COMMUNITY INTERPRETING: RE-CONCILIATION THROUGH POWER MANAGEMENT

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The language I am speaking of now,
that I am almost speaking,
is a language whose every syllable
is a gesture of reconciliation.
(Malouf 1990: 98)

This paper investigates current practices in community interpreting in Australia with a view to identifying the role actually played by the interpreter within the overall power dynamics of linguistically mediated triadic interactions. From the vantage point of the Australian context, which can boast a fully-fledged system of public sector interpreting services, the concept of 'power management' has been explored on the basis of data collected during interpreted encounters between members of the Italian community and representatives of Australian health care institutions. Assuming that the metaphor of the interpreter as a non-involved conduit is untenable in community interpreting situations, characterised not only by unequal power distribution between the primary parties, but also by the interpreter's advantage over both of them by virtue of his/her linguistic and cultural knowledge, the question which this paper attempts to answer is to what extent the interpreter's verbal and non-verbal choices contribute to a favourable outcome of the encounter in terms of "re-conciliation".

1. Introduction

Over the past decade, while research on conference interpreting has continued unabated along the stimulating routes opened up by linguistics and the cognitive sciences, the new, adjacent, field of community interpreting has increasingly attracted the interest of scholars worldwide. Although the activity itself has been practised for decades, community interpreting as a scholarly subject was long neglected, being perceived as a blurred, uncoordinated and disparate area

1 Although this paper is the outcome of a joint research project carried out by the two authors, parts 1, 2, 3 and 7 were written by Raffaela Merlini and parts 4, 5 and 6 by Roberta Favaron.

lacking the glamour and scientific attractiveness of the two major modes of conference interpreting, i.e. simultaneous and consecutive interpreting.

The late development of this field of study as well as the local dimension of community interpreting services and the consequent geographical separateness of their growth account for the persisting terminological confusion, as observed by Gentile, Ozolins and Vasilakakos (1996: 17):

> *Liaison interpreting* is the name given to the genre of interpreting where the interpreting is performed in two language directions by the same person. This activity has acquired a number of epithets according to the environment within which it developed and to the political considerations in the parts of the world where it is practised. In the United Kingdom, for example, this form of interpreting is called 'ad hoc' or 'public service' interpreting, in Scandinavia 'contact' interpreting and in Australia 'three-cornered' or 'dialogue' interpreting; the term 'community' interpreting is also used by a number of authors. The term 'liaison interpreting' was coined to distinguish it from 'conference interpreting' […].

If, on the one hand, the three authors clearly identify "liaison interpreting" as a generic term – alongside such expressions as "ad hoc", "contact", "three-cornered" and "dialogue interpreting" – circumscribing all forms of interpreting which are not classified as "conference interpreting", on the other, they seem to point to a terminological identity between this all-embracing label and the names given to one of its sub-categories, namely "public service" or "community interpreting". Emblematic of the attempt to resolve the above contradiction by signalling a distinction between interpreting mode and setting is the title of the work edited by Mabel Erasmus (1999), *Liaison Interpreting in the Community*. Yet, once reference to the interpreting setting is removed from the meaning of the term "liaison", ambiguity is reinforced rather than dispelled, since the demarcation between the fields of conference and liaison interpreting becomes blurred. If emphasis is placed on the technique – i.e. consecutive interpreting in face-to-face interaction, without note-taking and involving a *retour* into the interpreter's foreign language – then liaison interpreting would be an appropriate expression for a whole range of scenarios, covering, for instance, both the linguistic assistance offered to diplomats at receptions or banquets and the mediation work carried out in hospitals and police stations.[2] To complicate matters further, Roberts (1997: 8) indicates a restricted reference to interpreting in business negotiations:

2 An interesting discussion of the issue is found in Hertog & Reunbrouck (1999: 264-267).

> The terms 'liaison interpreting' and 'escort interpreting' are generally reserved for business-oriented *ad hoc* interpreting […].

Without dwelling further on the intricacies of the terminological debate, which has already diverted too much of the scholars' attention from the more interesting and substantive aspects of this interpreting activity, for the purposes of this paper "ad hoc interpreting" will be considered as the superordinate term encompassing two main sub-varieties, namely "community interpreting" and "liaison interpreting", where the latter, as suggested by Roberts, becomes a synonym of "business interpreting".

To set the scene for the discussion, a clarification of the specific interpreting setting explored in this paper is now called for. From the diverse field of "community interpreting" defined by Collard-Abbas (1989: 81) as the "type of interpreting done to assist those immigrants who are not native speakers of the language to gain full and equal access to statutory services (legal,[3] health, education, local government, social services)", the analysis was narrowed down to interpreter-mediated encounters between English-speaking medical staff and Italian-speaking patients in Australian health care facilities.

Owing to its fully-fledged system of public sector interpreting and translating services, which is the successful outcome of a gradual process of "reconciliation" between the diverse cultural and linguistic identities of a multi-ethnic population, Australia was chosen as an ideal vantage point for observation and study of current professional practices. More specifically, the collection of data took place in Melbourne, which to this day remains the largest Italian city in Australia (NLLIA 1994: 178). Although the bulk of Italian immigration to Australia dates back to the 50s and 60s, in the mid-80s there were still 100,000 Italian-born permanent residents in the capital city of Victoria, according to the 1986 census. The downward immigration trend, which started in the 70s and has continued ever since, explains the high median age of the Italian-born population, which in 1986 was just over 50 (NLLIA 1994: 178). The increasing number of elderly people who either have never acquired a command of the English language or have reverted to their native tongue in their old age is the main reason behind the sustained demand for Italian interpreting in the health sector. As regards the linguistic dimension, in

3 As Roberts (1997: 9) points out, the question whether legal interpreting belongs within community interpreting is far from settled. Many claim that the philosophical approach characterising legal interpreting brings it closer to court rather than community interpreting. This view was adopted in 1998 by a committee of the International Federation of Translators who defined "community-based interpreting" as follows: "any interpreting (paid or voluntary) where interpreters work in day-to-day life situations in the community (not including court or legal work)" (Harris 2000: 4).

