed to talk to the doctor about irrelevant things but the patient is not allowed to ask a question which may not have to do with the subject of discussion from the interpreter?

Neda had similarly observed interpreters refusing to listen to and answer patients' questions. She had also experienced being denied help with filling out forms:

> When the session is finished, if the patient has some questions or wants to fill out a form or something like that, the interpreter leaves, they don't stay and they make excuses for that behaviour. Although we have been told many times that if we have any questions, we should ask them when the interpreter is available, some interpreters unfortunately leave.

Neda is clearly aware of her entitlements in terms of interpreting support. This awareness had helped her to identify where interpreters may fail to fulfill their responsibilities to patients.

Another behavioural pattern that a few interviewed patients considered unprofessional was asking personal questions, which Mona referred to as "intrud[ing] on my privacy". As Mona described,

> A few wanted to intrude on my privacy, by asking me questions like 'where do you live? How many children do you have? What type of work did you do before coming to Australia? What do you do now?'

Neda reported dissatisfaction with another type of personal question she was asked by her impatient interpreter who questioned her attention and listening skills, as she recalled, "once I had a telephone interpreter and he said, 'Madam, why don't you understand'"?

These patients felt uncomfortable as a result of such unexpectedly personal questions. Mona kept it to herself and felt upset about it: "If I have an interpreter I get upset and if I don't have an interpreter I get upset again". In contrast, Neda was outspoken and reacted to her interpreter, as she reported, "I said, 'I do understand it sir, but I have problems with my ear', then he apologised. I said, 'you shouldn't treat me this way. If

we knew English, we wouldn't have asked for interpreters and be insulted'". In both situations, clearly the patients had felt upset.

The participants also expressed their dissatisfaction with being pushed by some interpreters to book appointments with them for future consultations. In this regard, Mona shared her experience of having interacted with interpreters who

> wanted to advertise themselves for my next appointment. They said, 'ask for me to interpret for you in your next visit so that the hospital will choose me again next time to interpret for you'. I do not like such advertising business.

Whilst good communication and accurate interpreting could build relationships between some patients and interpreters, remarks and comments made by interpreters outside what the code of practice and job description allow could negatively affect that relationship. In this regard, Mona lamented

> It only happens rarely that the interpreter comes on time and does her duties seriously with the patient and doctor, not asking personal questions from the patient and not from the doctor and not advertising for herself. I don't think I am the only one who criticises the interpreters for their behaviour.

Mona's critical view of interpreters is reflected in her belief that the number of interpreters who follow the code of conduct is less than those who do not.

Finally, finishing before the patient has been properly served was another example of interpreters' inappropriate behaviour from the patient's perspective. Neda considered such conduct as not in line with their responsibilities to patients. Recalling a situation where this happened, Neda believed she had been given wrong information by the interpreter regarding her planned hospitalisation, and the interpreter had left the hospital premises early due to personal reasons:

> I was going to be hospitalised in two days' time. Halfway through [the consultation], the interpreter told me that it was all finished for that day and I could go home. So I didn't know [what to do] and went home. Then they called me from the hospital asking me where I was. I asked 'why?' They said, 'Because you hadn't finished yet'. They asked me where the interpreter was. I said he had gone home. They said 'Why did he go home?' I came back to the hospital and the staff were very angry, not with me, but with the interpreter. They said, 'We even called him but he did not answer the phone'. One day I saw that interpreter and I asked him 'Why did you do what you did that day?' He replied that the job had finished. I said, 'Then why did the hospital ring me and ask me to return to

> the hospital?' He said, 'Because I had to go somewhere in Geelong'.[I replied], 'Well, if you were busy, you shouldn't have accepted this job so that someone else could have come instead of you'. He didn't say anything else, he had no answer.

Neda's experience is a reflection on the nature of freelance interpreting work, where an interpreter may accept multiple assignments with insufficient time between consultations. This type of behaviour definitely reduces the quality of the interpreting service, and results in dissatisfied patients. It is also perceived as being unprofessional as the interpreter puts his/her own interests ahead of the client's.

Patients' reaction to these undesirable situations was avoiding interpreters whose behaviour they did not find professional. Elmira, for example, had chosen to wait until her next appointment with a different interpreter to ask the doctor about what she had not understood, instead of asking the interpreter already assigned to her to repeat the translation. And Mona decided not to have any interpreters for a while, as previously discussed.

The experiences of Mona and Elmira in the above excerpts show how critical it was for each of them to positively connect with the interpreter assigned to their medical appointment, so they could feel satisfied and content. Having interpreters who acted in unpleasant and, in many cases, unprofessional ways, made it difficult for these patients to feel connected. The patient--interpreter relationship and feelings of comfort and trust toward the interpreter are of critical importance in achieving patient satisfaction with the quality of communication in their interpreter-mediated health consultation.

6.4 Other issues contributing to patients' satisfaction

The overarching focus of this thesis is understanding the nature of the range of contributions made by interpreters in facilitating HP--patient communication. The examples provided in the previous section reveal that the positive patient--interpreter relationship and the patient's comfort and trust are of critical importance in achieving patient satisfaction. Patient satisfaction did not emerge in a vacuum, but was connected to their background, as well. Specifically, cultural and educational influences on

patients, such as gender preference and level of education, contributed to their overall level of satisfaction.

In relation to female patients' preference for female interpreters, two patients interviewed, Kiana and Mona, insisted that having access to female interpreters made them feel more comfortable. Mona explained: “If there is a male interpreter, I'm not comfortable ... generally, I prefer a female interpreter because I am a female too”. Generally speaking, feeling comfortable signals the expectation of a productive interpreter mediated consultation. Kiana recalled a consultation about her pregnancy in which she became angry because a male interpreter had been assigned to her. As a consequence, Kiana refused to see her doctor with the male interpreter and rescheduled her appointment, which was an extra burden, being pregnant, to attend the hospital at another time and date, as well as causing disruption to the hospital's clinic. Such rescheduling was also a financial burden because Kiana's residency status required her to pay out-of-pocket expenses for every appointment at the hospital.

Another patient, Salma, preferred her interpreter to be the female in-house interpreter over a male agency interpreter. Interestingly, even though Neda did not say that she had a gender preference for her assigned interpreter, she seemed to remember vividly that both negative experiences happened when her interpreters were male: on one occasion described in section 6.3.2 her male interpreter wrongfully ended the session and left for Geelong for his next interpreting assignment. Another occasion was when Neda's male telephone interpreter was insensitive towards her, which resulted in Neda's defensive reaction:

> Once I had a telephone interpreter and he said, ‘Madam, why don't you understand’? I said ‘I do understand it sir, but I have problems with my ear’. Then he apologised. I said, ‘you shouldn't treat me this way. If we knew English, we wouldn't have asked for interpreters and be insulted’.

In contrast, male patients did not express any overt gender preference for interpreters and did not report any experience relevant to them and their interpreter in relation to gender.

Another issue that impacted on patient satisfaction with their interpreter was the level of education. Patients with a higher educational background were more critical of the interpreter in terms of communicating correct vocabulary, being on time, and acting professionally. For example, Mona, a retired teacher, criticised different aspects of her interpreters' performance, such as choice of words to translate 'diabetes', punctuality, and irrelevant conversations interpreters initiated with HPs. Kiana, having a Year 12 diploma and extensive administrative work experience in Iran, assertively rescheduled her doctor's appointment because she was assigned a male interpreter. Kourosh was another participant with a university degree, who expected quality interpreting and was critical of the interpreter's use of the word "weekly" instead of "daily" in his translation of the HP's prescription. In contrast, his wife, Elmira, Hassan, and Ahmad, who came from more limited educational backgrounds were not critical of their interpreters' performance and mainly focused on their interest in somehow communicating with their HP, including through involvement of English competent family members and friends.

6.5 Summary

This chapter has presented and analysed the views and experiences of patient participants in working through interpreters in communicating with their healthcare professionals. The patient participants in this study were from Afghan, Arabic or Persian backgrounds and all expressed their primary expectation of the interpreter transferring their messages accurately, thereby acting as a language 'conduit' in their communication with HPs.

For the interpreter to be viewed as an effective language 'conduit' ideally required both patient and interpreter to speak the same language dialect. However, this was not always the case, especially as most languages being discussed by patients were pluricentric. Dialectal variation created confusion and misunderstanding for some patients, especially those who were less familiar with different dialects.

Whilst the main role that patients expected from their interpreters was to transfer messages directly and accurately, just over half of the participants welcomed initiatives

beyond this ‘conduit’ role, expecting the interpreter to assist by acting as a clarifier, supporter and/or repeater.

The interviewed patients had both positive and negative experiences with an interpreter in the consultation. On the positive side, the presence of an interpreter facilitated communication with health professionals which resulted in the formation of trust, and feelings of reassurance and support for patients. On the negative side, some experienced shortcomings were unprofessional conduct or lack of punctuality on the part of interpreters. The data also revealed that patients’ educational background could influence the extent of their criticism about their interpreter’s conduct.

The vulnerable position of patients was evident in their treatment, as submissive parties who had to accommodate shortcomings at the hospital. Given the opportunity, their ability to choose an interpreter they were satisfied with changed the perceived power dynamics of their interaction with hospital staff and brought them satisfaction.

The analysis in this chapter (and the two previous chapters) has focused on the experiences of three parties in an interpreter-mediated health consultation. Analysis to date has highlighted how the language ‘conduit’ role is valued and seen to be central by all three groups. However, other roles have been identified by each group, and a range of other contributions made by interpreters have been commented on—both positively and negatively. In the next chapter, some actual interpreter-mediated consultations are examined for what they reveal about the role/s interpreters assume in actual dynamic and fluid interaction between the patient, the health professional, and the interpreter.

Chapter Seven – Analysis of Interpreted Interactions

The three preceding chapters presented the reported experiences and expectations of all three groups of participants in interpreter-mediated consultations. This chapter captures what happens in some actual interpreter-mediated consultations. It reports on the analysis of three health consultations with a focus on interpreters' roles and strategies for facilitating conversations between the health professional and patient. All recorded consultations took place in outpatient clinics and involved a triad comprising the treating doctor (Dr), an interpreter (Int), and the patient (Pt), with patients from Dari, Italian, and Arabic language backgrounds. Two interpreters (i.e. Arabic and Italian) were in-house, whereas the Dari interpreter was from an agency. In excerpts and full transcripts (see Appendices 2, 3, and 4) statements in languages other than English are presented as uttered, followed by a glossed literal English translation in square brackets. The line numbers in excerpts reflect those in full transcripts.

7.1 Characteristics of three interpreter-mediated consultations

Overall, the characteristics of each consultation were determined by the nature of the consultation and the nature of the individual attendant patients.

7.1.1 Overview of individual consultations

Dari consultation: Four people in total participated: a female 35-40 year old doctor; a 30-35 year old female native speaking Persian interpreter who had been assigned to be a Dari interpreter, but spoke mainly with a Persian accent throughout the consultation; a 50-55 year old male patient, who was a native speaker of Dari, but with good command of Persian, and his 16-18 year old son as his companion. The consultation involved a review of the patient's back pain condition. Prior to the actual consultation the researcher interviewed the patient for the interview component of this study; this revealed that the patient, who was born and raised in Afghanistan, had lived many years in Iran prior to coming to Australia. His exposure to interpreters in the past had given Ahmad the satisfaction and preference for Persian interpreters over Dari (see findings reported in Chapter 6 about Ahmad), hence his request for a Persian interpreter.

Whilst during the interview (see findings reported in Chapter 6), the patient's sentence structures were complete and correct, but during the recording of the triadic consultation, there were occasions where he spoke in long sentences with no verb; hence there was a lack of clarity in some meanings, with many repetitions of words, where the interpreter had to judge where to cut off repetition of the same words prior to interpreting for the HP. On the other hand, the interpreter must have assumed that the patient was not familiar with her Persian dialect and choice of words, therefore she repeated words and sentences in both Persian and Dari dialect to ensure the patient understood. Lack of initial briefing between the interpreter and patient could have contributed to the great number of repetitions. Towards the end of the consultation the HP left the room to discuss the next step in the medical process for the patient, that was, organising surgery with her colleagues.

When the HP left the consultation room, the patient, his son, and the interpreter waited together and the patient narrated his story to the interpreter about his back pain and how he felt better by seeing a natural healer in Iran. The patient described to the interpreter chronologically the steps he took in his trip to Iran that resulted in improving his back pain. In terms of the quality of his speech, the patient did not make any grammatical mistakes or repetition whilst telling his story to the interpreter, but when the doctor was asking him questions via the interpreter, in some instances, the patient was not responding with a clear sentence structure. In the excerpts below the patient made many repetitions and the sentence structure was incomplete when the doctor asked him about the switch in location of the pain in his body:

Example 1

Dari: Lines 61-89

Dr: Ok so it's switched a little bit
Int:

خُب. میگه پس بدل شده، ها؟

khob, mige pas badal shode, ha?
[Ok, she says therefore it has been swapped, yeah?]

Pt to **Int:**

آره، گشتن که هستن پارسال که میگشتُم پایِم درد میکرد گشتن کرده نمیتونستُم. امسال که هستِ باز که میگردُم کمرِم درد میکنه طرف پشت؛ مثل میسُزه که سُزش میکنَه. حال که حال که بشینُم حالي هم که از جایِم پاشیم هم سُزش میکنه هم میسُزه

Transliteration: areh, gashtan ke hastan, parsal ke migashtom, payem dard-mikard,

Translation: yes, getting-around that to be, last year that getting around-I, leg-my was-in-pain, getting around

gashtan-karde-nemitoonestom. Emsal ke haste baz ke migardom kamarem dard-mikona
getting-around-not-able-to-do-me. This-year that is when walking-I back-my pain-have-is

taraf-e posht, mesl-e misoza ke sozesh-mikona.
side-of back, like-of burning that burn-doing.

Hal ke hal ke hal ke beshinom hal ke az jayem pashim ham sozesh-mikona
Now that now that now that sit-I now that from place-my stand-up both burning

ham misoza
also burns

Exact translation:
[yes, in walking, last year when I was walking, my leg was in pain, I could not walk. This year when I walk my back hurts, at the back, like it burns, it burns. Now now now when I sit and want to stand up it both burns and burning]

Int to **Dr:**
He said that last year when I tried walking, while walking I had pain in my legs whereas this year while walking I have this burning pain in my back and it's right at my back

In this example, the patient repeated words like 'now', 'walking' or 'burning sensation' several times, which may have created the potential to take away the focus of his intended meaning. The interpreter removed those repeated words from the message to the doctor.

Example 1 is an exemplar of the potential impact of the patient's (low) education on the process of consultation, contributing to an understanding of what may have occurred when some health professionals (Chapter 5) were concerned that the patient may have talked for a long time, but the interpreter would only interpret a few words. The excerpt above showed the patient's repetition of the same matter in discussion, in a very basic sentence structure in which the interpreter omitted the repetitions when conveying the message to the doctor. The basic sentence structure with several repetitions the Dari patient used for explaining his pain resonated with narratives from some interpreters (Chapter 4) explaining the impact of the low level of education in some patients on the effectiveness of the consultation. When the researcher questioned Ahmad about his level of education during his earlier interview, he did not comment despite several attempts to probe, resulting in the researcher's conclusion that he did

not have formal education in his home country of Afghanistan. Comparing the translated utterance in Example 1 with the original message indicated that the interpreted message was concise which may confirm what some HPs (Chapter 5) had noticed as an imbalance between the patient's utterances with the interpreted equivalent. In this example, the reason for the imbalance duration was due to the convoluted and repetitious explanation of the same matter by the patient.

Arabic consultation: This consultation started with three people, the doctor in his 60s, the female Arabic in-house interpreter in her 40s, and the female patient in her 60s. When the consultation was nearly finished a diabetic nurse in her 30s, who had seen the patient previously, joined them. The doctor discussed with the diabetic nurse the results of the sugar tests the patient had brought in and summarised the patient's other diagnostic findings such as cholesterol and blood pressure. The doctor discussed with the nurse setting a suitable review time. Due to lack of clarity in some parts of the speech of the patient, only clear parts of the Arabic consultation were translated, transcribed and used for this chapter.

During the consultation, the doctor inquired of the patient via the interpreter if her current GP's name was still what it was in the hospital's records. The patient confirmed and added that she was considering changing her GP because he was not very helpful. At this time the telephone rang and the doctor answered it and started another conversation regarding a hospital matter. The interpreter and patient were quiet when suddenly the patient started talking to the interpreter (in Arabic) about her feelings of not being looked after properly by her current GP, step by step how the current GP had been dealing with every condition and linking it to her diabetes. The patient was even making the sound of the blood pressure machine, "swish …swish… swish" for the interpreter when narrating what her typical GP consultation looked like. She then expressed her ideal GP visit as the one she had had with her previous GP, who would call her if she was not feeling well and would take her concerns seriously by examining parts of her body where she had pain, as compared to the current GP who linked every issue to her diabetes, hence not taking her concerns seriously. The interpreter listened quietly to the patient. When the doctor finished his telephone conversation the

interpreter started interpreting the patient's narration. The doctor only listened and confirmed. When the nurse joined in, the doctor reported to the nurse about the possibility that the patient would change her GP. Interestingly, the nurse asked if the previous GP spoke Arabic, perhaps to establish the reason why the patient wanted to go back to him. When the doctor and the nurse were having a discussion about the patient's condition, the patient, for the second time, initiated talking to the interpreter regarding a GP-initiated health scare regarding her stomach. The interpreter listened to the patient quietly. When the doctor and the nurse finished their conversation, the interpreter interpreted what the patient had said earlier, even though it was not relevant to her diabetes and her sugar level, which was the main topic of discussion in the consultation. The nurse advised the patient to go back to see the doctor for her peace of mind regarding her concerns about her stomach pain.

During the consultation the doctor reported the results of the patient's blood sugar test results to be satisfactory. The interpreter transferred the message to the patient and initially added her own comment 'good results' in Arabic. The interpreter repeated the word 'good' in the L1 three times in three parts of the sentence, perhaps to give a positive boost/comment to the patient. It was noted that every time the results of the tests were reported by the doctor, such as blood sugar, blood pressure, and eye tests, the patient replied, indicating her appreciation by praising and thanking God, in Arabic. The patient also commented by thanking God every time she reported that she felt better from an unwell health condition. The interpreter only interpreted "Thank God" to the doctor when it was uttered for the first time.

During the Arabic interaction, the patient interrupted the interpreter constantly. The interpreter usually waited for the patient to finish her sentence before interpreting but suddenly the patient would interrupt by adding further remarks. The interpreter had to pause and listen to the patient's utterance before re-starting her interpretation. The patient did not keep quiet when the doctor was busy talking on the telephone or with the nurse. She initiated communication with the interpreter or the diabetic nurse by seizing the opportunity to talk in every quiet moment. The patient used some English words like 'exam' to refer to 'doctor's examination', 'community centre', the number

of blood sugar readings, 'X-ray', or 'thank you'. She conversed in English with the diabetic nurse telling the nurse she has missed her, "We miss you too much, long time no see no listen for me". Overall, the patient seemed to understand English, but needed the assistance of the interpreter for precise communication.

In both Arabic and Dari consultations the patients initiated talking with the interpreter when the doctor was not engaged with them for reasons such as leaving the consultation room or answering a phone call. This reflects what some interpreters in Chapter 4 experienced with patients who wanted to have a supporter or someone who listened to them. The Arabic and Dari examples in this current chapter demonstrate how patients preferred to converse in their first language with the interpreter when the doctor was not available, rather than remaining quiet and waiting for the health professional to become available.

Italian consultation: This consultation included four people: a male doctor in his 50s; a female in-house interpreter in her 40s; a female patient in her 60s with her husband of a similar age, as her companion, carrying all the scans and reports in a plastic bag. When it was the time to see the patient, the doctor came out of his consultation room and pointed to the Italian in-house interpreter to bring the patient in. The interpreter then called the patient's name, as the doctor pointed, and they all entered the consultation room. The doctor was in a telephone conversation regarding another patient's results, and finished the telephone communication before attending to them. For almost all of the consultation time the patient and her companion were quiet unless they were asked a question by the doctor or by the interpreter. The patient would answer each question and waited for the interpreter to translate to the doctor.

7.1.2 Summary analysis of consultations

Prior to considering the interpreters' contributions in detail, an overview of consultations in terms of their length and structure is helpful. In Table 7.1 basic information on languages, length of consultations and number of units of analysis is presented and in Table 7.2 a summary is provided of the different interpreters' use of communication enhancement strategies.

The basis for analysis across Tables 7.1 and 7.2 is ‘interpreted utterance’ which comprises what was said by the Doctor or the patient in turn by the interpreter to the listener in their language. In categorising each interpreted utterance, I compared the speaker’s utterance to its interpretation. If the interpreter exactly interpreted the entire speaker’s utterance, I would count it as an instance of direct message transfer only. In situations where the interpreter interpreted the doctor’s/patient’s utterance by a partial direct transfer together with at least one additional communication enhancement strategy, this was counted as two units; one categorised as an instance of direct message transfer and the other in relation to the nature of the enhancement strategy employed. Where the interpreter initiated a question to the doctor or patient to assist with her interpretation, this was counted separately and categorised according to the enhancement strategy used.

Table 7.1 highlights that the majority of interpreted utterances involved direct message transfer either solely or in conjunction with a communication enhancement strategy (i.e. acting as a language ‘conduit’). As the data in this table highlights, on average across the three consultations, approximately 60% of the analysed units involved direct interpretation (i.e. the interpreter acting in a ‘language’ conduit role). However, there was variation across the interpreters in their preference for direct message transfer: 62% was interpreted in Dari, 42% interpreted in Italian, and 76% of the Arabic consultation involved direct interpretation. The shortest consultation (Arabic) was the one with the highest proportion of direct interpretation, followed by the Dari consultation as the lengthiest with an average proportion of direct transfer. The Italian consultation had the lowest proportion of conduit-type interpreting.

The specific focus of this chapter is on remaining units of analysis by identifying and classifying other roles and associated communication enhancement strategies adopted (see Table 7.2 for a summary).

Table 7.1: Basic information on the three consultations

Languages	Duration	Number of units of interpreted utterances	Percentage of direct message transfer/ conduit	Number of direct message transfer/conduit
Dari	50 minutes	250	62%	155
Arabic	15 minutes	64	76%	50
Italian	29 minutes	107	42%	49

Table 7.2: Comparison of the interpreter's role and enhancement strategies

Languages	Clarifying	Probing	Simplifying	Adding Knowledge		Repeating	Accommodating dialect	Omitting conversational gambits
				Institutional	Cultural			
Dari								
% total utterances	8%	2.8%	5.6%	1%	0%	7.6%	5.6%	7.6%
No. of utterances	20	7	14	2	0	19	14	19
Arabic								
% total utterances	2%	4%	2%	2%	2%	2%	0%	10%
No. of utterances	1	2	1	1	1	1	0	7
Italian								
% total utterances	21%	11%	10%	4%	0%	0%	0%	12%
No. of utterances	22	12	11	4	0	0	0	13

The nature of the interpreter's enhancement of the communicative interaction between HPs and their patients is categorised (with illustrative examples from consultations in section 7.3). The presentation and discussion of the enhancement strategies exclude units where interpreters play their most typical role (transferring language as conduits), where their interpretation of utterances of the doctor and the patient provide a direct, complete, and largely word-for-word translation from one language to the other (see section 7.2 for examples).

In the more detailed analysis, the focus is on exchanges where interpreters go beyond their officially codified role of 'language conduit' and adopt a range of communication enhancement strategies, each of which extends their 'conduit' role in different ways. Their actions proactively apply strategies that appear to be conducive to effective communication of original messages by doctors and patients.

These communication enhancement strategies are categorised according to seven functions:

1. Clarifying
2. Probing
3. Simplifying
4. Adding institutional or cultural knowledge
5. Repeating
6. Accommodating dialects
7. Omitting conversational gambits

Each of these functions is discussed further, and relevant examples provided. However, prior to considering these, examples of interpreters performing their 'language conduit' role are briefly presented below.

7.2 Performing the language conduit role

The primary expectation from the interpreter was to act in a language conduit role, providing direct accurate translation, transferring messages accurately and directly without any distortion between the health professional and the patient. The following three excerpts, from each consultation, provide examples of the interpreters' 'conduit' role:

Example 2

Dari: Lines 1607-1616

Dr: Are you taking anything else for the pain?
Int to **Pt:**

چيز ديگه اي برا درد ميخورين؟

chiz-e digeyi bara dard mikhor-in?
thing-of other for pain take-you polite

[are you taking anything else for the pain?]
Pt:

نه

na
[no]
Int to **Dr:** No

Example 3

Arabic: Lines 28-41

Dr: Does she write down the result of the sugar test? |* Does someone else writes it down or?
Int: ente
you
Int:
va totahos sokkari aktebi beshi' natayej sokkari
and feeling sugar-your write-you thing results diabetes-your

ala var'a awhad atiki?
on paper or someone write

[and do you write the results of your diabetes on paper or someone else writes?]

*= overlap indication

Example 4

Italian: Lines 484-500

Dr: And how long did they have the scan? For how long?
Int to **Pt:**
per quanto tempo e' rimasta nella galleria, signora?
[How long you had your scan, madam?]

Pt to **Int:**
un paio di minuti
[a few minutes]

Int to **Dr:** A few minutes…

Dr to **Int:** No half an hour?
Int to **Pt:**
no mezz’ ora?
[not half hour]

Pt: No, no

7.3 Clarifying

In analysed conversations there were cases in which the doctor used medical terminology or abstract words, or presented potentially ambiguous explanations about hospital procedures the patient would go through. In order to facilitate communication, the interpreter went beyond mere translation of the doctor’s utterances to provide clarification by explaining technical terminology, unpacking abstract words, and giving concrete examples, adding details relating to hospital procedures referred to by the doctors. Across the three triadic consultations, the clarifying strategy was used mainly in relation to interpreting utterances of the doctors to their patients.

Example 5

Dari: Lines 4-23

Dr: My name is (doctor’s first name), I’m one of the Neurosurgery residents here.
Int:
خُب، این يكي از رزيدنت هاي،م م م چيزه، جراحي اعصابه، نيوروسرجريه، جراحي اعصاب.

Khob, in yeki az resident-haye mmm, chiz-e, jarahiy-e asab-e, neuroserjeriy-e, jarahiy-e asab
Ok, this one of resident-s of mmm, thing-of, surgery-of neurons-is, neurosurgery-is (English term), surgery of neurons

[OK, This is one of the residents of ummm neurosurgery (Persian equivalent), neurosurgery (English term), neurosurgery (Persian equivalent)]
Pt:
بله
bale
[yes]

Int:
يعني داره تخصصشُ ميگيره، مثلاً سال آخر تخصصشه
Yani dare takhasos-esh-o migire, masalan sale-akhar-e takhasos-esh-e
It-means (is) specialty-her-of getting, for example year-of last-of specialty-her-is

[It means she is completing her specialty; like she is doing her last year]

In the above Dari extract, the doctor's utterance includes medical terminology, in particular, the terms 'neurosurgery' and 'resident'. The way in which the interpreter explains the former is through using the Persian equivalent twice and the English term once. She clarifies the term "resident" for the patient as someone who is "completing her specialty" and provides further specific details about the doctor involved in this consultation, namely, "she is doing her last year". It is not clear if the interpreter specifically knows that the HP is doing her last year, or has taken the liberty of adding this detail for some other unknown reason.

Example 6

Dari: Lines 236-249

Int: (Translating the patient's utterance) When I stand up for 3-4 minutes, it's ok; but then the pain starts and while walking the pain is also there
Dr: Does it tend to get worse with more **activity** you do or not?
Int:
هرچي فعاليت بيشتر بکنيد، تکان بيشتر بخوريد، بگرديد، گشتن بيشتر بکنيد اينا، بدتر ميشه يا هرچه بيشتر تکان بخوريد بدتر ميشه يا...؟
harchi fa'aliyat bishtar bokonid, tekan bishtar bokhorid, begardid, gashtan bishtar bekonind
as-much activity more do-you(polite) move more do(you plite), walk, walking more do(you plural)

ina, bad-tar mishe ya harche bishtar tekan-bokhorid bad-tar mishe ya?
Like-this, worse becomes or as-much more moving-you (polite) worse becomes or?

[As you do more **activities**, more **movement**, **walking**, **more walking**, and **the like**, does it get worse? Or the more you move it gets worse, or?]

In Example 6, the doctor's utterance involves the abstract word of "activity". The interpreter initially translates the word using the exact equivalent for "activity" in Persian. She then clarifies using the more concrete alternative "movement" and, subsequently, "walking", which she mentions twice. The clarification and exemplification involved are potentially helpful, giving the example of walking and mentioning it twice, narrowing down the broader meaning of "activity". However, this approach potentially leads to misunderstanding, with the patient answering the question based on "walking", whereas the broader concept of "activity" was what the doctor had envisaged and asked about.

Example 7

Dari: Lines 1573-1582

Dr: Are you **on other tablets** at all for anything else?
Int:
هيچ گلي ديگه اي ميخورين براي هيچ مرض ديگه ؟ هيچ مشکل ديگه؟ يا فقط همين پانادول و اين؟

hich goli digeyi mikhorin baraye hich maraz-e dige?
Any tablet other take-you-polite for any disease-of other?

Hich moshkel-e dige? Ya faghat hamin Panadol va in?
Any problem-of other? Or only this Panadol and this?

[Do you take **any other tablet** for **any other disease**, for **any other issue**? **Or are you taking only Panadol and this one**?]

The turn produced by the doctor in Example 7 involves the question of whether the patient is on "other tablets" for "anything else". The interpreter clarified the doctor's question in her translation of the potentially ambiguous phrase "anything else", by using "disease" and "issue" as possible antecedents of the indefinite pronoun "anything". In her further attempts to clarify the doctor's question, the interpreter then incorporates in her translation of "other tablets" a specific type of tablet discussed earlier in the consultation, when she says "or are you taking only Panadol and this one?"

In Example 8 in Arabic the interpreter is clarifying for the patient what the "sugar problem" referred to by the doctor means, by asking the additional question "Is it going up or down a lot?"

Example 8:

Arabic Lines 52-70:

Dr: Has she had **any low blood sugar problems** that we know of?

Int to Pt:

أنتِ بيسير شيء مشاكل سكّري ام بينزل شيء ام يحبط كثير؟

anta beyasir shee mashakel sokkari
you changes thing problems your sugar

[you have problems in your sugar]

om beyanzel shee om yahbet katir
whether coming down a thing or going up a lot

[whether going down or going up a lot?]

[Do you have **any problem with sugar**? **Is it going up or down a lot**?]

In Example 9, the doctor uses the phrasal verb (verb + particle) “hold off”, the meaning of which cannot be understood based solely on the meaning of individual parts, but requires a broader contextual understanding. The interpreter clarified the meaning of the phrasal verb by expanding the doctor’s intended meaning in saying ‘hold off’. The interpreter also used the English word ‘stop’ with Persian/Dari past tense ending for further clarification for the patient. A similar approach to clarifying is evident in Example 10 in Italian where the interpreter adds the English word ‘problems’.

Example 9

Dari: Lines: 452-465

Dr: Last time you were here, I think, your symptoms had improved quite a bit so we were going to **hold off**
Int:
میگه دفعه قبل که اینجا شما بودین درد شما کمتر شده بود برا همین stop کردیم ، برا همین گفتیم حالا فعلا شاید ضرورت نیست

mige dafeye-ghabl ke inja shoma boodin dard-e shoma kam-tar shode-bood
says time-last that here you were pain-of you less had-become

bara-hamin stop kardim, bara hamin goftim
that-is-why stop did-we, that-is-why said-we

hala felan shayad zaroorat nist
now for-the-time-being may-be necessary-not

[She says last time that you were here, your pain had become less, that is why we **‘stop’ped**, that is why we thought may be the operation would not be necessary now]

Example 10

Italian: Lines 48-52

Dr: Ok, that’s the main reason for you to come here, right?

Int to **Pt:**

Signora, lo scopo della visita oggi e’ perche’ ha tanti problem con la schiena
[Madam, the scope of today’s visit is due to problems with your back?]

In summary, clarification occurred in three different contexts where further explanation was assumed to be required in communicating technical medical terminology, the meaning of generic abstract terms, and aspects of medical or hospital procedural arrangements. The purpose of the clarification was often to add details or, more concretely, explain some aspect of the utterance or its context, and included code switching to incorporate simple English words in some cases. By going beyond mere direct message transfer, in each of the examples analysed,

the interpreters were seeking to make the information or request by the doctor or the patient specific and more understandable for the other party.

7.4 Probing

Another major strategy adopted by interpreters to facilitate communication is through proactively probing the speaker's initial utterance, which appears to have been judged by the interpreter as being vague or incomplete. Through probing, as the following examples demonstrate, the interpreter seeks to develop a more thorough understanding of the idea being discussed and presents a clear interpretation to the message recipient. In clarification, interpreters attempted to ensure that patients comprehend HP utterances by proactively adding details they perceived to be relevant. Probing, however, involved eliciting a more detailed response from the speaker before interpreting the speaker's utterances to the other party. Transcript analysis indicates that probing is directed by interpreters to both patients and doctors.

In the exchange in Example 11, the interpreter probes the patient's initial response to reach a fuller answer to the doctor's question. She then interprets to the doctor the answers to all of the questions she asked from the patient in the process of probing.

Example 11

Dari: Lines 213-237

Dr: Right, what about when you are up moving and walking around, what happens to the pain?
Int:

وقتي سر پا هستين و ميگردين درد چطور ميشه؟

vaghti sar-e-pa-hastin o migardin dard chetor mishe?
When on-feet-are-you and walking-you pain how become-s?

[When you are on your feet and walking, how is the pain?]

Pt:

فقط يك سه چهار دقيقه خوبه باز درد پيدا ميشه

faghat yek 3 4 daghigha khoob-a baz dard peyda-misha
only one 3 4 minutes good-is again pain appear-s

[It is only good for 3 to 4 minutes, then the pain appears again]

Int: (facing the Pt):

موقع گشتن، درد پيدا ميشه؟

moghe-e gashtan dard peyda mishe?
Time-of walking pain appear-s?

[in time of walking, does pain appear?]

Pt:

بله

bale
[Yes]

Int to **Dr:** When I stand up for 3-4 minutes, it's ok; but then the pain starts and while walking the pain is also there.

In Example 12, after a brief initial greeting, the interpreter asks specifically about the health of the patient, who responds by informing her of an operation she had previously. The interpreter proactively asks the patient about the part of her body that was operated on, and after receiving the patient's response, interprets the full report to the doctor.

Example 12

Italian: Lines 3-31

Dr: How are you (patient's first name)?

Int: Come si sente signora?
[How are you feeling, madam?]

Pt: insomma tiriamo avanti ma non sono troppo bene!
[I'm ok- I'm going forward but I'm not fantastic]

Int: dove ti fa male signora?
[Where are you hurt, madam?

Pt: dove so fatta l' operazione …
[Had an operation]

Int: dove al ginocchio
[Where? knee?]

Pt: Ginocchio, si ho fatto il totale al 2001
[Had an **operation on my knee** in 2001]

Int to **Dr:** I had a **knee replacement** in 2001, but I'm still having problems with my knee

In this Italian example there are three rounds of question and answer between the interpreter and the patient before the interpreter interprets for the doctor. In initiating this probing without input from the doctor, the interpreter has taken the lead in questioning, a lead that the doctor would normally undertake. While initiating the probing eventually leads the interpreter to providing the doctor with a succinct summary of how the patient is feeling, it is evident that inaccuracies have been introduced by the interpreter in her summary. For instance, she

interprets “operation on my knee” as ‘knee replacement’, which was potentially misleading to the doctor in assessing the patient’s condition and pain situation.

Example 13 presents another example of probing by the interpreter, in this case the doctor’s potentially vague utterance as to how he will see the patient next time. The interpreter probes for specific details using her knowledge of the hospital procedure relating to appointment bookings. This leads to the doctor providing further information that the interpreter incorporates for the patient in the rest of this conversation.

<u>Example 13</u>

Italian: Lines 588-600

Dr:	So we’ll do that and then see you
Int to **Dr:**	Does she need to go and book her own appointment? Or does she get a letter in the mail?
Dr to **Int:**	No, the appointment will be booked by the girls and they will send the letter
Int to **Pt:**	quel foglietto signora basta che glielo da alle signorine al banco, le signorine al banco le faranno la prenotazione poi vi manderanno la lettera per posta. Ok? e poi lei ritorna qui a farsi lo scan [The form, madam, is enough for you to see the lady at the counter to organise an appointment. Then they will send you a letter by post. Ok? And then they will organise a scan]

Example 14 is a probing strategy being employed in an Arabic interaction, including the phrases “**Where? In the stomach?**” (written in bold), the Arabic interpreter was probing the patient in order to understand the sequence of events and to make sense of what the patient described before providing an interpretation for the doctor.

