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INTERCULTURAL COMMUNICATION AND INTERPRETER'S ROLES: WIDENING TAXONOMIES FOR EFFECTIVE INTERACTION WITHIN THE HEALTHCARE CONTEXT

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Abstract

Trespassing the boundary of neutrality and role adoption among interpreters have been previously studied in the public service field (Goffman 1981; Wadensjö 1998;Weiss and Stuker 1999;Farooq and Fear 2003; Angelelli 2004; Bot 2005; Leanza 2007; Hsieh 2008). However, this still remains a controversial issue

giving its high presence within interpreters' training nowadays, and the desire of hospitals to provide quality interpretation for patients when the goal is to reach an effective interaction between patients and healthcare staff, as well as promoting intercultural communication in these encounters. Studies in Spain such as Martin (2006) have highlighted the need for further research in the situation of community interpreting based on corpora which could lead to the improvement in training. The same issue is still highlighted by recent European Commission reports on medical interpreting regarding Spain among other European countries (Angelelli 2015).

The present paper aims to describe a new taxonomy established for the different roles adopted by the interpreter in the healthcare setting with face to face encounters, and the challenge of remaining neutral if success in communication is the ultimate goal. Our study offers a classification of the adopted roles within the healthcare context, an arena where feelings, emotions and delicate issues combine together making interpreting a challenging task. This research was carried out in a Spanish hospital[i]which provides face to face interpreting by a group of volunteer and professional interpreters to foreign patients in a multicultural setting. The importance of the study in the region lies in the fact that Andalusia has 87,434 of the 282,120 British residing population in Spain, according to the figures provided by the National Institute of Statistic up to January 2015[ii]. Half of these figures

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belong to Malaga province, the setting of our hospital. The aforementioned area also profits from an increase in health tourism, with several hospitals establishing partnerships with other European partner hospitals in order to receive their patients for treatment.

Keywords: interpreting, corpora, healthcare, role, encounters, taxonomy, communication, intercultural communication.

1. INTRODUCTION TO THE STUDY

1.1 Background and aims

The neutrality of the interpreter is one of the main issues currently discussed in forums, conferences and journals which deal with the standards of practice for interpreters working in the public service setting. The fact of not providing their opinion, avoiding being an advocate of one of the parties, keeping their work to a simple transfer of a message from one language to another are some of the main issues discussed in terms of neutrality (Prunč 2012, p.8).

Indeed, some previous studies have shown the lack of neutrality of the interpreter especially among

non-qualified ones (Farooq and Fear 2003); working in different fields such as police stations (Wadensjö 1998); mental health (Bot 2005) or pediatric consultations (Leanza 2007). Amongst some of the terms that have been established to describe the absence of neutrality in the interpreter's performance are: main speaker, animator, author (Goffman 1981), cultural informant or health agent (Leanza 2007), advocate for the powerless participant, or gatekeeper (Hale 2008, p. 118), among others. However, the engagement of the role of the interpreter in these types of encounters to assure a successful communicative process deserves more attention.

Although most of the codes of ethics and standards of practice emphasize the neutrality that the interpreter should adopt, the reality is often quite different. It is abundantly clear there are not strictly defined criteria on where the boundary lies in terms of the interpreter's involvement in the encounter (Roy 1993, p. 134).

However, proposals of unifying criteria in terms of standards of practice could be often directed towards promoting the invisibility of the interpreter because, as Kelly (2008, p.110) states, "the standards of practice for the profession dictate that

this would fall outside of the interpreter's role." Some authors have discussed this neutrality and invisibility (Metzger 1999; Angelelli 2004; Bot 2005). In other cases, it has been highlighted that translators should not omit, restrict or add anything to their interpretation because being faithful to form, the interpreter is acting ethically and correctly (Clifford 2004, p.92). Research literature has made clear this ideal practice stated in guidelines, which is neither possible nor desirable in the healthcare context where, as Goffman has suggested (1981, p.144) interpreters are not just active agents, but they also choose somehow those feelings that are being expressed. Meyer (2004) also claimed the lack of neutrality in his research focusing on patients and interpreters in the healthcare context.

The active role assumed by the participants in a conversation in the healthcare context has been analyzed in our study in terms of open disclosure, the process whereby practitioners engage with patients following an adverse event in hospital that has caused harm to the patient (Watson et al. 2015, p. 58), using the communication accommodation theory (Gallois et al. 2005) to investigate how health professionals and patients communicate in the specific health context of open disclosure. This

active position adopted by participants in healthcare demonstrates how "a team can work dialogically by sharing and caring collectively, and that doing so contributes to a healthier practice for all participants" (Pedersen 2012, p.541).

And finally, Bischoff et al. provided a summary of different research which has explored and classified the role of the interpreter in the public service field in order to analyse the interpreter's perception of their work, admitting that "although they start by discussing word-for-word interpreting, not least to please those health care professionals who stick to the "linguistic conduit" model, the interpreters see this as a starting point for building trust, so that they can then move towards non-word-for-word roles when necessary" (2012, p.17).

Bearing in mind aforementioned research, the aims of the study were the following:
1. The study was aimed at exploring the real practice of healthcare interpreting in a strategic setting in Andalusia as well as exploring communication challenges in order to improve quality standards.
2. To explore the work of interpreters and their strategies when facing communication challenges.

3. To adopt a multidisciplinary theoretical approach in order to gain insight into the interpreting process.
4. To examine pragmatic strategies of the interpreters' (both professional and non-professional) in order to facilitate the interaction with the service provider.
5. To learn from real practice and to take the features that work in this real practice even though they were not standardized strategies.
6. To create a wider taxonomy of the role of the interpreter which could be useful for training healthcare interpreters in further research, especially in the case of the Southern Spanish area, where tourism and healthcare tourism industry have traditionally been an important economic resource. Immigration also constitutes a powerful workforce and constitutes a significant percentage of the population (Lavado Puyol 2015).

1.2.Theoretical multidisciplinary approaches

The study has adopted a multidisciplinary theoretical approach in keeping with Hale's idea (2007, p.204) since we consider that within the research area of public service interpreting there are different factors and characteristics that merge

from different sources, thereby making it difficult to adopt one single approach. Thus the following four approaches were chosen for our study.

