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**(CO)-CONSTRUCTING THE ROLE OF HEALTHCARE
INTERPRETERS IN TURKEY:
INTERACTIONAL DYNAMICS IN TRIADIC
ENCOUNTERS**

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THESIS APPROVAL PAGE



DECLARATION

I hereby declare that this doctoral thesis titled as “(Co)-Constructing the Role of Healthcare Interpreters in Turkey: Interactional Dynamics in Triadic Encounters” has been written by myself in accordance with the academic rules and ethical conduct. I also declare that all materials benefited in this thesis consist of the mentioned resources in the reference list. I verify all these with my honour.

02/11/2021

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ABSTRACT
Doctoral Thesis
Doctor of Philosophy (PhD)
(Co)-Constructing the Role of Healthcare Interpreters in Turkey:
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It is undisputable that there is a growing need for interpreters due to the increasing global mobility between countries. In this respect, Turkey is no different, as an important destination for vacation and, increasingly, for healthcare services as well. Against this background, this study seeks to analyze the ways in which the role of interpreters both shapes and is shaped by triadic interactions in healthcare settings in Turkey. More specifically, recognizing the phenomenon of healthcare interpreting as “social action or social inter-action” (Wadensjö, 1995), the research questions raised in this study seek answers to how the role of the interpreter is (co)-constructed with the other parties-at-talk. To this end, the focus is not only on naturally- occurring data, but also on the user expectations and perceptions, as well as on the interpreters’ self-perceptions of role. To this end, the study employs various ethnographic data collection methods such as questionnaires for medical doctors and hospital executives, interviews with healthcare interpreters, participant observation, and audio-recordings of interpreter- mediated encounters. The data collected from the users and the interpreters was triangulated with the observation and the audio-recordings of real- life situations. This data was analyzed in accordance with Chesterman’s (1997) *expectancy norms* and *professional/process norms* as well as Goffman’s (1981) *participation framework*, shedding light on the relatively unexplored field of healthcare interpreting in Turkey. This study revealed discrepancies in the role

perceptions of users and interpreters; nevertheless, the interpreters conform to users' *expectancy norms*. Moreover, the interpreters emerge as active and competent participants in the triadic encounters, and thus, this study has the potential to inspire for further research in this neglected area.

Keywords: Healthcare interpreting, role, norm, participation framework, ethnography, user perception, expectations, self-perception



ÖZET
Doktora Tezi
Türkiye’de Hastane Çevirmenlerinin Rolünün (Ortak) İnşası:
Üçlü Görüşmelerde Etkileşimsel Dinamikler
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Çeviribilim Programı

Birçok sebepten dolayı ülkeler arası küresel hareketliliğin artmasıyla birlikte çevirmenlere olan ihtiyacın arttığı yadsınamaz bir gerçektir. Türkiye de bu konuda istisna değildir ve hem tatil açısından hem de sağlık hizmetleri açısından önemli bir destinasyondur. Bu bağlamda, bu çalışmanın amacı Türkiye’deki hastane ortamlarında çevirmenin rolünün üçlü görüşmeleri nasıl şekillendirdiğini ve bu üçlü görüşmelerde nasıl şekillendiğini incelemektir. Hastane çevirmenliği eylemini “sosyal eylem veya sosyal etkileşim” (Wadensjö, 1995) olarak kabul ederek, bu çalışmadaki araştırma soruları çevirmenin rolünün diğer katılımcılarla birlikte nasıl (ortak) inşa edildiğine yanıt aramaktadır. Bu amaçla, yalnızca gerçek etkileşim ortamlarından elde edilen veriler üzerinde değil; aynı zamanda kullanıcıların rol algıları ve beklentileri ile çevirmenlerin kendi rol algıları üzerinde durulmaktadır. Bu noktada doktorlar ve yöneticilere uygulanan anketler, hastane çevirmenleriyle yürütülen mülakatlar ile çevirmen aracılığıyla yürütülen görüşmelerin gözlemlenmesi ve bu görüşmelerin ses kayıtlarının alınması gibi pek çok etnografik veri toplama yönteminden faydalanılmıştır. Kullanıcı ve çevirmenlerden elde edilen, gerçek çeviri ortamlarının ses kayıtları ve gözlemleri ile üçlenen bu veriler, Türkiye’de sınırlı sayıda çalışma yapılmış bir alan olan sağlık çevirmenliğini araştırmak amacıyla, Chesterman’ın (1997) *beklenti (expectancy)* ve *profesyonel/süreç (professional/ process norm)* normları ile Goffman’ın (1981) *katılım çerçevesi (participation framework)* kavramlarıyla incelenmektedir.

Bu çalışma, kullanıcılar ve çevirmenlerin rol algılarında farklılıklar olduğunu, yine de çevirmenlerin kullanıcılar tarafından belirlenen beklenti normlarını karşıladıklarını ortaya koymuştur. Ayrıca, çevirmenlerin etkin ve yetkili katılımcılar olduğu da sonuçlar arasında yer almaktadır. Bu anlamda bu çalışma, hastane çevirmeninin karmaşık rolü üzerine yeni çalışmalara ilham verebilir.

Anahtar Kelimeler: Hastane çevirmenliği, rol, norm, participation framework, etnografi, kullanıcı algısı, beklentiler, öz algı.



**(CO)-CONSTRUCTING THE ROLE OF HEALTHCARE INTERPRETERS
IN TURKEY: INTERACTIONAL DYNAMICS IN TRIADIC ENCOUNTERS**

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ABBREVIATIONS

CAMHS	Child and Adolescents Mental Health Service
CP	Cognitive Processing
DI	Dialogic Discourse-Based Interaction
DI	Dialogue Interpreting
GP	General Practitioner
HCIS	New South Wales Health Care Interpreter Service
IT	Interpretive Theory
NCIHC	National Council on Interpreting in Health Care
PSIT	Public Service Interpreting and Translation
TRICC	Training Intercultural and Bilingual Competencies in Health and Social Care
TT	Target-Oriented Text Production

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INTRODUCTION

In the current era, more people are able to reside in countries other than their native ones, for work or education, embracing a new culture. On the other hand, some are forced by circumstances to leave their homelands and to take shelter in other countries. Whether the move is voluntary or not, the increased number of communities consisting of people with different ethnic origins and cultures has led to the increased needs for interpreters to enable and facilitate communication (Angelelli, 2004b: 98). This type of interpreting provided in public service institutions is commonly referred to as ‘community interpreting’ (Pöllabauer, 2013: 1). More generally, Wadensjö (1998: 49) defines the term ‘community interpreting’ as a type of “interpreting carried out in face-to-face encounters between officials and laypeople, meeting for a particular purpose at a public institution”. However, there are national variations on this concept, such as “public service interpreting” in the UK and “cultural interpreting” in Canada (Pöchhacker, 2004: 15). Despite these various differences in emphasis, all point essentially to a single concept of ‘community interpreting’, (Bancroft, 2015: 219). Schuster and Baixauli- Olmos (2018: 733) confirmed this, indicating that both the interchangeability of ‘public service interpreting’ and ‘community interpreting’.

The main distinction in Interpreting Studies, on the other hand, lies between Conference Interpreting and Community Interpreting (Hale, 2007: 31). Hale (2007: 32) categorizes the main differences between the two types as ‘Register’, ‘Language directionality’, ‘Proxemics’, ‘Mode’, ‘Consequences of inaccurate rendition’, ‘Level of accuracy required’, ‘Participants’, and ‘Number of interpreters’. In addition to the above-mentioned basic differences, a highly salient distinction is the psychological factor. Especially in Public Service Interpreting and Translation (PSIT), the emotional and psychological factors impact the interpreters; they are responsible for conducting language transfer between the parties while coping with contextual and situational stress imposed on them (Valero- Garcés, 2021: 18). In healthcare interpreting, for instance, it is sometimes the task of the interpreter to deliver bad news to the patients’ relatives and friends (Valero- Garcés, 2021: 18). Such factors increase the emotional burden on interpreters.

Thus, unsurprisingly, the “situational and socio-cultural context” came to the foreground in the 1980s (Pöchhacker, 2004: 76). Specifically, Cynthia B. Roy’s (1989) research on sign language interpreting and Cecilia Wadensjö’s (1992, 1998) research on community interpreting launched a new paradigm, called as “**dialogic discourse-based interaction**” or “**DI paradigm**” (Pöchhacker, 2004), leading to a new perspective in the field, where the interpreters were newly-conceived of as active participants with labels such as ‘cultural brokers’, ‘conciliators’, and ‘advocates’ (Diriker, 2001: 3; 2018: 23). Thus, a new scholarly trend directed focus to the interpreters as active participants in healthcare settings (Kaufert and Koolage, 1984; Wadensjö, 1998; Davidson, 2000; Angelelli, 2004a, 2004b; Bot, 2005; Leanza, 2007; Souza, 2016) and in legal settings (Berg-Seligson, 1990; Kadric, 2000; Hale, 1999, 2004, 2008), just to name a few.

Community interpreting is also practiced and researched in a variety of settings in Turkey. Research has focused on a wide range of community interpreting domains, such as sign language interpreting (Conker, 2017; Gökçe, 2018; Şen Bartan et al., 2021), legal interpreting (Doğan, 2004, 2010; Yücel, 2018), sports interpreting (Uyanık, 2015; Bulut, 2016, 2018; Dinar, 2017; Katar, 2019), healthcare interpreting (Güven, 2014; Öztürk, 2015; Turan, 2016; Şener, 2017; Duman, 2018; Toker, 2019; Katar, 2019; Özsöz, 2019)¹, and interpreting in disaster and emergency settings (Kahraman, 2003; Doğan and Kahraman, 2011; Kurultay and Bulut, 2012; Doğan, 2012, 2016). The number of Syrian refugees taking shelter in Turkey created greater communication and interpreter needs, and it is likely that this triggered academic research in the refugee context. There are invaluable contributions on the refugee issue (Kahraman, 2010; Doğan, 2017; Balkul, 2017, 2018; Ersoy, 2018; Şan and Koçlu, 2018; Koçlu, 2019; Polat Ulaş, 2021). This dramatic increase in the number of studies in the refugee context contributed to research in different community settings. This included increasing interest not only in healthcare interpreting, but also in other community settings, and will lead to the enrichment of both practice and training in the field in Turkey.

Since the “social turn” in interpreting studies (Pöchhacker, 2006; Balcı Tison, 2016), as indicated before, a number of scholars have investigated the interpreter’s role

¹ These contributions will be discussed more in detail in the Section 1.3.

from different angles. Along the same lines, with the questions addressed in this study, I will approach healthcare interpreting “as social action or social inter-action” (Wadensjö, 1995: 112). In interactionist approach, the language is conceived as *social activities*, which is also connected to multiple layers of context, and in this model, “meaning is conceptualized as co-constructed between *speaker* and *hearer(s)* in *interaction*” (Wadensjö, 1995: 114). In this scenario, the interpreter, participates in a “*social situation*” (Wadensjö, 1995: 112) where s/he is both “*relaying*” or “*translating*” and “*coordinating*” and “*mediating*” (Wadensjö, 1995: 112).

Within this framework, this research aims at exploring the interpreter’s role and interactional dynamics between the participants in triadic encounters, i.e., it traces the ways in which the role of interpreters shapes, and is shaped by the situational and institutional healthcare context. However, it is important to note Wadensjö’s (1999: 248) statement that the role of the interpreter is “dependent on the primary participants, on their mutual relations, on how they relate to the interpreter and on their communicative style”. Taking this as a departure point, this study set out to analyze how the role of the interpreter is co-constructed with the other parties-at-talk, and its implications on the interactions within a complex network of relations and interactional dynamics.

In addition to the above, the interpreter’s role is influenced by multiple factors, including expectations and perceptions of various parties. There is a lack of clarity, from the perspective of hospital executives, over which qualifications make healthcare interpreters eligible, or to what extent these executives are aware of the significance of the profession and the interpreter’s tasks in Turkey. Thus, other stakeholders’ expectations and perceptions of role are scrutinized in this study. With this aim in mind, this study attempts to answer the over-arching research question below:

1. How does the role of the interpreter shape, and how is it shaped by the triadic interaction?

This question will be supplemented by two more sub- questions:

2. How do gaze, forms of address and turns define, and how are they defined by the role of the interpreter in actual situations?
3. What are the points of convergence and divergence between users’ role expectations, interpreters’ role definitions, and actual interpreting practice?

Citing from Havighurst and Neugarten (1962), Aranda (2020: 23) defines the concept of role as “cluster of behaviours shared between a group of individuals fulfilling the same position in society and as a pattern of behaviour expected by other societal segments”. This role description clearly reinforces Wadensjö’s (1999:248) above-mentioned claim that role depends on its position in the constellation of the other parties involved.

Within the frame of those references, the issue of ‘role’ will be analyzed with data from three different sources: first, hospital executives and doctors regarding their role expectations on the interpreters, second, the interpreters regarding their own role expectations and perceptions, and finally, the audio-recordings and observations during interpreting process in triadic interactions. The findings from the participants will be compared with the data from real-life situations to seek answers to the abovementioned questions, to scrutinize how the interpreter’s role is reflected both within the institutional discourse, and the interpreter’s real-life performances. For this reason, the study aims to present an overall understanding and a detailed analysis of interpreter’s role in healthcare settings in Turkey.

This thesis is divided into 5 chapters, following the Introduction part. The first chapter is devoted to the literature review on healthcare interpreting, in Turkey and beyond, as well as conceptual foundations of the study. Relevant studies on international healthcare interpreting will be divided into two main sections, on the issue of role and on the user expectations and perceptions. Both sections reflect the approaches and the main topics of discussion of the study. These sections are followed by a detailed review of new initiatives and the studies conducted on healthcare interpreting in Turkey.

Chapter 2 presents the methodology adopted and theoretical framework. This study takes the form of a multiple case study based on ethnographic data collection methods. Importance is given to triangulation of data through questionnaires for medical doctors and hospital executives, interviews with healthcare interpreters, participant observation as well as audio-recordings of authentic interpreter- mediated doctor- patient consultations. The data collection methods were selected based on two theoretical frameworks, namely, Chesterman’s (1997) *expectancy* and *professional/ process norms* as well as Goffman’s (1981) *participation framework* and *footing*. The

users' and the interpreters' perceptions will be discussed comparatively, based on the concept of "norm", while the analysis of the authentic data is based on Goffman's (1981) *participation framework* and *footing*. Martinez- Gomez (2020: 111) recommends Goffman's concept of footing, enabling the participants to designate their conversational roles and expectations, as well as accounting for presumptions of others.

Following the detailed descriptions of methodology and theoretical foundations, Chapter 3, 4 and 5 involve data analysis. Chapter 3 introduces the analysis of the medical doctors' and hospital executives' questionnaires. After describing the doctors' and hospital executives' demographic profile, the investigation of their *expectancy norms* regarding the role of interpreters will focus on the categories of "eligibility", "role", "quality" and "positioning of the interpreter". The statistical analysis of the doctors' and the hospital executives' data will be discussed and at the end of the chapter, the data obtained will be compared in the "Discussion" section. The data and its categorization will shed light on their perceptions of the interpreter's role and their expectations from them.

In Chapter 4, the user expectations and perceptions of role will be complemented with findings from interviews with healthcare interpreters. Thus, the discussions in this chapter are two-fold. First, it traces the ways in which the interpreters perceive their own role, and second, it seeks to understand whether the interpreters conform to these *expectancy norms*, and accordingly, constitute *professional norms*. In other words, the users' quantitative data will be supported by the interpreters' qualitative data. To this end, as in Chapter 3, this chapter will also start with the interpreters' demographic information, categorized under the sections "language pairs", "educational background" and "experience in the field". After, the interpreters' data will be analyzed, and discussion will focus on comparison with the users' responses, namely, under the sub-headings "eligibility", "role", "quality", "positioning of the interpreter", and "interpreter's involvement". The chapter concludes with a joint analysis of users' and the interpreters' discourses on their expectations and perceptions of role.

Chapter 5 narrows down the analysis and investigates naturally-occurring interpreter-mediated doctor-patient interviews to triangulate and back up the data

provided in Chapter 3 and 4. Participants' discursive reflections on the issue of role will be extrapolated in real- life situations in order to deepen the discussions and understanding of the interpreter's role. After a detailed depiction of the participants' interactions and seating arrangements, particular attention will be paid to the primary parties' "forms of address", "gaze" and "turn-takings". In this chapter, I will attempt to understand whether, and if so, how the participants' role expectations and perceptions are reflected in actual practice.

At the end, in the Conclusion, I will provide my own evaluation of the findings. Ultimately, this study aims to draw a broadened picture as to the participants' interactional dynamics, and the intertwined contextual and situational factors shaping the role of the interpreter.

CHAPTER ONE

LITERATURE REVIEW AND CONCEPTUAL FRAMEWORKS

To underlie the analysis of this study whose objectives have been explained in detail in the Introduction part, in a robust and coherent manner, I will draw on findings of previous research conducted on healthcare interpreting both around the world and in Turkey. Thus, this chapter provides the selected scholarly studies relevant to the present study's research topic and the main concepts that will be investigated in the analysis sections (Chapter 3, 4 and 5). This chapter consists of two main sections. In the first part, the selected studies conducted on healthcare interpreting around the world will be examined under the categories of "Research on role" and "Research on user- oriented approach". In the second part, the studies conducted on healthcare interpreting in Turkey will be explained.

1.1. RESEARCH ON THE ISSUE OF ROLE

Due to the rapid increase in migration rates, the societies have become more globalized and harbor people from different ethnic origins with different languages who are not capable of speaking the region's majority language. Due to this increasing mobility, the importance of community interpreters cannot be ignored, and the research into this field "cannot be overemphasized" (Bolden, 2000: 387; Van de Mierop, 2012:1).

As in Translation Studies in general, there is a shift from a prescriptive approach towards a more empirical, interactional approach in Interpreting Studies. By the 20th century, Interpreting Studies witnessed both practical and methodological developments. While most studies focused on experimental approaches by the 1960s, the focus shifted towards a more interactive approach by the 1990s and 2000s, in part due to the dramatic development of the field of community interpreting in terms of practice and research (Pöchhacker, 2004). Furthermore, Pöchhacker classifies the development of Interpreting Studies into five paradigms: 1. "Interpretive Theory (IT Paradigm)", 2. "Cognitive Processing Paradigm (CP Paradigm)", 3. "Neurolinguistic Paradigm (NL Paradigm)", 4. "Target-Oriented Text Production (TT Paradigm)" and

5. “Dialogic Discourse-Based Interaction Paradigm (DI Paradigm)” (Pöchhacker, 2004: 67- 82). Since interpreting occurs within a certain socio-cultural context and this study attempts to analyze the role of the interpreter from different stakeholders’ perspectives, the way this study approaches interpreting could be considered in line with the dialogic discourse-based interaction paradigm.

Ever since Wadensjö’s (1998) influential study, which shifted the focus from a normative approach towards a descriptive one, the community interpreter has no longer been labelled as a “linguistic parrot” (Davidson, 2002: 1275). Instead, the interpreter started to be perceived as taking on several roles and exerting a significant impact both “on the interactional situation and on the construction of meaning” (Van de Mieeroop, 2012: 1). As a consequence, an increasing number of studies have investigated the role of the interpreter as co-participant within cross-cultural and cross-linguistic encounters in a variety of settings of community interpreting such as healthcare, legal, and social service settings, and demonstrated that the interpreter is an active participant providing communication in the encounters, even if they see themselves as an objective, neutral and unbiased participant interpreting just what is said, or not (Angelelli, 2004a; Wadensjö, 1998; Roy, 2000).

The concept of interpreter’s role, at the other end of the spectrum, is one of the most controversial issues and has attracted much attention and brought about much discussion and research from Anderson’s (1976) pioneering sociological analysis to Angelelli’s (2004) extensive survey-based research across professional domains (Pöchhacker, 2012: 45). There are two controversial points as asserted by Monteoliva-Garcia (2017: 4): “the type of actions the interpreter carries out and their effects upon other participants’ actions and upon the interaction; and the beliefs about and the perceptions of the interpreter’s role based on the actions they are expected to carry out or not”.

On the other hand, the discussion on the role of the interpreter is mostly rooted in sign language interpreting field (Roy, 2000; Dickenson, 2010) and has recently gained importance in community interpreting field (Pöchhacker, 2012: 45). The interpreter’s role has been investigated from different angles, one of which is related to the issue of participation (Pöchhacker, 2012: 45). Since this research sets out to explore the dynamics of interpreter- mediated interaction in healthcare settings and the

role of the interpreter with respect to forms of address, turn-taking as well as gaze directions, this part of the thesis will focus on the participation of the interactants, namely the research conducted on the issues of turn-taking, forms of address, and gaze rather than the role typologies developed for the interpreters (Leanza, 2007; Niska, 2002).

As stated by Davitti and Pasquandrea (2013: 1), the first scholar who provided evidence as regards the interpreters as fully-fledged participants in the interactions was Wadensjö (1998), who elaborates the interpreters both as ‘translator’ and ‘coordinator’. This study, as indicated before, inspired many scholars and directed the focus to the interpreters as active participants in the interactions. Merlini and Favaron (2005: 266), for instance, indicate that the interpretation of an utterance also depends on the turns in the interaction since each turn has a retrospective impact both on what was said and what will be said in return, taking into account the turn’s function to premeditate of an appropriate answer provided “so that a given sequence may be continued or completed”. That is why, turn-taking allocations have also been widely studied with regard to the role of interpreters.

The connection between the turns and the pronoun shifts was also observed in the study of Dubslaff and Martinsen (2005), which investigated the issue of role in relation to the use of direct vs. indirect speech of both primary parties and also untrained healthcare interpreters, based on four simulated interpreter-mediated healthcare encounters. The interpreters’ lack of medical terminology knowledge came to the fore as one of the factors leading to the pronoun shifts during the encounters.

Amalia Amato (2007) can also be counted among those scholars who followed in Wadensjö’s (1998) wake with the research in which she analyzed three authentic interpreter-mediated medical encounters within the framework of Wadensjö’s (1998) two categories of ‘zero renditions’ and ‘non-renditions’. In the study where she mostly focused on the turns taken by the primary interlocutors, it was contended that primary parties took less turns than the interpreters. When she analyzed the ‘zero renditions’, she found out that the interpreter gave privilege to the doctor as participant i.e. the doctor was observed to be the most ‘translated’ participant both in terms of turns and content. The ‘non-renditions’ of the interpreter, on the other hand, showed the fact that the interpreter was an active participant; however, showed different attitudes towards

the doctor and the patients, which was interpreted as “discretionary decisions” of the interpreters by the author (Amalia Amato, 2007: 38). Along the same line, Merlini and Favaron (2009) questioned how the concept of “norm” is implemented at Italo-American healthcare institution through data from both authentic and simulated interpreting performances, based on the use of first vs. third person. They concluded that it is up to the interpreter to decide which quotative to use in accordance with the requirements, even though the first- person usage is accepted as a norm at the institution.

Carmen Valero- Garces (2010) investigated the participants’ interactions in both dyadic and triadic exchanges within the scope of direct speech, the number and the type of turns taken by the interlocutors in healthcare setting, with the data obtained from both authentic recorded materials and role plays. Declaring that the quality of communication needs to be improved, Valero-Garces (2010: 245) suggests some solutions such as providing professional interpreting services with the design of adapted courses for training the parties or organizing seminars and courses regarding how to work with the interpreters (Valero-Garces, 2010: 245). In a similar vein, Van De Mieeroop (2012) analyzed different functions of the use of quotative “he/she says” of the parties in four interpreter- mediated interviews in healthcare context. One of the most striking points reached in the study is that the use of quotative has a distancing function in the renderings of both the patient’s and the doctor’s turns, which has different grounds. While interpreting the doctor’s turns, the use of quotative has been observed to be preferred in transferring disapproved information, in the patient’s turns it has been observed to reinforce the asymmetrical relationship between doctor and patient.

Instead of focusing directly on the quotative use, Krisztina Zimányi (2013) examined the turns taken by the parties and how the communication control is provided in mental healthcare in Dublin, Ireland. The results were gathered from the interviews with twelve healthcare interpreters and surveys submitted to eleven mental health professionals. It has become clear that there is not only one person dominating the communication flow during the interaction. Even though mental health professionals and interpreters have greater control than the client, they assert that the

client may also temporarily take control (Zimanyi, 2013: 108), which prove the balancing turn-taking flow between the primary parties.

In addition to the analysis on verbal output of the interpreters as well as primary interlocutors, other line of research contributing to the analysis of the role of interpreters include the non-verbal components such as gaze patterns, gestures, postures, etc. of the interlocutors. Yet, Davitti (2012: 114) indicates that very little research has been carried out which has specifically analyzed the gaze patterns in dialogue interpreting (DI). It is obvious that the research on verbal communication attracted greater attention when compared to non-verbal communication (Krystallidou, 2014). The first study conducted on gaze patterns in mediated interaction, according to Davitti (2012: 114), belongs to Ranier Lang (1978) who focused on gaze, posture, and gesture patterns of the parties in courtroom setting in Papua New Guinea. It was observed in the study that gaze, posture and gesture patterns i.e. directed or averted behaviors, might point to valuable insights as to the distribution of turns between the parties (Lang, 1978 in Davitti, 2012: 114).

Even though Lang's study was not conducted in healthcare settings, it, for sure, generated a basis for further research on the non-verbal patterns in a variety of interpreting settings. In the 2000s, the research on non-verbal components in interpreting studies has been on increase in healthcare encounters (Pasquandrea, 2011, 2012; Krystallidou, 2012, 2014; Wadensjö, 2001; Vranjes, 2017), in police interrogations (Monteoliva, 2017) and courtrooms (Licoppe, 2015; Licoppe and Veyrier, 2013) as well as in pedagogical interviews (Davitti, 2012, 2013, 2015, 2016; Davitti and Pasquandrea, 2017).

Within the scope of healthcare interpreting context, Cecilia Wadensjö (2001) can be exemplified who conducted a study focusing on interpreter-assisted therapeutic encounters with the data obtained from a corpus of video-recorded encounters encompassing three parties i.e. a patient, a mental healthcare provider and an interpreter. Wadensjö (2001) examined the physical positioning of the parties to each other and concluded that where the interpreter is positioned has a direct impact on the distribution of talk. While Wadensjö (2001) scrutinized the impact of positioning of the interpreter on the interaction, Hanneke Bot (2005) allocated a chapter where she analyzed gaze and gesture behaviors of the interpreter-mediated therapeutic

encounters in the Netherlands. The analysis of gaze patterns showed how they are different from ordinary monolingual talk, which, according to Hanneke Bot (2005: 140), could be conceived as an intrusive act.

