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Dynamics in interpreted interactions: An insight into the perceptions of healthcare professionals

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Dynamics in interpreted interactions: An insight into the perceptions of healthcare professionals

Cover Page Footnote

Author Note This article has been adapted from a presentation given at the 2012 conference of the Association of Sign Language Interpreters held at Bristol, England. The authors would like to thank Sharon Cox and Michelle Barnes for their assistance with the participant interviewing, and would also like to extend thanks to the many busy professionals who generously gave their time to complete the questionnaire and to meet us for interview; this article would not have been possible without their significant contributions. We would also like to thank Dr Rachel Sutton-Spence and two anonymous reviewers for their feedback on an earlier version of this article. Correspondence concerning this article should be addressed to Rachel Mapson E-mail: mail@rachelmapson.com

This study examines healthcare professionals' perceptions of interpreted interactions and how interactional dynamics can be affected by the presence and actions of an interpreter. Discussion of the qualitative data generated in this study with two theoretical models that provide a useful means of exploring the effectiveness of interpreter actions. The synthesis of personal and social expectations and contextual factors within the concepts of social networks (Watts, 2003) and rapport management (Spencer-Oatey, 2008) usefully mirror the complexity of interpersonal and contextual elements within interpreted interactions. These theories relate to qualitative data generated through interviews with a range of healthcare practitioners, including those practicing in primary healthcare and specialist hospital settings. These data provide insight into the consequences of interpreter behaviors and the impact that use of different interpreting strategies may have on healthcare professionals. Discussion of the data covers a range of issues relating to interactional dynamics in this specialized domain with particular focus on the perceived value of interpreter continuity, how dynamics alter in interpreted interactions, the impact of specific interpreting strategies such as consecutive/simultaneous mode, and the use of first or third person when interpreting from signed language into spoken language.

Background to the Research

Research on community interpreting has illustrated how the maintenance of relationships is a central element of interpreters' work (Sandrelli, 2001; Wadensjö, 1993). This research exemplifies how interpreting involves more than just language transfer, and highlights the necessity for interpreters to develop "dialogue management skills" for effective coordination of talk (Sandrelli, 2001, p.178). To do this effectively, interpreters need to maximize their knowledge of what participants want from an interaction. For healthcare interactions, signed language interpreters may derive information on the experiences and expectations of Deaf patients through a number of avenues. General information is available through research on Deaf consumers (Metzger, 1999) and the content of Deaf-led television programs on the subject. Some interpreters benefit from work environments where Deaf colleagues can share their experiences and expectations of interpreted interactions. In addition, specific information regarding individual patients typically can be obtained prior to healthcare appointments during waiting room conversation.

Contrastingly, knowledge about the expectations or perceptions of the healthcare professionals is more difficult to obtain, though the perceptions of the practitioners and their clients may differ significantly. Mason and Stewart (2001) state "the nature of the triad formed by both interlocutors and the interpreter is perceived differently by those involved" (p. 55). However, interpreters rarely benefit from meeting with healthcare professionals prior to a patient's appointment. Similarly, there is little more generalized knowledge about the professionals' expectations that is made available to interpreters. Though healthcare has been the focus of several influential studies on interpreting (Angelelli, 2004; Hsieh, 2007; Metzger, 1999; Swabey & Malcolm, 2012), this research has not incorporated focus on the perspective of the healthcare professionals.

Mesa (1997) and Pöchhacker (2000) examined clinicians' views about different interpreter roles in quantitative studies of healthcare professionals. These studies highlight some discrepancies between the expectations of the service users and the interpreters, though in both studies, the majority of clinicians concurred with the interpreters' view that cultural explanation was a valuable aspect of their work. Hsieh, Ju, and Kong (2010) conducted further research on the views of clinicians in their qualitative exploration of provider/interpreter trust. They identified four aspects of the provider/interpreter relationship as "interpreter competence, shared goals, professional boundaries and established patterns of

collaboration” (p. 170). This last point reinforces the benefits of interpreter continuity, with healthcare providers expressing that using a regular interpreter enhanced level of trust, enabled them to reflect more on their own language use and facilitated both interpreting accuracy and more comfortable interactional dynamics. Continuity has also been a focus within wider healthcare research. In Buetow’s (2004) discussion of provider continuity, he suggests that, to maximize the benefits of healthcare provision, the concept of continuity should be extended from a current clinician-focused model to incorporate all those involved in a patient’s care, including interpreters. This study identifies themes similar to those discussed by Hsieh et al. and contributes to a growing evidence base on how interpreters’ work in clinical settings is perceived by healthcare professionals.

Rapport management and social networks

Interactions involve language and behavior, and the inter-related nature of these elements is encapsulated in the concepts of social networks (Watts, 2003) and rapport management (Spencer-Oatey, 2008). Though unrelated to interpreting studies, these models provide a useful framework for exploring the dynamics of interpreted interaction. Spencer-Oatey’s (2008) rapport management theory combines personal and social expectations with contextual factors to facilitate understanding of how relationships are developed and maintained. She describes how the concept of rapport management has three main components: the goals of the interaction, the rights and obligations relevant to the context and, consideration of people’s self-image. There is a strong resonance here with interpreters’ involvement in maintaining interactional dynamics (Wadensjö, 1993), a process that involves not only sustaining the relationship between the primary participants but also the interpreter’s own relationship with each of those participants. Spencer-Oatey’s model highlights how rapport is managed not only through use of language but also through actions and behavior. Rapport is particularly relevant in interpreted healthcare appointments where a collaborative style of communication can be anticipated, and where development of rapport forms an important element of the process (Rudvin & Tomassini, 2011). Focusing on verbal and nonverbal issues is also highly relevant in this environment where the face-to-face nature of participant interaction influences interpreters’ linguistic and non-linguistic choices (Alexieva, 2000).