<u>Example 14</u>

Arabic: Lines 295-320

Pt to **Int:**

بزعني دكتر ... في شي روح عندو

Doctor (name of Doctor) scared me about something, to go see him

و مش عملوني X-ray لخوف شيءوني

and I did not do x-ray because of the fear that it might be something

أنتم شَحِبتَه لَعَملوني again - X-ray

that they were going to remove by having an X-ray again

بَتَلتُم لا بَتَلتُم

I told them no, I told them

Int to **Pt:**

اين؟ بالمعده؟

Where? In the stomach?

Pt to **Int:** Yeah

Int to **Dr:** Dr (name of Doctor) warned me a bit because I had an x-ray and he said there is something wrong in your stomach and I need to go back there again.

In Example 15 the interpreter, similarly, probes the doctor's explanation and presents the patient with a more elaborate response.

Example 15

Italian: Lines 614-624

Dr:	So, we'll get an MRI of your back done and then we'll see you, ok?
Int to **Dr:**	So, does she need another appointment?
Dr:	Yes
Int to **Pt:**	OK, allora signora, queste due glieli da alle signorine al banco questa per fare l'appuntamento per lo specialista [Ok, madam, these two forms are to be given to the reception and they will organise appointment with the specialist]

The examples provided above point to how the interpreters probed either the HP or the patient on several occasions to obtain additional information, including for specific details about her health condition, or when the interpreter judged the speaker's utterance as being potentially vague. Probing led to the speakers providing further details, thereby enabling the interpreter to present a more complete and elaborate interpretation of the message to the recipient, though, as the discussion/interpretation of Examples 12 and 15 has indicated, not necessarily accurate.

7.5 Simplifying

As well as strategies of clarifying and probing, analysis of the interpreted interaction highlights another strategy used by interpreters to facilitate medical consultations—simplification. Typically this occurred when the interpreters simplified the doctors' lengthy or complex utterances by presenting structurally or lexically simpler and shorter versions to the patients.

In the following exchange (Example 16), the doctor's question goes unanswered by the patient the first time the interpreter interprets it. The interpreter then simplifies the question by restructuring it (Your back, where is the pain worse?). This time, the patient shows an understanding of the question, responding immediately with "aha", and then proceeds to give a more detailed response.

<u>Example 16</u>

Dari: Lines 820-838

Dr: Where is the back pain **the worst**?
Int to **Pt:**

کجاي درد پشت شما بدتره؟

koja-ye dard-e posht-e shoma badtar-e?
where-of pain-of back-of you worse-is?

[Where is your back pain **worse**?]

Pt: (no response, silent for 2 seconds)
Int to **Pt:**

پشت شما، کجا دردش بدتره؟

posht-e shoma, koja dard-esh bad-tar-e?
back-of you(polite), where pain-its worse-is?

[Your **back,** where is the **pain worse**?]
Pt:

آها،

[Aha] (with a tone of showing understanding)

Example 17 shows the interpreter similarly simplifying the doctor's utterance for the patient: instead of maintaining the medical wording of "symptoms" in the doctor's sentence, "your symptoms had improved", she adopts lay wording and says "your pain had become less". Example 17 was also used as Example 5 to demonstrate another strategy (clarifying) used by the interpreter.

<u>Example 17</u>

Dari: Lines 452-465

Dr: Last time you were here, I think, **your <u>symptoms</u> had improved** quite a bit so we were going to hold off
Int:

میگه دفعه قبل که اینجا شما بودین درد شما کمتر شده بود برا همین stop کردیم ، برا همین گفتیم حالا فعلا شاید ضرورت نیست

mige dafeye-ghabl ke inja shoma boodin dard-e shoma kam-tar shode-bood
says time-last that here you were pain-of you less had-become

bara-hamin stop kardim, bara hamin goftim
that-is-why stop did-we, that-is-why said-we

hala felan shayad zaroorat nist
now for-the-time-being may-be necessary-not

[She says last time that you were here, **your pain had become less**, that is why we 'stop'ped, that is why we thought may be the operation would not be necessary now]

In the following interactions with Italian patients (Example 18), the Italian interpreter simplifies the word 'symptom' in the doctor's utterance into "hurt" when conveying it to the patient.

Example 18

Italian: Lines 137-140

Dr: Ok, what about the left leg, any symptoms there?
Int: la gamba quella sinistra fa male signora?
[Your left leg, does it hurt?]

In the following exchanges, the interpreter simplifies the doctor's lengthy question for the patient about knee pain or other pain into a structurally simpler and shorter question.

Example 19

Italian: Lines 59-64

Dr: Ok, so your knee pain, it's only the knee pain or pain coming from the back going like that to the knee?

Int: il dolore cominicia dalla schiena, signora?

[Does the pain start in your back?]

Similarly, in the excerpts below, the interpreter again lexically simplifies the doctor's explanations.

Example 20

Italian: Lines 100-105

Dr: Ok. Which is the most problematic issue here, is it the knee pain or back pain?
Int: Cosa ti da piu' fastidio signora il ginocchio or la schiena?

[Which hurts most, Madam? Your knee or your back?]

Example 21

Italian: Lines 177-180

Dr: Ok, and do you have any numbness in your thigh?
Int: le cosce sono dormentate signora?

[Are your legs asleep madam?]

Example 22

Italian: Lines 117-121

Dr: Ok. Alright, umm, do you have any tingling in your feet?
Int: I tuoi piedi ha qualche sensazione strano ai piedi?

[Your feet, do you have any strange sensation in your feet?]

In the above excerpts (Examples 20, 21, and 22), the interpreter simplifies the doctor's wording, substituting simpler phrases such as 'hurts most' for 'most problematic issue', 'asleep' for 'numbness', and 'strange sensation' for 'tingling'. In making these simplifications the interpreter is subtly changing the doctor's intended meanings, even to the extent of making the enquiries less precise, opening up the potential for miscommunication about the patient's precise symptoms.

The interpreters' simplifications of the doctors' complex or lengthy statements or questions is based on their judgments of what may help the patients understand better and respond appropriately. As presented, simplification took place either structurally by breaking down a complex segment, or lexically by replacing specialised medical words with more common terminology.

In another example (Example 23) of simplification in Arabic, the interpreter simplifies the doctor's question seeking information on the patient's 'blood sugar problems' into 'coming down' or 'going up'.

Example 23

Arabic Lines 52-70

Dr: Has she had any low blood sugar problems that we know of?

Int:

أنتِ بيسير شيء مشاكل سكري

anta beyasir shee mashakel sokkari
you changes thing problems your sugar

[you have problems in your sugar]

ام بينزل شيء ام يحبط كثير؟

om beyanzel shee om yahbet katir
whether coming down a thing or going up a lot

[whether going down or going up a lot?]

Pt:

لاء حلاً

[not now]

In all simplification examples discussed above, seemingly the interpreter's aim in the consultation was to facilitate the clearer transfer of the message from the speaker to the hearer by modifying the utterance/s to make it/them easier to understand. However, in most cases the simplification led to a less accurate message, and did create the potential for loss of aspect/s of message content, and consequent misunderstanding.

7.6 Adding knowledge: institutional and cultural

One enhanced strategy that interpreters performed was to add their own cultural or institutional knowledge while interpreting. This category includes interpreters' utterances assumed to assist patients' better understanding of how the hospital, as an institution, works. It also includes interpreters' utterances which aim to provide a better opportunity for patients to use hospital services for their health and well-being. The column 'Adding Knowledge' in Table 7.2 indicates the number of times interpreters assisted the parties by mediating their own knowledge institutionally or culturally.

Interpreters' adding their own knowledge has been related to hospital procedures or cultural knowledge. Examples 24, 26, 27, and 28 demonstrate that institutional knowledge constituted the process of administering the drip, booking a future appointment, or requesting a referral for allied health. The interpreter indirectly assisted the speaker to achieve the message they had in mind. In Example 27 when the Dari speaking patient explained the benefits of hydrotherapy at

the hospital site and that the hydrotherapy was stopped until his next turn came, the interpreter indirectly added the statement, as part of her own knowledge of how the hospital works, to the doctor, that with her referral the patient may be seen earlier.

Example 25 demonstrates how adding the interpreter's own cultural knowledge occurred when the Arabic interpreter responded to the doctor's cultural inquiry with her knowledge about written numbers in Arabic. It is important to highlight that across three language transcripts there was one example in Arabic where the knowledge added by the interpreter was of a cultural nature.

Example 24
Arabic Lines 3-12:

Pt:

حطوني ماسال احسنت شوي

hattooni maasaal ahsanet shoowey
(they)connected to me drip I got better a little bit
[They connected the drip for me and I got better a little bit]

Int to **Dr:** I was improving better in hospital; they gave me some oxygen and also a drip

In the above excerpt the interpreter added further details (perhaps reflecting her own knowledge about the hospital) to present the doctor with a sufficiently informative sentence.

Example 25
Arabic: Lines 120-142:

Dr to **Int:** I noticed there's one that she wrote as 1.2 and then said on the meter 10.2, is that how she writes 10?

Pt to **Dr:** Yeah, ten

Int to **Pt:**

... كتَب بالعَشرَة....

Hoo betiktabi | bel ashra va sajjeli be waha?
There you wrote as ten and wrote as one

Pt: |

لاء عشره

la, ashra
[No, ten]

Int to **Dr:** Oh yeah that's how 10 looks like in Arabic

Pt (in English) to **Dr:** Sorry

In Example 25, the doctor questioned the numbers on the sugar chart written by the patient, whether it was 10 or 1, due to the confusion caused for the reading. As soon as the doctor finished his question, the patient replied in English 'yeah, ten', indicating that she understood what the doctor asked. The interpreter, however, interpreted the exact question for the patient. The patient this time answered in Arabic, but the interpreter, instead of conveying her reply to the doctor, clarified the issue for the doctor with her knowledge of her mother tongue, Arabic, by informing the doctor, "that's how 10 looks like in Arabic".

Example 26

Italian: Lines 592- 604

Dr to **Int**: No, the appointment will be booked by the girls and they will send the letter

Int to **Pt**: quel foglietto signora basta che glielo da alle signorine al banco, le signorine al banco le faranno la prenotazione poi vi manderanno la lettera per posta. Ok? e poi lei ritorna qui a farsi lo scan

[The form, madam, is enough for you to see the lady at the counter to organise an appointment. Then they will send you a letter by post. Ok? And then they will organise a scan]

Pt to **Int**: all'ospedale
[at the hospital?]

Int to **Pt**:
all'ospedale, si, si qui a pian terreno
[at the hospital, yes, yes on the ground floor]

Example 26 involves the doctor helping the patient understand the process of booking an appointment. When translating, the interpreter explains this process in more detail and with greater clarity. She begins by mentioning "the form", the appointment slip given to the patient at the end of the consultation, with a date for the next consultation. The interpreter then translates the word "girls" used by the doctor into the Italian equivalent of "the lady at the counter". In her translation of "will send the letter", she adds "by post" to be specific as to where the patient would receive the letter. By asking "OK?" she checks the patient's understanding of the explanation. She proceeds to add further information regarding the scan discussed in detail earlier by clarifying that the scan will be organised after the appointment is booked. In the rest of the exchange, the patient asks about where to have the scan,

“all’ospedale?”[at the hospital?] to which the interpreter responds, as well as clarifying further where the scan will take place, as shown in the excerpt above.

Example 27

Dari: Lines 364-375

Dr: Right, so you can’t get an appointment, is that correct?
Int:

شما وقت نمیتونین بگیرین تا جولاي؟

shoma vaght ne-mitoonin begirin ta July?
You(plural-polite) time not-able-you take-you plural polite until July?

[You are not able to have an appointment **until July**?]

Pt:

او خو مرا جواب داد تا دگر اینا حالي دوباره مارا ببینند

oo kho ma-ra javab-dad ta degar ina hali dobare ma ra bebinand
he so declined-me until next-time they now again we(plural for I-polite) see

[He (physio) declined me (patient) until they (hospital/doctor) see me again]

Int to **Dr**: They (physio) said no, but maybe with your recommendation or referral maybe

We enter the above conversation where the doctor is asking a question to confirm her understanding of the patient’s inability to get to an appointment. The interpreter includes in her translation “until July” (in bold), mentioned by the patient earlier, to specify the time period during which the patient cannot get an appointment. When translating the patient’s response, the interpreter goes beyond the patient’s confirmation and, using her knowledge of hospital procedure, suggests respectfully to the doctor how she can help move forward the appointment (i.e. through a recommendation or referral).

Example 28

Dari: Lines 1958-1973

Pt:

خب اگه ما بریم دگر خب خبري میکنن ما را دگر؟

khob age ma berim degar khob khabari-mikonan ma ra degar?
Ok if we go-we again ok inform-do we again?

[OK, if we go, would they inform us again?]

Int: Would they be sending a letter in mail?
Dr: Yes
Int:

بله براي شما کاغذ روان میکنن

baraye shoma kaghaz ravan mikonan
for you-polite letter send-they

[Yes, they will send you a letter in mail]

In the above excerpt (Example 28) the turn produced by the patient in this consultation involves asking whether he would be informed about his next appointment. The interpreter translates the patient's question using wording that reflects the hospital procedure, with patients informed of their future appointments through mailed letters. Maintaining this specificity in her interpretation of the doctor's 'yes', the interpreter presents the patient with a complete response, which includes the detail 'sending a letter in mail'. By doing so, the interpreter makes the doctor--patient information exchange more efficient and potentially saves time, which would be probably spent in later stages of the consultation on giving necessary procedural details to the patient.

7.7 Repeating

I categorised repeating as a non-direct enhancement strategy performed by the interpreter to assist better understanding for the patient. This strategy mostly was used by the Dari interpreter and on one occasion by the Arabic interpreter. In the case of Dari, the interpreter, who was originally a Persian native speaker, repeated some medical or technical terminologies for the patient in Persian, Dari or even English to ensure the patient understood. It seemed that the interpreter assumed the patient's native Dari would have prevented him from understanding some medical terminology in Persian, therefore she used Persian, English, and then Dari equivalents of some technical terms to enhance the patient's understanding of the doctor's message. The researcher counted the number of times the Dari interpreter repeated the same word, phrase or question to the patient to be 15 times in the consultation, with examples as follows:

Example 29

Dari Lines 971-976

Dr: What did you use to do?

Int:

چه کار میکردین؟ وظیفه شما چي بود؟

che kar mikard-in? vazife-ye shoma chi bood?
What work were-doing(you-polite)? Duty-of you what was?

[What work were you doing? What was your duty?]

Two times she repeated a word or its equivalent e.g. the word “**residents**” in the excerpt below.

Example 30

Dari Lines 4-24

Dr: … I’m one of the … residents here.

Int:

يعني داره تخصصشُ میگیره، مثلاً سال آخر تخصصشه

Yani dare takhasos-esh-o migire, masalan sale akhar-e takhasos-esh-e
It-means (is) specialty-her-of getting, for example year-of last-of specialty-her-is

[It means she is completing her specialty; like she is doing her last year]

Int to **Pt**: [This is one of the residents…It means she is completing her specialty; like she is doing her last year]

One time she repeated a word or its equivalent three times, e.g. the word “**neurosurgery”** in the excerpt below.

Example 31

Dari Lines 4-14

Dr: … I’m one of the Neurosurgery … residents here.

Int:

...این يكي از رزيدنت هاي... جراحي اعصابه، نيوروسرجريه، جراحي اعصاب.

… in yeki az resident-haye … jarahiye asab-e, neuroserjeriy-e, jarahiy-e asab
…This one of resident-s of… surgery of neurons-is, neurosurgery (English term), surgery of neurons

[…This is one of the residents of neurosurgery (Persian equivalent), neurosurgery (English term), neurosurgery (Persian equivalent)]

One time she repeated a word or its equivalents four times, e.g. the word “**activity**” in the excerpt below.

Example 32

Dari Lines 238-249

Dr: Does it tend to get worse with more activity you do or not?

Int:

هرچي فعاليت بيشتر بكنيد، تكان بيشتر بخوريد، بگرديد، گشتن بيشتر بكنيد ... يا هرچه بيشتر تكان بخوريد...؟

harchi fa’aliyat bishtar bokonid, tekan bishtar bokhorid, begardid, gashtan bishtar bekonind

as-much activity more do-you(polite) move more do(you plite), walk, walking more do(you plural)

ya harche bishtar tekan-bokhorid …. ?
or as-much more moving-you (polite) … ?

Int: [As you do more activities, more movement, walking, more walking,….? Or the more you move … ?]

In the Arabic consultation, on one occasion the interpreter repeated the word "good" for the patient in relation to the doctor's comment about the results of the blood sugar testing in the patient. She interpreted it once. She has used the word [good] for interpreting doctor's "that's great, they are good…" and repeated "good" one more time, as in the example below.

Example 33

Arabic Lines 90-101

Dr:

That's great, **they're good** results |* They're generally between 7 and 11.

Int to **Pt** chuchutage: منيح

mnih

[good]

Int to **Pt**:

نتايج منيح، بين سبع و احدش، منيح

natayij mnih, bayn sab' vahdash, mnih
results good, between 7 and 11, good

[results are **good**, between 7 and 11, **good]**

*= overlap indication

7.8 Accommodating dialects

In the Dari consultation, the patient was from Afghanistan and the interpreter from Iran. Based on my observations, neither during nor after the consultation was there any mention of the fact that the interpreter and the patient had different Farsi varietal/dialectal backgrounds and that the interpreter was not a native speaker of Dari, the patient's dialect. Dari and Persian to some extent vary lexically and phonologically. Mindful of these differences, the interpreter at times accommodated the patient's dialect when interpreting in order to facilitate understanding. Unlike the strategies reported thus far, this strategy does not necessarily go beyond direct translation. However, accommodating the patient's dialect requires the interpreter to go beyond information transfer from a single language to another in a strict sense. In previous data analysis

chapters, dialectal accommodation was discussed as taking the interpreter linguistically beyond their language conduit role. In Chapter 6 from the patient's perspective we noted that if the interpreter did not accommodate her/his dialect, the patient misunderstood or did not fully understand the health professional's message. In Italian and Arabic consultations, the interpreters and patients shared similar dialects, and no attempts at dialectal accommodation were identified in these consultations.

In the Dari consultation, the interpreter accommodates the patient's dialect in two major ways, namely adopting words from the patient's Dari dialect which are different from those in her own Persian dialect (lexical accommodation), and pronouncing words in a Dari-like manner (phonological accommodation).

7.8.1 Lexical accommodation between interpreter and patient

There were instances through the consultation where the interpreter used Dari equivalents to translate key words in the doctor's utterances for the patient. Table 7.3 reports on some cases.

Table 7.3: List of terminology the Dari interpreter used for dialect accommodation

English word used by the doctor	Dari equivalent used by the interpreter	Usual Persian equivalent
talking	gap	harf
operation	amaliyat	amal-e jarrahi
tablet	goli, tablet	ghors
toilet	*tashnal	dastshooyi
doctor	dakter	doktor
to ask	porsan kone	so'al kone
switched	badal shode	ja be ja shode

*tashnal is the correct pronunciation but the interpreter pronounced it /nashtal/ in every instance.

The interpreter's choice in accommodating Dari terminology seemed to be determined by her familiarity with and knowledge of Dari. During the interaction the interpreter initially used the

Persian equivalent followed by the Dari one, indicating that her Persian variety/dialect familiarity was prominent in her initial choice of words in her mother tongue variety. Her second choice was to adopt the vocabulary of the dialect of the patient.

7.8.2 Phonological accommodation

As well as lexical accommodation, the interpreter also accommodated phonologically, by pronouncing some words in a Dari-like manner, as shown in Table 7.4. There were only three examples of phonological accommodation that occurred in the Dari consultation.

Table 7.4: Examples of Dari interpreter's phonological accommodation

Dari variation used		Persian variation		Meaning in English
show	/ʃəʊ/	shab	/ʃæb/	night
khaw	/khaʊ/	khab	/khɑ:b/	sleep
neveshta	/neveʃtæ/	neveshte	/neveʃte/	written

This list shows the level of linguistic accommodation the interpreter was prepared to use to sound like a Dari native speaker in pronouncing some terminologies for the patient. It seemed that the interpreter's choice in selecting words to accommodate phonologically was according to her knowledge and familiarity with those Dari terms, but not according to available Dari equivalents. In other words, she did not provide phonological accommodation for every existed Dari terminology.

7.9 Omitting conversational gambits

Besides clarifying, probing, and simplifying, analysis shows that interpreters also employ a strategy of omitting most numerous conversational gambits which the doctors or, to a lesser degree, the patients use to structure their utterances and manage the interactional flow of conversation. As can be seen in Example 34 the interpreter omits conversational gambits on two occasions. The first occasion is when the patient replies "it was good" to the doctor's question about whether the treatment has helped. The other occurs when the interpreter, in translating the doctor's response, leaves out the conversational gambit "OK good" (the doctor's acknowledgement of the patient's response).

Example 34

Dari Lines: 374-390

Dr: Do you find that it helps?
Int:

کمکتون کرد؟ خوب بود؟

komaketoon kard? Khoob bood?
Help-to-you did? Good was?

[Did it help you? Was it good?]

Pt:

بله خوب بود

bale, khoob bood
yes, good was

[Yes, it was good]

Int: Yes

Dr: **OK good**, and the last time you had been was in March?
Int:

دفعه آخر که بودین گفتین کي بود؟ مارچ بود؟

dafe-ye akhar ke bood-in goftin key bood? March bood?
Time-of last that were-you(polite) said-you(polite) when was? March was?

[When was the last time you said you had it? Was it March?]

The omission of conversational gambits occurs in Italian and Arabic interactions as well (Examples 35 and 36). In Example 35 the Italian interpreter does not interpret the expletive interjection "Oh Dio!" (Oh God – an expression Italians use frequently) and only interprets that part of the patient's utterance which bears medical value.

Example 35

Italian: Lines 126-135

Pt: Oh Dio! di notte mi brucia e non riesco neanche a dormire di notte
A point about exclamation Oh God! Which Italians use a lot
[Oh God! In the night it burns and sometimes I cannot even sleep]

Pt (continues)**:**
ma il giorno ho movimento e non mi fa male
[but in the day my movements it's ok]

Int: I had burning pain in my feet at night but during the day I'm ok.

In Example 36 in Arabic the patient responds with "thank you" in English and /alhamdolilah/ in Arabic, meaning, "Thank God" to the doctor[2], when the patient hears from the doctor that her eye examination had good results. In the actual recording of the interaction, the first time the patient used this phrase, the interpreter relayed it to the doctor, but, thereafter, she omitted the phrase in her communication with the doctor. Whilst the patient thanks the doctor in English and God in Arabic, the interpreter does not interpret anything back to the doctor.

Example 36

Arabic: Lines 193-218

Dr: Her eyes were tested at Westfield, I think and they were OK.

Int:

عملت فحص بوست فيلد لعينك و كان منيح فحص فعين

Amalat	fahas	be	westfield	be	aynak	va	kana	mnih	fahas
You did	test	at	westfield	for	your eyes	and	was	good	test

[You had your eyes tested in Westfield and the results were good]

Pt.:

Thank you الحمدلله

thank you, alhamdulilah
[Thank you. Thank God]

(The interpreter remained silent, not translating the patient's utterance back to the doctor.)

In all three consultations reported above, conversational gambits doctors or patients used to fulfill different discourse functions, such as acknowledging the previous turn, or showing appreciation, were not included in the interpreters' interpretations of their utterances. The focus of the interpreter was on key content relevant to the exchange of information to progress the medical purpose of the consultation. In the Arabic example, the patient, saying "thank you" in English, may have been the reason why the interpreter did not translate it to the doctor. A possible further reason for omitting conversational gambits is, given the face-to-face nature of consultations, non-verbal cues were accompanying the verbal exchanges effectively, making the verbally expressed gambits semantically redundant.

[2] The phrase /alhamdolilah/ described in Quora.com/in-which-situations-should-alhamdolillah-be-used cited 31 December 2019[2], is used in the Arab world and in other Islamic countries to "show appreciation whenever something good happens".

7.10 Summary

The principal goal of a healthcare interpreter is to facilitate communication between patients and health professionals. It is expected that the interpreter translates directly and accurately what each of the two main parties to the exchange say, in these three consultations, a doctor and their patient. This chapter has examined actual exchanges in interpreter-mediated consultations. Three triadic consultations, recorded by the researcher, were analysed by focusing on identifying exchanges where interpreters acted in a 'conduit' role, and situations where direct interpreting did not occur.

These analyses have highlighted that interpreters adopted a range of strategies that took their role beyond direct interpretation and transfer of the health professional's or patient's messages. The interpreters used strategies such as clarifying, probing, simplifying, and omitting conversational gambits, and, in one case, also accommodated the patient's dialect both lexically and phonologically in order to facilitate communication. The interpreters' inferred motivations for adopting these strategies were seemingly to expedite the overall message transfer process. However, in doing this, the interpreter effectively assumed a role other than that assumed of them by the medical specialist, as the precise transferrer of their messages. In some cases, the adoption of one or more of the strategies led to less precise or distorted message transference that could have generated miscommunication.

Complexities in the role of interpreters in healthcare settings were highlighted through experiences shared by interpreters, HPs and patients in Chapters 4 to 6. Analysis of actual interpreted-interactions in this chapter has provided an additional, in-practice lens on complexities of role/s and strategies interpreters employ to facilitate meaningful communication between patients and HPs. This additional lens has similarly highlighted that conceptualising the role of interpreter as being solely a neutral language 'conduit' role is too simplistic. Depending on the actual interactional context, interpreters diverged from direct language transfer in 25% to 58% of turns, with a range of strategies employed that modified or extended their role in interactions. Further comparison between reported behaviour from interviews and that observed in practice will be discussed in the next chapter.

Chapter Eight – Discussion

In reviewing the findings from analysis of interviews with interpreters, health professionals, and patients (Chapters 4-6), and interpreter mediated consultations (Chapter 7); it is evident that whilst the language conduit role of the interpreter is foregrounded, a range of perspectives and practices have been identified that make additional important contributions regarding facilitating patient--health professional communication. Here, I aim to integrate the major findings from these four chapters and discuss them in light of the relevant literature.
It is imperative to point out that some of the additional roles that interpreters in this study adopted, have similarities with the roles and functions of patient navigators, a distinct, explicitly recognised role that has been introduced recently in some of the US healthcare system (Crezee & Roat, 2019).

The research questions provide the scaffold for the discussion, so the chapter commences by considering findings related to different aspects of the 'language conduit' role, before considering additional roles that extend the interpreter's contributions beyond direct message transfer. The research questions are reiterated below:

Interpreting as message transfer (section 8.1)

- How do health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters?
- What factors affect the effectiveness of message transfer?
- What are the outcomes of effective and ineffective message transfer?

Interpreting beyond message transfer (section 8.2)

- What roles do interpreters fulfill beyond message transfer to facilitate health professional--health service user communication?
- What are interpreters', health professionals', and health service users' attitudes toward interpreters serving roles beyond message transfer?

8.1 Interpreting as message transfer

Before discussing findings related to the first research question, I will briefly review what the three groups of participants in hospital triadic medical consultations have said about their expectations and experiences of the primary role of the interpreter.

Interpreters (see Chapter 4) shared the perspective that their major professional role is direct and accurate message transfer between health service providers and service users. As reflected in the interviews, they explicitly showed a lack of interest in fulfilling roles beyond what a conduit model dictates. Interestingly, "I'm just an interpreter", "my role is just to pass it on", "you're just facilitating for the language barrier", were how interpreters expressed their perspectives. An exclusive focus on message transfer also manifested in some interpreters' use of the metaphor *linguistic pipe*, identifying interpreters' major role to be interpreting patients' concerns in the patient's own voice, be it explaining a symptom to a health professional or an inquiry with hospital reception about the waiting time.

In addition, most interpreters perceived their role in a way that minimised its complexity, as well as positioning themselves as a conduit. Their frequent usage of "just" reinforced their expectation of the limited boundary to their activity being this conduit function. However, presenting their role in such a way also serves to downplay the complexity of what performing the role of conduit entails. Henceforth, I propose to adopt an alternative term for this role, 'language transposer', when referring to this function as I see 'transposer' as better nuancing the complexities involved in the fulfillment of linguistic expectations of accurately and directly interpreting meanings from one language to another. Here it is worth noting how Pöchhacker (2004: 122) described different theories involved in testing interpreters and their memory to appreciate the "neurophysiological foundations of linguistic functions in bilinguals", Baddeley's (2000) "working memory", and Ericsson and Kintsch's (1995) "skilled memory", and memory capacity. These theories and tests indicated the complexity of cognition involved in interpreting practice. How interpreters in this study described the level of complexity involved in interpreting, suggests they tended to devalue their profession and their role as an interpreting professional, a finding that has not received significant attention in previous research.

The HPs in our study also emphasised the primacy of message transfer as the interpreter's role, only interpreting what was being said by the patient and avoiding additions or deletions. A quote from one HP worth reiterating here is "[a good interpreter] will tell you everything that

the patient says to them". Whilst some HPs seemed to be aware of inherent difficulties in interpreting linguistically and culturally, many assumed that such interpretation between languages was straightforward.

Finally, patients interviewed in this study idealised a good interpreter as being their voice, only interpreting the message between the patient and their treating doctor without judging them or adding their own personal comments to the interpreted message. In saying this, they positioned the interpreter as a person working on their behalf, and, therefore, having a particular allegiance to them personally, as opposed to the HP, or to the hospital as an organisation.

The finding that the interpreter's role has been defined predominantly by a focus on direct message transfer, is not surprising. In fact, as discussed in Chapter 2, the main role an interpreter is expected to fulfill is effective message transfer between medical service providers and service users. This is how national and international standards relating to interpreting have defined the interpreting profession. For example, according to the National Standards of Practice for Interpreters in Health Care (NCIHC) (2005), the standard role of an interpreter is to "render all messages accurately and completely, without adding, omitting or substituting" (p.5). Being an effective conduit involves relaying the closest equivalents in the target language (Bolden, 2000).

The literature includes many studies from different locations with ethical codes where interpreters saw their main role to be transferring messages between the parties involved (e.g. Fatahi et al., 2008; Flores et al., 2003; Hatton & Webb, 1993; Kaufert & Putsch, 1997; Leanza, 2005; Roat, Putsch, & Lucero, 1997). Across these studies, participants referred to this role using different metaphors. One example is interpreters in Hsieh's (2008) (US) study who considered their major role as serving the "voice" of the patients and the HPs, interpreting exactly what was being said. Other metaphors used by these interpreters to refer to their conduit role were "robots" or "machines functioning with great precision without getting emotionally involved" (Hsieh, 2008, p. 1370). Similar metaphors were reported by Avery (2001) (US), namely "instrument" and "black box".

While message transfer has been emphasised, this role has been described differently in other studies. Interpreters in Hsieh (2006) (US) perceived their role to "just interpret" remaining "faceless" and "in the background". Arabic speaking migrant patients in Sweden in Hadziabdic

et al.'s (2014) study also described the professional interpreter's task as interpreting the whole content of an encounter, even when related to sensitive topics like a cancer diagnosis. In Dysart-Gale's (2007) study (Canada), patients and HPs conventionally want interpreters to fulfill the "reliable default role" of transferring the message without any additions or deletions. In similar findings, Jungner, Tiselius, Blomgren, Lützén, & Pergert (2019) (Sweden) explain this concept by focusing on the professional boundaries of the interpreter's role:

> If the institutional user of the interpreter, that is the healthcare personnel, is made aware of these power relations (i.e. that the healthcare personnel are the ones who decide on the content of the information), and clearly lead the interpreter-mediated consultation; then the interpreter is given the opportunity to focus on their professional part of the interpreting assignment (i.e. to do language mediation and nothing else). The literature, as well as the interpreters in this study, point out that they are language mediators and not part of the healthcare team treating and advocating for the patient (p.660).

In light of the findings of the present study and those reported in other studies in the literature, there is undoubtedly a general consensus across different groups of health service providers and users as well as interpreters that the major role interpreters are there to fulfill is to effectively transfer messages between the other parties involved in a medical consultation. However, how each party perceived this 'language transposer' role operating in reality encompasses some subtle differences in emphasis. For example, the act of being a 'voice' for someone, as expressed by both patients and some health professionals, implies a level of special obligation to the interests of the person who is being voiced. Also noteworthy is the HP's emphasis on the importance of avoiding any omissions or additions, as being critical. Each party to an interpreted interaction values the interpreter's contribution a little differently, and apply subtly different criteria in evaluating the interpreter's performance of their role.

The next section focuses on how the participants in this study who use interpreting services (i.e. HPs and patients), judge how effective interpreters are in transferring their messages to the other party.

8.1.1 Identifying the effectiveness of message transfer

The first research question focuses on "How do health professionals and health service users evaluate the effectiveness of message transfer facilitated by interpreters?" The interview findings yielded a number of ways in which HPs and patients determined this effectiveness.

Negative experiences that HPs shared in their interviews revealed some specific evaluative criteria of the quality of interpreting they received. Many of these instances reflect a lack of understanding of what may be required on the part of the interpreter to ensure accurate message transfer. Interpreter-mediated consultations finishing on time for some HPs constituted their main way of judging whether the interpreter served as a good language transposer. By the same token, when a consultation became lengthy, these HPs tended to conclude that the interpreter is likely to have moved beyond their expected role, by adding to the content of their message or have even "gone off on a tangent". When they perceived conversations between patients and interpreters to be considerably longer than what interpreters reported back to them, they did not recognise that this may be the result of a process of "condensation" (Farooq & Fear, 2003, p. 108). Similarly, HPs would sometimes attribute not receiving the right answer from patients to their questions to the interpreter's failure to interpret their questions or the patient's responses correctly. Observing patients' dissatisfied facial expressions was another signal that led HPs to attribute as potential evidence of inaccurate interpretation. HPs also reported omissions, where interpreters would engage in a conversation with the patients, but would not report the content back to them at all, and finding interpreters' English skills questionable. Whilst some HPs reported experiences suggest that at times the interpreter may have exceeded their direct message transfer 'conduit' remit, they seemed to underestimate what was required in communicating health concepts between languages, and to assume that the interpreter was responsible when a patient did not respond as expected. In addition, these experiences suggest that the HPs had limited appreciation of the importance of negotiating "their and others' communicative strategies/goals" (Hsieh, 2010, p. 154) as part of the process of enabling successful bilingual interpreter facilitated encounters.

Patients also applied some specific evaluative criteria to judge the quality of the message transfer process. They reported being left out of conversations between interpreters and HPs which led them to consider interpreters were failing in their 'language transposer' role. Some patients who had some knowledge of English expressed concerns about the interpreter's English competence. On some occasions, they even raised concerns about the interpreters' command of their first language, because interpreters had asked them to repeat what they said, which patients attributed, potentially inaccurately, to the interpreter's limited comprehension or careless listening. In contrast, for some patients, a major measure for what constituted good interpreting was the interpreter spontaneously repeating the doctor's key points several times during the consultation in order to help them fully understand. The patients considered such

repetition as a caring gesture on the part of interpreters who did so. This repetition was also observed in the conversations analysed (see Chapter 7). Evaluation of message transfer from the patient's perspective was based on their satisfaction with their perceived level of both inclusion and understanding within the encounter. If achieving this level of understanding required the interpreter to move beyond direct message transfer to assist in other ways, such as reinforcing or repeating key messages, this was appreciated.

What was perhaps most frustrating for both parties (HPs and patients) was the feeling of uncertainty regarding how well interpreters fulfilled their role. Their uncertainty arose from their lack or limited command of the other language, which left them without an objective basis for evaluating these interpreters. This dilemma has been reported in other studies too. HPs in Hsieh et al.'s (2010) study, for example, shared their constant worry about the effectiveness of interpreter-mediated consultations due to the fact they do not have the language skills to evaluate interpreters' performances. And the only way they can trust interpreters' competence is based on interpreters having received training and obtained credentials. Pearson & Raeke's (2000) discussion of interpersonal and social trust is relevant to appreciating what makes for more trusting relationships within the institutional context of a hospital. Both patients and HPs remarked on having confidence and trust in the in-house interpreters. Both interpersonal and social trust is able to develop through regular, ongoing interactions involving an HP with the patient and the same in-house interpreter. Patients who required agency interpreters, as their languages were not provided in-house, had greater trust in the interpreter assigned to them if they had had the opportunity to be actively involved in the choice of interpreter, and were usually more trusting of an agency interpreter who had assisted them in a number of appointments.