Sergio Pasquandrea (2011) also contributed to the literature by conducting a research by intertwining both verbal and nonverbal video-recorded data from interpreter- mediated doctor- patient interviews. The study showed that doctors could monitor both the patients and the interpreters and maintain control over the interaction. Multimodal sources such as gaze, body language, gesture, etc. enabled the doctors to carry out mutual alignment with the interpreters.

Ian Mason (2012) analyzed the gaze patterns of five immigration officers and five interpreters via video-recordings of the participants. Claiming that gaze direction is of great cruciality in signaling attention and distribution of turns, Mason (2012: 177) further indicates that gaze also organizes the participation patterns. In that case, even the interpreter's head movement might function as "marker of turn organization" (Mason, 2012: 192). Also, immigration officer's gaze shift from asylum seeker towards the interpreter might incite the interpreter to take turn (Mason, 2012: 188).

At the same year, Demi Krystallidou (2012) focused on unveiling how the mediating agents' i.e. professional interpreters' moves in triadic interviews might impact the communication between the parties, with a specific focus on the patient-centeredness through the verbal and non-verbal cues such as gaze. Krystallidou (2012) concluded that the interpreter might both facilitate or hinder the communication between the doctor and the patient.

A more recent study has been conducted by Jelena Vranjes, Geert Brone and Kurt Feyaerts (2018) where they discussed the role of the gaze direction of the interpreter in especially management of turn- taking and sequence organization based on videos of nine interpreter- mediated interactions recorded with mobile- eye tracking glasses which enable the researchers to keep track of all gaze directions of the participants at the same time in a university setting. The study demonstrated that interpreters are important actors managing and coordinating turn- taking and sequence organization during the interaction. Moreover, it is found that the interpreter's gaze at the end of her turn determines the next speaker and the interpreter's gaze is also

fundamental for ongoing sequence organization in the interaction (Vranjes, Brone and Feyaerts: 2018, 23).

As revealed by the literature reviewed above, not only verbal patterns, but also non-verbal patterns such as gaze, gestures, etc. are of great importance in analyzing interactional dynamics in triadic encounters. The selected pioneer studies tackled above demonstrate that non-verbal cues such as seating positions or gaze directions of the parties are interconnected to the turn-taking allocations, flow of communication and also contribute to the participatory status of the interlocutors. Thus, both verbal and non-verbal data have been integrated into the current study and are analyzed in line with their discursive and interactional functions in order to obtain a thorough understanding of complex interactional dynamics in healthcare interpreting context in Turkey.

1.2. RESEARCH ON USER EXPECTATIONS AND PERCEPTIONS

Research on user expectations and perception can play a determining role and can provide an insight into the dynamics of the interpreter- mediated interactions. With the user- oriented surveys, the focus has shifted towards the most ignored research area in interpreting studies (Diriker, 2001: 26). Thus, a variety of scholars have focused on the users' expectations and perceptions of interpreters' role in healthcare settings. Pöchhacker (2000), for instance, explored the opinions of a total of 600 service providers such as nurses, medical doctors, therapists and social workers working in hospitals and family affair centers as well as the opinions of 16 spoken and sign language interpreters. Pöchhacker (2000) concluded that the role and task definitions of both spoken and sign language interpreters as well as providers differ from each other. In other words, the study revealed the fact that while the providers perceive the task and the role of the interpreters more than "just translate", the interpreters are found to have rather broadened the perception of their role in healthcare settings.

Raval and Smith (2003) examined the experiences of nine mental health practitioners working in Child and Adolescents Mental Health Service (CAMHS) in the UK with the help of interpreters. In accordance with the study results, Raval and

Smith recommend the practitioners to spend time with the interpreters so as to constitute alliance with them, which also helps the families to feel safe.

Similarly, Rosenberg, Leanza and Seller (2007) investigated the views of the doctors regarding how the professional and family interpreters impact the doctor-patient encounters. The study showed that doctors conceived professional interpreters to be more competent when compared to family interpreters. Furthermore, while they expect the professional interpreters to act as culture brokers, they expect the family interpreters to act as caregivers.

A year after, Fatahi et.al. (2008) analyzed a group of general practitioners' (GPs) perspectives of cross-cultural communications provided through interpreters in primary healthcare in Sweden, through the data collected from two group interviews and three personal interviews with experienced GPs. Declaring that the interpreter has come forward as having a 'balancing' role in the encounters, Fatahi et al. (2008) also suggest that physical positionings, appropriate length of consultation as well as preferring the same interpreter in each consultation might impact the outcome of the consultations.

Along the same line, Hsieh and Jung Hong (2010) explored healthcare providers' expectations and opinions as regards the contradictions of interpreters' emotional support in healthcare settings with the data collected through the interviews and focus groups conducted with healthcare providers. They came to the conclusion that even the interpreters' physical presence there is enough to relieve the patient. Moreover, the providers accepted the fact that the interpreters are also human- beings; however, they are also required to find a balance between their personal and professional boundaries. Yet, the providers also placed importance on the potential impacts of emotional support provided by the interpreters since it might have a negative effect on the quality of service.

Hsieh, Pitaloka, and Johnson (2013), on the other hand, focused on the providers' perceptions, expectations, and evaluations of interpreters' roles and practice with interviews carried out with 39 providers and survey submitted to 293 providers in different specialties. The study revealed that providers have varying expectations with regard to the interpreters' abilities.

More recently, Creeze and Jülich (2020) conducted a comparative analysis on the role expectations of both healthcare providers and healthcare interpreters in New Zealand. To this end, they submitted separate surveys to the 32 providers and 59 interpreters. The results of the survey research indicated divergences between their role expectations. One of the main divergences is that the healthcare providers expect the interpreters to summarize information and show empathy, which contradicts with the codes of ethics.

Quality is another important topic which is studied under the category of user expectations. Moser- Mercer (1996: 46) highlights that quality can also be measured by different perspectives and expectations of users, colleagues, employers, etc. Quality is a key concept in interpreting studies, and it has become an important criterion in everyday life. Yet, there is still not a universal consensus on how it should be described and utilized to evaluate it objectively (Collados Ais and Garcia Becerra, 2015: 368). Nevertheless, Collados Ais and Garcia Becerra (2015: 368) further claim that research on interpreting quality is one of the most productive and comprehensive research fields because there are a variety of studies conducted. Investigation of quality has also been a predominant concern in healthcare interpreting. Flores (2005) investigated the impact of interpreter on the interpreting quality in healthcare and concluded that trained interpreters and bilingual healthcare providers step forth as important agents facilitating communication between the parties and enhance patient satisfaction and results.

Blignault, Stephanou and Barrett (2009), on the other hand, examined case studies prepared by eighteen New South Wales Health Care Interpreter Service (HCIS) personnel- seventeen interpreters and one administration officer- reflecting their experiences regarding the interpreter's role. In other words, they indicated they sought an answer regarding how the interpreter achieves quality in healthcare encounters. According to the results of the study, it is demonstrated that even though HCIS established competency standards for improving professionalism in interpreting services and attempted to establish a new performance management system, assessing quality remained still problematic. Since the interpreters have to assess quality relying on subjective impressions such as a call from the party to have the same interpreter in the follow-up appointment, which is unreliable (Blignault et al. 2009: 231- 232). It

becomes further clear that increasing quality also leads to the interpreter's job satisfaction which, in turn, increases quality of healthcare services and improve patient outcomes (Blignault et al. 2009: 233).

Ozolins and Hale (2009:3) emphasize the fact that even though the interpreter might be competent and qualified enough, it is also of great importance for all stakeholders to have a mutual understanding as regards the role of the interpreters so as to reduce the unrealistic expectations from the interpreters. In other words, "quality in interpreting cannot be regarded as the sole responsibility of interpreters" (Ozolins and Hale, 2009:3). Furthermore, the studies reviewed above on user expectations indicate that understanding the users', in this context, the medical doctors' and hospital executives' perspectives and expectations, is of paramount significance in analyzing the role of the interpreters. Precisely because of that, in this study the users' expectations and perceptions of role and quality will be compared to that of interpreters. The comparative analysis of both users' and interpreters' quality perceptions will also shed light on their role perceptions and expectations. In addition to the analysis of user expectations, this study also aims at revealing the interpreters' self- perceptions of role and comparing it to that of the users', which is hoped to enrich the discussions and provide a broader picture of the healthcare context in Turkey.

1.3. HEALTHCARE INTERPRETING IN TURKEY- RESEARCH AND PRACTICE

Tourism is a significant sector which has an impact on the development of country's economy. Especially health tourism, which is regarded within the umbrella term "tourism", has higher impact on the country's economy when compared to tourism in general (Aslanova, 2013: 131). According to the definition by the Health Tourism Department affiliated to the General Directorate for Health Services of the Ministry of Health, 'health tourism' is a practice of travelling to another country with the purpose of receiving protective, therapeutic, and health promoting as well as rehabilitation services². As indicated by Kılınç (2017), health tourism can also be

² <https://saglikturizmi.saglik.gov.tr/TR,23587/saglik-turizmi-nedir.html>

perceived as an import of health services as an important international income-generating activity (Kılınç, 2017: 15). Turkey is also among the countries where tourism including health tourism has highly developed.

On the other hand, the number of foreigners taking shelter in our country because of the war in the neighboring countries has increased over the past decade, which has in turn increased the need for interpreters to ensure flawless communication in a variety of public settings including courts, police stations, social services, and hospitals. With the increase of numbers of foreigners living in Turkey, new initiatives have been taken. The duties of Department of Health Tourism under the establishment of the “Directive on Duties of the General Directorate of Health Services Department of the Ministry of Health” dated January 10, 2020 and numbered 244 include assistance and counseling services for the patients within the scope of Health Tourism as well as Tourist Health. Furthermore, Regulation on Health Tourism and Tourist Health has been published in the Official Gazette dated July 13, 2017 and numbered 30123. Pursuant to the Article 6 of the Regulation, International Health Tourism intermediaries are required to obtain International Health Tourism authorization certificate. This authorization certificate also encompasses a variety of criteria including being proficient in a foreign language. To this end, an intermediary should have one of the following as an evidence of being proficient in a foreign language;

- “[...] 4) At least one of the following documents must be provided in order to prove the proficiency of the foreign language*
- a) To have a minimum score of sixty-five points out of hundred either in English or in another language used by the international health tourist, for whom the service will be provided; from the examination organized or held by Higher Education Board (YÖK) or from the Foreign Language Proficiency Examination organized by the Measuring, Selection and Placement Center (ÖSYM) or to have an internationally valid certificate which is deemed equivalent to this score by ÖSYM.*
 - b) To have a document showing the B2 level (on the European Language Portfolio) language competence in English or in another language used by the international health tourist, for whom the service will be provided.*
 - c) Those with dual- citizenship IDs must have a certificate showing the B2 language level on the European Language Portfolio in Turkish language.*
 - ç) To have an undergraduate diploma showing that s/he has graduated from the Department of Translation& Interpreting.”³*

³ <https://shgmturizmdb.saglik.gov.tr/EN-69409/regulation-on-international-health-tourism-and-tourist-health.html> accessed on 23.08.2021

The criteria tackled above show the importance attached to foreign language level of the person who will undertake the interpreter's role. One of the biggest steps taken in healthcare field is the initiation of Sihat Project. Sihat Project, namely "Improving the Health Status of the Syrian Population under Temporary Protection and Related Services Provided by Turkish Authorities" refers to an adaptation training program planned as a 4-year-project initiated on the 1st December 2016 until the 1st December 2020. General objective of the program is defined as promoting and improving primary and secondary healthcare services provided to Syrians under temporary protection in Turkey by the Ministry of Health⁴. It is stated that a total of 708 medical doctors, 966 nurses/midwives, 11 psychologists, 11 social workers, 13 technicians, as well as 1144 patient guides speaking Turkish and Arabic have been employed (ibid).

As for academic research in the field, it could be asserted that even though community interpreting including healthcare interpreting is a commonly practiced type of interpreting, the number of studies conducted on healthcare interpreting in Turkey is limited in numbers. One of the reasons for this could be the challenge of accessing the data. Obtaining real-life data from the interpreted interactions at the hospitals is a challenge due to the nature of the interactions and the workload and working procedures and principles of hospitals. Furthermore, it is required to obtain consent from all participants, namely, healthcare providers, patients as well as interpreters. Thus, obtaining data from the community settings, in this case, healthcare settings is usually harder than obtaining simultaneous interpreting data. Yet, invaluable studies were carried out in the context of healthcare interpreting and it is obvious that such studies are on the increase.

As stated by Mine Güven (2014: 116), the first academic research on healthcare interpreting in Turkey was carried out by Ross and Dereboy in 2009 as a part of an EU-Grundtvig project called Training Intercultural and Bilingual Competencies in Health and Social Care (TRICC). Focusing on ad hoc interpreting services provided in state hospitals, Ross and Dereboy (2009) reveal that language barriers can hinder the communication between doctor and patient. They suggest assigning Kurdish-speaking doctors to areas where Kurdish is more common compared to Turkish and

⁴https://sihatproject.org/proje-faaliyetleri_0-657 accessed on 14.05.2020

improving Kurdish language competence of doctors, raising awareness of doctors regarding the nature, process and challenges of mediated communication and training interpreters (Ross and Dereboy, 2009).

Highlighting the need for trained medical interpreters at public health institutions, Mine Güven (2014) evaluates distance learning (DL) as an effective tool for medical interpreter training in Turkey. She proposes two certificate programmes: “a three-month programme” for healthcare professionals, some of whom are already ad hoc interpreters, and “a one-year programme” for prospective medical interpreters who have completed secondary education and can speak Turkish and a local/ethnic language at either C1 or C2 level (Güven, 2014: 8-9). Güven (2014) further suggests an in-service training for healthcare professionals in order to raise awareness regarding the importance of working with interpreters.

Two years later, in 2016, Dilek Turan published a book titled “Sağlık Hizmetlerinde Sözlü Çeviri” (Interpreting in Healthcare Services) whose objective is to evaluate the current status of the profession, requirements, legal and political frameworks as well as training in Turkey. Accordingly, Turan (2016: 224- 5) made some suggestions with regard to training of healthcare interpreters in Turkey such as providing the interpreters additional in-house training, integrating intercultural communication lectures, language and terminology lectures, linguistics, pragmatism, etc. into curriculum at the universities.

The most recent study has been conducted by Filiz Şan and Rana Kahraman Duru (2020) who specifically focused on healthcare interpreters’ working conditions during COVID-19 pandemic through the questionnaires submitted to the interpreters. As a consequence, Şan and Kahraman Duru (2020) put forth some kind of inefficiencies in working conditions of the interpreters, exemplifying that the interpreters cannot benefit from support packages under the status of healthcare workers. Thus, the working conditions should be revised when taking into account hygiene of their work environment, waiting room, and waiting period during the pandemic and the risk they have for catching COVID-19 virus⁵.

⁵ An article entitled “A Comparative Analysis of Role Perceptions and Expectations of Medical Doctors and Interpreters in healthcare settings” has been published as a part of this dissertation in 2021.

In the recent years, it could clearly be stated that the number of completed dissertations in this field has also rocketed. Türkan Öztürk (2015) is among those who has completed an MA thesis in which she aims at describing current situation regarding healthcare interpreting services provided in Turkey from the interpreters' perspectives. She has concluded that interpreters have different roles and duties apart from just interpreting, and they also assume the role of cultural mediator. Thus, interpreters need to have different capabilities in addition to interpreting capabilities.

Olca Şener (2017), in her master's thesis, analyzed the role of healthcare interpreters through the data from interviews conducted with interpreters and patients, participant observation as well as audio- recordings of interpreter- mediated doctor-patient encounters. Her study revealed that the interpreters went beyond their role as interpreters some of which could imply a risk for the quality of service. Another finding is that there is a gap between what the interpreters say they do and what they do in practice.

The doctoral thesis of Duygu Duman (2018) is also one of those recent dissertations where she focused on the healthcare interpreters' subjectivity experience before, during and after the interpreting process by benefitting from triangulation of data; namely, the transcriptions of the interviews conducted with a total number of 27 healthcare interpreters in 7 hospitals in Istanbul, research diaries and the document analysis conducted on national and international codes of ethics. Based on the analysis of data with hermeneutic approach, she investigated whether the interpreters are impartial or prejudiced agents. The results indicate that healthcare interpreters sometimes intentionally take sides with the patients with a view to advocating them or facilitating their treatment process. This, in turn, leads the interpreters to show more empathy towards the patients, which leads to less impartial stance and objectivity.

Likewise, Burak Özsöz (2019) aimed to investigate participatory dynamics in mediated three-party encounters in hair transplantation centers with the data on verbal and non-verbal dimension. It has been concluded that the interpreters contribute to a mutual negotiation of meaning with the primary parties and the development of the interaction.

Another study conducted in the context of healthcare interpreting belongs to Bahar Katar (2019), which investigated the tasks and role profile of interpreters as well

as difficulties encountered during doctor- patient interviews through the data obtained with semi- structured interviews with 17 healthcare interpreters as well as 4 coordinators in 6 private hospitals in Aydın and İzmir. She has concluded that there is a gap between the role definition in the literature and the role performance of the interpreters in the practice. She has further indicated that the interpreter not only provides interpreting services, but also plays a role as a consultant and mediator between the parties such as patients, their relatives and the health professionals.

Sıla Saadet Toker (2019), on the other hand, focused specifically on the adaptation training for Syrians and the host community, and aims to investigate the patient guides' opinions and satisfaction regarding the adaptation training program provided by the Ministry of Health and World Health Organization as a part of the "Adaptation Training to Turkish Health System for Syrians under Temporary Protection" under Sihat Project. Toker (2019) has concluded that average satisfaction level of the patient guides is at the medium level. When it comes to the improvement of the training, the results of the study have shown that the patient guides placed importance on the medical terminology.

The most recent thesis completed on this field is the master's thesis of Ayşe Erkmen (2020), which scrutinized the current circumstances of the profession of healthcare interpreting in Turkey. For this purpose, Erkmen (2020) has employed questionnaires to healthcare providers such as medical doctors and nurses, and the study has come to a conclusion that communication is provided by non-professional language mediators and that healthcare providers have reflected their dissatisfaction with the current interpreting services provided, which, in turn, highlights the need for professional interpreters.

All these studies elaborated above provide significant insights into the role of the interpreters not only from the interpreters' perspectives, but also from the healthcare providers' perspectives. It is also pleasing that even though the number of studies focusing on different aspects of the profession has increased in Turkey in recent years, the fact remains, however, that there is still much to be researched especially in triadic interactions in healthcare settings in Turkey. Thus, this study aims at contributing to filling this gap in the literature by providing different perspectives of

the participants as well as a detailed analysis of the complex dynamics between the parties in triadic interactions.



CHAPTER TWO

METHODOLOGY AND THEORETICAL FRAMEWORK

This chapter lays the foundations of the methodological approach and the theoretical framework used in this study, thus divided into two main sections. In the first part, an extensive and multifaceted methodological approach including ethnographic data collection methods, researcher's involvement, approvals as well as ethical principal will be demonstrated in detail. Later, in the second part of this chapter, the theoretical framework, namely, Toury's (1980) concept of 'norm' both in Translation Studies and Interpreting Studies as well as Goffman's (1981) concept of 'participation framework' and 'footing' will be investigated.

2.1. THE METHODOLOGICAL APPROACH

Pöchhacker (2011: 16) indicates that "[t]he study of interpreting is ultimately not a matter of philosophy or theory of science, but of *doing* science by asking research questions and answering them by adopting an appropriate method of inquiry". Sharing a similar opinion, Aguilar- Solano (2020) also emphasizes an appropriate methodological framework which could bolster the quality of research and the validity of its findings. In order to find an answer to the research questions explained in the Introduction part, this study can be framed as a (multiple) case study based on fieldwork and using ethnographic research methods, which consist of interviews with healthcare interpreters as well as questionnaires submitted to medical doctors and hospital executives, participant observation in interpreted interactions and audio-recordings of interpreter- mediated doctor and patient consultations.

2.1.1. Ethnography

Ethnography is a commonly applied method in Interpreting Studies and is also one of the main methods used in this research. Ethnography is defined as "a study of a social group or individual or individuals representative of that group, based on direct recording of the behavior and 'voices' of the participants by the researcher over a

period of time” (Hale and Napier, 2013: 84). It includes large-scale observations through participant observation where the researcher is dived into the daily life of the people and observes and interviews the group participants. Thus, the ethnographers provide ‘thick description’ of their culture (Geertz, 1973), and analyze the meaning of the behavior, the language, and the interaction among the participants of that group (Creswell, 1998: 68-69). In this regard, ethnography is used as one of the main methods in this study in order to reveal factors and constraints affecting the interpreter’s role, the expectations imposed on the interpreter by the users of the interpreting service and their perceptions of him or her within the healthcare setting. The focus is not only on the discourse used in the setting but also on all features of the interaction.

2.1.2. (Multiple) Case Study

This dissertation can be conceived as a case study based on fieldwork and ethnographic research methods. It is designed to triangulate data by attempting to bring in multiple perspectives from different stakeholders as well as analysis of actual interpreting performance in the scope of an interpreting service provided within the hospital. Creswell (2018) defines case study research as follows:

Case study research is a qualitative approach in which investigator explores a bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiples sources of information (e.g., observations, interviews, audiovisual material, and documents and reports), and reports a case description and case-based themes. (Creswell, 2018: 73)

By the same token, Leedy and Ormrod (2014: 141) also states that case studies focus on a specific individual or events with a view to gathering more detailed information. Multi-method case studies are especially powerful and attractive in a fieldwork setting (Pöchhacker, 2011: 20). Through case study research, researchers can not only examine people, events or places, but also the relationships between the participants and the institutions, and complex dynamics occurring between them (Yin, 2009). In this regard, using multiple sources in case studies enables the researcher to handle historical and behavioral issues from a broader perspective (ibid). Yin (2009) further asserts that any case study will be more satisfactory and will provide more accurate conclusions if it is based on a number of different sources of information.

Since case studies focus on a single group or community, the aim is not to generalize the findings (Aguilar- Solano, 2020: 38, Hale and Napier, 2013: 91). Rather, a case study aims to explore or study a specific case in all its dimensions based on a variety of data sources. Likewise, in this study, all the dynamics in a healthcare setting are analyzed aiming at providing in-depth information from a predefined community rather than collecting surface data from a broader group of participants.

2.1.3 Triangulation

As stated by Aguilar- Solano (2020: 36), the foundation of triangulation in social sciences was laid by Campbell and Fiske (1959: 101) who developed a mix-method approach to raise the acceptability and credibility of qualitative research results. It was coined by Webb et al. (1966) and furthered by Denzin (1978) (cf. Aguilar- Solano, 2020: 36). The term *triangulation* in social sciences is defined as “the mixing of data or methods so that diverse viewpoints or standpoints cast light upon a topic” (Olsen, 2004: 3). Denzin (1978: 304) also shows a similar approach to triangulation by implying that triangulation can provide different perspectives of a single phenomenon by “playing each method off against the other so as to maximize the validity of field efforts”. Thus, it asks of researchers to obtain more robust findings by utilizing a variety of means such as different data collection methods or theories. In this study, triangulation will entail bringing in different source of data such as an interview, questionnaire, participant observation as well as audio-recordings of interactions in order to increase the validity and credibility of the findings and provide deeper and broader understanding.

2.1.4. Data Collection Methods

In this study, multiple data collection methods are employed to provide an in-depth analysis of the interpreter’s role. These data collection methods and the ensuing data are then triangulated. In line with multi- methods approach applied in the present study, both quantitative and qualitative data are obtained and analyzed. While qualitative and quantitative findings provide an in-depth perspective of healthcare interpreting, through fieldwork, real- life contexts and naturally-occurring data are scrutinized.

2.1.4.1. Interview

Edley and Litosseliti (2010:176) define interview as a mechanism by which one party (the interviewer) draws important information from another. Interviews are used more widely in interpreting studies than in translation studies, since interpreting has a more common social perspective when compared to translation, which is considered as a more isolated activity (Saldanha and O'Brien, 2013:168). Thus, interview is a prevalent method used particularly in research on community interpreting (Saldanha and O'Brien, 2013: 168). It encompasses in-depth discussion on a specific topic with participants representing the culture of community under investigation and it aims at "gaining an understanding into the experience of other people and the meaning they make of that experience" (Hale and Napier, 2013: 95). Hale and Napier (2013: 97) also indicate that interviews can be *structured* using closed questions completed in a fixed timeframe, *semi-structured* in which the interviewer might have additional questions to guide the conversation, and *open-ended* where flexibility takes place. In this study, semi-structured interviews with open-ended questions were conducted to elicit data which also allows the participants to tell their experience freely and in detail. First, a pilot study was conducted with 4 healthcare interpreters working in a private hospital in Ankara during summer 2019. The interview included 33 questions and lasted approximately 16 minutes. However, the questions were too long and time-consuming, thus created problems to the interpreters for sparing time for an interview. By removing recurring questions, the interview questions were abridged to 27 questions prepared in Turkish and conducted with 13 healthcare interpreters in Izmir, Istanbul and Ankara. The interviews were audio-recorded, transcribed, and the quotes analyzed in this study were translated into English. Both personal and professional contacts were used for accessing the interpreters and the interpreters were accessed through purposive sampling method in which the aim is to generate a sample which could logically represent the population (Lavrakas, 2008). However, over the course of the research, coronavirus pandemic broke out. Thus, even though I could conduct interviews with the interpreters within the scope of pilot study face-to-face during summer 2019, the rest of the interviews were carried out via Skype or online because of the pandemic during summer 2020.

2.1.4.2. Questionnaire

Questionnaire is an important instrument especially as significant survey strategy for obtaining information from a particular group and is defined as a) “a list of questions each with a range of answers” and b) “a format that enables standardized, relatively structured, data to be gathered about each of a (usually) large number of cases” (Matthews and Ross, 2010: 201). A questionnaire might be employed in order to gather data regarding facts, opinions, behavior, attitudes, etc. of research participants (Saldanha and O’Brien, 2013: 152). One of advantages of questionnaires is that they are less time consuming when compared to other data collection methods such as interviews. However, they provide only an overview of the task or field under study. In this study, though, findings from interviews and questionnaires are used to complement one another, so as to benefit from both methods and remove the cons of each method. Since medical doctors and hospital executives have limited time for an interview, questionnaires were administered to hospital executives and medical doctors with an experience in interpreter-mediated interactions to elicit their expectations and perceptions regarding the role of the interpreters and quality in healthcare interpreting in accordance with the research objectives. The questionnaires were given to users in person. The number of hospital executives who participated in the survey research was 11, while the number of the medical doctors was 22. All users were based in Ankara and Izmir. The questionnaires employed to hospital executives include 23 questions, while there are 25 questions posed to doctors. The questions include demographic information such as gender, age, languages spoken, language level, role and quality expectations and perceptions of healthcare interpreters.