One interesting aspect of rapport-management theory is that of rapport orientation (Spencer-Oatey, 2008), which relates to individuals’ attitudes towards an interaction. Participants may seek to enhance rapport, maintain rapport or, in contrast, be neglectful of rapport or actively seek to challenge it. Spencer-Oatey (2008) suggests that interactions will proceed more smoothly if all participants share the same orientation type. For interpreters, difficulties may be more likely to arise when participants have contrasting rapport orientations. However, as a ratified participant within the interpreted interaction (Roy, 1993; Wadensjö, 1993), the interpreter’s own rapport orientation also will be influential in the development of rapport and interactional dynamics.

In his work on social networks, Watts (2003) describes two types of networks that can be related to interpreting practice. The first type, latent networks, relates to previous encounters between interactants. Watts describes how these latent networks result in equilibrium, with the implication of resolution, rather than equality, between participants. *Emergent networks* develop in every new interaction and build on latent networks where they exist, though the equilibrium achieved earlier may not necessarily be replicated. Watts relates these networks to interaction in its broadest sense rather than specifically to interpreter-mediated events. However, the involvement of an interpreter will create

additional complexity to social networks, and latent networks might exist between some or all the participants.

Aspects of emergent networks that resonate strongly with interpreting practice include those of power and subjectivity. Watts (2003) describes the exercise of power as a key issue in interactional dynamics. He describes how inappropriate use of power generates impoliteness or rudeness, which impacts on interactional dynamics and the way participants perceive one another. There is a strong connection between the use of power and the concept of rapport orientations (Spencer-Oatey, 2008), where impoliteness or rudeness would be associated with a rapport orientation that is either neglectful or challenging. However, Watts also emphasizes the individual nature of perceptions, thus reinforcing how all parties in the interpreting triad perceive the interaction differently (Mason & Stewart, 2001).

The two concepts of rapport management and social networks are used to frame the exploration of interactional dynamics in clinical settings in the present study. Using the perspective of healthcare professionals as a lens, we focus on the way power can be used and misused by interpreters, the contrasting nature of individual perceptions and, how interpreter continuity impacts on interactional dynamics.

Method

Data Collection and Participants

The data were collected through a feedback exercise conducted by an interpreting agency from the Southeast of England in 2012. Feedback on agency services was perceived as an important means of quality assurance and was collected in a number of ways from Deaf and non-deaf consumers, through feedback cards, the agency's website, email, and by the work of the staff member responsible for British Sign Language (BSL) community liaison. Obtaining consumer feedback was a contractual obligation for some services provided by the agency; however, the feedback additionally contributed towards the monitoring of individual interpreter performance and informed their professional development activities. A high proportion of the agency's interpreting provision was in healthcare settings; therefore, obtaining the views of healthcare professionals was highly significant given the amount of work conducted in this domain. The feedback collected for this study primarily represents healthcare professionals' views on the three permanent staff interpreters employed by the agency. The aim was to explore these professionals' experiences of having an interpreter present and how the practice developed by the interpreters within the agency works for them. This new knowledge would enable a shift from practice based on assumptions to one based on sound evidence. Data were generated in two ways: via a questionnaire and semi-structured interviews. All participants were provided with clear information about how the data were to be used, and informed consent was obtained in advance. The questionnaire was issued to 40 people, representing the range of healthcare professionals in contact with the agency interpreters, both in primary care and specialist hospital settings.

Following the questionnaire, semi-structured interviews were conducted with 12 participants who indicated they would be willing to participate in an interview. These interviews were conducted by the three members of the interpreting team, in pairs where possible, and were held at the convenience of the participants. In most cases, the interviews were conducted with individual healthcare practitioners, but on one occasion it was more convenient and appropriate for the participants to arrange a group discussion. The research team documented the interview data in the form of field notes.

Instrument

The questionnaire was developed to reflect areas of interest and importance to the agency. In recognition of the increasing pressures on healthcare practitioners, the questionnaire was designed to be as user-friendly and as quick-to-complete as possible. The questionnaire comprised of a combination of multiple-choice questions and those requiring a self-generated written response. In addition to these questions, brief personal details of the respondent, including years of professional experience were collected. The four multiple-choice questions included space for additional comments. These questions related to average frequency of interpreter use, the unimportance or importance of interpreter continuity, confidentiality and the appropriateness of information sharing, and quality of interpreter provision. Four additional questions required a more-detailed response regarding their views on what the healthcare professionals liked about the service provided by the agency, any change they thought was required, how interpreted appointments compared with non-interpreted appointments and, an opportunity to add further comments. Respondents were asked if they would be willing to be interviewed to expand upon their written answers.