8.1.2 Factors affecting the effectiveness of message transfer

The second research question to address here is "What factors affect the effectiveness of message transfer?" Within the boundaries of a 'language transposer' role for interpreters, the findings of this study yielded a number of factors affecting how interpreters fulfill this role, in particular, interpreter's linguistic skills and their medical/healthcare knowledge, patients' educational level, interpreter-patient dialect compatibility, gender compatibility, and time constraints for an interpreter-mediated consultation.

Interpreters' linguistic skills

In the previous section, it was discussed that there were patients and HPs who believed their interpreters' inadequate command of the patients' mother tongue and English impacted on their performance. A case worth recalling here is a Dari patient, familiar with Persian, who requested a Persian interpreter instead, because she considered Persian interpreters to have higher linguistic skills than those from her own dialectal background. Other studies have shown a similar emphasis on the importance of interpreter's linguistic skills from the perspectives of both HPs and patients (e.g. Hadziabdic et al., 2014 (Sweden); Hadziabdic & Hjelm, 2014; Lor et al., 2018 (US)).

In relation to the attribution of communication problems to the interpreter's linguistic competence in one or both languages, it is pertinent to point out that all interpreters interviewed and recorded for this study had NAATI accreditation at the 'professional level', and that evidence from three recorded interactions did not show any deficiencies in the interpreters' linguistic skills. Despite this finding and in a situation of perceived lack of control due to lack of a shared language, difficulties or inaccuracies in communication between the HPs and patients, such as the patient not responding to the HP's interpreted question, or the HP initially providing an inaccurate diagnosis (e.g. a polyp as opposed to the later corrected diagnosis of a fibroid), in some instances, were wrongly attributed to problems with the interpreter's linguistic competence and the quality of their message transferred.

Patients' educational level

Given that the success of message transfer in an interpreter-mediated consultation is "interdependent" on all participants' skills and knowledge (Elderkin-Thompson et al., 2001), in addition to the interpreters' language skills, patient-related factors also have an impact. One important factor that emerged from the data in this study relates to the impact of a patient's education level. The interviewed interpreters had formed judgements about the education level of their patient clients, and then explicitly discussed how the low level of education in some patients had impacted on how well they could remain in and fulfill their 'language transposer' role. A challenge specifically highlighted regarded their commitment to maintaining the register of the language produced by HPs, on the one hand, and on the other hand having to sometimes lower the register in their interpretation, or asking HPs to do so, when interpreting for patients with limited formal education.

The literature also reflects challenges in conveying health information to patients with limited education. Leyva, Sharif, & Ozuah (2005), for example, observed that even when education materials are interpreted into the patients' native language, their low education level may result in them finding it difficult to understand health information. Similarly, Butow et al. (2012) found that patients coming from limited educational backgrounds faced challenges in navigating the Australian health system, despite having received accurate interpreting. Based on interview data and recordings in this study, accommodation in the register used by the HP with assistance or input from the interpreter sometimes led to lengthy negotiation of meaning, and, despite the length of the interpreted interaction, was not always successful in assisting LEP patients with very low education levels to understand a message. As a consequence the patient sometimes remained confused or inaccurately understood (e.g. scans that had been performed – Italian recording; blood versus bladder – Eliza's narrative). In addition, based on the interpreters' reported experiences, they were much more likely to adopt strategies that moved beyond their 'language transposer' role with patients who had low education levels.

Interpreter--patient dialect compatibility

Interpreter--patient dialect compatibility was raised by some patients in this study as an important factor affecting how well information transfer occurs. Generally speaking, for languages spoken in various countries (i.e. pluricentric languages), different language varieties or dialects exist. The patients either preferred their interpreter to be from the same country of origin or familiar enough with their spoken variety and/or dialect. The significance of dialect compatibility was highlighted in some patients' experiences of differences in their own and their interpreters' dialects resulting in limited or inaccurate understanding. An interviewed patient from a Persian background, for example, recalled a consultation where the interpreter had used the equivalent from her own Dari dialect, which was different to the usual word in the patient's dialect and therefore the patient had become confused. In cases where direct compatibility was not possible, being familiar with the interpreter's variety and/or dialect was another factor that patients perceived as positively impacting on the effectiveness of consultations. While sharing exactly the same variety and/or dialect appeared to be an ideal situation for patients in an interpreter-mediated consultation, some prior familiarity with the other party's dialect was desirable and impacted on attitude towards the interpreter and satisfaction with the outcome of the consultation (e.g. a Sudanese patient who had lived in Egypt was satisfied with the Egyptian Arabic background interpreter). However, dialectal or varietal differences can sometimes be so confusing for patients that they may ask for an

interpreter from another language they are familiar with (e.g. an Iraqi Arabic speaking patient's difficulty with Lebanese Arabic of the in-house interpreter, led to communicating through a Persian agency interpreter). Other research aligns with the experiences of patients in this research. For example, using both quantitative and qualitative methodologies, Hadziabdic and colleagues (Hadziabdic et al. 2014; Hadziabdic & Hjelm, 2014; Hadziabdic, Lundin & Hjelm, 2015) report Arabic speaking patients and elderly patients, in general, having a strong preference for interpreters who speak their own dialect and come from their country of origin.

Interestingly, in contrast to patients in prior research, the interpreters in this study did not report overt concerns about dealing with dialect differences, seeing this as a normal part of their obligation to accommodate and assist, to the best of their ability. The analysed conversation involving dialect differences (e.g. Persian and Dari) demonstrated the interpreter's ability to improve communication by accommodating patient's dialectal differences in two major ways, namely through lexical accommodation, and phonological accommodation, and this led to good comprehension for the patient. So, whilst interpreter interviewees were aware of dialect differences, they were not overtly concerned about the impact on performance of their role compared to other recent research. For example, Lor et al. (2018) (US) reported that their interpreter participants highlighted confusions that may have resulted from subtle differences between dialects, and indicated they faced difficulties in accurate interpreting as well as patients' requests for explanation and repetition. Similarly, in Butow et al.'s (2012) Australian study interpreters explicitly considered differences in dialect that led to patients' limited understanding of the content of the consultation.

To address issues of dialect compatibility and accommodation, different recommendations have been proposed. Hadziabdic & Hjelm's (2014) advocate for the consistent use of interpreters sharing the patient's dialect and country of origin. Similarly, in mental health, Tribe & Lane (2009) (UK) emphasised the importance of establishing the client's first language and dialect and using an interpreter who speaks that language and dialect. Given that dialect can be so important to patients, Tebble (2012) (Australia) also suggested that when an interpreter is booked, not only the patient's language but also their dialect, if significant, should be noted. As she further explained:

> If only Chinese is specified for a Cantonese speaker who does not speak Mandarin, then potentially another interpreter may be required. Patients who do not speak the standard variety of their language need advice on how to register the specific dialect of their language in their file when requesting the services of an interpreter. (p. 41).

Findings from the present study have presented differing perspectives, though limited, which relatively diminish the importance of dialect as a factor to consider in interpreter-mediated consultations. Initially, there were a few cases where the interpreter's perceived interpreting skills would take priority over dialect compatibility. My data included examples where Afghan patients preferred Persian dialect interpreters over those from their own Dari dialect, due to their previous positive experience with Persian interpreters. Also, in interviews with HPs, it emerged that some patients from specific backgrounds did not want an interpreter present who was perceived as being a member of their specific community, due to it being a small community and thus their concern about news of their illness spreading to the community. This resonates with patients in Greenhalgh et al.'s (2006) (UK) study, who considered the mismatch between their dialect and interpreters' dialect as a favourable situation, simply because that meant interpreters did not belong to their immediate community.

From these contrasting perspectives it can be concluded that the nature and level of concern about dialect and/or varietal compatibility is ultimately about patients' perceptions and preferences. It is too simplistic to assume that patient preferences can be predicted based exclusively on their country of origin. This insight aligns with Hadziabdic et al.'s (2014) emphasis on the critical role of the patient in the choice of interpreter: "the use of interpreters in accordance with individuals' desire can prevent and limit poor communication, thereby increasing cost-effective, high-quality individualised healthcare" (p. 7).

Gender compatibility

Another factor that emerged from the interview data as potentially affecting the effectiveness of interpreter-mediated consultations was interpreter--patient and HP--patient gender compatibility. The most important finding related to this factor was that many female patients felt uncomfortable with male interpreters. This sense of discomfort was especially strong when the health issue was female-related, such as pregnancy, when patients were from certain backgrounds (e.g. in this case a Muslim background), and when male interpreters had to explain technical terminology to female patients. The inconvenience experienced by female patients was reported to be so obvious at times that it would result in the male interpreter feeling embarrassed and consequently the decision, on the part of the interpreter, to leave the consultation.

Likewise, several studies have reported concerns on the part of patients and interpreters as a result of gender difference. For example, female patients interviewed by Pardy (1996) (Australia) expressed their difficulties in speaking candidly to HPs in the presence of a male interpreter. They explained that they would mostly remain silent and avoid discussing their symptoms in detail or asking questions. Such gender-related concerns are not limited to female patients. Some male patient participants in Bischoff et al. (2012) (Switzerland) were not comfortable with their female interpreters which resulted in them not accepting their services. Patients interviewed by Weber et al. (2005) (Switzerland) also expressed reservations about how effective a cross-gender interpreter--patient interaction can be, due to awkward situations they had experienced previously. These patients also mentioned, like some participants in the present study, their special preference for being served by female patients when health issues were related to gynaecology and paediatrics as they thought women were more suitable to enter ‘woman's world' and ‘children’s world’ and also extreme health issues such as HIV, rape, and violence. The participants in Hadziabdic and Hjelm’s (2014) study expressed similar views and explained that such sensitivity had to do with cultural and religious issues dominant in patients’ cultures of origin. Sharing similar concerns, more than half of the participants in Hadziabdic et al.’s (2014) study considered interpreter--patient gender-compatibility essential and conducive to developing trust between the two parties. Weber et al. (2005) concluded that since gender identity matters in interpreter-mediated consultations, interpreters are never mere “word-to-word translating machines” (p. 138).

The gender of the interpreter, however, was not always the overriding consideration. In contrast to female patients, male patients in this study were more tolerant of gender difference. None expressed a gender preference in relation to the involvement of an interpreter in assisting their communication with the HP. Some female patients preferred a professional interpreter no matter their gender, to discussing female issues with a family member acting as their interpreter, irrespective of that family member’s gender. In the study conducted by Hadziabdic et al. (2014), patients were reported to feel uncomfortable talking about their issues with family interpreters and thus prefer to be served by an interpreter, preferably of the same gender. The strength of this preference varied depending on the patient’s cultural background. Regarding the fact that gender was not always perceived to be a determining factor in deciding which interpreters patients would prefer; Weber et al. (2005) reported that some of their interviewed interpreters, especially those with extensive experience in the field, did not attach considerable

importance to gender and recalled cases in which the difference of gender did not present any challenges in how well consultations went.

While issues around patient--interpreter gender compatibility had direct impacts on whether an interpreter would serve a patient and their treating doctor, the gender of the HP could also affect how the interpreter reported fulfilling their role. A few female interpreters in my findings reported their experiences with older women who felt embarrassed talking about female issues with their younger male doctors. The way this situation affected such interpreters' performance was that, due to their familiarity with and awareness of the culture of the patient, they would voluntarily step out of their 'language transposer' role in order to convince the patient to discuss the issues with their doctors. Hsieh (2006) similarly reported that the interpreter's awareness of cultural differences between the patient and HP resulted in her coming out of the conduit role in assisting the patient by "assess[ing] the communicative contexts and adopt[ing] non-conduit roles to resolve conflicts" (p. 722).

We can conclude from the findings of this study that gender and gender compatibility are areas of potential sensitivity, and awareness of the potential of gender to impact on the dynamics of an interpreted interaction is critical. However, it is too simplistic to assume that gender homogeneity is always preferable. Despite not making such an assumption, where possible, it is important to give the patient an option in relation to the interpreter's gender, especially if the topic of the consultation is sensitive and gender considerations may be pertinent. Whilst salience of the interpreter's gender and compatibility with the patient's gender is primarily an area of focus for female patients and health professionals, male interpreters were aware of the potential sensitivities around their involvement in certain circumstances. Hadziabdic & Hjelm (2014), for example, emphasise the importance of taking into consideration the patient's gender when finding an interpreter in order to prevent uncomfortable communication. Similarly, Delli Ponti & Forlivesi (2005) explain the importance of a gender-sensitive approach to assigning interpreters to female patients on the grounds that these patients should be enabled with a "physical and symbolic voice", rather than an exclusive focus on language transfer (pp.198-99). They extend this argument to male patients who may share similar concerns due to their cultural and religious backgrounds. Finally, Pardy (1996) takes the discussion to a macro institutional level and highlights the need for policies focused on increasing the availability of female interpreters and ensuring that women have a choice about their interpreter's gender. Salience of interpreter gender and compatibility with the patient's gender is primarily an area

of focus for female patients and health professionals. Greater sensitivity by male interpreters in making the female patient feel comfortable is needed.

Time constraints

A further factor participants mentioned as negatively impacting on the effectiveness of message transfer was limitations on time available for an interpreter-mediated consultation. Participants believed that limited available time could hinder effective transfer of information and adequate understanding on the part of patients. While an interpreter-mediated consultation was generally believed to require more time than provided, issues referred to by patients and HPs as further limiting available time were the interpreter arriving late, not showing up, or leaving early.

Time constraints, whether resulting from hospital scheduling arrangements or interpreter availability meant that interpreted health encounters were often experienced as highly pressured and rushed. HPs reported experiencing a sense of obligation on their part to ensure they had answered all questions before the interpreter left, which was sometimes not achieved. This pressure sometimes carried over to interpreters whose interpreting skills, as mentioned earlier, were sometimes evaluated by HPs based on their success in finishing consultations on time. Some interpreters shared a similar concern to HPs. They said that HPs' tight schedules had negative impacts on the quality of consultations and the time they had to foster HP--patient communication. At times this led the interpreter, based on the analysed conversations, to revert to almost simultaneous interpreting using the chuchutage technique to expedite the transfer of information in the limited time available. Limited time was also referred to as a major contextual constraint by general practitioners (GPs), interpreters and community representatives who represented the patient's perspective in Sturman et al.'s (2018) Australian study. Their participant groups all emphasised the need for more time in interpreted consultations for more effectiveness, and the difficulty of making such time available on the part of doctors and interpreters. As in this study, Sturman et al.'s participants experienced a sense of rush dominating some consultations, and the impact on their effectiveness increased when the GP appeared impatient with the other parties.

A time-related challenge specific to agency interpreters was the need for making arrangements with the hospital interpreters' office when consultations were likely to last more than the allocated time. In the analysed Dari consultation (Chapter 7) even though the interpreter had arrived on time, the consultation went over the expected time frame, requiring the interpreter

to have to ask the doctor to contact the office for their approval. Emphasising the value of HPs' time, Hsieh (2006) discussed that this condition put interpreters in her study in the difficult position of having to make time for patients to communicate their concerns, ask questions, and ensure they understood HPs' advice, on the one hand, while dealing with HPs who felt rushed on the other hand. A common consequence, Cox (2015) argues, is the exclusion of patients from the conversation.

8.1.3 Outcomes of fulfillment of the 'language transposer' role

So let us consider the related research question: "What are the outcomes of effective and less effective message transfer?"

When provided with an effective interpreting service, patients reported feeling relaxed and comfortable, and both HPs and patients felt satisfied and developed a sense of trust in their interpreters' skills. This trust would result in patients' preference for being regularly served by the interpreter(s) who they regarded as competent, rather than being served by different interpreters. Their preference to book the same interpreter was strong, especially when they had previously been served by interpreters whose competence they considered limited. Also when interpreters' effective performance was combined with good news communicated about patients' health in consultations, patients reported an emotional connection with the interpreter from whom they had directly received the good news in their mother tongue.

Whilst both patients and HPs remarked on the importance of interpreters adopting a professional approach, and expressed a preference for direct transfer of information, as per the 'conduit' model, their actual expectations were not completely consistent with the realities of the interactional context. For the patients their desire for an emotional connection to the interpreter meant that some sought affirmation and reassurance through the interpreter. In contrast, HPs were sometimes naïve in terms of their understanding of the cultural and linguistic issues associated with the interpreting process. As in Hsieh et al. (2010) the healthcare providers described their confidence in the interpreters when they remained within their professional boundaries, which resulted in developing trust in interpreters' skills in being neutral and faithful in message transfer.

Trust and confidence in the interpreter were extremely fragile. As the person in the middle, the interpreters tended to be easily blamed for problems that arose. Interviews with both HPs and

patients highlighted how communication breakdown very easily tended to be attributed to the quality of interpretation. This attribution occurred in many cases where the cause of the miscommunication was entirely other than the quality of the interpretation. The reality of interpreters sometimes needing to move beyond the 'language transposer' role also is evident in analysed interpreted interactions. Repair and communication strategies beyond the 'language transposer' role were proactively applied by interpreters to address gaps in communication and to expedite accurate flow of information in some cases, especially when the patient was elderly, and/or had a low education level and/or time was short. The perception of ineffective interpretation, even if wrongly attributed, had consequences. HPs and patients reported loss of confidence and trust in interpreters and their unwillingness to be served by interpreters they considered inefficient or ineffective. Patients, in particular, reported a sense of frustration and vulnerability, especially when subjected to perceived or actual exaggerations in the interpreting of potentially concerning news. Similarly, Hsieh et al. (2010) provide examples where healthcare providers shared their sense of losing trust in the competency of interpreters due to their own lack of skills in evaluating how well the interpreter remained neutral and effective in practice.

8.2 Roles beyond language transposer

Directed by the second set of research questions this section focuses on findings related to the interpreter undertaking roles beyond message transfer. First, interpreters' explanations of fulfilling beyond message transfer to facilitate health professional--patient communication are discussed. Second, factors that contribute to interpreters adopting these roles are explored. Finally, attitudes of health professionals', health service users' and interpreters' toward interpreters adopting such roles are further discussed and related to findings from other research.

Broadly, three additional adopted roles have been identified as being employed by interpreters. The first one, *acting as a conversational facilitator*, involves drawing more broadly on the interpreter's linguistic, medical and sociolinguistic knowledge to enhance the level of mutual understanding and engagement within the interaction. In contrast, the next two involve facilitating the quality of the HP--patient interaction by drawing on cultural knowledge in acting as a *cultural facilitator*, and by drawing on interpersonal and institutional understandings as an *experience facilitator*. Each of these three roles encompasses different dimensions and these are explored in greater depth below.

8.2.1 Acting as a conversational facilitator

Through analysis of actual recordings of interpreted interactions (Chapter 7) it was identified that interpreters facilitated the exchange between HP and patient by adopting a range of communication enhancement strategies to assist in ensuring mutual understanding of each other's messages. In doing so the interpreters were effectively acting as conversational facilitators—they assisted the conversation to flow more effectively by making adjustments to enhance the interaction of the two parties—HP and patient. These interventions overwhelmingly drew on their linguistic, sociolinguistic, and pragmatic knowledge of the two languages. In addition, as will be discussed in sections 8.2.2 and 8.2.3, there is evidence from both interview material and actual interactions of interpreters engaging in roles beyond that of direct message transfer.

Clarifying

Analysis of the interaction data (Chapter 7) highlighted that interpreters used strategies to clarify the HP's message to enhance the patient's understanding. Such clarifying occurred when the patients were exposed to technical medical terminology, generic abstract terms or potentially ambiguous explanations. Interpreters clarified words or concepts by going beyond mere interpretation of the message, and included more details and/or gave more concrete examples to foster patients' understanding.

Even though none of the interviewed HPs (Chapter 5) attributed clarifying the message as a responsibility of the interpreter, some interviewed interpreters (Chapter 4) said they would initiate requesting the HP to clarify the message for those patients who have a low level of education. They explicitly stated that it was not part of their 'language transposer' role to clarify the message automatically for patients, and said that if patients required clarification, they should ask for it. Some interviewed patients (Chapter 6) attributed the role of 'clarifier' to the interpreters when the message from the health professional was not clear; therefore, patients seemed to expect the interpreter to clarify the message for them.

Interestingly, how interpreters described their contributions to facilitating understanding (Chapter 4), and what actually occurred (Chapter 7) were not always consistent. This inconsistency was only possible to uncover due to the two different methods of data collection adopted for this research: one-to-one interviews to ask about participants' views and

experiences in practice, and actual interactions in consultations to analyse the data as it occurs in real situations. For example, Silvia's view expressed in her interview, in relation to her role when comprehension was a problem for the patient:

> It's not up to me if they [patients] don't understand. They have to tell me they don't understand. If they don't understand, I refer back to the doctor.

Despite expressing this view (Chapter 4), in the Italian interpreted interaction in which she participated (Chapter 7), Silvia stepped in without reference to the HP in clarifying the doctor's message (see Example 1 below).

Example 1

Italian: Lines 48 – 51

Dr: Ok, that's the main reason for you to come here, right?

Int to **Pt:**
[Signora, lo scopo della visita oggi e' perche' ha tanti problem con la schiena]
[Madam, the scope of today's visit is due to problems with your back]

Probing

Analysed conversations yielded examples of interpreters probing the speaker's initial utterance/turn, when it was vague or incomplete, to develop a more complete understanding of the idea of focus and then presenting a clearer interpretation to the message recipient. There were cases where the interpreter probed the patient's response to the doctor's question, if the interpreter did not perceive the response to be comprehensive or clear (e.g. the Italian interpreter in Chapter 7). There were occasions where the interpreter was presented with a potentially vague explanation by the doctor and as a result, probed the HP for specific details.

HPs interviews (Chapter 5) discussed probing as a strategy used by interpreters, named it as 'teasing out' the answer, which the researcher also noticed, as an observer, in some interpreter-mediated consultations. Some HPs alluded explicitly to the interpreter's probing to resolve ambiguities caused by patients. Compared with instances of cultural clarification (Chapter 5) where the interpreter usually sought the HP's approval to clarify, probing as evidenced in interpreted interactions (Chapter 7) and in HP interviews (Chapter 5) mainly occurred at the interpreter's discretion and judgment, and in interpreting in both directions.

Although the literature extensively acknowledges the mediatory role of interpreters by highlighting their multiple contributions to facilitating HP--patient communication, probing has not been paid due attention and where mentioned briefly, there has not much in-depth investigation. Angelelli (2004) was among the few studies which focused on probing. In her book length study of interpreting practice, Angelelli proposed new metaphors for interpreters' roles, one of which was 'the miner' that reflects the interpreter's commitment to "excavate until they get to the gold (the necessary information)" (p. 131). However, Angelelli proposes that this metaphor reflects the interpreter's role of probing answers given by patients who "may lack understanding of the history-taking process, or they may simply be ashamed to admit that they do not know the answers to the questions being asked" (p. 131). In her explanation of the metaphor, she does not discuss interpreters' probing of HP utterances, perhaps because patients' turns need probing more often than HPs'. Yet, the present study shows that doctors' utterances can sometimes be vague. In one of the cases observed in the present study, the interpreter had to seek further details from the HP about hospital procedure relating to appointment booking. Without this probing work, the patient would probably not have been able to fully understand the procedure and follow it accurately.

Simplifying

Analysed conversations included cases where interpreters simplified doctors' lengthy or complex utterances by presenting (to the patients) interpretations that were structurally and/or lexically simpler and shorter than HPs' utterances. While most interviewed interpreters explicitly expressed their unwillingness to proactively lower the register of utterances produced by HPs; they would sometimes advise HPs to simplify their language or seek their agreement to present the patient with a simplified interpretation of their turns. This approach by interpreters to dealing with complex or lengthy utterances is also reflected in the findings reported in other studies. However, most studies (e.g. Angelelli, 2004; Butow, 2012; Sleptsova et al., 2017), and this study, in contrast, report interpreters acting autonomously in making HP utterances comprehensible for patients, rather than initially seeking the HP's consent.

In the interpreted interactions (Chapter 7) there were a number of instances of simplification, by interpreters, of medical terminology without reference to the consulting HPs, despite interview responses from all but one interviewed interpreter indicating that the HP was always included in resolving miscommunication relating to medical terminology. This concurs with findings from some other studies that have also captured instances where interpreters

intervened similarly. For example, Pöchhacker (2000) reported specific tasks fulfilled by interpreters, such as simplifying technical language for patients, explaining technical terminology for them, and summarising lengthy utterances. Sleptsova et al. (2017) similarly reported shortening/summarising as a common undertaking by interpreters. Some interpreters in Angelelli's (2004) study also engaged in simplifying or exemplifying HPs' explanations for patients, sometimes with the purpose of diminishing patients' stress. Interpreters in Butow et al.'s (2012) study said that, based on their judgment of whether patients understood direct interpreting of HPs' turns, they would simplify the message as further explanation. This re-explanation of what the doctor said through using simple words and understandable syntactic structure was also observed in interpreters' practice by Gavioli (2015).

Greenhalgh et al. (2006) refer to this interpretation style as *double translation* as it involves message transfer both from one language to another and from medical jargon to everyday talk. The interpreter participants in Greenhalgh et al.'s (2006) study attributed the need for this double translation to patients' limited health literacy and attached significant importance to adopting this style, given potential clinical risks involved in lack of understanding on the part of patients. However, as reported by Hadziabdic et al. (2015), HPs expected interpreters to ask them to clarify or simplify the terminology, if necessary, rather than independently doing so based on their own judgment. In this study, whilst HPs tended to want and expect any need for clarification or simplification to be directed through them, not all were strict about this, and some were willing to trust interpreters to assist in making modifications to ensure the patient understood, given their level of health literacy. Based on the evidence of actual practices, whether sanctioned by the HP or not, all three interpreters whose interactions were recorded at times undertook simplifications and clarifications without reference to the consulting HP.

Repeating

In the interview chapters on findings repeating was mentioned as a strategy to overcome communication difficulties and to enhance patient's understanding. For example, HPs repeated their own utterances and asked the patients to repeat what they understood from the interpreted consultation with their HPs. One interpreter (Parvaneh) said she would repeat for patients to provide them with the opportunity to ask questions if they had not understood. Whilst this interpreter's repeating was to enhance the patient's opportunity to understand and ask questions, some patients found the interpreter's request to the patient (to repeat) as lack of

attention to the patient's utterance. This behaviour resulted in patients' losing trust and confidence in such interpreters and not wanting to be served by them. On the other hand, if the interpreter had repeated the HP's key points for the patient and asked them if they needed any of the material to be repeated, the patients found this to be a good characteristic in an interpreter.

In the patients' interview (Chapter 6), a female patient (Neda) said that when she requested repetition of the doctor's message, the male interpreter reacted impolitely and accused her of not listening carefully to what the doctor had said. This example shows that some interpreters may take the patient's request for clarification of the message negatively, as a sign of the patient's lack of paying attention to what was being communicated.

Analysis of interactions (Chapter 7) revealed that interpreters used repeating as a strategy to accommodate the dialect of the patient, to clarify the message, and reinforce the topic of conversation to enhance patient's understanding. The number of times repetition occurred as a conversation enhancement strategy depended on the flow of communication in terms of clarity of the message in the source language. Based on the interpreter's discretion in assessing how much clarity was needed, the interpreter repeated the word or phrase to enhance the patient's understanding.

Unlike the use of repetition in this current study, in the literature repetition has been accompanied with a sense of hesitation of the CALDB speaker in terms of interpreting the utterance of the witness in court, whereby the interpreter has omitted the repeated words to provide the court with a certain answer (Hale, 2007b), or the interpreter asked for repetition when they required clarification (Verrept, 2008).

Omitting conversational gambits

The analysed conversations included examples of omissions by interpreters, not of core content, but rather of conversational gambits that HPs or patients used to fulfill different discourse functions, such as acknowledging the other person's turn, giving positive feedback, or showing appreciation, which can broadly be described as forms of phatic communication. This type of omission may partially be accounted for by the nature of face-to-face contact of the HP and patient, in which non-verbal aspects of communication make verbal communication effectively redundant, and/or the patients' and HPs' understanding of short common words of

praise/positive feedback, for example, OK, good, or showing appreciation, or thank you in respective languages.

Omission has been reported as a relatively common practice on the part of interpreters. For example, based on the analysis of 12 interpreted consultations in England, Seale et al. (2013) reported 33.4% of utterances made by patients and 41.0% of those from HPs contained some talk that was not interpreted. Sleptsova et al. (2017) found that omitted information can be of a content, structural, or emotional nature. With a different underlying motivation, Farooq & Fear (2003) found that interpreters are likely to omit information related to sensitive personal issues, especially when they are family members or have a conflict of interest. In this situation, they reported, even minor omissions may be highly important. However, in contrast to omissions in some of these studies, in my study of interpreted interactions, there was no evidence of interpreters omitting core utterances of HPs or patients. Omissions did not have critical value in relation to medical content in consultations; rather they involved omission of more formulaic speech acts, referred to as conversational gambits, which usually function to maintain the smooth flow of an interaction. As such they are similar to what Flores, Abreu, Barone, Bachur, & Lin (2012) argued to be interpreter errors caused by natural redundancies in a conversational context, and therefore have no potential clinical consequences. Such omissions conform with what Hale (2007a) alludes to as a principle in the AUSIT code, which discourages interpreters from omitting anything in the core message. What Hale is suggesting as legitimate omission, also referred to by Pöchhacker (2008, p.13) as 'selective omissions', constitute omissions with no medical consequences, such as these conversational gambits.
Yet, what information to omit or not does not solely depend on its linguistic structure or discourse function. While in the present study, gambits were found not to be of medical significance; Tebble (2009) argues that gambits, such as the physician's positive feedback to the patient in the form of the acknowledgement "good", may be important to interpret, since such acknowledgement highlights the success of a medical procedure as the result of the patient's cooperation and expresses rapport. Tebble explains,

> These are very important in the establishment and maintenance of trust that patients have in the physician and whether they comply with the medical advice given during the exposition stage of the consultation. … The patient needs as much positive feedback as possible… When the physician utters this single word 'good' in the follow-up move it does have communicative value and needs to be interpreted. (p. 212)

In this study, the HP's reinforcing gambit of "OK, good" or "good" was usually not interpreted to the patient. However, this does not mean that the intention of this gambit was not appreciated by the patient, as most LEP patients still understand basic English expressions, such as OK and good.

8.2.2 Acting as a cultural facilitator

Interpreters interviewed in this study expressed their willingness to assist in cultural clarification where it was judged to be needed for a successful consultation. They showed awareness that a patient's cultural background may impact on the efficiency of the patients' interpreter-mediated conversation with HPs in different ways. Examples were patients' culturally constructed understandings of body organs, health issues, symptoms, and how medical services are received, and, as mentioned previously, preference for a female HP on the part of female patients who come from traditional patriarchal cultures. When culture appeared to influence the process of consultation, interpreters reported feeling obliged to step in and fulfill other roles, such as providing necessary insights to the HP, persuading the patient to accept the proposed treatment, and observing patients' culturally informed concerns and transferring them to the HP. Following an appropriate course of action on the part of the HP and relevant interpreting work by the interpreter, the interpreter would resume her/his message transfer role.

HPs interviewed also showed some level of understanding of their patients' cultural background and its impact on the process of the consultation, such as by influencing patients' decision making regarding treatments. They were also aware that patients would not talk to them about their cultural customs or habits; therefore, HPs would seek the interpreter's help with gaining insight about the patient's cultural background, understanding their intended meanings and assisting them in understanding HPs' views about helpful types of treatment, or convincing patients to accept treatment plans, such as surgery.

Across interview findings both interpreters and health professionals pointed out their experiences where the interpreter facilitated cultural clarification. Only patients interviewed did not identify any specific instances of cultural misunderstanding with their HPs in relation to their health condition. In interpreter mediated interactions (Chapter 7) there was an incident with the Arabic interpreter when the doctor asked the patient about the numbers she had written in her food diary notes being different with those of her blood sugar chart. In that case, the

interpreter responded to the doctor's question by providing a cultural clarification. Quick intervention of the interpreter in acting as a cultural facilitator meant that the patient did not appreciate the role the interpreter played. It appears that if any cultural ambiguity arises the interpreter may clarify it for the doctor without interpreting that question to the patient and asking for the patient's input. As a result the patient may not have awareness of the cultural issues that may arise in their healthcare consultation.

Interpreters and HPs separately in their interviews pointed out that cultural information may be deemed necessary for meaningful communication. For example, interpreters (Chapter 4) shared their experiences that informing HPs about cultural matters was crucial to the continuation of meaningful HP--patient communication. Some HPs (Chapter 5) described how cultural information interpreters provided, assisted them in having a better understanding of patients' performance. Interestingly, adding cultural knowledge was detected with lesser frequency as a communication enhancement strategy in these interactions (Chapter 7).

The literature includes a similar focus on the role of interpreters as cultural facilitators in supporting inter-cultural understanding of HPs and patients. This focus manifests in scholars' use of different metaphors. Avery (2001) and Norris et al. (2005), for instance, likened the healthcare interpreter to a 'bridge' that connects culturally distant HPs and patients. Angelelli (2004) referred to this role more broadly with the metaphor 'the multi-purpose bridge', which she used to explain interpreters' ability to navigate and bridge not only cultural but also other (educational, economic) divides of these two parties. Labun (1999) and Watermeyer (2011) used the phrase 'cultural broker' to explain the interpreter's role in mediating between two worldviews and providing a cultural framework to facilitate understanding of the message. In Bischoff et al. (2012) interpreters reported that they gradually accumulated knowledge of cultural difference as they gained experience in working with professionals and patients within medical settings, and that HPs sometimes gave them license to assume responsibility for mediating cultural difference.

The significance of interpreters' adoption of the role of cultural bridge in facilitating communication between HPs and patients has been explored in a number of studies. Kaufert et al. (1999), for example, documented the use of interpreters as cultural brokers for Aboriginal Canadians to resolve conflicting value systems of healthcare providers and patients during decision making about end-of-life care. Similarly, Hsieh (2010) reported occasions where

patients' cultural backgrounds interfered with their understanding of the proposed treatment, especially with diseases where there is a cultural stigma that may act as a barrier to patient's understanding of and consent to modern treatment. In a conversation analysed by Gavioli (2015), the interpreter similarly drew upon her shared cultural background with the patient to encourage her to follow the HP's instructions for using the prescribed medicine. In the reported conversation, the HP directly asked the interpreter to tell the patient to take medicine cautiously and in small quantities, drawing on his/her awareness of how the patient may misinterpret the doctor's advice as wanting to save medicine, she proactively ended her interpreting by reassuring the patient that the HP wanted to heal her.

Despite the interpreters in our study explicitly excluding themselves from undertaking a cultural mediating role, unlike in some other international contexts (e.g. Bischoff, 2012; Kaufert et al. 1999), evidence from their interviews and recordings show that, where needed to progress communication, such a role was sometimes performed. In most cases, such mediation involved explicit knowledge and cooperation of the HP in appreciating what the cultural issue was, and then either 1) authorising the interpreter to clarify to the patient in their own cultural framework (a cancer being a boy or a girl), or 2) requesting clarification from the interpreter to help them understand the patient's framework (use of methylated spirits to treat a skin condition). However, there were some instances where interpreters reported autonomously engaging in cultural mediation (i.e. without the knowledge and involvement of the HP), such as 1) in expressing diagnosis of impending death in a less direct way (e.g. choosing an alternative phrase to avoid 'blunt' words), or 2) persuading a patient to accept an outcome that was not usually culturally acceptable (e.g. to see a male doctor). In comparison with other research discussed above, whilst the cultural mediation role of interpreters tended to be less overtly acknowledged, it did occur, but usually only with guidance from the consulting HP. However, there was no evidence of HPs explicitly authorising the interpreter to engage in cultural mediation at their discretion (as had occurred in Bischoff, 2012). The interpreters occasionally reported covertly engaging in cultural mediation to assist with interaction of the patient with the HP, which resonates with Hsieh (2010) findings about conflict in authority that can occur when the expertise of the interpreter and the HP interact.