1.2.1 Discourse analysis theories

Medical discourse has been a matter of study for some scholars (Schiffrin et al. 2003; Fleischman 2003) considering it necessary to improve medical assistance and generate satisfaction in the patient (Fleischman 2003, p.472). We cannot ignore the usefulness of applying the foundations of critical discourse analysis (Fairclough and Wodak 1997, pp.271-280) that addresses social issues, power relationships and culture conforming ideology, as well as Van Dijk (2003), who focuses on relationships of power and Hatim (2008, p.88), who considers interaction as a process of negotiation. In this present corpus, the power relationships between doctor and interpreter and interpreter and patient are observed when working together with the doctor or the patient to facilitate the understanding of a message or when giving advice and adopting the role of health provider.

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1.2.2 Ethnographic theories

There is a wealth of ethnographic theories available and from them we chose the "participant observation" approach (Van Maanen 1995) to observe the behavior of individuals who participated in this study and their attitudes and beliefs about themselves and how this has affected interactions between participants. In our study, the dialogues were symmetrical from the point of view of the participation of the parties involved, and they all respected turn taking. It was also observed that participants suggested the topic of discussion or topical meaning according to the context (Areiza Londoño and Velásquez López 2002). In the area of medical consultation, it was the patient who proposed the topic (the reason for which the patient went for a consultation) and the rest of the dialogue evolved around this issue, while in other situations (referrals, doctor's visit to patients) it was the doctor or health professional who proposed the topic.

1.2.3 Constructivist approach

The constructivist approach has been very useful in analyzing the attribution of meaning to the

experience of building such meaning in processes where attributing it will depend on interpretive acts: in this respect we have considered Ferrara's concept of joint production (1994) as an ideal model for the analysis of oral interaction in the context of our study. Ferrara's phenomenon (1994, p.219) consists of an active, and complex joint productions in which the actors construct meaning by completing sentences, predicting sentence meaning, helping to finish a sentence that has not been understood or inciting the speaker to complete the information. In our corpus we observed how all the participants helped to construct the speech, especially the interpreter, suggesting possible endings to sentences.

1.2.4. Communication Accommodation Theory (CAT)

The Communication Accommodation theory regards communication as a dynamic process, each party bringing their own motivations to the encounter (Watson et al. 2015, p.59). This approach is necessary when analyzing encounters with different participants, with different experiences and different expectations. It was used in the present research as a method of analyzing the

entire communicative process, not just the speech styles but also non-verbal information (Gallois et al. 2005), as we considered that those elements influencing the decision of adopting a particular role go beyond speech structure.

Patients belong to all the social classes since they demand medical care for different reasons, as we have previously mentioned, such as emergency, special services of the hospital not provided in private clinics, maternity, surgery and many more. We could therefore place this sample within the phenomenon of globalized communities (Cronin 2008). Interpreters belong to various nationalities and use English as a lingua franca (Canagarajah 2013).

2. METHODOLOGY

2.1 Description of the study

We carried out an empirical study in the main hospital of Marbella, south of Spain, named Costa del Sol Hospital. The place was not chosen at random. The hospital is located in the touristic region of Andalusia which, according to the Official Tourist Board of Tourism of the Spanish

government[iii], received 1,186,226 tourists in August 2014 alone[iv], an increase of 5.6% compared to the previous year. There is a very large foreign population in the area, who are either permanent or temporary residents, tourists, healthcare tourists, immigrant workers or refugees.

2.2Recordings

The aim of the study was to compile a wide recording of data and from this to draw determining conclusions. It was carried out during the months of August, September and October 2010 in the Hospital Costa del Sol in the province of Malaga, a public hospital within the Spanish National Health Service network. The hospital is located in a strategic point: next to the exclusive tourist resorts and near the African border. Potential patients are immigrants, residents and tourists seeking emergency, specialized and high quality care not available in private clinics. The hospital is also one of the few in Spain with a pool of professionals and volunteer interpreters, who have been working in the centre for over twenty years. Whilst English and German were the predominant languages spoken by foreign patients, English (as a *lingua franca)* is most commonly used by patients and

health professionals. The group of interpreters is coordinated by a fellow interpreter, and it is made up mostly of volunteers, each of whom attends the hospital one day a week. This hospital in Malaga was the only center of respondents in Spain that allowed the recording of interpretation encounters for this research. After several meetings with the director and the group of interpreters, permission was obtained to record those encounters where patients and health professionals gave their permission—by means of a written consent. The researchers reached an agreement with the management of the hospital to use the data obtained for academic use only and that any information relating to the origins of patients, healthcare workers or interpreters would be disposed of. The group of interpreters was also previously informed about the purpose of this research and they agreed with the proposal.

Face to face interpretations occurred among both inpatients' and outpatients' clinics. In all recordings the authors of this study were present. The total amount of valid recordings of interpreting encounters with enough sound quality to be analyzed was thirty six; three recordings were discarded due to their poor sound quality. In terms of percentage, the English/Spanish language

combination is the most predominant, followed by German and French respectively.

Language	No. Recordings	% of the total corpus
English	32	89
French	1	3
German	3	8

Table 1.Summary with number of recordings classified per languages

The number of recordings where volunteer interpreters took part was the highest, as shown in table 2.

Type of interpreter	No. Recordings	% of the total corpus
Qualified	5	14
Volunteer	31	86

Table 2. Summary with number of recordings classified per type of interpreter used (professional and volunteer)

Finally, recordings were distributed as well in different areas within the healthcare contexts, the doctors' ward to patients being the most common.

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Context within healthcare field	No. Recordings	% of the total corpus
Doctor's ward visits	14	38.9
Social services	7	19.44
Medical consultation	6	16.66
Discharge	5	13.88
Medical questionnaire	2	2.55
Consent form	1	2.77
Information to relatives	1	2.77

Table 3. Summary with number of recordings classified per context

To fully acknowledge the importance of this corpus, we need to be aware of the pressures that the research field in public service interpreting usually faces. Researchers and trainers can hardly obtain corpora with real data, especially in the healthcare context.

