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DO YOU GET THE MESSAGE? DEFINING THE INTERPRETER'S ROLE IN MEDICAL INTERPRETING IN BELGIUM

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Abstract

This paper aims to investigate the field-level realities of the codes of conduct adhered to by different agencies in Belgium for community interpreters, and the degree of interpreter discretion in the application of these codes. We focus on the specific setting of the health care sector in Brussels, where community interpreters and intercultural mediators sent out by different agencies often operate in the same hospitals. Drawing on data obtained through participant observation, interviews with key actors in the field and desk research, we analyze how the codes of conduct applied by different agencies affect multilingual and intercultural communication in a hospital context, in particular at those levels of the communication process where misunderstandings occur most often.

Resumen

Este artículo analiza las distintas deontologías utilizadas por los intérpretes sociales de diferentes agencias en el contexto hospitalario en Bélgica y el grado de discreción que tienen en la aplicación de estas deontologías. Nuestro ámbito de estudio se localiza en la región de Bruselas, donde los intérpretes sociales y los mediadores interculturales operan en el mismo lugar, pero cada uno con su propia deontología. Los datos que se presentan proceden tanto de la revisión bibliográfica existente, como de la observación de los participantes en los hospitales públicos bruselenses, así como de entrevistas con personas clave en la interpretación social en estos hospitales. Los análisis realizados permiten testar cómo afectan estas diferentes deontologías a la comunicación

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multilingüe e intercultural, centrándonos en aquellos aspectos de la comunicación que conllevan un mayor riesgo de ser malinterpretados.

Keywords: Multilingual hospital setting. Community interpreting. Intercultural mediation. Code of conduct. Medical communication problems.

Palabras clave: Hospital multilingüe. Interpretación social. Mediación intercultural. Deontología. Problemas de comunicación en el contexto médico.

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1. Introduction

Research has shown that language barriers increase patient safety hazards in health care (Divi et al. 2007; Schillinger and Chen 2004; HIN 2010). The use of medical interpreters has proved to be successful in reducing language barriers in health care (Brisset, Leanza, and Laforest 2013). Progressive globalization, individual mobility, and increased migration are expected to trigger a surge in demand for medical interpreting over the next decades.

Not only is the deployment of medical interpreters important, also the role which is assigned to these interpreters during their deployment is a crucial determinant of the communication process. Over the years, the community interpreting profession has undergone a typical evolution of professionalization, with the formation of professional associations that have induced standardization and the development of comprehensive codes of conduct (Mikkelson 1996; Mikkelson 2012). As a result, a wide variety of codes of conduct have been compiled around the world, based on national and regional visions, priorities and values (Bancroft 2005; Hale 2007; Tebble 2012). According to Rudvin (2007, 48) this variation reflects ideological differences as

> those norms and ethical guidelines that are accepted as authoritative are often created by whatever the centre of decision-making power happens to be, both territorially and as a community of practice, in isolation from the network of interrelated professional systems and institutions."

One important point of divergence between these codes of conduct concerns the role the healthcare interpreter is expected to take on, and in particular the degree to which (s)he may become involved in the interpreted mediated communication process (Hale 2007, 62). The two extreme views in this regard are reflected by the *conduit model* on the one hand, and the *cultural brokerage model* on the other hand.

The *conduit model* or the *translation machine model* (Bot 2007, 82) is a concept within dialogue interpreting "in which the interpreter is seen as a 'non-person', a mere conveyor of messages in a different language." It sees interpreters as "a conduit transmitting messages between parties reliably and

without distortion" (Dysart-Gale 2005: 92). In the most extreme view of this model, interpreters are to take an *invisible* role, to act as a *machine*, and to remain *uninvolved* in the conversation they facilitate. This model performs very strongly at the level of enhancing the directness of communication between doctor and patient, and fostering neutrality. It may encourage doctors who are often reluctant to allow third parties to attend their consultation to work with interpreters (Gadon; Balch & Jacobs 2007). Interpreters that stick to a neutral conduit allow medical providers to maintain the authority over the interpretation of the patient's narrative (Hsieh 2010, 154). An additional advantage of this model is that a clearer distinction between the role of interpreter and of intercultural mediator facilitates the foundation of both roles on a "state-of-the-art model of professional practice" (Pochhacker 2008: 24).