Whilst HPs tended to be accepting of cultural difference, they did not report adapting their approaches to treatment to align with the patient's cultural beliefs. In addition, as Crezee (2013) reported, HPs tended to intervene to address perceived harmfulness of Chinese women's

dietary practices after childbirth, without acknowledging their cultural beliefs and involving them in the reasons for the recommendations they were making. In my research, however, the focus on the expectation for the interpreter in assisting with cultural mediation was to support the patient in accepting both the treatment being offered, and the hospital system to deliver treatment. As such, interpreters were seen by both themselves and HPs as being aligned with the mission of the hospital, and focused on achieving patient outcomes that were desired by and perceived to be in their best interests by the hospital system. In the analysed conversations the broader role an interpreter may perform in assisting the patient in navigating aspects of the healthcare system emerged more clearly, and this will be discussed further in the following sections.

8.2.3 Acting as an experience facilitator

This broad role captures initiatives that interpreters take in order to facilitate a positive atmosphere, and comfortable and informed consultation experience for patients and their HPs. Acting as an experience facilitator for interpreters encompasses two specific dimensions:

1) Facilitating a positive experience
2) Adding institutional knowledge

In both dimensions interpreters facilitate quality experience for HPs and patients by proactively expediting positive communication or providing relevant information to resolve lack of understanding about the process of how the hospital system works.

Facilitating a positive experience

The interview findings showed that most interpreters, HPs, and patients shared the idea that a key role of interpreters was to relax the atmosphere of consultations in order to facilitate more effective communication and message transfer, what I have chosen to refer to as facilitating a positive experience. Most interpreters reported being expected to improve the dynamics of communication between HPs and patients and to ensure the consultation proceeded smoothly and pleasantly. As evidenced from the analysis, the interviewed interpreters did not fulfill this role, only because they were expected to (and were willing to do so), for example, by slowing down the conversation and assuring patients of positive outcomes regarding consultations and resulting medication. Interviewed HPs also expressed appreciation of interpreters'

contributions to the atmosphere of consultations and its positive impact on the quality of information transfer. Patients also expressed feeling relaxed, comfortable, trusting and being satisfied about their reaction to an interpreter mediated consultation where they felt respected and listened to. And they were able to communicate in their first language with their HP without worrying linguistically as how to make themselves understood to the HP or how to understand the HP.

The literature also refers to positive experiences interpreters created within the consultation. For example, Pardy (1996) (Australia) reported, based on interviews with 56 immigrant women, that a competency of highest importance was interpreters' "capacity to relate in a relaxed and warm manner" (1996: 6). She then clarified this characteristic in interpreting as, "these are qualities or 'competencies' not often referred to in mainstream interpreting discourse" (Pardy, 1996, p. 6). There are other studies that report a similar focus on the interpreter's role in improving the participants' experience of the consultation. Interpreters in Bischoff et al.'s (2012) study (Switzerland) similarly believed that patients view the very presence of interpreters as a source of comfort, helping them to feel less anxious and stressed, in that "the interpreter enables people to feel safe in a foreign environment, confident and supported in making decisions, and able to deal with healthcare professionals without fear or mistrust" (p. 15). Interpreters interviewed by Wu & Rawal (2017) also reported that a key aspect of their work is creating an atmosphere which allows patients to feel comfortable talking about their concerns. Finally, in their qualitative study of interpreters', patients', and HPs' perceptions of interpreter roles, Hsieh, Pitaloka & Johnson (2013) (US) came up with the theme 'Patient Ally', a component of which was interpreters' ability to provide emotional support to patients. A key finding to emerge from this study is that the support role played by the interpreter in creating a comfortable and positive dynamic regarding the interaction between HP and patient was equally valued by both. Despite there being occasional reflections on dissatisfaction with a specific interpreter (as discussed in Chapters 5 and 6), both groups of participants valued the presence of an interpreter, and saw their involvement positively.

Adding institutional knowledge

Interpreters added their own knowledge of how the hospital works as an institution to facilitate better understanding mainly for patients and assist in smooth and less ambiguous HP--patient communication in dealing with aspects of hospital bureaucracy. For example, interpreters

added details related to hospital procedure, such as booking future appointments or requesting a referral for allied health, when interpreting HPs' utterance to assist the patient with understanding hospital procedure.

Even though it was revealed, from actual interaction, that interpreters assisted communication by adding their own institutional knowledge, such as a request for a referral for the patient or giving detailed explanation of how to book the next appointment, some interpreters (Chapter 4) specifically objected to requests from HPs or patients to assist in directing patients where to go, believing there were volunteers who could accompany patients to the right area, or take them to reception for booking the next appointment. The difference in what some interpreters rejected doing, with what they voluntarily contributed in the actual interaction, was that they assisted with their institutional knowledge within the consultation, and did not dedicate their time and expertise regarding their institutional knowledge outside of the consultation room.

In the analysis of the consultation conversations in diabetes care in primary care settings in London, Seale et al. (2013) observed that interpreters often answer the patient's questions directly and add their own material. The similarities between current findings and Seale et al. (2013) is in interpreters' adding their own material/knowledge in the consultation. The difference between this study and that of Seale and colleagues is in the nature of the material added: in my findings added material is mainly in relation to the hospital as an institution; in Seale et al. (2013) the interpreters were adding medical knowledge, which makes them 'co-diagnosticians' which was nevertheless considered to be "safe and reasonable", "given the regular experience some of them [interpreters] have in participating in these routine reviews, during which considerable knowledge of diabetes may have accumulated" (p. 126). In this study's interpreted consultations (Chapter 7) there was only one example of the interpreter stepping into a 'co-diagnostician' role, when she advised the patient to do their MRI at the hospital instead of a place closer to home. Interestingly, when the interpreter moved away from her direct interpreting role, in this instance, she shared her given advice with the doctor. This way of keeping the doctor informed was how the interpreter signalled her boundaries even when she moved beyond them. In comparison, Seale et al. (2013) did not discuss whether the interpreters shared with the doctor the medical knowledge they added, or how they kept their boundaries. It seems their aim was to save the doctor's time and shorten the duration of the consultation, therefore they answered the patient's questions without interpreting them to the doctor.

Adding details in the form of clarifying healthcare system procedures has been reported in several other studies as a common task for interpreters. The significance of this role is attributed to providing patients with assistance in understanding how the healthcare system worked. Angelelli (2004) compared interpreters in her study as acting like a multipurpose bridge, and who bridged cultural gaps and understandings of the health system for patients. As interpreters in Butow et al.'s (2012) study reported, patients' limited familiarity with the Australian health system may have led to their limited understanding of HP advice and instructions even when interpreted accurately. Interpreters participating in Lor et al.'s (2018) survey research in the USA talked about their common experience of working with patients who were unfamiliar with the Western healthcare system and, therefore, having to provide explanations in addition to what HPs say about Western healthcare systems in general or a specific clinic. In the USA context, Hsieh et al. (2013) found a component of what they characterise as the 'Patient Ally' role to be helping patients navigate the healthcare system. Bischoff et al. (2012) reported similar experiences by interpreters in the context of Switzerland where interpreters felt the need to help patients to understand how healthcare and society at large work. Finally, reporting the patient side of the story, Hadziabdic et al. (2014) (Sweden) found that interpreters informed patients of procedures and rules to be helpful to their adaptation to a new environment.

8.3 Participants' attitudes towards interpreters fulfillling roles beyond language transposing

The last research question, "What are interpreters', health professionals', and health service users' attitudes toward interpreters serving roles beyond message transfer?" is addressed in this section. The interview findings yielded variations in how HPs, patients, and interpreters themselves viewed interpreters going beyond a conduit role. In this section, the views of each of these key parties in a medical consultation are discussed.

8.3.1 HPs' attitudes

Interviews with interpreters and HPs (Chapters 5 and 6) showed that HPs hold somewhat differing views on interpreters fulfilling roles other than direct message transfer. It was reported that some HPs hold a positive view regarding interpreters' multiple roles. For example, some HPs said that two-way communication between the interpreter and the patient in the presence of the HP can have a positive impact on relaxing the patient and enabling them to talk.

The literature includes similar reports on HPs' positive approach to interpreters serving roles beyond message transfer. Hsieh et al. (2010), for example, reports that some HPs said they trust interpreters for their ability to make judgments in order to facilitate communication and, therefore, value such judgements on the part of interpreters. These HPs in Hsieh et al. (2010) commented "they hope the interpreters would feel comfortable to interrupt them if the interpreters need further clarification, believe that the providers' care is not culturally appropriate, or think that the patients' care is compromised" (p. 175). Similarly, Bischoff et al. (2012) found that sufficient mutual trust between HPs and interpreters would enable the latter to go beyond message transfer, and this trust could be so strong that sometimes HPs would even explicitly seek assistance with understanding their patients' cultural beliefs and values.

Another relevant finding of the present study was that HPs wanted interpreters to inform them before adopting roles in a consultation other than direct information transfer, so that the HP would still be in control of the consultation. An interpreter in Angelelli's (2004) study was proactively aware of this preference to maintain control on the part of HPs and of the benefit of HPs being able to trust interpreters. As Angelelli (2004) observed:

> Annette also realizes that the HCP [HealthCare Professional] must be able to trust the interpreter. If she expands on what the HCP has said, or she explains something to the patient, she is careful to keep the English speaker in the loop...If she summarizes a patient's story, she informs the doctor about the main points and lets him/her make the decision as to how much content she needs (p. 109).

In my study, some HPs talked about strategies they used to maintain control in the consultation, such as paying attention to differences between the duration of time in their own original utterance and that of the interpreted utterance and/or listening for familiar words they knew in other languages in the interpreting. HPs in Hsieh's (2010) study reported using similar control strategies in their own interpreted consultations.

The most negative perspective that some interviewed HPs reported adopting towards interpreters going beyond a language transposer role was explicitly objecting to interpreters who did so. The reason for these HPs resisting their interpreters' multiple roles was they found it frustrating to lose control over the content of a consultation. The interpreter was the only party in the triadic conversation who knew both languages, while the other two parties were essentially 'in the dark' as to the content transferred in the language unknown to them. Such a perspective on the part of HPs has been reported by other scholars too. The HPs in Hsieh's

(2010) study felt “powerless to interpreters’ manipulation over their voice” (2010, p. 4). Clinicians in Bischoff et al.’s (2012) research expressed a fear of losing control of the consultation, if an interpreter were to depart from this straight and narrow interpreting function. Sharing the same concern, clinicians interviewed by Leanza (2005) (Switzerland) felt excluded from the interaction when interpreters did more than mere interpreting, while to them interpreters were only instruments for communication with a patient rather than a real actor.

8.3.2 Interpreters’ attitudes

A few interviewed interpreters expressed a positive attitude towards adoption of roles beyond message transfer. Also analysed conversations showed interpreters’ regular active engagement in fulfilling such extensions to their primary language transposer role. However, in the interviews most participants showed a lack of willingness to discuss roles actively assumed beyond transferring information between HPs and patients. A reason some gave regarding this avoidance was the likely consequence of blurred boundaries. They explained that doing more than information transfer would position them as ‘helper’, a role which they believed should be typically fulfilled by patients’ children, friends, volunteers, or hospital staff. This positioning would result in patients feeling permitted to ask for further assistance beyond the information transfer role that interpreters were there to fulfill. Another reason given by interpreters as to why they avoided transcending their professionally assigned message transfer role was the expectation that HPs would sometimes have of them, to convince patients to accept a proposed treatment—a function that for interpreters was clearly beyond the scope of their job description and to be served by HPs.

The interpreters interviewed by Wu & Rawal (2017) (Canada) shared a similar view about roles they thought HPs should fulfill rather than interpreters. Whilst in my study, the role interpreters considered to be beyond their responsibility in convincing patients to accept a treatment; by contrast, the roles that Wu & Rawal’s (2017) participants avoided adopting were independently completing consent forms with patients and giving an opinion on a diagnosis that HPs they had worked with would sometimes ask them to do. Bolden (2000) (US) asserts, in this regard, that interpreters’ conduct greatly depends on their orientation to and understanding of their roles entail. In this study and in Wu & Rawal’s (2017), interpreters did not see their roles as extending to aspects of treatment, and actively avoided treatment-related tasks. While interpreters may be willing to sometimes play roles that are beyond direct message transfer, they proactively put limitations on the scope of their own role.

8.3.3 Patients' attitudes

Limited findings were evident relating to patients' attitudes toward interpreters fulfilling roles over and above direct interpreting of content in the consultation. While patients reinforced that their primary concern was that the interpreter act accurately in the language transposer role to ensure their needs were met; some expressed satisfaction with an interpreter going beyond a language transposer role, and/or dissatisfaction at the interpreter supporting them less than they had expected. The description by a patient of an interpreter interpreting "beautifully" suggested that the criteria for assessing the interpreter's performance was not solely the quality of direct message transfer, as this meant the interpreter had maximised the clarity of communication in a way they could understand. Other comments in interviews highlighted also that patients welcomed interpreters doing more than interpreting, since quite often their assistance in other roles facilitated communication with HPs and their navigation through the Australian healthcare system.

Patients across a range of other research studies have reported dissatisfaction with the extent and quality of interpreter services available to them. The Chinese cancer patients in Lim et al.'s (2019) Australian study reported on the helpfulness of professional interpreters, but raised their concerns in relation to time limitations with interpreters, and inaccuracies in interpreted cultural and medical concepts. Oncology migrant patients in Shaw et al. (2016) (Australia) reported on limitations in receiving interpreting services as they were only offered interpreting for critical meetings, regardless of their request to have interpreters, leaving the cancer patients "vulnerable to poorly coordinated care" (Shaw et al., 2016: 2408). Patients in Abbato et al. (2018) (Australia), Alsharifi et al. (2019) (Denmark), and Patriksson et al. (2017) (Sweden) reported they were not offered professional interpreting services at hospitals and consultations usually went on with patient's limited L2 or ad hoc interpreters.

8.4 Summary

In this discussion, the research questions reviewed drawing on findings and insights obtained by analysing the study's two main datasets: interviews with interpreters, HPs and patients, and analysis of interpreted interactions. From the analysis, it is evident that interpreters acted beyond their strict 'language transposer' role quite regularly in situations where the transposer role may not have provided a meaningful transfer of messages between the HP and patient. Three broad roles beyond that of 'language transposer' were identified and explicated as the

interpreter acted as a conversational facilitator, a cultural facilitator or an experience facilitator. I also discussed the diverse and differing attitude of HPs, interpreters, and patients towards interpreters fulfilling roles beyond 'language transposer'.

Table 8.1 summarises findings in relation to the four identified interpreter roles as reported across the datasets. If a role has been reported as being experienced, discussed or observed in the dataset, it is indicated with a tick (✔). If the role has not been mentioned or observed, I have indicated with a cross (✗). The purpose of this tabular presentation is to highlight similarities and differences in how the roles and strategies evidenced in actual interpreted interactions map against the roles identified and discussed in the interviews. The capacity to triangulate data from the two datasets has been significant in a number of ways. Across virtually all datasets there is recognition of each broad role. Exceptions are that patients did not explicitly mention examples of the cultural facilitation role, and interpreters, similarly, did not explicitly discuss the conversation facilitation role. Through analysis of interpreted interaction, greater depth emerged in understanding the practice of each role, with the breadth of strategies adopted being elucidated.

Table 8.1: Roles of interpreters as extracted in different datasets (Chapters 4-7)

Role of interpreter	Interpreter interviews	HP interviews	Patient interviews	Interaction recordings
Language transposer	✔	✔	✔	✔
Cultural facilitator	✔	✔	✗	✔
Experience facilitator	✔	✔	✔	✔
Facilitating a positive experience	✔	✔	✔	✔
Adding institutional knowledge	✗	✗	✗	✔
Conversation facilitator	✗	✔	✔	✔
Clarifying	✗	✗	✔	✔
Probing	✗	✔	✔	✔
Simplifying	✗	✗	✗	✔
Repeating	✗	✗	✔	✔
Omitting conversational gambits	✗	✗	✗	✔

The general implications of these findings for understanding the interpreting role/s are explored further in the final chapter. In addition, the implications of the research findings for the designation of professional standards and interpreter training and suggestions for further research will be discussed.

Chapter Nine – Conclusion

Two Melbourne public teaching hospitals opened their doors to me to observe, introduce my research, communicate with health professionals to invite them to participate, attend waiting areas to meet with and recruit patients, as well as introduce myself to my professional colleagues, the interpreters, and ask them to take part in this research. Each of these groups have shared their professional/personal and emotional experiences in hospitals (Chapters 4-6).

In Chapter 7, to provide a contrasting perspective, actual triadic interpreted interactions from hospital outpatient clinics were analysed. The findings linked back to the main line of argument that conceptualising and understanding the role of interpreters in healthcare as being that of a neutral language transposer, devalues other contributions expected of and made by interpreters in order to facilitate meaningful patient--HP communication. In concluding the discussion, the most important findings and insights will be briefly reviewed before revisiting the implications of the findings for the conceptualisation of interpreting and its application in practice. Finally, the limitations of the study and recommendations for future research will be discussed.

9.1 Interpreter-mediated consultations as dynamic contexts of communication

Collation and discussion of findings have provided evidence from different perspectives of how interpreters take on multiple roles, depending on what actually occurs in a consultation, regardless of their main role of direct message transfer as a 'language transposer'. A number of factors have been identified as affecting how well interpreters fulfill this primary 'language transposer' role, namely their linguistic skills across two languages, the patient's education level and understanding of specialist medical terminology and registers, interpreter--patient dialect compatibility, interpreter--patient and HP--patient gender compatibility, and constraints of the hospital context (i.e. time and other institutional pressures).

Different contextual issues also prompted interpreters to adopt roles beyond direct message transfer to assist in mediating aspects of the experience and context, and thus facilitated HP--patient communication. When a patient's cultural background and beliefs appeared to influence the consultation, interpreters sometimes provided cultural insights to the HP. On occasions when the patient seemed to be stressed, interpreters facilitated a positive experience by relaxing the atmosphere of the consultation and reassuring the patient of the HP's good intentions. When HPs used complex medical terminology or sentence structure, the interpreters clarified HPs'

utterances by giving concrete examples and simplified them by presenting lexically simpler and shorter utterances to the patient without referring back to the HP. In cases where interpreters found additional details about hospital procedures useful, they incorporated these details into their interpretation, in some cases without referring back to the HP. Another way in which interpreters coordinated conversation beyond message transfer was through probing HPs and, to a lesser degree, patients' initial utterances which could be vague or incomplete, presenting the recipient with a more complete and clear interpretation in their language. Finally, interpreters were observed to reduce redundancy in interpersonal communication by avoid interpreting conversational gambits used by the doctor or patient to fulfill discourse functions, such as giving positive feedback or showing appreciation, presumably because they perceived those gambits to be either medically unimportant, or implicitly understood through nonverbal or other means.

Comparisons across two datasets (interviews and conversations), across three groups of participants (interpreters, patients, and HPs), and between findings related to the roles interpreters fulfilled or were expected to fulfill, and what the professional code of conduct committed them to, yielded interesting insights into how the dynamics of a consultation and perceptions of parties involved impacted on interpreters adopting different roles beyond merely message transfer, and how adopting such roles was perceived by them, patients and HPs.

Most interviewed interpreters expressed their desire to solely perform a language transposer role, which their professional code of conduct required of them in accurately interpreting messages between two languages. However, their responses in their narratives and practice in recorded interactions highlighted that they were not against fulfilling additional roles as cultural or institutional mediators or improving the atmosphere of consultations. In addition, analysed conversations showed other roles that contributed to facilitating the accuracy and effectiveness of HP--patient communication exchange (i.e. clarifying, probing, simplifying, repeating, or omitting conversational gambits) to be proactively adopted by interpreters. As mentioned earlier, interpreters took on these roles spontaneously in response to issues which arose during consultations. A related trigger was their sense of vagueness in an HP's explanation, which led the interpreter to clarify their input. Another trigger was their sense of the influence of patient's cultural beliefs on how they responded to the HPs' questions or suggestions, which necessitated the interpreter mediating the conversation between the HP and the patient culturally. What this shows is that interpreters, while acknowledging their adherence

to professional standards and role expectations, had to respond to the dynamic nature of the consultation as well. Their strategies reflected their overriding aim of *maximising the quality of mutual understanding achieved between patient and HP*, taking into account (socio)linguistic, educational, institutional, and cultural barriers.

Most interviewed HPs approved of interpreters taking on roles beyond mere message transfer when these were intended to facilitate communication. In fact, some even appeared to be appreciative of interpreters teasing out patients' answers through direct questioning, or probing an HPs' input, which the interpreter found potentially vague, since by doing so the interpreter helped facilitate communication in an expeditious way. Such roles are not explicitly included in professional standards as being within the scope of the role of an interpreter or may even be discouraged, like adding or omitting, as the HP is expected to take the lead in dealing with vagueness or misunderstanding.

The HPs' usage of highly contextual medical 'incrowd' language may have resulted in a perception of vagueness in their speech. However, there are very limited instances of use of high-context 'in-crowd' language within the actual transcripts of interpreted interactions, suggesting that such specialist 'incrowd' language was only a minor contributor to miscommunication. In fact, most instances of failure to comprehend on the patient's part appeared to result from lack of understanding of basic medical information, such as the names of tests (e.g. X-ray versus CT scan). There was some evidence of HPs treating the interpreter as a colleague HP, and the interpreter assuming a function beyond mere interpreting in explaining medical functions. This occurred particularly with in-house interpreters, but the focus of the interpreter in such an example was more towards explicating aspects of how the hospital and medical system works.

While interpreters interviewed for this study expressed willingness to adopt certain roles beyond message transfer, they explicitly rejected others. One such role was advocating for patients as a support person, for example, by assisting them like a family member or friend, or giving directions in the hospital. Other roles they stated that they avoided, even if HPs wanted them to undertake them, were those whereby the interpreter entered the professional medical territory of HPs. For example, persuading patients to accept a proposed treatment, which interpreters reported being asked to undertake by HPs. Such an assigned role would position the interpreter as a medical adviser because recommending a medical treatment to a patient

assumes that the interpreter has the necessary knowledge and understanding to condone/attest to the usefulness of such treatment. Another role in this category which patients expected interpreters to adopt was to assure them of the accuracy of HPs' diagnoses. This role similarly positioned interpreters as medical experts. However, despite their claimed universal expressed avoidance of taking on such expert advisory roles, there was one example where the interpreter effectively assumed the role of co-diagnostician, in that she initiated questions about the patient's symptoms without any authorisation from the HP, and then reported the outcomes of her diagnostic questioning to the HP.

While most HPs were supportive and appreciative of interpreters performing multiple roles beyond message transfer, this receptiveness decreased when they considered the interpreter's adoption of such roles jeopardised their control in the consultation. HPs expressed a sense of discomfort when they felt left out of conversations that interpreters initiated with patients, especially when this was followed by interpreters' non-interpretation of content, which may have included potentially important input from patients. Therefore, while HPs accepted interpreters' direct questioning of patients, if this resulted in what they considered to be a lengthy conversation without the interpreter keeping them in the loop, they felt excluded and uncomfortable. What these observations suggested was that HPs' approach to interpreters' adoption of roles beyond message transfer depends on their perception of how well these roles served their agendas. HPs' expectations were not necessarily at odds with interpreters' professional standards. Expecting interpreters to keep them in the loop when interpreters engaged in dyadic conversation with patients was an entirely legitimate demand on the part of HPs, and consistent with the AUSIT (2012) code and interpreter training. However, sometimes HPs' interest in pursuing their own agendas took priority over interpreters' adherence to their code of conduct and led to HPs' making requests from interpreters which amounted to violation of their code. Perhaps the most illustrative example from the data is HPs asking interpreters to persuade patients to accept treatment, a function which is obviously outside the realm of an interpreter's professional role.

A similar inconsistency was evident with regard to patients. While, as shown in Chapter 6, patients attached enormous importance to accurate interpretation, in Chapter 4 interpreters reported being asked by patients on occasion to serve as their advocates, another role which goes well beyond the professional standards interpreters are expected to follow, because it serves a patient's personal agenda rather than maintaining the interpreter's neutrality. The

AUSIT Code of Conduct (2012) also clearly requires interpreters to avoid assuming roles involving patient advocacy and advice: "Practitioners do not, in the course of their interpreting or translation duties, engage in other tasks such as advocacy, guidance or advice" (p. 5).

In such a dynamic context with a changing emphasis on the part of HPs and patients on interpreters' fulfillment of varied and sometimes conflicting roles, interpreters were faced with two types of dilemmas, namely: 1) those roles which they more or less willingly fulfilled in order to facilitate communication, even though the code of conduct may have discouraged them, and 2) those that were expected to be fulfilled by patients and HPs which not only did the code of conduct a disservice, but also they themselves were unwilling to serve.

There are a number of issues which can be discussed in light of these findings and analysis. To begin with, any discussion of interpreters' roles should be informed by an understanding of the context in which they work. It was evident that the interviewees' focus on interpreters' multiple roles was based on perceived needs and priorities of the hospital in which they interacted with interpreters or served as interpreters. In this regard, Tebble (2009) argued that understanding the social context of interpreting rather than exclusively focusing on linguistic equivalence can improve the quality of interpreting. She concludes, "the language use of the speakers arises out of the speech situation; so too must the interpreter's" (p. 205). Jungner et al. (2019) emphasised the context of interpreting through likening it to a doughnut, the hole of which is the interpreter's narrow role of translation, surrounded by a rich context of interaction:

> When they (interpreters) feel obliged to interpret in a broader cultural context rather than carry out lexical translations, they end up in a situation where they not only make use of their discretionary power within the 'doughnut hole,' but sometimes even take a big bite of the entire doughnut, or even go outside the realm of the doughnut (p.660).

The second issue is that investigating the role/s of interpreters within the social context leads to recognition of the active part interpreters play in bilingual consultation. This work is reflected in a variety of roles, as in analysed conversations, or being reported as being played, as in interview chapters. In fact, it is clear the interpreters were found to engage in a constant process of negotiating their roles in light of understanding exigencies and requirements of the consultation in a given turn or moment. In Angelelli's (2004) words, an interpreter, "like the other co-participants in the interaction, constructs a message out of the interplay of linguistic and social features and not just out of propositional context, independent of the interlocutors" (p. 92). Jungner et al. (2019) conceptualised this active participation in communication on the

part of interpreters in terms of their use of contextual (local) or general (global) strategies to solve problems which occur on linguistic, cultural, emotional, etc. levels. While global strategies come from interpreters' preparation and training and are thus very much in line with professional standards, contextual strategies occur based on immediate understanding and handling of interaction dynamics, involving interpreters' active and strategic engagement in communication. Interpreters use a combination of contextual and general strategies to facilitate communication rather than merely adhering to the direct transfer of messages (Pardy, 1996), or in Avery's (2001) words, they strive to develop "shared understanding across language and culture" (p. 11). To highlight the reduced emphasis on message transfer as the interpreters' sole role and context-informed reconceptualisation of the domain of interpreters' work as involving multiple roles, Wadensjö (1992) refers to the 'normative role' and the 'typical role'. Highlighting the primacy and the overarching nature of the latter role, Bolden (2000) asserts: "Interpreters' actions are primarily structured by their understanding of the ongoing activity and only secondarily by the task of translation" (p.387). Interpreters develop their understanding of conversation by examining the context of communication and adopting appropriate non-conduit roles to deal with conflicts (Hsieh, 2006) and coordinate interaction (Gavioli, 2015).

The third issue is that while interpreters take an active role in a bilingual medical consultation, the functions they serve and how they contribute to the consultation depend heavily on the other parties' competencies and skills. It is noted that at the time that this research took place, a patient navigator role (Crezee & Roat, 2019) was not recognised within the Melbourne hospitals that were researched. However, some of the functions that the interpreters in this study adopted outside of their standard interpreting responsibilities did effectively constitute the interpreter adopting what the US system is now recognising as a patient navigator role, distinct from that of the interpreter role.

A helpful example is that an interpreter would not feel the need to simplify a message for the patient if the patient comes from an educational background that has prepared them to understand technical terminology or complex language structures that HPs use in their utterances. Similarly, an interpreter would not need to add details about how the hospital works in their interpretations if the patient is already familiar with the healthcare system in the host country, or the HP is more explicit by being able to better assume a lay perspective. An interpreter also would not need to make sense of less comprehensible and/or vague utterances of patients by guessing or probing the patient before transferring the message to the HP, if all

patients had a high level of health literacy and ability to express themselves coherently. In addition, an interpreter would not have to explain cultural issues that are relevant to the content and objectives of the consultation, if the HP knows about those aspects of the patient's cultural background and beliefs. These examples show that communicative behaviour and efficiency of an interpreter is dependent on that of other parties involved (Elderkin-Thompson et al., 2001). Therefore, while actively facilitating communication between patients and HPs, interpreters are not solely responsible for the effectiveness of communication and interactions (Hsieh, 2006). In this regard, Hsieh (2013) argues that if HPs and patients have high communicative skills, there may be less need for interpreters to adopt roles beyond message transfer. However, such comparability of skill levels may not be realistically achievable in many bilingual medical consultations in migration contexts. From the experiences in the two teaching hospitals with high proportions of migrant patients focused on in this study, there are always patients who have recently migrated to the host country or HPs who are gaining early experiences of serving patients from certain cultural backgrounds and, therefore, lack the skills necessary for effective intercultural health communication to ensure that the interpreter is only required to fulfill a direct message transfer role. Thus, the roles that the three parties in a triadic health encounter are involved in are interdependent. Yet, the interpreter has the sole and primary responsibility for what Jungner et al. (2019, p. 660) characterised as "carrying the bilingual conversation" and as such, may feel pressured to adopt a number of roles additional to direct message transfer to facilitate successful healthcare communication.

The multiplicity of roles interpreters assume and interdependence of their and the HPs' and patients' skills and performance lead us to the next issue, that of how well this dynamic reality is reflected in professional standards developed for interpreters. Codes of conduct and training programs developed for interpreters tend to primarily remain based on the conceptualisation of a conduit model of interpreting and are thus, in certain ways, detached from the reality of the contexts in which community interpreters work and despite research studies identifying other roles explicitly. According to Estrada et al. (2015), the conduit model "reflects a longstanding structuralist abstraction of language, reducing a complex whole into a formal cognitive system in which any speech exchange strictly involves the encoding and decoding of arbitrary signs, rendering the social context and speaking subjects irrelevant" (p. 279). The sense of commitment to this model underlies the interviewed interpreters' tendency, to adhere to a 'linguistic pipe' job description as their ideal, despite reporting elsewhere in the interviews, and in analysed conversations being observed, to adopt other roles. Similarly, reflective of the

influence of the language conduit conceptualisation is the interviewed HPs' wishes for interpreters to interpret 'everything' and their discomfort with interpreters engaging in dyadic conversations with patients, despite these same HPs recalling real situations where they would expect interpreters to serve roles beyond message transfer. Regarding patients, while the interviews with them (Chapter 6) showed a major concern with interpreters' skills, the interpreters reported (Chapter 4) being asked by patients to adopt roles outside the scope of direct message transfer. Such differences or rather contradictions between roles promoted in professional standards and considered by interpreters, HPs, and patients to be interpreters' major roles in an 'ideal' situation, on the one hand, and roles that interpreters actually fulfilled on the other hand, were reported fulfillling, or were expected to serve, confirm Estrada et al.'s (2015) argument that the model of interpreting underlying standards and training involves a strongly 'structuralist abstraction of language'. Further highlighting the reduced context in this model, Avery (2001) believed that a conduit model expects the interpreter to remain an invisible conduit in transferring HPs' and patients' messages "as if they are engaged in a same language exchange" (p. 4), failing to recognise that "the interpreter could already have connections with the patient community or with the medical institution in which the encounter was occurring" (p. 4).

What further complicates the situation and makes it increasingly difficult for interpreters to juggle conflicting roles is that they have no ownership over consultations, but have to assume the responsibility to facilitate the communication within them, beyond their professional job description (Jungner et al., 2019), often leading to internal conflicts or distress on the part of interpreters (Hsieh, 2006; Watermeyer, 2011). This distress and conflict was reflected in the sense of frustration expressed by some interpreters when interviewed. To address these conflicts and complexities in healthcare interpreting, Ji, Taibi, & Crezee (2019) advocated that interpreters need to develop service models that are more culturally effective and patient-centered. In this regard, Major & Napier (2019) refer to instances of miscommunication or unclear information which required interpreters to intervene and "speak as themselves" (2019: 184), so that accurate message transference could occur, as part of being "active participants in interaction" (2019: 184).

9.2 Revisiting theoretical models of interpreting

The overall objective of the medical consultation was described as meaningful and accurate communication between the HP and patient with the assistance of an interpreter. In this regard

two theoretical models (i.e. cognitive and interaction) were considered as being applicable to the data. These models were discussed as part of the literature review on interpreting (Chapter 2).

The **cognitive model** focuses on the internal mental process of language transfer that occurs in interpreting. It contributes the basis of a conduit perspective as it foregrounds and privileges the "human information processing focused" (Gerver, 1971 as quoted in Pöchhacker, 1994: 55) cognitive task of transferring verbal information accurately from language A to language B. However, as the data highlighted, such a narrow, cognitive model of the interpreting task is limited and not fully reflective of reality in community-based consecutive interpreting. Whilst the cognitive model may be more directly relevant to simultaneous conference-style interpreting, it has significant shortcomings in adequately capturing the dynamics of the community interpreting role.

The **interaction model** was developed to address shortcomings of the cognitive theoretical model. An interaction model better reflects interpreting within the dynamics of face-to-face interactions, where interpreters become active participants in the interaction not only as linguistic mediators, but also sociolinguistic and cultural mediators. Based on the findings of this research, the interaction model better reflects and accounts for the extent and nature of interpreters' intervention in the medical interaction. This model recognises and represents various social, institutional and communicative relations between the parties involved in the interaction.

The interaction model proposes that interpreters are interactants who respond to the communication situation actively in relation to other participants (Angelelli, 2004). As the only interactant who speaks the language/s of both participants, as well as sharing cultural background with the patient and having sufficient knowledge of the culture of the host country, health institutions and medical practices, the interpreter plays a pivotal mediating role in assessing comprehension and clarity of communication, and assisting in negotiation of meaning.

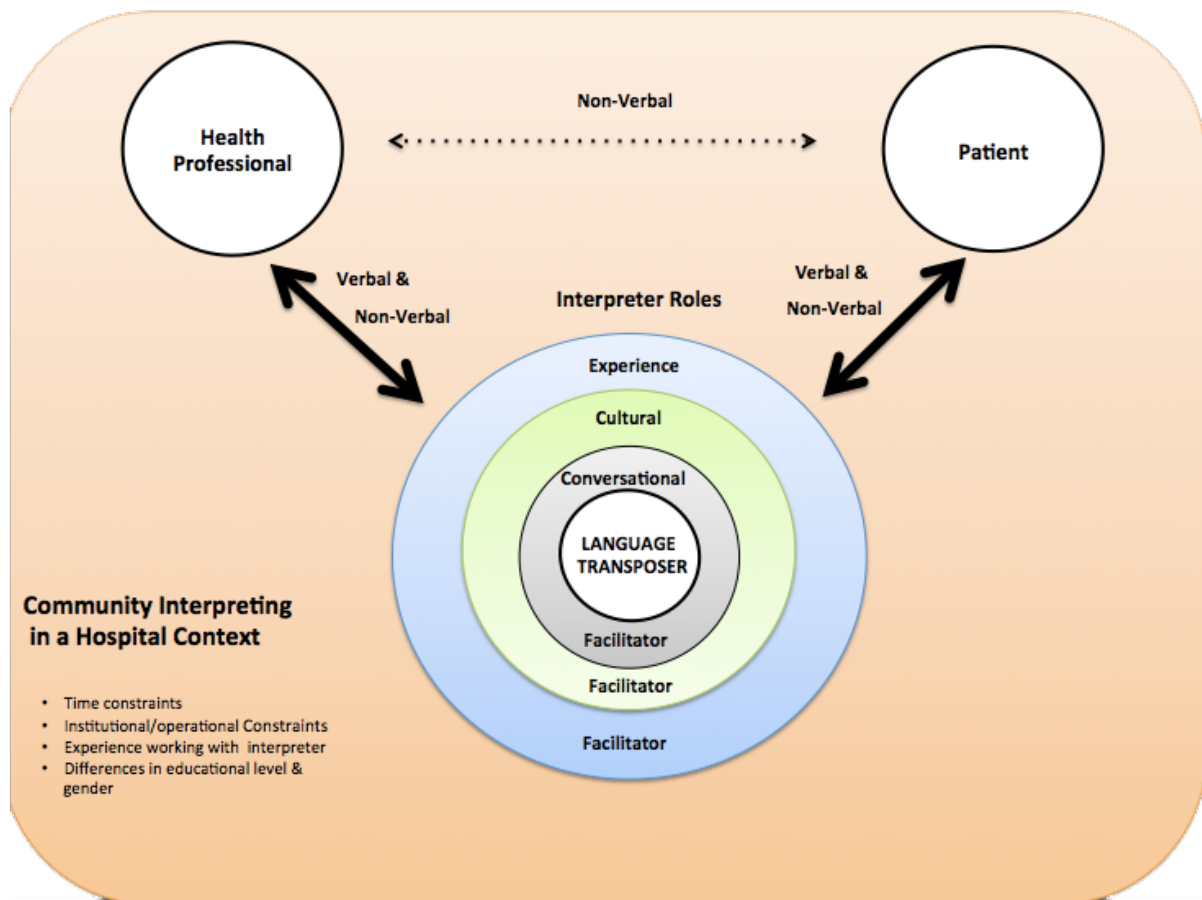
Within an interaction model, interpreting is acknowledged as a process involved in a "community activity performed by a human being in a particular interaction" (Pöchhacker, 2004: 53). From this viewpoint, interpreters may be regarded as linguistic and cultural

mediators whose presence influences the interaction between two parties (Muller, 2001). The interpreters in my study focused on the "intended meaning" of the speaker (i.e. the patient or the HP), and sought to communicate this meaning to the other party. Such actions position interpreters as mediators in discourse (Pöchhacker, 2004: 53) and active participants in the interaction, rather than merely as neutral, language conduits.