This is the reason why face to face interaction is relatively recent (Metzger and Roy 2011, p.59) and especially in hospital settings. Yet, we must

mention the works based on real data of Baraldi and Gavioli (2012), Tebble, (2012) and Angelelli (2004) which shed light on the need of a systematic research into the nature of the strategies adopted by the interpreter and their impact on a variety of contexts which could help to identify if certain models of interpretation are better to apply or to avoid in a given situation and what type of strategies could obtain the desired results (Metzger 1999, p.197).

2.3 Participants

The group of subjects taking part in this research made up of17 patients/users of this hospital. Some patients took part in more than one encounter which is why there are fewer patients than recordings. The group of patients comprised different nationalities, most commonly British (11), Swedish (1), Belgian (1), German (2), and African immigrants (2). The pool of interpreters was made up of seven foreigners who have lived in the area for many years, and two were Spanish. Most of them have been engaged professionally in the interpreting task for at least a decade. The interpreters' nationalities were Swedish (1), Mexican (1), British (2), Spanish (2) and Argentinean (1). Spanish interpreters were fully

qualified. Interpreters' ages ranged between 40 to 60 years of age. Volunteer interpreters did not receive previous training from the hospital, their experience came from the work they had been carrying out in that institution for more than 10 years. The healthcare staff were Spanish, a small number of which could speak some English. It was remarkable in all the recorded encounters, however, that they preferred to rely on the interpreter to deliver the message.

Encounters were recorded in various hospital settings hospital rooms (27), corridors (3) and consultation rooms (6). On most occasions the health provider was present while the interpretations were being performed, while in very few cases the interpreter, who was given the information beforehand some times when the doctor or nurse was leaving the room to take some documents or in the doctor's office, was conveying the message without those nurses or doctors being present especially, if reading prescription documents or something similar.

After compiling the recordings, the transcription of the conversations was done by the researchers (in case of English <> Spanish language pair) and by external interpreters in the pair of languages

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French, German <> Spanish. The conversations were transcribed in full form. In transcripts inconsistencies, grammatical errors, unfinished sentences, pauses etc. appear to reflect the actual interaction.

The transcription format chosen was the "horizontal transcription format" presented by Gallez[v] at the international conference Critical Link 2010. Traditionally, in interpreting studies the vertical format has been widely used, but it was felt that this type of transcription "biases the reader to perceive speakers as equally engaged and influential in the course of the interaction" (Edwards 1993, p.11). Whereas the use of the horizontal column is useful to detect asymmetries amongst parties (Edwards 1993, p.11). Asymmetry is very common in the health context, but also, as Gallez (2010) confirms, it is also easier this way to detect turn taking, to see whom the question being addressed, interruptions, etc, as well as being easier to compare the original message with its interpretation.

Three columns, A, B and C have been used, whereby column A represents the health provider's production, column B the interpreter's and C the patient's, respectively this format provides a clear and quick vision in order to distinguish each party's interventions:

	HEALTH PROVIDER (A)	INTERPRETER (B)	PATIENT (C)
1	A		
2		A^1	
3			B
4		B^1	
5	A		
6		A^1	
7			B

Table 4**.** Model of horizontal transcription

Reading of the transcription should be done from left to right when the provider starts the conversation; from right to left when the patient begins it or from the middle when it is the interpreter who initiates the encounter. In those situations where both parties speak at the same time, both utterances appear in the same row of the table.

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3. ANALYSIS

Once our data was collected and transcriptions of recording were finished, we classified the material according to the performance of the interpreters in each encounter and then we established the roles we are analyzing in this study. We tried to relate them to previous literature as appears in the following descriptions of the six proposed roles. However, our corpus could provide a further insight into interpreters' performance in our country, and especially in our region, and in an area where previous research (Martin 2006) has indicated the need for professionalization and quality, which was one of the main purposes of our study.

We focused our analysis on the attitude and the roles the interpreters adopted in the encounters of the corpus recorded and could identify similar reactions and roles of these interpreters. Subsequently six roles were identified as repeated strategies in the communication process whereby interpreters managed success in the communication even if attitudes such as taking control, trespassing the provider's boundary, or usurping the provider's roles were observed. Some of these practices have been discussed within the Code of Ethics and

Standards of Practice of some organizations, such as the National Council on Interpreting in Health Care, Code of Ethics and Professional Standards of the AICC, Australian Institute of Interpreters and Translators National Register of Public Service Interpreter, Institutions and Organizations that strongly promote the adoption of a neutral position.

3.1 The interpreter as a guide of the communication process

Swabey and Mickelson (2008, p.54) pointed out the role of the interpreter as "facilitator of the communication," a term also used by Hale (2008, p.112) in the case of sign language making arrangements for the best conditions of the encounters of the hard of hearing people (Comitre Narváez 2016).We propose the role of "guide" with the meaning of "to manage, to assist, to supervise". Since the interpreter tries to organise and supervise the information that is supplied and is in avid search of more details which are needed to make the result of the process satisfactory.

Interpreters ask questions, either because these questions have not been asked before, or because they are well aware of the process and know they are necessary, or because those questions, even if

asked, have not been answered by the user before and they must be repeated again.

Questions are not asked because of the interpreter's interest, but because the health provider needs a particular piece of information that is not being obtained because of the way the question is formulated. On the contrary, the interpreter, in that role of guide, asks those questions in such a manner that the information needed is obtained, thus facilitating the success of the communication process.