Limitations of the Study

The motivation underlying this study was to obtain feedback on the interpreting services of one agency and was not generated as part of an academic exercise, and this might have influenced the data. The participants were selected from the agency's client base, and from the respondents to the questionnaire, only self-selecting candidates were interviewed, potentially skewing results towards more positive responses. All the participants had experience of working with a particular subset of interpreters; therefore, responses reflect this experience rather than views about working with interpreters more generally. However, the particular pattern of interpreter provision experienced by these practitioners, with agency prioritization of interpreter continuity, allowed respondents to articulate their views about a facet of provision that might have been more difficult to obtain from those with less experience of such a model.

The qualitative data from this study were retrieved from field notes taken during the interviews rather than digital recordings. This means of data collection was designed to be accessible to all members of the research team, and to cause the least amount of intrusion or concern for the participants. By conducting the majority of the interviews in pairs, it was possible for the interviewers to compare their notes and co-validate their findings immediately post-interview to ensure accuracy of the data captured. Nevertheless, it is possible that certain comments and other nonverbal information were lost in this process.

The data from this study need to be interpreted with caution, particularly outside the UK, where healthcare systems differ from the National Health Service model or entail different commissioning structures for interpreting services. Likewise, healthcare practitioners with less experience with interpreter continuity may value this facet of provision differently. Nevertheless, the combination of quantitative and qualitative data, together with the wide range of healthcare practitioners who responded to the study, suggests that the high degree of commonality expressed in this study could potentially be shared by those working in similar healthcare systems elsewhere.

Results

Questionnaire Data

While this discussion primarily focuses on the data generated within the interview dialogues, a summary of the questionnaire data provides valuable contextual information to the discussion about interactional dynamics. Of the 40 people who received a copy of the questionnaire, 31 responded. This 75% return rate is high for questionnaire-based research and may be indicative of the affordance of the long-term working relationships developed with these professionals over many years. Those who returned questionnaires were all involved in interpreted appointments at least quarterly and some as frequently as once every two weeks, as shown in Table 1. The respondents represented the diversity of the healthcare profession including general physicians, primary care practice nurses, specialist nurses, surgeons, audiologists, hearing therapists, dentists, and ophthalmologists. The respondents also represented all echelons of staff grading, from highly experienced consultants to newly qualified practitioners.

Table 1
Frequency of Interpreter Use by Healthcare Professionals

	Weekly	Every two weeks	Monthly	Bi-monthly	Quarterly
N = 31	1	3	16	0	11

Note. Question referred to BSL/English interpreting services obtained within the last year.

The data indicated that healthcare professionals preferred continuity of interpreter provision. All respondents confirmed some degree of preference for interpreter continuity, with four stating it was “essential” (see Table 2). The healthcare professionals expressed a positive attitude regarding interpreters sharing information with one another when continuity of provision was impossible, with three practitioners describing it as “essential.” The responses suggest that clinicians view information-sharing as unproblematic, an opinion worthy of further exploration, though outside the scope of this article.

Table 2

Responses to Questions Regarding Interpreter Continuity

Question	Not at all	Where possible	Yes	Essential
If the same interpreter cannot attend a repeat appointment, is it appropriate for them to pass relevant information (a verbal briefing) about a previous appointment to the attending interpreter?	0	15	12	3
Is it beneficial to have the same interpreter attend repeat appointments with the same patient/s?	0	5	21	4

Note. N varies from 30-31 for these questions.

Interview data

Twelve of the 32 respondents were interviewed face-to-face, giving them the opportunity to expand on their questionnaire responses and to explore specific areas of interest identified by the three interpreter-interviewers. Interview responses reinforced the strong preference for interpreter continuity for individual patient appointments. The respondents made reference to how this enhanced quality of care, facilitated the development of trust and rapport with the patient while also creating a shared understanding of professional practices between healthcare practitioner and interpreter.

The healthcare professionals were asked to consider the potential effect of interpreters spending time with patients in the waiting room prior to an appointment. The majority of respondents viewed this as positive and an opportunity to enhance rapport between the patient and the interpreter. They described how this might reduce patient anxiety, both in relation to the appointment and around communication difficulties. Discussion regarding participants' experience of interpreters using consecutive and simultaneous modes of interpreting included exploration of any effects of switching between the two modes during an appointment. The general preference was for simultaneous interpretation, although the need for accuracy and clarity in communication was described as paramount. Many of those interviewed made unprompted comparisons with their experience of working with spoken language interpreters. When asked to talk about their experience of interpreters using the first and third person when working into spoken English, this had either gone unnoticed or was considered necessary for the sake of clarity to provide an accurate interpretation.

More divergent views emerged from discussion of the coordinator role of the interpreter, particularly in reference to what healthcare professionals expected the interpreter to interpret from signed language to spoken English. While some practitioners expected to know everything that was signed by their patient, both prior to and during the appointment, others wanted only clinically-relevant material and expected the interpreter to use his or her own judgment to do this appropriately. Similarly, for inter-clinician exchanges, some expected that the interpreter would identify that these were not intended for the patient and, consequently, an interpretation would not be given.

