Remote Interpreting via Skype - a viable alternative to in situ interpreting?

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Abstract

On the basis of a study carried out in Graz in 2009, the paper deals with the question of whether or not interpreting via Skype can be a viable alternative to in situ interpreting.

The field of interpreting has been undergoing continuous changes (see Riccardi 2000: 75). After the ascent of consecutive interpreting, when interpreters had to improvise by learning by doing and the subsequent breakthrough of simultaneous interpreting with the Nuremberg Trials (see Baigorri Jalón 1999: 29ff; 21ff.), another type of interpreting has gradually evolved: Remote Interpreting (RI). RI is defined as follows: “Remote Interpreting [...] refer[s] to situations in which interpreters are no longer present in the meeting room, but work from a screen and earphones without a direct view of the meeting room or the speaker” (Mouzourakis 2006: 46; original emphasis)
1. Two types of RI
1.1 Video conference interpreting

To hold video conferences, a video conference system consisting of data reception technology (video camera, microphone etc.), data processing devices (a high-speed computer with a video conferencing card) and data reproduction devices (screens, loud speakers etc.) is needed at each location. Conferences between two and twenty locations are possible. Video conferences are carried out in special studios or by means of a personal computer allowing for whiteboarding (see Braun 2004: 10; 2001: 273f.).

Interpreting in video conferences can take the following forms:
1) RI when interpreters are present at the conference venue and interpret external speakers’ contributions, e.g. words of greeting (see Braun et al. 1999: 293).
2) RI when a conference is held at two venues (A and B) which are connected to one another via tele-conference. The interpreters are either present at venue A or at venue B and interpret from there (see Braun 2004: 89; Heynold 1998: 324ff.).
3) RI with two conference venues (A and B) whereby the interpreters are present neither at venue A nor at venue B but interpret from a location C. This is also called tele-interpreting (see Braun et al. 1999: 293; Braun 2004: 89).
4) RI at a conventional conference whereby the interpreters do not work in the conference room, but in another room. This form of interpreting is highly disputed (see Braun 2004: 89f.).

Since 1976, nine major studies on RI via video conference have been carried out by the United Nations or the European Union’s institutions. Comments on these remained rather sober with interpreters criticising unacceptable sound quality as well as feelings of alienation and, consequently, loss of information (see AIIC Technical & Health Committee n.d.; Commission Européenne Service Commun Interprétation-Conférences 2000; European Parliament Interpretation Directorate 2001a, 2001b; Kurz 2000: 99f.; Mouzourakis 1996: 21, 2006: 62f.). Consequently, the “Code for the Use of New Technologies in Conference Interpreting” demanded high-quality image and sound transmission as well as a restriction of working hours to no longer than two hours a day for RI (see AIIC 2000).

Several studies have been carried out at universities as well as in courtroom settings. For the ViKiS-project, job interviews between two interlocutors were simulated. It was found that interlocutors gradually developed special communication strategies in order to prevent the occurrence of problems in understanding (see Braun 2003: 179ff., 2004: 337). Fowler investigated consecutive interpretations of court hearings for detainees. Interpreting in this setting was especially difficult due to noise in the courtroom and interferences with the video conference system (2007: 9-12).

This chapter offers only a brief – and hence subjective – selection of experiments on video conference interpreting and telephone interpreting. For a comprehensive overview on research in this field, see Andres/Falk (2009) and Korak (2010: 21-35; 44-62).
1.2 Telephone interpreting

Telephone interpreting refers to all settings where interpreters work over the phone either at the same location as one of the interlocutors or at a different location altogether (see Lee 2007: 231). For telephone interpreting a normal telephone line and a telephone are sufficient. There are numerous devices available such as three-way, cordless, mobile or dual-receiver phones, the loud speaker key on different phones and voice points (see ibid. 237; Kelly 2008: 31). Though telephone interpreting is normally done in the consecutive mode, a teleconference bridge makes simultaneous interpreting possible (see O’Hagan 1996: 77).

Oviatt et al. compared conversations interpreted over the phone to on-site interpretations. They concluded that telephone interpreters actively managed conversation by using the first person to explicitly refer to themselves and the third person to refer to the interlocutors, thus avoiding misunderstandings (1990: 1-3; 11ff.). A first study on simultaneous telephone interpreting in the medical setting was undertaken by Hornberger et al. In concluding, the authors state that compared to on-site interpretations, telephone interpretations were more complete and exact and appeared to strengthen the doctor-patient relationship (1996: 845; 854ff.).

Wadensjö compared telephone interpretations of police interviews to on-site consecutive interpretations. She concludes that telephone interpreters take on an additional coordinating function in order to ensure that the parties involved understand one another (1999: 254; 256; 259ff.). Ko had interpreters with no previous experience in telephone interpreting interpret three hours a day for eight weeks. Ko concludes that, contrary to findings from other studies, interpreters are able to cope with the audio-only transmission in telephone interpreting as well as with exhaustion and concentration problems if high-quality equipment is used (2006: 331f.; 334f.).