In table 5, this active role can be observed since the interpreter clarifies questions in order to obtain direct answers and could help to fully understand the message. The interpreter asks the patient a direct and clear question which has not been posed by the social worker:

Social worker (SP)[vi] – A	**Interpreter (SP/FR[vii]) – B**	**Patient (FR) – C**
[...] es una solicitud de de petición de un pasaporte y que nos la ha mandado el consulado en francés y en otro idioma que ellos tienen allí en Bélgica, que es flamenco no sé eh		

¿vale? *[…] it is an application to request a Passport and it has been sent by the Consulate in France and in other language they've got there in Belgium, that is Flemish I don't know eh ok?*[viii]		
	[…] Il faudrait que vous signiez là pour que le consulat puisse commencer à faire les papiers. Ici on a, on a mis ça en français et en flamand. **Vous parlez français ou vous parlez tous les deux?** *It is necessary you sign here so the Consulate can start the paperwork.* *Here, we have it in French and in Flemish. Do youspeak*	

	French or both?	
		Flamand ! *Flemish!*

Table 5. Sample of conversation where the interpreter acts as a guide of the communication

In this situation, we face a case of leading questions as defined by Tiersma (1999, p.164). This type of question is used by the interpreter to suggest answers to the speaker. Leading questions are classified in four types, and the one used by the interpreter is a disjunctive question (the interpreter offers more than one choice as an answer, and the choices are mentioned in the question).

Once the patient has chosen his preferred option, the interpreter continues facilitating and controlling the communication in order to complete the form:

Social worker (SP) – A	**Interpreter (SP/EN) – B**	**Patient (EN) – C**
Bueno eh preguntarle él ahora mismo con quien vive si vive solo si tiene aquí		

familia en España que le pueda echar una mano. *Well eh ask him if he lives right now who he is living with if he lives on his own if he has some family in Spain that could help out.*		
	_____ would like to know if you live here alone or if you have family here?	
		A little yes
	Do you live here alone?	
		No
	Do you have children?	
		No my wife
	You have your wife lives with you	

		Yes
	Él no tiene sus hijos aquí pero que su esposa vive con él *He doesn't have any children here but his wife lives with him*	
Vale y una vez que le den el alta él va a contar con su mujer para que le ayude a las actividades básicas como pueden ser el aseo personal la alimentación… *Ok and once he is dismissed from hospital he is going to control with his wife so that she helps him out with his basic needs such as personal hygiene food...*		

	When they send you home can you count on your wife to do your personal cleaning and to look after you to cook for you to clean you and so on?**Is she capable of doing that?**	
		She is capable yes but she is she is quite old.
	Que ella sí puede hacerlo pero que ella está viejita también. *She is capable but she is old too*	

Table 6. Sample of conversation where the interpreter acts as a guide of the communication

In this previous example, the user does not provide a clear answer related to the question regarding the fact if he was living alone or with his family. The interpreter believes that information is lacking and she starts asking probing questions in order to

obtain straightforward "yes" or "no" answers (Do you have children?) and the interpreter ends by adding a question (not being asked by the provider) related to his wife's capacity to perform house chores. This might be part of the aforementioned teamwork building (Ozolins 2015) of the usual procedure in Spanish hospitals, when an elderly patient leaves there is some concern about providing essential help or advice after hospital discharge. The interpreter believes this question is appropriate and she guides the communicative process. However in this situation, following the aforementioned Codes of Ethics, the interpreter should not have trespassed the boundary of the provider, not asking questions which have not been asked and so just adopting the "conduit model".

This role has proved to be successful in terms of the communication process, since every time the interpreter tried to facilitate the communication, the message was better understood and misunderstandings were kept to a minimum or were inexistent. Therefore, it could be suggested that this role is appropriate if used for the purpose of guiding the communication process and the strategy must seek the results of satisfactory communication by joint production (Ferrara 1994)

since the different participants of the interaction collaborate and the interaction thus reaches its goal. This would also mean the rewording or using of different ways to pose questions which might prove to be a satisfactory technique to facilitate communication on specific occasions, obviously bearing in mind the accuracy prescribed in the Code of Ethics and therefore the findings should be considered for future training since situations are not standardized in real encounters and future interpreters should be able to face challenging situations. Health care settings, where the need for efficiency and time saving strategies are most of the time a key factor may demand interpreters to be the guide of the conversation, thus to solve communication problems swiftly.

3.2 The interpreter as a promoter of the communication

Under this role, the interpreter completes the doctor's speech, asking questions to obtain more information about a particular issue being discussed. This role could be regarded as trespassing on the health professional's work. However, sometimes these probing questions help to complete the diagnosis and sometimes the

questions are formulated because the interpreter is familiar with the communicative process related to a specific pathology.

In table 7, we can observe how starting from a piece of information provided by the interpreter,(for some time the patient has undergone several colonoscopies periodically, but he stopped)the interpreter becomes interested in obtaining additional data, even though this has not been requested by the doctor. However, this interpreter believes it is necessary, or they are questions that could be easily asked later on; such as when was the last time those tests were carried out and what the results were:

Doctor (SP) – A	**Interpreter SP/EN[ix]) – B**	**Patient (EN) – C**
	Yeah, sí. Le habían recomendado tener una colonoscopia como cada dos años para de revisión y lo hizo algunos años pero después paró. Después ya no se hizo más colonoscopias **when was the last colonoscopy you had?** *Yeah yes he was recommended to have a colonoscopy every two years*	

	to monitor and he did it for some years but then he stopped after that and he didn't have any more	
		I think it was five years ago
	[…] **and the results?**	
		And the results everything was normal there was a little bit of XXX[x]

Table 7. Sample of conversation where the interpreter acts as a promoter of the communication

Being familiar with protocols in certain situations helps the interpreter to suggest questions they could ask the patient, or adding information that could have been forgotten by the provider and adopting this role could be beneficial in critical situations. For instance, when there is an emergency, or in a standard consultation to avoid missing any search for information that can be crucial. In the settings where we carried out our study the health providers

are in favor of the interpreters who are regular and frequent collaborators with the institution, using this role, as they were familiar with protocols and this was done in order to optimize communication. Although, it could be possible that health professionals might feel that the interpreter is overstepping the line of his/her duty (and they may prefer to handle and lead the communication themselves), inevitably questions must be asked and follow a established structured dialogue, which may be very common and repetitive in the healthcare context of a specific service, and the speed of services makes that efficiency prevail (Roat 2010, p.97).