Discussion

The qualitative data form the main focus of this discussion, structured around the distinction between latent and emergent networks (Watts, 2003). Initially the discussion focuses on the concept of latent networks before exploring how healthcare practitioners perceive interpreters' involvement in emergent networks.

Influence of Latent Networks

In the context of an interpreted interaction, the shared latent networks described by Watts (2003) imply continuity of interpreter provision. Interpreters will only be part of a shared latent network if they have interpreted for the same clinicians and patients before. Continuity of interpreter provision was a focus of the interview discussions and the following comment reflects the general views of the participants:

The same interpreter provides a continuity of care; you are part of the patient's healthcare package. The familiarity and trust in you also confers trust on the doctor and the things they are saying...reduced anxiety and increased trust is really important for consultations and the same interpreter help both patient and doctor. (Consultant Ophthalmologist)

Interpreter continuity is seen as having clear benefits to the medical professional and, as a result, for the Deaf patient. This consultant indicates that interpreters can be viewed as team members rather than invisible conduits. While research by Angelelli (2004) and Hsieh (2007) illustrates that interpreters view themselves as part of the healthcare package, the data here suggest healthcare professionals may also share this perception.

Interpreters may value being part of a latent network with the other participants. One of the benefits of this is the shared knowledge of what has happened in the past, which may help considerably with the process of language transfer as well as understanding the dynamics of the interaction. The data in the present study suggest that shared knowledge also benefits the practitioners

It is useful for the same interpreter to attend all appointments. This continuity makes it easier; the dynamics don't need to start afresh. The same interpreter would be familiar with my explanations of the patient's ailment or treatment, and would be familiar with technical words, how to translate them, and spellings of words. (Consultant Rheumatologist)

As this consultant described, one benefit of a latent network is that the dynamics and relationships have already been established. This development of rapport is something that will naturally be influenced by the rapport orientations of those involved (Spencer-Oatey, 2008). In interpreted interactions, development of positive rapport between Deaf and non-Deaf clients will be impossible unless positive rapport is shared by the interpreter. One participant relayed a positive remark relating to a scenario where an interpreter's involvement actively enhanced rapport between those involved.

I see the interpreter and patient (under 16) having a relationship (that is developed in the waiting room), a professional friendship; interpreters are part of the healthcare package, with clinician and interpreter working in partnership. Because of this familiarity and trust I sense the patient not wanting to disappoint the interpreter and it enhances compliance with treatment and success. (Consultant Ophthalmologist)

Interactions with this particular patient had somewhat transformed in the three years since interpreter provision commenced. Prior to that time, the patient exhibited a challenging rapport orientation and was described by the consultant as a "stropy teenager," a reluctant attendee brought by his parents who helped with communication. After the interpreter's involvement, the patient transformed into an "animated and motivated individual." The clinician ascribes the change in the patient not wishing to disappoint the interpreter, thus enhancing compliance with treatment; however, the interpreter involved in these appointments has an alternative explanation.

I think the compliance and change in the patient's mood has come from the relationship he and the consultant have been able to develop since an interpreter has been included in these consultations. The consultant has all the interpersonal skills needed to engage with this young person. They just didn't share a language.

What is common to both perspectives is the suggestion that development of rapport takes time, thereby reinforcing the benefit of the latent networks afforded by interpreter continuity. Positive outcomes from the development of rapport between the interpreter and the Deaf patient were recognized by another consultant who appreciated that the better

interpreters know the patients, the better the interpretation is likely to be. This audiology consultant described a preference for dialogue with the interpreter following each appointment in order to check that all had gone well and to discuss issues of cultural sensitivity or what could be changed to improve future interactions. Where professionals value interpreter expertise, sharing the knowledge of Deaf community and culture is potentially invaluable. Involvement like this still could be considered as rapport management to facilitate future encounters. Rapport management is therefore not necessarily limited to happening within the interpreted interaction, but is something that may be done off-line before or after the appointment.

Not all interpreting assignments draw on latent networks involving all participants. In some situations partial latent networks may exist. For example, there may be a latent network shared only between the healthcare professional and the Deaf patient. Previous encounters may not have been interpreted or may have been facilitated by a different interpreter. Participants described how alternative interpreters “got the job done” but had a negative impact on interactional rapport. This provides further evidence that developing rapport needs time and suggests that when there is no interpreter continuity, the rapport aspect of the interaction is the one that may be forfeited. The following quotation exemplifies this, indicating how interpreters may negatively impact dynamics in ways that are perhaps not immediately apparent:

When another interpreter had to attend from your team, they were good but the teenage patient was not quite as lively... It could be different with an adult or different type of appointment and treatment, but for these six-monthly checks though, continuity is a significant factor for an emotive issue. (Consultant Ophthalmologist)

This comment suggests that some Deaf patients may be better able to cope with changes in interpreter provision than others. Particular consideration might be given to younger people, vulnerable adults, or anyone less experienced of interactions with different communication professionals, although Rudvin and Tomassini (2001) point out that all patients in healthcare settings can be considered vulnerable to some degree.

