

Interpreter Mediated Medical Encounters in North Italy: Expectations, Perceptions and Practice

SARA PITTARELLO

University of Trieste

Abstract

This paper aims to investigate expectations and perceptions regarding the figures who mediate between healthcare personnel and foreign patients in Italy. The objective is to explore the distinction – seemingly unique to Italy – between the two terms “interpreter” and “mediator” and the reasons behind this separation. Healthcare providers and interpreters/mediators were questioned about their respective opinions through questionnaires and interviews. Both categories worked in local health units of a Northern Italian region, predominantly in the Emergency Departments. Special attention was paid to the following aspects: interpreter/mediator’s roles and tasks, invisibility versus active participation and the use of personal pronouns and indirect speech. In order to examine the level of consistency between perceptions and practice on these topics, 26 mediated encounters were observed according to prearranged parameters. These consultations involved the same subjects who had previously participated in the questionnaires. Four sessions, which proved to be particularly relevant for the purposes of this research, were subsequently transcribed and examined from a qualitative point of view. The method of the case study, herein adopted, allowed for the analysis of the subjects’ behaviour from different points of view, in line with the overall objective of providing a holistic view of the themes investigated. Drawing on Inghilleri’s suggestion of “interpreting” as a “zone of uncertainty” (2005), the paper also refers, in particular, to Leanza’s new typology of roles (2007),

to Davies & Harré's theory of positioning (1990) and to Bot's description of reported speech (2007).

1. Introduction

The need for professionals to enable interlinguistic and intercultural communication is increasingly being felt in medical settings today, as the presence of foreign patients is on the rise. This is not always provided for, however, by national health policies, with the exception of numerous Northern European countries and almost all English-speaking countries, such as Australia.

In the last twenty years, studies on interpreting have consequently paid increasing attention to medical settings as one facet of a new and attractive field of research, known as Community Interpreting,¹ and much has already been written on the identity and tasks of the community interpreter. What all the studies have in common, notwithstanding the country to which reference is made, is the frequent lack of terminological and deontological clarity. The expressions “community interpreting” and “public service interpreting” – together with their hyponyms “medical/healthcare/health interpreting” – are more frequently used abroad to denote the interpreting mode herein examined. In Italy, where research in this field is rather recent, two phrases seem to coexist to designate the same mode, namely “interpreting in the social field” and “linguistic-cultural mediation” (Merlini 2009: 58). Furthermore, the term “mediator” is often coupled with such adjectives as “linguistic”, “cultural”, “intercultural”, “social”, “socio-cultural”,² which indicate that greater attention is paid to either the linguistic or the cultural aspect.

This paper attempts to detect the “lowest common denominator” among the numerous definitions and explain, insofar as is possible, the reason for such uncertainty and confusion. The distinction between the term “interpreter” and “mediator”, which seems to be unique to Italy, has hence intentionally been reproduced throughout the paper by constantly repeating the two terms. The study, which draws on the author's MA thesis, investigates how the role of community interpreters in a medical setting is perceived and understood in Italy by healthcare personnel, with the aim of comparing their expectations and needs with the opinions of community interpreters who work in the field. The results are then analysed with reference to interpreting practices, to highlight possible similarities and/or differences between interpreters and mediators, which may account for the above-mentioned distinction.

1 The term was introduced at the First International Conference on Interpreting in Legal, Health and Social Service Settings which was held in 1995.

2 Bochner (1981) was the first to suggest the term “mediator”.

The starting point for the present investigation is Inghilleri's suggestion of the interpreting profession in public services as a "zone of uncertainty" and the ensuing vulnerability of the interpreter's status (2005: 69, 72). The author draws on Bourdieu (2000), who describes these "zones of uncertainty" as "contradictory and potentially liberatory spaces within a social structure", which may cause conflicting world views and thus upset the relevant *habitus* – the way in which we build objective reality and evaluate the external world through our participation in well-structured social practices. The lack of a clear definition for the public service interpreter is thus explained to a certain extent and justifies the relentless research of those who work in this sector for a better definition of their own identity as against other professions and as against other interpreting modes.

2. Who is the interpreter and who is the mediator?

Without dwelling on the terminological debate, it should be highlighted that this paper proceeds from Roberts' definition of community interpreting³ (1997: 8) and its three subcategories of medical, legal and public service interpreting. As Pöchhacker observed (1997), each country seems to have a different understanding of the community interpreter's identity, which is reflected in the way they define role, scope and professional status. The difficulty in the emergence of a distinct professional profile and the over-abundance of terms defining this profession,⁴ according to Pöchhacker, may be due to the lack of international consensus (Chesher *et al.* 2003: 275). In Italy, the scene seems to be even more complex owing to the presence of numerous calques from English (Mack 2005: 7, Rudvin 2005: 31) and to the addition of terms referring to the mediation field.

The question which must then be explored is the following: according to researchers and to those who work in the field, who is the interpreter and consequently who is the mediator? The main objective is to find out the reason for the attitudes of other countries – and their underlying tenets – compared to Italy. Several authors argue that the community interpreter is, by definition, a mediator as well (Wadensjö 1998: 6-7) and "cultural brokering" is among the factors which distinguish community interpreting from other interpreting modes (Roberts 1997: 12). Mediation is therefore seen as a function of community interpreting and, more specifically, of interpreting in medical settings (Bochner 1981) or as one of the roles which

3 The expression will be used hereafter as a hyperonym referring to both interpreters and mediators.

4 For an exploration of the terms most frequently in use in this field, see Riccardi (2001: 82-84), Napolitano (2005: 28-29) and Mack (2005: 3-10).

the interpreter is called upon to perform (Weiss & Stuker 1999: 258). This ability should also be desired in the attempt to deliver a better performance (Meyer *et al.* 2003: 78). Interestingly, the two concepts are frequently associated by researchers, who use expressions such as “interpreter-mediated interaction” and “interpreter’s mediation” (Wadensjö 1998: 62) – hence the choice of the title (interpreter-mediated medical encounters).

In Italy, on the contrary, there appear to be two different figures who are entrusted with the task of interpreting in medical settings, as confirmed by the figure described in the healthcare structures of a Northern Italian region: if the local health units in the seaside resorts of Jesolo and Caorle and in Portogruaro make explicit reference to the profile of “administrative assistant-interpreter”, the hospitals of Bussolengo (Verona), Feltre (Belluno), Mestre (Venice), Montebelluna (Treviso), Montecchio (Vicenza) and Padua, just to mention a few examples, have introduced a mediation service aimed at foreign users who are not familiar with, or fluent in Italian. The distinguishing feature does not seem to be the role performed, but rather their ethnic belonging to a minority culture and a migrant community (Favaro 2001, Belpiede 2002). Italian policy-makers have not been able to provide a better and clearer definition of who the mediator is at either national or regional level (Mack 2005: 8-9, Belpiede 2008). This contributes to the coexistence of the terms “interpreter” and “mediator” to designate the profile of those who work in medical settings. One may therefore question the reason for this peculiarity which is not to be found anywhere else.

2.1 Community interpreter users: immigrants and tourists

At the first international conference on community interpreting, its recipients were described as “those who are not fluent speakers of the official language of the country” (Roberts 1997: 11). According to Pöchhacker (2007: 37), it is an accurate definition, since it includes tourists and business professionals. This argument holds true for medical interpreting too, as a subcategory of community interpreting: reference is then made to all foreigners who do not have full command of the official language spoken in one country, regardless of their nationality or the reason for their presence there.

Numerous authors, however, tend to associate this interpreting mode with migrant users. The hallmark of community interpreting, according to Collard-Abbas (1989: 81), resides in its goal to assist immigrants who are not native speakers and to help them have equal and full access to the services provided by law. Gentile *et al.* (1996: 9) maintain that liaison interpreting – and consequently medical interpreting – traces its origin back to the first migration flows. Riccardi (2001: 83) and Martinsen (2002:

257) are of the same view when they identify immigrants as the main users of this form of interpreting, while Tomassini (2005: 116) highlights that it was immigration which brought about the problem in Italy of ensuring full access to services for all those who could not speak Italian fluently. This gave birth to a new profile, i.e. “the social interpreter” or “linguistic-cultural mediator” in the healthcare system. Lack of recognition and the lower status of community interpreting – if compared to conference interpreting – are hence ascribed to the origin of its users and seem to explain the great confusion which reigns in this field, with regard to role and identity and which does a disservice to the emergence of a well-defined profession. When reference is made to the “mediator”, the same position may easily be found: according to Dallari *et al.* (2005: 190), the main function of mediators consists in facilitating migrants’ access to social and health services.⁵

The weak position of social interpreting, however, which allows for non-professionals – relatives, friends or nurses – to be employed as community interpreters, could become an opportunity to enable those who work in the field to define a role which corresponds to their true identity and thus assert “who they are” and not “who they must be” (Bourdieu 2000, cited in Inghilleri 2005: 82).