1986, Italian was, after English, the second most common language spoken at home in all Australian states. It should, however, be pointed out that the label "Italian" is a necessary generalisation in statistical surveys, since it subsumes a wide spectrum of regional varieties. Speakers of standard Italian are, in reality, a tiny minority if compared to dialect speakers.

The data obtained through selective and structured observation of the interpreting sessions have been used to explore the following questions: what is it, in real-life cross-cultural interactions between real people with their socially determined *personae* and in concrete physical environments, that is likely to bring about effective communication? More specifically, what is it, in the interpreter's performance, that leads to this result? And, most importantly, is this result a product of the interpreter's conscious or even unconscious use of "power management strategies"? This paper is an attempt to provide some answers to the above questions.

2. The role "riddle"

Moving on from contextual information to the theoretical premises of this study, one of the crucial aspects which needs to be addressed in the first place is the socio-institutional framework within which community interpreters are called upon to provide their professional service. Unlike other forms of ad hoc interpreting, community interpreting invariably occurs in situations characterised by status differential and hence by unequal power distribution between the two clients, the one accessing public services and the other providing them. In Shackman's words:

> A community interpreter […] is responsible for enabling professional and client, with very different backgrounds and perceptions and in an unequal relationship of power and knowledge, to communicate to their mutual satisfaction. (1984: 18)

Given the specificity of this communicative context, it is not surprising that a large part of the existing literature on community interpreting focuses on the vexed issue of the interpreter's role as third participant in the interaction. Whether the aim of publications is to describe current practices or to provide guidelines, the general impression is one of discordant approaches or vagueness of formulation.

A brief perusal of the views expressed over the past decade by different authors shows a continuum ranging from absolute neutrality/invisibility to direct involvement as conciliator, with intermediate positions being variously referred to as active participation, assistance, cultural brokering and advocacy (Roberts 1997: 10-15). Starting from the lowest degree of involvement, the goal of

"invisibility" – although the term itself is carefully avoided – seems to be implied in the following statement by Gentile (1991: 30):

> The role of the interpreter can be summarised as one where he/she is required to conduct himself or herself in a manner which makes the situation with an interpreter, as far as possible, similar to a situation without an interpreter.

This view raises at least one crucial question: is it realistic to compare a dyadic, linguistically and culturally homogeneous interaction with a triadic encounter where the interpreter is a visible, ratified participant and the only person with knowledge of both interlocutors' cultures and languages, and expect a similar outcome from two such diverse settings? Challenging the applicability of Goffman's category of "non-person" to the community interpreter's role and drawing on Simmel's theory that the number of people making up a group influences the social interaction that takes place among them, Wadensjö (1998: 11) observes:

> Indeed, there is a reason to believe that interactions involving three or more individuals have a complexity which is not comparable to interaction in dyads. The interpreter-mediated conversation is a special case. It is obvious that the communicative activities involved in this kind of encounter are in some senses dyadic, in other respects triadic, and the active subjects may fluctuate in their attitudes concerning which of these constellations takes priority.

If one considers talk as a series of activities performed by all participants which results in a joint construction of meaning, and not exclusively as successive texts produced by individual speakers, then, as Wadensjö (1998: 6-7) argues, community interpreting must be seen as a mediating as well as a translating task. From this perspective, Knapp-Potthoff and Knapp's (1986) equation between the interpreter's tendency to act as a "true third party" rather than a "mere medium of transmission" and his/her lack of professionalism does not reflect either the nature or the complexity of community interpreters' professional practices.

Taking, for example, the domain of interpreting in cross-cultural psychotherapy, admittedly a very specific context, yet one which shares many features with other community interpreting settings, the interpreter's "anonymity" may even be counterproductive, as Mirdal of the Institute of Clinical Psychology at the University of Copenhagen explains:

> In a therapeutic situation the interpreter cannot and must not remain invisible. It is important to be aware of the role the interpreter plays, not only in the overt communication but also in the non-verbal interactions that take place between the three parties. […] The interpreter is herself in

> a process of integration between two cultures, and her position in this process is not irrelevant for how she is going to perceive and present the patient's problem to the therapist and the therapist's views to the patient. (1988: 327-328)

Whilst warning against the dangers of the interpreter showing overindulgence and excessive empathy towards the patient, the author argues that the patient's natural tendency to establish a more personal relationship with the interpreter, whom he sees as a closer and less threatening figure than the therapist, is, if kept within limits, a desirable process, given that "most patients are not particularly motivated to start therapy" (1988: 329) and what keeps them in treatment is this personal relationship with the interpreter.