Another form of latent networks consists of the interpreter and the Deaf person, but not the healthcare professional, potentially a common situation when working in local Deaf communities. Several participants commented on the time interpreters spend chatting to patients in the waiting room. For most, this was unproblematic; some had not given much thought to the matter before. Participants noted that interpreters had a potentially calming presence there and a subsequent reduction in patients' anxiety about either the appointment or communication issues, once again facilitating the development of rapport. Other participants related the benefit of knowing that the interpreter and patient were both ready to be called. Punctuality may be crucial when clinics operate tight schedules; being late may negatively influence the dynamics of any subsequent interaction. The following quotation is indicative of remarks concerning waiting room chat:

It doesn't affect my view on your impartiality. It is necessary for the patient to spend this time with you in order for them to feel comfortable, and to make sure both patient and interpreter understand each other, and for the patient to gain trust. (Consultant Rheumatologist)

This professional appreciated that pre-appointment conversations were useful for building rapport between the interpreter and the Deaf patient, sentiments that were echoed by the other participants but which raise a number of issues regarding the waiting time interpreters spend with Deaf clients. Further consideration might be given to how waiting time is used and the

type of conversations that are appropriate to hold. Wider issues to consider relate to the practice of interpreters meeting with Deaf clients beforehand, rather than with the clinicians, when it is the healthcare team who has commissioned the interpreter's service. In fact, one professional, while appreciating the usefulness of this waiting room chat, expressed a desire for interpreters to share that information with them beforehand so they could adapt their approach accordingly. In the UK, this practice is more common in mental health settings but atypical in other healthcare appointments, despite potential benefits to the practitioner.

The interpreter's relationship with the Deaf patient in the waiting room was not the only issue that attracted attention. For example, audiologists often work in pairs. Sometimes this is because a senior audiologist is supporting a junior colleague, or it may be due to the complexity of the case. The audiologist teams frequently spend time away from the patient, at the computer or other equipment, analyzing test results and formulating prescriptions, and while this is going on, there may be exchanges happening between the patient and interpreter.

“While professionals are busy elsewhere in the room it is useful to have your summary of ‘chat’ between interpreter and Deaf patient for non-relevant exchanges. For clinically relevant material I’d like to know the details.”

(Consultant Clinical Scientist – Audiology)

If a Deaf patient had talked about “the game/match” over the weekend, the interpreter could easily relay “we were just talking about the football,” facilitating the development of rapport between clinician and patient who may continue that conversation between themselves. However, when a Deaf patient divulges things under these circumstances, it is not always clear if the information is solely for the interpreter, or to be shared.

Complications may occur when the expectations of Deaf and non-Deaf clients differ.

On some occasions there may be a latent network involving the clinician and interpreter, but not the Deaf patient. Similarly to a fully shared network this can bring benefits to understanding of the type of interaction that may occur and the working practices of the individual healthcare professional.

“Working with an interpreter you know means you have got over the awkwardness of that initial meeting and have established ways of working together, like finding positioning that works for everyone.” (Dentist)

Work with dentists provides an excellent example of these benefits. The issue of anxiety at the dentist is one that many people can understand. The data here indicate the importance of the interpreter's recognition about how personal views and experiences may unconsciously come to the fore and influence interactional dynamics. This particular dentist went on to describe how familiarity with the interpreter enabled her to be confident that no additional anxiety was being passed on to the patient, exemplifying the provider/interpreter trust outlined by Hsieh et al. (2010). When interpreters are new to a clinician, a lack of trust could perhaps be anticipated, and this point was exemplified by one audiologist who commented about using more “checking strategies” when the interpreter was someone new to them. This conscious strategy by the practitioner would be unknown to the interpreter, but could impact the dynamics of the interaction, and the strategy indicates how participant relationships and message content are inextricably linked (Spencer-Oatey, 2008). In these circumstances the interpreter could explore ways of working so that actions and choices facilitate the development of trust for future encounters. In a similar way the following comment picks up on how the perceptions of newly qualified healthcare professionals might differ from those with more experience, again highlighting how interactional dynamics may be affected in ways the interpreter may not appreciate:

“When I was more new to my work I was less confident in appointments. If the interpreter was not interpreting as I spoke I wondered if I was saying something stupid, it wasn’t a big thing. It’s not like that now and I don’t consciously change my behavior because there is an interpreter but the appointment does change. When things go wrong, having an extra person there intensifies things, there’s a heightened sense of being seen to have difficulties. (Audiologist)

Data also suggest that familiarity with the interpreter helped reduce the feeling of intrusion that might be experienced when working with an interpreter and helped the clinician focus on the task at hand rather than being distracted by the communication professional.

It helps to have the same person; we know why things are being done that way, familiarity with us and the content/processes means it doesn’t feel like an intrusion. Your focus is on the patient, clinician and the appointment. There are other interpreters who are distracted by the surroundings and seem interested for their own sakes in what we are doing; we then have to explain ourselves to them. (Consultant Clinical Scientist - Audiology)

The “other interpreters” referred to by this clinician are typically those working with spoken languages. This highlights the fact that interpreter is not there for personal benefit; the appointment is between the clinician and the patient. However, being unobtrusive does not equate to invisibility and does not imply that the interpreter is not present or involved in the appointment.

The data suggest that latent networks involving the interpreter may not only be useful to the interpreter, but they may benefit the healthcare practitioner. Where an interpreter is involved in a partial network, this may also facilitate understanding of the dynamics and goals of the interaction. In situations where the interpreter has no prior involvement, the data suggest value in adopting a flexible approach, opening dialogue with the practitioner, and developing sensitivity to other existing networks.