2.2 Roles and tasks of medical interpreters: recent studies and new approaches

The need to overcome the discrepancy between the abstract and real roles of community interpreters (Pöchhacker 2007: 243) has led to numerous empirical studies, especially in Northern European and American countries. These studies aim to identify a common frame of practice and compare interpreting theories with perceptions and feelings of those who work in the field, including healthcare personnel.

In the course of time, following the increasing attention devoted to medical interpreting as one of the main branches of community interpreting, three approaches may be distinguished, ensuing from the application of new linguistic discoveries to the interpreting field. The first approach stems from *conversation analysis* (Drew & Heritage 1992) and examines discourse organisation and asymmetries in mediated encounters (Wadensjö 1998, Roy 2000, Bot 2007, Merlini & Favaron 2007), whereas the second gathers studies on *discourse analysis* (Mason 2005). More recently, researchers have focused on the interactional role of interpreters, closely tied to pre-determined normative models and to constant realignments of the subjects during interaction (Inghilleri 2005, Merlini 2009: 62).

5 For a detailed list of authors who take a similar stand, see Allaoui (2005: 44).

The role of medical interpreters has consequently been examined on a regular basis through different research methods. Pöchhacker (2002) offers a comparative description of the most relevant studies carried out up to the 1990s, according to the method of research they implemented – surveys, experiments, corpus-based analyses and case studies.

More recent studies, following the same methodological patterns, have resorted to questionnaires (Pöchhacker 2000, Angelelli 2003, Cheshier *et al.* 2003, Creeze 2003, Tomassini 2005) or interviews (Bot 2003, Allaoui 2005), or have analysed recordings of mediated encounters (Bot 2003, Meyer *et al.* 2003, Meyer 2004, Bot 2007, Dubslaff & Martinsen 2007, Merlini & Favaron 2007, Valero Garcés 2007). On certain occasions, an integrated analysis has been carried out and questionnaires or interviews have been compared to “real” practices (Bot 2003, 2007, Leanza 2007). Other authors have favoured an illustrative point of view, as has Dallari *et al.* (2005), who described the interpreting practices in the local public services of an Italian region.

Each study contributes to a deeper understanding of medical interpreting by exploring one of its features – the interpreter’s role (Leanza 2007, Pöchhacker 2007), degree of visibility (Angelelli 2003), impartiality (Valero Garcés 2007) and use of personal pronouns and indirect speech (Bot 2007, Dubslaff & Martinsen 2007), their knowledge and command of medical terminology (Meyer 2004) and their positioning and alignment, which are reflected in the privileged pattern of turn-taking and topic control (Merlini & Favaron 2007). Expectations and opinions of healthcare personnel and/or interpreters outline an interesting profile with regard to interpreters’ main tasks, qualities and responsibilities (Allaoui 2005, Tomassini 2005) and stress the importance of ethics and personal attitudes to work in this sector (Cheshier *et al.* 2003). The same approach has led Creeze (2003) to the conclusion that cultural differences – one of the main obstacles to smooth communication – are responsible for a different understanding of the concept of health and disease and consequently determine diverging expectations in users and medical personnel. Expectations also proved to act as a tool to investigate whether the interpreter’s profile is deemed – by the health services of Bologna – more or less suitable than the mediator to satisfy their needs (Dallari *et al.* 2005).

With the view to carrying out an integrated analysis and exploring the behaviour of the same subjects from different perspectives, the research herein presented is based on the methodological approach of the “case study”, which Pöchhacker (2002: 105) recommends, since it combines different techniques of analysis – surveys (questionnaires or interviews), participant observation, study of text corpora and document analysis. A holistic view and a wider perspective of the subject are thus achieved, if compared to all the other methods when taken individually.

3. The theoretical framework: positioning, zones of uncertainty and roles

The comparison between expectations and opinions on the one hand and real practices on the other hand draws on the theory of discourse analysis in terms of identity and “positioning”. The latter concept was first introduced by Davies & Harré (1990: 48) and is the reference point for this study: whenever people speak, they tell – more or less explicitly – one or more personal stories and by doing so they position themselves (reflexive positioning) and the others (interactive positioning) and make sense of their world experience. From this point of view, discourse is seen as a multi-faceted process through which meanings are dynamically and gradually shaped.

Positioning is more flexible than the concept of role, since it implies the joint participation of all interlocutors in the creation of identities, which are deeply linked to the position taken by each participant during the conversation. Positions themselves may vary in the course of the same interaction and may sometimes be in contrast with “dispositions” (Inghilleri 2005: 70), which is the case when reality and expectations differ, for example. This holds true especially for ill-defined professions, whose fields are rather uncertain with regard to the position occupied by interlocutors in the social space. The *habitus* – the way objective reality is built – may, as a result, be destabilised, which calls for an intervention to define or redefine one’s own social position. Only occasionally do significant social transformations occur, which subvert the existing order, whereas the overall tendency is towards re-establishing the previously existing social/interactional stability (Inghilleri 2005: 71-72).

Interpreting falls within the category of ill-defined professions: representatives of well-established professions (in this case doctors) tend to project their own perceptions of reality onto interpreters (Inghilleri 2005: 73). As a result, completely different expectations and opinions coexist on the identity of the interpreter/mediator – especially in medical settings – and the tasks they are called upon to perform:

Interpreters must respond to numerous and sometimes contradictory expectations, and everyone, including the interpreter, has his or her own idea of what an ideal interpreter should be. (Chesher *et al.* 2003: 274)

The uncertain position and the ensuing contradictions which characterise interpreting, however, may favour a re-definition of practice and professional profile, for interlocutors to be positioned within new patterns established by the interpreters themselves. This requires a direct observation of mediated encounters and an investigation of the linguistic behaviour and role of interpreters/mediators in real cases. Inghilleri’s suggestion about defining interpretation as “a pedagogic discourse” (2005:

72) is therefore legitimated, as is the choice of this paper to adopt the research method known as “case study” (Pöchhacker 2002: 105).

The identities projected while speaking reveal the role played by interlocutors in that precise moment. Despite being rather static in comparison to “positioning”, the concept of “role” is useful to examine the interpreter/mediator’s position from their point of view and from that of healthcare personnel. Among the numerous studies carried out on the topic, this paper draws on the new role typology advanced by Leanza (2007: 11-34) as an integration of Jalbert’s taxonomy (1998, quoted in Leanza 2007: 13-14), since it offers the advantage of not contrasting interpretation and mediation. According to Leanza, the roles perceived by doctors, interpreters and patients are an indication of the interactional process at stake.

The five categories identified by Jalbert⁶ are *translator*, *cultural informant*, *culture broker/cultural mediator*, *advocate* and *bilingual professional*. These correspond to a gradual increase in the interpreter/mediator’s active participation and solidarity with either the user or the institution. The five categories are resumed and expanded by adding four new roles: *active translator*, *monolingual professional*, *welcomer* and *family supporter*. The reason for this integration is explained by Leanza with the need to account for interpersonal factors, such as the relation between doctors and interpreters, and for a more complex reality where roles may frequently intertwine and overlap and where participants’ expectations may not always coincide. Observation of mediated encounters reveal that the presence of interpreters tends to maintain the asymmetry between healthcare providers and patients.

Without dwelling on Leanza’s definition of each role, it should only be underlined that they indicate a more or less active position of interpreters and their preferred alignment with either patients or medical/nursing staff. Leanza goes even further in proposing a new organisation of the above mentioned roles, according to how cultural differences are tackled by the community interpreter, who may act as:

1. A *system agent*, when she⁷ is aligned with the institution (*monolingual and bilingual professional*);
2. A *community agent*, when cultural differences are recognised as having equal importance (*cultural informant, culture broker and advocate*);
3. An *integration agent*, when migrants are assisted throughout their integration in the receiving community (*welcomer, family supporter*);
4. A *linguistic agent*, when she only provides a linguistic contribution and maintain an impartial attitude towards the other participants (*translator*).

6 For a comprehensive definition of each role, see Leanza (2007: 13-30).

7 In this paper, the feminine pronominal forms have been used to refer to interpreters and mediators.

It is interesting to note that even here the role of cultural mediator is immediately associated to immigrants: Leanza suggests that the community interpreter becomes a *community agent* when “the minority (**migrant**) norms and values are presented as potentially equally valid” and acts as an *integration agent* when she “finds resources to help **migrants** (and people from the receiving society) to make sense, negotiate meaning and find an ‘in-between’ way of behaving”.⁸

This paper aims at responding to Leanza’s invitation to investigate the role of community interpreters so as to increase data available and provide more detailed information on what happens during mediated encounters in various medical settings.

4. Research field and data collection

The present research was carried out in the Northern Italian region of the Veneto, which, as a popular tourist destination, has the third highest presence of foreigners in Italy. The Veneto region also has a unique network of both public and private social and healthcare services: 61 public hospitals divided into 21 Local Health Units (Ulss), which all enjoy extensive autonomy.