A weakness is however that it tends to negate the presence of this third party, which may hamper the communication process (Bot 2007). The conduit model has inspired many codes of conduct but has also been criticized in the literature as it tends to consider the act of interpreting as a merely linguistic issue, negating important practical elements (van Nunen 2010). Dysart-Gale (2005) finds that the conduit model may generate a misleading neutralism rather than a *nuanced interpretation*, and that it is less suitable for the medical context (Putsch 1985). In general, recent literature tends to consider the conduit model as *out of date* (Napier 2011: 59).

The *cultural brokerage model* encourages the interpreter to take a more pro-active perspective by intervening in situations where the communication is hampered by cultural differences (Kaufert & Koolage 1984; Verrept 2000); and assigns some roles to the interpreter which have traditionally been associated with intercultural mediators. According to Greenhalgh (2006: 1185) interpreters should, in addition to biomedical information, also "convey the key personal, historical, cultural and religious elements that form the context in which a particular biomedical problem emerges and is played out." This leans towards Bot's model (2007: 83) of *interactive interpreting*, where interpreters are seen as active participants in the dialogue; or towards Avery 's concept (2001) of *embeddedness*. In this view, interpreters are considered as *visible*, acting in a more *human* way, and to be *involved* in the conversation. Supporters of this approach argue that the interpreter should not be treated as a *ghost*, that interpreting does not happen in a social vacuum, and lastly, that the interpreter's role should be prescribed taking into account the specific setting of interaction (Wadensjö 1995; Wadensjö 1998; Angelelli 2008).

In practice, the boundaries between both approaches are not always clear. Avery (2001) refers to the pendulation between on one side the conduit model's focus on the act of interpreting and on the other hand the embeddedness model's focus on the patient's holistic well-being as a creative tension. Hale (2007: 41) argues that the two approaches often overlap in their expectations.

Recent research on the community interpreters' role by Brisset et al. (2013) argues that there is a need for research that connects communication difficulties to the specific roles assigned to the interpreter, rather than researching each of these aspects (roles, difficulties, and communication characteristics) separately. Angelelli (2008) argues that all codes of conduct should be empirically grounded and tested rather than prescribed. In response to this call for additional research, this paper studies the role assigned to medical interpreters by community interpreter agencies belonging to different centers of power in Belgium –and the degree of interpreter discretion in the application of these codes. We focus on the specific setting of the health care sector in Brussels, where community interpreters and intercultural mediators sent out by different agencies often operate in the same hospitals.

Drawing on data obtained through participant observation, expert interviews with key actors in the field and desk research, we analyze how these codes of conduct and the varying expectations surrounding their application affect multilingual and intercultural communication in a hospital context, in particular at those levels of the communication process where misunderstandings occur most often.

This paper is structured as follows: in the next two sections, we describe the setting of our research and the data collection strategy. Section 4 describes the historical legacy of the different codes of conduct that apply; and Section 5 shows how the different codes of conduct affect communication, focusing on four specific cases. Section 6 wraps up and discusses the policy implications of these findings.

2. Research setting

The Brussels healthcare sector provides an interesting case for studying the effects and the interaction of divergent codes of conduct for community interpreting given its multicultural and multilingual setting. Figures of Deboosere (2009) suggest that almost 50% of the Brussels population held a foreign nationality at birth. The city's multicultural and multi-ethnic character is strongly reflected by the diversity amongst hospital patients as well as hospital staff. To enhance access to health care for these patients, intercultural

mediators and community interpreters are called in. Because of the particular governance system in Belgium, these agents respond to different governments.

In particular, Belgium has six governments: one at the federal level, one for each of the three linguistic communities (Dutch-speaking, French-speaking, and German-speaking), and one for each of the economic regions within Belgium (Flanders, Wallonia, and Brussels). The governments of the Dutch-speaking community and of the Flemish region have been merged into one. While geographically located within the Dutch-speaking community, Brussels is officially bilingual (Dutch and French). This implies that for topics related to language, education, and/or culture, the governments of the Dutch-speaking and the French-speaking community are responsible. Health issues are however a competence of the Federal Government.