At the opposite end of the spectrum, one of the weaknesses of questionnaires is the fact that they are not the best instruments for collecting explanatory data such as emotions, opinions, or personal experience, even though they are appropriate for collecting exploratory data (Saldanha and O’Brien, 2013: 152). Thus, the quantitative analysis of the questionnaires applied to hospital executives and medical doctors will be complemented by the qualitative analysis of the data obtained from semi-structured interviews with healthcare interpreters and will be triangulated by discourse analysis of participant observations and audio-recordings in interpreter-mediated interactions.

2.1.4.3. Participant Observation

Participant observation is described by Kawulich (2005) as “a process enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities.” It is also a popular method used in ethnographic research in which researcher makes an observation and takes notes regarding the attitudes of groups or individuals (Hale, 2007: 231). Therefore, the data was also collected through participant observation of interpreted interactions aiming to reveal richly detailed data regarding the setting, participants, and the case under this study. Another advantage of participant observation is that it allows researchers to observe and analyze non-verbal components such as expression of feelings, also analyze who interact with whom, to determine how participants communicate with each other as well as to reveal how much time is spent on certain activities (Schmuck, 1997). Thus, participant observation is especially useful for analyzing the gaze directions and its impact on both the interpreter and the users in this study. In addition to the analysis of gaze directions, the objective is to observe the whole interpreting process and compare what the participants say they do and what they do and how they react in real-life situations.

After informing the parties regarding the objective and scope of the study, and obtaining approval from all participants, I started to collect data through participant observation in summer 2020. I observed four different doctor- patient- interpreter interactions. In addition, I took notes to keep track of the communication and the parties' gaze directions. Aguilar- Solano (2020: 41- 42) asserts that even though participant observation allows to capture broader picture of the interpreters' social contexts, their interaction with other participants, and the interactional dynamics, it also has limitations since it heavily relies on researchers' descriptions and interpretations of fieldnotes, which are shaped by researchers' worldviews (Silverman in Aguilar- Solano, 2020). Thus, audio-recordings are required to provide more reliable data, minimize bias and increase the trustworthiness of the findings (ibid: 42).

2.1.4.4. Audio- Recordings of Interpreter- Mediated Interactions

The fourth data collection method used for analyzing the interpreter's role is audio-recordings of doctor-patient and interpreter interactions. Upon receiving permission from all participants, a total of four interactions, which was also observed, were audio-recorded in a private hospital in Izmir during summer 2020. Total of four interactions lasted approximately 86 minutes and were conducted in German and Turkish. The German and Turkish parts were translated into English by the author. The two dialogues took place between doctor-patient and interpreter, while the remaining encounters mostly took place between the dietician, patient and the interpreter.

To sum up, the data obtained from qualitative and quantitative methods will be backed by the analysis of audio-recordings, putting forth a richer perspective of the healthcare interpreter's role in Turkey.

2.1.5. Researcher's Involvement, Approvals and Ethical Issues

A challenge encountered by the researchers in interpreting studies is obtaining permission from the participants and authorities. This study also faced many obstacles, as it was required, on the one hand, to deal with institutional barriers to obtain permission and raise awareness regarding the importance of research within the healthcare setting, on the other hand, it was very hard to persuade the participants to participate in the research. More than a few interpreters were reluctant to take part due to their individual concerns. Some of the interpreters were possibly afraid of losing their jobs, whilst others did not want to allocate time.

Furthermore, many hospitals declined my request to conduct a research and record interpreter-mediated interactions, even though I specifically highlighted that all the names of participants as well as institutions would be kept confidential. Some hospital authorities were adamant that the interpreted encounters between doctor and patient should not be observed and audio-recorded. Thus, they declined my request by reference to hospital rules on confidentiality. It might be due to the similar reason that some medical doctors did not want to fill out the questionnaire forms. In brief, I

attempted to access the doctors and the executives through personal contacts and a snowballing method. Thus, it can be claimed that being able to conduct such research especially focusing on real-life data in interpreting studies depends mostly on the researcher's ability of persuasion. After consulting to a high number of doctors and executives in person, in the end, I succeeded in securing permission from them to allocate time for the study.

Besides difficulties regarding taking permission, the coronavirus pandemic caused challenges of access during the data collection phase. In early 2020, the global coronavirus pandemic broke out all over the world, which obliged many countries to close their borders and as a result of which all the flights were cancelled. This unprecedented situation affected any sector that includes mobility. Thus, the healthcare sector and healthcare interpreting were not an exception. The first foreign patients started to travel to Turkey in the mid July. After being able to get approval from a doctor who has his own nursing home stating that he gives importance to such academic research and waiting a couple of months for the foreign patients to come to Turkey, I could participate in doctor-patient interviews in July 2020. Before attending the interactions, the doctor and the interpreter were informed about the scope of the thesis and a consent form indicating that the researcher will audio-record the interaction, the participants in the study will remain anonymous in any publication and the notes taken during observation will be used solely for academic purposes, was signed by the participants. After the doctor, the dietician and the interpreter signed and affirmed the form, the patients were informed regarding the research and the consent form was also signed by the patients.

Questionnaires, on the other hand, were approved by the ethics committee of one private hospital as well as Dokuz Eylül University Rectorate. Likewise, all interviewees were sent a consent form including objectives and the scope of the research via e-mail due to the ongoing pandemic. All interviewees gave consent by sending back E-mail indicating that they read the consent form and approved it.

For ethical and confidentiality reasons, all participants, i.e., doctors', hospital executives', patients' as well as interpreters' names will not be revealed. The participants have been anonymized and coded as Int for interpreter, DR for doctor, D for the dietician and P for patient. Only the related dialogue parts of the participants

will be provided for the analysis. The complete version of the interviews and the dialogues will not be listed in order to secure the confidentiality of all participants involved in this study.

2.2. TRANSLATIONAL NORMS

Translation, as a communicative and a social act, includes shared forms of behavior formed by shared ways of thinking which shows that a translator's behavior is not idiosyncratic; instead, other actors including editors, publishers and readers also have a shared knowledge regarding translational behavior. Such shared notions have been entitled as "conventions", "norms", or "rules" (Brownlie, 1999: 7).

The concept of norms in translation studies was first brought in by Jiri Levy (1969) and by Itamar Even-Zohar (1971); however, it was mainly expanded and pioneered by Gideon Toury (1980) and his followers in the late seventies (Brownlie, 1999: 7). Defending the opinion that translation activities should be considered as a cultural activity rather than mere generation of utterances from one language into another, Toury (1995: 54) asserts that "'translatorship' amounts first and foremost to being able to play a social role, i.e., to fulfill a function allotted by a community- to the activity, its practitioners and/ or their products- in a way which is deemed appropriate in its own terms of reference".

Toury takes the definition of norm from sociology and describes norm as follows:

The translation of general values or ideas shared by a community as to what is right and wrong,-adequate and inadequate- into performance instructions appropriate for and applicable to particular situations, specifying what is prescribed and forbidden as well as what is tolerated and permitted in a certain behavioural dimension [...] (Toury, 1995: 55).

Norms are fundamental in social interaction since their existence and the large number of situations to which they apply ensure the constitution and continuation of social order (Balci Tison, 2016: 49). According to Toury (1995: 54), translation is a norm-governed activity and subject to various types of sociocultural constraints on a varying degree. These sociocultural constraints may be described between two extremes: essential rules at one end and "subjective idiosyncrasies" (Schjoldager,

1995: 67) at the other. Norms are located in the middle ground of this scale (Toury, 1995: 54). Toury (1995) posits three major translational norms in descriptive translation studies which are *initial norms*, *preliminary norms* and *operational norms* (Toury, 1995: 55- 61). The **initial norms** govern the translator's strategies where s/he can either choose to adopt norms of the culture of source text or to the norms of target text. The former is labelled as a choice for "*adequacy*" to the source text culture, while the latter refers to the translator's orientation as "*acceptability*" in the target culture (Toury, 1995: 56- 57). Initial norms can also be employed in interpreting studies in terms of the distinction between transcoding and 'interpreting proper', or form-based and meaning- based interpreting (Garzone, 2015: 282). **Preliminary norms**, on the other hand, deal with *translation policy* and *directness of translation*. The former refers to the factors including the decision regarding the text type to be translated from which author and which source languages, whereas the directness of translation deals with the tolerance for translating from languages other than the source language. To put it another way, those norms include decisions to work directly from the original language or from a translation of another language (Toury, 1995: 58).

Operational norms refer to translator's decisions made during the translation process. They also provide the basis for the decisions taken during the interpreting process regarding how the interpreter deals with "general and "local" translatorial and textual problems" (Garzone, 2002: 113). *Matricial norms* govern the degree of fullness of translation such as additions, omissions, changes occurred, its location in the text and the textual segmentation (Toury, 1995: 58- 59). Matricial norms play a significant role for interpreters since they utilize these norms as emergency or repair strategies during interpretation, which, in turn, contribute to the quality of performance (Garzone, 2002: 114). *Textual linguistic norms* are related to the selection of material to formulate the target text (Baker, 1998: 164).

Indicating that some norms serve as " solutions to problems posed by certain interaction situations" (Ulmann- Margalit in Chesterman, 1997: 64), Chesterman (1997: 64) holds the opinion that translation norms could also be categorized under this type since they regulate the process whereby communication can be provided in a situation where it would otherwise be impossible. He extended the approach of Toury's (1995) operational and initial norms to include *product* and *process norms*.

Chesterman (1997: 64) especially put emphasis on product norms, indicating that product norms are constituted by expectations of the target language readership which, in turn, constitute *expectancy norms*. These expectancy norms are composed of “user expectations” (Garzone, 2015) and determined by the receivers of the translation as to what the translation (of a given type) should be like (Chesterman, 2017: 174). The expectations could be regarding text type, discourse conventions, style, register, appropriate degree of grammatical and statistical distribution of text features of all kinds, about collocations, lexical choice, etc. (Chesterman, 1997: 64). Moreover, they can be affected by economic and ideological factors as well as power relations within and between cultures (Chesterman, 1997: 64). Put it differently, expectancy norms are also validated by norm-authorities such as teachers, translator critics, publisher’s readers, i.e., those who are “experts” (Chesterman, 1997: 66). In a similar vein, users of interpreting have also expectations regarding the interpreted product i.e. as to how interpreting should be performed and service users’ opinions concerning what a good interpretation should be like also shape interpreters’ *professional norms* (Garzone, 2015: 283). For example, hospital executives’ discourse on healthcare interpreting might function as a “norm-authority” shaping the interpreting performances in healthcare setting. **Professional or process norms**, on the other hand, administer the translation process and “from the translator’s point of view, these norms are subordinate to the expectancy norms, because they are themselves determined by the expectancy norms” (Chesterman, 1997: 67). If a translation is deemed as conforming to the expectancy norms, then the translator of the text is accepted as being a professional (Chesterman, 1997: 67- 68). According to Garzone (2002: 11), the distinction between *expectancy norms* i.e. ‘user expectations’ and *professional* or *process norms* referring to the ‘translator’s inclination to take these expectancy norms into consideration, are defined as “two sides of the same coin, strictly interdependent and mutually reinforcing” by Garzone (2002, 116).

Bearing in mind the definition of norm in translation studies, it can also be clearly observed that interpreters work closely with binding norms which are accepted and expected in a community and they also have to perform in accordance with the expected professional norms (Koscalkowska-Okonska, 2011: 27).

2.3. TRANSLATIONAL NORMS IN INTERPRETING STUDIES

For a long period of time in history, research on interpreting mainly focused on cognitive issues (Wang, 2012: 199). This was also promoted by Baker's observation:

[...] The vast majority of research [on interpreting] has been, and continues to be, devoted to investigating cognitive aspects of interpreter performance, for example mental overload, attention span, and the effect on interpreter performance of variables such as increased input rate, heavily accented speech, environmental noise and so on. Little or no attention has so far been given to investigating constraints which arise from the nature of the role played by the interpreter and the pressures on him or her by other participants in specific settings (Baker, 1997: 111).

However, interpreting activities and behaviors require not only investigation of integral cognitive processing factors, but also external social and cultural factors since interpreter's performance is formed by all these factors together (Wang, 2012: 199). According to Wang (2012: 199), there are three major factors shaping interpreter performance, which are "a) the interpreter's interpreting competence", "b) the cognitive conditions on-site", and "c) norms of interpreting". Miriam Shlesinger extended the discussion on the notion of norm in translation studies to interpreting studies, especially with respect to simultaneous interpreting, in an article published in *Target* in 1989. She doubted whether norms could be applied to interpreters' performances and enumerated a number of methodological obstacles regarding the use of norms in interpreting studies. She stressed that the occurrence of shared values or ideas was difficult in interpreting settings due to the rarity of recurrent situations of the same type. She further claimed that even though interpreters are exposed to a spoken text in a particular target language, it is unlikely that the interpreter relates his or her own output to interpreted target texts. (Shlesinger, 1989:111- 112) Thus, she put forward that a variety of technical, logistical as well as legal hurdles should be managed in order to be able to extrapolate the concept of norms in interpreting studies (Shlesinger, 1989:111- 114).

In a response to these ideas, Brian Harris (1990), on the contrary, adopts a more positive approach than Shlesinger (1989) in terms of extracting norms from professional interpreting community and lists a number of norms prevalent in professional conference interpreting with examples (Monacelli, 2009: 15). These

norms entail speaking in the first- person, turn- taking process in booth during interpretation, working into one's A language (native language), and norms concerning the acceptability of the target language production (Harris, 1990: 115-117). Through the end of his paper, he also speaks of "one another more fundamental and universal norm" which is '*the true interpreter norm*' or the '*honest spokesman norm*' by highlighting its importance as:

[T]his norm requires that people who speak on behalf of others, interpreters among them, re-express the original speakers' ideas and the manner of expressing them as accurately as possible and without significant omissions, and not mix them up with their own ideas and expressions. (Harris, 1990: 118)

Harris (1990: 119) pinpoints that these norms are required since they help interpreters be trusted in order to provide the functionality of the system. Despite the methodological difficulties which are especially associated with interpreting activities, considerable progress has been made within the scope of corpus- based research. Among these is Anne Schjoldager who conducted an empirical research into simultaneous interpreting and translation and explored norms as a methodological tool through the data gathered from four different groups of subjects in 1995. Her objective was to analyze similarities in TT/ST relations and to generate a hypothesis regarding translational norms in simultaneous interpreting (Schjoldager, 2001: 230). Even though she illustrates some methodological problems in her dissertation, she shows the applicability of translational norms in simultaneous interpreting.

According to Daniel Gile (1999), the research into norms of interpreting should not necessarily be based on large speech corpora. Rather, norms could be traced more effectively through the analysis of "extratextual sources" (Toury, 1995: 65), namely, through interpreters' self-assessments, users' remarks, and written materials on interpreting (Gile, 1999: 101).

Those "extratextual sources" was used by Ebru Diriker (2004) who examined norms in simultaneous interpreting through discourse of reference books, professional institutions, codes of ethics, as well as interviews with interpreters, organizers, speakers and users. Diriker (1999:78) also explicitly makes it clear that questionnaires are significant means to understand the norms advocated by those within the interpreting field and those outside of it.

Apart from Diriker (1999, 2003, 2004), there are also scholars examining norms in simultaneous interpreting and church interpreting in Turkey. In her PhD thesis, Esra Özkaya (2015) focused on the norm of impartiality in Turkish conference interpreting setting through triangulation of data which comprise of professional organizational discourse of interpreting associations both in the world and in Turkey, questionnaires submitted to professional conference interpreters, and authentic recordings of professional conference interpreters' interpreting performances. To put it another way, Özkaya (2015) compares the discourses of professional organizations, interpreters' self-perceptions regarding impartiality and their interpreting performances in authentic situations. More recently, Alev Balcı Tison (2016) explored Toury's *preliminary norms* with a view to analyzing institutional interpreting policy in church settings, *expectancy norms* through interviews conducted with commissioners and interpreters, questionnaires for preachers, interpreters and congregants. Lastly, she explored Chesterman's *process (professional) norms* through a corpus of five recordings of interpreted speeches in church. Balcı Tison (2016) compared the "expectancy norms" obtained from users in terms of implications for their institutional role to the "process norms" by specifically focusing on the applications of those expectancy norms in interpreting. Her findings shed light on the discrepancies between interpreters' and users' role perceptions and expectations and the role played by the interpreters in real-life situations.

All the above-mentioned studies and the studies not cited here show the applicability of translational norms in interpreting studies, specifically from a sociological perspective in which interpreter is analyzed as an agent within socio-cultural context. This study also scrutinizes the interpreters within sociocultural context. For this endeavor, Chesterman's **expectancy norms** will be extrapolated through questionnaires submitted to medical doctors and hospital executives regarding their role perceptions and expectations. Lastly, Chesterman's **professional (process) norms** will be examined through interviews conducted with interpreters as to how they perceive their own role and what they believe is expected from them. The findings will help to illustrate the points of convergence and divergence between their discourse and by doing so, it aims to answer the third research question.

2.4. GOFFMAN'S *PARTICIPATION FRAMEWORK AND FOOTING*

Another theoretical concept utilized in this study is Goffman's (1981) *participation framework*. Since *participation framework* forms basis on footing, it seems necessary and important to provide information to demonstrate the relevance of the concept to the interpreting studies and to picture better understanding in dialogue interpreting. Goffman (1981: 128) describes footing as "the alignment we take up for ourselves and the others present as expressed in the way we manage production or reception of an utterance". In other words, it refers to "a person's alignment as speaker and hearer to a particular utterance" (Wadensjö, 1998: 87). Within a conversation, participants might change footings as they change their alignments with each other from moment to moment, based on linguistic and contextual signals of their utterances (Marks, 2012: 3). So, according to Goffman (1981: 128), "participants over the course of their speaking constantly change their footing, these changes being a persistent feature of natural talk". That is to say, participants assume different and shifting roles vis-à-vis each other during their speech (Mason, 1999: 152). Furthermore, Goffman (1981:130-131) broadens the common speaker- hearer model by underlining different types of participants. For instance, a hearer of a conversation (or a recipient or a listener) might be *ratified* participant who has an official status in the encounter who is the "addressed" one to whom the speaker expects to turn over the speaking role (Goffman, 1981:132-133). Among the mode of *ratified* listening, Goffman also includes the *unaddressed* and the *bystanders* (Wadensjö, 1998: 88). A hearer of a conversation might also be *unratified* participant who could listen to the speaker, but does not have an official status (Goffman, 1981: 131-132). According to Goffman (1981:131-132), this person could access the encounter as an unratified participant in two socially different ways: one can either plan this on purpose as an "eavesdropper", or one could accidentally come about it, which ends up with "overhearing". In a nutshell, "a ratified participant may not be listening, and someone listening may not be a ratified participant" (Goffman, 1981: 132).

Goffman further indicates that in addition to various hearer roles, participants also assume different speaker roles and they have a "participation status" relevant to

the utterance and all the speaker and hearer roles assumed by the participants constitute “participation framework” (Goffman, 1981: 137). Goffman defines three speaker roles for the participants, namely “animator”, “author”, and “principal”, which all form “production format” (Goffman, 1981: 226). “Animator” is defined as “the sounding box from which utterances come” (Goffman, 1981: 226). To put it another way, animator is the person who produces a speech. “Author” is described as “the agent who puts together, composes or scripts the lines that are uttered”, while “principal” is “the party to whose position, stand, and belief the words attest” (Goffman, 1981: 226).

Goffman (1981: 145) proposes the term ‘speaker’ as “an individual (who) is animating their own words, ideas, and positions”. Metzger (1999: 330-331) relates this term to dialogue interpreters indicating the fact that dialogue interpreters also animate the ideas and positions of others in a second language, and explains further:

[A] dialogue interpreter is constantly shifting back and forth between these three aspects of being a ‘speaker’, sometimes animating the words of one participant, sometimes those of another, and still at other times giving voice to ideas and positions of their own (for example when explaining something about the interpreting process to other participants) (Metzger, 1999: 331).

Goffman’s notions provided new perspectives on interpreting studies research and thus will be evaluated in detail in the below section.

2.5. PARTICIPATION FRAMEWORK AND FOOTING IN INTERPRETING STUDIES

Goffman’s influential work on human behavior was also the source of inspiration for researchers in Interpreting Studies since the researchers started examining interactive nature of interpreted interviews (Metzger, 1999:327). The *participation framework* especially provides new insights for dialogue interpreters and reveals the distinctions between conference interpreting and dialogue interpreting, which, in turn, bring novelties in the discipline (Metzger, 1999: 327-328). As stated by Mason (1999:151), the first research to have focused on Goffman’s work pertains to Keith (1984) where he benefitted from Goffman’s concept ‘footing’ to analyze the relationship between interpreter and the speaker in liaison interpreting. Nevertheless, it was Wadensjö’s (1992, 1998) work which attracted a great deal of attention in

interpreting studies (Mason, 1999: 151-152). While Goffman provides a wealth of information on the various ways in which speakers participate in a conversation, he does not delve into the complexities of the listener roles (Roy, 2000:31). Yet, it was Wadensjö (1998) who developed 'reception format' in parallel with the 'production format' of Goffman (Roy, 2000: 31). *Reception format* includes three different modes of listening, "that is, analytical roles describing diverse ways to relate the others' utterances while being exposed to them" and these 'hearer' roles are "responder", "recapitulator", and "reporter" (Wadensjö, 1998: 91-92). A "reporter's" role is "to memorize for repetition words just uttered by another speaker", while a role of "responder" is "to take discourse further by introducing content of their own, or at least- by back-channeling, gazing, etc.- to make salient that they accept being so addressed" (Wadensjö, 1998: 92). A "recapitulator" role, in Wadensjö's view, is "to take over the floor, and then, when subsequently speaking, to recapitulate what was said, giving an authorized voice to a prior speaker or group of prior speakers" (Wadensjö, 1998: 92).

More recently, the analysis of Merlini and Favaron (2003, 2005) relies on the combination of Goffman's "participation framework" (with the hearer roles as "addressed" and "unaddressed") and "production format" (with speaker roles as "principal", author" and "animator") with Wadensjö's (1998) "reception format" (with three listening modes as "responder", "recapitulator" and "reporter") (Merlini and Favaron, 2003: 219). They broaden the previous models and suggest a new one based on "the interconnection between the speaker's alignment to the interpreter (in other words, whether or not h/she addresses the interpreter) and the response of the interpreter as subsequent speaker (for instance, his/her use of direct or indirect speech)" (Merlini and Favaron, 2003: 219). In this regard, Merlini and Favaron connect the interpreter's assumed hearer and speaker modes, that is, the interpreter's alignment to the other interactants "as expressed by pronoun use and choice of address" (Pöchhacker, 2012: 56). In the model of Merlini and Favaron (2005: 280) the footing of "principal" refers to the interpreter as "initiator of a communicative act". It means that, the interpreter commences a conversation or produces an utterance when there is no utterance by the primary interlocutors related to the interpreter's utterance. The interpreter's answers to the utterance of a primary speaker, regardless of being

explicitly addressed or not, refers to the footing of “responder”. When the interpreter addresses to the other participants directly by using first-person singular, s/he choose the footing of “reporter”. However, when the interpreter shifts from first-person singular to the third-person, s/he also shifts from the footing of “reporter” to that of “narrator”. By doing so, s/he also takes a distance from the speaker. Likewise, the interpreter might choose to use first person plural and eliminate the distance between the speaker and herself/himself and thus choose the footing of “pseudo-co-principal” (Merlini and Favaron, 2005: 279- 280). Even so, by using third person plural, the interpreter behaves as if s/he took sides with the primary speaker. Lastly, Merlini and Favaron provide two categories of the interpreter’s choices between the first-person and the third-person. When the interpreter renders the primary speaker’s utterance to the other party by using the first-person singular, then s/he adopts the footing of “direct recapitulator”. However, when the interpreter uses the third-person singular, then s/he adopts the footing of “indirect recapitulator” by keeping his or her distance from the other interlocutors (Merlini and Favaron, 2005: 279- 280).

All in all, this study has been inspired from the above-mentioned influential studies which paved the way for a new paradigm in interpreting studies. Thus, in addition to the role expectations and perceptions of stakeholders, this study also aims at demonstrating the interactional dynamics as well as verbal and non-verbal components in triadic interactions in detail by basing the analysis on Goffman’s (1981) ‘participation framework’, Wadensjö’s (1998) ‘reception format’ and even Merlini and Favaron’s (2003 and 2005) combined model of both (see Chapter 5).

CHAPTER THREE

ANALYSIS OF USER EXPECTATIONS AND PERCEPTIONS OF ROLE

Following an in-depth discussion of literature review, methodology and theoretical framework of the present study, this chapter now investigates the interpreter's role in healthcare settings with the data obtained from the users through questionnaires, which constitute expectancy norms in relation to the issue of role. To this end, a total of 33 questionnaires were distributed to the users in private hospitals and clinics based in Ankara and Izmir, 22 of whom are medical doctors and 11 of them are hospital executives. First, a description of purpose and design of the questionnaires will be demonstrated, followed by demographic information of the users. The results will be discussed within the scope of expectancy norms under different headings related to the role. The findings obtained from the users in this chapter will be analyzed, compared and contrasted in the next chapter with the analysis of interviews with healthcare interpreters. In other words, *the expectancy norms* revealed by the users in this chapter will be sought in the interpreters' answers and to what extent *the professional norms* are construed by the interpreters will be scrutinized.

3.1. PURPOSE AND DESIGN OF QUESTIONNAIRES

The questionnaires prepared in Turkish includes 23 questions and 25 questions for the hospital executives and the doctors, respectively. In addition to the demographic information of the users, the questions were on the issues of qualifications, quality, role, task, status, and position with a view to eliciting the users' preferences and expectations. The questionnaires are composed of multiple-choice questions, questions based on five-point scale, and one open-ended question at the end of the questions, soliciting further comments (see Appendix). The questions submitted to the doctors and hospital executives as well as asked to the interpreters were parallel to each other in order to compare their results. The questions were asked in Turkish, then all the questions stated here in the Figures and in the text were translated from Turkish into English.