It was therefore deemed necessary to define further the boundaries of the research field: out of seven provincial administrations, three provinces were selected as the main object of the analysis, namely *Belluno*, *Padua* and *Venice*. These areas satisfied the prerequisites laid down by the author: a wide and increasing presence of foreigners, of a permanent (migrants) or seasonal (tourists) nature; pure geographical symmetry, to include a seaside and a mountain resort, a city of art and a centre attracting a workforce; and a high demand for English and German in interpreting/mediation services. The latter requirement responds to the objective of observing collected data directly. The distinction between migrants and tourists has also proved essential, since the healthcare assistance provided in Italy to foreigners differs greatly according to their nationality.

For the sake of data comparison and in an attempt to concentrate the analysis on units with a large turnout of foreigners, the choice was made to privilege mediated encounters in Emergency Departments, which better highlight the need to communicate with patients immediately and effectively, owing to the “emergency” nature of the event. Good communication is nonetheless of the utmost importance in other wards where the number of foreign patients is on the increase, in particular Gynaecology, Obstetrics, Paediatrics and Infectious Diseases.

8 The emphasis was added by the author of this article.

As far as *Belluno* is concerned, data was collected in the city hospital – which registers a high percentage of migrants due to the important industrial pool surrounding the city – and in the two healthcare units of *Agordo* (ski resort) and *Feltre*, a city with an increasing migrant population. In the provincial administration of *Venice*, attention was focused on *Mestre*, owing to its large migrant community, and *Jesolo*, a seaside resort which is highly appreciated by tourists from Austria, Germany and from Northern European countries (especially Denmark, Sweden, Norway). With regard to *Padua* – a city of art which attracts many foreign workers – the investigation focused on its main hospital and on health services distributed across the territory.

As may easily be inferred from the following chart (Table 1), which summarises the main features of the interpreting/mediation services operating in the above-mentioned structures, encounters with non-native speakers are not always mediated by the presence of dedicated staff – as is the case in *Belluno* and *Agordo* – and interlinguistic services are often coordinated by cooperatives. Qualification and training of personnel are consequently entrusted to cooperatives, such as “*La Frontiera*” in *Padua*, or to private institutions, for example *ENAC* in *Feltre* (*Istituto Nazionale Canossiano*), to the detriment of an objective evaluation and comparison of the skills and expertise of interpreters/mediators. In the case of *Mestre*, a draft agreement was signed between the Municipality, which avails itself of an external cooperative, and three services of the Local Health Authority (*Usls 12*). These services comprise Family Planning clinics, the Department of Hygiene and Public Health and the Department for Infectious Diseases, which is also where the Outpatients’ clinic for immigrants is located. Mediators are only available by appointment.

Direct recruitment of interpreters only occurs in *Jesolo*, where they are selected through a yearly competition and employed on a temporary contract from May to September, owing to the substantial number of foreign tourists who visit the area in summer. A seminar is held at the beginning of the season to train interpreters on administrative aspects, since they are required to perform administrative duties as well. They work shifts and a telephone interpreting service is guaranteed during the night. Out of a total of fifteen to twenty interpreters recruited every summer by the Local Health Authority no. 10 (*Assl 10*), four of them work in the Emergency Department of *Jesolo* and two in the Healthcare Service for Tourists (*Medicina Turistica*), opposite the Emergency Ward. Another interpreter is responsible for translating all the documents regarding hospitalisations, relations between the hospital and the respective sickness funds of each patient and other relevant economic aspects. All interpreters wear white coats and are therefore frequently mistaken for medical personnel, although their qualification is indicated in Italian on the breast pocket. Interpreters in the Emergency Department, however, are required never to leave the side of medical or nursing personnel,

whereas in the Healthcare Service for Tourists, which is similar to outpatients' clinics, interpreters may also welcome patients and collect their personal data and information on symptoms, which may explain the reason why the interpreters tend to report the case to the doctor at the beginning of the consultation. This greater autonomy enjoyed by interpreters in the Healthcare Service for Tourists might be justified by the relatively lower severity of its patients' conditions, since more complex cases tend to be referred to the Emergency Department.

The mediation service introduced in 2003 in Padua, a city with a strong reputation for its hospitals and academic tradition in the medical field, is contracted to an external cooperative which provides mediators to both the Hospital Trust and the Local Health Authority no. 16. The service may be activated on call by all departments and healthcare services, by forwarding their request to the relevant Public Relations Offices, which then contact the cooperative.

As far as the linguistic aspect is concerned, the greatest demand in Padua is for classical Chinese and Arabic, while Belluno and Feltre have a higher percentage of requests for Arabic spoken in Morocco and classical Chinese. Mediations in Albanian, Romanian, Chinese and Bengali are the most frequent in Mestre, whereas Jesolo and Agordo mainly deal with German and English. It is worthwhile investigating the correspondence between the languages spoken and the designation which each structure has chosen for the linguistic service, since it confirms the positions and views which have emerged from the interviews and questionnaires.

4.1 The case study as research method

The initial project of a semi-structured interview was reviewed to respond to the need for higher comparability in results (Corbetta 1999: 135, vol. 2). A questionnaire was tailored to meet the needs of a greater number of subjects participating in the research, who often had a scant amount of time available. The choice for the most suitable research method implied an in-depth analysis of the principles of social research, whose description is beyond the scope of this paper.⁹ The aim is to investigate the expectations and needs of healthcare personnel regarding the interpreter/mediator's role in medical settings and then compare them with opinions and perceptions of interpreters/mediators in the field.

An integrated analysis proved to be the best way to pursue the above mentioned objective, since the behaviour of interviewed subjects is studied from several points of view, thus providing a more complete and

9 On this, see Corbetta (1999, vols. 2 and 4) and Pittarello (2009: 62-63).

| Structure | Coordinating internal service | Interpreters/mediators' hiring procedures | Name of the Service | Tasks e/ Functions | Type of work relationship | No. of collected questionnaires |
|---|--|--|--|---|--|--|
| ED – Belluno Hospital (Uiss 1) | None | None. The Municipality or the Questura (= police H.Q.) are occasionally contacted and they contact mediators in turn | Occasional linguistic-cultural mediation | Only mediation | - | 5: 2 ED doctors, 3 ED nurses |
| ED – Agordo Hospital (Uiss 1) | None | None | - | - | - | 5: 2 ED doctors, 3 ED nurses |
| ED e/Obstetrics – Feltre Hospital (Uiss 2) | URP (Public Relations Office) | Mediators are directly hired | Linguistic-cultural mediation | Mediation e/ Translation | Direct. Work relationship: occasional work with on call pay | 4: 3 midwives, 1 ED nurse |
| ED, Paediatrics, Gynaecology, Burn Centre, Infectious Diseases – Padua Hospital Trust | URP (Public Relations Office) | Mediators are indirectly hired through a cooperative | Linguistic-cultural mediation | Mediation | Agreement with a cooperative. Mediators work for the cooperative on the basis of an occasional work contract or a per project contract | 8: 4 ED doctors, 2 ED nurses, 1 paediatrician, 1 social worker in healthcare |
| “S. Antonio” Hospital e/ Family Planning Clinics of Padua (Uiss 16) | URP (Public Relations Office) | Mediators are indirectly hired through a cooperative | Linguistic-cultural mediation | Mediation | Agreement with a cooperative. Mediators work for the cooperative on the basis of an occasional work contract or a per project contract | 9: 1 EW doctor, 5 EW nurses, 1 paediatrician, 1 gynaecologist, 1 nurse |
| ED e/HST – Jesolo Hospital (Uiss 10) | 4 interpreters in ED e/2 in HST. 1 interpreter available for all the other wards | Interpreters immediately available in ED e/ HST; immediate availability in wards after phone call; phone availability in the night | Interpreting | Interpreting, admission duties, collection of patients' data, administrative functions related to reimbursement of expenses | Seasonal personnel hired by the Local Health Unit as “Administrative Assistant – Interpreter” | 7: 2 ED doctors, 5 ED nurses |
| ED – “Umberto I” Hospital of Mestre (Uiss 12) | None | None. Occasional hiring through the Municipality, which contacts a cooperative | Occasional linguistic-cultural mediation | Mediating e/ accompanying patients to local health services | Agreement between some wards and the Municipality. Mediators' work relationship regulated by the cooperative | 17: 4 ED doctors, 9 ED nurses, 4 social workers in healthcare |

Table 1. Organisation of the mediation/interpreting services in the healthcare units involved in the research¹⁰

¹⁰ Questionnaires were also distributed to two social health workers of the Department of Hygiene and Public Health of Mestre and to three volunteers of the Padua Green Cross.

holistic frame. Pöchhacker's proposal (2002: 106) to resort to the case study as preferred method of research was welcomed and the project was structured into four different stages: a *questionnaire* was followed by the opportunity to expand on a specific question or further to comment on a certain topic during an *interview*, which would be expressly recorded and transcribed. Results were subsequently compared to reality through the analysis of mediated encounters which the author observed directly (**participant observation**). The encounters which proved more relevant to the objectives of this paper were transcribed and commented from a qualitative point of view (**corpus-based analysis**).