Moving now towards the other end of the spectrum, a clear illustration of the interpreter's cultural brokering and advocacy functions, as cited in Giovannini (1992) and reported in Roberts (1997: 26), is the *Cultural Interpreter Training Manual* issued by the Ontario Ministry of Citizenship. Listed among the interpreter's roles and responsibilities are the following: to explain cultural differences and misunderstandings; to advise the client about rights and options; to ensure that the client has all relevant information and controls the interaction; to explain what may lie behind the client's responses and decisions; to challenge racially/culturally prejudiced statements or conclusions; to identify and resolve conflicts. When the interpreter is called upon to concentrate on the last of the above points, advocacy gives way to conciliation, a function which, according to Diane Schneider of the Community Relations Service of the U.S. Department of Justice, "is performed more frequently than one might imagine, without being defined as such" (1992: 57).

Leaving aside, for the moment, the latter approaches which allow no ambiguity as to the nature and scope of the practitioner's role, but are considered by many to fall outside the range of interpreting proper, and looking at the more canonical landscape of normative literature, one cannot fail to recognise the relevance to today's situation of the comment made in the late 1970s by Anderson that "the interpreter's role is always partially undefined – that is, the role prescriptions are objectively inadequate" (1976: 216).

Among the many instances which could be offered in support of the above statement, the following example was chosen because of its relevance to the context of this research project. Both the Victorian Central Health Interpreting Service (CHIS) and the Victorian Interpreting and Translating Services (VITS)[4]

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4 Both CHIS and VITS are state services catering for interpreting and translating needs in a variety of fields. CHIS was set up in 1980 and provides medical interpreting through a team of full-time and sessional staff supplementing the interpreters employed by hospitals and other health care agencies. VITS was created in 1991 as a result of the amalgamation of four different services, namely

require that their interpreters should be NAATI[5] accredited and should practise in accordance with the professional Code of Ethics, as set out by the Australian Institute for Interpreters and Translators (AUSIT)[6] in consultation with NAATI. Quoting from the *CHIS Interpreters' Competency Profile*, a booklet which was produced to "help clarify the role of an interpreter within the CHIS context" (CHIS: iii), practitioners are expected to be able

> to maintain a clear focus on the interpreter's role while evaluating each situation and issue and making appropriate decisions by taking into account the singularity of each situation. (CHIS: 4)

Is not the "riddle" analogy a fitting one for this masterly sample of cryptic language? The puzzled reader is momentarily relieved of this mind-bending exercise by the reference to the *AUSIT Code of Ethics* providentially appended to the leaflet. There the following golden rules are to be found:

> Interpreters and translators shall not exercise power or influence over their clients. (CHIS: 2)
>
> A professional detachment is required for interpreting and translation assignments in all situations. (CHIS: 5)
>
> Interpreters shall convey the whole message, including derogatory or vulgar remarks, as well as non-verbal clues. […] Interpreters shall not alter, make additions to, or omit anything from their assigned work. Interpreters shall encourage speakers to address each other directly. (CHIS: 6)

While acknowledging the difficulty of envisaging general guidelines for a whole range of interpreting situations, the reader is again left pondering over the practical meaning of expressions such as "power", "influence" and "detachment". And, if the reader is an experienced community interpreter, s/he might point out that the dynamics of a three-party encounter often involve frequent shifts in addresser-addressee patterns, and might object that certain

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the General Interpreting Service (GIS), the Mental Health Interpreting Service (MHIS), the Education Interpreting Service (EIS) and the Legal Interpreting Service (LIS) (Ozolins 1998).

5 The National Accreditation Authority for Translators and Interpreters (NAATI) was established in 1977 and entrusted with the tasks of setting professional standards, developing and implementing accreditation procedures and approving interpreting and translation courses (Ozolins 1998).

6 The Australian Institute of Translators and Interpreters (AUSIT) was founded in 1987 as the national professional organisation of I/T practitioners (Ozolins 1998).

omissions and additions are necessary for a "favourable outcome" of the encounter, which will be defined in terms of "re-conciliation".

Although the term "conciliation" has been borrowed from Diane Schneider (1992), an alternative reading will be suggested here. The role of "conciliator" usually implies the notion that the interpreter is there to defuse tensions between institutions of the host-country and members of ethnic communities. The task of conciliation is generally placed outside the interpreter's sphere of competence, yet descriptions such as the following are not uncommon:

> […] it is interpreters and (sometimes) translators who are the everyday buffers and negotiators of cultural and linguistic difference within Australia (Taylor 1995: 9),

where the use of figurative language hints at a conflictual situation requiring interpreters to lessen the shock of two cultures clashing with each other. The alternative definition, which is less evocative of warlike scenarios, is derived from the Latin root *concilium*, meaning "assembly", "gathering", "meeting". Thus the "conciliator" could be described as the one who brings people together, or more precisely, the one who enables people to talk to each other by providing a common communicative environment. From this perspective, "re-conciliation" can be read as the "coming back" to the kind of unifying "language" David Malouf (1990) might be referring to in the quotation placed at the beginning of this paper.

3. Sitting on a "power" keg?

Given the indefiniteness of the community interpreter's role(s) in the existing literature, a possible solution to the above-mentioned "riddle" was sought in the observation of the interpreters' daily practices. The approach adopted in this research project is, thus, a descriptive one. The need for a similar perspective was felt by Cecilia Wadensjö in her recent work *Interpreting as Interaction*, where she explains:

> My point of departure was that the literature on interpreting was dominatingly normative in character and that ideas of how interpreters 'should' perform partly blocked the sight in investigations of actual cases of interpreting. (1998: 83)

In line with Wadensjö's view, the present study refrains from suggesting an *a priori* set of rules dictating what the interpreter "should" and "should not" do, and confines itself to the investigation of the interpreters' responses to the power asymmetry and the strategies they use to manage it.