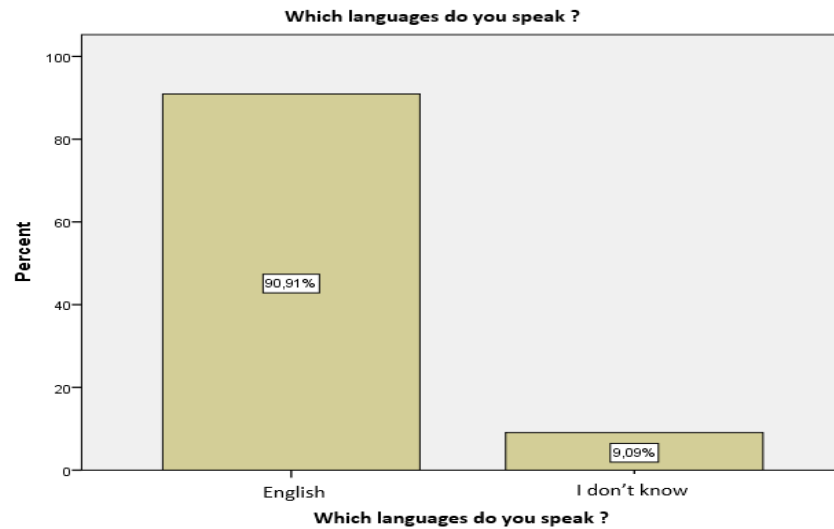
3.2. PARTICIPANTS

Similar questions were asked to the both groups, i.e. doctors and hospital executives in order to be able to compare their answers. However, a few demographic questions were specific and different for each group. In general, age, sex, foreign language knowledge and level were asked to the users. In addition, the hospital executives were asked how many years they have been working as a hospital executive and additional questions regarding the recruitment process were asked. Each data set of demographic information of the doctors and hospital executives will be presented separately.

3.2.1. Demographic Information of Medical Doctors

A total of 22 medical doctors working in private hospitals and clinics in Ankara and Izmir filled out the questionnaires. The doctors were reached through personal contacts and a snowballing method. Out of 22 doctors, only 7 are female, the remaining 15 doctors are male. The doctors were between 29 years and 75 years old. With regard to their foreign language knowledge and level, more than %90 of doctors indicated that they speak English and only %9 asserted that they do not speak any foreign language, which could also be seen in the Figure below.

Figure 1: Foreign Language Knowledge of the Doctors

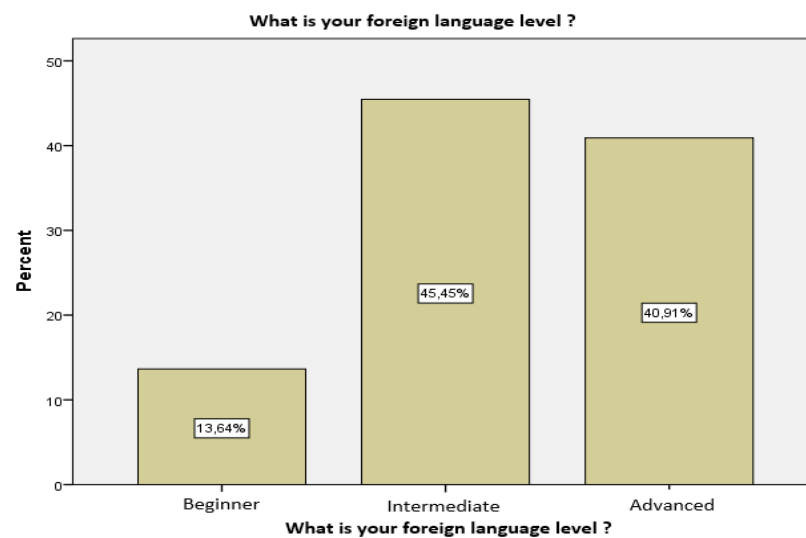


Source: Prepared by the Author.

However, three doctors indicated that they could speak other languages in addition to English. One doctor could speak English and German, one could English and Swedish, while the other doctor could speak English, Russian, and Azerbaijani.

When it comes to their foreign language level, many doctors (45,45%) surmised that they are intermediate in English.

Figure 2: English level of the doctors



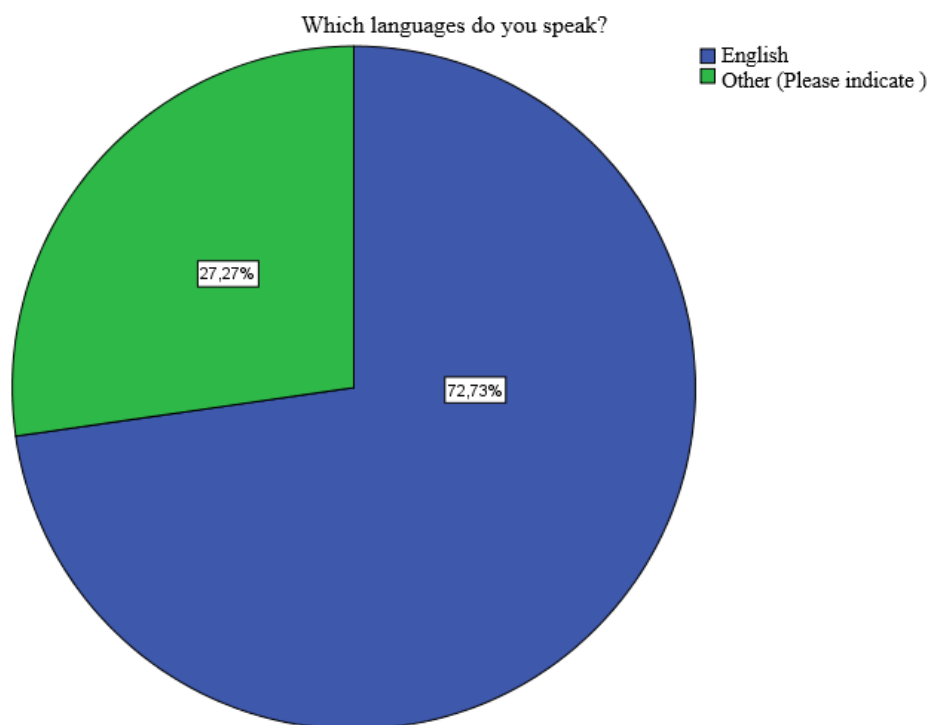
Source: Prepared by the Author.

%13,64 of them indicated that they are beginner and %40,91 are advanced. Thus, a larger proportion of doctors are not capable of communicating with foreign patients on their own. At this point, interpreters play an important role by providing flawless communication between the parties. The doctors who could speak second, or even third language indicated that they have either intermediate or advanced level of foreign language.

3.2.2. Demographic Information of Hospital Executives

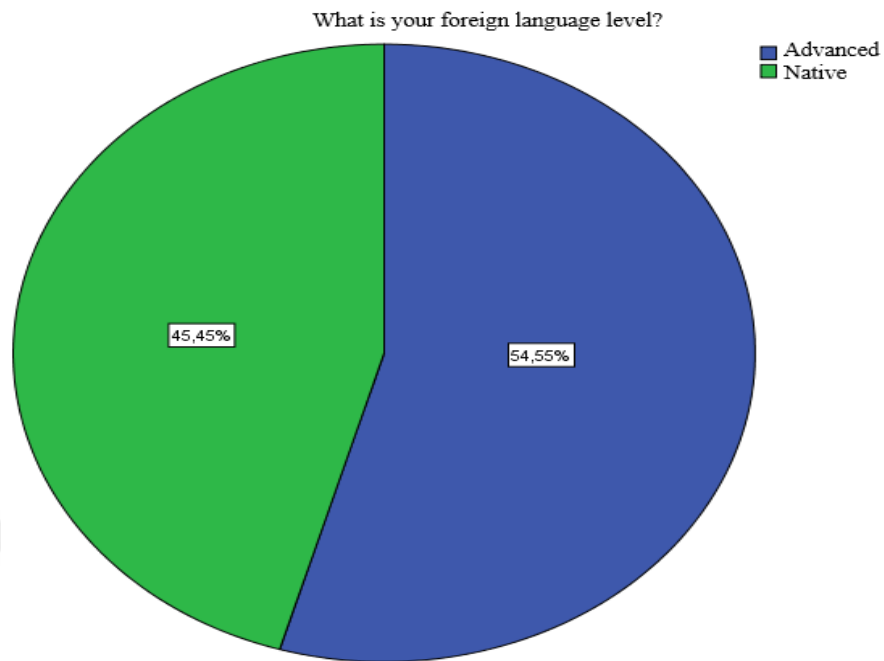
11 hospital executives were submitted questionnaires. 6 of the hospital executives are female, while 5 of them are male. Their ages range from 27 to 52. Almost all executives (8 executives out of 11) asserted that they could speak English (see Figure 3) and have a very good command of it (see Figure 4). Apart from English, some executives could speak Russian, Arabic, Ukrainian, French, or Spanish. 5 executives are native speakers, while 6 of them are advanced.

Figure 3: Language Knowledge of the Hospital Executives



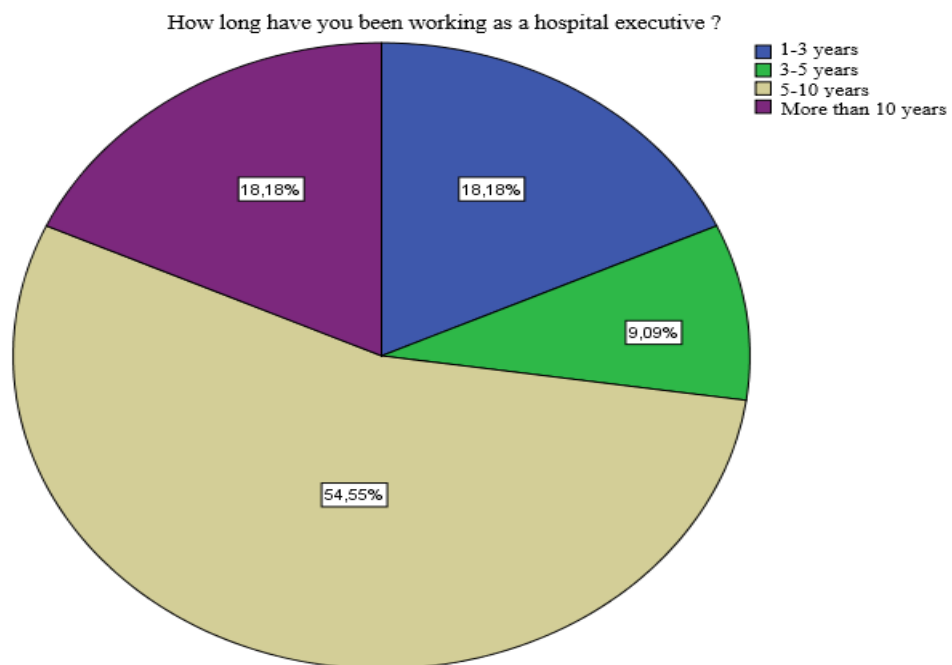
Source: Prepared by the Author.

Figure 4: English Level of Hospital Executives



Source: Prepared by the Author.

Figure 5: Work Experience of the Hospital Executives



Source: Prepared by the Author.

As can be seen in Figure 5, more executives (6 out of 11 executives) work for 5-10 years in the sector as an executive.

3.3. DATA ANALYSIS

3.3.1. Expectancy Norms

The answers given by the doctors and the hospital executives will be discussed first, followed by the analysis of its implications for this study. Expectancy norms with regard to eligibility, role, quality, as well as positioning will be searched and analyzed. In this study, the term “norm” is regarded as general values and ideas shared in relation to the interpreter’s qualifications in healthcare settings. In other words, the responses of the doctors and the executives constitute their expectancy norms and are analyzed and discussed together with regard to the differences and similarities between the two.

The answers of the users given to each sub-section revealed inconsistencies in terms of their expectations and perceptions of the interpreter’s role in healthcare settings. It might be evaluated as an indicator of the fact that the users have an ideal interpreter image in their mind who is a neutral and uninvolved agent. However, they expect and perceive the interpreter more than neutral agent in practice. Thus, this chapter attempts to unfold and discuss the inconsistencies with regard to the issue of role.

Furthermore, the findings pertaining to quantitative data obtained from the questionnaires given to the doctors and the hospital executives will be used to compare and verify the qualitative data obtained from the interviews with healthcare interpreters. All findings of quantitative and qualitative data will be triangulated in the following chapter where actual interpreting performances and triadic interactions as well as power dynamics between the parties will be scrutinized.

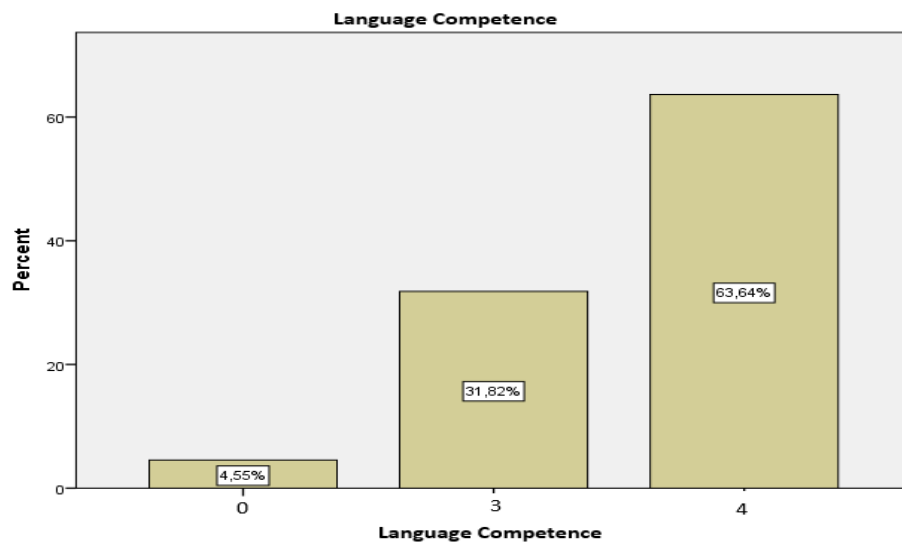
3.3.1.1. Eligibility

One of the questions posed to the users deals with the users’ preferences of the interpreter’s eligibility or qualifications since it gives important cues regarding their perceptions of interpreters. A number of qualifications were listed in order for the

doctors and the hospital executives to rank their importance on a scale from 0 (= the least important) and 4 (= the most important). 5 qualification criteria were presented: Language competence, Training in the field of translation and interpreting, Medical terminology knowledge, Cultural background knowledge, and Experience in the field. While the doctors and the hospital executives agreed on the “language competence” as the most important eligibility qualification, they dissented when it comes to the order of importance of the other qualifications. They adopted different approaches towards the eligibility criteria for the interpreters. The doctors, on the one hand, looked from their own perspective by emphasizing “terminology”, “training in the field”, the hospital executives, on the other hand, adopted more institution-oriented approach by placing more importance on “cultural background knowledge” and “experience in the field” following the criterion “language competence” since the interpreter’s knowledge of both target and source culture as well as his/her experience in the field come to the fore as crucial criteria for reinforcing the patient’s satisfaction, thus, attracting more patient to the hospital and gain money.

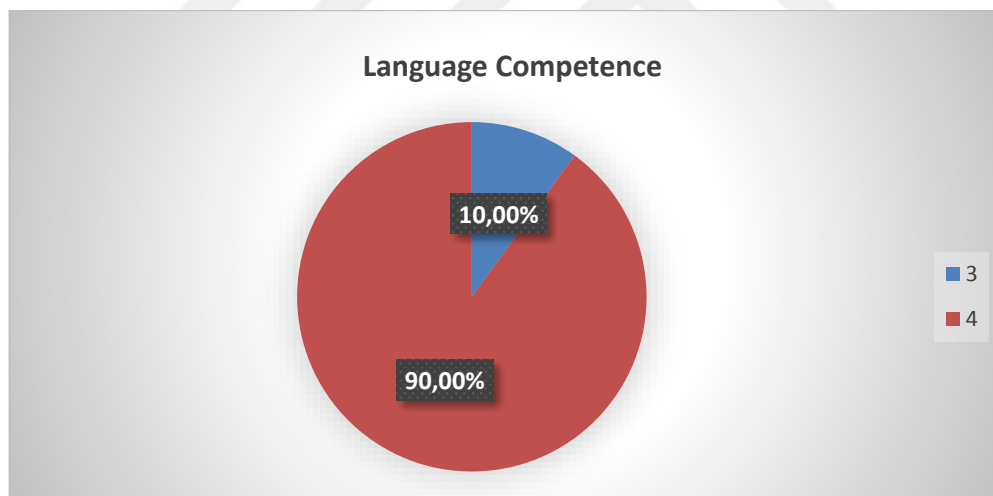
The criterion of “**language competence**” is the mere eligibility qualification on which both users shared the same opinion. A large number of doctors and hospital executives regarded the criterion of “language competence” as the most important criterion, with 95,46% saying it is “very important” or “the most important” in total. 14 doctors out of 22 (63,64%) rated it 4 and indicated that it is the most important criterion. In the same way, almost all hospital executives (10 out of 11 executives) rated it as “very important” or “the most important” criterion (see Figure 6 and 7).

Figure 6: Doctors' Ratings of the Criterion of "Language Competence"



Source: Prepared by the Author.

Figure 7: Hospital executives' Ratings of the Criterion of "Language Competence"

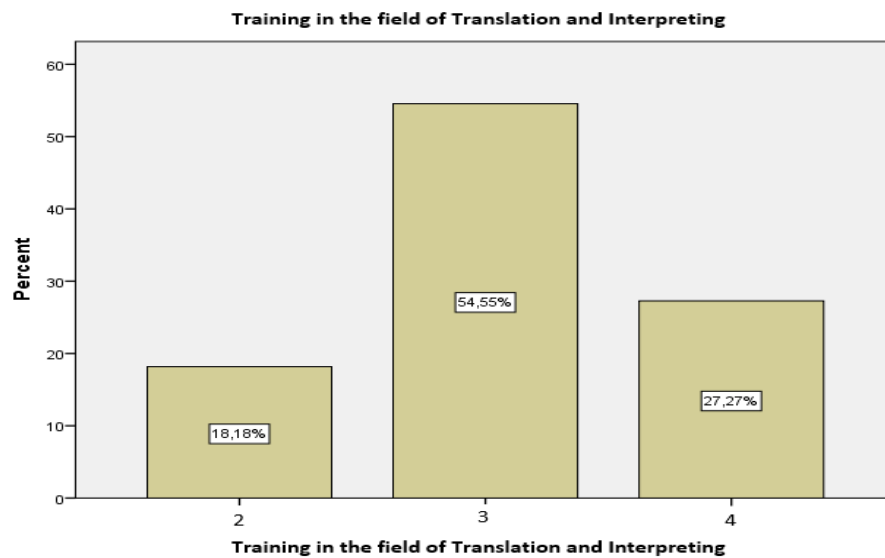


Source: Prepared by the Author.

However, there is a divergence in the ratings of the doctors and the hospital executives for the criterion of **"training in the field of translation and interpreting"**. Most of the doctors (%81,82) comprehended it "very important" or "the most important", rating it 3 or 4, whereas a larger number of hospital executives (88,89%) regarded it "moderately important" or "less important", rating it 1 or 2. That is why, the executives tend more likely to think training in the field less important than

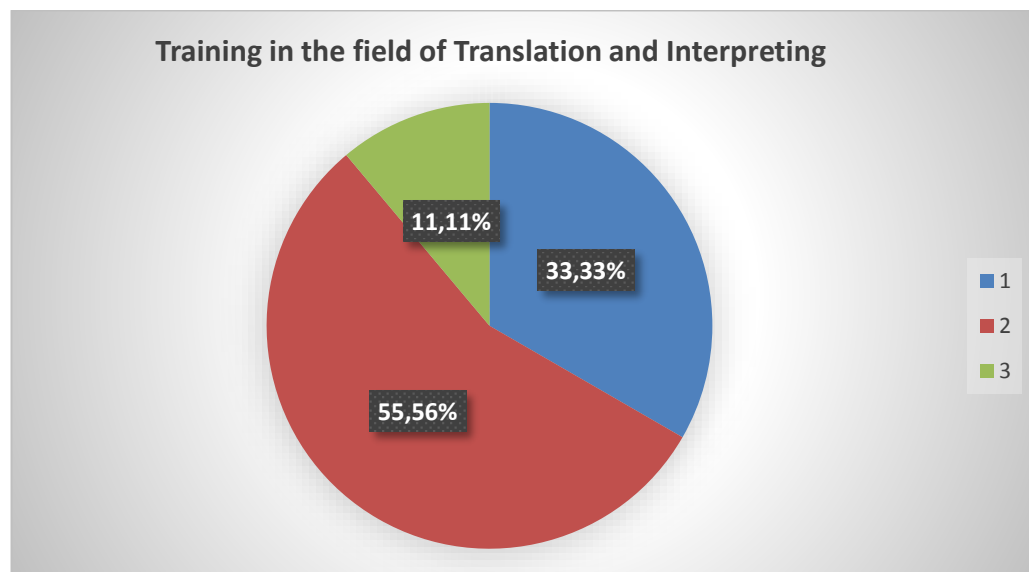
language competence (see Figure 8 and 9), which might account for the recruitment of untrained interpreters.

Figure 8: Doctors' ratings of the criterion of "Training in the field of translation and interpreting"



Source: Prepared by the Author.

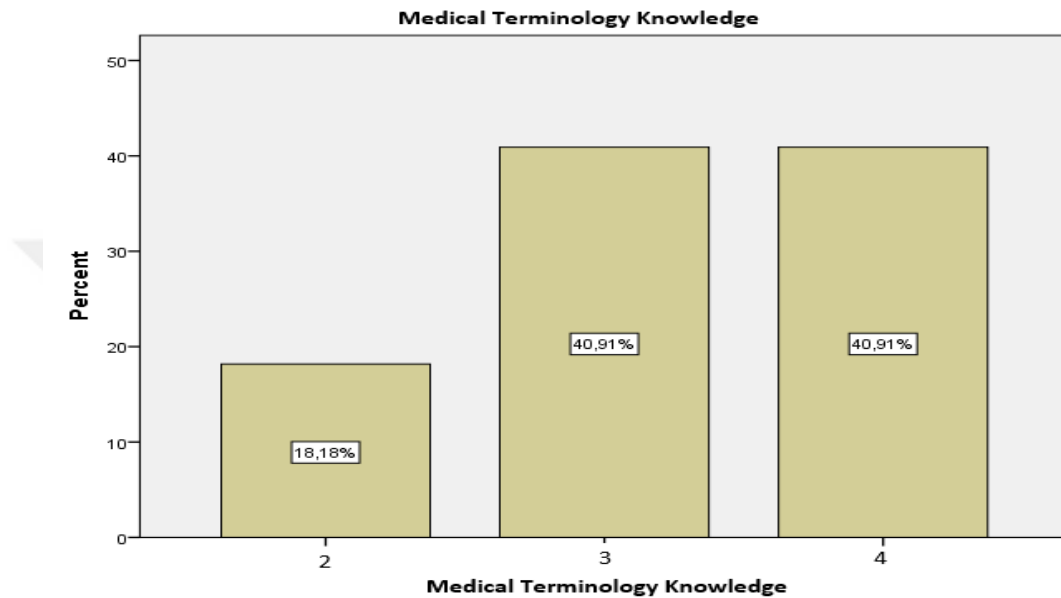
Figure 9: Hospital executives' ratings of the criterion of "Training in the field of translation and interpreting"



Source: Prepared by the Author.

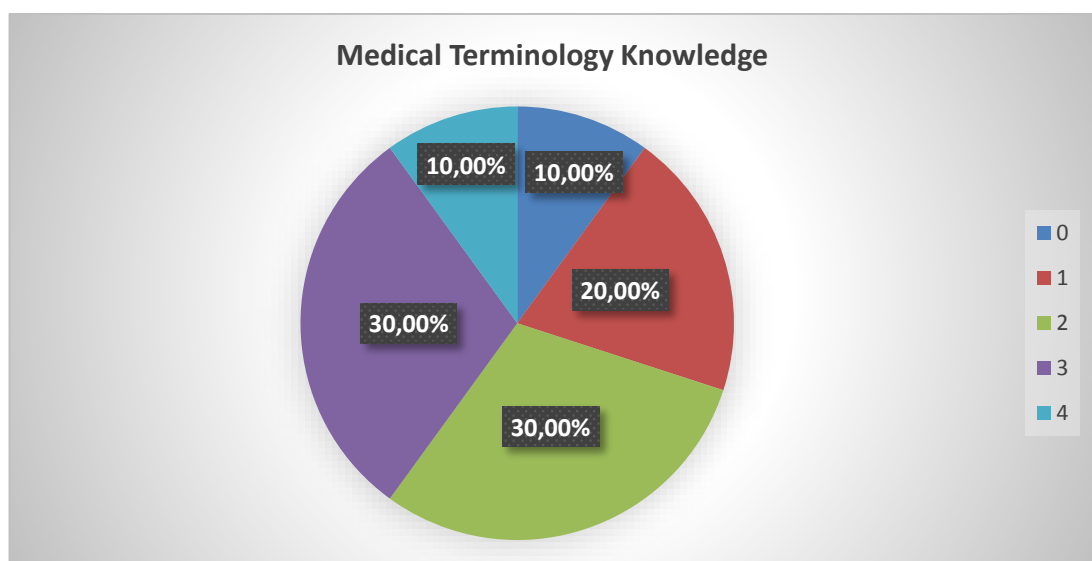
Similar results were again obtained in the criterion of “**medical terminology knowledge**”. The doctors (81,82%) proved that they attach importance to terminology knowledge by rating it 3 or 4.

Figure 10: Doctors’ ratings of the criterion of “Medical terminology knowledge”



Source: Prepared by the Author.

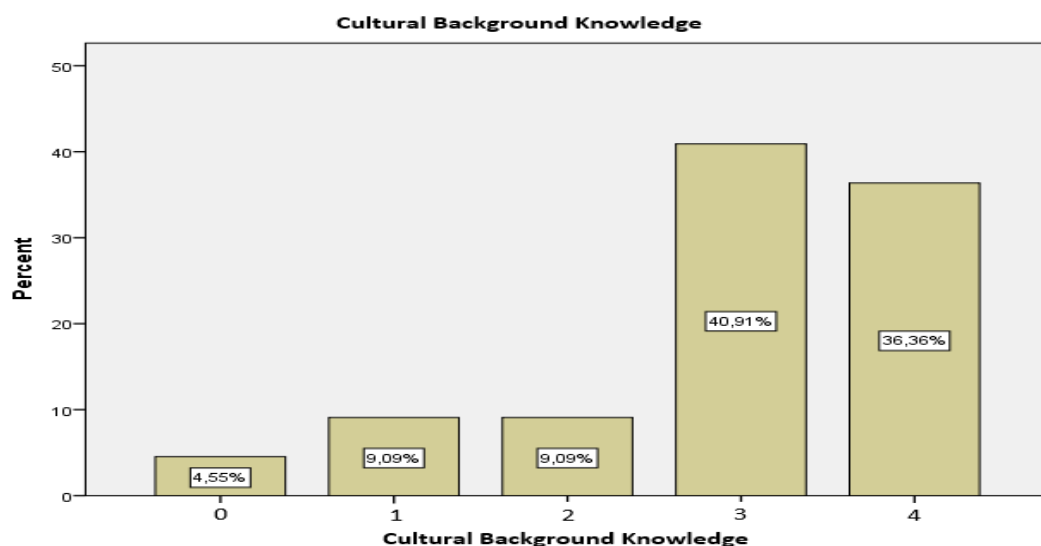
Figure 11: Hospital executives’ ratings of the criterion of “Medical terminology knowledge”



Source: Prepared by the Author.