Emergent Networks

Watts (2003) discusses how the balanced latent networks created in previous interactions are not necessarily replicated in new encounters. Whether or not interpreters are part of a shared latent network, there are other immediate issues that need to be attended to regarding interactional dynamics. The four dynamic, contextual factors relevant for rapport management described by Spencer-Oatey (2008) are relevant here. These include the type of activity, the message content, participant relationships, and interactional roles. These components emphasize the inseparable relationship between language and context. In an interpreter-mediated event, one of the manifestations of the interplay of these components is the interpreter’s use of first and third person.

Use of first and third person. Interpreters have many decisions to make whilst working and one is over whether to use first or third person, both for the participants and for the interpreter, if they make a direct contribution such as a clarification (Wadensjö, 1998). Interpreters might perceive switches between the two modes as potentially problematic. Data from this study allow the exploration of how this may be perceived by hearing clients.

Now you mention it, yes, there is use of both first and third person, from BSL to English, but there’s no lack of clarity and actually I would expect the switching to occur and it’s always obvious what’s going on and what the patient is saying first-hand. (Consultant Ophthalmologist)

Other participants echoed this view. One participant astutely observed that perhaps use of first person was an indication that the interpreter had more confidence in understanding the Deaf patient. Interpreters may consciously use both first and third person in BSL-English interpretations. One reason for switching to third person is to seek clarification or deal with a self-repair such as, “I made a mistake there, sorry. What John said was ...”, which would indeed indicate an earlier problem with comprehension. However, participants described switches, such as this helping the flow of conversation, and of sounding more natural than a fixed first-person interpretation. Rudvin and Tomassini (2011) comment on the use of first and third person specifically in relation to medical interpreting work, advising that a shift to third person may be helpful in “highly emotive contexts” (p.53), where greater communicative clarity may be achieved through paraphrasing essential information. Certain healthcare practitioners may encounter emotive situations on a regular basis and will be highly experienced at dealing with them. The data in the present study indicate that clinicians draw on body language and visual cues to help make sense of the incoming message and are therefore not reliant solely on the spoken interpretation. This exemplifies how rapport is managed through a combination of contextual, verbal, and non-verbal means.

Coordination of communication. The interpreter’s coordinator role when working in liaison settings has been described as a central element of interpreting work (Sandrelli, 2001; Wadensjö, 1993). The data in this study illustrate practitioner perceptions about the ways in which interpreters conduct this facet of their work; in situations involving a high level of collaboration and question/answer style exchanges, one may anticipate active coordination throughout.

This discussion has already touched on situations where conversations take place between clinicians or between interpreter and patient, and these clearly form part of interpreters’ decision-making over when, and when not, to interpret information. Some clinicians expressed personal preferences for what conversations should be interpreted, such as conversations between Deaf parents of a child patient. While some practitioners expressed a desire for every comment to be interpreted, others equated this with the private exchanges that hearing parents might have, and therefore expected no interpretation to be given. The same can occur in reverse with inter-clinician chat that is not intended for sharing. The wide range of views expressed about this suggests that it would be advisable for interpreters to double-check these requirements with the clinician, particularly where there is no latent network and expectations have not been established.

The coordination activity of the interpreter (Sandrelli, 2001) is possibly easiest for healthcare professionals to perceive when it becomes problematic. One audiologist commented that in some interactions with spoken language interpreters, she felt he had to interrupt a private conversation, because of the excessive dialogue between the patient and interpreter. Sometimes, the need to have a dialogue with the Deaf patient is a necessity, such as clarification. The data indicate the importance of transparency in these situations. Interpreters can achieve this through being honest when information is missed, or not understood, or if there is cultural bridging that needs to be made. Failure to do this may be unsatisfactory from the clinician’s perspective, and perhaps suggests that the interpreter is exercising too much power over the interaction (Watts, 2003). Use of overt physical power by an interpreter also emerged from the data:

There was one appointment where the BSL interpreter pushed me to the side; the appointment was completely skewed and reorganized by the interpreter and I was

physically pushed out from where I sat. The fluidity had gone and it was operating on the interpreters' terms. (Consultant Clinical Scientist – Audiology)

Though the interpreter referred to by this participant was not identified, the clinician emphasized that the interpreter was not a member of the agency staff. While this situation might be extreme, it exemplifies how interpreters can exercise an inappropriate degree of power and possibly a neglectful rapport orientation (Spencer-Oatey, 2008). When this happens, the interactional dynamics will be negatively affected for everyone. Interpreter power can be expressed through language use and actions, and though shifting the seating arrangements might seem an innocuous action, it can have unseen impact on the other participants.

For interpreters, effective rapport management involves constantly monitoring the interlocutors to help compensate for the difficulty participants may have in evaluating each other directly. The data suggest this may become more complex when either or both the participants has some ability to use the language of the other.