The concept of "power" is a complex and multi-faceted one, which may pertain to a wide range of domains and conjure up ideas of political authority, physical force or psychological control, to mention just a few examples. However, for the purposes of this paper its contours need to be re-drawn. Fowler's words may serve as a suitable starting point:

> 'Power' is not a very satisfactory technical term, but its everyday usage will be adequate to get us going. Let us say that power is the **ability of people** and institutions **to control the behaviour** and material lives **of others**. […] It is also a very general concept: an abstraction picking out one feature in an indefinitely large number of very diverse kinds of relationship. When we talk about power we may be referring to relationships between parents and children, employers and employees, doctors and patients, a government and its subjects, and so on. […] **These power relationships are not natural and objective; they are artificial, socially constructed intersubjective realities**. (1985: 61; bold added)

First of all, power is defined as an "ability", a skill which can be acquired and practised, and which, if strategically applied, may determine and influence other people's behaviour. Secondly, power becomes manifest only in the context of social interaction, and in this arena power configurations are in a process of constant change and redefinition, according to the identities, roles and "moves" of the main actors. Though power relationships are not "objective" realities, the recurrence of similar patterns may account for their becoming a "natural", in the sense of "familiar" or "common", feature of certain contexts. In other words, a given configuration may be considered representative of a given institutional setting; the "discourse" which, over time, becomes associated to it contains crystallised reflections of the power configuration typical of that setting. Taking the instance of doctor-patient interviews, Fairclough (1989: 2) observes:

> […] the conventions for a traditional type of consultation between doctors and patients embody 'common-sense' assumptions which treat authority and hierarchy as natural – the doctor knows about medicine and the patient doesn't; the doctor is in a position to determine how a health problem should be dealt with and the patient isn't; it is right (and 'natural') that the doctor should make the decisions and control the course of the consultation and of the treatment, and that the patient should comply and cooperate; and so on. A crucial point is that it is possible […] to find assumptions of this sort embedded in the forms of language that are used.

The quotation clearly reveals the crucial role that language – seen in its socio-institutional dimension as "discourse" – plays in the maintenance and perpetuation of widely accepted power relationships. The connection between language and power rests on solid scholarly foundations. As underlined in the

introduction to the proceedings of the first international conference on language and power (1980), "power has been conceptualised in a number of useful ways […]; but, regardless of its definition, the resources available to exert or resist influence are recurrent, similar and – in societies at peace – chiefly *verbal*" (Kramarae, Schulz & O'Barr 1984: 11). If language is the key element of most power relationships, what happens in "unequal encounters where the non-powerful people have cultural and linguistic backgrounds different from those of the powerful people?" (Fairclough 1989: 47). And once the frame is extended to include the interpreter as a third participant, in what ways will the dynamics of power relationships be affected? Will the social gap be maintained or substantially altered? Will it be reinforced or reduced? It is in this sense that the focus of the analysis concerns what has been called the "management of power", in other words the interpreter's "power to control the power" wielded by his/her two clients.

As will be explained in the following, the parameters used to analyse the interpreter's behaviour have been borrowed from functional linguistics and discourse analysis. In particular, Martin was drawn upon in his discussion of "tenor", which is defined as "the negotiation of social relationships among participants" (1992: 523). Martin's use of the labels "status" and "contact" was also preferable to either Hasan's (1977) or Poynton's (1990) terminology. Both Hasan's "social role" and Poynton's "power" (Martin's status) would have given rise to confusion between the general concepts expressed so far and their actual "realisations".

4. Data Collection[7]

Data were collected in Melbourne over a period of five months, from the beginning of March to the end of July 2001. A total of 32 interpreting assignments were observed at the following venues: public hospitals (19 assignments), rehabilitation clinics (4), the patients' houses (3), mental health centres (2), community health centres (2) and nursing homes (2). Assignments covered a wide range of medical fields: mental health (8 assignments), diabetes (5), speech pathology (4), pre-admission and admission procedures (4), oncology (3), occupational therapy (2), physiotherapy (2), gastroenterology (2), internal medicine (1) and dentistry (1).

Twelve NAATI accredited interpreters were involved in the project. They were all female, with ages ranging from 27 to 60 years. They worked either on an *ad-hoc* or permanent basis. While the sessional interpreters were provided by

7 We would like to thank Adolfo Gentile, Chairman of NAATI, whose generous help was essential to the research project.

interpreting agencies (CHIS and VITS) and sent to health care centres for individual assignments, the in-house interpreters - recruited either by hospitals themselves or by CHIS - worked for a single institution on a full-time basis. Since Italian is still a required language in the medical sector, most hospitals have an in-house Italian interpreter, but are sometimes compelled to book external interpreters through the agencies, given the volume of assignments.

Anonymity requirements have led to the renaming of practitioners. For the purpose of straightforward identification with their profession, interpreters have been given fictional Italian names, all beginning with the letter "I"[8]: 6 sessional interpreters (Irene, 4 assignments; Irma, 2; Ilaria, 2; Ilenia, 1; Isabella, 1; Itala, 1) and 6 in-house interpreters (Ines, 5 assignments; Iolanda, 5; Ilde, 4; Ippolita, 3; Iva, 3; Ida, 1).