3. Data collection strategy

Our research draws on participant observation in hospitals where interpreters and mediators work, and participant observation in training and exam sessions in the agencies where interpreters are being trained and certified. In addition, we conducted expert interviews (Bogner 2005) with key actors in the field of community interpreting in Belgium, and desk-research to fill the remaining gaps in our study and to frame our findings in the broader framework offered by the existing literature.

Unstructured participant observation (Mulhall 2003) was carried out in two public hospitals in Brussels, where all three above-mentioned agencies operate. This provided us with first-hand insights into the field-level practice of multilingual and intercultural communication in the Brussels public hospitals. We observed the context in which patients and staff interact, and the practical and communication problems they face in this interaction. In particular, we learned about particular conditions under which interpreters may face difficult professional dilemmas.

In addition, we studied the texts of the two Codes of Conduct; and reviewed the existing literature on the interpreters' role in a medical context to analyse these differences. Then we carried out a series of expert interviews with key persons (quality managers) involved in the decision process in the different agencies in order to find out what their official stance was with regard to their respective Codes of Conduct, and the degree of discretion assigned to interpreters in applying it.

We interviewed the quality and human resources managers of SeTIS and of Brussel Onthaal, and the quality manager of the Flemish training and certification agency COC. We interviewed each person individually using a list

of explicit professional dilemmas, which a community interpreter which operates under their coordination may face, to find out what would be the appropriate response in their view. These dilemmas were developed based on the field experience we gained in the hospitals during our participant observation sessions and were structured around four cases. Using the Standards of Practice of the International Medical Interpreters Association (IMIA 2007) as a benchmark, we analyze the advantages and drawbacks of the Codes of Conduct under study.

4. The different Codes of Conduct

The multilayered governance structure described above has led to a relatively complex situation in which three different governments are dealing with multilingual patient issues in the Brussels public hospitals (EQUAL 2009). First, the Federal Public Service for Health, Food Chain Safety and Environment financially supports a large group of well-trained on-site intercultural mediators (Verrept and Bot 2013: 123) in some hospitals with the main objective of carrying out cultural brokerage (FOD VVVL 2011a). Second, hospitals can call in external community interpreters which are either under contract with the community interpreter agency "Brussel Onthaal", sponsored by the Flemish Community (Brussel Onthaal 2013) and under the coordination of the Flemish agency COC;[1] or with the French Community agency, SeTIS-Bxl,[2] which is partly funded by the French Community (SeTIS-Bxl 2013a). Because they have to respond to different governments or agencies, these different groups of agents follow different training programs and have to adhere to different codes of conduct.

There have been efforts in the past to create a unified national Belgian Code of Conduct for community interpreters in the French and the Flemish Community (Bancroft 2005). To this end, a federal coordination platform[3] was set up, with member agencies from both Communities, including SeTIS (French Community) and COC, a Flemish agency which offers support to

1. Flemish Central Support Cell for Social Interpreting and Translation (in Dutch: Centrale Ondersteuningscel Voor sociaal tolken en vertalen)
2. Service de Traduction et d'Interprétariat en milieu Social. Strictly speaking, SeTIS is also responsible for community interpreting in the German-speaking community, but as this concerns a minority within the total population, we will ignore this for now.
3. National Coordination of Social Translation and Interpreting Services (in French COFETIS: Coordination Fédérale de la Traduction et de l'Interprétariat Social; in Dutch FOSOVET: Federaal Overleg voor het Sociaal Vertalen en Tolken)

various Flemish community interpreter agencies, for instance at the level of training and certification of community interpreters.

In line with what can be expected based on Rudvin (2007), however, there was a major divergence of opinions between SeTIS and COC. In 2008, the Flemish agency COC left the platform as its view on the code of conduct seemed irreconcilable with the code proposed by its French-speaking counterparts (Pierre 2011). The federal coordination platform was dissolved shortly afterwards, and as a result SeTIS and COC continue to apply different codes of conduct.