2. RI: Requirements for interpreters, advantages and disadvantages

Due to the upsurge in new technologies for RI and as future interpreting is likely to be embedded in an entirely new context, technical know-how, flexibility and openness are demanded from interpreters (see O’Hagan/Ashworth 2002: 106). Challenges such as speakers with a strong accent might aggravate an already difficult setting such as telephone interpreting. On the other hand, attentive speakers might be able to make up for the non-existing visual channel by informing the interpreter about an important non-verbal element (Wadensjö 1999: 252f.). Some interpreters describe the lack of the visual channel as a benefit helping them to safeguard neutrality whereas others admit to feeling insecure and criticise loss of control in telephone interpreting as they are unable to see, e.g. in medical settings, what doctors and patients do (see García García 2002: 13; Lee 2007: 240; Wadensjö 1999: 249).

Interacting parties in videoconferences cannot control what they are looking at as what they see depends on the camera position (see also Braun 2003: 169;
The delay of about 0.2-0.4 seconds for an utterance to reach the interlocutors in videoconferencing may lead to unsettlingly long pauses in turn-taking, unnoticed speech overlaps or incidental remarks being heard too late. It is also difficult to deliberately interrupt other speakers to clarify a misunderstanding. Interpreters therefore need to develop strategies to correct themselves or to regulate turn-taking between interlocutors (see Braun 2003: 169; 2007: 40). Riccardi highlights the significance of concentration and anticipation strategies as well as automatisms (2000: 83). Dickinson emphasises the importance of phatic functions (fill words such as “I see”) which enhance conversation flow and help overcome lack of visual information in telephone interpreting (2003: 259).

The cost-saving potential of RI must not be neglected and is mainly relevant to large institutions such as the European Union that want to cut travel expenses and save space in conference rooms (see Mouzourakis 1996: 36). An asset of telephone interpreting lies in its quick availability: “Telephone interpreting may save time, money and – in cases if [sic] urgency – human suffering” (Wadensjö 1999: 249).

With reference to interpreters’ resentment towards RI, Shlesinger claims that studies in community settings yielded positive results, e.g. when it comes to patient satisfaction rates. She suspects that interpreters might be tempted to judge the RI-situation a priori as unpleasant and detrimental to quality and thus encourages further research as well as a dialogue between researchers, trainers and institutions (2009: 9ff.). Mouzourakis (2006: 55) sharply criticises hardliners who still assume that it does not matter whether interpreters are present in the meeting room or work from a screen and also criticises the fact that conventional booths were turned into remote booths for the studies on RI. Moreover, it is mostly technicians who spearhead the debate on the future of RI. Thus, a stronger participation of interpreters is urgently needed (see Buck 2000).

3. What does the future hold?

To overcome interpreter alienation, Mouzourakis (2000) suggests a virtual reality where interpreters navigate through the conference room with a joystick zooming in on the objects/people they want to see more clearly. Another scenario is interpreting over the internet, which includes whiteboarding. So-called “transterpreting”, which was first presented at a conference in 1996, is another hybrid form of RI. Participants, who were unable to attend the conference, could read the transcription of the speeches online, chat with other online participants or direct questions to conference participants at the venue. The speeches and questions were interpreted by an interpreter assisted by a protocolist who typed the interpretation on a computer (see O’Hagan/Ashworth 2002: 59).

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2 A description of a company that offers consecutive and simultaneous interpreting over VoIP can be retrieved from Lang (2009). For guidelines on interpreting over the internet, refer to Selhi (2000).
Psychological aspects, such as the effects of working entirely on one’s own, are to be taken into account (see Moser-Mercer 1997: 195). Furthermore, reactions of users of different age and socio-cultural backgrounds to RI need to be investigated as well as the impact of RI in stressful situations such as police interviews or in hospitals (see Braun 2006: 8f.). RI also calls for new ways of training in order to make adaptation to new technologies easier for the next generation of interpreters (see Braun 2007: 42; Ko 2006). It needs to be added, however, that several universities such as the department for translating and interpreting at the University of Graz already include RI in their curricula. Kalina points out that, if RI is to be implemented in the community setting, working conditions should resemble those in conference interpreting when it comes to working hours, team size, technical skills and interpreter training (2009: 400). Braun adds that there is an endemic lack of guidelines in RI settings and calls upon interpreting research to bridge this gap (2006: 7f.).

4. Interpreting via Skype

Skype is a free programme that can be used for phone calls to other Skype users (see Skype Limited 2009). The programme relies on the so-called VoIP (Voice Over Internet Protocol) technology (see Telekom Austria AG 2006: 123). First, the programme is downloaded and an account is created. After adding the desired contacts, other users may be called by clicking on the green button in the Skype call menu (see fig.1; own editing). To end a call, simply click on the red button (see fig. 2; own editing).