The subjects involved in the four steps of this project were to a large extent the same, consequently respecting the fundamental requirement of the case study method. With the exception of one case, all interpreters and mediators who participated in the encounters had previously filled in the questionnaire and, on certain occasions, had also granted an interview. The same holds true for the healthcare personnel involved.

4.2 Questionnaire

A total of 85 questionnaires were completed by interpreters/mediators (25 – of whom 9 were interpreters and 16 were mediators) and healthcare personnel (60) between 30th April and 16th July 2008 in the healthcare units mentioned in par. 4. All the questions were worded and organised following the main principles of the quantitative research method (Corbetta 1999, vol. 2, Favero 2003).¹¹ It should be underlined that for the sake of clarity and in order to avoid any misunderstanding which might have hindered the comparability of results, the author preferred personally to explain each question to every respondent. The questionnaire was divided into four sections, two addressing all the subjects and two distinguishing between the two categories of respondents (interpreters/mediators and healthcare staff). The first section targeted the profile of the interviewed subject, whereas the second (19 questions) sought subjects' opinions on interpreting in general and on interpreting/mediation in medical settings. There followed a section (5 queries) designed for healthcare personnel and, to conclude, a specific part for interpreters and mediators only (14 questions). Out of a total of 39 questions, excluding the first section, there were 30 multiple-choice questions and 9 open-ended questions.

11 As a reasoned choice approach was used, the comparison between results only provides an indicative evaluation of the emerged trends and has no intention of justifying the statistical representativeness of data. Furthermore, the interviewed subjects were selected according to specific characteristics and not in a probabilistic way (Corbetta 1999: 35, vol. 4).

Without discussing each query at length, a few words should be spent on the main themes investigated, which aimed to confirm or controvert previous research in the same field. The second part explored respondents' opinions as to whether there is any difference between interpreting and mediation and the distinguishing factors between the following: competences, interpreter/mediator's nationality, user's nationality, presence of operators during the encounter, education and training, role, status and prestige. Interviewed subjects were subsequently asked to provide a definition of the terms "interpreter" and "mediator" and to focus on the main roles they play, according to Leanza's classification (2007). The following questions were primarily concerned with respondents' personal experience in the medical field and their views on whether interpreters/mediators should be a 'visible' or 'invisible' presence, the factors enhancing the quality of their performance and the importance of training courses aimed at interpreters/mediators themselves and/or at healthcare providers.

In the fourth section, interpreters and mediators were interviewed about, among other things, their perceptions regarding the social position and the level of recognition of their profession, the relationship they normally establish during the encounter with the other participants and their preference for a neutral position or their solidarity with either of the two parties. The subsequent question was closely linked to the principle of "impartiality", since it investigated the pronouns used when reporting to the doctor and to the patient, which required a great amount of awareness of their own preferred style.

4.3 Interview

Subjects who were willing to expand on a specific feature were interviewed immediately after completing the questionnaire. All interviews – which followed the semi-structured interviewing method – were recorded and transcribed, in order to examine the underlying reasons which might have led to a specific response in the questionnaire. A total of 15 interviews were held, 9 of which were granted by medical and paramedical personnel and 6 by interpreters and mediators.¹²

12 On two occasions, two subjects participated in the same interview. Another 3 preliminary conversations with medical and administrative representatives of the healthcare units concerned or of other local services were included. Although they were not directly involved in the survey, they provided remarkable insights and thoroughly illustrated the interpreting/mediation needs in their own local units. The total number consequently rises to 18 interviews. Each of them was given an ascending number, which reflects their chronological order. In order to retain interviewees' privacy, no reference was made to the names of people or places.

The main themes which were explored were the distinguishing factors between interpreters and mediators, the mediator's nationality which is deemed more suitable to accomplish the tasks required in medical settings, concerns and uncertainties regarding training courses for interpreters/mediators, professionalism, the factors which affect the quality of performance and the use of personal pronouns.

4.4 Participant observation

The desire to compare the questionnaire responses with real practices required the author's participation in mediated encounters, with the view to verifying the degree of coherence between expectations and opinions on one side and the verbal/non-verbal behaviour of interlocutors on the other. A further objective was to examine possible similarities or differences between interpreters and mediators in Italian medical settings.

Two of the healthcare facilities involved were selected, since they offer a linguistic service for foreigners. For the purpose of this research, the choice fell upon a medical centre offering a "mediation" service – Padua Hospital Trust and Local Health Unit no. 16 – and a unit recruiting "interpreters" – Jesolo Hospital (Assl 10).

A total of 26 encounters – 8 with the participation of mediators and 16 with interpreters – were observed from 16th June to 27th August 2008 and subsequently commented on the basis of an Observation Sheet, which draws on previous research (Favaron 2002, Napolitano 2005). A major difference – and advantage – was in this case the authorisation to record the encounters, which proved useful to the analysis of features which would have been otherwise difficult to evaluate. Each encounter was then given an ascending number, according to their chronological order.¹³

In the main hospital of Jesolo, all the encounters observed took place in either the Emergency Department (10) or the Healthcare Service for Tourists (8), while in Padua a wider range of departments were involved in the project: Paediatrics (2), Gynaecology (1), Birth Registration Office (1), Burn Centre (1), Outpatient Clinic (1), Obstetrics Clinic (1), Department of Infectious Diseases (1).

13 The main characteristics of each meeting were briefly outlined in a chart, to which reference is made (Pittarello 2009: 143). Anonymity requirements have led to the renaming of both medical and paramedical staff on one side and of interpreters and mediators on the other. For the purpose of straightforward identification with their roles, the fictitious names begin with the letter "D" for doctors, with "I" for interpreters and with "M" for mediators. A brief description of interpreters and mediators' profiles was provided in order to contextualise their performance in the light of the training they received.

As far as the Observation Sheet is concerned, it comprised five main sections: four of them correspond, to a large extent, to the structure and terminology of Favaron's model (2002: 74-75)¹⁴, whereas the addition of a fifth part was aimed at highlighting the most significant aspects featuring the encounter. In the introductory section, *general information* about the session was reported, followed by a list and description of the interlocutors and by a part concerning *purpose* and *content* of the encounter and the *physical position of participants*.¹⁵ The second section focused on features of **verbal interaction**, such as *accent* and *speech rate* (phonology), *use of personal pronouns*, which is one of the most relevant aspect of the present research, and *role* played by the interpreter or the mediator, on the basis of Leanza's typology (2007: 11-34).¹⁶ The following section concentrated on **non-verbal interaction** and – more narrowly – on participant's behaviour in terms of *visual contact*, while the fourth part referred to the main characteristics of the encounter, including *register*, presence of *technical terms*, *status*, *body language* and *turn-taking control*. The concluding section, as previously mentioned, summarised the most striking aspects of each encounter.

4.5 Corpus-based analysis

Out of the 26 observed encounters, four were selected to be transcribed and investigated as they better illustrated the most relevant results which were attained. For the sake of coherence with the overall objectives of this research, the analysis regarded two encounters involving a mediator and two interactions mediated by interpreters. The first two encounters took place in the Department of Infectious Diseases and in the Burn Centre of the Padua Hospital Trust and were mediated by the same person, who was asked to translate respectively for a Tunisian patient (T.I)¹⁷ and for a

14 For a comprehensive description, see Merlini & Favaron (2003: 216-217).

15 The latter three parameters were borrowed from Napolitano's Observation Sheet (2005: 55).

16 Only the Italian rendition was examined for mediations involving languages which were not familiar to the author and which could not be recorded (4 assignments). When recording was available (3 encounters), the phonological traits of the unfamiliar languages were nevertheless analysed thanks to the invaluable contribution of two interpreters of French and two Arabic mother-tongue speakers, who translated the turns and commented on the phonology.

17 The transcriptions follow, to a large extent, Atkinson & Heritage's graphical conventions (1984). Each transcription was identified by a Roman numeral preceded by T, to avoid confusion with the Observation Sheets. For the first two encounters (T.I & T.II), two independent qualified native speakers of Arabic were recruited to help with the translations, which were then compared. They were subsequently asked to provide an explanation for the few divergent renditions. Hence, the analysis only regarded the Italian translation, without considering the typical traits of the spoken language.

Moroccan woman, whose three-year-old child suffered severe burns (T.II). The last two interactions occurred in the Emergency Department (T.III) and in the Healthcare Service for Tourists (T.IV) of the Jesolo Hospital and were mediated by different interpreters for two Austrian patients.

The conversations were not analysed from a quantitative point of view, but rather offered a wider perspective since they explored the interactional dynamics which were embedded in the linguistic behaviour. Consequently, each encounter was examined in its entirety, so as to evaluate the level of coherence that emerged from translation choices.