It is rather difficult when the patient is able to communicate both orally and by using BSL and switches between these in the appointment. Usually, it is because they are able to lip-read the clinician; however they can miss a vital part of the conversation. It would be useful to explain to the user how it is best to get the most from the BSL interpreting service before the appointment. (Audiologist)

The data indicate that clinicians value a flexible approach, as Deaf patients might value the positive attitude of the clinician communicating directly with them. In situations like this, it may be necessary for the interpreter to monitor the communication that is happening, checking that the direct communication is effective; interpretation may not be required. Interpreters may utilize their knowledge of signed language, English and of Deaf people and their culture to identify misunderstandings and intervene when appropriate.

Modes of interpreting. Though signed language interpreters primarily interpret simultaneously (Grbić & Pöllabauer, 2006), healthcare settings are one of the domains in which a “blend of consecutive and simultaneous interpreting” can be adopted (Russell, 2005, p.140). These settings lend themselves to a mixture of interpreting modes due to the brief turn-taking that characterizes these encounters. Comments regarding the use of both interpreting modes emerged from the data.

A number of participants compared working with signed language and spoken language interpreters. The data indicate that clinicians have a preference for the simultaneous modality that is more easily afforded to signed language interpreters and the benefit this can have on interactional dynamics.

You have the advantage of working simultaneously, compared to spoken language interpreters. There is a better flow to the appointment, the conversation is contemporaneous with the patient getting the right stuff at the right time, I get their feedback at the points of expected responses; the physical feedback, nods to show they are understanding and listening. I'm never sure with spoken language interpreters working consecutively how much paraphrasing and editing has been done. (Consultant Ophthalmologist)

This comment may indicate a false sense of security. Clinicians perhaps find it harder to perceive, or evaluate, how much paraphrasing signed language interpreters are doing. As clinicians expressed a preference towards simultaneous interpreting, this raises the issue of how an interpreter may be perceived when consciously deciding to work consecutively,

particularly as other studies have highlighted practitioners' concerns over the effect on interactional dynamics created by interpreting in this mode (Pöchhacker, 2000). This may be due to the relationship between interpreting modes and the exercise of power in emergent networks (Watts, 2003). The interview data suggest that clinicians may retain more power when interpreters work in simultaneous mode.

I feel there are no control issues in BSL-interpreted appointments. With spoken language interpreted appointments I often feel that the interpretation is not perhaps 100% accurate, I am not convinced or trusting that what I said is accurately conveyed. The reason I don't feel this way about BSL interpreters is more because of the use of simultaneous interpreting methods, as opposed to anything else. (Consultant Rheumatologist)

Not all participants share the predominant preference for interpretation in simultaneous mode. Interpreters need flexibility to adapt to the preferences of individual clients. The subjectivity highlighted by Watts (2003) was another theme that emerged from the data.

It's easier when it isn't simultaneous, otherwise it's like a *feedback loop*, seeing the interpreter render what I've just said, so sitting slightly behind me might be less of a distraction. It's like hearing your voice in headphones with a short delay, it really throws me. In reverse though, I prefer simultaneous BSL to English as it feels more *live* and I can match non-verbal cues and signals with what I am hearing. (Consultant Clinical Scientist - Audiology)

The particular requirements expressed by this clinician were previously unknown to the interpreting team. Working practice with this clinician could be adapted so that an explanation could be given to the patient during introductions, agreeing upon seating to everyone's satisfaction. These arrangements could be reviewed at the end of the appointment with the interpreter either included in that discussion or consulted separately.

Physical positioning. In comparison with spoken language interpreters, physical factors relating to positioning and lighting are greater considerations for signed language interpreters (Grbić & Pöllabauer, 2006). Rudvin and Tomassini (2011) highlight the importance of seating arrangements for interpreting in healthcare settings, while Wadensjö (2001) describes how positioning and eye gaze can affect interactional dynamics in spoken interpreted situations. These issues become more crucial when a signed modality is involved, and consideration of physical positioning and movement during interpreted interactions was raised by a number of participants.

"We move around in sessions and do exercises; I change my mind about what we're going to do too. Collaborating with the BSL interpreter and taking guidance on positioning and communication is important." (Physiotherapist)

This physiotherapist went on to describe an ideal scenario in which problems with communication could be rectified as the appointment progresses with the clinician and interpreter working collaboratively, for example, to ensure that questions are re-phrased suitably. Remarks like this exemplify how the elements to building and establishing rapport involve not only the content and structure of the language used, but also non-verbal issues, which in some situations, may include positioning and movement within the room.

Another participant expressed personal preference related to interpreter positioning, highlighting how individual subjectivity (Watts, 2003) is evident in discussions on this issue. The data suggest that participants are aware of positioning and its effects on the interaction.

Positioning is the only thing that could alter the relationship between me and my patient. I prefer the interpreter to sit to my side but slightly behind so that I can't see them. This allows me to concentrate on speaking directly to the Deaf patient, without the temptation to turn and look at the interpreter. (Consultant Rheumatologist)

This clinician wants to behave normally and talk directly to the patient in order to facilitate the establishment of rapport. Deaf people may also prefer this behavior, although they will need to look at the interpreter, too. The clinician manages the "temptation" to look at the interpreter by controlling positioning. In this situation, it is the clinician, rather than the interpreter, exercising power.

The data generated in this study provide useful evidence both to support and challenge our working practices as interpreters. As such, these data contribute towards an empirical base to inform decision-making on use of interpreting strategies and the effect these strategies may have on interactional dynamics.