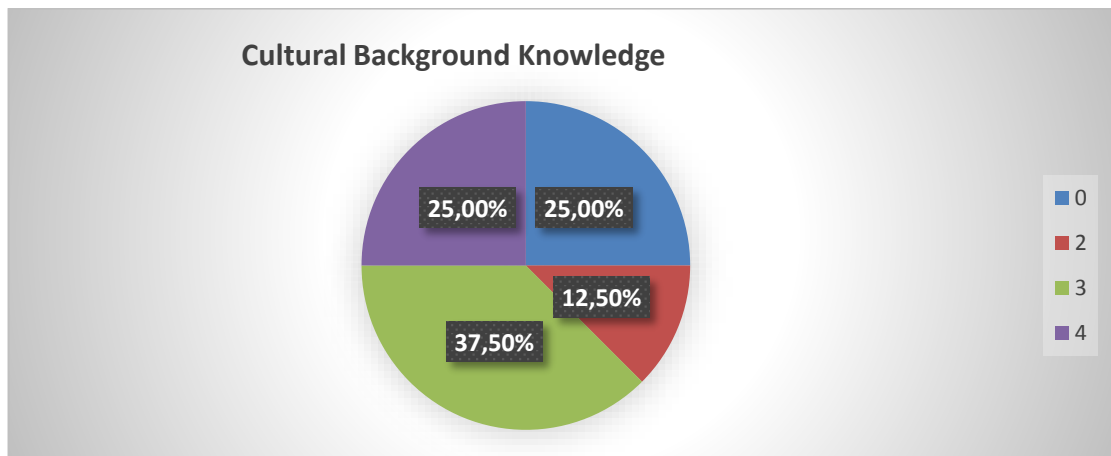
However, the hospital executives' results show that they do not share the same opinion. Despite the balanced ratings, more executives (60%) consider terminology knowledge less important, rating it 0, 1 or 2 (see Figure 10 and 11). Like terminology, language competence, and training in the field, **“cultural background knowledge”** was also of great importance for the doctors. More than half of the doctors (77, 27%) believe that it plays an important role in interpreter's qualifications, saying that it is “very important” or “the most important”. Especially one doctor draw attention to the significance of culture in financial terms during the encounters with foreign patients. He specifically asserted that he likes joking to the patients. However, he also complained about the fact that when the interpreter interprets the doctor's wordings, the patients do not laugh at all and as a consequence, the patient chooses another doctor to be operated, which leads to a potential patient loss for the doctor. Hence, the doctor prefers the interpreter to transfer the core message and style of the original speech in a way that could enable the patient to laugh. On the same issue, most hospital executives (62,5%) agreed on the importance of cultural background knowledge, even though quarter of the hospital executives consider it the least important criterion by rating it 0 (see Figure 12 and 13).

Figure 12: Doctors' ratings of the criterion of “Cultural background knowledge”



Source: Prepared by the Author.

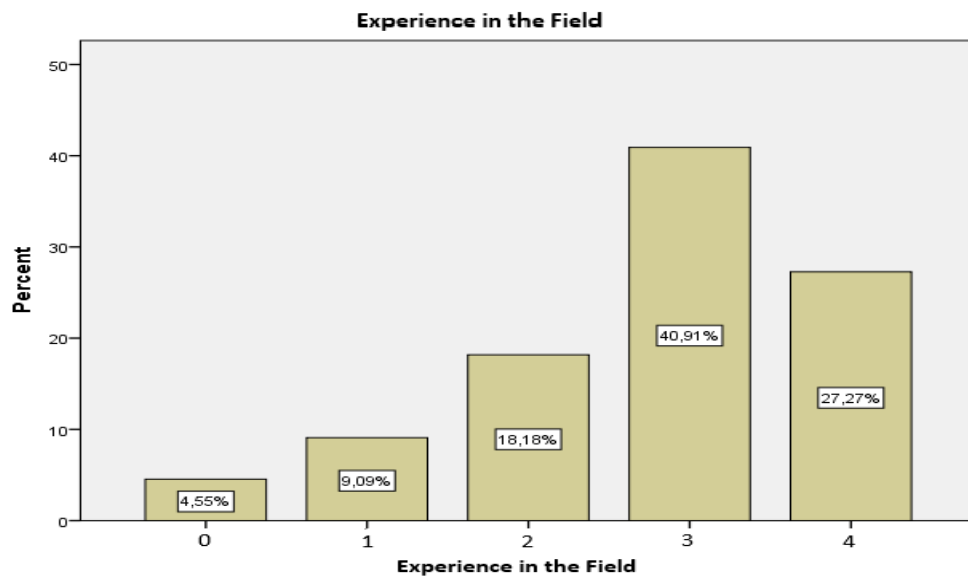
Figure 13: Hospital executives' ratings of the criterion of "Cultural background knowledge"



Source: Prepared by the Author.

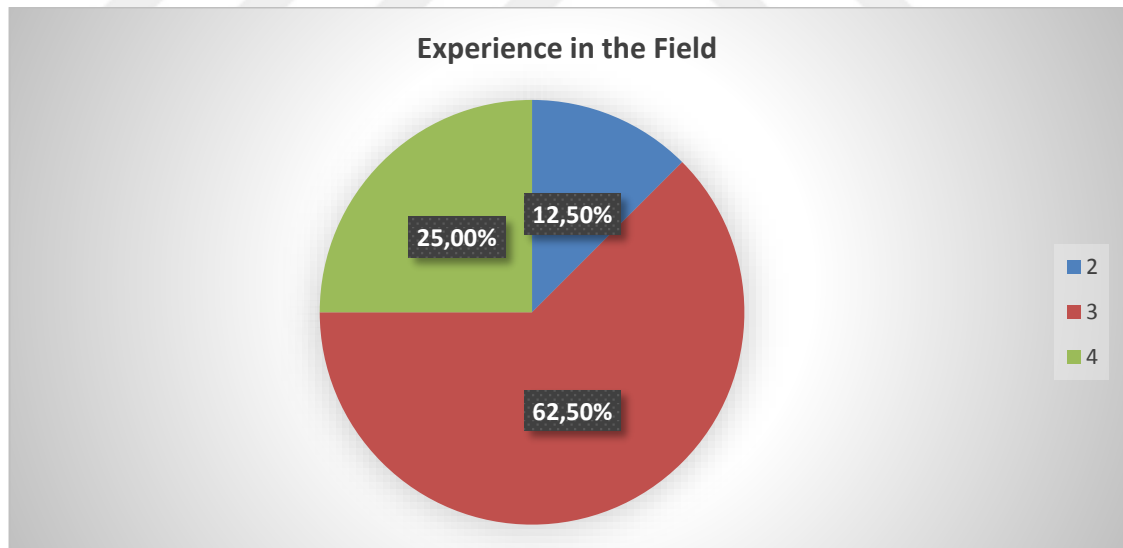
Another criterion on which both doctors and hospital executives agreed is **"experience in the field"**. A vast majority of hospital executives (87,5%) and medical doctors (68,18%) said that it is either "very important" or "the most important" criterion in healthcare interpreting. When the ratings are taken into account as a percentage, it becomes obvious that hospital executives paid greater attention to experience in the field than the doctors.

Figure 14: Doctors' ratings of the Criterion of "Experience in the field"



Source: Prepared by the Author.

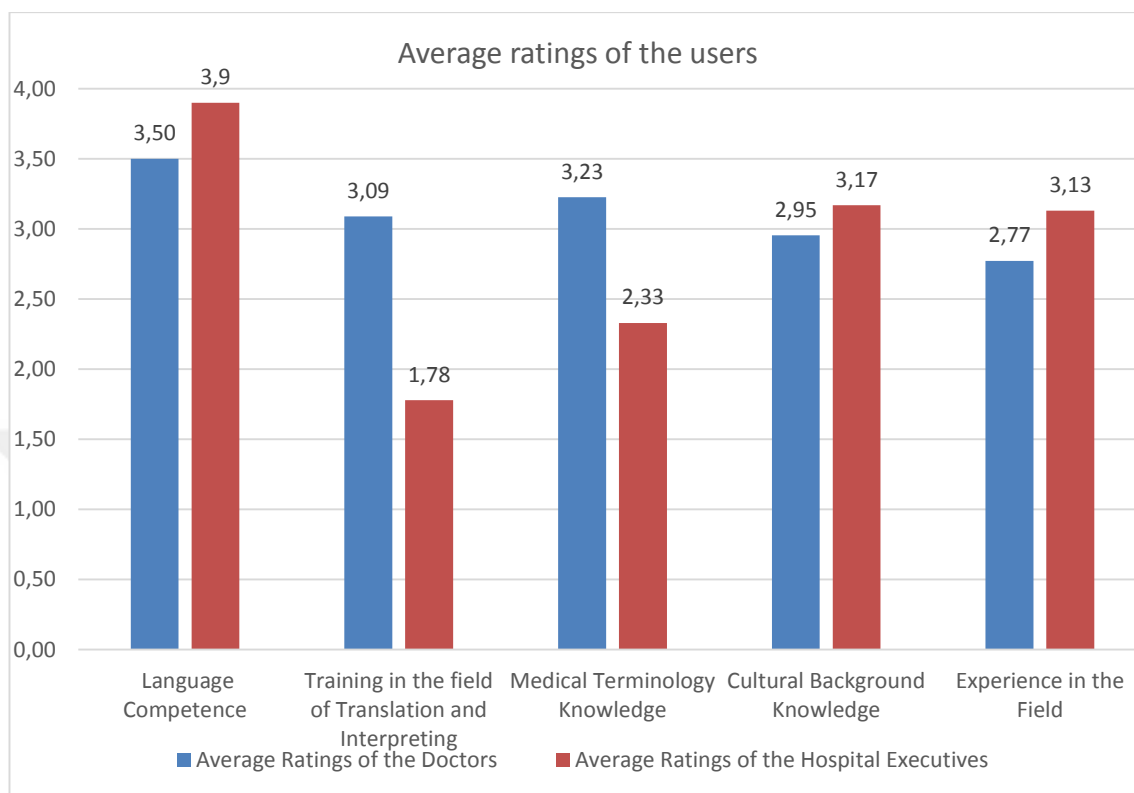
Figure 15: Hospital executives' ratings of the criterion of "Experience in the field"



Source: Prepared by the Author.

In addition to the analysis of detailed individual ratings of the users for the eligibility criteria stated above, the users' average ratings for each criterion also need to be calculated and evaluated together as shown in Figure 16 below. The intent was here to compare and rank the users' results.

Figure 16: Doctors and hospital executives' average ratings of eligibility criteria, where 0 is the lowest and 4 is the highest



Source: Prepared by the Author.

Displaying the average ratings of the users above, it is possible to determine which criteria come forward and which ones are regarded not important at all.

Language competence was obviously top priority of the users and ranked first both by the doctors and the hospital executives among five eligibility criteria for the interpreters. The doctors' average rating was 3,5 and the hospital executives' rating was 3,9 on a scale from 0 to 4. Nearly all executives said that the interpreter should first have a language competence, as one would expect in any kind of interpreting setting.

Language competence was followed by **medical terminology knowledge** as regarded as the second important criterion by the doctors for the interpreter's eligibility for being healthcare interpreter. Surprisingly, hospital executives did not consider that the interpreter's medical terminology knowledge as important as the doctors did and it was ranked 4th overall. This divergence between the doctors' and the executives'

ratings on the issue of terminology might be because of the fact that the doctors commonly use medical terminology during the encounters not only with foreign patients, but also with the local ones. Thus, the interpreter is expected to understand and transfer the terminology thoroughly uttered by the doctors, which is of great importance in terms of patient's well-being and treatment process. However, this results clearly show a lack of awareness with regard to medical terms on the executives' sides. It reveals that the executives do not care about the correct usage of the medical terms. In other words, it might mean that if the interpreter makes a mistake about the misinformation of any medical term, that would easily be forgiven by the executives.

Another huge divergence between the ratings occurred on the criterion of **the training in the field**. It was ranked third overall by the doctors, whereas it was ranked last by the hospital executives. Nonetheless, this kind of ignorance might cause the interpreter to take wrong and unethical decisions on critical cases, since training is an important factor in guiding the interpreter's decision-making process. This, in turn, might cause decrease in the service quality. Such degradation of the quality is also related to the doctor's medical treatments, who is a significant actor in the triadic encounters. It might culminate in a lack of confidence of the patient to both doctor and the institution.

Even though the criterion **"cultural background knowledge"** of the interpreters was regarded important by the doctors, it was ranked fourth overall, while it was ranked second by the hospital executives. The executives apparently view this criterion more important than the others, after language competence. However, the doctors yielded different opinions than the executives. The reason of this criterion regarded the second important criterion might be because of the fact that if the interpreter could possess both cultures' components, s/he could make the patient feel at home. Thus, the satisfaction of the patients might increase, so does financial gains of the institution, which reveals the executives' institution- oriented approach.

The criterion ranked last by the doctors was **experience in the field**. It was voted 3,13 on average and ranked third by the executives and 2,77 by the doctors out of 4. It shows that the executives considered experience in the field as a more significant eligibility criterion than the doctors did since it might facilitate the decision-

making process of the interpreters at critical points and increases the patient's satisfaction.

To sum up, both doctors and executives expected the interpreter to have a very good command of language. Following that, they exhibited divergences in their expectations. The executives were towards the criteria which might strengthen the patient and interpreter relationship with the help of the interpreter's knowledge of both cultures and experience in the field. The doctors, at the other end of the spectrum, highlighted the terminology knowledge and training of the interpreter, which might strengthen the interpreting service provided.

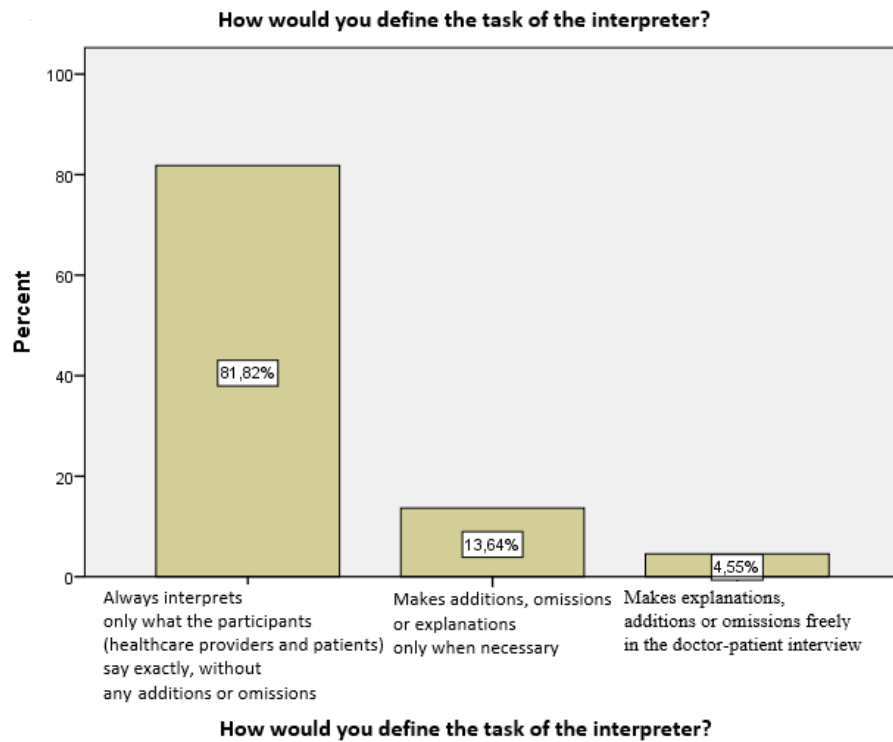
3.3.1.2. Role

Four interrelated questions were asked in order to unveil the expectancy norms shared by the users with regard to the role of the interpreters. These questions include the interpreter's role, tasks, expectations and status perceptions of the users. The data obtained from the transcripts detected huge inconsistencies in the users' answers and proved the role conflicts the users experienced within themselves. At first glance, both doctors and executives described the interpreter as a "translation machine" and "conduit" (Bot, 2007: 82) who exerts no power in the interactions. However, when the same question was asked in another way, they accepted that the interpreter is an "active participant" (Wadensjö, 1998) who shapes and controls the interaction, which also proves the fact that they approved the power the interpreter possesses. In the following question posed regarding the tasks of the interpreter, they persisted their ideas that a vast majority of users declared they expect the interpreter to assume various roles within the hospital, which will be discussed in terms of its consistencies and inconsistencies below.

The first question in this section (Question 11 for doctors, Question 12 for executives) asked the users to describe the task(s) of the interpreters in healthcare settings. There were three options, first of which was "The interpreter always interprets what the participants (healthcare providers and patients) say exactly, without any additions or omissions". The second option was "The interpreter makes additions,

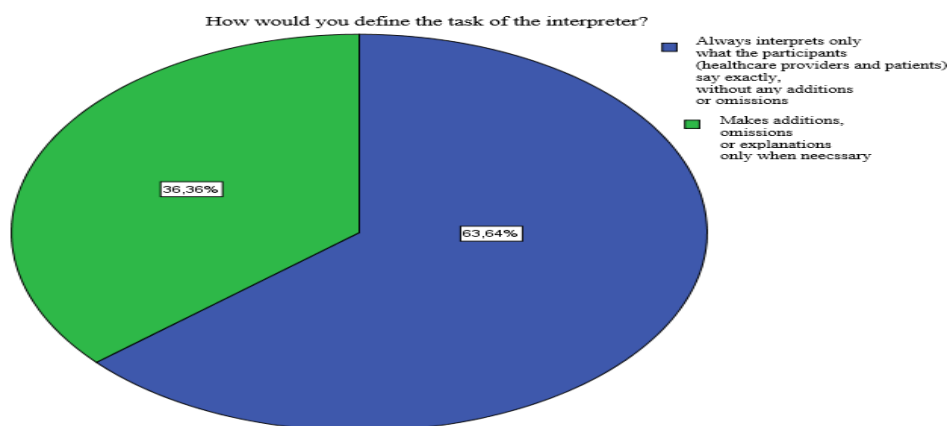
omissions or explanations only when necessary”. The last option was “The interpreter makes explanations, additions or omissions freely in the doctor- patient interview”.

Figure 17: Question 11, doctors’ descriptions of tasks of the interpreter



Source: Prepared by the Author.

Figure 18: Question 12, hospital Executives’ Descriptions of Tasks of the Interpreter

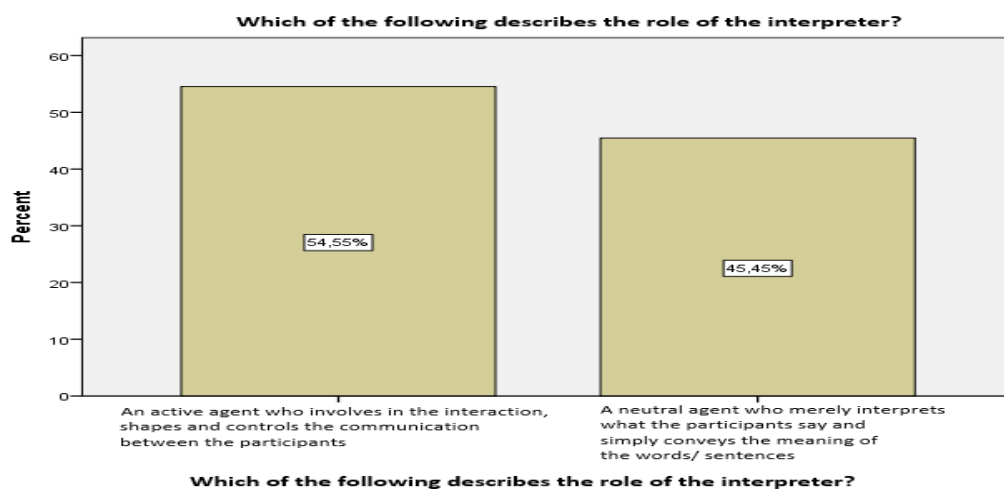


Source: Prepared by the Author.

As seen in Figure 17 and Figure 18, 18 out of 22 doctors (81,82%) and 7 out of 11 hospital executives (63,64%) clearly indicated that “The interpreter always interprets what the participants (healthcare providers and patients) say exactly, without any additions or omissions”. This result shows a clear tendency towards the users’ perceptions of the interpreter as a “translation machine” (Bot, 2007), which refers to literal, word-for-word translations. An overwhelming majority of the doctors and the executives seem to expect the interpreter only to transfer the words, not the meaning. Thus, the parties should make an inference from the interactions on their own. However, it should not be ignored that this kind of translation might lead to inaccurate translations since it ignores the pragmatic dimension of language (Hale, 2007: 42).

To take this issue further, Question 12 (in questionnaire for doctors) and Question 13 (in questionnaire for hospital executives) were directed to reveal the users’ role perceptions of the interpreters. This question and the previous one is especially crucial for this study as they associate directly to the active role and involvement of the interpreter, striving to find out whether the users preferred the interpreters to play an active role or stay as neutral agents. The users were presented two options: “[The interpreter] is an active agent who involves in the interaction, shapes and controls the communication between the participants.” and “[The interpreter] is a neutral agent who merely interprets what the participants say and simply conveys the meaning of the words/ sentences”.

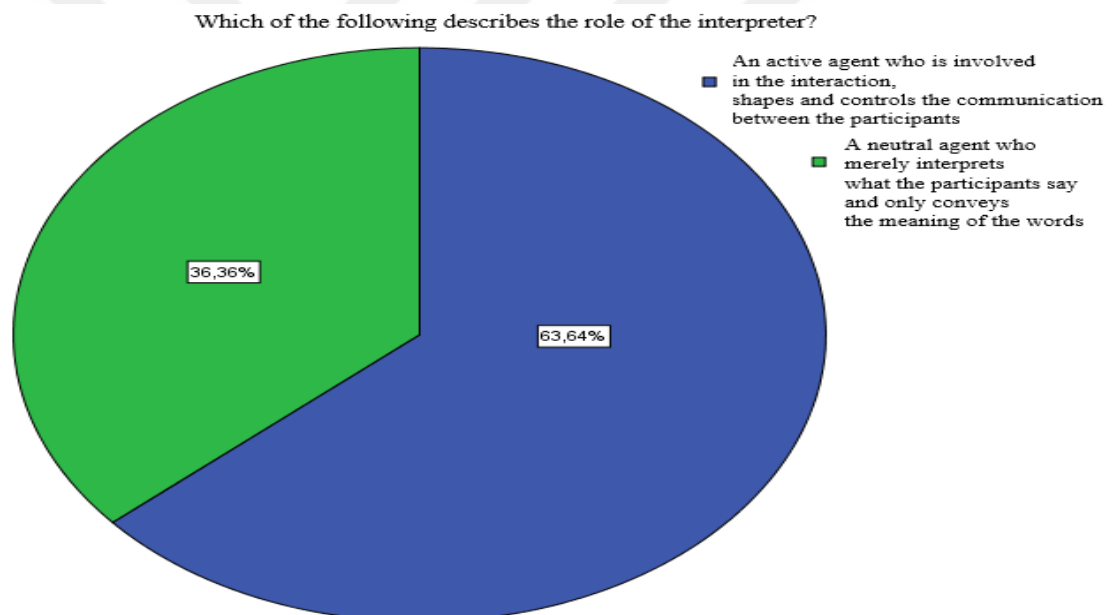
Figure 19: Question 12, Doctors’ Role Perceptions of the Interpreter



Source: Prepared by the Author.

The answers of the doctors in the Figure 19 show that there is a slight difference between the ratings for the two options. While 12 doctors (54,55%) thought that the interpreter is an active participant who not only transfers messages, but also coordinates and shapes the interaction, which indicates the interpreter's involvement in the interaction, 10 doctors (45,45%) thought the opposite side that the interpreter should only convey the words of the parties without involving in the process, which refers back to the metaphor of “translation machine”. When this question was asked to the hospital executives, a higher percentage of the executives than the doctors perceived the interpreter as an active participant during the interaction (see Figure 20).

Figure 20: Question 13, Hospital Executives' role Perceptions of the Interpreter



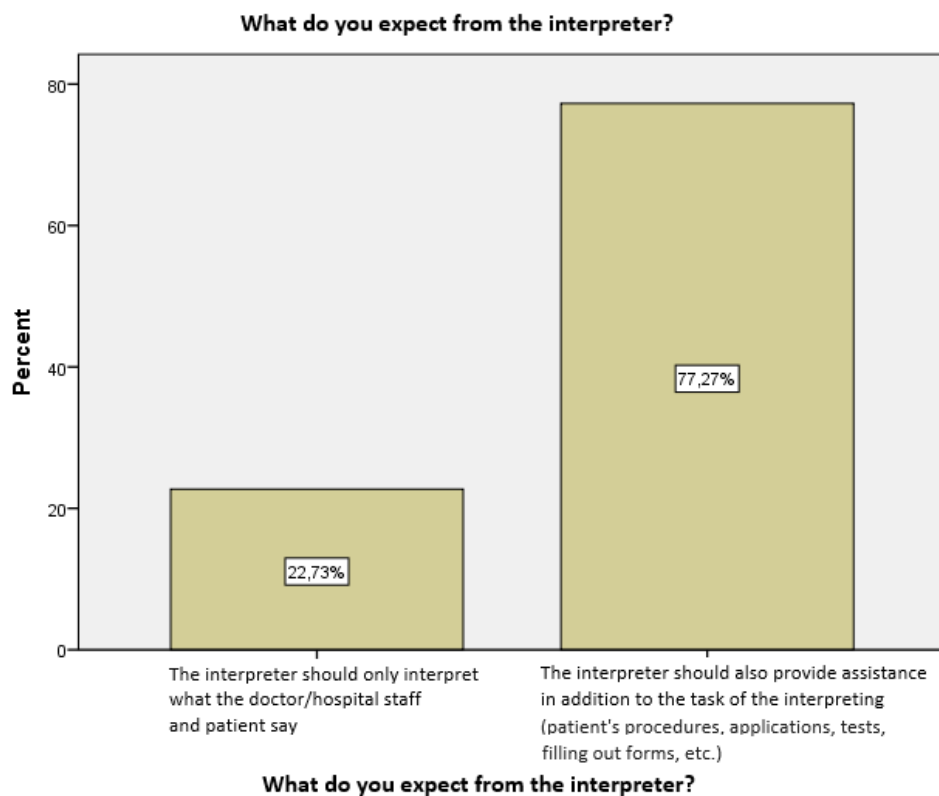
Source: Prepared by the Author.