As for the methodology, data were collected through observation of interpreted sessions. Additional information was gained in post-assignment interviews with interpreters. Whilst authorisation for the recording of the latter posed no problems, health care professionals were adamant that their encounters with patients should not be recorded. They justified their flat refusal by a reference to unspecified "hospital rules on confidentiality". In certain cases, even observation was denied, for instance during some assignments in the mental health field, where, as the medical staff explained, "issues of a sensitive nature would be discussed" and "the slightest disturbance might undermine the outcome of the session". Wadensjö herself, though she succeeded in securing permission from the Swedish institutions, nevertheless raises the issue of privacy:

> One needs access to institutional settings where such encounters normally take place. Lay people, institutional professionals and interpreters, i.e. the prospective research subjects, must give their acceptance before one intrudes into their private and/or working life. (1998: 82)

Sticking to the research method based on recordings and full transcripts would have required a shift away from authentic to simulated interaction. In this case, for the reasons illustrated above, and given that, as Wadensjö again points out, "the forms in which discourse data is collected […] also have implications for the kind of analyses that can be performed" (1998: 82), a radical change in the nature of the original project would have been unavoidable.

Therefore, the only alternative to recordings was the systematisation of the observation process through the use of a ready-made "observation sheet", which would present the researcher with a set of pre-selected parameters, thus helping her note down the largest number of relevant data. Whilst the inevitable

8 The idea was borrowed from Wadensjö (1998).

shortcomings of having to collect information on the spot, without the possibility of subsequent revision, were not totally overcome, they were somewhat mitigated. What remains, however, alongside a necessarily selective analysis, is the subjective perception of relevance.

5. The Observation Sheet

The blank observation sheet, in a graphically condensed form, appears as follows:

OBSERVATION SHEET			
INTERPRETER:	AGE:	SEX:	
Assignment no.:	Place:	Date:	Time:
Participants: – English-speaking client: – Italian-speaking client: – Other participants: Situation: Briefing: – with the English-speaking client: – with the Italian-speaking client:			
GENERAL OBSERVATIONS			

OBSERVATIONS ON THE VERBAL INTERACTION				
	English-speaking client	Interpreter		Italian-speaking client
Phonology		EN>IT	IT>EN	
– Tone of voice	☐unmarked ☐marked	☐unmarked ☐marked	☐unmarked ☐marked	☐unmarked ☐marked
– Accent	☐standard ☐non-standard	☐standard ☐non-stan.	☐standard ☐non-stan.	☐standard ☐non-standard
– Loudness	☐low ☐medium ☐high	☐low ☐medium ☐high	☐low ☐medium ☐high	☐low ☐medium ☐high
– Speech rate	☐low ☐medium ☐high	☐low ☐medium ☐high	☐low ☐medium ☐high	☐low ☐medium ☐high

Syntax			
Lexis			
Divergent Renditions – Additions: 1. phatic 2. emphatic 3. explanatory 4. others – Omissions – Substitutions			
Footing			
OBSERVATIONS ON THE NON-VERBAL INTERACTION			
English-speaking client		Interpreter	Italian-speaking client
Conclusions			
– Register: – Footing: – Status: – Contact: – Degree of power management:			

Introductory information concerning the interpreter (identification name, age and sex), details about the assignment (place, date and time), the participants in the interaction, the situation and the pre-session briefing were filled in, alongside the general observations and the conclusions, either before or after the actual encounter. As far as the participants are concerned, in the context of this study the English speaker is always a member of the institutions providing the services, while the Italian speaker is the client who accesses the services, i.e. the patient. Following Bell's (1997: 246) classification of audience members in terms of "addressees", "auditors", "overhearers" and "eavesdroppers", the researcher fell into the category of "overhearer", being known to the ratified participants but not one of them, whilst people accompanying the patient fluctuated between "auditors" (known and ratified, but not addressed participants) and "addressees". The situation contains information about the goal of the interview and the relevant stage within the overall clinical process, i.e. consultation or treatment session, while the **general observations** contain the detailed description of the encounter in terms of topics discussed, actions performed and other noteworthy events.

Unlike the above information, specific examples of the **verbal interaction** had to be taken down in the course of the interview. Given the undeferrable nature of a large part of the note-taking process, some of the points contained in the observation sheet refer to the prevailing features of the interaction taken as a whole. This applies in particular to phonological indicators, since a micro-segmental analysis was clearly unfeasible. The relevance of phonological aspects to the study of medical consultations is underlined by Cicourel who argues that "doctor-patient discourse may reveal status and power differences as reflected in the way intonation and stress are employed" (1985: 195). Reference was made to two of the three dimensions of tenor[9] identified by Martin, namely "status" – "the relative position of interlocutors in a culture's social hierarchy"– and "contact" – "their degree of institutional involvement with each other" (1992: 525). Using his terminology, the authors of this project established the following correspondences:

	TONE OF VOICE	ACCENT	LOUDNESS	SPEECH RATE
STATUS – dominant		standard	high	
– deferential		non-standard	low	
CONTACT – involved	marked			low
– distant	unmarked			high

At the lexical level, the following indicators of contact were selected:

	LEXIS	
STATUS – dominant	technical	formal
– deferential	non-technical	colloquial
CONTACT – involved	non-technical	colloquial
– distant	technical	formal

The heading "Divergent Renditions" refers to the more evident differences between the interpreter's translation and the preceding original. The observation sheet contains three main categories: additions, omissions and substitutions. The first category is subdivided into four groups: phatic, emphatic, explanatory and

9 The third dimension, "affect", defined as the degree of emotional charge in the relationship between participants (Martin 1992: 525), was thought to be of less significance for the purpose of this study and was therefore not included.

others. The latter type of additions is somewhat different from the preceding ones, since it does not include expansions of the original utterances, but rather instances of the interpreter's autonomous intervention as "principal", to use Goffman's (1981) terminology. Omissions, which correspond to Wadensjö's categories of "reduced" and "zero" renditions (1998: 107-108), refer here to deliberate strategies instead of translation errors (for the distinction between "omission" and "loss" see Falbo 1999: 75). Finally, substitutions designate shifts at the semantic level.