The research findings have enabled me to identify that interpreters adopted four overarching roles in the community interpreting hospital context. These roles contributed to the mediation of communication between HPs and patients to maximise meaningfulness, accuracy, and mutual comprehension. The roles are captured in Diagram 9.1 with each drawing on different components of the interpreter's expertise: linguistic, sociolinguistic/conversational, cultural, and contextual (interpersonal and institutional). These overarching roles are:

1. ***Language transposer*** (i.e. message transferer as 'language conduit'): this was the primary role identified by all participants – the interpreter transposes lexically accurately what has been said in Language A to Language B and vice versa. The extent to which this role predominates depends on a range of background and contextual factors.
2. ***Conversational facilitator***: the interpreter adopts communication enhancement strategies drawing on their sociolinguistic and pragmatic understandings of the intended communication to facilitate clarity in the HP--patient communication. Strategies identified were clarifying, probing, simplifying, repeating, and omitting conversational gambits.
3. ***Cultural facilitator***: the interpreter assesses the situation as one where there may be miscommunication (actual or potential) between the participants due to cultural differences in intended or expressed meanings. Strategies adopted included providing cultural explanation, clarification, or (re-)interpretation.
4. ***Experience facilitator***: the interpreter facilitates a positive, relaxed and informed atmosphere for the HP and patient in the consultation. To facilitate such an experience, the interpreter uses interpersonal skills to ensure the comfort of participants and contributes information and support in assisting the patient in negotiating the hospital's institutional structures and processes.

Diagram 9.1 – Overarching roles of interpreters in healthcare setting captured in this study



9.3 Professional codes and interpreters' practice

As the findings have revealed, where deemed necessary, the interpreters mediated with their own (socio)linguistic, cultural or institutional knowledge to assist in providing clear and comprehensive communication to support the HP–patient interaction. In doing so, the position of the code of ethics in their professional conduct needs to be considered.

Like every profession, interpreting has a code of ethics and a code of conduct for practitioners (interpreters) to follow. These codes privilege the practitioners (interpreters) adhering to their main role in direct message transfer as a language transposer.

What this research adds to understanding the role of interpreters in healthcare interactions is that in order to achieve meaningful communication, the interpreter may sometimes feel required to include further information or exclude redundancies rather than provide an exact linguistic transposition. They evaluate every utterance, to gauge whether it can be transferred directly from L1 to L2, or requires further explanation or refinement. The role of the interpreter encompasses that of acting both as a linguistic conduit and beyond.

In-depth analysis in this study has confirmed that conceptualising and understanding the role of the interpreter in the healthcare setting as a neutral language transposer is too simplistic. Importantly, it also devalues the range of contributions expected and made by interpreters in facilitating HP--patient communication in Australian hospitals.

It is important to recognise that the primary focus on 'conduit' in the professional code is contradictorily *protective of interpreters*, as well as being somewhat *problematic for the recognition of their professional role*. Due to the emphasis on the 'conduit' role, interpreters' non-conduit contributions may not be well recognised. Also, as was found in this research, interpreters themselves 'devalue' their non-conduit related contributions, meaning that much of what they contribute is 'invisible'. In fact, *invisibility* is built into how they are encouraged to practice. The code and its approach to practice limits willingness to discuss or 'own' activities that exceed the boundaries of 'conduit' practice. Yet, the tight 'conduit' definition of the professional boundary protects the interpreter in feeling empowered to reject or push back on expectations to assume other roles. As such, the role definition as expressed in the AUSIT code provides <u>a protective 'cloak'</u> that maintains the interpreter's right to control expectations placed on them, and to protect themselves from exceeding official professional boundaries. As

an interpreting professional the individual may and does choose, as required for the sake of expediting the communication, to put the protective cloak aside, but ultimately that decision is theirs.

9.4 Implications and applications of the findings

The findings of this study offer implications and applications directed towards improving interpreting services. We acknowledge the potential that exists in the interpreters to adopt a secondary, adjunct role, when required. Some of these adjunct roles, as perceived by the interpreters, occurred due to lack of understanding of their role by HPs or patients. For example, the findings revealed that not all HPs were familiar with the interpreter's official role and how to work effectively with them, even though the guidelines for HPs on how to work effectively with interpreters are available online and in print.

These recommendations, however, are based on the findings of the research that took place in the Australian context where healthcare interpreting was being practised according to the AUSIT code of conducts and NAATI examination. These recommendations, in general could also benefit other countries in terms of improving communication in healthcare settings, even though it needs to be recognised that they may not follow the same system as in Australia. Having said that the discussed themes in Chapter 8 that emerged from this study had similarities with international studies that took place where the governed system for certification and training may have differed compared to the Australian system. In particular, the research has reinforced the value for enhancing HP--patient communication in interpreters being able to move beyond their direct 'conduit' language transfer role. However, the findings and other international research have highlighted also that such additional roles benefit from being formally recognised and codified within the healthcare system, if they are to be practised. Also, that interpreters should not be prevailed upon to take on such additional roles, unless they consent and have sufficient training in relation to specialist terminology, cross-cultural communication and role boundaries.

Based on the findings these are the recommendations for responsible authorities like hospital management to implement enhancements in education and training for HPs, patients and interpreters.

9.4.1 Hospital management

The specifics of the research findings suggested that at times interpreters perform non-conduit roles to facilitate and enhance HP--patient communication. This action of interpreters can be beneficial for the hospital in maximising the quality of the HP--Patient communication. However, it does require extra time to be allocated for this purpose when booking interpreters. This extra time allocation is recommended to be utilised for briefing and debriefing before and after consultations to assist HPs in understanding how the patient has taken the treatment options and plans in relation to their cultural beliefs (if evident) and to give the interpreter the opportunity to raise any cultural or educational barriers observed on the part of the patient with the HP in a less formal environment. It also would give the HP the opportunity to ask the interpreter about the possible barriers that may exist on the approach proposed in the treatment plan for the patient. These barriers may be of a cultural, linguistic or educational nature that prevent the patient in accepting a particular treatment. The debriefing time would also provide the opportunity for HPs to enquire about any unexpected observed behaviour during the consultation, such as the interpreter appearing to have talked more to the patient than would be expected with word for word interpretation. It would also benefit the patients to have a briefing and/or debriefing time with their interpreter in a less formal manner to ensure that the treatment options and plans had been fully understood.

9.4.2 Health Professionals

1. Make online training and practical guidelines for all HPs easily available

There should be further attempts to make online information and training easily accessible and attractive for all HPs. Due to HPs being time poor, it is important for such training to be short, concise, and to the point.

In addition, there are guidelines for HPs that explain the interpreters' role/s and constraints about what they can contribute to HP--patient communication. However, not all HPs seem to be aware of these guidelines. My study uncovered that some HPs may assign roles that were not part of the interpreters' responsibilities. Increasing awareness and adoption of these guidelines would enhance HPs awareness of role boundaries for interpreters and how to effectively work within them. A simple internet search shows that many guidelines have been developed over the past 15 years for HPs, some generic and inclusive of HPs in different areas, such as *Working with Interpreters Guidelines* (Queensland Health, 2007), and some developed for specific groups of professionals, such as the *Guide for Clinicians Working with Interpreters*

in Healthcare Settings (Migrant and Refugee Women's Health Partnership, 2019), and *Working with Interpreters: a Practice Guide for Psychologists* (Australian Psychological Society, 2013), and earlier, the *AUSIT Guidelines for Health Professionals Working with Interpreters* (AUSIT, 2006) developed for professionals in mental health and speech pathology.

2. Invest to increase access to interpreters for HP consultations

Based on our study's findings, when HPs gain awareness of the importance of the presence of an interpreter for better communication, they more often plan to run their consultations with an interpreter present. Some HPs raised their frustrations and concerns that some hospital interpreters were not available when they needed them due to high demand. As a result they were forced to run some consultations without an interpreter. Therefore, it is a recommendation to hospital management, including the language services units of hospitals and their representatives, to maximise their budget allocation for greater availability of interpreters for in-demand languages. Overall, increased interpreter assistance will facilitate better communication in HP--patient consultations. Overall, whilst it is only economical to hire in-house interpreters in high demand languages, where feasible this employment has advantages in enhancing the patient's hospital experience. Over time in-house interpreters acquire more institutional knowledge and develop a rapport with the HPs and patients they are supporting, thereby enabling them to act more as part of the hospital 'team'.

9.4.3 Patients

1. Install simple posters related to communication with support of an interpreter in hospital waiting areas

The interpreters revealed that some patients do not have awareness of the roles interpreters play. Therefore, designing and installing simple, visually communicative posters on the role of interpreters in all main community languages in the waiting area for patients would assist in patient education. Such an initiative is already practised in some hospitals, but not all.

2. Install patient feedback boxes for comments and criticisms

Patients shared their frustration with some interpreters, when they did not act ethically. They did not have any resource to make their voices heard, specifically due to their low English language and IT skills. It is therefore recommended that every hospital provide a physical means (e.g. a locked box) for patients to provide confidential comments and feedback. They

should be encouraged to write feedback in their own language. And at the end of every month the feedback could be sent confidentially to an independent interpreting and translating agency to provide translations to the hospital. Such an arms length approach would ensure confidentiality for patients in providing their comments and criticisms without being known to hospital interpreters. In addition, illiterate patients should not lose their rights and privileges in making their voice heard. It is also my recommendation that the interpreters inform patients before or after the consultation is over about patients' rights to complain confidentially to a designated hospital ombudsperson. Interpreters can act as a bridge to redress the gap between the hospital as a healthcare institution and patients who may not have had proper understanding of how the healthcare system works.

9.4.4 Interpreters

1. Refine interpreter training to better address their roles

Another implication of this study is the need to refine interpreter training so as not to rely so much on a language transposer model in representing the work of interpreters, in light of the dynamic and multifaceted nature of interpreted consultations. In this study, interpreters were found to engage in a constant process of negotiating their roles in light of an understanding of exigencies and requirements of the consultation in a given turn or moment, and depending on HPs' and patients' competencies and skills relevant to communication, such as HPs' understanding of patients' relevant cultural belief and educational background. The multiplicity of roles that interpreters may be expected to play or choose to assume and interdependence of interpreters', HPs', and patients' skills and performance is not adequately reflected in professional standards developed for interpreters. There is room for improvement in the existing code of conduct and guidelines on interpreting practice in addressing what really happens 'on the ground' within a consultation, and the scope and boundaries within which interpreters can exercise their professional judgment.

The dynamics of a triadic consultation can be more effectively taken into account in the ways in which codes require interpreters to facilitate communication. At the same time codes and training can be refined to define interpreters' roles and conduct in a more flexible and context-sensitive manner. Possible challenges and risks in fulfilling more varied roles can thus be acknowledged and problematised. Perhaps an effective and informed way to refine professional standards is a data-driven one, where perceptions of the parties involved, namely interpreters, HPs, and patients, can be explored and factored into modifications. This approach would draw

the standards closer to the reality of an interpreted consultation. It could also serve to enhance the value placed on professional interpreting as it would make more explicitly valued the interpreter's professional judgement and expertise that tends to be devalued.

9.5 Limitations and recommendations for future research

This multi-method research has been solely qualitative in its data collection, allowing scope for further quantitative and qualitative research to validate the depth and generalisability of what this study has revealed about the role/s and practice of interpreters in hospital settings. In relation to the scope of the study, for future replication and validation, the researcher suggests a focus on the differences in specialty, experience, and practice of HPs, as well as more recordings and analysis of actual interactions and their use in ongoing training, including more patient language groups, participant demographics, and size of the dataset. I also recommend including quantitative data collection via a questionnaire to extend insights so they are more generalisable. This would provide a new dimension to the collected data, not only through interviews and analysis of actual triadic recordings, but to integrate these with quantitative results.

The study included a broad scope of participants, ranging from highly specialised HPs, such as brain surgeons and infectious disease doctors, through to nurses and midwives attending patients' day-to-day well-being with no life threatening illnesses. Finding common ground between these HPs in the research may have compromised what every specialised HP group aimed to achieve in interviews and triadic consultation. A variety of specialties in the research acted in positive and negative ways. On the positive side it assisted the researcher in seeing that every specialised area in healthcare has slightly different expectations and views about working with interpreters. On the negative side it limited the capacity to explore further in-depth patterns of expectations and approaches in working with specific groups of HPs (i.e. physiotherapists, infectious disease specialists, etc.).

Another limitation was the limited size of datasets, specifically the number of patient participants in one-to-one interviews and the number of actual recordings of triadic consultations in the proposed languages. Data analysis revealed further avenues to be explored with more data, and this would assist in validating and refining the proposed roles that have been identified in this study.

This research only catered for four language groups based on the greater number of patients in those groups at the hospitals. This limited the ability of the researcher to interview patients from her own language background to increase the chance of interviewing patients without always relying on the assistance of an interpreter. Future research could be carried out for other language groups to incorporate a wider demographic spread across different language communities.

This study has highlighted challenges experienced by many migrants, their HPs, and interpreters as follows:

- The hardships that some migrants experienced due to lack of English language skills increased their physical or emotional distress in dealing with health problems.
- Interpreters generally have been migrants themselves. Therefore, they generally cared compassionately about other migrants who were not privileged in having a good command of English. One of the challenges that interpreters faced was their personal assessment of the situation in an interpreted interaction, concerning if and when to intervene with their own cultural or institutional knowledge, whilst maintaining their professionalism and abiding by the ethics of their profession.
- The challenges that HPs had in making sense of the quality of interpretations given they were expected to work seamlessly with in-house and agency interpreters, some of whom they would be working with on a one-off basis. HPs needed to trust interpreters in relaying messages to patients and vice versa to provide correct diagnosis and treatment.

What the research has demonstrated is that insights into the real experience of interpreters, as well as those who communicate with and through interpreters on a daily basis (e.g. HPs), or who undertake anxiety provoking visits to large hospitals to be treated by specialist doctors and allied health personnel (e.g. patients) can assist in progressing knowledge and policies to improve context-specific training and service outcomes delivered by interpreters and HPs in major hospitals.

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APPENDICES

Appendix 1 – Information about consent and question areas

Appendix1.a - Participants Consent Forms

Appendix1.b - Areas of Questions for Participants

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

Health Professional

Headed with Institution's name or on Institution's Letterhead

Participant Information and Consent Form
the Rose/Smith's Hospital

Full Project Title: the Role of Interpreters in Health encounters

Principal Researcher: Professor Helen Borland

Associate Researcher: ……….

Student Researcher: Ms Mojdeh Mahdavi

1. Introduction

You are invited to take part in this research project that is a project for Ms Mahdavi's PhD at Victoria University. You have been invited to participate in an interview because you use an interpreter in order to speak and communicate with your patients at the hospital. By participating in this interview you are sharing with us your experiences of using an interpreter.

2. What is the purpose of this research project?

This project aims to find out what your views and experiences are of the role of the interpreter in a health professional's consultation with their patient/client. Also we are interested in understanding the strategies you use in working with interpreter and patient to try to avoid and/or resolve misunderstandings if they arise.

3. What does participation in this research project involve?

This is a qualitative research project that consists of two parts.
Part One: To participate in part one of this project, I am asking one hour of your time for one to one interviewing. The interview takes place at the hospital at a time suitable for you. I will tape-record the interview in order to write it up and analyse it.
Part Two: In part two, I would tape-record an actual consultation that you are having with the presence of an interpreter and a CALDB patient. CALDB patient is an abbreviation used for culturally and linguistically diverse background patient, is a patient who is a non native speaker of English. Debriefing interview would take no longer than 10 minutes. Debriefing is a short interview that is performed between the researcher and the individual participants (you) immediately following the end of consultation session. At the debriefing time, the participant will be asked how well, in their point of view, the consultation went. The consultation will take place in the normal manner, but with a recording being made, afterwards you will be briefly and confidentially asked to share your reflections with Ms Mahdavi about how effective the communication between participants was from your perspective.
You could consent to participate in both part one and part two of the interviews or either of them.

As a way of thanking you for your participation in this project, I will give you $20 gift card (or a movie ticket).

4. What are the possible benefits?

Your contribution, as a health professional, to the research will assist hospitals in improving their language service provision and their training for staff working with interpreters. We

will also provide you with a short report of the outcomes of the research, if you wish to receive this.
The hospital would also benefit from this in a way that new knowledge and understanding about the role and practice of language service provision leading to the capacity to enhance the quality of interpreting provision and training in the use of interpreters for their staff; as well as understanding of how cultural competence can and should be applied to interpreted intercultural health encounters. Intercultural health encounters are referred to the conversations between a health professional and a patient from non-English speaking background who would possibly have different health beliefs due to his/her culture.

5. What are the possible risks?

It is possible that discussing your experiences of health interactions may lead you to feel some personal distress. If such an event occurs, the interview will be stopped and you will be provided with support, including a referral to counselling if you feel the need for such additional assistance. Any counselling or support will be provided by staff who are not members of the research team. Any adverse event will be reported immediately to the researcher's faculty ethics officer at Victoria University and the hospital's consumer advocate on……, so that further action and support can be provided as appropriate. VU will assign a trained psychologist for counselling if needed.

The interview or recording would only be resumed if you agree that you wish to continue. In addition, you as the participant have the right to withdraw from the interview or recording at any time. Also you can request to have the material you have contributed to the project to be withdrawn and returned to you, if you decide afterwards that you no longer want to participate.

6. Do I have to take part in this research project?

Your participation in this research is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

7. How will I be informed of the final results of this research project?

If you wish, you could have a summary of results sent to you (by mail, email, or phone; whichever you prefer) on completion of the project. The results of the project will be available on VU library and other journal articles may also arise from it. The final results can be expected to become available in the form of a completed PhD thesis, but the analysis of the interview data will be available soon after completing the interviews.

8. What will happen to information about me?

Your personal information will be de-identified and treated confidentially and a pseudonym will be used. The data will be kept in a locked secure place where only the researcher and her supervisors will have access to it. The data is purely used for this research only and will not be used for any future research. The data will be stored for five years and will be destroyed afterwards. In reporting the project results no individual will be able to be identified.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers contributed by you and about you. Please contact one of the researchers named in the beginning of this document if you would like to access your information.

10. Is this research project approved?

This project is approved by Victoria University where the research will be carried out. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Victoria University and the Human Research Ethics Committee of the Hospital.

Version A - Consent section to be used if consent is to be provided by individual participants themselves

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described. (Please circle)

Participate in part one   participate in part two   participate in part one and two

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) …………………………………………………

Signature   Date

Interpreter's name (if applicable)(printed). . . . .

Signature   Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) …………………………………………………

Signature   Date

[If relevant and appropriate, include a witness signature]

Note: All parties signing the consent section must date their own signature.

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

CALDB Patient

Headed with Institution's name or on Institution's Letterhead

Participant Information and Consent Form
the Rose/Smith's Hospital

Full Project Title: the Role of Interpreters in Health encounters

Principal Researcher: Professor Helen Borland

Associate Researcher: ….

Student Researcher: Ms Mojdeh Mahdavi

1. Introduction

You are invited to take part in this research project that is a project for Ms Mahdavi's PhD at Victoria University. You are invited to take part in this research project. I spoke to you previously when you came for your appointment at the hospital. You have been invited to participate in an interview because you use an interpreter in order to speak and communicate with your treating health professional at the hospital. By participating in this interview you are sharing with us your experiences of using an interpreter.

2. What is the purpose of this research project?

This project aims to find out what the patient perspective is on the role of the interpreter in a health professional's consultation. Also what your experiences have been of using an interpreter to assist you and whether you have experienced any problems in the process.

3. What does participation in this research project involve?

This is a qualitative research project that consists of two parts.
Part One: To participate in part one of this project I am asking one hour of your time for one to one interviewing. The interview takes place at the hospital at a time suitable for you. I will tape-record the interview in order to write it up and analyse it. If I am not able to communicate with you directly in your preferred language, I will assign an interpreter to have the interview with me.

Part Two: In part two, I will tape-record an actual consultation that you are having with the health professional and the presence of an interpreter. Debriefing interview would take no longer than 10 minutes. The consultation will take place in the normal manner, but with a recording being made. Afterwards you will be briefly and confidentially asked to share your reflections with Ms Mahdavi about how effective the communication between participants was from your perspective.

You could consent to participate in both part one and two of the interviews or either of them. This project does NOT involve accessing patients' medical records.
As a way of thanking you for your participation in this project, I will give you $20 gift card (or a movie ticket).

4. What are the possible benefits?

Your contribution to the research is an opportunity for you to have your needs and expectations heard by service providers who are trying to provide you with quality language services.

5. What are the possible risks?

Discussing your experiences may lead you to feel some personal distress. If such an event occurs, the interview will be stopped and you will be provided with support, including a referral to counselling if you feel the need for such additional assistance. Any counselling or support will be provided by staff who are not members of the research team. Any adverse event will be reported immediately to the researcher's faculty ethics officer at Victoria University and the hospital's consumer advocate on ……, so that further action and support can be provided as appropriate. VU will assign a trained psychologist for counselling if needed.

The interview or recording would only be resumed if you agree that you wish to continue. In addition, the participant has the right to withdraw from the interview or recording at any time. Also you can request to have the material you have contributed to the project to be withdrawn and returned to you, if you decide afterwards that you no longer wish to participate.

6.Do I have to take part in this research project?

Your participation in this research is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

7. How will I be informed of the final results of this research project?

If you wish, you will receive a summary of results sent to you (by mail, email, or phone; whichever you prefer) on completion of the project. The results of the project will be available on VU library and other journal articles may also arise from it. The final results can be expected to become available in the form of a completed PhD thesis, but the analysis of the interview data will be available soon after completing the interviews.

8. What will happen to information about me?

In reporting the project results, no individual will be able to be identified. Your personal information will be de-identified and treated confidentially and a pseudonym will be used instead of your real name. The data will be kept in a locked secure place where only the researcher and her supervisors will have access to it. The data is purely used for this research only and will not be used for any future research. The data will be stored for five years and will be destroyed afterwards.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers contributed by you and about you. Please contact one of the researchers named in the beginning of this document if you would like to access your information.

10. Is this research project approved?

This project is approved by Victoria University where the research will be carried out. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Victoria University and the Human Research Ethics Committee of the Hospital.

Version A - Consent section to be used if consent is to be provided by individual participants themselves

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it*.*

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described. (Please circle)

Participate in part one participate in part two participate in part one and two

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) ……………………………………………………

Signature Date

Interpreter's name (if applicable)(printed). . . . .

Signature Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) ……………………………………………………

Signature Date

[If relevant and appropriate, include a witness signature]

Note: All parties signing the consent section must date their own signature.

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

Interpreter

Headed with Institution's name or on Institution's Letterhead

Participant Information and Consent Form
the Rose/Smith's Hospital

Full Project Title: the Role of Interpreters in Health encounters

Principal Researcher: Professor Helen Borland

Associate Researcher: ….

Student Researcher: Ms Mojdeh Mahdavi

1. Introduction

You are invited to take part in this research project that is a project for Ms Mahdavi's PhD at Victoria University. I spoke to you previously when you came for an interpreting appointment at the hospital. You have been invited to participate in an interview because you are an interpreter who assist patients in communicating with health professionals at the hospital. By participating in this interview you are sharing with us your experiences of being a medical interpreter.

2. What is the purpose of this research project?

This project aims to find out what your views and experiences are of the role of interpreter in a health professional's consultation. Also, we are interested in understanding the strategies you use in dealing with issues in interpreting information between health professional and patient including where misunderstanding appears to be occurring. Also, if cultural issues arise in a consultation, how will they be understood and dealt with in the interpreted health encounters.

3. What does participation in this research project involve?

This is a qualitative research project that consists of two parts.
Part One: To participate in part one of this project I am asking one hour of your time for one to one interviewing. The interview takes place at the hospital at a time suitable for you. I will tape-record the interview in order to write it up and analyse it.
Part Two: In part two I would tape-record an actual health-related consultation with your presence and the presence of a health professional and a CALDB patient. CALDB patient is an abbreviation used for culturally and linguistically diverse background patient, is a patient who is a non native speaker of English. Debriefing interview would take no longer than 10 minutes. Debriefing is a short interview that is performed between the researcher and the individual participants (you) immediately following the end of consultation session. At the debriefing time, the participant will be asked how well, in their point of view, the consultation went. The consultation will take place in the normal manner, but with a recording being made, afterwards you will be briefly and confidentially asked to share your reflections with Ms Mahdavi about how effective the communication between participants was from your perspective.

You could consent to participate in both part one and part two interviews or either of them.

For this interview you will be paid as for your normal interpreting session at an assignment.

4. What are the possible benefits?

It is an opportunity for you to share your experiences and perceptions and contribute to enhancing understanding of your role and the sources of miscommunication that may occur and approaches in line with your professional ethics, that can be used to address these. Your contribution to the research will assist hospitals in improving their language service provision and their training for staff working with interpreters. We will also provide you with a short report of the outcomes of the research, if you wish to receive this.

5. What are the possible risks?

It is possible that discussing your experiences may lead you to feel some personal distress. If such an event occurs, the interview will be stopped and you will be provided with support, including a referral to counselling if you feel the need for such additional assistance. Any counselling or support will be provided by staff who are not members of the research team. Any adverse event will be reported immediately to the researcher's faculty ethics officer at Victoria University and the hospital's consumer advocate on…., so that further action and support can be provided as appropriate. VU will assign a trained psychologist for counselling if needed.

The interview or recording would only be resumed if you agree that you wish to continue. In addition, the participant has the right to withdraw from the interview or recording at any time. Also you can request to have the material you have contributed to the project to be withdrawn and returned to you if you decide afterwards that you no longer wish to participate.

6. Do I have to take part in this research project?

Your participation in this research is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project at a later stage.

7. How will I be informed of the final results of this research project?

If you wish, you will receive a summary of results sent to you (by mail, email, or phone; whichever you prefer) on completion of the project. The results of the project will be available on VU library and other journal articles may also arise from it. The final results can be expected to become available in the form of a completed PhD thesis, but the analysis of the interview data will be available soon after completing the interviews.

8. What will happen to information about me?

In reporting the project results no individual will be able to be identified. Your personal information will be de-identified and treated confidentially with a pseudonym used. The data will be kept in a locked secure place where only the researcher and her supervisors will have access to it. The data is purely used for this research only and will not be used for any future research. The data will be stored for five years and will be destroyed afterwards.

9. Can I access research information kept about me?

In accordance with relevant Australian and/or Victorian privacy and other relevant laws, you have the right to access the information collected and stored by the researchers contributed by you and about you. Please contact one of the researchers named in the beginning of this document if you would like to access your information.

10. Is this research project approved?

This project is approved by Victoria University where the research will be carried out. The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Victoria University and the Human Research Ethics Committee of the Hospital.

Version A - Consent section to be used if consent is to be provided by individual participants themselves

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it*.*

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described. (Please circle)

Participate in part one participate in part two participate in part one and two

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) ……………………………………………………

Signature Date

Interpreter's name (if applicable)(printed). . . . .

Signature Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) ……………………………………………………

Signature Date

[If relevant and appropriate, include a witness signature]

Note: All parties signing the consent section must date their own signature.

PARTICIPANT INFORMATION AND CONSENT FORM (PICF)

CALDB Patient (simplified language for translating)

Headed with Institution's name or on Institution's Letterhead

Participant Information and Consent Form
the Rose/ Smith's Hospital

Full Project Title: the Role of Interpreters in Health encounters

Principal Researcher: Professor Helen Borland

Associate Researcher: ….

Student Researcher: Ms Mojdeh Mahdavi

1. Introduction

You are invited to take part in a research project for Ms Mahdavi's PhD at Victoria University. You have been invited to participate in an interview because you use an interpreter to speak with your doctor at the hospital. By participating in this interview you are sharing with us your experiences of using an interpreter.

2. What is the aim of this research project?

This project aims to find out your view on the role of the interpreter in your consultation with your doctor. Also we want to know about your experiences of using an interpreter and if you have had any problems in using an interpreter.

3. What does participation in this research project involve?

This research has two parts of interview. You can participate in part one, or two, or both parts.
Part One: In part one I will have an interview with you for about one hour, and ask you questions about your experiences of using an interpreter at the hospital. I tape record the interview to assist me in writing up what you have said. If I am not able to communicate with you directly in your preferred language, I will assign an interpreter to help me in the interview with you.

Part Two: In part two, I will tape-record an actual consultation/appointment that you are having with the doctor in the presence of an interpreter. After finishing the appointment I will ask you how you think the appointment was in relation to effective communication between you, doctor and interpreter.

You could agree to participate in both part one and two of the interviews or either of them.
This project does NOT involve accessing your medical records.
As a way of thanking you for your participation in this project, I will give you $20 gift card (or a movie ticket).

4. What are the possible benefits?

Your contribution to the research is an opportunity for you to have your needs and expectations heard by hospital service providers. They are trying to provide you with quality language services.

5. What are the possible risks?

Discussing your experiences may lead you to feel some personal distress. If such an event occurs, the interview will be stopped and you will be provided with support, including a referral to counselling if you feel you need it.

The interview or recording would only be resumed if you agree that you wish to continue. Also, you have the right to withdraw from the interview or recording at any time.

Later on if you decide that you do not want to participate in the project, you can request the interview material to be sent back to you or withdrawn from the project.

6.Do I have to take part in this research project?

Your participation in this research is voluntary. If you decide to take part and later change your mind, you are free to withdraw from the project.

7. How will I be informed of the final results of this research project?

If you wish, you will receive a summary of results sent to you on completion of the project. The results of the project will be available on VU library.

8. What will happen to information about me?

You will not be identified as an individual when I report the project results. I will give you a false name when refer to your personal information and will keep it in a locked secure place that is only accessible to me, and my supervisors. The information you give me is only used for this research and will not be used for any future research.

9. Can I access research information kept about me?

According to relevant Australian and/or Victorian privacy laws, you have the right to access the information collected and stored by the researchers contributed by you and about you. Please contact one of the researchers named in the beginning of this document if you would like to access your information.

10. Is this research project approved?

The ethical aspects of this research project have been approved by the Human Research Ethics Committee of Victoria University and the Human Research Ethics Committee of the Hospital.

Version A - Consent section to be used if consent is to be provided by individual participants themselves

I have read, or have had this document read to me in a language that I understand, and I understand the purposes, procedures and risks of this research project as described within it.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this research project as described. (Please circle)

Participate in part one   participate in part two   participate in part one and two

I understand that I will be given a signed copy of this document to keep.

Participant's name (printed) ……………………………………………………

Signature   Date

Interpreter's name (if applicable)(printed). . . . .

Signature   Date

Declaration by researcher*: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's name (printed) ……………………………………………………

Signature   Date

[If relevant and appropriate, include a witness signature]

Note: All parties signing the consent section must date their own signature.

Appendix1.b - Areas of Questions for Participants

Question Areas for Semi-Structured Interviews

Question Areas for health professionals:

Experience and Background in their Profession – eg. Can you tell me a little bit about your professional background and experience?

Working with CALDB patients and cultural awareness – e.g. Can you tell me a little bit about the sort of patients you see in your work here at Hospital X in relation to their backgrounds? What proportion are CALDB? What proportion of CALDB have difficulties with English? Are particular cultural backgrounds more common than others? Do you know anything about cultural differences in how patients believe their illness has been caused? If so, can you tell me about this? Have you ever had an experience where there seemed to be cultural factors affecting the patient's attitude to your treatment of them? Can you tell me about this? Have you ever had an experience where there seemed to be cultural factors that affected the patient's attitude to their illness? Can you tell me about this? What do you see as the main challenges in dealing with patients from a diverse range of cultural and linguistic backgrounds? From your experience how helpful is the concept of cultural competency in helping health professionals to deal with their patients?

Working with Interpreters – eg. How often do you need to involve an interpreter when you are consulting with a CALDB patient? When do these situations arise most commonly? Can you tell me a little bit about your experiences of working with an interpreter in communicating with patients? Can you tell me about an experience when you were happy with the consultation? What about one where you were concerned about how it went? Do you know anything about the different interpreter levels? In your experience how does the level of interpreter affect how well the consultation seems to go? If you are using an interpreter, have you ever had the experience that you felt that the patient may not have understood something fully? What have you done in such circumstances? How do you make sure the patient has understood you?

Questions Areas for Interpreters

Experience and Background in their Profession

1. Can you tell me a little bit about your professional background and experience as an interpreter?

2. What about your training – where did you learn interpreting and how have you been assessed?

3. How much of your work is in health settings/hospitals?

4. How did you learn what you need to know to work in the health/medical field (eg. terminology)?

Assisting in Health Interactions – e.g. How often do you act as an interpreter for CALDB patients speaking language Y in this Hospital? Can you tell me a little bit about your experiences of working with health professionals in communicating with patients? In your view, what do doctors expect from you, as an interpreter? What do patients expect from you? Do all interactions go smoothly? Can you tell me about an example of an interaction where you felt that things went well in the interpreted interaction? Can you tell me about an example of an interaction where you felt that things did not go as well as you would have hoped or expected? How can/do you account for the difficulties you or the doctor or patient had in this situation? Have you ever had the experience that you felt that the patient may not have understood something fully? What have you done in such circumstances? How do you make sure the patient has understood you? From your experience, are there circumstances where problems of miscommunication or misunderstanding most commonly arise? What causes such problems from your experience? Have you heard of the concept of 'cultural competency' and if so, what does this mean to you?

Working with CALDB patients (focus on the specific group the interpreter is working with) – e.g. Can you tell me a little bit about the sort of patients you assist in your work here at Hospital X in relation to their backgrounds? Have you ever had an experience where there seemed to be cultural factors affecting the patient's ability to understand the health professional? Can you tell me about this? Have you ever had an experience where there seemed to be cultural factors that affected the patient's attitude to their illness? Can you tell me about this? What do you see as the main challenges in acting as an interpreter with patients?

Questions Areas for CALDB Patients

Experience and Background– e.g. Can you tell me a little bit about your educational background and work experience in Australia and overseas? How much do you understand English? In a consultation room, to what extent can you understand what is being said even if you are not able to respond in English?

Needing Assistance in Health Interactions – e.g. How often do you come to hospital? Can you tell me a little bit about your experiences of communicating with health professionals through an interpreter? In your view, what do you expect from the interpreters? What do you expect from doctors? Do all interactions go smoothly? Can you tell me about this? Can you tell me about an example of an interaction where you felt that things went well in the interpreted interaction? Can you tell me about an example of an interaction where you felt that things did not go as well as you would have hoped or expected? How can/do you account for the difficulties you or the doctor or interpreter had in this situation? Have you ever had an experience where you felt that the doctor may not have understood something fully? What have you done in such circumstances? How do you make sure the doctor has understood you? Have you ever had an experience where the doctor did not seem to understand about your culture in relation to your illness? Can you tell me about this? From your experience, are there circumstances where problems of miscommunication or misunderstanding most commonly arise? What causes such problems from your experience?