![Figure 1: How to start a call via Skype](image)

Another feature offered by Skype is video-calls via a webcam. It is also possible to send data and chat messages to interlocutors as well as to hold audio-only conferences between three or more users. Before interpreting via Skype, it is advisable to test audio and video settings by clicking on the sidebar “call” and then on “audio settings”.
5. Study on interpreting via Skype

Between February and June 2009, audio and video calls between two participants as well as three-party audio-only calls were conducted. Furthermore, three interpretations were simulated with the author of the study interpreting at home and the two interlocutors at another location. The feasibility study on interpreting via Skype was carried out from July to November 2009 at the gynaecological department of the Landeskrankenhaus, a public hospital in Graz, Austria. In total, 17 doctor-patient consultations were interpreted for 14 different patients: nine were Turkish-, five Russian- and three Arabic-speaking. Seven interpreters did the interpreting (three interpreters each for Turkish and Russian, one for Arabic). The interpreters interpreted at home and were called on their mobile phones beforehand to verify their availability. After this, the hospital staff video-called them via Skype and the consultation began. Nine interpretations were recorded, three were also videotaped. Before each consultation, the patients were asked to sign a document in their mother tongue indicating that they agreed to take part in the study. Immediately after each interpreting session, patient, doctor and interpreter filled in a questionnaire. Guided interviews were carried out with doctors and interpreters after the end of the study. The interpreters were asked to listen again to the audio recordings of their interpretations and to comment on them. The study was approved by an ethics committee.

Figure 2: How to end a call via Skype

5.1 Patients’ questionnaire

The patients’ questionnaire is centred on the hypothesis that patients generally welcome the idea of interpreting via Skype. Furthermore, it is investigated whether or not patients who have previously used an interpreter are more open towards interpreting via Skype. The results are structured according to the language in order to investigate whether or not patients from certain cultures find interpreting via Skype more inviting than others.
On average, the 14 patients surveyed indicated they were satisfied (1.53) with interpreting via Skype. The majority of patients (10 out of 14) had no experience with interpreting. Four patients had already used an interpreter. The patients were also asked to judge the fact that the interpreter was not present in the hospital. During the majority of interpretations, the patients would have preferred the interpreter to be on-site (8 out of 17 interpretations); during six interpretations, the patients voiced no preference whatsoever; and during the remaining three interpretations, the patients preferred interpreting via Skype.

Overall, Turkish-speaking patients were the most satisfied with interpreting via Skype (very satisfied: 1.44) followed by Russian-speaking (satisfied: 1.6) and Arabic-speaking patients (satisfied: 1.67). The Russian patients had had the most experience with interpreters (three out of three); only one out of nine Turkish and none of the Arabic patients had used an interpreter before. Only Turkish-speaking patients claimed to prefer interpreting via Skype over on-site interpreting. Three out of nine Turkish-speaking, two out of three Arabic-speaking as well as three out of five Russian-speaking patients would have preferred an on-site interpreter.

There seems to be no correlation between interpreting experience and openness towards interpreting via Skype as only one of the three Turkish-speaking patients who claimed to prefer interpreting via Skype had previously worked with an interpreter. Similarly, there is no visible indication that patients from certain cultures are more open to this kind of interpreting than others. Nonetheless, it needs to be noted that Turkish-speaking patients were the only ones to prefer interpreting via Skype over in situ interpreting. It can be assumed that patients ideally favour an on-site interpretation, but that they judge interpreting at a distance far better than no interpreting at all. This assumption is corroborated by the personal remarks of the patients expressing their gratitude.

5.2 Doctors’ questionnaire

The hypothesis underlying the doctors’ questionnaire is that interpreting via Skype is also positively welcomed by the doctors. They were asked to rate their satisfaction as well as the image and sound quality. The hypotheses that doctors can easily manage the technical effort required for interpretations via Skype and that this kind of interpreting is time-saving, were also analysed.

In general, doctors were very satisfied (1.35) with interpreting via Skype. Sound quality was judged to be good (1.65), just like image quality (good: 2.06). The doctors rated the technical effort needed for interpreting via Skype as low (1.82) and the amount of time saved as great (4.35). All doctors noted that they would

3 Satisfactory with interpreting via Skype could be rated 1 (= very satisfied), 2 (= satisfied), 3 (= rather satisfied), 4 (= rather dissatisfied) or 5 (= very dissatisfied).
4 The term technical effort refers to the technical know-how that it is necessary to handle the equipment and the programme Skype.
5 When rating sound or image quality, participants could choose between 1 (= very good), 2 (= good), 3 (= satisfactory), 4 (= poor) and 5 (= very poor). Technical effort could be rated as 1 (= very low), 2 (= low), 3 (= moderate), 4 (= high) or 5 (= very high). Time-saving could be rated as 1 (= very little), 2 (= little), 3 (= moderate), 4 (= great), 5 (= very great).
not mind whether the interpreter was present or not as communication would not suffer and Skype was sufficient for effective communication. Doctors listed advantages of interpreting via Skype with time-saving being the most frequent answer (five times) followed by flexibility (three times) and cost-saving potential (once). One doctor claimed this method would not disturb the course of events in a hospital.