3.3 The interpreter as a spokesperson on behalf of the health provider

A triadic exchange is not always the case in hospitals, especially when patients are discharged. It could be the case that the nurse provides a number of instructions and leaves the room, so the interpreter will be in charge of conveying these instructions to the patient afterwards. This fact means effectively there is an exchange of roles since the interpreter will become at that moment a spokesperson on behalf of the health provider

conveying the medical information on his/her own, and not together with the nurse. In previous research, the role of "co-therapist" (Weiss and Stuker 1999; Métraux and Alvir 1995) has been discussed in those situations in which the interpreter has been working closely with the therapist performing the provider's role. In our taxonomy, we observed that the interpreter not only acted as a health provider (a separate role differentiated in this research) but s/he was also the representative of the public service, on some occasions being the only person with the patient and answering questions related to how the hospital works.

In this instance, the production and reception of the message happen at different intervals, making it more difficult for the patient to find out who is the producer of the message (Bührig et al. 2012, p.411). In the present corpus, the following situation is frequently found: the interpreter is on his/her own with the patient and transmits the words of the provider, but with this one not being present. This happens especially in the discharge procedure when the patient is going to be sent home from hospital and the doctor or nurse communicates a number or instructions that are

also in written form, in the dismissal report, provided to the patient.

However, there are situations that require a lot of attention: as follows in the case where a nurse has already explained all the instructions to the interpreter and then those are communicated to the patient by the same interpreter. Here, we are dealing with important pieces of information because of the sensitivity of the case and because the instructions are loaded with delicate information such as "be careful to keep it sterile" or "empty the bag into the sink". Facing the need to convey this information as clearly as possible, the ideal situation for the interpreter should have been to have the nurse present and carefully interpret the message step-by-step. In table 8, to better visualize the invisibility of the public service, the column related to the nurse is empty as we could not record anything from her since she does not speak, although she is present in the room) and it is the interpreter who is conveying the indications as shown:

Nurse (SP) – A	**Interpreter (SP/EN) – B**	**Patient (EN) – C**
	Now what she was saying too was that when	

	he changes the bag is to be careful obviously with keeping it sterile	
		(Relative) Yeah
	So, erm, and you can just empty the bag into the sink or into the toilet?	
		(Relative) The toilet yeah
	basically and you can wash the top with water but the thing is don't stick your hands all over it	
		(Relative) No
	you know you can get gloves in the pharmacy to be sure, it makes it easier and, erm, and that's about it I think. Is there anything else?	

Table 8. Sample of conversation where the interpreter acts as a spokesperson on behalf of the health provider

In addition, it may be the case that the interpreter is forced to look for the medical staff who have been absent to solve an unexpectedly posed question. As noted in table 9, it is now the interpreter who goes to fetch the nurse in order to answer a question from a relative of the patient. In this case, the column of the nurse is blank not because she is not speaking, but because she has left the room momentarily.

Nurse (SP) - A	**Interpreter (SP/EN) – B**	**Patient (EN) - C**
		Urine. Well I XXX When I was visit XXX the hall of my mother I am using the same toilet I don't know if it's better to check
	(the interpreter goes	

	to look for the nurse and asks her a question) **The nurse says that** erm, normally it's something that is just passed in the urine and that normally you pick up here in the hospital, but if you want to be absolutely sure, if you're not feeling well, go to your own doctor	
		No because I had to fill her urine to a bottle I don't know if I have
	Did you have gloves?https://goo.gl/	
		No, nobody told me
	[...] If you want to are you going to be here in the hospital tomorrow morning?	

		XXX yes?
	The only thing you can do is when the doctors come round in the mornings because the doctors are not here in the afternoons they're around in the mornings, when the doctor comes around, if you'd like to speak to him and see what the doctor says **maybe he can reassure you** but there's nothing that the nurse can do now.	
		[...] And what kind of bug is it?
	I told you a minute ago I've forgotten the name already kleiklei something?	
		Klei…

	(the interpreter asks another nurse who is not taking part in the conversation) ¿Cómo dijiste que era el virus este? *What did you say this virus was?*	
		[...] I'm living now downtown in _____, there is a medical laboratory I think they're also doing urine, if I can tell them exactly
	Why don't you come round in the morning and speak to the doctor who comes to see your mother? And then you can ask the doctor and see, you know, whether there is any risk for you or not...	

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Table 9.Sample of conversation where the interpreter acts as a spokesperson on behalf of the health provider

In table 9, the interpreter performing her work without the nurse or doctor present faces several hurdles: first, although the interpreter provides an answer to the first question asked (the relative may not have contracted the infection because it is transmitted by urine and usually this is contracted in the hospital itself), the user asks some other questions and the interpreter does not know how to answer. The relative wants to know if it is dangerous to handle her mother's urine without gloves, or if she really should have a test herself to confirm that she is not infected. All the interpreter can do in this situation is to urge her to ask the doctor the following day because she does not know the answer herself and does not have any healthcare worker nearby to ask.

Another obstacle the interpreter faces is missing some important information — such as, in this case, the name of the virus: an issue that could be solved by taking notes of specific terminology. Furthermore, the answers provided by the interpreter are vague and full of subjectivity; as shown by the use of phrases such as "maybe he can

reassure,""why don't you come," and finally, "the only thing you can do," a phrase used to convey a suppose only solution that has not been confirmed either by the nurse or the doctor.

The adoption of this role could be considered a time saving strategy if instructions are clearly expressed in a written document and do not cause any misunderstanding, the interpreter could perform sight translation of a written document (discharge, prescriptions, etc.) while the provider could be assisting other patients. However, on the other hand, questions arising about a procedure, treatment or even medical instructions when discharging a patient could be answered by the interpreter (taking the risk of providing a wrong answer) or the communication comes to a halt, the provider must call on to give the right answer to the question, before returning to the patient, all of which is prolonging the process and resulting in a waste of time.

Thus interpreters might become the spokesperson on behalf of the provider when necessary and, if so, they must ask for confirmation from the healthcare professional as shown in table 9. As we can see in this instance the intervention of the interpreter is positive in the sense that the patient and his/her

relative have been alerted to a potential risk and a solution will thereby be sought. However, following the advice of the standards of practice, the interpreter should not be alone with the patient, and should not take up the role of the provider.