Working with Interpreters – eg. Do you always have interpreter? Is it always one interpreter or does it change? Do you prefer one interpreter over another and why ? How do you feel comfortable using an interpreter? What helps you to feel comfortable with using an interpreter? Can you tell me a little bit about the sort of interpreters who are assisting you here at Hospital X in relation to their backgrounds (are they from the same country? Do they speak the same dialect as yours? What do you see as the main challenges in conversing with your health professional through an interpreter (that is possibly changed every time you see your health professional)? When using an interpreter, have you ever had the experience that you felt that you have not understood something fully? What have you done in such circumstances?
Can you tell me about a good experience you have had with using an interpreter for a health consultation?

Appendix 2 – Excerpts of interpreter mediated communication in Dari

1 **Dari Conversation Analysis Transcripts Triad** | = *smbol of overlapping utterances*
2 Dr Hello Mr (patient's first name).
3 Pt Hello
4 Dr My name is (doctor's first name), I'm one of the Neurosurgery residents here.
5 Int:
6 خُب، این یکي از رزیدنت هاي،م م م چیزه، جراحي اعصابه، نیوروسرجریه، جراحي اعصاب.
7 Khob, in yeki az resident-haye mmm, chize, jarahiye asab-e, neuroserjeriy-e, jarahiy-e asab
8 Ok, this one of resident-s of mmm, thing-of, surgery of neurons-is, neurosurgery (Eng. term), surgery of neurons
9
10 [OK, This is one of the residents of ummm neurosurgery (Persian equivalent),
11 neurosurgery (English term), neurosurgery (Persian equivalent)]
12 Pt:
13 بله
14 bale
15 yes
16 [yes]
17 Int:
18 Yani dare takhasos-esh-o migire, masalan sale akhar-e takhasos-esh-e
19 It-means (is) specialty-her-of getting, for example year-of last-of specialty-her-is
20 یعني داره تخصصشُ میگیره، مثلاً سال آخر تخصصشه
21 [It means she is completing her specialty; like she is doing her last year]
22 Pt:
23 بله
24 [Yes]
25 Dr: Now I know you've been here before for your back pain and leg pain, how
26 has it been going since the last time you were here?
27 Int:
28 میگه قبلاً هم شما اینجا بودین که پادرد و پشت درد داشتید یه دفعه ي قبل
29 mige ghablan ham shoma inja boodin ke pa dard va posht dard dashtid
30 says before also you(plural) here were that leg pain and back pain had(plural)
31
32 ye dafeye ghabl
33 one time of before
34
35 [She says you were here before, when you had leg pain and back pain, once before]
36
37 Pt:
38 بله
39
40 [Yes]
41
42 Int:
43 میگه از اون وقت تا الان شما چطور بودین؟
44 mige az oon vaght ta alan shoma chetor boodin?
45 Says from that time til now you(polite) how been
46 [she asks how have you been since then?]
47 Pt:

48 من از پارسال که بود پایِم زیاد درد میکرد کمرِم دردش کم بود، ولي امسال که هستَ دردي کمرِم زیاد شدَه از
49 پایِم کم
50 man az parsal ke bood pa-yem ziyad dard mikard kamarem dardesh kam bood,
51 I from last-year that was leg-my a lot pain was back-my pain-its little was,
52 vali emsal ke hasta dardi-kamarem. ziyad shoda az payem kam
53 but this-year that is pain-of back-my a lot. become from leg-my little
54 [Last year my leg was in a lot of pain, my back pain was little; but this year my back
55 pain has been a lot, from my leg been little]
56 Int: last year I had more pain in my legs and less pain in my back whereas this year I
57 have more pain in my back and less in my leg
58
59
60 Dr: Ok so it's switched a little bit
61 Int:
62 خُب. میگه پس بدل شده، ها؟
63 khob, mige pas badal shode, ha?
64 Ok, says therefore (it)changed(swapped)[3], yeah?
65 [Ok, she says therefore it has been swapped, yeah?]
66 Pt:
67 آره، گشتن که هستن پارسال که میگشتُم پایِم درد میکرد گشتن کرده نمیتونستُم. امسال که هستِ باز که میگردُم
68 کمرِم درد میکنه طرف پشت؛ مثل میسُزه که سُزش میکنَه. حال که حال که حال که بشینُم حالي هم که از جایِم
69 پاشیم هم سُزش میکنه هم میسُزه
70 *Transliteration: areh, gashtan ke hastan, parsal ke migashtom, payem dard-mikard,*
71 Translation: yes, getting-around that to be, last year that getting around-I, leg-my was-
72 in-pain, getting around
73 *gashtan-karde-nemitoonestom. Emsal ke haste baz ke migardom kamarem dard-*
74 *mikona*
75 getting-around-not-able-to-do-me. This-year that is when walking-I back-my pain-have-is
76 *taraf-e posht, mesl-e misoza ke sozesh-mikona.*
77 side-of back, like-of burning that burn-doing.
78 *Hal ke hal ke hal ke beshinom hal ke az jayem pashim ham sozesh-mikona*
79 Now that now that now that sit-I now that from place-my stand-up both burning
80 *ham misoza*
81 also burns
82
83 [yes, in walking, last year when I was walking, my leg was in pain, I could not walk.
84 This year when I walk my back hurts, at the back, like it burns, it burns. Now now
85 now when I sit and want to stand up it both burns and burning]
86
87 Int: He said that last year when I tried walking, while walking I had pain in my
88 legs whereas this year while walking I have this burning pain in my back and it's right
89 at my back
90
91 Dr: can you show me where you get the pain?
92
93 Int:
94 نشون بدین کجا درد میکنه
95 neshoon-bedin koja dard-mikone

[3] The word /switched/was translated into Dari expression of /badal shode/= has been changed, swapped.

96 [4]show-you-plural (polite) where pain-is
97 [Show where the pain is]
98 Pt:
99 ایناها
100
101 inaha
102 here it is
103 [Here]
104 Dr: Ok
105 Pt:
106 این قسمت درد میکنه بگویین، ناخن خود را گرفتیم بگویین
107 in ghesmat dard-mikone, begooyin, nakhon-e-khod ra gereft-im, begooyin
108 this part pain-is, tell-you (plural,polite), nail-of-mine holding-we, tell-you (plural, polite)
109 [Tell her this part is painful, where (we) are pointing with (our) nail, tell her] the
110 ending is the respectful plural
111 Int: right there where I'm touching with the tip of my finger, that's where the pain
112 is
113 Dr: Just on the left side,?
114 Int:
115 سمت چپ، ها؟
116 samt-e-chap, ha?
117 Side-of-left, ha?
118 [left side, yeah?]
119 Pt:
120 ها، يك وقت خود هيچ نميفهمم يك وقت چپ درد ميگيره يك وقت راست درد ميگيره
121 ha, yek-vaght khod hich ne-mifahmam yek-vaght chap dard-migire yek-vaght rast
122 dard-migire
123 ha, one-time self not-at-all not-understand-me one-time left pain-gets one-time right
124 pain-gets
125 [Yeah, sometimes, I myself even don't know, sometimes the left side is painful,
126 sometimes the right side is painful.]
127 Int: sometimes it's on the left hand side and sometimes it's on the right, it
128 doesn't…..; he can't tell, it's…, it varies
129 Dr: Ok. Do you have pain there at the moment?
130 Int:
131 الان درد دارید اونجا؟
132 alan dard darid oonja?
133 Now pain have-you(polite) there?
134 [At the moment, do you have pain there?]
135 Pt:
136 آره، ها، میسوزّه بگو
137 areh, ha, misooza, begoo
138 yeah, ha, burning-it tell(you, single, not the polite form)
139 [Tell her Yes, yeah, it's burning]
140 Int Yes, burning pain
141 Dr: Burning pain? And does the pain only stay in the back or does it also go
142 down the legs?

[4] Interpreter used the purposive language with the polite form of addressing the patient

143 Int:
144 درد شما فقط تو کمر میمانه یا اینکه به پاتون هم میکشه؟
145 dard-e-shoma faghat too kamar mimaneh ya inke be pa-toon ham mikeshe?
146 Paine-of-you(plural,polite) only in back stays or that to leg-your also pulls?
147 [Your pain only stays in the back or also pulls to your leg?]
148 Pt:
149 فرق میکنَه، بعضي وقتا در پایِم میکشه درد اینطور در مغز گوشت، بعضي وقتا نمیکشَه

150 fargh-mikon-a bazi-vaght-a dar payem mikesha dard intor dar maghz-e-goosht
151 differ-s some-time-s in leg-my pull-s pain like-this in marrow-of flesh
152 bazi-vaght-a ne-mikesh-a
153 some-time-s not-pull-s
154 [It differs, sometimes pain pulls in my leg like in the marrow of the flesh, sometimes
155 it doesn't]
156 Int: It varies, sometimes it actually [5]shoots in, ummm…, umm.., deep in her leg,
157 in her thigh and sometimes it doesn't, but he said that it actually goes deep, it's a deep
158 inside the flesh pain
159 Dr: And you were saying the symptoms in the legs are better, is that correct?
160 Int:
161 ولي درد پاي شما بهتره ها؟
162 vali dard-e pay-e shoma behtar-e, ha?
163 But pain-of leg-of you better-is, ha?
164 [But the pain in your leg is better, yeah?]
165 Pt:
166 ها از پارسال کمتر شدَه
167 ha, az parsal kamtar shod-a
168 ha, from last-year less became
169 [Yeah, it is less than last year]
170 Int: It's less than last year |
171 Pt:
172 ولي خوب نشدَه
173 vali khoob-na-shod-a
174 but good-not-became
175 [But didn't become well]
176 Int: | but it's still there
177 Dr: Right, ok.
178 Dr: Do you have the back pain every single day?
179 Int:
180 هرروز شما درد کمر دارید ها؟
181 har-rooz shoma kamar-dard darid, ha?
182 Every-day you back-pain have, ha?
183 [Do you have back pain 'every day, yeah?]
184 Pt:
185 آره همین چیز گلي پانادول میگیریم شبها که زیاد درد میکنَه گلي پانادول میخوریم
186 areh, hamin-chiz goli Panadol migir-im shab-ha ke ziyad dard-mikona
187 yeah, as-this tablet Panadol take-we (plural) nigh-s that a lot pain-s

[5] interpreter used 'shoots in' for conveying the meaning of the pain pulling in (the flesh)

188 goli-e Panadol mikhor-im
189 tablet-of Panadol eat-we
190 [Yes, [6]we take Panadol tablets, at nights when it is too painful we take Panadol
191 tablets]
192 Int: Yes, everyday and when the pain is a lot especially at night [7]I take Panadol
193 tablets
194 Dr: Does it tend to get worse at night, does it?
195 Int:
196
197 شبها بدتره؟ وقت شبا بدتره؟
198
199 shab-ha badtar-e? vaght-e shab-a badtar-e?
200 night-s worse-s? time-of night-s worse-is?
201
202 [Is it worse at night? At night time is it worse?]
203
204 Pt:
205 ها، شبا زيادتره
206
207 ha, shab-a ziyad-tar-e
208 ha, night-s a lot-more-is
209 [Yeah, at nights it is more]
210
211 Int: Yes it's worse at night
212
213 Dr: Right, what about when you are up moving and walking around, what
214 happens to the pain?
215 Int:
216 وقتي سر پا هستين و ميگردين درد چطور ميشه؟
217 vaghti sar-e-pa-hastin o migardin dard chetor mishe?
218 When on-feet-are-you and walking-you pain how become-s?
219 [When you are on your feet and walking, how is the pain?]
220
221 Pt:
222 فقط يك سه چهار دقيقه خوبه باز درد پيدا ميشه
223 faghat yek 3 4 daghigha khoob-a baz dard peyda-misha
224 only one 3 4 minutes good-is again pain appear-s
225 [It is only good for 3 to 4 minutes, then the pain appears again]
226
227 Int (facing the Pt)
228 موقع گشتن، درد پيدا ميشه؟
229 moghe-e gashtan dard peyda mishe?
230 Time-of walking pain appear-s?
231
232 [in time of walking, does pain appear?]
233 Pt:

[6] patient used plural form of pronoun as sign of respect(culturally) to the hearer
[7] interpreter did not convey cultural respect of patient, but conveys it according to doctor's cultural norm and expectation

234 بله
235 [Yes]
236 Int: When I stand up for 3-4 minutes, it's ok; but then the pain starts and while
237 walking the pain is also there
238 Dr: Does it tend to get worse with more activity you do or not?
239 Int:
240 هرچي فعاليت بيشتر بكنيد، تكان بيشتر بخوريد، بگرديد، گشتن بيشتر بكنيد اينا، بدتر ميشه يا هرچه بيشتر
241 تكان بخوريد بدتر ميشه يا...؟
242 harchi fa'aliyat bishtar bokonid, tekan bishtar bokhorid, begardid, gashtan bishtar
243 bekonind
244 as-much activity more do-you(polite) move more do(you plite), walk, walking more
245 do(you plural)
246
247 ina, bad-tar mishe ya harche bishtar tekan-bokhorid bad-tar mishe ya?
248 Like-this, worse becomes or as-much more moving-you (polite) worse becomes or?
249 [As you do more activities, more movement, walking, more walking, and the like,
250 does it get worse? Or the more you move it gets worse, or… ?]
251 Pt:
252 ها، بدتر ميشه
253 ha, bad-tar [8]misha
254 ha, worse becomes (a=Dari ending)
255 [Yeah it becomes worse]
256 Int: Yeah it gets worse with activities
257 Dr: Ok
258 Pt:
259
260 تا ٢٥ اپريل هم من هفته اي يك روز در فيزيوتراپي آب گرم ميبرد نِه!
261 Ta 25 April ham man hafte-yi yek rooz dar fizioterapy ab-garm mibord, ne?
262 Until 25 April also I week-ly one day in physiotherapy water-warm took, right?
263 [Until 25th April, I once a week in physiotherapy warm water took, right?]
264 [until 25 April the physiotherapist was taking me to warm water every week, ok?]
265 Int:
266 ٢٥ روز ؟
267 25 rooz?
268 25 days?
269 [25 days?]
270
271 Pt
272 نه، ٢٥ اپريل سه ماه، سه ماه مكمل، ما هفته اي يك روز در آب گرم ميبرد.
273 Na, 25 April, 3 mah, 3 mah mokamel, ma haftey-i
274 No, 25 April, 3 months, 3 months complete, we (for respect) week-ly
275
276 yak rooz dar ab-e garm mibord
277 one (a=Dari dialect in yak) day in water-of warm was taking
278 [No, 25th April, three entire months, s/he was taking us in warm water once a week]
279
280 Pt
281 باز خود از همو فيزيوتراپي محلي تقريبا ١٥-٢٠ نفر بود چيز نشان ميداد.

[8] a= Dari ending

282 Baz khod az hamoo fizioterapy mahali taghriban 15, 20 nafar bood chiz neshan-midad
283 Again self from same physiotherapy local approximately 15, 20 people were, things
284 was showing
285
286 [Also at the local physiotherapy there were 15 -20 people and s/he was showing us
287 things].
288
289 Pt
290 باز از ما که بود یه طرف همین بغل در همین لحظه سُك میگرفت پاِیم، در ايي طرف، ايي طرف.
291
292 Baz az ma ke bood ye taraf hamin baghal dar hamin lahza
293 Again from we(plural of I, polite) that was one side this side in this moment
294 Sok-migereft payem, dar yee taraf, yee taraf
295 Getting poked leg-my in this side, this side
296
297 [as for me, at one side, this side, right then my leg was getting poked, on this side, this
298 side]
299
300 Pt
301 باز ديگر تمرينش خوبتر بود اگر هميرا انجام ميدادُم همي بغله در همي هفته را سُك ميگرفت.
302 Baz digar tamrin-esh khoob-tar bood. Agar hamira anjam-midadom,
303 Again another exercise-its good-er[9] was, if this-one do-ing-I
304 Hami baghala dar hami hafta ra sok-migereft.
305 This side in this week get-poked
306 [The other exercise was better but if I was doing it in the week, it would be getting
307 poked on this side]
308 شُو هيچ خَو نميرفتُم
309 [10]show hich [11]khaw nemiraftom
310 night not-at-all sleep not-sleeping
311 [At night I was not able to get any sleep at all]
312
313 Int He's saying that for 3 months until 25th April I was taking this warm
314 hydrotherapy and while the practising was good but then….
315 Sound of turning pages on the file by the doctor
316
317 گفتين وقتي که ورزش ها رو ميکردين شُوِش خَو نميرفتين، ها؟
318 goft-in vaghti ke varzesh-ha ro mikardin [12]showesh [13]khaw-nemiraftin, ha?
319 Said-you when that exercise-s were-doing-you(plural) night-its sleeping-not, ha?
320 [You said that when you were doing the exercises, you were not able to sleep at
321 nights, yeah?]
322 ها، ايي ورزش ايي بغل پايين ميكند
323 ha, yee varzesh yee baghal payin mikonad
324 ha, this exercise this side down goes
325 [Yes this exercise this side goes down]

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[9] Dari expression for better
[10] Dari word for night used by patient
[11] Dari word for sleep
[12] Dari word for night used by interpreter
[13] Dari word for sleeping used by interpreter

326 Interpreter: when he did this particular exercise on the side and downwards then he
327 couldn't sleep the night and the burning pain was there
328 Doctor: All right ok, are you still having physiotherapy?
329 Interpreter:
330 هنوز...|
331 [Still … [
332 Doctor: … |And chiropractic treatment?
333 Interpreter: Ok.
334
335 میگه هنوز شما فیزیوتراپي دارین؟ کایروپرکتینگ و فیزیوتراپي ؟
336 mige hanooz shoma fiziotorapy darin? Kiroprakting va fiziotorapy?
337 says still you plural-polite) physiotherapy having? [14]Chiropracting and
338 physiotherapy?
339 [She says are you still having physiotherapy? Chiropracting and physiotherapy?]
340 Patient:
341 نه، تا ۲۵ اپریل که بود بعد از او گفت تا جولاي دیگه تو آمده نمیتاني چون اینجا دیگر نفر منتظرمه
342 na, ta 25 April ke bood ba'd-az-oo goft ta July dige to amade-nemitani
343 no, until 25 April that was after that said until July you coming-cannot
344 chon inja digar nafar montazer-am-a
345 because here other person waiting-me-are
346 [No, it was until 25 April, then he said you cannot come until July because other
347 persons are waiting here]
348 Interpreter: It was only until 25 April and they said that there's someone waiting for
349 the services and they can't take it until July
350 Dr: this year?
351 Int:
352 همین سال، ها؟
353 hamin sal, ha?
354 Same year, ha?
355 [This year, yeah?]
356 Pt:
357 بله
358 bale
359 yes
360 [yes]
361 Int: Yes
362 Dr: Right, so you can't get an appointment, is that correct?
363 Int:
364 شما وقت نمیتونین بگیرین تا جولاي؟
365 shoma vaght ne-mitoonin begirin ta July?
366 You(plural-polite) time not-able-you take-you plural polite until July?
367 [You are not able to have an appointment until July?]
368 Pt:
369 او خو مرا جواب داد تا دگر اینا حالي دوباره مارا ببینند
370 oo kho ma-ra javab-dad ta degar ina hali dobare ma ra bebinand
371 he so declined-me until next-time they now again we(plural for I-polite) see
372 [He declined me until they see me again]
373 Int: They said no, but maybe with your recommendation or referral may be

[14] the word ending is incorrect-used by interpreter

374 Dr: Do you find that it helps?
375 کمکتون کرد؟ خوب بود؟
376 komaketoon kard? Khoob bood?
377 Help-to-you did? Good was?
378 [Did it help you? Was it good?]
379 Pt:
380 بله خوب بود
381 bale, khoob bood
382 yes, good was
383 [Yes, it was good]
384 Int: Yes
385 Dr: Ok, good and the last time you had been was in March?
386 دفعه آخر که بودین گفتین کي بود؟ مارچ بود؟
387
388 dafe-ye akhar ke bood-in goftin key bood? March bood?
389 Time-of last that were-you(polite) said-you(polite) when was? March was?
390 [When was the last time you said you had it? was it March?]
391 Pt:
392 نه ۲۵ اپریل
393 na, April
394 no, April
395 [No, 25 April]
396 Int: 25th of April
397 Dr: And since you stopped, has the pain started to get worse or has it been bad like
398 this for some time?
399 Int:
400 میگه وقتي که خلاص شد از اون آب گرم و اینا، درد شما بدتر شد یا این درد بد شما یه چند وقتیه که هست؟
401 mige vaghti ke khalas-shod az oon ab-e-garm o in-a
402 says when that finish-become from that water-warm and things
403 dard-e shoma bad-tar shod ya in dard-e bad-e shoma ye chand vaghti-ye ke hast?
404 Pain-of you(polite) worse become or this pain-of bad-of you one some time that exist?
405 [She says when the warm water finished and all, did your pain become worse or has
406 this bad pain of yours existed for some time?]
407 Pt:
408 آره اگر این تمرینا رو مَ در خانه انجام نتُم یك درد زیاد میشه، درد پیدا میشه، بسته بدنم درد میکنه اگر همو
409 تمرینا باز درخانه انجام میدیم باز درد کمتر میشه
410 areh. Agar in tamrin-a ro ma dar khana [15]anjam-natom yek dard ziyad misha
411 yeah, if this exercise-s of I (single) in house do-not one pain a-lot becomes
412 dard payda-misha [16]basta badan-em dard-mikona
413 pain appear-becomes all body-my pain-does
414 agar hamoo tamrin-a baz dar khane anjam midim baz dard kamtar misha
415 if same exercise-s again in house doing-we(plural) again pain less becomes
416 [Yes, if I don’t do these exercises at home, the pain increases, the pain appears, all
417 my body aches. If we do the exercises at home, then the pain becomes less].
418 Int: If I do the exercises at home then the pain is less but if I don’t do the exercises the
419 pain is more
420 Dr: Ok and are you doing the exercises?

[15] word in Dari dialect
[16] word in Dari dialect

421 Int:
422 انجام میدین تمرینا رو؟
423 anjam mididn tamrin-a ro?
424 Doing do-you(polite) exercise-plural ?
425 [Are you doing the exercises?]
426 Pt:
427 آره
428 [Yes]
429 Int:
430 Yes
431 Pt:
432 خو حال قراره تا کي میرسم برم، چرا عمل نمیکنید دیگه؟
433 kho hal gharare ta key miresom berom, chera amal-nemikonid diga?
434 So now appointment-is till when reach-I go-I, why operate-not-do-you-plural then?
435 [So now until my turn reaches to go, why don't you operate?]
436 Int: He says yes I do, but for how long am I going to go like that and why am I not
437 getting the operation?
438 Dr: Ok, is that something that you want to?
439 Int:
440 میخواید؟ عملیات را میخواین؟
441 mikhayd? Amaliyat ra mikhayin?
442 wanting-you(plural)? Operation wanting-you(plural)?
443 [do you want it? Do you want the operation?]
444 Pt:
445 آره دیگه، این ۲۰۰٦ تا به حال ما خوب نشدیم دیگه
446 are diga in 2006 ta be-hal ma khoob na-shodim diga
447 yes, so this 2006 till now we good not-become-we then
448 [Yes, since 2006 I have not become well]
449 Int: Yes, because I'm having this pain from 2006 until now
450 Dr: Last time you were here, '**I 'think**, your symptoms had improved quite a bit so
451 we were going to hold off
452 Int:
453 میگه دفعه قبل که اینجا شما بودین درد شما کمتر شده بود برا همین استاپ (stop) کردیم ، برا همین گفتیم
454 حالا فعلا شاید ضرورت نیست
455 mige dafeye-ghabl ke inja shoma boodin dard-e shoma kam-tar shode-bood
456 says time-last that here you were pain-of you less had-become
457 bara-hamin stop kardim, bara hamin goftim
458 that-is-why stop did-we, that-is-why said-we
459 hala felan shayad [17]zaroorat nist
460 now for-the-time-being may-be necessary-not
461
462 [She says last time that you were here, your pain had become less, that is why we
463 stopped, that is why we thought may be the operation would not be necessary now]
464 Pt:
465 نه ، نه درد کمتر نشده بود، درد بود خو اینجا که عکس گرفت باز گفت که از تو حالت بهتر شده
466 na, na, dard kamtar na-shode-bood, dard kho bood
467 no, no, pain less not-become, pain so was
468 inja ke aks gereft baz goft ke az to hal-et behtar shoda

[17] zaroorat=common Dari word used by interpreter

469 here that picture took then said that from you well-you better became
470 ['**No, 'no** the pain had not become less, the pain was there. Here that took the image
471 said that you were better]
472 Int: He is saying that the pain was there but the imaging showed that I was better but I
473 had the pain
474 Dr: I see, right. Regardless the plan always was to bring you back to see where the
475 things are at anyway and I have a look at your legs and back in a minute.
476 Int:
477 میگه به هر حال قرار ما این بود که ما شما را اینجا بیاریم و ببینیم که شما چطور هستین و الان من شما را
478 معاینه میکنم، پشت و پاي شما را معاینه میکنم.
479 Mige be-har-hal gharar-e ma in-bood ke ma shoma ra inja biyarim va bebinim
480 Says however agreement-of us this was that we you(polite) here bring-we and see-we
481 Ke shoma chtor hast-in va alan man shoma ro moayene-mikonam
482 That you how are(polite) and now I you examine
483 Posht va pay-e shoma ra moayeneh-mikonam
484 Back and leg-of you examine-I
485
486 [She is saying however our agreement was that to bring you here and see how your
487 are and now I examine you, I examine your back and leg.
488
489 Pt:
490 بله
491 [Yes]
492 Dr: A few more questions first
493 Int:
494 چند تا سؤال پرسان کنه
495 chand-ta soal [18]porsan-kone
496 a-couple-of question asks
497 [she will ask a few questions]
498
499 Dr: Any problems or changes with the bladder or the bowl?
500 Int:
501 هیچ تغییري این نکرده که شما وقتي ادرار بکنید یا برین مثلا نشتال، مدفوع بکنید، یعني دفع بکنین، هیچ
502 تغییري ایجاد نشده؟
503
504 hich taghiri in na-karde ke shoma vaghti edrar-bekon-id ya berin masalan [19]nashtal
505 no change this not-done that you when urinate(you polite) or go(polite) for example
506 toilet
507 madfoo-bekon-id, yani daf-bekon-in hich taghiri ijad nashode?
508 Faeces-do(polite), which-means pass-off-you(polite) any change formed?
509 [Has there been any changes in when you urinate or for example you go to the toilet
510 (wrong Dari expression for toilet), passing faeces, that is you pass off, any changes
511 formed?]
512 Pt:
513 نه
514 [No]
515 Int: No

[18] Dari word used by interpreter with Persian ending of -e
[19] Dari word for toilet is /tashnab/ but interpreter used it incorrectly

516 Dr: And can you tell me about the leg symptoms, which leg and what happens?
517 Int:
518 پاي شما چطوره؟ كدوم پاتون بده و چه جوريه؟ دردش چيه؟
519
520 pa-ye shoma chetor-e? Kodoom paa-toon bad-e va chejooriy-e?
521 leg-of you(polite) how-is? Which leg-you(polite) bad-is and how-is?
522 dard-esh chiy-e?
523 pain-of what-is?
524 [How is your leg? Which of your leg is the bad one and how is it? What is its pain?]
525 Patient:
526 اينه، اين پايِم
527 in-e, in pay-em
528 this-is, this leg-my
529 [This is, this leg]
530 Int: That one
531 Pt:
532 وقتي درد شروع ميشه
533 vaghti dard shoroo-misha
534 when pain start-s
535 [When the pain starts]
536 Int: When the pain starts
537 Pt:
538 از همين جا شروع ميشه
539 az hamin-ja shoroo-misha
540 from here start-s
541 [It starts from here]
542 Int: It starts from here
543 Pt:
544
545 اينطَه (اينطور) ميايه
546 inta miya-ya
547 like-this come-s
548 [It comes like this]
549 Int: And it's got down like that
550 Pt:
551 ايي رقم ايطو مياد پشت پا
552 yee ragham yeeto miyad posht-e pa
553 this shape like-this comes back-of leg
554 [Like this it comes to the back of leg]
555 Int: And ends on the front of …
556 Pt:
557 بعضي وقتا فرق ميكنه. بعضي وقتا همي مغز گوشت اينجا همي بسته ايطو لا(lock) ميشه، بگو، همي بُگو
558 درد ميكنَه
559 bazi vaght-a fargh-mikon-a. Bazi vaght-a hami maghz-e gosht inja
560 some time-s differs-it. Some time-s marrow-of-flesh (Dari expression for deep) here
561 hami basta eeto lakh mish-a ,
562 (This seems to be a Dari expression, not understandable for researcher)
563 begoo, hami bogoo dard-mikona
564 say(you-singular), hami(=Dari expression say) (you-singular) pain-has

565 [Sometimes it varies. Sometimes deep inside the flesh (not understandable what he
566 means) tell her, tell her it is painful]
567 Interpreter: But sometimes deep inside the flesh in the thigh it actually cramps, it sorts
568 of gets really hard and crampy
569 Dr: Ok.
570 Dr: Ok, when you're saying it's going down your leg, is that pain or is that numbness
571 going down the leg?
572 Int:
573 اینکه میکشه پاي شما، درده یا سرّه، بي حسه، کدومه؟
574 inke mikesh-e pa-ye shoma(plural-polite), dard-e ya serr-e, bi-hess-e, kodoom-e?
575 that pull-s leg-you pain-is or insensible-is, numb-is, which-is?
576 [What pulls your leg, is it pain or insensible? Is it numbness? Which one?]
577 Pt:
578 درد
579 [pain]
580 Int: pain
581 Dr: Pain, how often does it go down the leg like that?
582 Int:
583 مثلا چند وقت یکبار این درد میکشه تو پاي شما میره پایین اینطور که گفتین؟
584 masalan chand-vaght-yek-bar in dard mikeshe
585 for-example how often this pain pulls
586 too pa-ye shoma mire-payin intor ke goftin?
587 In leg-you goes-down like that said(you plural polite)
588 [For example how often does this pain go down to your leg like what you said?]
589 Pt:
590 اي تقریبا هرروز هستَه
591
592 ee taghriban har-rooz [20]hasta
593 this almost ever-day is
594 [This is almost every day]
595 Int: Every day
596
597 Patient continues:
598
599 ولي گرمي که هسته کمي خوبَه
600
601 vali garmi ke hast-a kami khoob-a
602 but warmness that is little good-is
603 [But in warmness, it is a little better]
604
605 Interpreter asks patient:
606 وقتي گرمِه، خوبِه؟
607 vaghti garm-e[21] [22]khoob-e?
608 when warm-is good-is
609 [When it is warm, it is good?]
610 Pt:

---

[20] Dari ending on the verb -a
[21] Persian ending on verb –e used by interpreter
[22] Persian ending on verb-e used by interpreter

611
612 گرم که باشَه هوا ، خوبَه ولي کم که يخ شد ايي درد اضافَه ميشَه
613 garm ke bash-a hava, khoob-a vali kam ke yakh-shod ee dard ezafa-misha
614 warm that is weather, good-is but little that ice-became this pain is-added
615 [If weather is warm, it is good but when it becomes a little cold, this pain is added]
616 Interpreter: It's every day but when weather is warmer the pain is better, when it's
617 colder then the pain is more
618 Dr: Is it just the right leg or does it happen in the left side as well?
619
620 پاي چپتونم ميشه يا فقط راسته؟
621
622 pa-ye chap-etoon-am mishe ya faghat rast-e?
623 leg-your left-you(polite)-also becomes or only right-is?
624 [Does it also happen to your left leg or is it only the right?]
625
626 Pt:
627
628 همي درد که اضافَه ميشَه، پاي چپ ميگيره؛ اگر گرمي باشَه فقط اين پاي راست
629
630 hami dard ke ezafa-misha, pa-ye chap migira;
631 when pain that increases, leg-of left gets
632 agar garmi basha faghat in pay-e rast-a
633 if warmness to-be only this leg-of right-is
634
635 [When the pain increases the left leg gets (in pain), if it is warm then it is only the
636 right leg]
637
638 Int: When it's warm then it's only my right leg but when the pain comes then the left
639 leg also gets painful
640 Dr: And what do you feel in the left leg? Is it similar or what happens on the left side?
641 پاي چپ تون هم عين همين درده يا اينکه...؟
642 pa-ye chap-etoon ham eyne hamin dard-e ya inke?
643 Leg-of left-you (polite) also same this pain-is or else?
644 [Does your left leg have the same pain or..?
645 Pt:
646
647 نه پاي چپم فقط عينمي کون پايِم درد ميکنَه ايي
648
649 na, pay-e chap-am faghat eynami [23]koon-e pay-em dard-mikona ee
650 no, leg-of left-my only same-as heel-of leg-my pain-does this
651 [No, only my left leg, it's only the heels, here]
652 Int: No, the left leg is only there, in heels, it's only in the heels
653 Pt:
654 اينجا درد ميکنَه
655 inja dard mikona
656 here pain does
657 [It is painful here]
658 Int: In the heels

[23] Dari expression for heel used by patient which means bottom in Persian

659 Dr: In the heels, nothing up there?
660 Int:
661 بالاي ران شما نيست؟
662 bala-ye ran-e shoma nist?
663 Up-of leg-of you is-not?
664 [Is it not up your thigh?]
665 Pt:
666 نه
667 [No]
668 Int: No
669 Dr: And is it pain in the heel or numbness
670 درده توي اون پاي شما يا سره، بي حسه؟
671 [Is it pain in your leg or is it numbness, no feelings?]
672
673 Pt:
674 نه بي حسه
675 na, bi-hess-e
676 no, numb-is
677 [No, it is numb]
678 Int: No it's numbness
679 Dr: Is the numbness there all the time?
680 هميشه بي حسه يا بعضي وقتا؟
681 hamishe bi-hess-e ya bazi-vaght-a?
682 always numb-is or some-time-s?
683 [Is it always numb or sometimes?]
684 Pt:
685 بعضي وقتا
686 [Sometimes]
687 Int: Sometimes
688 Dr: Everyday?
689 Int:
690 هر روز؟
691 [Everyday?]
692 Pt:
693 ها هر روز
694 [Yeah, every day]
695 Int: Yeah
696 Dr: Everyday but on and off?
697 Int:
698 هر روز ولي يه وقت بي حسه يه وقت نيست ها؟
699 har-rooz vali ye-vaght bi-hess-e ye-vaght nist, ha?
700 Everyday but one-time numb-is one-time not, ha?
701 [Everyday but sometimes it is numb and sometimes it is not, yeah?]
702 Pt:
703 ها
704 [Yeah]
705 Int: Yeah
706 Int:
707 فرق ميكنه
708 fargh-mikon-a

709 differ-s
710 [It differs]
711 Pt:
712 فرق میکنه
713 [It varies]
714 Int: Yeah
715 Dr: Ok. You said that the back pain is worse, how long has it been worse for, just the
716 last few weeks or months?
717 میگه شما گفتین درد پشتتون بدتر شده
718 mige shoma goft-in dard-e posht-e-toon bad-tar shode[24]
719 says you said(you-polite) pain-of back-of you(plural-polite) worse became
720 [She says you said your back pain became worse]
721
722 Pt:
723
724 ها
725 [Yeah]
726 Int:
727
728 چند وقته بدتر شده، چند هفته س یا چند ماهه؟
729 chand-vaght-e bad-tar shode, chand hafta-s ya chand mah-e?
730 how-long-is worse become, couple week-is or couple month-is?
731
732 [How long has it been worsened, couple of weeks? Or months?]
733
734 Pt:
735
736 ها تقریبا همي ٥ ماه ٦ ماه میشه
737 ha, taghriban [25]hami 5 mah 6 mah misha
738 yeah, about (hami=Dari expression, not known exact meaning) 5 month 6 month
739 becomes
740 [Yeah, it is about 5 to 6 months]
741 Int: May be five or six months now
742 Dr: Five or six months
743 Pt:
744
745 ها
746 [Yeah]
747 Dr: Ok, alright. You last went to physio. Are you attending physiotherapy here?
748 Int:
749 میگه شما اینجا فیزیوتراپي میرید؟
750 mige shoma inja fiziotorapy mirid?
751 Says you here physiotherapy going-you(plural-polite)
752 [She asks are you going to physiotherapy here?]
753 Pt:
754 نه در بانتي هست

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[24] Persian ending –e used by interpreter
[25] hami= is Dari expression, does not seem to have any particular meaning, used by patient.