Table 1 illustrates the ratings of sound and image quality for each interpreter:

<table>
<thead>
<tr>
<th>Interpreter</th>
<th>Language</th>
<th>Interpretations</th>
<th>Sound Quality</th>
<th>Image Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpreter #1</td>
<td>Arabic</td>
<td>3</td>
<td>1.67</td>
<td>2.67</td>
</tr>
<tr>
<td>Interpreter #2</td>
<td>Russian</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Interpreter #3</td>
<td>Russian</td>
<td>2</td>
<td>1</td>
<td>1.5</td>
</tr>
<tr>
<td>Interpreter #4</td>
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<td>2</td>
<td>3</td>
<td>3</td>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Interpreter #6</td>
<td>Turkish</td>
<td>5</td>
<td>1.2</td>
<td>1.6</td>
</tr>
<tr>
<td>Interpreter #7</td>
<td>Turkish</td>
<td>3</td>
<td>2.33</td>
<td>2.67</td>
</tr>
</tbody>
</table>

Table 1: Overview of evaluations of sound and image quality for each interpreter

To sum up, there were no significant differences concerning satisfaction rate between different languages. However, satisfaction was the lowest with Russian interpretations, which might be explained by significant connection problems during one of these interpretations. Doctors’ satisfaction is also reflected by the fact that all doctors claimed they did not mind that the interpreter was not present. Overall, sound quality was rated better than image quality. It needs to be questioned critically that doctors stated few disadvantages. In fact, it seems that, when recruiting interpreters in a hospital, it is primarily quickness that counts, which is also underpinned by the comments on Skype’s time-saving potential.

5.3 Interpreters’ questionnaire

The interpreters’ questionnaire placed emphasis on sound and image quality and on potential problems. Interpreters were to comment on the frequency of occurrence of these problems in order to determine whether or not there might be technical problems that would make it impossible to interpret via Skype. Furthermore, it was examined whether or not interpreting via Skype requires a stronger intervention on the part of the interpreter and whether or not interpreters may become used to this kind of interpreting.

Interpreters rated overall sound quality as good (1.71) with Turkish interpreters submitting the best rating (good: 1.56) followed by Arabic (good: 1.67) and Russian interpreters (good: 2.2). In general, interpreters claimed to find sources of disturbance for sound quality barely disturbing (1.76).

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6 The column “interpretations” lists the number of total interpretations carried out by the interpreter. The columns “sound quality” and “image quality” contain the average rating of sound and image quality by the doctors.

7 Here, interpreters were able to choose between 1 (= not disturbing), 2 (= barely disturbing), 3 (= rather disturbing), 4 (= very disturbing) and 5 (= absolutely disturbing/made interpreting impossible).
The interlocutors could not hear the interpreter occasionally (2.33) during six out of 17 interpretations; and during four interpretations the interpreters were occasionally (1.75) unable to hear the interlocutors. During three interpretations the interpreters could often (3) hear themselves talking (= echo). The interpreters claimed that during three interpretations there was often (2.67) white noise to be heard. During one interpretation, a technical overlap was often (3) experienced.

Interpreters rated image quality as good (1.71). Turkish interpreters appeared the most content (good: 1.56) followed by Arabic (good: 1.67) and Russian interpreters (good: 2). Overall, sources of disturbance concerning image quality were rated not disturbing (1.35). Altogether, interpreters noticed significantly less problems with image quality than with sound quality. During two interpretations, the interpreter was not seen from the hospital. This occurred rarely (1). There was a frozen image during one interpretation (rarely) and a blurry image during another (often).

When comparing the ratings of sound and image quality to the technical features of the equipment used by the interpreters, it can be found that

- Interpreters who used computers with high RAM power and processor speed as well as broadband internet reported significantly fewer problems than others
- Interpreters who had equally good equipment, but a slower internet connection (e.g. 8 mbit/s or mobile internet) faced problems with sound quality
- Interpreters whose equipment had lower RAM power and processor speed reported white noise and were not heard by the hospital and vice versa
- An echo presumably occurred due to acoustic feedback because the interpreter interpreted via an integrated microphone and not via a headset

Sound problems mainly arose due to slow internet connections or low RAM and/or processor speed of the computers used to interpret. An echo may be countered by using a headset. Image problems might be due to the speed of the internet connection. It cannot be determined to what extent adaptation to a new interpreting environment may influence interpreters’ stamina. It could also not be shown that interpreters assumed a moderating function to guide the consultations. Though interpreters claimed that during five interpretations speech overlaps occurred, only two of them felt they had to intervene more than usual.