Specific aspects to be investigated were the prevalent *role* played by the interpreters and the mediator, their preferred *alignment* (as revealed by the *use of personal pronouns, address forms and reported speech*), *conversational initiative, active participation* opposed to *invisibility* and the *relationship* established with the other primary interlocutors.

5. Discussion of results

The prevailing trends emerging from the results obtained will be illustrated in the following discussion, which concentrates on those findings and parameters which turned out to be the most significant.

As a preliminary remark, it should be highlighted that the case study method, adopted herein as a form of integrated analysis offering a holistic view of the topic under examination (Pöchhacker 2002), has proved to be the most appropriate tool to indicate the frequent divergence between expectations and reality. This can be seen from the contrasting results of questionnaires and surveys – which both focused on expectations, opinions and perceptions – if compared to the outcomes of the participant observation and corpus-based analysis – which aimed at investigating real practices.

5.1 Perceived profile of interpreters/mediators

Interestingly, an overall trend toward a convergence of ideas between the healthcare personnel and interpreters/mediators was noticed in the way the interviewees responded to the questionnaire. In case of divergent views, doctors and nurses often seemed to have a clearer position on the matter. For the sake of clarity and brevity, the two groups of respondents will be hereafter referred to with letter *a* for the medical/paramedical staff and letter *b* for interpreters/mediators.

5.1.1 Factors of distinction

As far as the profession of interpreters and mediators is concerned, two different profiles emerged from both questionnaires and interviews. The majority of respondents believed that the concept of interpreting differs from mediation especially in the following factors, which are nevertheless listed in a different order: *field of application* (67.87% of responses in group *a* and 65.21% in group *b*), *training* (64.29%, group *a*; 69.56%, group *b*) and *role* (40.07%, group *a*; 82.60%, group *b*). The subsequent factor was the nationality of both interpreters and/or mediators (30.36%, group *a*; 47.48%, group *b*) and that of users (37.50%, group *a*; 21.74%, group *b*). Interestingly, interpreters and mediators were more inclined than healthcare providers to recognise foreign nationality as a prerequisite for the profession of mediators. The importance attached to nationality emerged clearly from other responses and from the interviews, where respondents seemed to identify mediators with foreigners who have deep knowledge of the foreign culture and language.

Moreover, there was an overall trend throughout the survey to distinguish between two categories of foreign users – tourists and immigrants – and to underline the need for interpreters to deal with the first and for mediators to communicate with the latter. It is no coincidence that the selected structures which registered a higher percentage of foreign tourists unconsciously chose to designate – or referred to – the service offered to foreign patients as “interpreting” (Agordo and Jesolo, see par. 4), while those healthcare centres where immigrant patients were numerous tended to speak about “mediation”.

To conclude, *prestige* (10.71%, group *a*; 8.69%, group *b*) and *status* (19.64%, group *a*; 21.74%, group *b*) turned out to be of minor importance, thus contradicting Ghiazza’s suggestion (2002: 106) that the main difference between the concepts of interpreting and mediating lies in the dissimilar level of social recognition attained and not in the training they received.

5.1.2 Interpreter and mediator: definition, role and tasks

With specific reference to medical settings, the majority of the healthcare staff – rather surprisingly – tended to define interpreters as “professionals of language and culture” (57.14%) and mediators as “tools to overcome linguistic and cultural barriers” (58.93%), whereas interpreters and mediators privileged the second definition for both profiles (respectively 43.49% of interpreters and 43.48% of mediators). This result is in contrast with Leanza (2007: 20), who noticed doctors and nurses’ difficulty to recognise the professionalism of interpreters.

Both interpreters and mediators, however, pointed out that their activity differed in that the first mainly deal with linguistic problems, whereas the

latter are more frequently confronted with cultural differences. This specification, shared by medical staff, is in line with the responses given to the subsequent question and concerning the principal role played by interpreters and mediators during the encounter. According to both categories of respondents, interpreters should almost exclusively be assigned the task of translating (*a*, 76.78%; *b*, 69.56%), compared to mediators, who are seen first and foremost as Cultural Informants and Culture Brokers (around 80-85% of responses in both groups).¹⁸ They should therefore help both healthcare providers and patients better to understand each other, thanks to their knowledge of the foreign culture. The second task they are called upon to perform is to be a point of reference for patients (*a*, 64.29%; *b*, 69.56%). Despite not being recognised as pivotal, the role of Advocate, which implies coming to the defence of patients, was indicated by a considerable percentage of respondents (*a*, 46.42%; *b*, 52.17%). In this regard, it is worthwhile recalling the opinions of the German interpreters interviewed by Favero (2003: 129), who did not include this role among their tasks, thus leading the researcher to the conclusion that “advocacy” should not be considered a possible role of interpreters in the social field. Her position is shared by Leanza (2007: 20), who maintained that in the observed medical encounters doctors were not prone to acknowledge this role, since they mainly regarded interpreters as “instruments for obtaining or translating information”. In the collected data, instead, translation becomes of minor importance if compared to other tasks: only 7.14% of doctors/nurses and no interpreter/mediator chose this heading. It may consequently be inferred that if interpreters in the social field are also allowed to act as mediators, doctors are ready to recognise the pre-eminence of other factors to the sole translation. This is in contrast with what emerged from Meyer *et al.* (2003: 78) and Leanza (2007: 28), who noticed that doctors expected that interpreters in medical settings only translated what was said.

The analysis of real practices (26 encounters), however, showed that both interpreters and mediators played several roles simultaneously and actively translated the turns of speech (active translation – 22 cases). On several occasions (14), they also took the initiative, for example by posing questions to patients, which were then reported to the healthcare provider, thus taking on the role of Bilingual Professionals (Leanza 2007: 14). In fewer cases (9), they also conveyed their personal points of view to the medical staff on aspects which they considered relevant to the

18 In this specific case, the two roles identified by Leanza (2007: 14) were analysed from a different perspective: reference was made, in two subsequent posts of the questionnaire, to the mediators’ ability to explain cultural differences to the user or to the healthcare provider, since the purpose being pursued was further to detect the alignment of interpreters/mediators with either the represented institution or with patients and the expectations of medical/nursing staff in this respect.

consultation – acting therefore as Monolingual Professionals. Interestingly, the task of “welcoming” patients was carried out by both mediators (4) and interpreters (7), although the latter were not required to do so. At the end of the encounter, interpreters (5) and mediators (6) explained to patients where a specific department, pharmacy or shop was located and consequently acted as Family Supporters (Leanza 2007: 21). It was also observed that both categories fulfilled the function of Cultural Informants (4 mediators and 7 interpreters), yet for different addressees: while interpreters explained to patients administrative aspects concerning the service delivered, mediators tended to address doctors and nurses to illustrate specific features of the patient’s culture which could have been relevant to the success of the consultation/treatment. To conclude, the roles of Culture Broker and Advocate were almost exclusively the mediator’s prerogative (respectively 4 and 5 cases), since only one interpreter took on both roles during the same encounter, to ‘mediate’ in a situation of conflict between the primary interlocutors.

Hence, with regard to roles and tasks, no clear distinction was noticed in the practice between interpreters and mediators, who both participated actively and did not limit themselves to solely linguistic translation.

5.2 Invisibility or active participation? An uncertain position

A much debated question is whether interpreters and mediators in medical settings should be “invisible” (Angelelli 2003: 16) or whether they should actively participate in the encounter. In this specific case, a high percentage of respondents (41.67%, group *a*; 48%, group *b*) admitted that it depended on the circumstances and only few pronounced in favour of the interpreters’ invisibility (*a*, 21.67%; *b*, 20%). The interpreter’s active participation was desirable, however, for a great amount of those questioned (respectively 35% and 28%), who seemed to privilege an interactive model of interpreting (Wadensjö 1998). Once again, results are at variance with the marked preference for interpreters’ invisibility as emerged from the interpreters’ responses in Favero (2003: 129) and from the expectations of healthcare staff in Leanza (2007: 20). The same findings, however, confirm the opinions of patients interviewed by Bot (2003: 31) and the outcomes of Angelelli’s survey (2003: 24), who noticed that interpreters in medical settings believed they were more visible than interpreters working in other fields.

According to respondents, the active participation of interpreters and mediators was more desirable when cultural explanations were necessary or during simple sessions, such as anamnesis, examination and illustration of the informed consent. It was also advisable to create empathy with patients or to make them feel at ease, which is the case with children. Interpreters/mediators should instead remain neutral and

invisible when the diagnosis is delivered or when patients are in severe conditions (for example dressing of wounds and resuscitation).

As far as the part specifically addressed to interpreters and mediators is concerned, an interesting result was that the overwhelming majority (72%) – of whom more interpreters (77.78%) than mediators (68.75%) – expressed their uncertainty with regard to their social position. In confirmation thereof, 68% of those questioned believed that the recognition of the profession was inadequate and 84% (more interpreters than mediators) said their category was not sufficiently protected by law.