3.4 The interpreter as a health provider

In the healthcare context, as in other public service fields, it might happen that the interpreters need to perform the role of the provider in a given situation: They ask themselves questions, cross-examine information and suggest measures to take.

In the following excerpt, there is an exchange of information where, in order to help the administration of the patient's medication, both the provider and the interpreter try to interpret the information that is not clearly expressed in a prescription. It seems the interpreter knows the context, maybe because she/he has already worked there, and the provider is willing to share this kind of discussion with the interpreter:

Doctor (SP) – A	**Interpreter (SP/EN) – B**	**Patient (EN) – C**
	Do you have any way to get in touch with those people that erm, have taken your pills so we can know the name of the pills? XXX	
Ajam. Estoy buscando pero no... *Aham. I'm looking for it but I can't…*		
	Porque el sintrón no es un disgregante plaquetario eso es otra… *Because sintrom is a platelet disperser that is other…*	
es un anti coagulante *it is an anticoagulant*		
	es una anticoagulante, los weifers esos *it is an*	

	anticoagulant, those weifers	
Ajam, sí es como la warfarina *Ahem, yes - it's like warfarine*		
	Es como la Warfarina. *It'slikewarfarine* Do you remember the name of Warfarine? does it make any sense?	
		No it starts with an s
[…] ¿Tromalitsería? *Could it be Tromalit?*		
	Tromalit?	

Mira ves es que aquí lo único que aparece recomienda antigregación con acetil ácido Look, here the only thing that comes up is a recommendation for antiggregation with acetyl acid		
	Claro eso es aspirina *Of course that is aspirin*	

Table 10. Sample of conversation where the interpreter acts as a health provider

The adoption of this role has been observed among volunteer interpreters who have a long experience of working in this context and in the institution under our study. Their knowledge of certain procedures, drugs and diseases makes them feel very comfortable suggesting options or providing medical advice. This role should not be adopted just by any interpreter, if it is not supervised carefully by health professionals, even if the question or the answer is very simple and known by average people. In training interpreters, this role

should be emphasized because, as it has been confirmed in previous literature (Ozolins 2015) and in this study, it happens in "real practice".

3.5 The interpreter as a friend of the patient

One of the most important statements of most codes of ethics and standards of practice in the healthcare context is impartiality and avoiding being an advocate for one or other of the parties, neither the provider nor the patient.

Yet, in real life situations this is not always possible as the aforementioned literature shows. Perhaps, what we have gathered in our research it is not just advocating, but also a strategy to find out the information needed. In the following examples we see how the interpreter gets closer to the role of "friend" of the patient.

This empathy towards the patient has also been observed when the interpreter uses the patient's own first name[xi]. In the following conversation, all the questions the interpreter has asked to the patient have been initiated with the use of the patient's first name, a decision taken by the interpreter and not by the provider. In this situation, besides being in a

foreign country the patient's situation was extremely vulnerable. The interpreter, a lady, therefore, wanted to show empathy, to appear as someone to trust and to show that she could help the patient. For that purpose, she made the effort to remember the patient's first name and that is why she used it every time she was addressing him. This caring attitude (Pedersen 2012, p.533) helps a joint action between the people involved in the communication process, using what Hodges (2007a, 2007b) calls "moral dimension of conversing."

Social worker (SP) – A	**Interpreter (SP/EN) - B**	**Patient (EN) – C**
Vale, ¿y qué familia tiene? Padres, hermanos *Ok, and what family has he got? Parents, brothers or sisters?*		
	(patient's name) what family do you have? friends, brothers, sisters?	
		brothers and

		my grandmother
y pregúntela si tiene hijos, si está casado *and ask him if he's got children, if he is married*		
	(patient' name), are you married? Have you got children?	
		No
_____, why did you come to Spain?		
	(patient's name),why did you come to Spain?	

Table 11. Sample of conversation where the interpreter acts as a friend of the patient

In encounters with interpreters being present, this kind of research should be carried out in order to analyze if the fact that the interpreter is being actively engaged with the patient showing interest and empathy leads to the same results regarding

patients' satisfaction. In most of our recorded encounters, the intervention of interpreters seemed to prove the same comforting effect.

In Western medicine, medical discourse is generally associated with a biomedical framework, mainly based on health as a biological phenomenon in which the doctor cares about the patient's problem, providing a diagnosis and prescribing treatment. Thus, this discourse moves away from the theory of social approach. In this context within the patient is seen as an individual, leaving both the physician and the interpreter the roles of persons interested in the patient's health involving listening and engaging empathy. Therefore, this position called 'biomedical' is the one generating asymmetry in discourse between doctor and patient (Mishler 1984, p.120).Whereas the social approach focuses on the patient holistically, a person with a life and, at that particular time, suffering from a disease (Cordella 2004, p.25).

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Doctor (SP) - A	**Interpreter (SP/EN) - B**	**Patient (EN) - C**
¿Tiene mucha hambre? *Are you very hungry?*		
	Are you hungry?	
		Yes
Bueno, ¿tiene dolor? *Well, areyou in pain?*		
	are you in pain?	
		very very hungry
	pain in your stomach?	
		Yes
	that's why you are hungry! (laughter)	
[…] Ok ¿tiene mucha sed? *Ok. Are you thirsty?*		
	Are you thirsty?	

		Yes
	yes? hungry and thirsty!	(laughter)
		thanks for telling me! (laughter)

Table 12. Sample of conversation where the interpreter acts as a friend of the patient

Although both positions are focused on asking questions, answering them and acknowledging, the biomedical approach uses a discourse concentrated on the part of the body that needs healing. Typically, the patient adopts the social approach while the doctor usually opts for the biomedical one.

The light hearted tone adopted between the doctor and the interpreter, when making certain comments or providing an opinion is important in alleviating the seriousness of the issue they are dealing with. However, such comments should be handled sensitively depending on the situation. In the following example, we see how the interpreter provides his opinion using lightness to make the patient smile and be more relaxed.