4.1. French Community Code of Conduct for community interpreters

The French Community agency SeTIS has two branches, notably SeTIS-Wallon, which coordinates SeTIS' activities in the Walloon region; and SeTIS-Bxl, which coordinates SeTIS' activities in the Brussels region. The French Community Code of Conduct (henceforth referred to as French Code for the sake of convenience) is a generic code for community interpreters, which means it has not been adapted to specific contexts, such as education, interaction with social agencies, or medical interpreting.

Interpreters who wish to work for SeTIS need to go through an introductory training session. However, they are not subject to a specific test of adherence to the French Code (e.g. through role-play as is the case in Flanders). There is no official certification. In this sense, we can consider the French Community interpreters' organization as exhibiting a lower level of "professionalization" (Mikkelson 1996).

With regard to the role of the interpreter the French Code stipulates that the community interpreter is a social worker who is called in by a frontline service. His/her task is to facilitate verbal comprehension between two parties who do not have a language in common. By no means, the interpreter is allowed to take on the role of a frontline service worker or to provide direct help to the beneficiary (the client of the frontline service). The interpreter is not an "intercultural mediator" in that (s)he is not allowed to intervene in conflicts between the frontline service and the beneficiary. His/ her core task is to translate everything that is being said, without omitting or censoring utterances from either party involved. On the other hand, the interpreter is encouraged to solve misunderstandings that originate from cultural or contextual differences, drawing on his/her own experience with immigration, or with being an immigrant in a foreign country, and if possible with the geopolitical and cultural context. But, when engaging in mediation, (s)he is to

clearly inform both parties that (s)he is doing so (see Article 2 of the French Code (SeTIS-Bxl 2013b)).

4.2. Flemish Community Code of Conduct for community interpreters

The Flemish Community Code of Conduct (which we will refer to as the "Flemish Code" for reasons of simplicity) is compiled by COC and applies to community interpreters sent out by Flemish agencies, but also to those from *Brussel Onthaal*, which receives its financial support mainly from the Flemish Community. In collaboration with the existing Flemish community interpreting agencies, COC developed a standard of practice for community interpreters in Flanders, and a corresponding quality label. A quality council, with one representative from each Flemish community interpreting agency, is responsible for the management and updating of this standard of practice in consultation with professional and academic experts within the field of interpreting (Pierre 2011).

The adherence to the Flemish Code is explicitly tested during the community interpreting certification exams organized by COC by means of role-play. All community interpreters who wish to work for an official Flemish community interpreting agency are required to pass this certification exam.

Like the French Code, the Flemish Code is designed for a general context, hence for use in education (including the integration courses organized by the Flemish Community), interaction with social agencies, and in a medical context. There are no specific modules for medical interpreting. This could in itself constitute a problem, as health and education sectors often have a different approach to language mediation (Rudvin and Tomassini 2008).

The task of the interpreter is defined quite strictly in the Flemish Code. For instance, before beginning a session the interpreter is required to clearly explain his role to all parties involved in the interaction by stating "I will interpret everything that is said, without additions, omissions or adjustments" (Van De Mieroop, Bevilacqua & Hove 2012: 24). The Flemish code stipulates that in no instance, the interpreter may engage in a conversation with one of the parties. Just like in the French Code, the interpreter is to translate every utterance without adding or omitting elements and (s)he is not allowed to take on the role of a mediator. The Flemish code also prescribes in more detail how neutrality should be guaranteed. For example, the interpreter is strongly advised not to wait in the same room as the patient before a session; and more generally, never to stay alone with the beneficiary (Kruispunt Migratie Integratie 2013).

When it comes to establishing the degree to which culture can be taken into account, the training manual of the Dutch speaking agency says that

> when cultural stumble blocks arise due to the fact that the two speakers have different cultural origins, and as a result hamper the communication, an intercultural mediator should be called in […] this is not the job of the interpreter, and as result deontologically unacceptable (De Bontridder & De Groote 2011: 86)

The same training manual compares the act of mediation to remove cultural obstacles as giving first help to someone who is bleeding after a street accident in that sense that by giving a person non-professional care, one risks doing more harm than good (De Bontridder & De Groote 2011: 87).