The concept of footing and its transposition into workable observation parameters posed the most difficult challenge. Footing, as defined by Goffman (1981: 128), is "the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance". The author's well-known distinction between "participation framework" (with the notions of hearers as "addressed" and "unaddressed" recipients) and "production format" (encompassing the speaker's roles as "principal", "author" and "animator") has been combined, in this study, with Wadensjö's (1998: 91) "reception format" (embracing three modes of listening: "responder", "recapitulator" and "reporter"). More precisely, the model suggested here is constructed on the interconnection between the speaker's alignment to the interpreter (in other words, whether or not he/she addresses the interpreter) and the response of the interpreter as subsequent speaker (for instance, his/her use of direct or indirect speech).

The following table is offered as an illustration. For the sake of simplicity, only the English-speaking client, i.e. the health-care professional, is cast in the role of original speaker, whose utterances are processed by the interpreter first in his/her capacity as either addressed or unaddressed listener, and then in his/her function as autonomous producer (i.e. principal) or re-producer (i.e. recapitulator (a) and (b), reporter, narrator, pseudo-co-principal). The labels "narrator" and "pseudo-co-principal" have been created to classify instances which were seen to fall outside the more traditional categories. The former refers to instances in which the interpreter uses indirect speech to translate an utterance that the original speaker has addressed directly to the other client; the latter groups examples of the interpreter's use of the first person plural to include him-/herself in the utterance of the original speaker.

SPEAKER	INTERPRETER		
	LISTENER		SPEAKER
	ADDRESSED	UNADDRESSED	
When did Mr. Rossi start feeling ill?	✘		PRINCIPAL It's been more or less a week.
Could you ask Mr. Rossi when he started feeling ill?	✘		RECAPITULATOR (a) Sig. Rossi, quando ha iniziato a sentirsi male?
			RECAPITULATOR (b) Il dottore chiede quando ha iniziato a sentirsi male.
		✘	REPORTER Sig. Rossi, quando ha iniziato a sentirsi male?
Mr. Rossi, when did you start feeling ill?		✘	NARRATOR Il dottore chiede quando ha iniziato a sentirsi male.
		✘	PSEUDO-CO-PRINCIPAL Sig. Rossi, ci può dire quando ha iniziato a sentirsi male?

Observations on the non-verbal interaction refer to features such as gestures, spatial relationships between participants and eye contact. At the end of each session, on the basis of collected data, the researcher provided an overall assessment – concerning register, footing, status, contact and degree of power management – which she noted down in the section **Conclusions**.

So as to facilitate the final analysis, a second intermediate assessment, relating to the performance pattern of each interpreter as displayed through the whole range of her sessions, was carried out by the researcher on the basis of a grid.

6. Discussion of results

The following discussion will illustrate the prevailing trends emerging from the 32 assignments by focusing on those parameters which turned out to be the most significant.

6.1. Briefing

Given the hectic nature of hospital activities, briefings are not routine occurrences, as was confirmed by the interpreters themselves during the post-assignment interviews. When no briefing takes place, in-house interpreters have an obvious advantage over their sessional colleagues, since they are part of the hospital staff and, as such, already know both patients and doctors. During the observation period, three types of situation were thus identified: those in which the briefing was carried out; those in which it was not; and situations in which a briefing would have been superfluous due to previous contacts.

Considering the briefing with the health care practitioner first, out of the total 32 assignments, 14 briefing sessions were recorded, with 3 instances of the remaining 18 assignments for which no briefing was necessary. The number of briefing sessions between the interpreter and the Italian-speaking patient was considerably lower, 2 out of 32, with only 8 cases of the remaining 30 where the interpreter was already familiar with the context.

The markedly higher frequency of pre-session encounters between interpreters and health care professionals seems to suggest the willingness of the latter to devote time to a conversation which is clearly seen as a useful contribution to the successful outcome of the consultation process. It also signals, however, the interpreter's reluctance to get too close to the patient before the actual session starts. In fact, although the briefing is a welcome occasion for the interpreters to gain an idea of the patients' pronunciation features and accents, most of them said that a prolonged conversation might be counterproductive, since the patients tend to explain their medical conditions and expect them to subsequently fill in this information during the interview and speak literally "on their behalf".

6.2. Phonology

Bearing in mind the methodology used in this study, results will take the form of general comments on the most recurrent phonological patterns. Accent and loudness turned out to be the least relevant indicators. With reference to the latter, only a few instances were recorded where patients with psychological disorders tended to raise their voice. These shifts in loudness were not reproduced by the interpreter.