Conclusion

Pöchhacker (2000) recommends that any discussion of interpreting quality needs to take into account the perspectives of all those involved. This research report helps redress the imbalance of attention in healthcare interpreting, which has historically concentrated predominantly on Deaf clients and interpreters themselves, by examining the views of healthcare practitioners. The exploration of the perceptions of healthcare professionals identifies some fundamental issues relating to the use of specific interpreting strategies. It also highlights how successful interpreted interactions require more than attention to effective language-transfer alone. The data indicate the potential benefit of active involvement by the interpreter, in collaboration with the healthcare practitioner, before, during, and after appointments. This suggests that, like interpreters, clinicians are shifting away from the notion of the interpreter as an invisible conduit (Roy, 1993).

Both the questionnaire and interview data indicate that healthcare professionals prefer continuity of interpreter provision, a view that may be important to convey to service commissioners and providers. While not all agencies provide or prioritize interpreter continuity, these data suggest that this should be more of a consideration if interpreting provision is to meet with the practices preferred by the clinicians. Additionally the data illustrate how involvement in latent networks can facilitate interpretation in numerous ways, not only through enhancing knowledge of the terminology used, but positively impacting on interactional dynamics by potentially reducing interpreter intrusiveness and developing trust between all participants. The effective collaboration between interpreter and clinician afforded by a shared latent network may result in improved quality of care and patient outcomes.

The process of conducting this research was a positive one, opening dialogue between interpreters and healthcare practitioners that allowed the chance for interpreters to explain previous actions, facilitated an openness to make changes in the future, and further developed interpreter/client relationships. The positive experience of those involved suggests that such an exercise could be considered a useful tool both to enhance service provision and for interpreter development. Through sharing these findings with a wider audience, it is hoped that these insights into the perceptions of the medical profession can be transferred from a localized benefit to informing the profession more generally.

References

- Alexieva, B. (2000). A typology of interpreter-mediated events. In F. Pöchhacker & M. Shlesinger (Eds.), *The interpreting studies reader* (pp. 218-233), London, UK: Routledge.
- Angelelli, C. (2004). *Medical interpreting and cross-cultural communication*. Cambridge, UK: Cambridge University Press.
- Buetow, S. (2004). Towards a new understanding of provider continuity. *The Annals of Family Medicine*, 2, 509-937.
- Grbić, N., & Pöllabauer, S. (2006). Community interpreting: Signed or spoken? Types, modes, and methods. *Linguistica Antverpiensia*, 5, 247-261.
- Hsieh, E. (2007). Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science and Medicine*, 64, 924-937.
- Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research*, 20, 170-181.
- Mason, I., & Stewart, M. (2001). Interactional pragmatics, face and the dialogue interpreter. In I. Mason (Ed.), *Triadic exchanges: Studies in dialogue interpreting* (pp. 51-70). Manchester, UK: St Jerome.
- Mesa, A.-M. (1997). *L'interprète culturel: un professionnel apprécié. Étude sur les services d'interprétation: le point de vue des clients, des intervenants et des interprètes*, Montréal, Québec, Canada: Régie régionale de la santé et des services sociaux de Montréal-Centre.
- Metzger, M. (1999). *Sign language interpreting: Deconstructing the myth of neutrality*. Washington, DC: Gallaudet University Press.
- Pöchhacker, F. (2000). The community interpreter's task: Self-perception and provider views. In R. P. Roberts, S. E. Carr, D. Abraham, & A. Dufour (Eds.), *Critical link 2: Interpreters in the community*. Philadelphia, PA: John Benjamins.
- Roy, C. (1993). The problem with definitions, descriptions and the role metaphors of interpreters. *Journal of Interpretation*, 6, 127-154.
- Rudvin, M., & Tomassini, E. (2011). *Interpreting in the community and workplace: A practical teaching guide*. Basingstoke, UK: Palgrave Macmillan.
- Russell, D. (2005). Consecutive and simultaneous interpreting. In T. Janzen (Ed.), *Topics in signed language interpreting* (pp. 136-164). Philadelphia, PA: John Benjamins.
- Sandrelli, A. (2001). Teaching liaison interpreting. In I. Mason (Ed.), *Triadic exchanges: studies in dialogue interpreting* (pp. 173-196). Manchester, UK: St Jerome.
- Spencer-Oatey, H. (Ed.). (2008). *Culturally speaking: Culture, communication and politeness theory*. London, UK: Continuum.
- Swabey, L., & Malcolm, K. (Eds.). (2012). *In our hands: Educating healthcare interpreters*. Washington, DC: Gallaudet University Press.
- Wadensjö, C. (1993). The double role of a dialogue interpreter. In F. Pöchhacker & M. Shlesinger (Eds.), (2002). *The Interpreting Studies Reader* (pp. 354-370). New York, NY: Routledge.
- Wadensjö, C. (1998). *Interpreting as interaction*. New York, NY: Longman.
- Wadensjö, C. (2001). Interpreting in crisis: the interpreter's position in therapeutic encounters. In I. Mason (Ed.), *Triadic exchanges: studies in dialogue interpreting* (pp. 67-85). Manchester, UK: St Jerome.
- Watts, R. (2003). *Politeness*. Cambridge, UK: Cambridge University Press.