Still, these results put forward an undeniable fact that users perceive the interpreter as an active participant, not as a translation machine. This result is especially striking because it contradicts with the previous results where the vast majority of the doctors and the executives considered interpreters as neutral and uninvolved agents (see Figure 17 and Figure 18).

When asked what the users expect from the interpreters in terms of their tasks within the hospital, the alternatives given to them were: “The interpreter should only

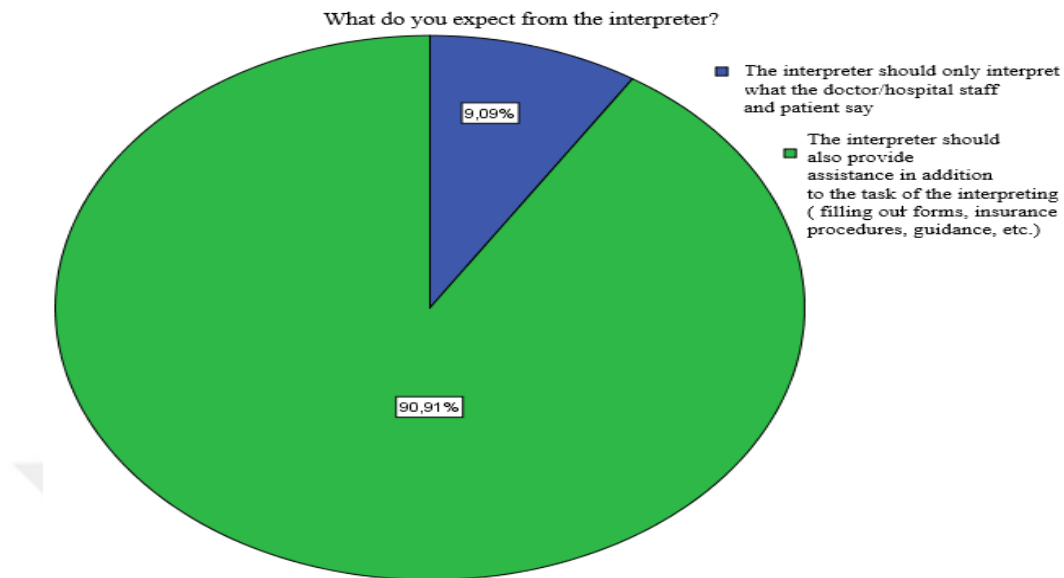
interpret what the doctor/ hospital staff and patient say” and “The interpreter should also provide assistance in addition to the task of the interpreting”. A total of 17 doctors (77,27%) and almost all hospital executives (10 executives out of 11) preferred the interpreter to undertake and deal with responsibilities apart from the task of interpreting. The answers given to this question clearly illustrate that the users expect the interpreters to go beyond just interpreting and undertake many other responsibilities such as dealing with insurance claims or forms of the patients and guiding the patients during the hospital procedures, etc. (see Figure 21 and Figure 22).

Figure 21: Question 14, Doctors’ Expectations From the Interpreters



Source: Prepared by the Author.

Figure 22: Question 14, Hospital Executives' Expectations From the Interpreters

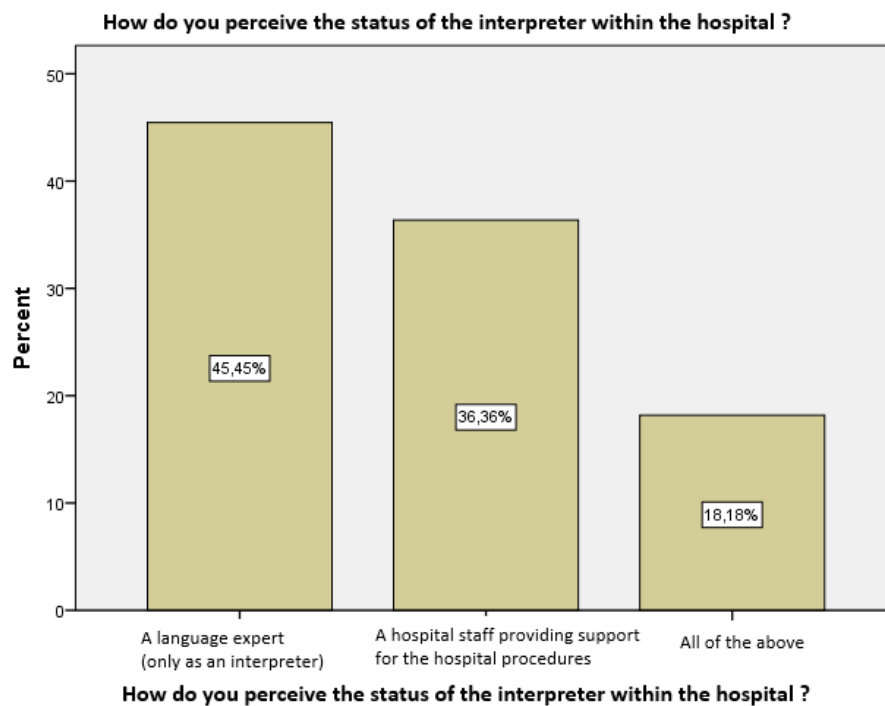


Source: Prepared by the Author.

This shows that it is appropriate for the interpreters to take these responsibilities regardless of whether they have been trained to give such kind of assistance to the patients. This clearly indicates the tendency of the users towards the perception of the interpreter's role as a hospital attendant, guide, counsellor, etc. instead of an "interpreter".

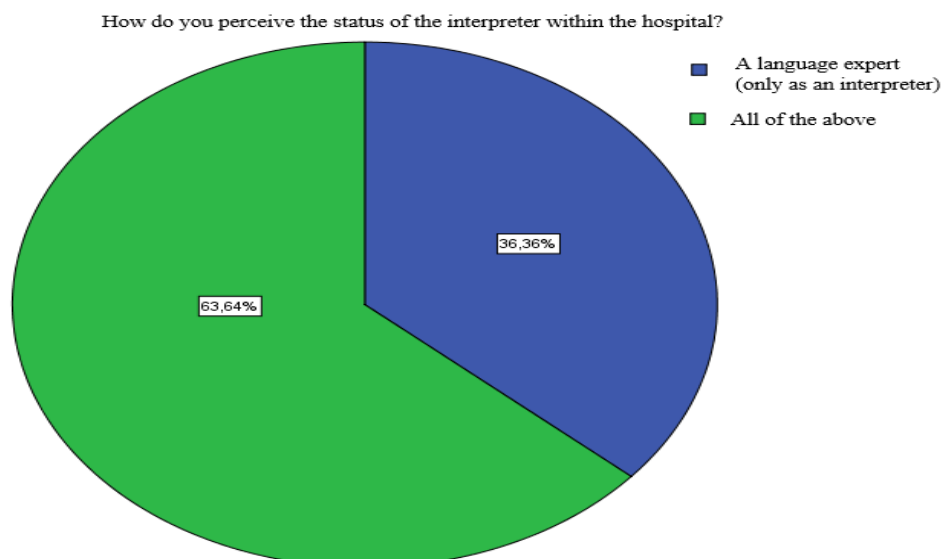
The last question on the issue of role was almost the same with the above questions in order to reveal the users' status perceptions of the interpreters. The users had four options to choose: the interpreter is "an expert with his/her medical terminology knowledge", "an expert with his/her language capabilities (only as an interpreter)", "a hospital staff giving support for the hospital procedures", and "all of the above".

Figure 23: Question 23, Doctors' Status Perceptions of the Interpreter



Source: Prepared by the Author.

Figure 24: Question 22, Hospital Executives' Status Perceptions of the Interpreter



Source: Prepared by the Author.

In this part of the question, there is a divergence between the answers of the users. When looked at the results of the doctors, it can be figured out that there is a modest difference between the second alternative and the third alternative. 10 doctors (45,45%) perceived the interpreter as a language expert who only deals with the interpreting process, while 8 doctors (36,36%) perceived the interpreter as a hospital staff who are also responsible for other tasks in addition to interpreting and 4 of them (18,18%) chose the last alternative in which the interpreter is assumed to be an expert both in language and medical terminology as well as deals with the hospital procedures. Yet, more doctors tended to think the interpreter only as a language expert. It comes again as a surprise since it contrasts with the results obtained from the doctors' expectations (see Figure 23). A vast majority of doctors clearly accepted their expectations from the interpreters not only as a language expert but also as a hospital staff being responsible for a lot of tasks within the hospital. Now their answers to this question revealing that a higher percentage of them perceive the interpreter only as a language expert are in stark contradiction.

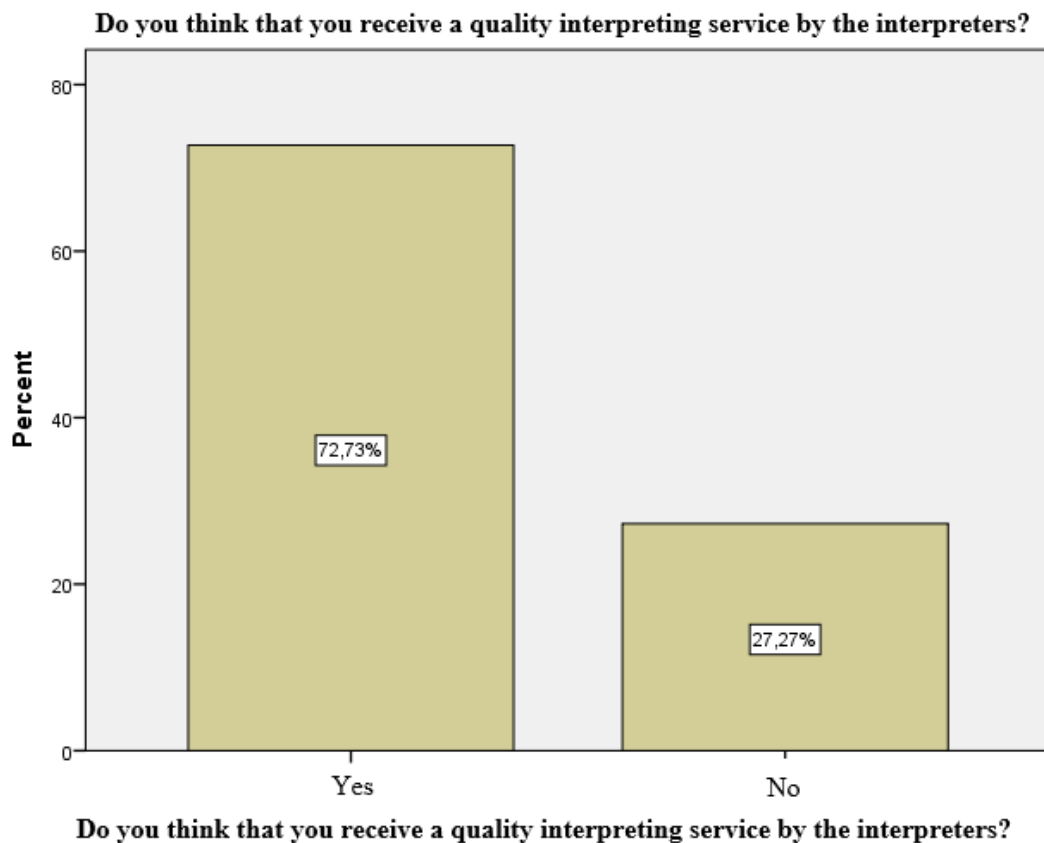
This situation is not valid for the answers of the hospital executives. A great majority of the hospital executives (63,64%) clearly chose the last option in which the interpreter is regarded not only as a language expert or medical terminology expert but also the one who conducts all kinds of procedures of the hospital. In this regard, their answers to this question get along with their expectations from the interpreters.

To wrap up the outcomes gathered in this section, it can certainly be alleged that there were tricky questions so as to be able to demonstrate the real views of the users. Thus, the same or similar questions were asked in different ways in order to understand the user perceptions as such. Thus, it seems that this approach has worked, and some contradictory answers were obtained from the users. While the users seem to depict the interpreters more as translation machines, the following questions elicited great variations in their answers in that they seem to perceive the interpreters more than just being "interpreters" who perform various tasks and assume active roles in shaping the interactions. All these inconsistencies in the answers show that there is not yet a full awareness regarding the role of the interpreters among the doctors and an inhouse training might be useful at this point.

3.3.1.3. Quality

Questions 9 and 10 (for the doctors) and Question 11 (for the hospital executives) attempted to find out the users' expectations and perceptions of quality in healthcare interpreting. Moreover, since the doctors are the ones who are important participants in triadic interactions, they were additionally asked to evaluate the quality of interpreting service in terms of their general satisfaction. In Question 9, it was asked whether the doctors think that they receive a quality interpreting service by the interpreters.

Figure 25: Question 9, Doctors' Opinions of the Quality of Interpreting Service Provided



Source: Prepared by the Author.

As can be seen in the above figures, 16 doctors (72,73%) thought that they receive a quality interpreting service. Only 6 doctors (27,27%) said “sometimes”

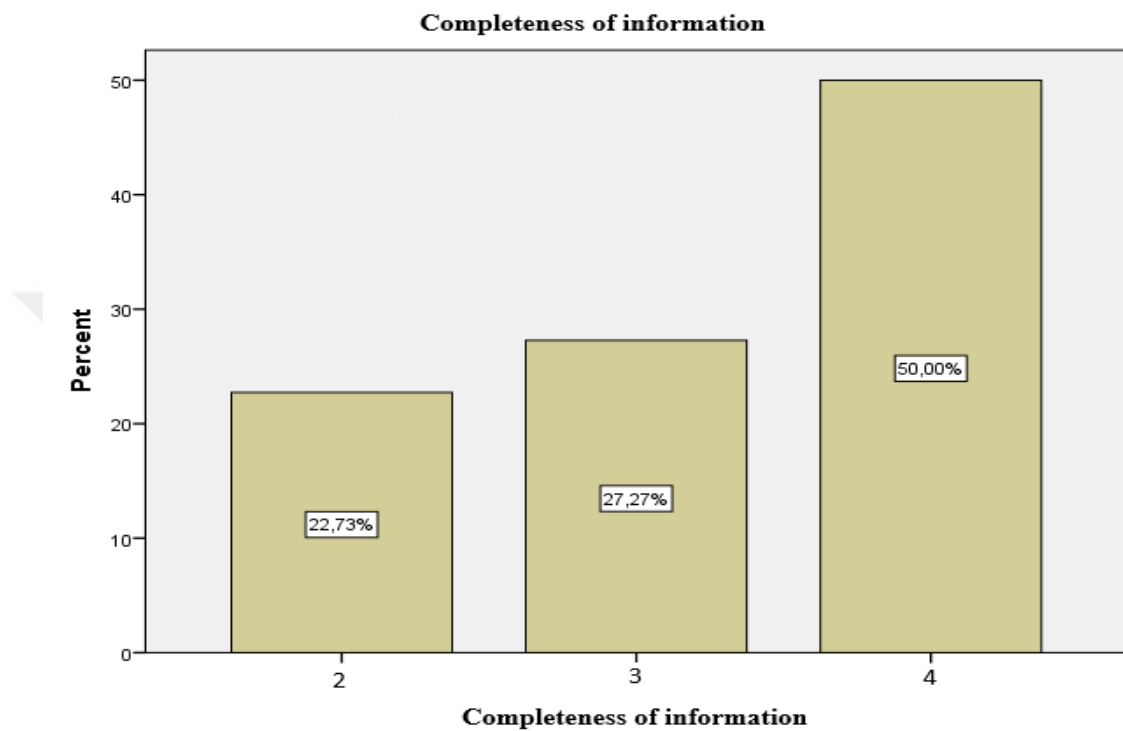
indicating they think that they are not always provided a high quality of interpreting service and get sometimes problems. To delve into this issue, the users were further asked to rank the quality criteria in accordance with their importance. They were provided 4 options: Completeness of information, Fidelity to the original speech, Fluent delivery, Correct terminology usage. The quality criteria ranked by the users brought the fact to light that the users have different expectations and attitudes towards the interpreters. While the doctors perceived the interpreter more as a transmitter of a message correctly and completely, the hospital executives expected more than that. According to the doctors, the most important two quality criteria were “fidelity to original speech” and “completeness of information”, which are interconnected to each other. The less important criteria were “correct terminology knowledge” and “fluent delivery”, respectively. This shows that the doctors expected the interpreter to render the utterances without any additions or omissions and considered “terminological knowledge” less important because they perceived themselves as the “authority” in the interaction. From the perspectives of the doctors it can be asserted that the doctors possess the information required encompassing terminological information. The interpreters are, then, merely expected to transfer this knowledge obtained from the doctors completely. Likewise, “fluency” was not considered as important as correct information transfer. In this scenario, the interpreter is perceived as an uninvolved, passive participant in the interaction.

The answers of the hospital executives revealed the fact that they comprehended the interpreter as more ‘authorized’ since they attached more importance on the criterion “correct terminology usage” than the doctors. Even though both doctors and hospital executives agreed on the cruciality of the criterion “completeness of information”, the executives had a shade of contradictory in their answers in that they ranked the “fidelity to original speech” as the least important criterion, while they remarked that “completeness of information” was their top priority.

The first quality criterion discussed is “**completeness of information**”. In the light of the ratings of the users, it can clearly be said that both the doctors and the hospital executives gave exactly the same answer and said that completeness of information is “very important” or “the most important” quality criterion. Both 77,77%

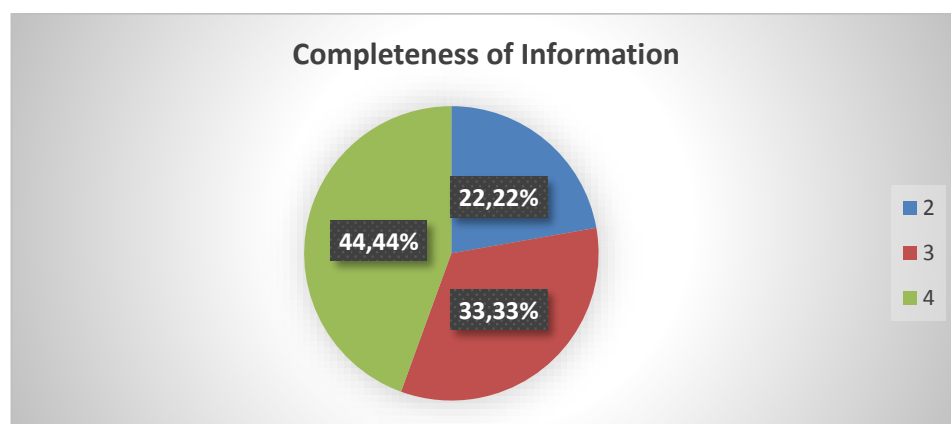
of the doctors and 77,77% of the executives rated it either 3 or 4 (see Figures 26 and 27).

Figure 26: Question 10, Doctors' Ratings of Quality Criterion of "Completeness of Information"



Source: Prepared by the Author.

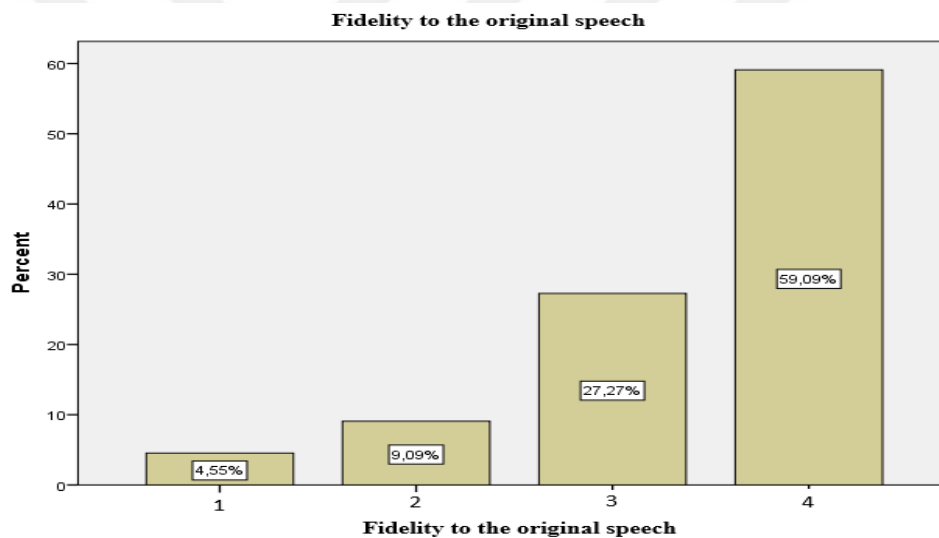
Figure 27: Question 11, Hospital Executives' Ratings of Quality Criterion of "Completeness of Information"



Source: Prepared by the Author.

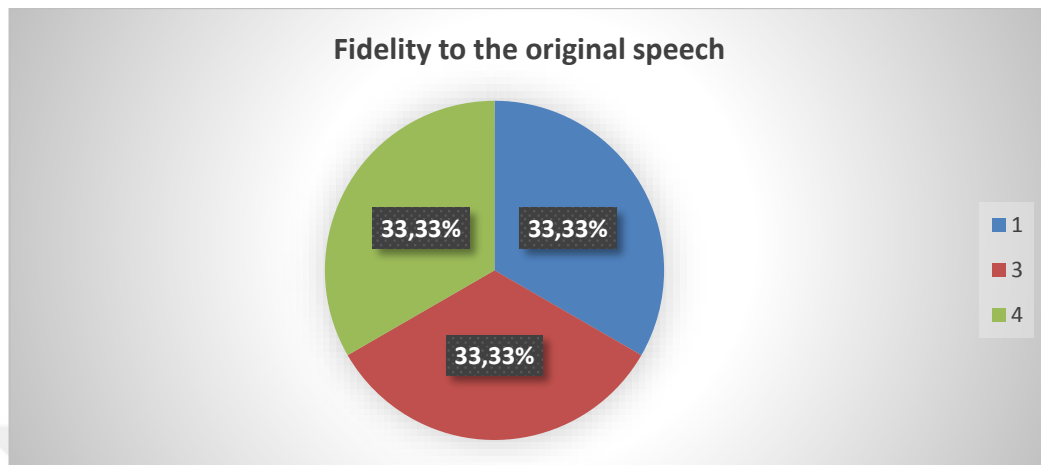
However, “**fidelity to original speech**” became more of an issue than the completeness of information. Alone more than half of the doctors (59, 09%) indicated that it is “the most important” quality criterion, while the majority of them (86,36%) rated it 3 or 4. Thus, there is no doubt that there is a tendency towards the right-handed side. The hospital executives, on the other side, have a homogenous rating between 1, 3 or 4. Even though majority of the executives (66,66%) intended it as an important criterion, there are also some of them (33,33%) who considered it not that important (see Figures 28 and 29).

Figure 28: Question 10, Doctors’ Ratings of the Quality Criterion of “Fidelity to the Original Speech”



Source: Prepared by the Author.

Figure 29: Question 11, Hospital Executives' Ratings of Quality Criterion of "Fidelity to the Original Speech"



Source: Prepared by the Author.

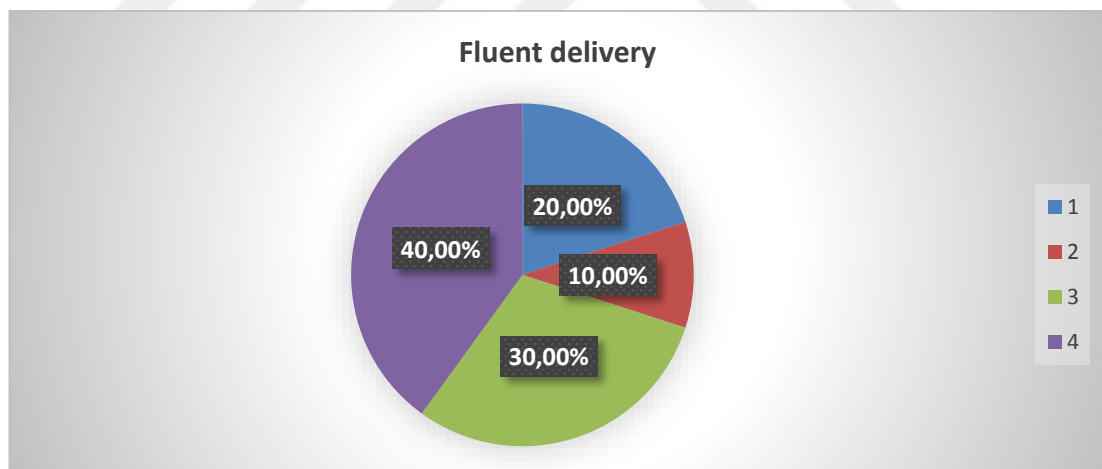
“Fluent delivery” was another category provided to be rated by the users. When it comes to the answers of the doctors, we can see that there is a decline in their ratings in percent. While “fidelity to the original speech” was rated 3 or 4 by 86,36% of the doctors and “completeness of information” was rated 3 or 4 by a total of 77,27%, “fluent delivery” was only rated 3 by 50% of the doctors and 4 by 18,18% of them, so a total of 60,18% of the doctors regarded it “very important” or “the most important”. This shows that the doctors did not regard the criterion of “fluent delivery” as important as the completeness of information and fidelity to the original speech. The hospital executives seemed to hold a different view on the fluent delivery of the interpreter. 40% of the executives rated it 4 as “the most important” criterion and 30% of them rated it 3 as a “very important” criterion. This demonstrates that hospital executives attached more importance to “fluent delivery” (see Figures 30 and 31).

Figure 30: Question 10, Doctors' Ratings of the Quality Criterion of "Fluent Delivery"



Source: Prepared by the Author.