5.3 Impartiality, personal pronouns and reported speech

Interpreters and mediators' uncertainties are reflected in the unclear perception of their own role and alignment with the primary interlocutors: most of the interviewed felt solidarity with foreign users (60%), whereas 8% of them declared they were closer to the healthcare staff and another 8% specified that they were closer to whichever party who needed empowerment, be it the user or the healthcare provider. A small percentage (28%) believed they were absolutely impartial. Results are hence in contrast with what emerged from Favero's survey (2003) on the concept of "neutrality" of interpreters in the social field in Germany, where the overwhelming majority (72.5%) believed they were impartial.

As a further indication of interpreters and mediator's insecurity, they were convinced they used personal pronouns in a consistent and systematic way to report information to the other participants: a vast majority (64%) stated that they resorted to the third person singular when they addressed the medical staff, while none of the respondents seemed to report information provided by patients in the first person singular. Another 36% admitted that they varied their choice according to the circumstances. A similar outcome emerged when subjects were questioned about how they reported what was said by patients to the healthcare personnel: the third person singular seemed to be the preferred option for a larger group of respondents (80%), whereas 4% declared that they always translated in the first person singular and 12% specified that their choice depended on the circumstances. Interestingly, an interpreter replied that she resorted to the first person plural.

The subsequent comparison between these responses and the practice highlighted a certain degree of inconsistency in the pronominal use, which denoted a continuous change in the position of interpreters and mediators during the encounter and therefore confirmed Dubsclaff & Martinsen's studies on the discrepancies between perceived preferences and practices of interpreters who did not receive any training and the underlying reasons (2007: 53-76).

The use of personal pronouns and specific address forms is a useful key to understanding the alignment of interpreters and mediators with either of the parties: if the third person singular indicates detachment and intention to deny all responsibility for the utterance, the use of the first person may either suggest a cooperative attitude and the endeavour to share the responsibility about what is being said (Amato 2007: 126) or express a strictly personal view and consequently the highest degree of autonomy and detachment from the original utterance.

Shifting from one pronominal form to the other, therefore, tends to signal a different level of involvement, which might be influenced by one's personal story, sensitivity and sharing of opinions. The interpreter/mediator will decide – often unconsciously – whether to speak *on behalf of* (first person) or *about* (third person) the interlocutors. Resorting to the first person, moreover, may also indicate an autonomous intervention of the interpreter/mediator, who becomes a full participant.

What was said also applies to reported speech, which confirms the further attempt to detach oneself from the source of the utterance. An experimental study on the roles played by interpreters in the medical field has recently underlined the limited use of the indirect mode in their renditions (Amato 2007: 109-125). For the sake of clarity, the terminology hereafter adopted refers to the description of changes in the perspective of person provided by Bot (2007: 85), who draws on Haarus' taxonomy (2003):

| Perspective Reporting verb | Perspective unchanged | Perspective changed |
|----------------------------|---|---|
| Yes | 1. Direct representation <i>he says I went to school</i> | 2. Indirect representation <i>he says (that) he went to school</i> |
| No | 3. Direct translation <i>I went to school</i> | 4. Indirect translation <i>he went to school</i> |

Table 2. Taxonomy of change of perspective of person
(original utterance: "I went to school")

Interpreters may consequently employ four different strategies, depending on whether they use reporting verbs (1. and 2. above) and the same perspective of person (1. and 3.) or not, as illustrated by the following examples:

Example 1 (Direct Representation)

D¹⁹: *dovrebbe essere Lei a dirci cosa può prendere, non noi*

You²⁰ should tell us what You can take, not us

I: *was können Sie nehmen? Dass...Sie wissen besser als der Arzt, **sagt er***

what can You take? As...You know it better than the doctor, he says

Example 2 (Indirect Representation)

P: *das juckt noch ein wenig*

it is still itching a bit

I: *questo qua **gli** prude un po' meno, gli fa meno prurito, **dice***

this is itching a little bit less, it makes it itches less, he says

Example 3 (Direct Translation)

D: *misuriamo la Sua pressione*

we take Your blood pressure

I: *erst messen **wir** die [sic] Blutdruck*

first we take the blood pressure

Example 4 (Indirect Translation)

P: *welche Tabletten kann ich nehmen?*

what medicines can I take?

I: *che genere di medicinali **deve**...*

what kind of medicines does she have...

The opposite change may also take place, as was the case when doctors/nurses referred to the patient in the third person singular while the interpreter/mediators' rendition adopted the English pronoun "you" or the German polite form "Sie". Bot (2005: 181) defines this change as "reverse rendition", since the perspective in the rendition of the interpreter/mediator is more 'direct' if compared to the original:

Example 5

D: *chiedi se è diabetica*

ask her if she is diabetic

I: *sind Sie Diabetiker? [sic]*

are You diabetic?

In the following example, the doctor explicitly asks the interpreter to translate the utterance and refers to the patient in the third person

- 19 The initials D., P., M. and I., in the quoted examples, refer respectively to Doctor, Patient, Mediator and Interpreter and indicate the turns of speech. Features of interest are shown in bold.
- 20 To differentiate formal tokens of address from informal ones in the English translations, the first will appear with capital letter (e.g. German Sie/Italian Lei = You; German du/Italian tu = you). All the excerpts from transcripts of interpreter performances are both left in the original forms – language mistakes have, therefore, not been corrected – and also translated in English.

singular. In the interpreter's rendition, the reporting verb is added and the patient is addressed directly. The use of the reporting verb may be justified by the potentially conflicting content of the utterance: in doing so, the interpreter clarifies that she is not responsible for what she says.

Example 6

- D: e dille che... lei ha sottovalutato troppo quel discorso delle macchie sulla lingua
and tell her that... she has underestimated that subject of the spots on the tongue too much
- I: **der Arzt meint Sie** haben das Problem auf der Zunge auf diesen Flecken untergeschätzt [sic]
the doctor means You have underestimated the problem on the tongue on these spots

As emerges from the examples above, Bot's concept of "inverse rendition" involves the inverse change in the perspective of the person described in Table 2 (Example 5), which may be associated with the use of a reporting verb (Example 6). The author of this paper suggests using the expressions "inverse indirect translation" and "inverse indirect rendition" to describe respectively the first and the second strategy.

In most of the encounters examined, interpreters and mediators tended to report information provided by patients to the healthcare staff in the third person singular, predominantly without reporting verbs (indirect translations), whereas the data collected by Bot (2007: 92) showed a widespread use of representation forms. A wider range of pronominal forms were instead employed when translating to patients: questions were mainly rendered as indirect translations/inverse indirect translations; diagnoses and treatments were chiefly explained in the form of direct translations/inverse indirect translations or as indirect representations; potentially conflicting or embarrassing information were mostly provided as indirect representations/inverse indirect representations. The frequent lack of consistency in the pronominal choice was often noticed within the same turn:

Example 7

- D: allora, adesso sentiremo l'ortopedico. Probabilmente questo dito resterà sempre così
well, we will now ask for the orthopaedic's advice. This finger is likely to stay forever like this
- I: okay. Now **we** talk with the orthopaedic and **the doctor says** that maybe the finger will remain always, forever like this

At this point, it should be stressed that the strategies adopted by interpreters and mediators may frequently have been influenced by the linguistic behaviour of the healthcare staff, who tended explicitly to invite them – in the imperative form – to translate what they were going to say

(“dille/digli che” – *tell her/him that*; “se vuoi chiedergli” – *if you want to ask him*; “chiedi(le/gli) se” – *ask (her/him) if*; “gli spieghi che” – *explain to him that*). What is more, a doctor, predominantly expressed himself in the first person plural (“adesso misuriamo la Sua pressione” – *now we will take Your blood pressure*). Interpreters and mediators may have perceived this attitude as an invitation to act as fully recognized participants, which might explain the reason why they too used the first person plural. The following example well illustrates the alignment of the interpreter with the medical class:

Example 8

- D: gli prescrivo i farmaci... intanto **io** gli prescrivo qualcosa
I prescribe him medicines... in the meantime I prescribe him something
- I: **wir** verschreiben Ihnen ein Medikament
we prescribe You a medicine

It was also noticed that both interpreters and mediators actively participated in the conversation, by adding personal comments and frequently taking the floor (turn-taking control). On these occasions, they were more likely to use the first person plural, which further emphasised their strong identification with healthcare providers. Patients seemed to be aware of the interpreter/mediator’s full participation, as demonstrated by a patient in the Emergency Department, who complimented the interpreter at the end of the encounter by saying: “sehr gute Ärztin” (*very good doctor*). The interpreter/mediator’s recognition as fully ratified participants (Bot 2003) is clear in an encounter where the patient apologised for her complaints by explaining to the interpreter that she was the only one who could understand her language. The interpreter therefore becomes a point of reference and a more sympathetic and caring figure to whom patients are encouraged to express their own mood (Merlini & Favaron 2003: 226, Merlini 2007: 434). This illustrates the patient’s emotional dependence on the interpreter/mediator, which is of extreme importance in medical encounters and, consequently, in the relation established between the primary interlocutors.