5.4 Guided interviews with doctors

The guided interviews with doctors focus on how doctors feel during an interpretation via Skype. Interviewees were asked to remark on whether or not this method could be used regularly. In order to clarify whether or not patients tend to be “left out” in RI situations, doctors should specify who they saw as their

8 The frequency of sound or image problems could be rated either 1 (= rarely), 2 (= occasionally), 3 (= often), 4 (= very often) or 5 (= constantly).
9 It can be ruled out that any of the sound and image problems occurred due to the technical equipment at the hospital as the computer used for interpreting had a high processor speed (1.8 Ghz) and a RAM of 1 GB. The table top microphone and the camera used at the hospital were high-quality devices as well.
direct interlocutor. The interview ended with an open question: interviewees should think of a particularly revealing or interesting situation that occurred during the interpretations and comment on it.

In total, seven doctors were interviewed. All doctors had had previous experience with interpreters; however, only four of them had used Skype before. Five doctors immediately identified the interpreter as their primary interlocutor. Two doctors were visibly hesitant and then designated both patient and interpreter as equal interlocutors. In general, the majority of doctors felt comfortable with RI via Skype: “it worked really well. It was unproblematic” (AA3: 1:46-1:50). One doctor stated that with RI via Skype the same interpreters might be used more than once, thus providing the patients with more information. Two doctors found this method less tedious than having interpreters come to the hospital. One doctor highlighted patients’ satisfaction and added that interpreters’ remoteness might be regarded as a benefit by some patients who want to safeguard their privacy. Skype was deemed not recommendable for more complex situations (preoperative consultations, explaining certain illnesses etc.). Another doctor advised against RI via Skype if interlocutors need to move around frequently.

All doctors agreed that Skype was welcomed by the patients as all of them accepted taking part in the study. Similarly, all doctors thought that Skype could be used for future interpretations; however, the proviso that legal frameworks need to be clarified was added and security concerns were voiced. The logistic effort needed (contacting the interpreters, switching on and handling the technical equipment etc.) was estimated to be low by some doctors. Others were more sceptical and added that logistics might bear the risk of getting side-tracked. The doctor who took care of logistics reported the effort to be high; however, if RI via Skype was to be carried out in a call centre, it would be low. One noteworthy difference seen when interpreting takes place via Skype was that doctors can no longer obtain additional information on the patients’ culture from the interpreters:

I learnt to understand cultural values and traditions through interpreters. However, during video interpreting the situation is rather austere. [On site-interpreters] provide me with information on the patient’s behaviour before and after [the interpretation] when, e.g. a Muslim refuses to shake hands [...] and one would misunderstand it. In these situations, [...] the cultural interpretation is needed and this is almost exclusively possible in an on-site interpretation. (AA2: 12:38-13:44)

One doctor described the screen as a small but noticeable barrier and added that it was somehow like a filter to her. The final question was answered very differently. One interviewee was reminded of a situation where she held an information sheet in front of the camera for the interpreter to see. She added that contrary to on-site interpreting, she always looked at the interpreter and not at the patient. Two doctors recalled the positive atmosphere and patients’ reactions to this form of interpreting who started to laugh and make gestures. Two doctors were embarrassed by a noticeable interpreting mistake and one doctor remembered the patient directly answering a question that was asked in German.
5.5 Guided interviews with interpreters

The key research question for the guided interviews with the interpreters revolved around the challenges that arise when interpreting via Skype. Primarily, the interview questions aim at the interpreters’ role and the differences between RI via Skype and on-site interpreting. Moreover, it was to be determined whether or not interpreters noticed any particularities in doctors’ behaviour. They were also asked to evaluate doctors’ and patients’ attitudes towards RI via Skype and should evoke a special problem during the interpretations and comment on it.

In total, five interpreters were interviewed all of whom had university training in interpreting. One interpreter had more than ten years of interpreting experience, two interpreters had little experience. Two interpreters had previously used Skype, while another one had used a similar programme.

Some interpreters mentioned problems due to interlocutors being far away from the computer or speaking very quietly, while others named technical problems and noise interference. One interpreter admitted to feeling unfamiliar with the situation at the beginning. Another interpreter commented on the impairment of body language. Two interpreters explicitly referred to the lack of an introduction into the patient’s medical history as a disadvantage of RI. One interpreter had the feeling that she was given more time for the interpretation in situ. Another interviewee noticed that the doctor disconnected and did not listen to her when she was interpreting.