Figure 31: Question 11, Hospital Executives' Ratings of Quality Criterion of "Fluent Delivery"

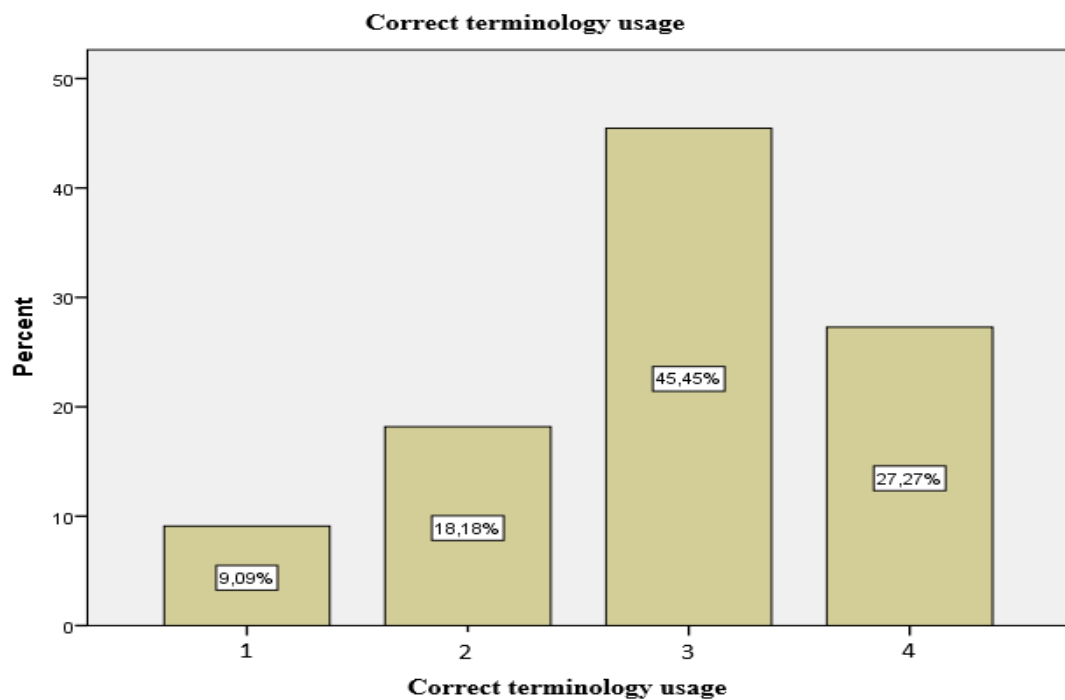


Source: Prepared by the Author.

The last option of quality criteria is **"correct terminology usage"**. More hospital executives (44,44%) considered it the most important quality criterion than the doctors (27,27%). Yet already, when looked at the ratings of 3 or 4 in total in percent, most of the doctors (72,72%) thought it as an important criterion than the executives (66,66%) (see Figures 32 and 33). This option was especially tricky for the users as to compare the results obtained in the eligibility criteria of the interpreter.

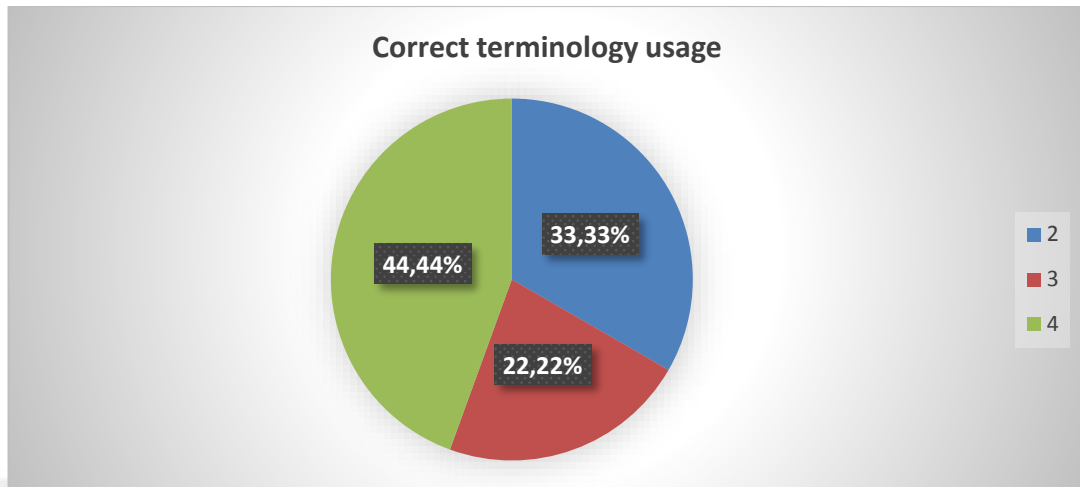
Similar option was also provided to be ranked in the eligibility part. And the result is astonishing. The hospital executives ranked the criterion of “medical terminology knowledge” fourth overall; however, we can see that generality of the executives (66,66%) rated it 3 or 4 (see Figure 33).

Figure 32: Question 10, Doctors’ Ratings of the Quality Criterion of “Correct Terminology Usage”



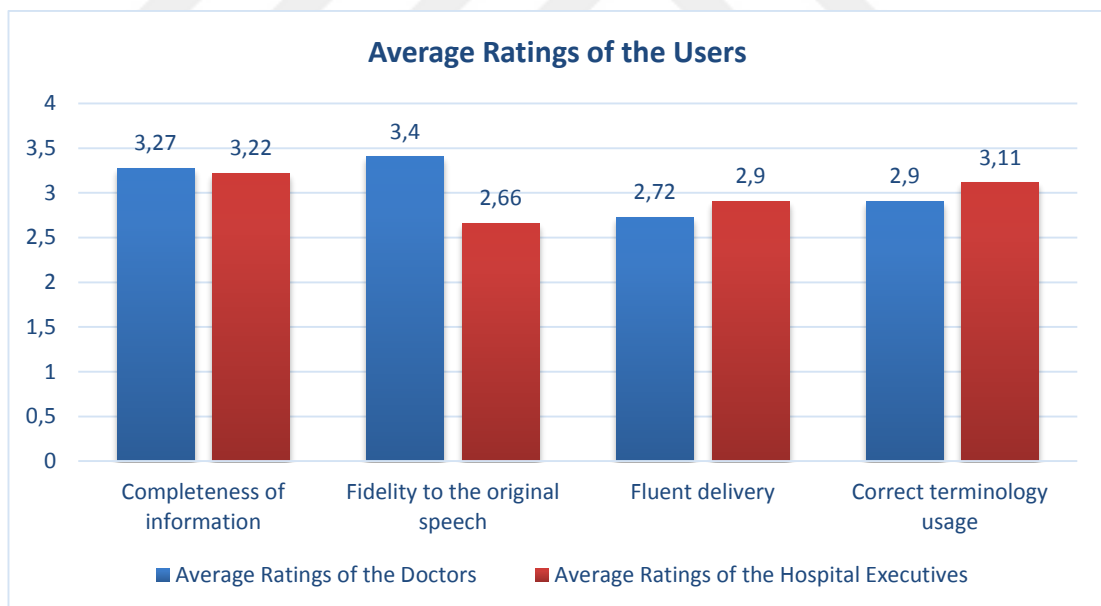
Source: Prepared by the Author.

Figure 33: Question 11, Hospital Executives' Ratings of Quality Criterion of "Correct Terminology Usage"



Source: Prepared by the Author.

Figure 34: Doctors and hospital executives' average ratings of quality criteria, where 0 is the lowest and 4 is the highest



Source: Prepared by the Author.

The average ratings of the users enable us to compare the results together. The scoring results are shown above, where 4 is the highest score and 0 is the lowest. In this regard, it can be said that there is no consensus on any of the quality criterion as a

top priority. For the doctors, **“fidelity to the original speech”** had the highest priority among the others. It was scored as 3,4 in average out of 4. However, quite interestingly, the hospital executives did not appear to hold the same opinion. An average score rated by the executives was only 2,66 and it ranked last among the other quality criteria. This means that the hospital executives are open to the interpreter’s additions, omissions, or alterations of the original speech.

The other quality criteria ranked second by the doctors is **“completeness of information”**. It comes as no surprise because completeness of information is already related to the fidelity to the original speech. We can certainly understand from this result that the doctors do not prefer the interpreter to make additions, omissions or to change anything of the source language, which turns the interpreter again into a “translation machine”. Surprisingly, the hospital executives also shared similar opinion on the completeness of information, and it was a top priority of them. Thus, it contradicts with the previous score since the two quality criteria are directly linked to each other. While fidelity to the original speech was ranked last, completeness of information was ranked first by the executives, which are completely dissimilar.

“Correct terminology usage” ranked second overall by the executives behind the completeness of information and ranked third by the doctors behind fidelity to the original speech and the completeness of information. The doctors’ average rating was 2.9 compared to 3,4 for fidelity to the original speech and 3,27 for the completeness of information. These average ratings point out that there is a sharp decline in this quality criterion. One can infer from this answer that the doctors do not concern about the correctness of the medical terms used by the interpreter. The executives valued using correct terminology more than the doctors. This result is remarkable since the executives ranked medical terminology knowledge fourth overall for the eligibility of the interpreter at the part 3.3.1.1. Now their average rating was 3,11 and ranked second.

“Fluent delivery” was ranked last by the doctors as the least important quality criterion and ranked third by the executives. The doctors do not seem to worry about the speech speed of the interpreter as long as s/he transfers the message of the source language as closely as possible. On the other hand, the executives viewed fluency more important than the fidelity to the original speech. They might consider that the doctors have a limited time during the encounters with the patients, so the interpreter should

be fluent in transferring the messages of the parties. This does not set time aside for the interpreter to ask for repetition, clarification, or something else, which needs a high qualification in a range of aspects for the interpreter.

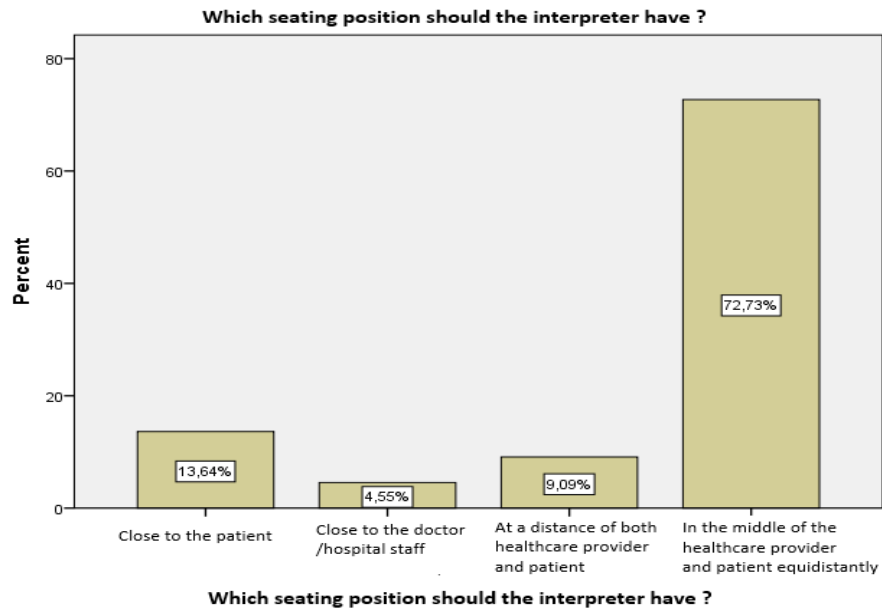
As a conclusion in this part, it can be said that the quality criteria and their order in importance gave enormous cues regarding the users' perceptions of the interpreter's role. The doctors did not think the interpreter as an "authorized" participant with his/her her medical terminology knowledge. Rather, the interpreter was considered as a transparent participant who merely transfers the messages of the parties completely. However, the executives expected the interpreter to have medical terminology knowledge, which puts the interpreter beyond transferring messages. The interpreter gains also a status of an "expert".

3.3.1.4. Positioning of the interpreter

Another category introduced for answers to the users is positioning of the interpreter. Positioning of the interpreter during the doctor-patient encounters is also a significant factor which might affect the involvement and visibility of the interpreter. In this sense, the interpreter's awareness regarding the power of his/her positioning is crucial. However, the users' preferences from the interpreters might also play a decisive role. A large number of doctors (72,73%) and all hospital executives expect the interpreter to stand "in the middle of the parties", signaling the principle of impartiality.

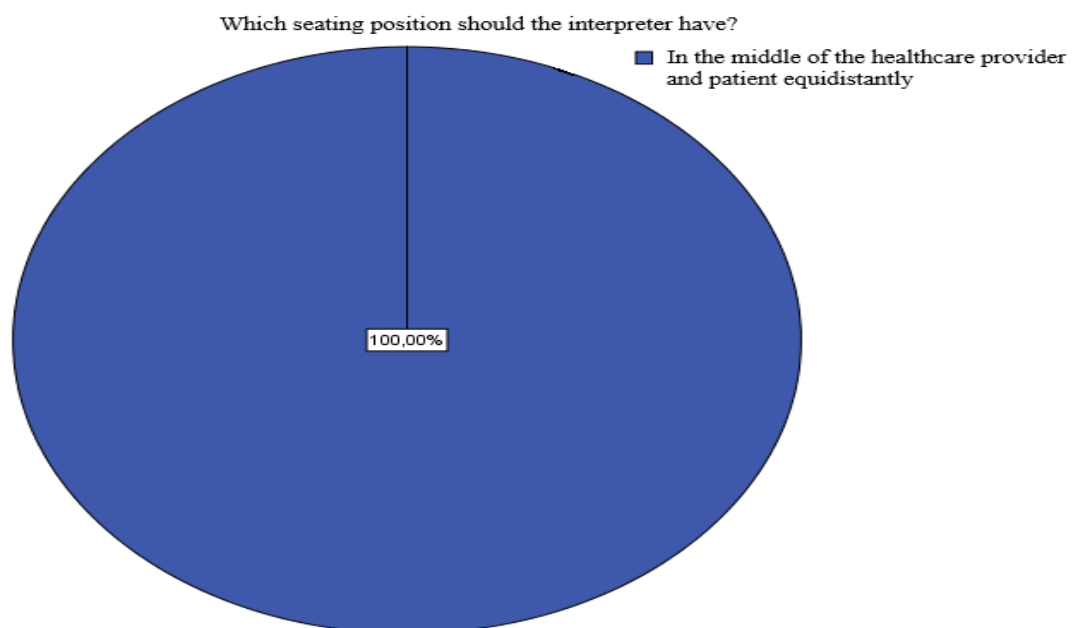
In order to obtain data to find out the users' expectations and preferences as regard to physical positioning, i.e., seating arrangements of the interpreters, Question 20 (for doctors) and Question 18 (for hospital executives) were asked which sitting position the interpreter should have. There were four options presented, which are "close to the patient", "close to the doctor/hospital staff", "at a distance of both healthcare provider and patient", and "in the middle of the healthcare provider and patient equidistantly".

Figure 35: Question 20, Doctors' Preferences of Seating Arrangement of the Interpreter



Source: Prepared by the Author.

Figure 36: Question 18, hospital Executives' Preferences Of Seating Arrangement Of The Interpreter



Source: Prepared by the Author.

As seen in Figure 35 and Figure 36, most of the doctors (72,73%) and all of the hospital executives (100%) prefer the interpreters to be in the middle of the parties. The answers given to this question seem to suggest that the users desire the interpreter to be an impartial, neutral and uninvolved agent during the interactions, which makes the interpreter invisible as well.

3.4. DISCUSSION

The quantitative data obtained through the questionnaires submitted to the users, i.e. doctors and hospital executives, provide an elaborative analysis of the users' perceptions regarding healthcare interpreters and the answers of the users shed light on the inconsistencies in terms of their expectations and perceptions of role. In the light of their responses, certain conclusions drawn are presented below.

The questions were asked to the users intentionally to elicit their perceptions and expectations, i.e. *expectancy norms*, in relation to the role of the interpreter in general terms. Within the scope of this purpose, several topics related to the issue of role were analyzed and discussed under the sub-headings. According to the results, there are certain points of divergence and convergence between the doctors and the executives.

The **eligibility criteria** for being healthcare interpreter was the first category of questions posed to the users. "Language competence" is the most important eligibility criterion to be a healthcare interpreter in terms of the users' perspectives. 14 out of 22 doctors and 10 out of 11 hospital executives clearly indicated that they have a strong expectation for an interpreter to have a good command of language, as one would expect in any kind of interpreting setting. Following the language competence, the users revealed different approaches. The least important two criteria selected by the executives, which are "medical terminology knowledge" and "training in the field", turn out to be the second and the third important eligibility criteria for the doctors. The divergence at this point might hint the differences in their perceptions. For instance, executives' rankings showed that they drive forward the interests of the institution with the interpreter's good command of both target and source cultures, which enables the interpreter to keep with good relationship with the patient. It might

also be reinforced with the interpreter's experience in the field, which is another point underlined by the executives but not by the doctors.

Another category investigated the **role** perceptions and expectations of the users, which entailed a number of inconsistencies within itself. Both doctors and the executives were detected to be in a contradiction while answering the questions with regard to the role of the interpreter, except one question. When asked how they describe the task of the interpreter, a large number of doctors (81,82%) and hospital executives (63,64%) said that the interpreter always interprets exactly what the participants say, without any additions or omissions. Thus, the interpreter is expected to be an uninvolved and invisible agent. However, a tricky question was posed after this question and the users were asked to define the role of the interpreter. Surprisingly, a majority of the users (54,55% of the doctors and 63,64% of the hospital executives) considered the interpreter as an active participant coordinating and shaping the interaction. Being an active participant might refer to the freedom given to the interpreter to make additions, omissions or alterations in order to coordinate the interaction and provide smooth communication. However, the users described the interpreter as an uninvolved agent, which was the exact opposite. Furthermore, the users indicated that the interpreter should not only conduct interpreting services between the parties during the interactions, but also provide support for additional tasks related to the patient. These expectations of the users imposed on the interpreter lead to the interpreter to play more than an interpreter role and to assume a range of roles of hospital attendant, a relative of the patient, a guide, or a representative, which are all beyond the role definition of the interpreter. In a similar vein, the users were further asked how to perceive the status of the interpreter within the hospital. This question is where the doctors and the executives diverge. The hospital executives gave steady answers with regard to the status of the interpreter and asserted that the interpreter is both language and medical terminology expert. S/he also deals with other duties than interpreting. As a result, we can certainly deduce that the hospital executives expect more than interpreting job from the interpreters. Yet, we cannot say the same thing for the doctors since they contradict their answers again and said that they perceive the interpreter as a language expert. On the other side, they indicated that the interpreter should conduct additional tasks. When the interpreter does more

than interpreting just as imposed on them, then they cannot solely be perceived as language experts, but also a part of the hospital team who is responsible for everything within the hospital such as dealing with the patients' procedures, applications, tests, etc.

Expectations on **quality criteria** was another topic of concern and the users revealed different approaches in this section again, which also gave important hints regarding their role perceptions. Four options were presented to the users, namely, completeness of information, fidelity to the original speech, fluent delivery, and correct terminology usage (translated from Turkish). The replies of the doctors and the executives proved different approaches again. The doctors' top two quality criteria were "fidelity to the original speech" and "completeness of information", which could be related to each other and cannot be separated from one another. It means that complete and correct transfer of message is the most important quality criteria for the doctors. These two criteria further show that the doctors strongly preferred the interpreter to render what is just being said, without any additions and especially omissions for the completeness of the speech, referring to the interpreters as translation machines. This result is clearly inconsistent with the role description of the doctors (see Figure 19) since they described the interpreters as active participants who shape and control the interaction. Furthermore, they even seem to encumber the interpreters with various tasks, leading them to assume various roles in return (see the Figure 21). Apart from those criteria, "using correct terminology" was ranked third overall out of four criteria. It reveals the fact that the doctors do not exactly want the interpreter to possess terminology knowledge. Rather, s/he is expected to render what is provided from the doctor. In this case, it is the doctor who has the knowledge and thus the 'authority'. However, this perspective shifted when it comes to the executives' answers since they underlined the importance of using correct terminology usage. Hence, the executives expect the interpreter to have terminology knowledge and the same 'authority' with the doctor. Yet, even though the executives emphasized the "completeness of information" as the most important criterion, they contradicted their expectation since they selected the "fidelity original message" as the least important criterion. One might consider from this result that the interpreter is given an area of freedom as regards interpreting strategies such as additions, alterations, explanations,

etc. However, they also indicated that the interpreter should render all the messages intended completely, which is in stark contradiction.

The last category was the users' preferences about **positioning of the interpreter**. Quite large numbers of the doctors (72,73%) and all hospital executives (100%) preferred the interpreter to be in the middle of the parties. Thus, the interpreter could stand in an equal distance to both parties as a neutral and uninvolved agent again.

The results analyzed in the sub-sections above are linked to the role perceptions and expectations of the users. When all the answers given by the users are evaluated, there is an overall picture of their expectations and perceptions and most of them are contradicted. They, on the one hand, showed tendency towards perceiving the interpreters as 'translation machines' with their task description of the interpreter, their selection of quality criteria as well as their expectation regarding physical positioning of the interpreter. On the other hand, they drew a completely dissimilar picture where they described the interpreters as active participants who are also expected to bear all the loads imposed on them. The reason of these inconsistencies in the users' answers might be because of the fact that the gap between how they image the interpreter in their minds and what they expect the interpreter to do in real life. In some of the questions, they depicted the interpreter as passive, neutral and uninvolved, i.e. "how the interpreter should be" in theory. However, when it comes to their expectations in practice, they defined the interpreter as an active, involved agent who could cope with a number of tasks and responsibilities. Thus, all their discourses actually prevail the inconsistency between "what they should expect from the interpreter" and "what they expect in real life". The similar results were also obtained by Ebru Diriker (2001) in the context of conference interpreting where the interpreters were depicted as translation machines who never get involved in the process in the de-contextualized accounts, whereas the interpreter's involvement in shaping the renditions became visible in the contextualized accounts. Thus, it can be deduced that similar results on the user's side seem to yield to the context of healthcare interpreting in Turkey.

The answers of the users will be compared with the interpreters' in the next chapter in order to obtain more palpable findings.

CHAPTER FOUR

ANALYSIS OF INTERVIEWS WITH HEALTHCARE INTERPRETERS

Following the detailed description of the methodology and the theoretical concepts “norms”, “participation framework”, “reception format”, and analysis of questionnaires obtained from the users, the present chapter is composed of interviews held with healthcare interpreters aimed at providing strong evidence of the interpreters’ self-perceptions concerning healthcare interpreting in Turkey. These findings obtained from the interviews will be analyzed in search of “**professional norms**” and compared with the findings regarding “**expectancy norms**” determined in accordance with user surveys. Since the professional norms are determined by the expectancy norms of users (Chesterman, 1997: 67), this analysis will seek an explanation as to whether the interpreters conform to the expectancy norms defined by the users. This section begins with the purpose and design of the interviews, continues with a brief description of the interpreters’ demographic information, an analysis of interview data, and ends with a discussion of the findings.

4.1. PURPOSE AND DESIGN OF THE INTERVIEWS

Interviews were conducted with 13 interpreters working in healthcare settings in Turkey between March 2020 and October 2020. Before this period, a pilot study was conducted with four healthcare interpreters who work in private hospitals in Ankara during summer 2019, which enabled the researcher to observe duration of the interviews and accessibility (See Chapter 2). However, those interpreters interviewed within the scope of the pilot study were not included in this analysis. On the other hand, the responses of these 13 interpreters will open up an opportunity to compare the role perceptions and expectations to that of users’ and to what happens in real- life situations. More importantly, one of the interviewees (INT13) is the one whose actual performance was audio-recorded and will be analyzed in this study (see Chapter 5). This will provide the opportunity to strengthen the findings and to compare the interpreter’s meta-discourse to actual practice. The interviews were semi-structured, allowing the interpreters to express their experience more freely. Thus, the responses

of the interpreters turned into a discussion, revealing more detailed information regarding their role in healthcare settings.

A total of 27 questions were posed to the interpreters regarding demographic information of interpreters such as their age, language combination and level, training, experience in the field, etc., their employment process, role and quality perceptions, involvement, both their expectations from the users and the users' expectations from them, qualifications which should be possessed by the interpreters, their responsibilities in addition to the task of interpreting in hospitals, strategies in transferring non-verbal components and their positioning during the interpreting process.

First, brief information will be given as regards the interpreters' language combination and language level, educational background, and experience in the field. Then, their answers will be analyzed under various related headings. In terms of confidentiality, the interpreters will be coded as INT (1-13).

4.2. INTERPRETERS

The interpreters play an indispensable role in healthcare settings by enabling communication between the parties. All the interpreters involved in this study work in private hospitals or clinics in Ankara, Istanbul and Izmir. In addition, there is also mix of genders, with 7 female interpreters and 6 male interpreters. Their ages vary between 22 and 47 years. The interpreters who participated in this study are not those observed in the MA thesis completed and defended by the author in 2017 (Şener, 2017). Further information about the interpreters will be given under the headings "Language pairs", "Educational background", and "Experience in the field" below.

4.2.1. Language Pairs

The interpreters in the present study have different language combinations. Among the interpreters interviewed, 7 of them work in a single language combination. More specifically, 4 interpreters (INT2, INT3, INT4 and INT 6) have the language combination of English and Turkish, 2 interpreters (INT11 and INT13) work between

German and Turkish, while a single interpreter (INT 9) has the language combination of French and Turkish. The rest of the interpreters work between more than 2 languages or even 3 languages. For instance, 3 interpreters (INT5, INT7 and INT 8) render between English-Turkish- German, whilst INT1 works between Arabic-English-Turkish, INT12 works between English-French-Turkish, and INT10 is capable of speaking and also interpreting between English-German-Dutch- Turkish. All the interpreters, except two of them, indicated that they have advanced or C1 and C2 foreign language level. Nevertheless, INT1 asserted that his language level for English is intermediate and INT12 indicated that he has B2 level for French. Lastly, there are 2 interpreters who are natives. INT11 and INT13 are natives German who were born and raised in Germany.

4.2.2. Educational Background

Educational background of the interpreters is also of great significance since it might have impact on their strategies and choices during the interpreting process. Thus, one of the questions asked to the interpreters refer to the educational background of the interpreters. All the interpreters, except three (INT1, INT11 and INT 13), have acquired training in the field of Translation and Interpreting. The other three interpreters who did not receive education in this field, have a bachelor's degree in various fields. To summarize, it can be concluded that all interpreters hold a bachelor's degree, most of whom graduated from the Department of Translation and Interpreting.

4.2.3. Experience in the Field

Their professional background, in other words, their experience as a healthcare interpreter in this sector is another factor playing an important role. Their work experiences might have positive effects on their strategies, since they can learn the ways to cope with the difficulties encountered during interpretation. On the other hand, this experience might lead interpreters to take initiatives during interpretation, and thus, it might also have a negative effect, such as violating ethical principles (Şener, 2017). In this study, the experience of the interpreters ranges from 3 months to 11

years. INT9 is the most experienced interpreter working in this sector for 11 years, while INT11 has only 3 months of experience in this profession.