755 na, dar Bunty hast
756 no in Bunty is
757 [No it is in Bunty]
758 Interpreter (turned to patient):
759 کجا؟
760 koja?
761 Where?
762 [Where?]
763 Pt:
764
765 بانتي در التم
766 [Bunty in Eltham}
767 Int: In Bunty….Eltham
768 Dr: Aah, Bunty, ya, ok. Now, one minute. Do you have symptoms of tingling in the
769 toes or the leg as well?
770 سر انگشتاي شما سر انگشتاي پاتون يا تو پاتون سوزن سوزن هم ميشه؟
771 sar-e angosht-a-ye shoma sar-e angosht-a-ye pa-toon ya too pa-toon
772 tip-of finger-s-of you tip-of finger-s-of leg-you (plural-polite) in leg-you (polite
773 plural)
774 soozan-soozan ham mishe?
775 Needle-needle also become-s?
776
777 [Do you get pins and needles on tip of your toes or in your leg?]
778 Pt:
779 سر انگشتا سوزن سوزن نميشه ولي قطع پام ميشه، قطع پام
780 sar-e angosht-a sooza-soozan ne-mishe vali [26]ghat pa-m mishe, ghat-e pa-m
781 tip-of finger-s needle-needle not-becomes but (ghat=Dari expression) leg-me
782 becomes, (ghat) of leg-me
783
784 [The tip of the toes are not getting pins and needles but (ghat) of my leg is, my leg]
785
786 Int: Not the toes but the sole of my foot, it does get tingling
787 Dr: Tingling!
788 Int: Pins and needles he said
789 Dr: On the right foot?
790 Int:
791 پاي راست؟
792 pa-ye rast?
793 Leg-of right?
794 [Right foot?]
795
796 Pt:
797 ها پاي راست
798 ha, pa-ye rast
799 ha, leg-of right
800 [Yeah, right foot]
801 Int: Yes

[26] ghat=Dari expression used by patient, seems to be a part associate with leg/body; unknown to researcher

802 Dr: And is that come and go or is it there constantly?
803 Int:
804 همش هست یا میاد و میره؟
805 hama-sh hast ya miyad-o-mire?
806 All-of is or comes-and goes?
807 [Is it all the time or comes and goes?]
808 Pt:
809 نه میاد و میره
810 na, miya-d o mir-e
811 no come-it and go-es
812 [No it comes and goes]
813 Int: Sometimes it comes
814
815 Dr: Comes and goes
816
817 Dr: Where is the back pain the worst?
818 Interpreter to doctor: Where?
819 Dr: Uhum
820
821 Int:
822 كجاي درد پشت شما بدتره؟
823 koja-ye dard-e posht-e shoma badtar-e?
824 where-of pain-of back-of you worse-is?
825 [Where is your back pain worse?]
826 Patient is silent.(for 2 seconds)
827 Interpreter to patient:
828 پشت شما، کجا دردش بدتره؟
829 posht-e shoma, koja dard-esh bad-tar-e?
830 back-of you(polite), where pain-its worse-is?
831 [Your back, where is the pain worse?]
832
833 Patient: (silent for one second), then said:
834 آها،
835 aha
836 (aha, with the tone of understanding something)
837 [I see]
838 Pt:
839 آها، این همین سمت این يك خط بگویید یه خط درد میکنه
840
841 aha, in hamin-samt in yek khat begooyid ye khat dard-mikon-a
842 aha, this this-side this one line tell(you-polite) one line ache-s
843 [Yeah, this side in this one line, you tell, one line, is in pain]
844 Interpreter (addressing patient):
845 ۱۰ سانت؟
846 10 sant?
847 [10 centimetre?]
848 آره فقط يعني همین زیسته پایین این سره در گشتن درد همینجه پیدا میشه يك خط
849
850 areh, faghat yani hamin zista payin in sar-a dar gashtan
851 yes, only means same (zista= unknown to researcher) down this side-is in walking

852 dard haminje pyeda-misha yek khat
853 pain here appears-s one line
854 [Yes, only means here down this side when walking the pain appears in one line]
855 Int: If you imagine a line while walking I feel back pain in that line
856 Pt: (continues)
857 حالي فعلا كه هست درد همينجاست
858 hali felan ke hast dard haminjast
859 at the moment now that is pain right-here-is
860 [At the moment the pain is right here]
861 Int: At the moment the pain is in that spot when he walks it's in that line
862 (15:25 minute)
863 Dr: And sometimes it shoots down the right leg?
864 Int:
865 بعضي وقتا ميكشه به پاي راست شما
866 bazi-vaght-a mikesh-e be pa-ye rast-e shoma?
867 Sometime-s pull-s to leg-of right-of you(polite)?
868 [Sometimes it pulls to your right leg?]
869 Pt:
870 بله
871 [Yes]
872 Yes.
873 Dr: Do you have weakness in your legs as well?
874 Int:
875 پاتون ضعيف تر هم شده؟
876 pa-toon zayif-tar ham shode?
877 Leg-your(plite-plural) weak-er also become?
878
879 [Has your leg also become weaker?]
880 آره ها ايي پايم ضعيف شده
881 areh, ha, yee pa-yem zayif shoda
882 yeah, aha, this leg-my(singular) weak has become
883 [Yes, yeah, this leg of mine has become weak]
884
885 Int: Yes, that one is weak
886 Pt: (continues)
887 در گشتن فهميده ميشه
888 dar gashtan fahmide-misha
889 in walking understood-it-is
890 [It is understood in walking]
891 Int: While walking I can tell that it's weak
892 Dr: How long has it been the problem for the weakness?
893 اين ضعف پاي شما چند وقته؟
894 in zaf-e pa-ye shoma chand-vaght-e?
895 this weakness-of leg-of you(plural) how-long-is?
896 [How long is the weakness in your leg?]
897 Pt:
898 ضعف پاي من خو از وقت بود از پارسال
899 zaf-e pa-ye man kho az vaght bood az parsal
900 weakness-of leg-of I(singular) so from time was from last-year
901 [The weakness of my leg was from last year]

902 Int: My weakness was from last year
903 Dr: So for abut 6 months or so?
904 Int:
905 مثلا ٦ ماه يا يك سال؟
906 masalan 6 mah ya yek sal?
907 For-example 6 months or one year?
908 [Like 6 months or one year?]
909
910 Pt:
911 يَك سال، يَك سالّه كه ايي ضعيفَه ولي درد كه هستَ در كمرم ٦ ماهَه شروع شدَه
912 yak sal, yak sal-a ke yee zayif-a vali dard ke hast-a dar kamar-em 6 mah-a shoroo-
913 shod-a
914 one year, one year-is that this weak-is but pain that is in back-my 6 month-is started
915 [One year. It is one year that it is weak but the pain in my back started 6 months]
916 Int: One year. The leg has been a year but the back pain is worse during the past 6
917 months
918 Dr: Yes, yes, ok.
919 Dr: Has your leg ever given way or collapsed under you?
920
921
922 هيچوقت پاي شما تا حالا از زيرتون دررفته، يا ديگه فرمان نبره؟ ميدونين؟ پاي شما يه دفعه بي اختيار بشه؟
923
924 hichvaght pa-ye shoma ta-hala az zir-e-toon dar-raft-e,
925 Ever leg-of you(polite) so-far from under-of-you(polite) ran-away
926 ya dige farman-nabare? Midoonin? Pa-ye shoma ye-dafe bi-ekhtiyar beshe?
927 Or no-longer obey? You know(polite)? Leg-of you(polite) suddenly without-control
928 becomes?
929 [Ever your leg so far ran away from under you, or not obey you no longer? You
930 know? Your leg suddenly becomes without control?]
931
932 Pt:
933 نه
934 [No]
935
936 Int: No
937
938 Dr: Ok, good I might think of more questions as we go along. Can I have a good look
939 at your legs on the bed?
940
941 Int:
942 روي تخت شما رو معاينه كنه، پاي شما رو معاينه كنه
943 rooye takht shoma ro moayeneh-kone, pa-ye shoma ro moayene kone
944 on bed you(polite) examine(she), leg-of you examine(her)
945 [She examine you on the bed. She examine your leg]
946
947
948 Dr: Can you take your shoes off?
949
950 Int:
951 كفشتون را در آريد

952 kafsh-etoon ra dar-arid
953 shoe-your(polite plural) take-off
954 [Take your shoes off]
955
956 Dr: And do you work or retired?
957 Int
958 کار میکنین یا بازنشسته هستین؟
959 kar mikonin ya bazneshasteh-hastin?
960 Work-do (you-polite) or retired-are(you-polite)
961 [are you working or retired?]
962 Pt:
963 نه، بازنشسته هستم
964 na, bazneshaste hastam
965 no retired am-I
966 [No, I'm retired]
967
968 Int: Retired
969 Dr: Retired. What did you use to do?
970 Int:
971 چه کار میکردین؟ وظیفه شما چي بود؟
972 che kar mikard-in? vazife-ye shoma chi bood?
973 What work were-doing(you-polite)? Duty-of you what was?
974 [What work were you doing? What was your duty?]
975 Pt:
976 از او پیش؟ از او پیش در فارم کار میکردیم در التم طرفاي التم
977 az-oo-pish? Az-oo-pish dar farm kar mikardim dar Eltham tarafaye Eltham
978 before-that? Before-that in farm work was-doing(I-singular) in Eltham, around
979 Eltham
980 [Before that? before that I was working in the farm in Eltham, around Eltham]
981 Int: I was a farmer, around Eltham, I was a farmer
982
983 Dr: Alright. Ok, and now where do you live?
984 Int:
985 الان کجا زندگي میکنید؟
986 alan koja zendegi-mikonid?
987 Now where live-doing(you polite)
988 [now where do you live?]
989 Pt:
990 حال همین جا در التم
991 hal haminja dar Eltham
992 now here in Eltham
993 [now here in Eltham]
994
995 Dr: Eltham
996 Dr: Excuse me one minute someone's at the door
997 Dr: Ok. Can you lift up your jeans so I can see the knees? Good, and this one, and I
998 take the socks off as well
999
1000 Int:
1001 جوراب شما را در میاریم

1002 joorab-e shoma ra dar-miyarim
1003 sock-of you(polite) take off-we
1004 [we take off your socks]
1005 Dr: Thank you
1006 Dr: Alright, I get you to lie down in a minute but stay sitting for the minute
1007 Int:
1008 الان یه دقیقه بشینید بعداً میگه دراز بکشید
1009 alan ye daghighe beshin-id badan mige deraz-bekeshid
1010 now one minute sit-you(polite) then will-tell(she) lie-down(you-polite)
1011 [now sit for one minute then then she will tell you to lie down]
1012 Pt:
1013
1014 خُب
1015 [ok]
1016 Dr: Does it feel the same way both sides?
1017 Int:
1018 هر دو طرف یه جوره الان یا فرق میکنه؟
1019
1020 har-do taraf ye-joor-e alan ya fargh-mikone?
1021 Both side same now or differ-s
1022 [Both sides are the same nor or differ?]
1023 Pt:
1024
1025 آها، يَك چيزَه
1026
1027 aha, yak chiz-a
1028 aha, one thing-is
1029 [yeah, it's the same]
1030
1031 Int: Same
1032
1033 Dr: Does it feel normal to touch?
1034 Int:
1035
1036 وقتي دست ميزنِه به پاي شما، عاديِه؟
1037
1038 vaghti dast-mizan-e be pa-ye shoma adi-ye?
1039 When touch-es to leg-you(polite) normal-is?
1040 [when she touches your leg, is it normal?]
1041
1042 Pt:
1043 عاديِه
1044 adi-ye
1045 normal-is
1046 [it's normal]
1047 Int: Yeah
1048
1049 Dr: Here and here?
1050
1051 Int:

1052 اینجا چي؟
1053 inja chi?
1054 Here what?
1055 [what about here?]
1056
1057 Pt:
1058 عاديِه
1059 [it's normal]
1060 Int: Normal
1061
1062 Dr: Normal? Here and here?
1063
1064 Int:
1065 اینجا چي؟
1066 inja chi?
1067 Here what?
1068 [what about here?]
1069
1070 Pt:
1071 اینجا یه احساسي داره
1072 inja ye ehsasi dare
1073 here one feeling has
1074 here has a feeling
1075 [here there is a sensation]
1076 Int: On that side there is a sensation
1077
1078 Dr: Of…?
1079 Int:
1080
1081
1082 احساس چي دارین؟
1083 ehsas-e chi dar-in?
1084 Feeling-of what have-you(polite)
1085 [what feelings do you have?]
1086 Patient is silent, (for 3 seconds)
1087
1088 Int:
1089 قلقلك؟
1090
1091 ghelghelak?
1092 Tickling?
1093 [tickling]
1094 Pt:
1095 ها قلقلك
1096 ha, ghelghelak
1097 aha tickling
1098 Pt: [Yeah, tickling]
1099 Int: Tingling
1100 Dr: Tingling? Here?
1101 Int:

1102 اونجا نه
1103 oonja na?
1104 there, no?
1105 [not there?]
1106 Pt:
1107 نه
1108 [no]
1109
1110 Dr: Is that normal?
1111 Int:
1112 اینجا عادیِه یا فرق میکنه؟
1113 inja adi-ye ya fargh-mikon-e?
1114 Here normal-is or differ-s
1115 [is it normal here or different?]
1116 Pt:
1117 نه عادیِه
1118
1119 na adi-ye
1120 no normal-is
1121 [no it's normal]
1122 Int: Normal
1123
1124 Dr: Normal
1125 Dr: Here and here?
1126 Pt:
1127 ها همي پاي راستِم هست همو كه قلقلك ميده
1128 ha, hami pa-ye rast-em hast hamoo ke ghelghelak-mide
1129 ha, (hami=researcher not sure what equivalent to use) leg-of right-my(singular) is
1130 same that tickles
1131 [yeah this is my right leg, the one that tickles]
1132 Int: It's like tingling on that side
1133 Dr: Like tingling?
1134
1135 Dr: This is normal
1136 Int:
1137 اون عادیه، ها؟
1138 oon adi-ye ha?
1139 That normal-is, ha?
1140 [that one is normal, yeah?]
1141 Pt:
1142 عادیه
1143 normal-is
1144 [it's normal]
1145 Int: Normal
1146
1147 Dr: Normal. So there is tingling there, there and there
1148 Int:
1149 پس قلقلك اونجاها هست ها؟
1150
1151 pas ghelghelak onjaha hast ha?

1152 So tickling those-spots is ha?
1153 [so the tickling is in those spots, yeah?]
1154
1155 Pt:
1156
1157 ها، بله
1158 [yeah, yes]
1159
1160 Dr: Just relax
1161 Int:
1162 شُل کنید
1163 shol-kon-id
1164 loosen up-you-polite
1165 [loosen up]
1166
1167 Dr: Now can you kick forward with all your strength?
1168
1169 Int:
1170 با همه قدرتتون هل بدین جلو
1171 ba hame ghodrat-etoon hol-bedin jelo
1172 with all power-you(polite) push forward
1173 [with all your power push forward]
1174
1175 Dr: Push push push
1176 Int:
1177 هل بدین هل بدین
1178
1179 Hol-bedin hol bedin
1180 Push-youpolite push-you-polite
1181 [push push]
1182
1183
1184 Dr: Strong
1185 Int:
1186 محکم
1187 mohkam
1188 strong
1189 [strong]
1190 Dr: Now pull back
1191 Int:
1192 حالا بکشین عقب محکم بکشین عقب
1193 hala bekesh-in aghab mohkam bekeshin aghab
1194 now pull-you(polite) back strongly pull-you(polite) back
1195 [now pull back, pull back strong]
1196 Dr: Strong strong
1197 Int:
1198 محکم محکم
1199 mohkam mohkam
1200 strong strong
1201 [strong strong]

1202
1203 Dr: It does feel a bit weak
1204 Int:
1205 میگه به نظر میاد ضعیفتره
1206 mige be-nazar-miyad zayif-tar-e
1207 says seems-like weak-er-is
1208 [she says it seems like weaker]
1209 Pt:
1210
1211 اها
1212 [aha]
1213
1214 Dr: Just lift all way to the top
1215 Int:
1216
1217 بکشین بالا خودتونو
1218
1219 bekesh-in bala khodetoono
1220 pull-you(polite) up yourself(polite)
1221 [pull up yourself]
1222
1223 Dr: Keep it up there don't let me push it down
1224 Int:
1225 همون بالا نگهش دارین نذارین این ببرتش عقب
1226
1227 hamoon bala negahesh-darin na-zarin in bebaratesh aghab
1228 same up keep-it-you(polite) don't-let her take-it back
1229 [keep it up there don't let her push it back]
1230 Dr: This one, up, keep it up
1231 Int:
1232
1233 این يكي, محکم بالا نگهش دارین
1234 in yeki mohkam bala negahesh dari-in
1235 this one strong up keep-it-you(polite)
1236 [this one, keep it up strong]
1237
1238 Dr: Good. Try this one again
1239 یه بار دیگه اونو محکم نگه دارین نذارین هل بده عقب
1240
1241 ye-bar-dige oono mohkam negah-darin na-zarin hol-bede aghab
1242 one more-time that-one strong keep-you(polite) don't-let push-she back
1243 [one more time keep it strong, don't let her push it back]
1244
1245 Dr: That's a bit weak
1246 Int:
1247 میگه ضعیفه یه کم
1248 mige zayif-e ye-kam
1249 says-she weak-is a-bit
1250 [she says that's a bit weak]
1251

1252 Pt:
1253 آها
1254
1255 [aha]
1256
1257 Dr: Ok. Relax
1258 Int
1259 خُب شُل کنین
1260
1261 khob, shol konid
1262 ok, loosen-up-you-polite
1263 [ok, relax]
1264
1265 Dr: Bring your feet stress your ankles up
1266 Int:
1267 فقط جلو پاتون را بیارید بالا
1268 faghat jelo patoon ro biyarid bala
1269 only front foot-you-polite bring-you-polite up
1270 [only bring the front of your feet up]
1271
1272 Dr: Keep it up there don't let me push them down
1273 Int:
1274 بالا نگهش دارین نذارین هل بده پایین
1275 bala negahesh darin nazarin hol-bede payin
1276 up keep-you-polite don't-let-you-polite push-she down
1277 [keep it up there don't let her push it down]
1278
1279
1280 Dr: Push down
1281 Int:
1282 فشار بدین پایین
1283
1284 feshar-bedin payin
1285 push-you-polite down
1286 [push down]
1287
1288 Dr: Good, lift up
1289
1290 Int:
1291 بیارین بالا پاتونو
1292 biyar-in bala pa-toono
1293 bring-you-polite up leg-you-polite
1294 [lift up your leg]
1295
1296 Dr: All the way keep it up
1297 Int:
1298 بالا نگه دارین نذارین ...
1299
1300 bala negah-dar-in nazar-in
1301 up keep-you-don't let

1302 [keep it up don’t let…]
1303
1304 Dr: Strong
1305 Int:
1306 محکم
1307 mohkam
1308 strong
1309 [strong]
1310
1311 Dr: Strong
1312 Int:
1313 محکم
1314 [strong]
1315
1316 Dr: Good. Stand up
1317 Int:
1318 سر پا شید
1319 sare-pa-shid
1320 stand-up-you plural polite
1321 [stand up]
1322
1323 Dr: Ok just hold my hands
1324 Int:
1325 دستش رو نگه دارین
1326
1327 dast-esh ro negah-dar-in
1328 hand-her hold-you-plural polite
1329 [hold her hand]
1330
1331 Dr: Come on to your toes
1332
1333 Int:
1334
1335 بیایید سر پنجه
1336
1337 biya-yid sar-e panjeh
1338 come-you-polite tip-of toe
1339 [come on to your toes]
1340
1341 Dr: And down, good
1342 Int:
1343
1344 بیایید پایین
1345 biya-yid payin
1346 come-you-plural down
1347 [come down]
1348 Dr: Up
1349 Int:
1350 بالا
1351 bala

1352 up
1353 [up]
1354
1355 Dr: Let me check your reflexes
1356 Int:
1357 میخواد عکس العمل پاتون را ببینه
1358 mikhad aksol-amal-e pa-toon ra bebine
1359 wants-she reflex-of leg-your plural see-she
1360 [she wants to see your legs' reflex]
1361
1362 Dr: Just relax
1363 Int:
1364 شل کنین
1365
1366 [relax]
1367
1368 Dr: Can you lie down on the bed?
1369 Int:
1370
1371 دراز بکشین
1372 deraz-bekesh-in
1373 lie-down-you-plural-polite
1374 [lie down]
1375
1376 Dr: Give me your leg all the weight
1377 Int:
1378 همه پاتون رو ...
1379
1380 hame pa-toon ro …|
1381 all leg-you polite
1382 [all your leg…]
1383
1384 Dr: |That's better
1385
1386 Dr: Just roll your sleeves up
1387
1388 Dr: Relax your arm
1389 Int:
1390
1391 شل کنید
1392 shol konid
1393 loosen-up-you-polite
1394 [relax]
1395
1396 Dr: Good, fine, have a sit up
1397 Int:
1398 خُب بشینین
1399
1400 khob beshinin
1401 ok sit-you-plural

1402 [ok sit down]
1403
1404 Dr: Alright you can put your shoes and socks back on
1405 Int:
1406 خب میتونین جوراب و کفشتون رو بپوشین
1407 khob mitoonin joorab va kafsh-toon ro bepooshin
1408 ok can-you-plural sock and shoe-your-plural-polite wear-you-polite
1409 [ok you can wear your socks and shoes and socks]
1410
1411 Dr: Is it sore if I touch in the back?
1412
1413 دست میزنه به پشتتون درد میگیره؟
1414 dast-mizan-e be psoht-etoon dard-migire?
1415 Touch-she to back-your-polite pain-gets?
1416 [when she touches your back, does it get pain?]
1417 patient is silent.(1 second)
1418 Dr: Is it sore to touch there?
1419 آره؟ وقتي دست میزنه درد داره؟
1420 areh? Vaghti dast-mizane dard-dare?
1421 Yes? When touches-she pain-has?
1422 [Yes? When she touches, does it have pain ?]
1423 patient is silent. (1 second)
1424 Interpreter to patient:
1425
1426 وقتي دست میزنه درد داره؟
1427 vaghti dast-mizan-e dard-dare?
1428 When touches-she in-pain-is?
1429 [when she touches, is it in pain?]
1430
1431 Pt:
1432 نه
1433
1434 [no]
1435
1436 Int: No
1437
1438 Dr: Ok, not sore to touch but sore inside, yeah.
1439
1440 Dr: Ok, I let you have some time to put your socks on
1441 Dr: in regards to…., wait, we'll have a chat in a minute,
1442
1443 میگه الان با شما گپ میزنم
1444 mige alan ba shoma [27]gap-mizanam
1445 says-she now with you talk-I
1446 [she says I'll talk to you in a minute]
1447
1448 Dr: I just write a couple of things down while we're waiting
1449

[27] Dari exression used by interpreter gap-mizane

1450 يه دقه يه چيزي نوشته کنه بعدا با شما گپ ميزنه
1451 ye daghe ye chizi neveshta-kone badan ba shoma gap-mizane
1452 one minute one thing writes-she then with you talk-her
1453 [One minute she writes something then she will talk]
1454
1455 Pt:
1456
1457 باشه
1458 [ok]
1459
1460 Dr: Ok in regards to having an operation I will need to speak with the neurosurgeons
1461 in the other room.
1462 ميگه در رابطه با عمليات بايد با اين جراح هاي اعصاب در اين اتاق کناري گپ بزنم.
1463 Mige dar rabete ba amaliyat bayad ba in jarrahhaye-asab dar in otagh kenari gap-
1464 bezanam
1465 Says in regards to operation must with this neuro-surgeons in room next talk-I
1466 [she says regarding operations I need to talk to the neurosurgeons in the next room]
1467 Pt:
1468 خُب
1469 [Ok]
1470
1471 Dr: There are many things to consider when having an operation for this type of pain.
1472 Sometimes it does not always fix the problem and sometimes things like
1473 physiotherapy can help more. But I'm still going to have a talk to them about it.
1474
1475
1476 ميگه من به هر حال ميرم باهاشون گپ بزنم ولي در رابطه با مشکلات اينطور که شما دارين، وقتي که صحبت
1477 عمليات، گپ عمليات ميشه، عمليات ممکنه مثلا فيزيوتراپي بهتر باشه از عمليات. شايد فيزيوتراپي بيشتر کمك بکنه
1478 از عمليات ولي من به هر حال ميرم دربارش گپ ميزنم.
1479 Mige man be-har-hal miram bahashoon gap-bezanam vali dar-rabete ba moshkelate
1480 intor ke
1481 Says I however go-I with-them talk-I but in-regards-to problems like-this that
1482 Shoma darin, vaghti-ke [28]sohbat-e amaliyat, [29]gap-e amaliyat mishe,
1483 You have-you-polite, when talking-of operation(Persian), talking-of operation (Dari)
1484 amaliyat momkene masalan fizioterpay behtar bashe az amaliyat.
1485 Operations may-be for-example physiotherapy better-be from operations
1486 Shayad fizioterapy bishtar komak-bekone az amaliyat
1487 May-be physiotherapy more help-do from operations
1488 vali man be-har-hal miram darbarash gap-mizanam
1489 but I any-way go-I about-it talk-I
1490 [she says however I go talk (Dari dialect) with them but in regards to problems like
1491 this that you have, when talking(Persian dialect) about operations, talking(Dari
1492 dialect) about operations, operations may be, for example physiotherapy would be
1493 better than operations. May be physiotherapy help more than operations but anyway I
1494 will talk (Dari dialect) about it with them]
1495 patient:
1496 خُب

[28] Persian expression used by interpreter for talking
[29] Dari expression used by interpreter for talking

1497 [Ok]
1498 (interpreter did not transfer patient's confirmation to the doctor)
1499
1500 Dr: Do you have any other medical problems at all, such as with your heart or your
1501 lungs or anything?
1502
1503 میگه شما هیچ مشکل صحي دیگه اي ندارین؟ شش شما خوبه یا قلب شما خوبه مشکلي نیست؟
1504 mige shoma hich moshkel-e [30]sehi digeyi na-dar-in? shosh-e shoma khoob-e
1505 says(she) you any problem-of health other not-have-you(polite)? Lung-of you good-is
1506 ya ghalb-e shoma khoob-e moshkel-i ni-st?
1507 Or heart-of you good-is problem-any is-not?
1508 [she says do you have any other health problem? Your lungs or heart is good, no
1509 problem?]
1510
1511
1512 نه شش و قلب خوبه مشکل نداریم اما دیابتیز، قندمون بالا هستّه تابلت میخوریم
1513
1514 na shosh o ghalb khoob-e moshkel nadar-im ama diabetes, ghand-e-moon
1515 no lung and heart good-is problem not-having-we but diabetes, suger-of-ours
1516 bala hasta tablet mikhor-im
1517 high is tablet take-we
1518 [no, lungs and heart are good, not problem but diabetes, our sugar is high, we take
1519 tablets
1520 Int: she hasn't got any problem with her lungs or heart but he's on tablets for diabetes
1521 Doctor: Yeah, what tablets?
1522 چه تابلت، چه گلي میخورین؟
1523 che tablet, che goli mikhorin?
1524 What tablet(English name), what [31]tablet(Dari expression) take-you-polite?
1525 [what tablet(Eng), what tablet(Dari) do you take?]
1526 no answer from patient. (1 second silence)
1527 interpreter asks again
1528
1529
1530 گلي قند چي میخورین؟
1531 [32]goli-ye ghand chi mikhor-in?
1532 tablet-of sugar what take-you-polite
1533 [what diabetes tablet do you take?]
1534
1535 Patient (to his son):
1536 گلي قند چي بود نامش؟
1537 goli ghand chi bood nama-sh?
1538 Tablet diabetes what was name-its?
1539 Diabetes tablets, what was its name?
1540 Patients' son (in English): I think it was Dymocrine or Dympcrine, something like
1541 that

[30] Dari term used by interpreter
[31] Dari term used by interpreter
[32] Dari expression is used by interpreter

1542 Dr: Dymocrine?
1543 Pt:
1544 دو دانه بود يكي ديگش؟
1545
1546 do dana bood yeki-diga-sh?
1547 Two piece was another-one-its
1548 [There were two, what was the other one?]
1549
1550 Dr: Dyformen?
1551 Patient's son: Yeah
1552
1553 Int (to Dr): There were two tablets
1554 Dr: Dyformen?
1555 Int:
1556 Dyformen بود؟
1557 Dyformen bood?
1558 Dyformen was?
1559 [was it Dyformen?]
1560
1561 Pt:
1562 ها Dyformen بود
1563 ha, Dyformen bood
1564 yeah Dyformen was
1565 [yes, it was Dyformen]
1566
1567 Pt:
1568 بله
1569 [yes]
1570 Int: Yes
1571
1572 Dr: Are you on other tablets at all for anything else?
1573 Int:
1574 هيچ گلي ديگه اي ميخورين براي هيچ مرض ديگه ؟ هيچ مشكل ديگه؟ يا فقط همين پانادول و اين؟
1575
1576 hich goli digeyi mikhorin baraye hich maraz-e dige?
1577 Any tablet other take-you-polite for any disease-of other?
1578
1579 Hich moshkel-e dige? Ya faghat hamin Panadol va in?
1580 Any problem-of other? Or only this Panadol and this?
1581
1582 [Do you take any other table for any other disease? Any other problem? Or taking
1583 only Panadol and this one?]
1584
1585 Pt:
1586 نه غير پانادول ديگه هيچ چيز نخوردم
1587
1588 na gheyr-e Panadol dige hichchiz na-khord-am
1589 no except-of Panadol else nothing not-take-I
1590 [No except Panadol I did not take anything else]
1591 Int: Nothing except Panadol

1592
1593 Dr: How much are you taking for the pain?
1594 Int:
1595 چقدر پانادول میخورین برا درد؟
1596 cheghadr Panadol mikhorin bara dard?
1597 How-much Panadol take-youpolite for pain?
1598 [How much Panadol are you taking for the pain?]
1599 Pt:
1600 فقط شبي كه درد بگيره زياد، باز از همو ميخورم
1601
1602 faghat shab-i ke dard–begir-e ziyad baz az hamoo mikhoram
1603 only night-any that pain-get-s a lot again from that take-I
1604 [only the nights that there is a lot of pain, I take Panadol]
1605
1606 Int: When there's a lot of pain at night then I take Panadols
1607
1608 Dr: Are you taking anything else for the pain?
1609 Int:
1610 چيز ديگه اي برا درد ميخورين؟
1611 chiz-e digeyi bara dard mikhor-in?
1612 thing-of other for pain take-you polite
1613 [are you taking anything else for the pain?]
1614 Pt:
1615 نه
1616 [no]
1617 Int: No
1618
1619 Dr: Ok. I'm just going to write down the results of your last scan, ok? And then I go
1620 talk to the doctors out there
1621 Int:
1622 الان نتيجه عكس شما را از دفعه قبل نگاه ميكنه بعد ميره با اين داكتر هاي اتاق كناري گپ ميزنه
1623 alan natije-ye aks-e shoma ra az dafe-ye ghabl negah-mikon-e
1624 now result-of image-of you from time-of previous look-she
1625 bad mire ba in dakter-ha-ye otagh kenari gapmizan-e
1626 then go-she with this doctor-s-of room next talk-she
1627 [now she is going to look at your results from last time and then she will go talk to the
1628 doctors in the next room]
1629 Pt:
1630 باشه
1631 [Ok}
1632 Doctor's pager started beeping,
1633 Dr: Alright sometimes whilst I wait for them there's a little bit of a wait I'm sorry but
1634 at least I get to speak with the surgery consultants about it, Ok?
1635 Int:
1636
1637 ميگه يك كم ممكنه صبر كنين يك كم طول بكشه ولي با جراحش گپ ميزنيم
1638 mige yek-kam momkene sabr-koni-n yek-kam tool-bekesh-e
1639 says-she little-bit may-be wait-you little-bit take-long-it
1640 vali ba jarrah-esh gap-mizan-im
1641 but with surgeon-its talk-we

1642 [she says may be you wait little, it may take a bit of time but I talk to its surgeon]
1643
1644 Patient:
1645 باشه
1646 [Ok]
1647 Int: Ok
1648 Dr: Ok?
1649
1650 Dr: But stay here
1651 Int:
1652
1653 همینجا صبر کنین همینجا باشین
1654 haminja sabr-konin haminja bashin
1655 here wait-you polite here be
1656 [wait here, stay here]
1657
1658
1659
1660 Doctr about beeping her pager
1661 I'm not sure about this, I just have to take the calls for a while
1662
1663 12 minutes patient waited in the consult room with his son and interpreter. The patient
1664 initiated talking to the interpreter about his back pain…
1665 Patient addressed the interpreter:
1666
1667 از ٢٠٠٦ که ما همینجا میاییم تا بحال فقط اینها پرسان میکنند تا به حال نشده حالي خوب نمیشه این رقم
1668
1669 [since 2006 that we come here; so far they only ask questions. There has never
1670 been…, such things do not get well]
1671
1672 پارسال قرار بود که عمل کنن من پیش از این عمل من رفتم ایران
1673
1674 [last year they were supposed to operate but prior to the operation I went to Iran]
1675
1676 Int:
1677 آها
1678 [aha]
1679 Pt:
1680
1681 ایران رفتم در اونجا باز یکي از همین دوستاي ما گفت این یك تجربه کاره داکتر نیست درباره همي دیکس کمر باز
1682 شماره داد در او زنگ زدیم
1683 [When I went to Iran, a friend of mine said there is an experienced person but he is
1684 not the doctor, in relation to the back disk, he gave his number to ring]
1685
1686 Pt:
1687
1688 باز او گفت تو در کجا هستي من گفتم من فلان جا هستم گفت ما میایم همونجا
1689
1690 [He asked where are you? I said I am in such and such place. He said I will come
1691 there]

1692
1693 Pt:
1694
1695 خانه دوستاي ما بود همونجا آمد زانوي ما بسيار درد ميكرد
1696 [It was my friend's house, he came there; my knee was in a lot of pain]
1697
1698 Pt:
1699
1700 باز او گفت ۳۰۰ گرام دنبه گوسفند و نميفهمم ديگه چي بود خرما چند گرم خرما گفت مخلوط كن. سه تقسيم كن
1701 ۳۰۰ گرام را سه روز مصرف كن. ٢٤ ساعت ٢٤ ساعت بعد از او كه اين خلاص شد در من زنگ بزن.
1702 [he said mix 300 grams of lamb's fat, and other ingredients that I can't remember,
1703 with the dates. Divide the mixture into 3 portions; use one portion for each day, for
1704 24 hours. When they all finish, call me.
1705
1706 باز من ميايم در جا ميكنم اين بند را.
1707 [Then I come to fix the bone]
1708 همون را كرديم باز اين آمد بند را در جا كرد. از همو بعد راستي كم ذره كه خوب شد
1709 [I did that, he came and fixed the bone. After that truly it was a bit better]
1710
1711 دو ماه بعد از او اينجا آمدم. اينجا كه آمدم باز مرا راهي كرد در يك سري معاينه ماشين كه ميندازه اينجا
1712 [Two months later I came here. They sent me to those examining machines]
1713
1714 از اون صبايش پيش داكتر كه آمديم گفت تو از پارسال به ذره بهتر شدي. گفتم بهتر شدم؟ گفت آره.
1715 [In the morning when I came to see the doctor, he said you are a bit better compared
1716 to last year. I said, "I am better?", he said, "yes"].
1717
1718 گفتم درد همو اضافه هست راستي كه اينطور درد ميكرد اين كون پايم هيچ گشته نميتانستم
1719 [I said the pain has increased. Truly my heel was so painful that I could not walk]
1720
1721 Int:
1722
1723 بله
1724 [Yes]
1725 Pt:
1726
1727 پس من گفتم درد خو هسته گفت نه اگه درد هسته همي كمرت از پارسال كه خوبتون
1728 [then I said the pain exists, he said, "if the pain exists but your back is better than last
1729 year".
1730
1731
1732 باز من خيلي خوش اومدم و گفتم در جاي شده چون او همي داكتر مث اين نيه كه عكس بگيره و عكس را سيل كنه
1733 نه؟
1734 [Then I was happy and thought that the bone is fixed to its place; because he was not
1735 like this doctor to take x-ray and look at it, right?]
1736
1737 او فقط از پشت پوست با دست خود سعي ميكرد همون در جاي كند
1738 [he only tried to fix it by touching it behind the
1739 Int:
1740