All the interpreters were of the opinion that doctors found interpreting via Skype appealing as it was fast, simple and easy to organise with a larger interpreting pool. The interpreters’ comments on the doctors’ behaviour were quite divided with some thinking the doctors spoke faster than usual and others reporting them to speak extremely slowly and excessively articulately. All interpreters would work via Skype again in the future. Two consider it practical as it allows them to work at home and one interpreter would even prefer interpreting via a mobile phone due to reasons of mobility.

Several interpreters mentioned that patients had appeared hesitant or surprised at first whereas others affirmed they seemed content to have an interpreter at their disposal. One of them added, however, that this largely depends on the degree of trustworthiness the interpreter is able to transmit – a task that is again complicated by her remoteness: “I was just some image in a box” (AD: 13:58-14:02). Concerning their stamina, two interpreters believe it to depend on the interlocutors: “when all […] stick to certain rules I feel more comfortable. With one patient […], who spoke very clearly and openly, I would have been able to interpret for more than an hour” (AD: 20:08-20:29). These rules, however, are very important. Thus, interlocutors should not become entangled in details or make too much noise. The act of putting down a pencil alone is enough to be conceived as disturbing by the interpreter who is very much dependent on the microphone and the headset. Three interpreters could not think of any problem that occurred when interpreting. During one interpretation, the patient did not understand why the interpreter used the first person to refer to the doctor whereupon the interpreter then switched footing to the third person.
Nearly all doctors saw the interpreter rather than the patient as their direct interlocutor. This is reflected by the fact that all of them used the third person to address the patient ("Ask her if she... "). Furthermore, it seemed that two of them claimed that patients and interpreters were on an equal footing because this was the answer they were socially expected to give. Hence, it can be concluded that interpreting via Skype bears the danger of communication no longer taking place in a triad with all interlocutors possessing equal rights and doctors talking about patients rather than to patients. While all doctors thought that patients would like interpreting via Skype, interpreters were far more sceptical and criticised that patients seemed timid or insecure. They also found it hard to build up a relationship of trust with them. In this respect, more detailed studies on patients’ satisfaction are needed.

Referring to the differences between interpreting in situ and RI, doctors cited the lack of personal contact and interpreting being reduced to interpreting alone. This, in turn, leads to less information for the interpreters, which was seen as a downside by several of them. The interpreters seem to think they are more visible when they are present at the hospital. Here, further analysis of the interpreters’ self-perception when interpreting via Skype is required. Overall, doctors seem to favour on-site interpreting over interpreting via Skype, whereby telephone interpreting would come after interpreting via Skype for some. In this respect, a comparative study involving various types of interpreting would be interesting.

5.6 Replay-method combined with an immediate conversation between the author of the study and the interpreter

After the guided interviews, Retrospection with Replay combined with an immediate conversation between the author of the study and five interpreters following Hansen (2006) was carried out. The interpreters listened to audio recordings of their interpretations and were asked to pause the recording whenever they felt they wanted to comment on something. Contrary to Hansen, the emphasis was not placed primarily on interpreting problems. Above all, interpreters should comment on sound and image disturbances or situational problems.

To refresh interpreters’ memory, they were read their questionnaire for the respective interpretation and received a short overview on the topic. Even so, the time difference between interpreting and the Replay posed a problem as interpreters were at times unable to remember the situation in detail (see also Hansen 2006: 6f.). The author sees another disadvantage of the Replay method in that interpreters who seemed more introverted made fewer comments than others. It can be assumed that the way interpreters deal with the Replay also depends on whether or not they listen critically to their interpretations at home.

One interpreter noted that the doctor spoke in illogical segments. See example 1 (DA12):

10 Transcription of the recordings is based largely on Wadensjö (1999): colons signal pauses, author’s comments are put in square brackets and interruptions are marked by insertions. “D” signals doctors’ utterances, “I” stands for interpreter and “P” for patient.
Example 1:
[07:05] D: In principle, a spontaneous normal birth is possible. Er ::
[07:10] There are however, two risks. Firstly, there is a slightly higher
[07:13] probability or risk that that the uterine scar [emphasised]
[07:16] ruptures.
[After the above statements, the interpretation for the patient follows.]
[07:39] However, there is a low risk for this to happen.
[The doctor pauses again and the interpreter starts interpreting.]

The interpreter noted that for her it would have been easier to interpret longer and connected passages as opposed to short passages with an illogical structure. The interpreter also regards the interruptions as disturbing for the patients as they might not be able to remember what the doctor had said before. It seems as if doctors – and maybe this can be explained by the common practice of recruiting untrained interpreters – tried to make their statements short and allegedly “interpreter-friendly”.