4.3. Federal Standards of Practice for intercultural mediators

In Belgium, like in many other countries, intercultural mediation programmes have been developed and implemented in health and social services to improve access to and quality of care for ethnic minorities (Verrept 2012). In this context, the intercultural mediator is a full staff member of a hospital whose work objectives involve overcoming, to the extent possible, problems that originate from language barriers, socio-cultural differences, and ethnic tensions (Verrept 2013: 5-6). In order to accomplish this the mediator should be able

> to accompany relations between migrants and the specific social context, fostering the removal of linguistic and cultural barriers, the understanding and the enhancement of one's own culture, and the access to services (Chiarenza 2004).

The Federal Ministry does not have a code of conduct but puts forward a Standards of Practice document (FOD VVVL 2011a). These Standards of Practice differ from the two Codes of Conduct discussed before, as it applies to intercultural mediators, rather than to community interpreters. Especially when the community interpreter's role is interpreted as in the conduit model, there will be a strong divergence between the roles of community interpreters and intercultural mediators.

According to Bancroft (2005, 11), the task description of intercultural mediators in Belgium builds on the Standards of Practice of the International Medical Interpreters Association (IMIA, 2007). Correspondingly, their main duties consist of cultural brokerage, advocacy for patients, interpreting, and

mediation in conflicts that are caused by linguistic and cultural misunderstandings (FOD VVVL 2011b).[4]

As our paper primarily addresses the role taken by community interpreters in a medical setting, the case study analysis focuses on the differences between the Flemish and the French Code.

5. Case studies

Section 4 shows that the ideas put forward in the French and the Flemish Code are both close to the *conduit* model. This implies considerable divergence with the Standards of Practice of the International Medical Interpreters Association (IMIA).

In our analysis below we will show that, in spite of these apparent similarities between the French and the Flemish code, there is a discrepancy when it comes to expectations regarding the actual application of the codes in the field. There where the Dutch-speaking agency demands a strict adherence to the code, the French-speaking agency is more lenient and gives more discretion to the interpreter, to act in accordance with his/her own situational judgment. In other words, the latter seems to consider the code as a set of guidelines rather than as a prescriptive document which should be strictly followed.

5.1. Case 1: In the waiting room

A hospital visit often includes an episode of waiting time in the waiting room together with the interpreter or mediator. Whether the interpreter can or should interact with the patient at that point has proved to be a controversial issue internationally (Bancroft 2005). The diverging views outlined below are thus exemplary for the global discussion.

The IMIA Standards of Practice prescribes "When possible, [the medical interpreter] speaks to the patient prior to the triadic encounter to assess the patient's linguistic register and style (e.g. dialect, formality of speech etc.)".

4. Still, some lack of clarity remains as to what intercultural mediation exactly means in the Belgian context, what these tasks actually consist of, and how they should be organised (Verrept 2013: 2). This is why the Belgian Ministery of Public Health is currently devising a new modified Standard of Practice, in consultation with mediation practitioners and legal experts (pers. comm. Verrept, 2014). The Standards of Practice are to be seen as a *guide book* to help the mediator to properly execute and organise his/her job, rather than as a *straitjacket* (Verrept 2013: 10).

The Flemish Code, in contrast, suggests that the interpreter goes and sits in a separate location in order to avoid personal contact with the patient. The reasoning behind this (as clarified by COC during the expert interview) is that patient contact prior to the consultation may have a negative impact on the interpreter's neutrality. In addition, time constraints do not allow for a proper assessment of the patients' register and knowledge; and this is not considered as the interpreter's responsibility either.

While the French Code also suggests that there should be no patient contact prior to the consultation, expert interviews at SeTIS suggest that it is left up to the interpreter to assess whether prior contact is likely to negatively affect neutrality.

Research by Verrept (2008) suggests that prior contact may enhance the medical communication process. In particular, patients feel less isolated when they meet someone from their own ethnic group (Verrept 2012, 121). Verrept also believes that the psychological impact of such comfort may even be more important to facilitate doctor-patient communication than merely overcoming a linguistic barrier. Along the same lines, Leanza (2007) highlights the interpreter's role in offering a warm welcome in the hospital.