The interpreter's comment has a lighthearted tone and shows his intention to ease the tension of the patient and divert the attention from her disease: "that's why you are hungry!" In these cases we should be sure that the patient is able to understand the joke and, of course, avoid any kind of misunderstanding about what has been said with the purpose of creating empathy. In this case, the easy going nature of the interpreter has been shared with the patient and, therefore, achieved the intended effect.

Light hearted humour is present also as a conversational strategy within the speech act theory following Hertzler (1970, p.87) who considers humour and laughter as expressive forms of communication, being essential elements in the group socialization process.

In short, the adoption of the role of a friend of the patient is quite common in both the biomedical context and in the social services, associating it with comfortable situations, friendliness, empathy with the patient, or simply showing interest and concern for what is happening to that patient. However, it should be handled with caution, bearing in mind it does not affect accuracy in communication.

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3.6 The interpreter as a cultural mediator

The interpreter also takes on the role of a cultural mediator. Mediation is not only used to break the language barrier, but also to provide access to certain procedures for patients who are not familiar with certain administrative processes. Interpreters working in the context of hospitals and health centers must be familiar with the cultural aspects of their working languages as well as the healthcare system of different countries.

In the following conversation, the patient must obtain a medication whose prescription had to be signed and stamped by a health official. This information is conveyed by the doctor, who is present, but he neither speaks, noroffers clarification about what this stamp means. The interpreter adapts the message to explain the procedure:

Doctor (SP) - A	**Interpreter (SP/EN) – B**	**Patient (EN) - C**
	Right, these are the prescriptions	
		Right

	but one of them, which is a special nutritional drink, erm, **needs a stamp on it**	
		Oh right - who do I get a stamp off of?
	you have to go to the health centre with this and they will stamp it for you there	

Table 13. Sample of conversation where the interpreter acts as a cultural mediator

The concept of interpreter and the concept of cultural mediator have been often differentiated in research literature. However, it does not always happen in real practice when health providers or institutions are involved in the provision of interpreting services, as recent reports on health interpreting state, such as Angelelli's (2015). A cultural mediator as such has no formal training and is more focused on helping immigrants and foreign patients, accessing public services, providing administrative advice and information or

even just helping them to fill in forms. However, the interpreter has formal training and qualifications and should not perform any of these tasks, unless absolutely necessary or on the few occasions (Meyer et al. 2010) as shown in the example above.

3.7 Application of analysis

The samples shown could be related to the concept of value hierarchy (Hodges and Baron 1992); encounters with interpreters as sometimes, alleviation, or caring should be predominant instead of being neutral. Likewise, Chesterman (2001) concept of Ethics of communication will apply to the ultimate goal of the healthcare interpreters' encounters analyzed in this study.

Chesterman's aforementioned concept focuses not on representing the other but on communication with others "to further intercultural cooperation between parties who are 'Other' to each other, thus the Ethical Translator is a mediator working to achieve cross-cultural understanding" (2001, p.141).

Latest research in ethical codes related to the role

of the interpreter (Ozolins 2015, p.327) "has shown intense debate over role, ethics and how well ethical codes can inform practice debate". Ozolonis (*Ibid.)* also points out that a highly critical school heavily criticized code of ethics favouring impartiality, neutrality and a restrictive role (Valero Garcés and Martin 2008; Angelelli 2004; Bot 2003; Clifford 2004; Metzger 1999; Roy 2000; Tate and Turner 2002; Wadensjö 1998).

Those discussions can shed some light on the understanding the vast amount of interpreting practice, whether professional or non-professional, and in our case offers a representative panorama of Spain, a crossroads both of tourism and immigration with an increasing trend in health tourism, healthcare communication, involving a large number of professional and non-professional interpreters. These samples can be used with the purpose of enriching training courses offered to professional and long-term volunteer interpreters in order to improve their strategies.

As Roat (2010) proposes, extracts from real interpreting can be used to train future interpreters by showing what strategy should have been chosen when a real challenge has to be faced. We agree with Roat and Crezee (2015, p.251) who put

forward that healthcare interpreting is a field still evolving, a field that still needs skilled linguists, compassionate hearts, creative problem-solvers and a new generation of leaders. And bearing in mind the present panorama, our corpus might shed some light on the development of training materials to enhance interpreters' skills.

4. DISCUSSION

The study was aimed first at exploring the real practice of health care interpreting, as well as exploring communication problems in order to improve quality standards, for the profession itself, and then to feed future training scenarios both in professional accreditation settings and in higher education.

The corpus of recordings has been analysed using a multidisciplinary point of view and different theoretical principles as discourse analysis and ethnographic approaches, and attempts to explore and describe the reality as the participants of the conversation experience it and provides a discussion to the actions of these participants. Furthermore, this research is based on the accessible population contribution in a

cosmopolitan setting where we obtained the samples and observations of encounters was made in the natural environment of the subjects, without disturbing their performance, and after this observation and analysis of the data by themes or categories, conclusions have been obtained (Creswell 2003, pp.181-183). The characteristics of the sample subjects (both interpreters and users) and the settings allow us to generalize results that would apply to both local for globalized healthcare interpreting.

As previous literature has highlighted, there are not many compilations of real materials in the healthcare settings (Angelelli 2004; Bischoff et al. 2012; Bot 2003 etc.) due to different reasons among which are the time constrains of healthcare, confidentiality of patients conditions among many other reasons related to the healthcare field. However, our compilation allows us to match the second aim of this study which was exploring the work of interpreters and their strategies when facing problems and also the third aim focused on analyzing pragmatic strategies used by interpreters (both professional and non-professional) to facilitate the interaction with the service provider.

The thirty six recording and transcripts form a corpus large enough for a qualitative study (Cresswell 2009, p.181) of interpreting strategies and interaction with the users and service providers, both professional and non professional interpreters, real practice and professional needs. It is also focused on a specific area, which, to a certain extent, involves a varied multicultural component of users worthy of this study. So the corpus could be regarded as an example of the increasing population mobility within the phenomenon of globalization and the need of interpreting. Consequently, it becomes enormously difficult to predict the geographical origin of the potential users of these services and their cultural characteristics that are no longer exclusively the inhabitants of neighbouring countries (Cronin 2008, p.128).