Example 2 (DA₉) reinforces the assumption that in RI via Skype doctors are tempted to withdraw from the conversation:

Example 2:
[03:20] I: Er... doctor?
[03:21] [P continues to speak with I]
[03:29] I: Doctor? ::::
[03:30] [P begins again to speak with I]
[03:32] D: Yes, please, what er I I'll tell him.
[03:34] I: Great, well she er she is telling me that she was examined
[03:37] yesterday and she therefore does not need an examination
[03:40] today, because it hurts when she is examined. Er Isn't yesterday’s
[03:43] examination enough?
[03:44] D: Okay.
[03:49] D: I'll tell doctor [Name].
[03:51] I: Okay, fine.

Here, the doctor explains to the interpreter that he is now going to examine the patient and asks the interpreter to remain online. Then he turns away to talk to his colleagues without waiting for the interpretation. Meanwhile, the patient tells the interpreter that she does not want an examination, whereupon the interpreter tries to call the doctor (Er... doctor?). As he does not react, she again talks to the patient and then decides to call the doctor again. Another doctor answers (Yes, please, what's er I I'll tell him.). Finally, the interpreter is able to interpret what the patient has said, whereupon the doctor again promises to tell the other doctor.

Another interpreter also commented on the doctors’ behaviour in the Replay; see example 3 (DA₁₂):

Example 3:
[08:54] I: Of course, in this case I would er I'll er stick to your
[08:58] D [interrupting]: Okay.
[08:59] I: recommendations and and [noticeably rushed] er because well I do not
[09:03] have very strong epileptic seizures [...] and this is of course why I
[09:14] don't want again for my er epilepsy to er to be in the
[09:17] foreground and to become apparent aga
[09:22] also be a problem [continues talking]
[09:21] D: Right and it would
The interpreter stated that the doctor tried to interrupt her because he had already been given the information necessary. In turn, the interruption made her feel as if she needed to go on quickly and appears very rushed in the recording.

Here, the question arises as to why the doctors apparently still strive to go on as quickly as possible with the consultation even though interpreting via Skype is time-saving for them. However, maybe the doctor from example 3 was simply stressed as the recording also proves that this particular interpretation was very difficult to organise. Furthermore, redundancies in the interpretation occurred, as the interpreter sought to interpret very thoroughly.

The following examples (DA10) show that doctors attempted to explain difficult terms with simpler words (examples 4 and 5) or reiterated parts of their speech to make them more intelligible (example 6).

**Example 4:**
02:15 D: [...] This is most likely a urinary tract infection, 02:18 er an infection of the bladder.

**Example 5:**
04:19 D: I’m going to translate the word for you, I’ll use a rather technical 04:21 term now. Her vital signs, which means her blood pressure, her pulse 04:27 er are great and also the lab results are unremarkable meaning 04:30 that this is not easy er to explain.

**Example 6:**
01:37 D: Well, the the post operational pain is rather normal 01:40 I’d say. She er she hasn’t told us until now about the urine 01:44 and the problems passing water. This might be a urinary tract infection, but has 01:47 n nothing to do with the operation. 01:49 I: I see [Wants to start interpreting.] 01:49 D: This means the pain is normal and as for the the th passing water 01:54 we’ll talk about that later. Just tell her this now.

It seems as if the doctor employs these and other strategies to guarantee that the interpreter understands him (better). This behaviour suggests that doctors want to make sure interpreters understand everything correctly due to legal safeguards. In example 6 it is interesting to note that the doctor tries to encourage the interpreter to start interpreting (“Just tell her this now.”). Here, it seems as if the doctor wants the consultation to proceed more quickly. At the same time, he again tries, as noted in example 1, to produce short utterances in order not to overload the interpreter with information.

The Replay method in combination with a personal talk showed that interpreters encountered specific situative problems when interpreting via Skype. Nonetheless, it also revealed strategies that doctors used to facilitate communication. It needs to be investigated, however, whether or not these particularities are also characteristic of other interpreting situations such as telephone interpreting.

6. Conclusion and outlook

The feasibility study on Skype showed that, in principle, interpreting via Skype is technically possible. It came to fewer sources of disturbances than expected and interpreters, in general, knew how to handle them. The study pinpointed several
strategies employed by the doctors such as consciously using redundancies or overarticulating. One strategy used by the interpreters was to switch footing to the third person when doctors or patients did not appear to understand them. Interpreters encountered problems due to their remoteness, illogically segmented utterances or interruptions by doctors.

Nonetheless, a call for further and more detailed research on RI via Skype in Community Interpreting settings needs to be made once again, especially when it comes to interpreters’ feelings of alienation, their stamina and their role as well as doctors’ and patients’ satisfaction with this new way of interpreting. The examination of the development of monitoring and adaptation strategies in analogy to Braun (i. a. 2007: 32ff; 40) would be an excellent field of research along with the analysis of turn-taking in analogy to Wadensjö (i. a. 1999: 256; 259ff.). Moreover, studies on whether or not RI turns the conversation from a triad into a mere dialogue with only two people communicating at once would be interesting.