On the other hand, tone of voice and speech rate were more productive markers. Interpreters, on the whole, tended to speak with a marked tone of voice when they addressed the Italian-speaking client, thus showing an involved attitude, even when the doctor kept an uninvolved stance, which was quite often the case. However, when translating for the English-speaking professional, a

less marked intonation was the most common feature. As for the second parameter, it was interesting to note that a slower pace characterised the interpreters' translations for the Italian-speaking patients, whilst a generally faster one marked the renditions into English. In other words, the interpreter seemed to work on the premise that the patient needs maximum clarity, and consequently opted for a slow speech rate regardless of the pace chosen by the professional. Conversely, the slow-paced utterances of the patients were invariably "accelerated", on the assumption that a speedy delivery was a more effective way to pass on information to the medical staff.

To sum up, observation of phonological features indicated that, on the whole, the modifications brought about by the interpreter increased the degree of *contact* between the interlocutors and raised the patient's *status*.

6.3. Lexis

Before discussing the interpreters' renditions, an overview of the language varieties spoken by the interlocutors is of the essence. As already mentioned, patients were mostly poorly-educated, elderly immigrants, whose language was a mixture of dialect, colloquial expressions and archaic terms, far removed from standard Italian and heavily influenced by English. The existence of a particular variety of Italian in Australia, which is commonly referred to as "Australitalian", has been documented by many authors, among them Andreoni (1978), Bettoni (1984) and Leoni (1988; 1991). Their studies have shown that, alongside the straightforward inclusion of English terms, Australitalian is characterised by the addition of Italian morphemes to the roots of English words. Of the many instances noted in the course of this research, only a few examples will be provided from either category:

– "quando mi capita di mangiare qualcosa di *wrong*", "gli è venuto uno *stroke*", "ho *trouble*", "non mangio *junk food*";
– "ho cinque *kidsi*", "*bucco* un'altra volta l'interprete", "mangio *vegetabili*", "mia moglie ha avuto un'infezione ai *langhi*"

With reference to the language used by health-care practitioners, it was generally observed that it displayed a much higher degree of formality, although technical jargon did not feature prominently.

Given this divergence, lexical adjustments were the rule rather than the exception in the interpreters' renditions, and were principally meant to help the Italian-speaking patients overcome the difficulties of potentially "obscure" terms. The most frequent occurrences were paraphrases of English expressions which, though belonging to everyday language, were felt by the interpreter as too difficult to be understood. The following are some examples:

– Are there any problems when you have to *prick* the finger? > Ha problemi quando *fa il puntino di sangue*?
– I want to keep him on this *treatment*. > Dovrà continuare con *tutte queste medicine*.
– You have to do a *blood test*. > Deve fare *un test che tira il sangue dal braccio*.
– We'll have *to use a feeding tube*. > Dovranno *mettere un tubo dentro*.
– Her *nerve condition* cannot be *healed*. > *Quella dei nervi è una cosa* che non si può *salvare*.

Less frequent were the instances in which terms pertaining to the medical domain were replaced with commonly used words and phrases, as in the following examples:

– Do you ever suffer from *oesophagitis… reflux*? > Le capita di soffrire di un po' di *acido*?
– How does it go with the *nose oxygen prompter*? > Come va con il *naso* e con quest'*affarino*?

Most interestingly, in some cases the interpreters, realising that even the common Italian term was incomprehensible to the patient, decided to accommodate the lexical choices of the latter, by adopting the Australitalian variant, as in the following examples:

– Deve *spingere* ...deve *pusciare* le mani tra loro.
– Puoi usare il macchinario … la *mascina* per muoverti.

In the translations for the health care professionals, on the other hand, lexical substitutions were used mainly to raise the register and improve on the style:

– Devo mangiare *cibo sciacquabudella*. > I have to eat very, very *plain food*.
– *Tegnu* solo colesterolo > *I have only got* cholesterol.
– *Mi viene*…. come si dice …. il vomito. > I *suffer from a desire* to vomit.

The above-mentioned adjustments are some of the most frequent strategies employed by interpreters to reduce the divide between a "language consistently delivered in a low register (or a dialect) and one in a high register where explanations are rarely given clearly" (Burley 1990: 149-50).

6.4. Divergent renditions

Additions were by far the most numerous instances of divergence from the original utterances, and featured almost exclusively in the translations into Italian. Phatic additions – such as "…., OK?", "…., ha capito?", "…, va bene?" – were occasionally used by the interpreter to check whether or not the patient had understood the doctor's statement or instruction. A higher frequency was recorded for emphatic additions. These entailed the repetition of phrases or even whole sentences, as the following examples show:

– What does the fruit of this tree look like? > E com'è questo frutto che fa l'albero? *Mi spieghi il frutto. Mi spieghi che tipo di frutto è, troveremo la parola*. *A cosa assomiglia*?
– Any questions? > Domande? *Volete chiedere qualcosa all'infermiera*?
– OK. It has been organised. OK. > Hanno organizzato già. *È tutto apposto*. *Hanno già organizzato*.

The most recurrent type of addition, however, was the explanatory one. Unlike lexical substitutions, this procedure consisted in translating a given English word and providing, immediately afterwards, an explanation of its meaning. Here are a few examples:

– Do you have any paranoid thoughts? > Ha dei pensieri paranoidi, *sospettosi*?
– We're going to do a gastroscopy with biopsy. > Faranno una gastroscopia con biopsia, *prendono un pezzettino di tessuto*.
– Then we will take an x-ray of your throat. > Le fanno i raggi, prende una foto, un raggio da questa parte della faccia per vedere la gola.