The widespread use of the first person singular frequently indicated autonomous interventions aimed, for example, at giving advice to patients. When addressing the healthcare staff, personal comments were mainly used to summarise a rather long turn, provide cultural explanations or highlight aspects which were not said by patients, but deemed important to be conveyed. Cultural details were mainly given by mediators who translated for Moroccan and Tunisian patients, to explain to the doctor, for example, some distinctive features of the emotional rapport between mothers and children in the Arab world.²¹

21 Only one interpreter was faced with a cultural problem, owing to the difficulty in converting the Anglo-Saxon weight system. For more details, reference is made to the author’s MA thesis (Pittarello 2009: 152, 183).

The use of the indirect speech, as already mentioned, was not frequent and tended to be limited to specific cases, especially to express detachment from an original utterance which had a potentially conflicting or embarrassing content, as in the following example:

Example 9

- D: se posso dare un consiglio, che farà bene anche per la pressione... di perdere qualche chilo
if I may give some advice, which will be also good for the blood pressure... to lose some kilos
- I: **der Arzt empfiehlt** so einige Kilo abzunehmen... **persönliche Empfehlung des Arztes**
the doctor suggests losing some kilos... doctor's personal advice

In this case, the interpreter reported the doctor's advice in indirect speech and stressed that the doctor was the real source of the utterance. On other occasions, the interpreter/mediator's personal comment made explicit reference to the doctor without the use of a reporting verb. This occurred, for example, in two encounters: in the first, the interpreter felt the need to apologise to the patient complaining for the long wait by underlining that it was necessary for her to be visited by the doctor who was present there; in the second, the mediator explained to a patient who was feeling threatened that the doctor's advice was only aimed at helping him.

6. Conclusions

A number of relevant findings have been yielded by the study reported in this paper. The analysis of questionnaires and interviews identified the coexistence of two terms in Italy to describe the figures who mediate between healthcare providers and foreign patients in medical units. "Interpreters" are seen as professionals whose main task consists in a purely linguistic translation, whereas "mediators" are described as instruments to overcome cultural barriers, who generally perform several tasks simultaneously. This distinction of roles is at variance with previous studies on medical interpreting. Although skills, roles and training were considered the main distinguishing factors by both categories of respondents (healthcare staff and interpreters/mediators), in other responses and during interviews special attention was attached to nationality. Moreover, the healthcare units with a high turnout of tourists from Central and Northern European countries tended to adopt the term "interpreting" to designate the linguistic service aimed at foreign patients, whereas the word "mediation" was preferred by medical centres dealing with immigrants. This is in line with the Italian literature pertaining to the topic, whereas the international trend is toward a distinction between different fields of the same profession, ie. "interpreting".

With the view to investigating whether this typically Italian distinction was justified, opinions and expectations were compared to interpreting practices, which highlighted that both interpreters and mediators were frequently playing several roles at the same time and that they were almost never confining themselves solely to “translation”. Their renditions revealed some inconsistency in the use of pronominal and address forms, which were on certain occasions affected by the linguistic behaviour of healthcare providers. The indirect mode of interpreting (third person singular) was preferred when rendering patients’ turns, while the first person singular was predominantly used to mean *self* and not *other* (direct mode) and to express personal comments. The frequent autonomous interventions and turn-taking control confirmed the active participation of both interpreters and mediators during the encounter and their attempt to separate their own identity from the source of the utterance. On many occasions, however, they both adopted the first person plural to render the doctor’s speech, which may indicate their identification with the institution, thus contradicting their belief in a greater solidarity with patients, as emerged from questionnaires. Reported speech (direct/indirect representation) tended only to be used in case of embarrassing or potentially conflicting contents and confirmed the need for both interpreters and mediators to distance themselves from the words they rendered.

The above-mentioned trends demonstrated that interpreters and mediators were fully ratified participants in the encounters and were recognised as such by the primary interlocutors, who tended to address them directly. Healthcare providers, in particular, frequently invited them to translate by adding reporting verbs in the imperative form, thus revealing that they did not take the translation task for granted. This contradicts what had been previously stated in the questionnaire.

The discrepancy between perceptions and practice with regard to pronominal forms, roles and preferred alignment and the frequent personal comments shed light on the interpreters and mediators’ scarce awareness of their own position and identity, while no great difference was observed in the strategies and attitudes adopted by the two profiles. Instead of focussing on the divergent features, it would be more profitable to investigate expectations and needs of those who work in the field, in order to plan targeted training courses and raise their awareness on the issue. A useful tool to enhance this professional position would be to analyse further the behaviour of the same subjects from different perspectives in other case studies, thus contributing to self-reflection and self-definition. In conclusion, the data collected suggests that “mediator” and “interpreter” should be considered as expressions of the great versatility of the same interpreting profession, whose various modes are all worth receiving further attention by researchers.

References

- Allaoui R. (2005) *Dolmetschen im Krankenhaus*, Bd. 1 v. *Migration – Gesundheit – Kommunikation*, N.-J. Albrecht, T. Borde und L. Durlanik (eds.), Göttingen, Cullivier.
- Amato A. (2007) *I ruoli dell'interprete nell'interazione medica: uno studio di caso*, unpublished PhD Dissertation, Dipartimento di Studi Interdisciplinari su Traduzione, Lingue e Culture, University of Bologna.
- Angelelli C. (2003) "The interpersonal role of the interpreter in cross-cultural communication. A survey of conference, court, and medical interpreters in the US, Canada and Mexico", in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds.), *The Critical Link 3: Interpreters in the Community*, Proceedings of the "Third International Conference on Interpreting in Legal, Health, and Social Service Settings" (Montréal, Québec, 22-26 May 2001). Amsterdam/Philadelphia, John Benjamins, 15-26.
- Atkinson J.M. & Heritage J. (1984) (eds.) *Structures of Social Action: Studies in Conversation Analysis*, Cambridge, Cambridge University Press.
- Belpiede A.R. (2002) (ed.) *Mediazione culturale. Esperienze e percorsi formativi*, Torino, UTET.
- Belpiede A.R. (2008) "La mediazione linguistico culturale in Italia", paper presented at the Conference "Dentro e oltre la mediazione. Scambi e prospettive" (Auditorium S. Margherita, Venice, 19 June 2008).
- Bochner S. (1981) (ed.) *The Mediating Person: Bridges Between Cultures*, Cambridge, Schenkman Publishing Company.
- Bot H. (2003) "The myth of the uninvolved interpreter interpreting in mental health and the development of a three-person psychology", in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds.), *The Critical Link 3: Interpreters in the Community*, Proceedings of the "Third International Conference on Interpreting in Legal, Health, and Social Service Settings" (Montréal, Québec, 22-26 May 2001). Amsterdam/Philadelphia, John Benjamins, 27-36.
- Bot H. (2005) *Dialogue Interpreting in Mental Health*, vol. 19 of *Utrecht Studies of Language and Communication*, W. Herrlitz, S. Ongstad and P.-H. van de Ven (eds.), Amsterdam/New York, Rodopi.
- Bot H. (2007) "Dialogue interpreting as a specific case of reported speech", in F. Pöchhacker and M. Shlesinger (eds.), *Healthcare Interpreting: Discourse and Interaction*, Amsterdam/Philadelphia, John Benjamins, 77-99. [published in 2005 in *Interpreting*, 7:2, 246-258]
- Bourdieu P. (2000) *Pascalian Meditations*. Transl. by R. Nice. London, Polity Press.