Some initial recommendations can be derived from the insights obtained in the feasibility study on RI via Skype. On a technical level, when interpreting via Skype interpreters should use
- a computer with good processing power (at least 1 Ghz), high RAM (at least 1 Gb) and broadband internet (at least 8 mbit/s download; no mobile internet)
- a headset in order to suppress noise and to avoid interferences
- a high-solution camera and close their internet browsers and other applications.

However, it is not sufficient to fulfil the technical requirements only. Customer education is essential in order to offer Skype as a professional service and to provide interpreters with optimum working conditions in this new and demanding setting. This means that users of interpreting services are to be sensitised about the particularities of the conversational situation and are to be informed about what they can contribute to an efficient communication via Skype. They should therefore
- strive to complete contributions on a certain topic and not create unnatural interruptions
- wait for the interpretation or for possible questions
- actively contribute to successful communication by seeing interpreters and interlocutors as dialogue partners on an equal footing and, thus, not having interpreters do all the work on their own
- see to it that interpretations via Skype preferably take place in a quiet and sufficiently lit environment
- not begin side conversations with other people in the room
- not interrupt interpreters and interlocutors

The present study has shown that interpreters mostly did not receive any information on the patients’ medical history and that the ad-hoc starts in the interpreting situation unsettled them. To counter this, interpreters are to be provided with an obligatory briefing. In the medical setting, this briefing should include the patient’s medical history as well as information on the patient’s current troubles. Moreover, the aforementioned issues might also be discussed in an additional training course for users of future interpreting services via Skype.
This crash course could also comprehend an introduction into the use of the programme Skype as well as a simulation of an interpretation via Skype.

When planning to offer commercial interpreting via Skype, it is indispensable to consult interpreters and involve them in the planning. Beyond that, legal frameworks for interpreting via Skype need to be clarified. It can be assumed that questions concerning the decoding of data sent via Skype are of primary importance in this respect. When using Skype to interpret (e.g. at the asylum office) all interpretations could be recorded with the help of a computer programme that records in MP3 format (such as the No.23 Recorder used for the present study). This would allow the use of such data in later procedures. However, legal provisions on data protection most likely need to be consulted first. Furthermore, interpreting via Skype is to be remunerated appropriately.

Doubtlessly, new technologies and new ways of interpreting are going to alter the way interpreters will work in the future. Today’s young professionals nearly exclusively use the internet to prepare for their assignments whereas experienced interpreters still had to fight their way through weighty tomes. Even in the booths, the use of the computer is becoming more and more frequent. Science is constantly developing cutting-edge tools such as Personal Digital Assistants (PDAs) or forms of Augmented Reality, which are also partly used for interpreting (see i.a. Drechsel 2005: 19f.) and hold enormous potential for the future. New settings always bring about new challenges; but maybe also advantages such as the ability to work at home or to have everything at one’s disposal at the click of a mouse. Professionalisation in CI might also be supported by new technologies given that the internet, for example, offers better marketing possibilities in the field of translating and interpreting. However, in RI as well as in all other settings, the recruitment of professional interpreters is vital to the survival of the profession. Maybe interpreters and translators will be forced to fight even more for fair interpreting conditions and wages, as the World Wide Web opens channels for untrained individuals to offer their services online.

Where are the limitations of RI in general and/or RI via Skype? This question is going to appear ever more frequently when new technologies are used for interpreting. One initial conclusion from this feasibility study on RI via Skype is that the use of Skype should be limited to short and simple conversations and should not be used with patients who are mentally ill.

RI has already made its entry into Austria. Recently, interpreters who were not present in the conference room interpreted at a conference in Graz. A thesis on simultaneous interpreting via Skype with a separate audio channel is being written at the University of Vienna. Thus, we cannot close our eyes to new technologies: we should try to keep pace just like we as professional interpreters always do. It is doubtful that new technologies in interpreting – as alleviating as they may be for the profession – might come to replace “conventional” interpreting altogether. Just because we like to chat with our friends or send quick messages via Facebook, that does not mean that we do not feel like having a coffee with them in the “real world”. The same applies for on-site versus Remote Interpreting.
References


Remote Interpreting via Skype


Recordings cited

**GUIDED INTERVIEWS WITH DOCTORS**
AA₁: 19:06 min., recorded on 1 December 2009
AA₂: 05:01 min., recorded on 3 December 2009

**GUIDED INTERVIEWS WITH INTERPRETERS**
AD₁: 29:05 min., recorded on 4 December 2009

**INTERPRETATIONS**
DA₉: 22:04 min., recorded on 14 October 2009
DA₁₀: 06:36 min., recorded on 14 October 2009
DA₁₂: 13:25 min., recorded on 18 November 2009