5.2. Case 2: Detecting and reporting confusion

Misunderstandings in multilingual communication can occur at various levels. It is important to distinguish between patients who have low proficiency in French or Dutch (the two official languages of the hospital under study) and those who do not speak any of these languages at all. For instance, when a patient has sufficient knowledge of French or Dutch for an informal chat, (s)he may give the impression that s/he understands everything that is said by the medical staff. However, (s)he may still have important problems with reading and understanding prescriptions, or numbers. Even confusions between terms such as month, day, week, and year may have serious consequences for treatment and for patient health.[5]

At the level of history-taking, confusion of numbers and time units can also lead to serious problems. Information errors may slip unnoticed into

5. We heard for example of the case in which a (Rif speaking) mother went to see a doctor with her son who suffered from a severe skin rash. During the previous consultation she had not properly understood her son's cortisone prescription. Instead of three times a week, she had applied the cortisone ointment thrice a day, resulting in even more severe skin problems.

medical records, potentially resulting in increased patient hazards and medical costs.

On this topic, the IMIA Standards of Practice stipulate that the medical interpreter "picks up on verbal and nonverbal cues that may indicate the listener is confused or does not understand and checks whether clarification is needed by the listener."

The Flemish Code, in contrast, states that "The interpreter is only to translate what has been said without omitting or adding details. Furthermore, the interpreter is to stick to the interpreting performance without performing other tasks." The expert interview with COC suggests that, if the interpreter has the impression that the patient does not understand the clinician's message in spite of a correct translation, the interpreter should not intervene. This means that (s)he should not adapt his/her register to what (s)he deems more understandable; (s)he should keep to the register used by the clinician. In COC's view, it is the clinician's task, not the interpreter's, to detect misunderstandings. The underlying reason cited is that it is unclear whether the interpreter is really capable of gauging the patient's comprehension.

According to COC, the interaction should take place as if two native speakers were talking to each other. Within this framework, they argue that a native Dutch patient might as well experience some communication problems, and hence it is not the responsibility of the interpreter to intervene. In their view, it is the responsibility of the patient and of the doctor (who may inquire about this through the interpreter) to ensure the clinician's message is well understood by the patient. Their training guide reads as follows (De Bontridder & De Groote 2011: 96):

> An interpreter enables communication between two (or more) parties, who do not understand each other's language. Nothing more, nothing less, as if he were subtitling the conversation. He tries to convey the message (the content and the intention of the speaker) as correctly and faithfully as possible in the other language, this means without additions, omissions, or modifications He shall never ever give his own opinion.

The French Code states that "everything that has been said is to be translated without censoring elements". Similar to the Flemish Code, community interpreters are prescribed to only engage in translation. However, the quality manager of SeTIS replied in an expert interview that a community interpreter is to be a social interpreter in the first place, and has to accompany the patient in communication. This implies that the interpreter can go beyond translation and when required, pro-actively report to the clinician that the patient may not have understood well what was being said.

This issue of going further than only translating what has been said, reflects well the international discussion on this topic. Hale describes the issue as follows (2007: 62):

> One crucial question [...] is whether in the medical setting interpreters are to attempt to place the patient in the same situation as a patient who does not require the services of an interpreter [...], or whether the interpreter is to help the health care provider improve doctor–patient communication, even when a monolingual patient would not have the benefit of such help.

In this context, Greenhalgh et al. (2006) note that interpreters often need to *double translate*: not only from one language to another, but also from medical jargon to everyday talk; as many patients would not be able to understand direct translations of what is said by medical staff, as a result of low health literacy. They find that health professionals consider such misunderstandings as a source of significant clinical risk, and argue that "intermediaries may have to play a critical advocacy role."

Leanza (2007) on the other hand notes that clinicians may feel excluded from the interaction when interpreters do more than interpreting alone. They tend to see the interpreter as an instrument for communication with a patient, rather than as a real actor in the clinical communication process. Pochhacker (2008) advocates for a clear distinction between "the professional function of cross-cultural mediation" and that of "professional interpreting in community-based settings". While he agrees that these can coexist even in a single person, it means that person needs to have the professional qualification to assume that role, and to communicate this role clearly to his/her clients.