- Chesher T., Slatyer H., Doubine V., Jaric L. & Lazzari R. (2003) "Community-based interpreting – The interpreter's perspective", in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds.), *The Critical Link 3: Interpreters in the Community*, Proceedings of the "Third International Conference on Interpreting in Legal, Health, and Social Service Settings" (Montréal, Québec, 22-26 May 2001). Amsterdam/Philadelphia, John Benjamins, 273-292.
- Collard-Abbas L. (1989) "Training the trainers of community interpreters", in C. Picken (ed.), *ITI Conference 3*, Proceedings of the "Third Annual Conference of the Institute of Translation and Interpreting" (London, 28-29 April 1989). London, Aslib, 81-85.
- Corbetta P. (1999) *La ricerca sociale: metodologia e tecniche*, Bologna, il Mulino, 4 vols.
- Creeze I. (2003) "Health interpreting in New Zealand – The cultural divide", in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds.), *The Critical Link 3: Interpreters in the Community*, Proceedings of the "Third International Conference on Interpreting in Legal, Health, and Social Service Settings" (Montréal, Québec, 22-26 May 2001). Amsterdam/Philadelphia, John Benjamins, 249-260.
- Dallari G., Previti D. & Ricci S. (2005) "Interprete o mediatore culturale? Le aspettative di un servizio sanitario italiano", in M. Russo and G. Mack (eds.), *Interpretazione di trattativa. La mediazione linguistico-culturale nel contesto formativo e professionale*, Milano, Hoepli, 183-193.
- Davies B. & Harré R. (1990) "Positioning, the discursive production of selves", *Journal for the Theory of Social Behaviour*, 20:1, 43-63.
- Drew P. & Heritage J. (1992) (eds.) *Talk at Work. Interaction in Institutional Settings*, Cambridge, Cambridge University Press.
- Dubslaff F. & Martinsen B. (2007) "Exploring untrained interpreters' use of direct versus indirect speech", in F. Pöchhacker and M. Shlesinger (eds.), *Healthcare Interpreting: Discourse and Interaction*, Amsterdam/Philadelphia, John Benjamins, 53-76. [published in 2005 in *Interpreting*, 7:2, 211-236]
- Favaro G. (2001) *I mediatori linguistici e culturali nella scuola*, Bologna, Editrice Missionaria Italiana.
- Favaron R. (2002) "L'interprete ai raggi X. Interpretazione in campo medico in Australia: la gestione dell'interazione da parte dell'interprete", unpublished MA Thesis, SSLMIT, University of Trieste.
- Favero E. (2003) "Neutrale o di parte? Proposta di un questionario per gli interpreti in campo sociale", unpublished MA Thesis, SSLMIT, University of Trieste.
- Gentile A., Ozolins U. & Vasilakakos M. (1996) *Liaison Interpreting. A Handbook*, Melbourne, Melbourne University Press.

- Ghiazza S. (2002) "Capire per integrarsi, integrarsi per capire: il 'mediatore' linguistico e culturale nella città di Genova", unpublished MA Thesis, SSLMIT, University of Trieste.
- Haarhuis J. (2003) "Perspectiefgeruik van tolken tijdens psychotherapie" unpublished MA Thesis, Faculty of Arts, University of Utrecht.
- Inghilleri M. (2005) "Mediating zones of uncertainty. Interpreter agency, the interpreting habitus and political asylum adjudication", *The Translator*, 11:1, 69-85.
- Jalbert M. (1998) "Travailler avec un interprète en consultation psychiatrique", *P.R.I.S.M.E.*, 8:3, 94-111.
- Leanza Y. (2007) "Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers", in F. Pöchhacker and M. Shlesinger (eds.), *Healthcare Interpreting: Discourse and Interaction*, Amsterdam/Philadelphia, John Benjamins, 11-34. [published in 2005 in *Interpreting*, 7:2, 167-192]
- Mack G. (2005) "Interpretazione e mediazione: alcune osservazioni terminologiche", in M. Russo and G. Mack (eds.), *Interpretazione di trattativa. La mediazione linguistico-culturale nel contesto formativo e professionale*, Milano, Hoepli, 3-17.
- Martinsen B. (2002) "Public service interpreting: challenges and how to meet them", in G. Garzone, P. Mead and M. Viezzi (eds.), *Perspectives on Interpreting*, Bologna, Clueb, 257-267.
- Mason I. (2005) "Projected and perceived identities in dialogue interpreting", in J. Munday (ed.), *IATIS Yearbook 2005*, Seoul, IATIS, 30-52.
- Merlini R. (2007) "L'interpretazione in ambito medico. Specialità di lessico o di ruolo?", in D. Poli (ed.), *Lessicologia e Metalinguaggio*, Roma, Il Calamo, 433-452.
- Merlini R. (2009) "Seeking asylum and seeking identity in a mediated encounter. The projection of selves through discursive practices", *Interpreting*, 11:1, Amsterdam/Philadelphia, John Benjamins, 57-92.
- Merlini R. & Favaron R. (2003) "Community interpreting: reconciliation through power management", *The Interpreters' Newsletter*, 12, 205-229.
- Merlini R. & Favaron R. (2007) "Examining the 'voice of interpreting' in speech pathology", in F. Pöchhacker and M. Shlesinger (eds.), *Healthcare Interpreting: Discourse and Interaction*, Amsterdam/Philadelphia, John Benjamins, 101-137. [published in 2005 in *Interpreting*, 7:2, 263-302]
- Meyer B. (2004) *Dolmetschen im medizinischen Aufklärungsgespräch. Eine diskursanalytische Untersuchung zur Wissensvermittlung im mehrsprachigen Krankenhaus*, Bd. 13 v. *Mehrsprachigkeit*, W. Grieshaber und J. Rehbein (eds.), New York/München/Berlin, Waxmann Münster.

- Meyer B., Apfelbaum B., Pöchhacker F. & Bischoff A. (2003) "Analysing interpreted doctor-patient communication from the perspectives of linguistics, interpreting studies and health sciences", in L. Brunette, G. Bastin, I. Hemlin and H. Clarke (eds.), *The Critical Link 3: Interpreters in the Community*, Proceedings of the "Third International Conference on Interpreting in Legal, Health, and Social Service Settings" (Montréal, Québec, 22-26 May 2001). Amsterdam/Philadelphia, John Benjamins, 67-80.
- Napolitano F. (2005) "Il ritorno di Malinche: osservazione sociolinguistica di interventi di mediazione interculturale in Valle d'Aosta", unpublished MA Thesis, SSLMIT, University of Trieste.
- Pittarello S. (2009) "L'interprete e il mediatore nelle strutture sanitarie del Veneto: aspettative, percezioni e prassi", unpublished MA Thesis, SSLMIT, University of Trieste.
- Pöchhacker F. (1997) "Is there anybody out there? Community interpreting in Austria", in S.E. Carr, R. Roberts, A. Dufour and D. Steyn (eds.), *The Critical Link: Interpreters in the Community*, Papers from the "First International Conference on Interpreting in Legal, Health and Social Service Settings" (Geneva Park, Canada, 1-4 June 1995). Amsterdam/Philadelphia, John Benjamins, 215-225.
- Pöchhacker F. (2000) "The community interpreter's task: self-perception and provider views", in R.P. Roberts, S.E. Carr, D. Abraham and A. Dufour (eds.), *The Critical Link 2: Interpreters in the Community*, Selected Papers from "The Second International Conference on Interpreting in Legal, Health and Social Service Settings" (Vancouver, BC, Canada, 19-23 May 1998). Amsterdam/Philadelphia, John Benjamins, 49-65.
- Pöchhacker F. (2002) "Researching interpreting quality. Models and methods", in G. Garzone and M. Viezzi (eds.), *Interpreting in the 21st Century. Challenges and Opportunities*, Amsterdam/New York, John Benjamins, 95-106.
- Pöchhacker F. ([2000] 2007) *Dolmetschen. Konzeptuelle Grundlagen und deskriptive Untersuchungen*, Bd. 7 v. *Studien zur Translation*, M. Snell-Hornby (ed.), Tübingen, Stauffenburg Verlag.
- Riccardi A. (2001) *Dalla traduzione all'interpretazione - Studi di interpretazione simultanea*, Udine, il campo.
- Roberts R.P. (1997) "Community interpreting today and tomorrow", in S.E. Carr, R. Roberts, A. Dufour and D. Steyn (eds.), *The Critical Link: Interpreters in the Community*, Papers from the "First International Conference on Interpreting in Legal, Health and Social Service Settings" (Geneva Park, Canada, 1-4 June 1995). Amsterdam/Philadelphia, John Benjamins, 7-26.
- Roy C.B. (2000) *Interpreting as a Discourse Process*, New York/Oxford, Oxford University Press.

- Rudvin M. (2005) "La formazione di interpreti in ambito sociale in Italia e all'estero", in M. Russo and G. Mack (eds.), *Interpretazione di trattativa. La mediazione linguistico-culturale nel contesto formativo e professionale*, Milano, Hoepli, 131-143.
- Tomassini E. (2005) "Esigenze formative e modelli di formazione per l'interprete nei servizi pubblici in ambito medico", in M. Russo and G. Mack (eds.), *Interpretazione di trattativa. La mediazione linguistico-culturale nel contesto formativo e professionale*, Milano, Hoepli, 115-129.
- Valero Garcés C. (2007) "Doctor-patient consultations in dyadic and triadic exchanges", in F. Pöchhacker and M. Shlesinger (eds.), *Healthcare Interpreting: Discourse and Interaction*, Amsterdam/Philadelphia, John Benjamins, 35-51. [published in 2005 in *Interpreting*, 7:2, 193-210]
- Wadensjö C. (1998) *Interpreting as Interaction*, London/New York, Longman.
- Weiss R. & Stuker R. (1999) "Wenn PatientInnen und Behandelnde nicht dieselbe Sprache sprechen – Konzepte zur Übersetzungspraxis", *Sozial- und Präventivmedizin*, 44:6, Basel, 257-263.