The fourth goal of our work was to learn from real practice and to take the features that work in this real practice, even though they were not standardized strategies and thus after analyzing the samples, recurrent roles emerged in which both professional and non professional interpreters do not strictly follow neutrality patterns.

The discussion of the interpreter's neutrality poses the question of how we can make it happen, theoretically speaking. As mentioned before, the professional duty according to ethical codes is very clear: interpreters should be neutral and objective, they can have the ideas they like, but they should not alter the message to suit their beliefs (Hale 2008, p.121). This concern is constantly mentioned and taught from the very first stage professional interpreters' start their training. However, studies based on real encounters such as the one presented have provided evidence that neutrality is almost impossible as shown in aforementioned research (Wadensjö1992; Angelelli2004; Baraldi and Gavioli 2012; Hale 2007, and Roat and Crezee2015).

The variety of roles adopted by the interpreter in our research is influenced by different variables such as being fully qualified or non-qualified, having years of experience in that field(and thus familiarity with the procedures and topics discussed) and the atmosphere experienced during the encounter itself —if the parties are happy due to positive information conveyed, and if they know each other from previous encounters etc.

Thus, as a result of our fifth aim, we propose a taxonomy of interpreters' roles, as a result of analyzing the most recurrent situations in the encounters and thus the role adopted by interpreters. This taxonomy could be useful for training healthcare interpreters in a further study duly under preparation especially in the Spanish context. Furthermore, our sixth aim, the use of multidisciplinary theoretical approach in order to have a deeper insight into the interpreting process, allows us to understand the behavior of interpreters, which in most cases has a positive attitude to reach satisfactory communication, although it could be in conflict with ethical codes in certain encounters.

The findings of this corpus can be applied to the training of interpreters in the future by means of pedagogical resources taken from the situations we have analyzed, focusing on the different roles described in our taxonomy, highlighting its risks but also the advantages of these roles. Although studies in interpreters' role have been previously done as aforementioned literature has shown (Hale 2007; Wadensjö1992) and many others, our study tries to gather a deeper insight into real practice with quite a good number of samples of a Spanish multicultural setting which can be useful for local or national formal and informal training which is in

acute need as stated in reports and research (Martin 2006; Angelelli 2015). We should reflect deeply on the use of those as strategies of communication and barriers and if they are valid or not in certain situations to solve communication barriers, bearing in mind that there has been an increase in the number of studies on the topic of conversational issues in healthcare as frequently, some human errors have been associated with a lack of communication (Pedersen 2012, p.533).

This research has proven that when adopting different roles during the course of the encounter, the interpreter is the main driving force of the interaction. This aspect is interesting for interpreters' training because, in many cases, the conversation must be restored —and this falls within the domain of the interpreter in order to achieve a satisfactory communication with the purpose of providing the required assistance by all means. Findings in our study confirm that interpreting is not a static activity; it is linked to communication process and human strategies in order to achieve a satisfactory understanding Furthermore, there is no evidence of a corpus of healthcare interpreting in Spain of this length so far up to this point, which makes our research vital and useful for taking action in training in our country

and national university programs (Angelelli 2015), especially in Andalusia, where four universities train future interpreters and where the influx of foreign patients is one of the highest of Spain. Therefore, real practice should be used to shed light on theory and training in this field. There is always an effort of cooperation on the part of the interpreters both professionals and non-professionals. We can find explanations to this in the universalist approach where people's actions should be akin to people in all cultures and societies (Klyukanov 2010) which favors communication.

Finally, a Communication Accommodation Theory (CAT) as proposed by Gallois et al. (2005) should be applied to analyze these encounters because these kinds of interactions are intergroup encounters. Watson et al. (2015) have researched the use of this theory in the healthcare context and found that each participant plays an important role in the conversation, bringing their own experiences to it, influencing how the person communicates, moving away from interpersonal interactions to intergroup ones (2015, p.58-59). Therefore, using CAT, we could propose a number of communication strategies in encounters with interpreters, reflecting the different behaviors he or

she adopts such as a friend of the patient or a health provider and incorporating them into the curriculum, because as previous literature and the present research has shown, it is almost impossible to be neutral. Therefore and we should reflect on the external factors that impede this neutrality in order to take them into account when discussing roles in training future interpreters to be aware of the fact that neutrality is a must which is often trespassed in favor of effective communication and thus they should be fully aware that the limits of this trespassing must be cautious (Roat 2010).

As Ozolins (2015) states, education and professionalism must be raised in interpreting and this is especially true in the vital field of healthcare. Therefore our proposal is based on an insight into the real practice which might contribute to the understanding of interaction processes and enhancement of interpreting training.

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NOTES

[i]We must express our deepest gratitude to the main public hospital Costa del Sol and its management team, healthcare workers, patients and interpreters for all their support with our research aimed at improving quality in communication. See their website: http://www.hcs.es/[Accessed: 1-12-2017]
[ii]http://www.ine.es/[Accessed: 1-12-2017]
[iii]http://www.iet.tourspain.es/es-es/estadisticas/frontur/paginas/default.aspx[Accessed: 1-12-2017]
[iv]http://www.iet.tourspain.es/es-ES/estadisticas/frontur/mensuales/Nota%20de%20coyuntura%20de%20Frontur.%20Agosto%202014.pdf [Accessed: 1-12-2017] The research presented in this study has been (partially) carried out in the framework of research projects VIP (FFI2016-75831-P), INTERPRETA 2.0 (PIE17-015the TACTRAD teaching teaching network (719/2018 UMA) and the TRAJUTEC thematic network (University of Malaga).
[v]Gallez, Emmanuelle. 2010. "Advantages of a horizontal transcription format for interpreted interactions." Paper presented at the 6th Critical Link Conference, Aston University, 26-30 July 2010.
[vi]SP: Spanish
[vii]FR: French

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[viii]When the language of the excerpt is different from English we provide a translation using italics.
[ix]EN: English
[x]Symbol XXX represents those parts of the conversation that have been impossible to transcribe due to noisy background.
[xi]Due to privacy issues the proper name has been omitted.