5.3. Case 3: Use of the first person

Guidelines for professional interpreters stipulate that interpretation of a medical consultation should be set up according to a triadic scheme. This implies that the doctor is seated in front of the patient and can make eye contact; and that the interpreter or mediator sits on the side and preferably speaks in the first person when interpreting. Such a spatial scheme is considered to stimulate *direct* conversation between doctor and patient.

In a medical consultation, however, circumstances often impede such *good practice*, as consultation as well as interpreting is often carried out under severe time constraints. As a result, spatial distribution is not always optimal; and doctors often talk in the third person rather than addressing the patient directly (hence, speaking "about" the patient to the mediator; rather than "to" the patient via the mediator). This may lead to the patient not feeling engaged in the conversation, or feeling *excluded* from the communication event. As

a result, the communication process may be disrupted, and the patient may refrain from pro-actively disclosing crucial medical information.

In this context, the IMIA prescribes that the medical interpreter "uses the first person ("I") form as the standard, but can switch to the third person, when the first-person form or direct speech causes confusion or is culturally inappropriate."

The Flemish Code prescribes that the interpreter should always speak in the first person; (s)he should not switch to speaking in the third person. This is in line with Dubslaff & Martinsen (2007) who argue that constant use of the first person enhances directness between the two parties, avoids manipulating behavior, and fosters accuracy, brevity and direct face-to-face contact between the parties. During the expert interviews, COC argued in favor of applying this rule in a strict sense. Use of the first person fosters the illusion of a direct exchange between the monolingual parties (Wadensjö 1997), supporting COC's view that interaction should take place as if two native Dutch speakers were talking to each other.

According to the French Code interpreters should preferably use the first person, but the expert interviews reveal that in some particularly sensitive cases, they may use the third person. Hence, as in the first case we discussed, interpreters in the French Community apply a similar code, but in a less strict way – which means that in practice, their behavior may be more in line with what is prescribed by the IMIA standards.

Bot's (2007) view is that the use of the third person can function as a *space builder* to indicate that what has been said comes from the primary speaker and not from the interpreter. In response to the objection that this can hamper the directness of communication, Bot argues that one cannot deny that a mediated or interpreted interaction consists of three actors. This remains however a contentious issue in the literature, as for example Tebble (2012) considers that a proper briefing prior to the consultation can also enable the physician and the interpreter to understand their respective roles.

5.4. Case 4: Supporting aftercare

We already mentioned before that the erroneous understanding of time (figures and concepts of tomorrow or yesterday) can cause confusion with respect to future appointments. Numbers dictated by both patients and doctors can be wrongly dictated or understood, despite some knowledge of the local language.

Research has shown that language barriers are a common cause of not showing up at a follow-up appointment (Gruzd, Shear & Rodney 1985). In

case of a consultation with a specialist, this may mean that a patient will have to wait for another three weeks for a new appointment. At the same time, a scheduled consultation has been missed. For this reason, the IMIA suggests that the interpreter should ensure that a patient gets an appointment with the appropriate resources, and with an interpreter if needed.

In contrast, the Flemish Code prescribes that the interpreter should never (independently) accompany a patient to make further appointments, as they believe this may again affect neutrality. Interpreters should only help patients fix appointments if hospital staff members accompany them to the registration desk. In the expert interview COC rejects the idea that medical interpreters can be deployed as *a substitute* for a doctor or a social worker. In this view, the interpreter's assignment ends when a consultation is finished, and hospital staff leave.

The French Code also points out that the interpreter should not replace the social worker or the doctor for instance, but in the expert interview, this view is qualified as community interpreters are allowed to help and accompany patients, as long as they do not formally replace the social worker or medical staff. The decision is left to the interpreters' assessment. This brings actual interpreter behavior more in line with the IMIA Standards of Practice, which recommends the community interpreter to accompany the patient to ensure that (s)he understands the details of the follow-up meeting.

5.5. Discussion

The analysis of the four cases reviewed above shows that different expectations regarding the application of a code of conduct can lead to significantly different behavior of community interpreters and mediators, sometimes with important implications for patient health and hospital organization matters. In particular, it shows that, even if the Flemish and the French Code resemble each other in writing, there is a notable difference in the degree of strictness with which the Codes are expected to be applied.