1741 صحيح
1742 [correct]
1743
1744
1745 دگر ما خوش شدم گفتم خوبه دیگر ايي اگر میخواي فیزیو بده من در فیزیو برم
1746 [Then I was happy and said that is great, if you want, give me physio sessions to
1747 attend]
1748
1749 بعد همون تمرينات را انجام میدادم تا بحال. ولي باز درد کمرم اضافه شده سوخت میکنه
1750
1751 [then I was doing the exercises up until now but my back pain increased, it is a
1752 burning sensation]
1753 Int:
1754
1755 بله
1756 [yes]
1757
1758 Pt:
1759
1760 يكي درده يكي ميسوزه. اين كه ميگردم سوزش دارد در يك خط. از همو خاطر من فكر كردم اگر اينه عمل نكنم
1761 نخواهم خوب شوم
1762 [one is in pain, the other is burning sensation. When I walk I have burning sensation
1763 in one line. That is why I thought if I do not operate I will not get better]
1764
1765 Int:
1766
1767 بله صحيح
1768 [Yes, correct]
1769
1770 Int:
1771
1772 من فكر كنم چترم را بيرون جا گذاشتم برم بيارم
1773 [I think I left my umbrella outside, I'll go get it]
1774
1775 5 minutes later the doctor is back to the consultation room and interpreter is back to
1776 the room.
1777
1778 Dr: Sorry about the wait. Could I ask you to come into one of the other rooms? One of
1779 the registrars going to talk to you about having a procedure done
1780 Int:
1781
1782 ميگه يكي از اين كسايي كه مث خودش رجيسترار هستن تو اتاق كناري ميخواد كه راجع به عمليات و كارهايي كه
1783 انجام بشه باشما گپ بزنه.
1784
1785
1786 Mige yeki az in kasayi ke mese khodesh registrar hastan too otagh kenari mikhad
1787 Says-she one of this persons who like herself registrar are in room next wants
1788 Ke rajebe amaliyat va kar-hayi ke anjam-beshe ba shoma gap-bezane
1789 That about operations and things that to-be-done with you talk

1790 [She is saying one of those who are like her, a registrar, in the next room wants to talk
1791 to you about the operation and things to be done]
1792 Pt:
1793
1794 بله
1795 [yes]
1796 Int:
1797 بیاین شما این اتاق دیگه
1798 biyayin shoma in otaghe-dige
1799 come-you-polite you this room-another
1800 [You come to the other room]
1801 Pt:
1802 خُب باشه
1803 khob bashe
1804 ok ok
1805 [Ok ok]
1806
1807 Dr: Yeah?
1808 Int: Yeah
1809
1810 Int: My time is actually up unless you talk to the interpreter's office and they approve
1811 it.
1812 Dr: we just need you for the consent at least, yeah.
1813 Interpreter: My time was up by 20 minutes ago. So if you don't mind contacting the
1814 interpreter's office and letting them know?
1815 Dr: OK, We absolutely swamped at the clinic, what do I call?
1816 Interpreter: I think interpreters' office.
1817 Dr: what is that?
1818 I don't know. That's in the Smith's hospital
1819 Dr: OK, Can I call them after? At least we just bring you around
1820 Interpreter: Yeah
1821 Dr: Yeah, I'm happy to give them a call.
1822 Conversation after seeing the HP's colleagues
1823 Dr: we are also going to get another X-ray and another MRI scan of the back because
1824 the last scan you had was 12 months ago now
1825
1826 Int:
1827
1828 خب یه اسکن دیگه، یه عکسبرداري دیگه از پشت شما و یه ام آر آي دیگه انجام میدن چون آخریش یکسال پیش بوده
1829
1830 khob, ye skan-e dige ye aksbardariye dige az posht-e shoma va ye MRI dige
1831 ok, one scan-of other one X-ray other from back-of you and one MRI other
1832 anjam-mid-an chon akharish yek sal pish boodeh
1833 will-do-them because last-one one year ago has-been
1834 [Ok, they will do another scan, another X-ray and another MRI because last one was
1835 one year ago]
1836 Patient
1837
1838 بله
1839 [yes]

1840
1841 Doctor: Yeah?
1842 Interpreter: Yeah
1843
1844 Doctor: good. Mmmm, let me just look something on that. Alright, I shall organise
1845 these scans for you to have at outpatient and you'll be put on a waiting list for the
1846 operation; in the meantime if the operation doesn't come back we'll see you again in
1847 clinic.
1848
1849 Int:
1850
1851 میگه که اسم شما را تو لیست انتظار براي عملیات میذارن و این براي شما جور میکنه که این عکسبرداري و ام آر آي
1852 انجام بشه. براي شما یه وقت دیگه میذارن که اگر تا اونموقع نوبت عملیات شما نشد شما را ببینن اینجا.
1853 Mige ke esm-e shoma ra too list-entezar baraye amaliyat mizar-an
1854 Says that name-of you in waiting-list for operation will-put-them
1855
1856 Va in baraye shoma jooro-mikone ke in aksbardari va MRI anjam-beshe
1857 And this for you organise that this X-ray and MRI to-be-done
1858
1859 Baraye shoma ye vaght-dige mizar-an ke agar ta oonmoghe nobat-e
1860 For you one appointment-other organise-them that if till that-time turn-of
1861
1862 Amaliyat-e shoma na-shod shoma ra bebinan inja
1863 Operation-of you not-become you see-they here
1864
1865 [she says your name will be put on a waiting list for the operation and this will
1866 organise the X-ray and MRI for you to be done. They will make another appointment
1867 for you, if the operation doesn't come, they will see you here]
1868
1869 Pt:
1870
1871 بله
1872 bale
1873 yes
1874 [yes]
1875
1876 Int: That's right
1877
1878 Dr: Good. Now no metal in the body anywhere?
1879
1880 Int:
1881 شما هیچ چیز فلزي در بدن شما تو تن شما نیست، ها؟
1882
1883 shoma hich felezi da banad-e shoma too tan-e(synonym for body) shoma nist, ha?
1884 You no metal in body-of you in body-of you isn't, ha?
1885 [There isn't any metal in your body, inside your body, yeah?]
1886 Pt:
1887
1888 نه
1889 [no]

1890
1891 Int: No
1892
1893 Dr: No pacemaker?
1894
1895 Int:
1896
1897 باتري قلب ندارين؟ پیس میکر، نه؟
1898 batri-ye ghalb nadarin? Pace-maker, na?
1899 battery-of heart not-have-you-polite? Pacemaker, no?
1900 [you don't have heart battery? Pacemaker, no?]
1901 Pt:
1902
1903 نه
1904 [no]
1905 Int: No
1906
1907 Dr: Ok, no clips or coils in the brain?
1908 Int:
1909 توي سرتون هیچ کلیپس و هیچ وسیله فلزي تو سر شما نیست؟ تو مغزتون، ها؟
1910 tooye sar-etoon hich clips va hich vasileye felezi too sar-e shoma nist?
1911 In head-you-polite no clips and no equipment-of metal in head-of you isn't?
1912
1913 Too maghz-etoon?
1914 in brain-your-polite
1915
1916 [In your head no clips and no metal equipment in your head? In your brain, yeah?]
1917
1918 Pt:
1919 نه
1920 [no]
1921 Dr: No metal in the eye?
1922
1923 Int:
1924 هیچ چیز فلزي تو چشم شما نیست؟
1925 hich chiz-e felezi too cheshme shoma nist?
1926 No thing-of metal in eye-of you isn't?
1927 [no metal thing isn't in your eyes?]
1928
1929 Pt:
1930
1931 نه
1932 [no]
1933
1934 Int: No
1935
1936 Dr: Good, OK I'll organise these for you, make your appointment and then you'll be
1937 contacted regarding the procedure, ok?
1938
1939 Int:

1940 در رابطه با عملیات با شما تماس میگیرن. الان این وقت رو تو بیرون باید بگیرین
1941 dar-rabete-ba amaliyat ba shoma tamas-migiran.
1942 In relation to operation with you-polite will-contact-they
1943
1944 Alan in vaght ro too biroon bayad begirin
1945 Now this appointment in outside must take-you-polite
1946
1947 [In relation to the operation they will contact you. Now you need to make this
1948 appointment outside]
1949
1950 Pt:
1951 بله، باشه، چشم
1952 [yes, ok, sure]
1953 Dr: Ok, alright
1954 Pt:
1955
1956 خب اگه ما بریم دگر خب خبري میکنن ما را دگر؟
1957 khob age ma berim degar khob khabari-mikonan ma ra degar?
1958 Ok if we go-we again ok inform-them we again?
1959
1960 [ok, if we go would they inform us again?]
1961
1962 Int: Would they be sending a letter in mail?
1963
1964 Dr: Yes
1965 Int:
1966 بله براي شما کاغذ روان میکنن
1967 baraye shoma kaghaz ravan mikonan
1968 for you-polite letter send-they
1969 [they will send you letter in mail]
1970 Pt:
1971
1972 يك جان تشكر
1973 [thank you very much]
1974 Int: Thank you very much
1975 Dr: Pleasure
1976 Pt: Thank you
1977 Dr: Lovely to meet you
1978 Doctor to interpreter: Thanks for your help
1979 Dr: Now you’ve got your appointment?
1980 Pt: Ok.
1981 Dr: Good, see you later, bye bye
1982
1983

Appendix 3 – Excerpts of interpreter mediated communication in Italian

1 **Italian Transcripts Triad conversation** | = *symbol of overlapping utterances*
2
3 Dr: How are you (patient's first name)?
4
5 Int:
6 Come si sente signora?
7 [how are you feeling, madam?]
8
9 Pt:
10 insomma tiriamo avanti ma non sono troppo bene!
11 [I'm ok- I'm going forward but I'm not fantastic]
12
13 Int:
14 dove ti fa male signora?
15 [Where are you hurt, madam?]
16
17 Pt:
18 dove so fatta l' operazione …
19 [Had an operation]
20
21 Int:
22 dove al ginocchio
23 [Where? (knee)?]
24
25
26 Pt:
27 Ginocchio, si ho fatto il totale al 2001
28 [Had an operation on my knee in 2001]
29
30
31 Int: I had a knee replacement in 2001, but I'm still having problems with my knee
32
33 Pt:
34 duemila uno? (asking her husband)
35 2001?
36
37 Dr: Ok, alright, what about your back?
38 Int:
39 Come va la schiena signora?
40 [How is your back, madam?]
41
42 Pt:
43 insomma non e' che e' tanto bene
44 [not too good]
45

46 Int: No, my back is sore as well
47
48 Dr: Ok, that's the main reason for you to come here, right?
49
50 Int:
51 Signora, lo scopo della visita oggi e' perche' ha tanti problem con la schiena
52 [Madam, the scope of today's visit is due to problems with your back]
53
54 Pt:
55 Si
56 [Yes]
57 Int: Yes, that's correct
58
59 Dr: Ok, so your knee pain, it's only the knee pain or pain coming from the back going
60 like that to the knee?
61
62 Int:
63 il dolore cominicia dalla schiena, signora?
64 [Does the pain start in your back]
65
66 Pt:
67 tante volte mi comincia dal ginocchio
68 [a lot of times my pain starts from my knee]
69 Pt continues:
70 poi il dolore va dalla schiena ma non sempre alla schiena
71 [Then my pain goes to my back but not all the time]
72
73 Int asks the Pt:
74 alla schiena
75 [in the back]
76 Pt (replies to the Int):
77 non sempre, ma quando lo sforzo allora mi fa male la schiena
78 [not all the time but when I force it my back hurts]
79 Pt to Int:
80 pero di solito il dolore inizia al ginnochio e si trasferisce alla schiena
81 [but I think initially starts at my knee and then the pain goes to my back]
82
83 Int:
84 Pero'non sempre]
85 [but not all the time]
86
87 Pt:
88 non sempre
89 [not all the time]
90
91 Int: Ok, usually the pain starts in my knee and goes to my back however this is not
92 always the case but in most instances it is
93 Dr: Ok.
94 Pt:
95 perche forse lo sforzo molto perche' il peso c'e' l'ho

96 [because I strain it a lot as I'm quite overweight]
97 Int: But if I strain myself because I'm quite overweight, I do get back pain
98 independent of the knee (this is the added information by the interpreter)
99
100 Dr: Ok. Which is the most problematic issue here, is it the knee pain or back pain?
101
102 Int:
103
104 cosa ti da piu' fastidio signora il ginocchio or la schiena?
105 [Which hurts most? Madam? Your knee or your back?]
106
107 Pt:
108 veramente tutte e due
109 [Truthfully both]
110
111 Pt:
112 a volte mi female anche il femore mi fa male anche il femore
113 [At time the femur hurts as well]
114
115 Int: Ok, basically they're both quite painful also sometimes I have pain in my femur
116
117 Dr: Ok. Alright, umm, do you have any tingling in your feet?
118
119 Int:
120 I tuoi piedi ha qualche sensazione strano ai piedi
121 [Your feet, do you have any strange sensation in your feet?]
122
123 Pt: No
124 Int: No
125
126 Pt:
127 Oh Dio! di notte mi brucia e non riesco neanche a dormire di notte
128 (oh Dio! This might make a point about exclamation Oh God! Which Italians use a lot)
129 [Oh God! In the night it burns and sometimes I cannot even sleep]
130
131 Pt continues:
132 ma il giorno ho movimento e non mi fa male
133 [but in the day my movements it's ok]
134
135 Int: I had burning pain in my feet at night but during the day I'm ok.
136
137
138 Dr: Ok, what about the left leg, any symptoms there?
139 Int:
140 la gamba quella sinistra fa male signora?
141 [Your left leg, does it hurt?]
142
143 Pt: Quella operata?
144 [The one operated?}]
145

146 Pt:
147 magari tutte e due i piedi di notte scusa della
148 [both feet at night, sorry for that]
149 Pt continues:
150 mia espressione di notte mi bruciano e non riesco neanche a dormire
151 [At night it burns and I cannot sleep]
152
153 Int:
154 pero le gambe tutte e due
155 [so are you saying both legs?]
156
157 Pt:
158 no quando sono riposata sto bene non mi fa male quando sto riposata quando
159 cammino solo che mi bruscia si le dita ma io cio la diabete anche forte
160 [No, when I'm rested I'm better; it does not hurt me when I'm resting; when I'm
161 walking my toes are burning because I have high level diabetes]
162
163 Int: Ok
164 Pt : Scusa chiedo scusa forse e' causata dalla diabete?
165 [sorry I apologise maybe it's caused by diabetes?]
166
167 Int: My diabetes is actually quite high so I don't know if the burning I have in my toes
168 is due to the diabetes
169
170 Dr: Ok, so no similar symptoms like the right knee pain on the left side?
171 Int:
172 quindi con il ginocchio quello sinistro non e' chef a male come quello destro?
173 [then with the left knee, does it hurt like the right one?]
174 Pt: No
175 Int: No
176
177 Dr: Ok, and do you have any numbness in your thigh?
178 Int:
179 le cosce sono dormentate signora?
180 [Is your legs asleep madam?]
181
182 Pt: No
183 Int: No
184
185 Dr: And does your pain increase after you walk?
186 Pt: si
187
188 Int:
189 Quando camina le fa piu male?
190 [when you walk does it hurt more?]
191
192 Int:
193 yes
194
195 Dr: Is that the knee pain that increase or pain going like this?

196
197 Pt:
198 non mi fa male qua
199 [no it hurts here]
200
201 Pt:
202 qua chiedo scusa non e proprio qua, mi fa male e a volte mi blocco e non riesco
203 camminare
204 [here I'm sorry no it's right here, this is where it hurts, it locks up sometimes and I
205 can't walk]
206
207 Int:
208 Quindi si deve fermare?
209 [So you have to stop?]
210
211 Pt:
212 Questo si fai fermare?
213 [this is where I need to stop?]
214
215 Pt:
216 si, si
217 [Yes,yes]
218
219 Int: There, there, so then I have to stop because the pain in my knee is severe so I
220 have to stop walking
221
222 Dr: Ok and this pain that you had in your knee, did it improve after surgery or?
223 ... same or worse?
224
225 Int:
226 dopo si e' fatta l'operazione al ginocchio signora il dolore ha migliorato o e' rimasto
227 ugale?
228 [after you had your operation did the pain get better or stay the same?]
229
230 Pt:
231 no, no, ha migliorato di tanto
232 [no, no, it is better, a lot better]
233
234 Int: No, no, it improved quite dramatically
235
236 Dr: So how much of that pain do you still have?
237 Int:
238 prima… il dolore prima di avere di farsi l'operazione a rispetto adesso e
239 [before… the pain before having the operation, is now]
240 Int:
241 aumentato di piu, di meno
242 [now is it better or worse?]
243
244 Pt:

245 non c'e paragon
246 [there is no comparison]
247
248 Int:
249 molto meglio?
250 [it is better?]
251
252 Pt:
253 si, molto meglio
254 [Yes, it is better]
255
256 Int: It's actually much better, although I have pain now it's better than before I had
257 the surgery
258
259 Dr: Ok
260
261 Int: It was worse before I had the knee done
262
263 Dr: Ok that's very good. Ok, as far as your back is concerned I'll just do a few
264 examinations
265
266 Int asks Dr: Does she need to take off her jacket?
267 Dr: Yeah, that's fine
268
269 Dr: Ok, oh yeah this is the big operation
270
271 Pt:
272 Yes, si
273 [yes, yes]
274
275 Dr: Ok just keep it bent
276
277 Int:
278 piega il ginocchio signora
279 [bend your knee, madam]
280
281 Dr: You can sit back a bit to be comfortable
282
283 Int to Dr: You want her to sit down, doctor?
284 Dr to Int: Oh no, that's ok, she can sit there
285
286 Dr to Pt: I just tap your knee
287
288
289 Dr: Keep it bent
290 Int:
291 piega il ginocchio
292 [bend your knee]
293
294 Dr: Just like this, yeah.

295
296 Dr: Just let go
297
298 Dr: Leave it loose, leave it loose
299 Int:
300 scioglia scioglia
301 [relax relax]
302
303 Dr: Yeah, that's good, that's good
304
305
306 Dr: Relax, push down a little bit, little push, little push
307 Int:
308 Giu, un po'po' po'
309 [down]
310
311 Dr: Yeah, that's good, that's good
312 Dr: Straighten your leg, …
313
314 Int:
315 dritta la con la gamba signora
316
317 [straighten your leg]
318
319 Dr: Straighten your leg, …
320 Int:
321 dritta dritta
322 [straight, straight]
323
324 Dr: Keep it straight, … straight
325 Int:
326 lascia la gamba dritta
327 [leave your leg straight]
328
329 Int:
330 l'altra gamba dritta
331 [other leg, straight]
332
333 Dr: Can you stand up?
334 Int:
335 si alza in piedi, signora
336
337 [stand up, madam]
338
339 Dr: Ok
340 Pt:
341 scusa
342 Int: I lose my balance
343
344 Dr: I'll hold you

345 Int:
346 il dottore ti reggi, sinora
347 [The doctor will hold you, Madam]
348
349 Dr: Stand on your toes
350 Int:
351 fa come il dottore signora
352 [Please do what the Dr. is doing]
353
354 Pt:
355 scusa
356 [sorry]
357 Int: That's ok signora
358
359 Dr: That's enough, enough, do that
360 Int:
361 fa cosi…. Signora
362 [do this…., Madam]
363
364 Dr: I hold you, I hold you. Don't worry you won't fall down
365 Int:
366 il dottore ti reggie non cade non cade
367 [the doctor will hold you, you won't fall you won't fall]
368
369 Dr: Ok, that's enough
370
371 Dr: You want to sit down? Yeah?
372 Int:
373 si siede signora
374 [please sit Madam]
375
376 Patient: Thank you very much
377
378 Dr: Ok, no problems
379
380 Dr: So…., you're supposed to have an MRI scan, do we know what happened to that?
381
382 Int:
383 signora, si e' fatto la MRI scan?
384 [Madam, have you done an MRI?]
385
386 Pt:
387 si, si
388 [yes, yes]
389
390 Int to Pt:
391 qui a Smith's?
392 [here at Smith's?]
393
394 Pt: no no a Smith's li' a Werribee

395 Int to Pt:
396 Mai quindi, i risultati la copia ha il suo dottore di famiglia
397 [but have your family doctor given you a copy?]
398
399 Int to Dr: I think they brought the MRI
400
401 Dr: Sorry, ok, I didn't see that
402
403 Dr: Where did they have the MRI?
404 Int: At Werribee they had it near where they live. They didn't have it here at Smith's
405 but they have that one
406 Dr: Ok. That's ok, that's not a problem
407
408 Dr: There's no MRI.
409 Int:
410 non c'e' la copia della MRI
411 [No, there is no copy of the MRI]
412
413 Dr: Only X-rays
414 Int:
415 sono solo non la tak, si la tak
416 [it's only you haven't put the form in the CT Scan]
417
418 Int to Dr: Apparently she didn't have the MRI but I don't know (changes to third
419 person)
420
421 Dr: When was that done?
422 Int:
423 Quando si e' fatta il tak?
424 [When did you do the X-ray?]
425
426 Pt: qualche mesi
427 [a few months ago]
428
429 Int: A few months ago
430
431 Dr: A few months ago, where was that done?
432
433 (Int prompting Pt)
434 Int to Pt: At Werribee
435
436 Pt: Werribee
437 Int to Dr: Werribee
438
439 Dr: Ok, you can keep this, because this letter says you did have a CT scan. After the
440 MRI scan did they give you a disk? CD?
441
442 Int:
443 il disco dopo?
444 [the disk after?]

445 Pt is silent, not answering the question.
446
447 Int to Dr: I think she had the CAT scan; she is confused
448 Dr to Int: Oh, yeah, she had that two years ago.
449 Int to Dr: The CAT scan?
450
451 Dr: Yeah, after that we had seen her and asked for an MRI scan
452 Int to Dr: But apparently she doesn't have a disk
453
454 Dr to Pt: We'll have to look at your back to see if that is the reason for your Problem.
455 I wouldn't think so but better to check that out
456
457 Int to Dr: So, she'll have another MRI scan
458 Dr to Int: No, same MRI, we'll have a look at that
459
460 Int to Dr: Ok, so does she need to do another MRI scan?
461 Dr to Int: No, the same MRI scan we need to look at that
462
463 Int:
464 Ok, avete una coppia del disco
465 [Ok, have you got a copy of the disc]
466
467 Int: (turning to Dr) They don't have a copy
468 Dr: yeah, all they need to do is call them and tell them to give them the CD
469 Int: va dove la signora si e' fatta lo scan e e si fa dare un copia del disco
470 [when you had your scan, can you pleas ask them for a copy of the disc?]
471
472 Int to Dr: There's some confusion as to they don't remember where they did the scan
473 now
474
475 Int: I wasn't given anything after I had /my wife had the procedure so I don't know if
476 she should have another one
477
478 Dr: Did you go through a tunnel?
479
480 Pt:
481 si si la tunnel
482 [Yes, yes tunnel]
483
484 Pt: Yeah
485
486
487 Dr: And how long did they have the scan? For how long?
488 Int:
489 per quanto tempo e' rimasta nella galleria, signora?
490 [How long you had your scan, Madam?]
491
492 Pt:
493 un paio di minuti
494 [a few minutes]

495
496 Int: A few minutes, I just went in and out
497
498 Dr: No half an hour?
499 Int:
500 no mezz' ora?
501 [not half hour]
502
503 Pt: No, no
504
505 Dr: Was it noisy?
506
507 Int:
508 tanto rumore?
509 [was it noisy?]
510
511 Pt:
512 si, si, tanto rumore, ma praticamente non sono la'per mezz' ora
513 [yes, yes, very loud but I wasn't there for half hour]
514
515 Int: I wasn't there for half an hour, I just went in and I went out straight a way
516
517 Pt:
518 un paio di minuti
519 [Only few minutes]
520
521 Int: It was a matter of few minutes
522
523 Dr: Specific question, was that like a donut or was that like a tunnel?
524
525 Int:
526 Era un forma di ciambela?
527 [The shape like doughnut?]
528
529 Pt:
530 ciambel
531 [doughnut]
532
533 Int: Yes, a doughnut
534
535 Pt:
536 alla come una ciambella, poi sono entrata dentro
537 [It was like a doughnut and then I went in it]
538 Dr laughs: OK
539 Pt:
540 perche' ride perche' ride?
541 [why are you laughing? Why are you laughing?]
542
543 Int: What was so amusing?
544

545 Dr: I was thinking about the donut, sorry, no they haven't had an MRI. Ok?
546
547
548 Int:
549 quello non e' MRI, quello e 'un altro esame
550 [This isn't an MRI, it is another test]
551
552 Dr: Which is unfortunate but there's MRI written here in 2009 so I thought you have
553 had one
554
555 Int to Pt:
556 hanno detto che s'e' l'ha fatta MRI nel 2009, pero forse e' meglio che ripetiamo e
557 facciamo un' altra
558 [they stated that you did an MRI in 2009 and they think it's best if you do another]
559
560 Int continued: pero' secondo me se le conviene e' meglio che se la fa qui perche'
561 dopo quando lei viene a vedere lo specialista tutti i risultati sono qui
562 [it is best if you do it here and when you need to see the specialist it is all here for
563 them]
564
565 Pt:
566 si e'meglo
567 [yes, it is better]
568
569 Int to Dr: I told them it's better if you have it done here so when they come to see you
570 at least the results are all online
571 Pt:
572 perche' chiedo scusa a volte mi mandano a destra e sinistra
573 [I'm sorry sometimes they send me here and there and I get confused between MRI
574 and scan]
575
576 Int: Sometimes I get them confused
577
578 Dr: That's ok, many people get confused with CT and MRI
579
580 Int: I beg your pardon, doctor?
581
582 Dr: Many people get confused with that, don't worry about that
583
584 Int:
585 non si confonde tra il tac e il MRI sono quasi uguali ma pero' c'e una differenza
586 [don't get confused because they are nearly the same but there is a difference]
587
588 Dr: So we'll do that and then see you
589 Int: Does she need to go and book her own appointment? Or does she get a letter in
590 the mail?
591
592 Dr: No, the appointment will be booked by the girls and they will send the letter
593 Int:

594 quel foglietto signora basta che glielo da alle signorine al banco, le signorine al banco
595 le faranno la prenotazione poi vi manderanno la lettera per posta. Ok? e poi lei ritorna
596 qui a farsi lo scan
597 [The form, madam, is enough for you to see the lady at the counter to organise an
598 appointment. Then they will send you a letter by post. Ok? and then they will organise
599 a scan]
600 Pt:
601 all'ospedale?
602 [at the hospital?]
603 Int:
604 all'ospedale, si, si qui a pian terreno
605 [at the hospital, yes, yes on the ground floor]
606
607 Pt:
608 io qui mi sono operata a Smith's
609 [I was operated on here at Smith's]
610
611 Dr: So, we'll get an MRI of your back done and then we'll see you, ok?
612
613 Int: So, does she need another appointment?
614
615 Dr: Yes
616
617 Int:
618 ok, allora signora, queste due glieli da alle signorine al banco questa per fare
619 l'appuntamento per lo specialista
620 [Ok, madam, these two forms are to be given to the reception and they will organise
621 appointment with the specialist]
622
623 Int:
624 e questo per fare lo scan
625 [and this to organise a scan]
626
627 Int:
628 ok?quindi facciamo questa poi ritorniamo a per vedere i risultati
629 [ok? lets do this first and return with your results]
630
631 Pt:
632 come si chiama?
633 [what is his name?]
634
635 Int: What's your name, doctor?
636
637 Dr: James
638
639 Int: Dr. James.
640
641 Dr: My name is James
642
643 Pt: Haa, James, Ok

644
645 Dr: Is your doctor Fred Sam?
646
647 Pt: Fred Sam, yeah
648
649 Dr: I'll try and I'll write a letter to him so that he also can follow up, okay?
650 Int:
651 Il dottore scrivera' una lettera per il dottore Sam
652 [The doctor is going to write a letter to your Dr. Sam]
653
654 Int:
655 e guarda quello che abbiamo discusso oggi
656 [and he'll see what we have discussed today]
657
658 Pt:
659 grazie, grazie
660 [thank you, thank you]
661
662 Pt: Thank you, thank you very much doctor (says in English)
663
664 Dr: No problem
665
666
667
668

Appendix 4 – Excerpts of interpreter mediated communication in (Lebanese) Arabic

Arabic Writing and Transcript | = *symbol of overlapping utterances*

Referered to text as Lines 3-12

Pt.:

حطوني ماسال احسنت شوي

hattooni maasaal ahsanet shoowey
(they)connected to me drip I got better a little bit
[They connected the drip for me and I got better a little bit]

Int.: a month ago I was in hospital | I was improving better in hospital |
Dr.: yeah yeah
Int.: they gave me some oxygen and also a drip

Dr: Oh good, Ok.

Pt:

ليحولّيَ منيح الحمدلله

[I am good, thank God]

Int: Yeah I'm feeling, I'm better now, thank God

Referred to text as Lines 28-41

Dr: Does she write down the result of the sugar test? | Does someone else writes it down or?
Int: ente
you

Int:
va totahos sokkari aktebi beshi' natayej sokkari
and feeling sugar-your write-you thing results diabetes-your

ala var'a awhad atiki?
on paper or someone write

[and do you write the results of your diabetes on paper or someone else writes?]

Pt.:
ana aktob
I wrote
[I wrote]

45 Int:
46 I write them myself
47

48 **Referred to Lines 52-70**
49
50 Dr: Lovely, thank you, that’s good. Has she had any low blood sugar problems that
51 we know of?
52
53 **Int:**

54 أنتِ بيسير شيء مشاكل سكري
55 anta beyasir shee mashakel sokkari
56 you changes thing problems your sugar
57

58 [you have problems in your sugar]

59 ام بينزل شيء ام يحبط كثير؟
60 om beyanzel shee om yahbet katir
61 whether coming down a thing or going up a lot
62

63 [whether going down or going up a lot?]

64 Pt:

65 لاء حلاّ
66 [not now]

67

68

69 بعد عملولي مسال
70
71 after doing the drip

72

73 لاء
74 No

75

76 Int to Dr:

77 After I had the drip, no.

78 Pt:

79
80 نزل شوي بس
81
82 [it went down a bit]
83
84 Int: Yeah, before it used to go low but at the moment no.
85

86 **Referred to Lines 90-101**

87 Dr:

88 That's great, they're good results. | They're generally between 7 and 11.

89 Int to Pt chuchutage: منيح
90 mnih
91 [good]
92 Int to Pt:
93 نتايج منيح، بين سبع و احدش، منيح
94 natayij mnih, bayn sab' vahdash, mnih
95 results good, between 7 and 11, good
96
97 [results are good, between 7 and 11, good]

98 Pt:
99 Bas amberehl belyoumain be centar be community centar
100 I went two days to centre to community centre
101 Vo talla beghabne enkhaleshna likoz amitla
102 And went up sadness we finished sugar went up
103
104 Satab'ash amitla arba'tash albathi youmaik
105 sixteen went up fourteen I have gone two days
106 Int:
107 Yesterday because we had a farewell party in the community center what happened
108 we were upset and I noticed that my sugar level went high 14, 16.
109 Dr:
110 I can see that, yes that's right.
111 Pt:
112 Roohikalam be centar be community centar
113 I will not go to centre to community centre
114 Int:
115 I won't be going for two weeks, to the community centre.

116 **Referred to text as Lines 120-142**
117 Dr:
118 I noticed there's one that she wrote as 1.2 and then said on the meter 10.2 , is that how
119 she writes 10?
120
121 Int:
122
123 Hoo betiktabi | bel ashra va sajjeli be waha?
124 There you wrote as ten and wrote as one
125 Pt (English): yeah, ten
126 Pt (Arabic):
127 لاء عشره
128 la, ashra
129
130 [No, ten]
131 Int:
132 Oh yeah that's how 10 looks like in Arabic.
133
134 Dr:
135 Ok, I get you

136
137 Pt (English):
138 sorry
139
140 Dr:
141 That's Ok. I understand. That's good then
142
143
144
145 Pt (English): Sometimes …
146 Pt (Arabic): emo taktob beomnih
147 Can't write good
148
149
150 Int:
151 Yeah, sometimes I can't write well because of my hand
152
153 Dr:
154 Yeah, alright that's good, so I think we were saying
155
156 Pt: hala arba'ata ahsra Belbait arba'ashra sabah
157 here fourteen at home forty in the morning
158
159 Int:
160 Half an hour ago it was 14 with the nurse
161
162 Pt (English):
163 Morning, tell this one; come here tell forty
164
165 Dr:
166 Yeah, Ok., is the insulin dose the same at 20 units?
167
168 Int:
169 Bada moalel insulin andek ashrin vahdi abokra?
170 So doing insulin for you 20 units morning
171
172 Pt:
173 ma ashiya be'amloon
174 at evening I do
175
176 Int:
177 Yeah I take it now in the evening
178
179 Dr:
180 Yes, what time?
181
182 Int:
183 Ay siya'a tekhziha?
184 What time you get it
185

186 Pt:
187 Themani, themani vo nos
188 Eight eight and half
189
190 Int:
191 Eight, eight thirty
192
193 **Referred to text as Lines 193-218**
194
195 Dr:
196 Yeah, alright, ok. Her eyes were tested at Westfield, I think and they were ok
197
198
199 **Int**:
200 عملت فحص بوست فيلد لعينك و كان منيح فحص فعين
201
202 Amalat fahas be westfield be aynak va kana mnih fahas
203 You did test at westfield for your eyes and was good test
204
205
206 [You had your eyes tested in Westfield and the results were good]
207
208 **Pt**:
209 Thank you الحمدلله
210
211 [Thank you. Thank God]
212
213
214 Pt:
215 Thank you (in English)
216 Alhamdolilah (in Arabic)
217
218 [Thank God]
219
220 Int.:
221 Yes, That's good
222
223 Dr:
224 Yeah, is her GP still Dr Gary?
225
226 Int.:
227 Hakim al'an ba'd doctor Gary?
228 Doctor now still doctor Gary?
229
230 Pt:
231 Bas am befakker beghayyerooh
232 But I am thinking change him
233
234 Int:
235 But I am thinking of changing him
236 Dr:
237 Yeah
238 Pt:

239 Mabesa'edni
240 Not helping me
241 Int:
242 He is not helping me much
243 Dr:
244 Oh, OK
245 Doctor's telephone rings and he talks on the telephone. The patient initiate talking to
246 the interpreter in Arabic and she switches to English. When the doctor finished the
247 telephone call, the interpreter started interpreting what the patient had said.
248 Pt:
249 Rejali am bevajni "don't worry" be olooli
250 My legs have pain "don't worry" he tells me
251
252 Sa'ali doctor taghol la 'ali sokkari sokkari mnih mnih
253 I ask doctor he tells me no it's good it'syour sugar your sugar good good
254
255 Bas sajjal swish swish
256 Only writes swish swish
257
258 (English) very good, nice, yeah"."bye bye", bye bye.
259 (Arabic) Laa,
260 no
261
262 (English) Sometime you help, you look sick people, sometime two week no come for
263 you, no you give me telephone, what has been looking your life
264 Int:
265 Yeah, the local doctor isn't really helping me much because I keep telling him I have
266 sore legs |
267 Dr: Yes
268 Int: I ask him to give me something he takes my blood pressure and he keeps
269 telling me it's ok but he thinks the pain in my legs is due to the diabetic problem I
270 have. I believe doctors should help. He should call me like every two weeks but he
271 doesn't do that.
272 Dr:
273 I can see that, yeah. Yes, that's right. Ok.
274 …..
275 Pt:
276 Pt started talking in Arabic about her previous doctor, for the sake of the research,
277 only the parts that were used for analysis will be translating from Arabic into English
278 ……..
279 Nurse comes in, ….
280 Pt to nurse in English: We miss you too much, long time no see no listen for me.
281

282 **Referred to text as Lines 295-320**
283 Pt:
284
285 بزعني دكتر ... في شي روح عندو
286 Doctor (name of Doctor) scared me about something, to go see him
287
288
289 و مش عملوني X-ray لخوف شيءوني
290 and I did not do x-ray because of the fear that it might be something

291
292 أنتم شَحِبتَه لَعَملوني X-ray - again
293 that they were going to remove by having an X-ray again
294
295 بَتَلتُم لا بَتَلتُم
296
297 I told them no, I told them
298
299 **Int** to **Pt:**
300
301 اين؟ بالمعده؟
302 **where? In the stomach?**
303
304 **Pt** to **Int:** Yeah
305
306 **Int** to **Dr:** Dr (name of Doctor) warned me a bit because I had an x-ray and he said there is
307 something wrong in your stomach and I need to go back there again
308
309 ….
310
311
312
313