As for "other additions", i.e. autonomous interventions by the interpreter, they fulfilled one of the following functions:[10] asking for clarification when the interpreter had not fully understood the concept; pointing out that the client had not understood the message although the rendition was correct; alerting the client to a possible missed inference. It is worthy of note that a few instances were also recorded in which the interpreter spoke in the professional's stead, by supplying the required information to the patient.

The few occurrences classified as omissions were mostly aimed at simplifying the doctor's utterance by leaving out technical elements, which could be inferred from the context; for instance, the statement "You had a gastroscopy, this test." was translated simply as "Le hanno fatto questo test."

Instances of substitution were even rarer. On the whole, the interpreters did not depart in any noteworthy way from the content of the original messages. When modifications were made, their purpose was to soften remarks by the medical staff which might have alarmed the patient, as in the following case:

– These tablets will help you stop feeling paranoid > Queste pastiglie *l'aiuteranno a stare tranquilla*.

6.5. Footing

Observation of the interpreters' footing produced interesting findings. The mode of "principal", whereby the interpreter was directly addressed by either the doctor or the patient and gave a straight answer without translating for the other

10 These functions correspond to three of the four categories identified by Zimman (1993: 219).

client, was relatively rare. It was recorded in 6 sessions with reference to the translation into Italian and only 2 into English. At the other extreme, the alignment as "reporter", which is how many like to think of the interpreter's function, was also infrequent in both directions, present, as it was, in 7 English-Italian and 2 Italian-English sessions.

The footing of "recapitulator (a)", whilst almost the rule for renditions into English – it featured as the predominant alignment in 27 sessions – was hardly evident in the renditions for the Italian patients (1 session only). In translating for the latter, interpreters tended to adopt the footing of "narrator", that is they used indirect speech although the doctors had addressed their patients directly. This was the prevalent footing in 22 sessions, as against a presence in only 3 sessions when the translation was from Italian into English.

It is worth mentioning that in one session the interpreter tended to associate herself to comments made by the medical staff, by using the first person plural to translate a direct address – utterances such as "I am going to ask you some yes or no questions." were interpreted along the lines of: "Adesso le facciamo delle domande e lei deve rispondere col sì o col no." – thus adopting the alignment described above as "pseudo-co-principal".

6.6. Non-verbal features

While spatial distribution of the participants was mainly dictated by the features of the physical environment and did not yield indicative results, eye contact turned out to be a relevant aspect. The patients' preferred visual orientation was towards the interpreter, whom they clearly saw as a less threatening figure than the representatives of the medical profession.

7. Conclusions

The analysis of the *corpus* has shown that the degree of the interpreter's "power management", entailing an alteration of the interpersonal metafunction in terms of *contact* and *status*, ranged from medium (15 out of 32 sessions) to high (11 sessions), with only 6 sessions where such management was kept at a minimum level.

This resulted from the tendency displayed by the interpreters, in their rendition for the Italian-speaking patient, to use a more emotionally marked intonation than the doctor's, a lower speech rate and a less formal register, and to make additions of an explanatory nature to the original statements. Conversely, translations for the English-speaking professional were characterised by emotional distancing, as signalled by a less marked intonation,

a higher speech rate, a raising of the level of formality and a reduced presence of additions and omissions.

By combining these patterns with the prevailing footings, it is possible to make an educated guess about the interlocutors' mutual perceptions, as projected by the interpreter. On the one hand, taking on the role of "narrator", the latter signals to the patient a separation between her identity and the doctor's, thereby achieving a double goal: maintaining the professional's authority, and at the same time, showing the interpreter's more sympathetic, caring and "involved" attitude. On the other hand, in her role as "recapitulator (a)", the interpreter merges her identity with that of the patient through the use of direct speech, so that the alterations she makes to the original utterances result in the raising of the patient's *status* as perceived by the health care practitioner.

A comparison between these findings and the opinions expressed by the interpreters in post-session interviews sheds light on their awareness – or lack of it – of such a role. There were two prevailing stances among interviewees. Some interpreters said that the main goal of their activity was to facilitate communication by whatever means, and accepted that this might entail deviations from the theory of invisibility and impartiality. One of the most recurrent comments to this effect was the following: "If, at the end of an assignment, I perceive that my two clients did not really understand each other, then I take this to mean that I did not do my job, although I might have stuck to the rules". The opposite view was expressed by those interpreters who consider themselves "linguistic mediators" and firmly reject the role of "social workers". In practice, however, the behaviour displayed by the latter did not diverge substantially from that observed in their differently minded colleagues. One example should suffice. During the interview, the interpreter referred to as Ilaria unhesitantly stated that renditions must be as close as possible to the preceding original, that paraphrase, additions and, even more importantly, autonomous interventions should be avoided or kept to a minimum. Yet, during her assignment she was frequently observed responding on her own initiative, thus switching from translator to principal. Once again Wadensjö's words are illuminating:

> The general case exists like an idea, while actual cases take place in reality, and each demands unique efforts from their participants, including the interpreter. (1998: 4)

The interpreters' unique efforts at "re-conciliation", as they were observed in this study, cast a new light on the notion of power, whereby all negative connotations are lost and what is left is the ability to create a "common communicative environment". Awareness and acceptance of the interpreter's "powerful role" might be promoted by making it more transparent to clients.

Paraphrasing Veronica Taylor's "Still invisible, still transparent?" (1995: 9), a possible cue might be: "No longer invisible, yet more transparent."

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