The Flemish Code is expected to be followed strictly, in that the interpreter is not allowed to personally accompany a patient to an appointment or signal that a patient might not have well understood a particular piece of information. In contrast, the French speaking agency allows the interpreter to use his/her own situational judgment in interpreting the Code on the spot.

The Flemish Code was designed for a generic context and, judging from the expert interviews, there does not seem to be a particular willingness to adapt this Code to specific contexts such as the health care setting, including a broader role for the interpreter. The main reason invoked is that such

adaptation may require the interpreter to take on additional responsibilities, which is not desirable. Hsieh (2009: 136) argues that taking on such responsibilities may require (extensive) additional training. The Flemish Code fits in with the official policy with regard to integration which was elaborated by the Flemish Government in 2009, and which looks at the community interpreter as a tool for the complete integration of foreign language speakers into Flemish society.

Central to this policy is the concept of *zelfredzaamheid* (Bourgeois 2011), literally translated as "the ability to live/do things independently, ability to cope/manage for oneself" – implying that "the immigrant should not be pampered" (Bruylant 2012). According to Wets (2007), this shows that the Flemish Government has shifted from a collective approach, where it was the community's responsibility to support the integration of the immigrant, to a more individualistic approach today where it is foremost the immigrant's own responsibility to find his/her way in Flemish society.

To date, the French community government has not developed a specific integration policy; nor has it undergone a similar ideological evolution towards the concept of *zelfredzaamheid*. This may be one of the reasons why earlier attempts to create a joint Belgian Code of Conduct failed (see above). Since then, the French Community agencies have maintained a Code of Conduct of which the practical implementation hovers between the cultural brokerage model and the conduit model. While giving less assurance over the quality and standardization of community interpreter interventions, the lower level of professionalization observed in the French Community offers interpreters a higher level of discretion and flexibility – which may have its value when applying a generic and non-context specific code.

6. Conclusion and policy implications

In this paper, we have studied the application of two distinct Codes of Conduct by different community interpreters operating in the same hospital. While the two codes of conduct resemble each other in writing, and are largely in line with the conduit model, the degree of interpreter discretion in the application of these codes (as authorized by the agencies by which they are sent out) differs. One agency requires a strict adherence to the Code; the other agency considers its Code merely as a set of guidelines, and allows for interpreters' situational judgment in its application. In the latter case, this may be the result of a weaker degree of professionalization and standardization of the profession of community interpreting.

Neither the Flemish Code, nor the French Code have been adapted to the specific setting of the healthcare sector. This is an important shortcoming. De facto, those interpreters who have more discretion in applying the rules are likely to show a behavior that is more in line with what has been described as good practice under the IMIA Standards of Practice, which is developed specifically for a medical setting, and reflects clear elements of cultural brokerage.

Our results support the recommendation that a new Code of Conduct should be developed, both on the Flemish and on the French-speaking side, which is adapted to the medical context, and in line with international state-of-the-art practice as reflected in the IMIA Standards of Practice, as well as to the local medical context.

It would be good if a unified Code of Conduct could be developed. The divergence between different codes of conduct may have an important cost in itself. In particular, as mediators and community interpreters who work in the same hospital adhere to a different Code of Conduct, this may cause confusion for both medical staff and patients. In particular, if some interpreters take on more responsibilities than others, patients and medical staff may have similar expectations when dealing with other interpreters. If a patient has been offered help in fixing an appointment by a community interpreter once, a doctor may rely on the community interpreter to take care of this the next time as well. If this does not happen, patients may be lost in confusion.

Finally, in our opinion, the idea that an interpreter-mediated encounter should ideally resemble as much as possible a monolingual encounter between two native speakers, and that therefore any help or interference beyond purely linguistic issues would give foreign speaking patients an “unfair” advantage over native speakers is not valid. One needs to acknowledge that, while, after the consultation, a native speaker goes back to a society where (s)he was born and raised and where it would be relatively easy to find support in a local social network; the foreign-speaking patient may come home to a society of which (s)he does not speak the language, and with whose institutions (s)he may not be familiar – especially in the case of recent arrivals – and usually without a strong local social network to fall back on. Therefore, we suggest that a broader perspective should be taken in the discussion over the role of community interpreters in a medical context.

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