4.3. DATA ANALYSIS

The answers of the interpreters were analyzed under different headings and sub-headings related to the issue of ‘role’, which provide a comprehensive understanding in this unique setting and reinforce the discussions of the users (see Chapter 3). In contrast to the users, the interpreters provided more persistent and robust data with regard to the perceptions of their role. Their responses proved that they place more importance on the contextual factors and behave in line with those factors. Because of the context they work in, the interpreters seem to perceive themselves more than just an “interpreter” who only deals with rendering between languages, rather, as a “facilitator” and/or an “advocator” both for the users and the patients. The interpreters adopt these roles by moving back-and-forth between their ‘professional identity’ and ‘personal identity’, which, in turn, reflects the ‘in-betweenness’ of the interpreters. “Professional identity” could be defined as a “set of beliefs, attitudes and understandings about one’s **professional** role as a result of his/her work activities”⁶. “Personal identity”, on the other hand, could be defined as “the social particulars of an identifiable individual”⁷. Within the scope of these definitions, the interpreters are, on the one hand, responsible for looking after the hospital’s interests by satisfying the user expectations. On the other hand, they feel obliged to move beyond their ‘professional boundaries’ by acting intuitively towards the patients with their ‘personal characteristics’. One of the reasons of those roles adopted by the interpreters towards the patients could be their perceptions of the patient as a “minor”, underlining the power inequalities between the parties, which is again an outcome of the healthcare context and a key feature distinguishing community interpreting from conference interpreting. Therefore, they might adopt a patient-oriented approach from time to time as an attempt to remove the power imbalance and increase the ‘patient autonomy’ in

⁶ This definition was obtained from <https://www.igi-global.com/dictionary/professionalidentity/23722> on the 10th May, 2021.

⁷ This definition was obtained from, <https://www.oxfordreference.com/view/10.1093/oi/authority.20110803100319176> on the 10th May, 2021.

the interactions. Although user expectations emerge as an important factor shaping the role of the interpreter, the interpreters also seem to shape their own role in line with the contextual requirements, which lead to the role of a “facilitator” and/or an “advocator” for both parties.

Within this regard, the answers of the interpreters will be discussed under the sub-headings of “eligibility”, “role”, “quality”, “interpreter’s involvement”, and “positioning of the interpreter” in detail and at the end of this chapter, a discussion of the findings obtained from the users and the interpreters, in other words, convergences and divergences of their discourses will be discussed comparatively as regards the interpreter’s role.

4.3.1. Eligibility

First, the issue of eligibility criteria from the interpreters’ perspective will be discussed in this part. All the interpreters were asked as to what kind of qualities the healthcare interpreters should have in healthcare settings. The answers of the interpreters tell us three important components in general: *personal characteristics*, *language knowledge* and *medical terminology knowledge*. Differently from the users, most of the interpreters, namely 10, highlighted the importance of personal characteristics in healthcare settings, which includes being *patient*, *having the sense of responsibility* or *empathy*, as well as *a sociable personality*, which comes as a result of the healthcare context. The other components regarded as important by the interpreters are *language knowledge* and *medical terminology knowledge*.

4.3.1.1. Personal Characteristics

Differently from the conference settings, the healthcare settings where interpreters work require certain personal characteristics, as stated by the interpreters. Those characteristics include being patient, having the sense of responsibility, a sociable personality as well as showing empathy. All these characteristics advocated by the interpreters could be evaluated as an intuitive act of the interpreters as a necessity of the setting. This paves the way for the interpreter to strengthen not only

his/her professional skills, but also certain personal skills in order to provide flawless service for the patients. In other words, personal skills or characteristics seem to matter more than interpreting skills for the interpreters.

INT5 was among those interpreters who highlighted the significance of showing empathy towards the patients since they are already “patients” and need the interpreter’s additional care:

EX1:

*... well the **social relationships** are important because ... it is required to have good verbal communication skills. ... because the patient [...] they come as sick and have a question mark in their minds and feel nervous. ... that’s why, **it is important to understand them and to show empathy towards them**. Then, it is sometimes required to intervene with the hospital staff. It means that it is important to keep good relationships with both the doctors, the staff working there and the patients. [...] [INT5]*

*[... tabi ki **sosyal ilişkiler** önemli çünkü ... sözlü olarak iyi iletişim kurabiliyor olmak lazım. ... çünkü hasta- [...] en nihayetinde hasta olarak geliyorlar ve kafalarında bir soru işareti, bir gerginlik var. ... o yüzden hani **anlayabilmek, biraz empati yapabilmek önemli o noktada**. Gerekli yerlerde müdahale edebiliyor olmak lazım hastane personeline de. İşte ...ya o herkes aslında işini, ilişkilerini iyi tutmak önemli. Hem doktorla hem orada çalışanlarla hem hastayla. [...]*

As could be understood from the statement above, dealing with the emotional state of the patients – such as anxiety and nervousness - comes to the fore as the task of the interpreter. Then, the capability of maintaining good social relationships with the parties is the prerequisite for providing good care service for the patients. The same approach was also adopted by INT2, specifically indicating the context in which they work. Since they directly deal with the patients, they should be more tolerant towards the patients, which, in turn, requires an intimate relationship and collaboration with both the doctors and the patients in order to make the patients feel better:

EX2:

*[I] think it is more important to have a **social personality**. It means that it is important to be a social in order to have pleasant relationships both with the doctors within the hospital and the patients, which will enable them to feel more comfortable. I think that it is the most important point. [INT2]*

*[[B]ence her şeyden önce birazcık böyle **sosyal bir kişilik olması** daha önemli açıkçası. Yani hem hastane içerisindeki doktorlarla o ilişkiyi kurabilmek için hem*

de hastalarla daha böyle ona aslında rahat hissettirebilmek için sosyal bir kişilik ve de böyle ... anlayışlı bir kişi olmanız önemli bence. En önemlisi bu.]

The sensitive nature of the interpreting context was again stressed by INT7 who emphasized the fact that the target audience of the interpreter is a “patient”, even when s/he comes to have a cosmetic surgery, which might refer to “insignificant” surgeries compared to serious health problems. Even in those situations, the interpreter should be sympathetic towards the patient, undertaking his/her all responsibilities, and might be blind to his/her faults, if there is any:

EX3:

*[T]he person you are dealing with is a patient. It means that s/he has trouble, even if s/he comes for a cosmetic surgery. Therefore, it is necessary that the **interpreters should be patient**. It is very important. **The interpreters should have the sense of responsibility**. This job is sometimes very tiring, but it needs to be fulfilled with hundred percent. Even ninety percent of fulfillment will not be enough since this job does not tolerate faults. [INT7]*

*[[M]uhatap olduğunuz kişi hasta. Yani estetik ameliyatı olmaya dahi, ... dahi gelmiş olsa muzdarip olduğu bir konu var, deritli olduğu bir konu var. O yüzden **sabırla anlayışla yaklaşmak gerekiyor**. Bu çok önemli. **Sorumluluk sahibi olmak gerekiyor**. Bazen çok yıpratıcı yorucu olabiliyor bu iş ama hiç ödün vermeden görevin neyse bunu yüzde yüz yapman gereken bir iş. Yüzde doksanı kaldırmaz çünkü hataları çok tolere edebilecek bir iş değil.]*

As exemplified above, one of the most reiterated point is the sense of “responsibility” in this context. INT9 made a striking statement regarding the significance of the profession as a healthcare interpreter and undertaking all the responsibilities of the patients:

EX4:

*Of course, language knowledge ... is definitely important. It is, for sure, very important to have a good command of language and terminology. However, apart from that, the interpreter should show **empathy and embrace his/her job**. It is certainly not about working as a healthcare interpreter to gain money because s/he could speak foreign language(s). ... the interpreter should **have the sense of responsibility and undertake the responsibility**. The interpreter should really love his/her profession, which cannot be performed otherwise. The interpreter should love “people” and be aware of the responsibilities of the profession s/he carries out. [...] [INT9]*

*[Tabi dil kesinlikle ... önemli. Dile ve teknik terime hâkim olması çünkü o tıbbi terimler çok ayrı bir şey, çok önemli. Onun dışında da kesinlikle bir **empati ve işini sahiplenmesi gerekiyor**. Yani gerçekten mesleğe odaklı yani para kazanayım biraz, işte dil biliyorum diye yapılacak bir iş değil. ...sorumluluk*

*sahibi olması gerekiyor bir çevirmenin. **Bu sorumluluğu alması gerekiyor.** Sevmeden yapılacak bir iş kesinlikle değil. İnsan sevmesi gerekiyor ve yaptığı işin sorumluluğunun bilincinde olması gerekiyor. [...]]*

Leaving aside the importance of language and terminology, INT9 takes a step beyond working as a healthcare interpreter and focuses on the sensitive nature of their profession in which the patients' wellbeing takes precedence over all other interests including the financial interests. It becomes evident through these comments that working as a healthcare interpreter requires dedication. Similarly, INT12 indicated that it is important to take the psychological condition of the patient into account while dealing with the patient. The answer of INT12 demonstrated that the patient's health condition is a determining factor in shaping the interpreting strategies applied by the interpreter and thus, the interpreter strives to talk to the patient positively even in negative cases.

EX5:

*First of all, a lot of patience is needed. ... **the interpreter should not be an easily-tempered person** because the interpreters encounter with the patients and it is **needed to understand the psychology of the patients**. Otherwise, for instance, s/he could have psychological problems as well. When the patient asks for something, it is not very acceptable to say that "No, you cannot do this". Instead, positive responses could be presented to something negative such as "We can help you in that way". The interpreter should be in a position to provide such options. [...]] [INT12]*

*[İlk önce çok sabır gerekiyor. ... **çok kolay sinirlenmeyen bir yapıya sahip olmak gerekiyor** çünkü karşımızdaki sonuçta bir hasta ve onun **psikolojisini anlamak gerekiyor**. Öbür türlü bir hasta olarak- mesela psikoloji hastası da olabilir, bu bir- hasta bir şey istiyorsa, "Hayır, onu yapamazsınız" demek çok kötü bir şey. Onun yerine "Size direkt şu şekilde yardımcı olabiliriz" hani olumsuz bir cevap değil; olumsuz bir şeyin olumlu yönden bir cevabı- hani bunu verebilecek bir durumda olmak lazım. [...]]*

It was further remarked by INT13 who advocated to create such an environment where the patient feels himself/herself at home:

EX6:

*I certainly think that **the interpreter should have intimate relationship with the patients** because the patients coming to our hospital feel nervous. All in all, they make an important decision or take a big step. Thus, I am of the opinion that it is important to have such an interpreter with whom the patient could feel safer and comfortable. [INT13]*

[Bence kesinlikle hastayla olan ilişkilerinin çok yakın ve samimi olması gerektiğini düşünüyorum çünkü zaten hastaneye gelen hastalarımız genelde yani illa ki bir tedirginlikleri oluyor. Sonuçta önemli bir karar ya da büyük bir adım atıyorlar. Yani çevirmenden dolayı böyle daha samimi ve rahat olabilecekleri, güven sağlayabilecekleri bir insan olması- önemli olduğunu düşünüyorum açıkçası rahatlık açısından ve güvenme açısından.]

All the opinions expressed above by the interpreters display a “hospitable” stance towards the patient which might hint the fact that they perceive the patient as a “minor”. Thus, their responses put forth the fact that they attempt to be kind towards the patients, make them feel better, assume their responsibilities by keeping intimate relationships with them, and ultimately, provide ‘equality’ in the distribution of power between the parties, which can be said to emanate from their personal characteristics.

4.3.1.2. Language and Medical Terminology Knowledge

Following the personal characteristics, 5 interpreters indicated that knowledge of language and terminology is a must. Language and terminology knowledge are for sure, crucial in any type of interpreting setting. However, the interpreters urge upon the language and terminology knowledge by pointing to the context and the difference between the knowledge levels of the doctor and the patient. Hence, it is the interpreter who equalizes the different level of competences of the parties especially with a good command of language and terminology knowledge and who comes forward as an agent coordinating and shaping the power dynamics in the interactions.

At this point, INT4 gave a conspicuous example, comparing healthcare settings with conference settings and referring to the critical role played by the interpreter to fill the gap between the parties. According to the remarks of INT4 below, it is not sufficient to be good at medical terminology. The interpreter should be able to grasp the ‘sense’ of the message given by the doctor and transfer it to the patient in a way that s/he could understand easily, which requires the interpreter to possess other qualifications in addition to their language and terminology knowledge.

EX7:

*First of all, the interpreter should **have a good command of language** and also should improve himself/herself about **terminology**. Especially in terms of... simplifying the message, the interpreter should focus on the question, “How can*

*I simplify this message?”. Because you can use that jargon in the same way in a conference. However, it does not happen in hospital. **Both parties have different language level and capacity**, and the doctor sometimes loses himself/herself in the terminology, while you are interpreting. Thus, you should have a good command of terminology knowledge and able to simplify and explain the message in order that the patient could understand it. [...] [INT4]*

*[Bir kere **dile çok iyi hâkim olmak** ve sadece dile hâkim olmak değil, **terminoloji** konusunda kendisini geliştirmesi gerekiyor. Ve yani dili özellikle ... basitleştirme konusunda da çok “Nasıl basitleştirebilirim?”. Bunun üzerine çok düşünülmesi gerektiğini düşünüyorum çünkü normal bir ortamda çeviri yapıldığında-konferansta yani- o jargonu aynı şekilde kullanabiliyorsunuz. **Ama hastanede öyle olmuyor. İki tarafın da dil yeterliliği, yetkinliği çok farklı** ve hastaya siz çevirirken- o terminolojiyi bazen doktorlar çok benimsemiş oluyorlar. Sizin o terminolojiye çok hâkim olup, hastanın doğru algılaması için biraz daha sadeleştirme, açılım yapabilmemiz gerekiyor. [...]]*

In the same way, INT8 pointed to the healthcare context and inevitable results which might occur if the interpreter does not acquire the needed knowledge and competence:

EX8:

*[I]t is necessary **to be able to use both languages**. I think that its awareness should be high especially in health settings because even the slightest mistake might lead to undesired results. Therefore, every message should be clear. It is required to have **good command of terminology, diseases, and treatments**, that is, the whole process. [INT8]*

*[[İ]ki tarafı da **iki dili de çok iyi kullanabilmek gerekiyor** ama sağlıkta biraz daha bu bilincin çevirmende yüksek olması gerektiğini düşünüyorum aslında çünkü en hani küçük bir hatada bile en küçük bir yanlış anlaşılma bile sonuçları- istenmeyen sonuçlar çıkabiliyor ortaya. O yüzden hani her şeyin net olması gerekiyor aslında. Çok iyi hâkim olmak gerekiyor gerçekten **terminolojiye** ve **hastalıklara, tedavilere** yani bütün süreci aslında iyi biliyor olmak lazım.]*

INT8 explicitly grants authority to the healthcare interpreters not only with their terminology knowledge, but also knowledge of diseases and the treatment process of the patients as the doctor possesses. By doing so, INT8 actually elevates the healthcare interpreters to the position of the doctors, which constitutes a sample as to how they perceive themselves within the hospital. In a similar vein, INT12 expressed this sensitive nature of healthcare settings and the cruciality of terminology knowledge:

EX9:

[I]t is necessary to have sufficient translation knowledge because if we cannot transfer what the doctor says to the patient, it might lead to big problems in medical terms. We take risk too much in the health department. If we say “right”

*instead of “left”, the patient might lose his/her healthy kidney. There is such risk. Therefore, **medical knowledge is also needed in this setting.** [INT12]*
*[[Y]eteri kadar çeviri bilgisine olmak lazım çünkü hastanın söylemek istediği bir şeyi hocaya tam olarak yansıtamıyorsak medikal anlamında da çok büyük riskler doğurabiliyor çünkü sağlık bölümü sonuçta çok riske girebiliyoruz. Sol yerine sağ dersek hastanın sol böbreğinin yerine sağlam böbreğini alabilirler. Böyle bir riski var. O yüzden aynı zamanda da **tıbbi bilgiye de ihtiyaç var.**]*

The interpreters’ medical knowledge including diseases, terms and treatments becomes prominent again since the ultimate message is transferred by the interpreter to the patient, not by the doctor. So, the opinion shared by INT12 above enhances the aspect brought by INT8, advancing the interpreter to the doctor’s position. The need to possess some medical knowledge indicates that the interpreters have the same degree of authority with the doctor.

In conclusion in this part, it can be expressed that the traces of the impact of the context on the interpreter’s role are found in the eligibility part. The interpreters put forward certain personal characteristics, which they find critical in healthcare setting. It can further be deduced that they also exhibit patient-centered behaviors in the strategies they resort to during interpreting.

4.3.2. Role

Following the issue of ‘eligibility’, the issue of ‘role’ will be discussed, and it entails the most comprehensive analysis since it is directly related to the main research question of this study. As highlighted by Hale and Napier (2013: 65-66), it is important to ascertain the real opinions of the participants by asking different indirect questions which will lead a researcher to a conclusion. This is because the participants might not want to reveal their real perspectives and might express the ‘ideal’ answer in contrast to their own thoughts. Hence, different questions pointing to role were asked both to the users and the interpreters so as to compare the results and provide solid findings. In other words, it can be said that different aspects of the issue of role were analyzed since each question triggered various discussions concerning the interpreter’s role.

This section set out to elicit data as regards the interpreters’ self-perception of role in general. However, the questions related to the user expectations and perceptions

of role were also directed to the interpreters to acquire an overall understanding of the issue of role, which will be discussed comparatively at the end of this chapter.

With this aim, there are four different types of questions aiming at unravelling the perception of role in healthcare context in the interview. The first question regarding 'role' posed to the interpreters was "How can you describe your role as a healthcare interpreter?", aiming to reveal the interpreter's self-perception of role. The second question attempts to provide an insight into the user perceptions of role from the interpreter's perspective with the questions "What is the 'role' perception of users (doctors and hospital executives)? Do you think that your role as a healthcare interpreter is conceived correctly?" and "How do you conceive prestige/position of healthcare interpreter within the hospital?", which will enrich the discussions obtained from the questionnaires in Chapter 3. Lastly, the question "Do you have other responsibilities apart from interpreting?" was asked. Thus, the issue of role will be discussed under three sub-headings: "interpreter's self-perception of role", "user's role perceptions and expectations from the interpreters' perspective", and "tasks and responsibilities in addition to interpreting". Aside from the role perceptions, interpreters' prestige in the hospital will also be examined in this part. The objective here is to provide a more detailed analysis regarding especially the users' role perceptions and expectations. Even though the questionnaires distributed to the doctors and the hospital executives provide valuable data in terms of their expectations, the data obtained from semi-structured interviews with interpreters bolster the discussions with a variety of examples. To put it another way, their answers were hoped to provide data regarding the users' expectancy norms in relation to the interpreter's role in more detail. Thus, this aim has been achieved, and the gap between the interpreters' perceptions and the users' perceptions of role emerged from the findings in this section. The implications and hints regarding this gap will be traced in the interpreters' responses in different sections below. At the end of the section, the analysis part titled "tasks and responsibilities in addition to interpreting" will reveal whether the interpreters conform to these expectancy norms in terms of role.

4.3.2.1. Interpreters' Self-Perception of Role

It can be asserted that the interpreters provided similar responses to the question eliciting the interpreter's self-perception of role and all the interpreters emphasized again their sensitive role in this setting especially in bridging the gap between the parties. The interpreters stated that they are more than 'interpreters' in two ways: a) by providing physical support and b) psychological support, which leads the interpreters to behave as if they were a "guide", a "counsellor" for the patients and a "representative" for the hospital. While physical support includes escorting the patient within the hospital and coordinating the whole procedure process, psychological support includes conversing with the patient in order to relieve him/her, which are all far beyond the interpreter's capacity as an interpreter. However, while the tasks regarding the physical support could be due to user expectations imposed on the interpreter, psychological support could be explicated as an instinctive behavior as a part of the interpreter's personal characteristics, underpinned in the 'eligibility' section. Therefore, one can talk about a role shift of the interpreter from being an 'interpreter' who only provide renditions between different languages, towards being a 'relative' or a 'close friend' of the patient. This shift can further be interpreted as the interpreter's shift from his/her "professional identity" towards "personal identity". For example, INT13 highlights the importance of the role she plays both for the patients and the doctors, especially facilitating the procedures of the patients:

EX10:

*[I] think that I play an important role especially for the people who cannot speak foreign language because **we are together all the time as if we were conducting our own procedures**. That is, I am, in fact, of the opinion that I play very important role for both parties who are doctors and patients. [INT13]*

*[[D]il bilmeyen yani hiç bilmeyen hastalarda özellikle bence çok büyük bir rol oynadığımı düşünüyorum çünkü **yani hastaların eli, ayağı oluyorum aslında hastanede ya da o süreç boyunca**. Yani her iki taraf için de doktor için de hasta için de çok önemli bir rol oynadığımı düşünüyorum açıkçası.]*

The same expression was voiced by INT12. Moreover, she said that her role was even extending the scope of being healthcare interpreter within the hospital as she provided support for the patient's personal needs even when s/he was out of the hospital:

EX11:

[...] That is, it is not only about interpreting, **we are together all the time as if we were conducting our own procedures.** We conduct all their procedures and follow up the whole process until they come back to their country. One of our patients even had to go shopping once. We contacted with the hotel where s/he stayed in and gave one of the hotel staff's name. By doing so, we enabled the patient to do shopping. [INT12]

[...] Aslında yani sadece tercümanlık değil, **hastanın eli ayağı gibiyiz.** Hastanın her işlemini biz yapıyoruz ve hasta ülkesine gidene kadar bütün süreçlerini biz takip ediyoruz. Hatta bir hastamızın bir kere bir alışveriş yapması gerekti. Bu alışverişini de otel- otelle konuşup, otelden bir personel belirttirip o personelle alışveriş yaptırmasını sağladık.]

The remarks of INT12 evoke the interpreter's "facilitator" role even outside the hospital and also imply the interpreter's perception of the patient as a "minor" again who could accomplish nothing without an interpreter. This view was also justified by the expressions of INT10, indicating that the patient could not find his/her own way without the help of the interpreter:

EX12:

The moment the patient gets his/her foot in the door of the hospital, s/he is under your responsibility until s/he leaves the hospital. **You should provide all kinds of supports because s/he cannot find his/her way when you leave him/her alone** That's why it is required to handle this immediately. [INT10]

[Bir hasta geldiği zaman aslında kapıdan girdiği andan çıktığı ana kadar sizin sorumluluğunuz altında oluyor. Ona her şekilde yardımı sunmanız gerek çünkü zaten **kendi başına bıraktığınız zaman kendi yolunu bulamıyor.** ... o yüzden hızlı bir şekilde bunu halletmek lazım.]

This example reveals a clear fact that the patient is perceived as a "victim" and a "minor" who are 'navigated' merely by the interpreter. Therefore, INT1 described his role as a "guide" navigating the patient by providing all types of supports within the hospital:

EX13:

((Our role is)) In the administrative division, let's say **as a guide**, as a manager ..., as a person who helps patients during their treatment process. [INT1]

[İdari bölümünde, diyelim ki idari bir şekilde **rehber gibi**, idari gibi... hastaların ... tedavi sürecinde destek olmak, yardımcı olmak.]

In addition to navigating or guiding the patient, INT4 made a striking statement that they establish a special bond with the patient, resulting in moving away from their "professional" identity:

EX14:

[Y]ou have a special bond with the patients. They count on you. It means that you cannot say “Okay, I am done interpreting” and step aside. You need to help them as much as possible because you are the only person with whom they can communicate. Some of the hospital staff could speak English, and some cannot. That’s why I tried to help as much as I could as I mentioned. [INT4]

[H]astayla bir bağınız da oluyor. Ayrıca size güveniyorlar. Yani sizden “Tamam, çevirdim” deyip bir kenara çekilemiyorsunuz. Mümkün olduğunca insanlara yardımcı olmak durumunda kalıyorsunuz çünkü iletişimde tek nokta siz- sizsiniz. Hastane personelinin bir kısmı İngilizce biliyor, bir kısmı bilmiyor. O yüzden bahsettiğimiz diğer alanlarda da tabi ki yardımcı olmaya çalıştım elimden geldiğince.]

In the example above, INT4 admitted that the patients count on them and thus they create a personal relationship with the patients, going beyond the role of an “interpreter”. As a result of this “bond”, the interpreters seem to mention providing psychological support to the patients as well. More importantly, INT1 said the interpreters endeavor to help the patients get proper treatment and proper medicine:

EX15:

*From my perspective, interpreters do important things. For example, **we strive to enable patients to receive an appropriate treatment, a correct medicine.** Sometimes, how can I say? It is sometimes conducted as a **psychological guidance.** That is, when the illness of a patient is explained, (I say) “It is not important, it is not a serious illness”, “I say ‘disease’ but it is curable disease, don’t bother. Medical science has progressed”. Let me give an example. We have patients awaiting a liver transplant. The patient comes (and asks), “Tell me, what happened?”, “How will it be?”, “Which procedure will be followed?”. Then we explain. For example, I know that illness. Then I say “I have seen many patients transplanted. There is nothing to be afraid of”. “You will be better”. So, **we provide something like psychological support. We advocate them as if we were a guide or a counsellor.** [INT1]*

*[Benim bakış açısından tercümanlar çok önemli şeyler yapıyorlar. Mesela hastanın ... **tedavi anlamında bir uğraş, doğru ilacı alması için, doğru tedaviyi alması için bir uğraş yapıyoruz.** Bazen bir şey mesela nasıl diyeyim? **Psikolojik rehberlik** gibi de oluyor. İşte hastanın- hastaya bir hastalığı açıklandığı, yapıldığı zaman, şey yapıldığı zaman önemli bir ... “Yok işte önemli değil, çok ... büyük bir hastalık değil”- hastalık dediğim de “tedavisi mümkün”, “canını sıkma”, “bak işte tıp gelişti, tedavin mümkün olabilir”. Mesela örnek vereyim size: karaciğer nakli hastalarımız oluyor işte. Geliyor hasta “Nasıl?” “Anlatın bana, ne oldu?”, “Nasıl olacak?”, “Ne yapılacak?”. İşte anlatıyoruz ona. Mesela daha önceden gördüğüm hastalık. “Benim çok gördüğüm hastalar nakil oldular”, “çok, yani o kadar da korkacak bir durum yok”, “Daha iyi olacaksın”. **Yani psikolojik bir destek gibi bir şey oluyoruz. Bir- rehberlik gibi, danışmanlık gibi, destek gibi oluyoruz.**]*

Motivating, consolidating and guiding the patients psychologically could be grounded on the personal relationships created with them. In a similar vein, INT6 mentioned conversing with the patient in order to ease the patient's pain:

EX16:

[I] need to talk about anesthesia before the procedure since it is a bit painful process. The patient needs to be patient for ten minutes or so. ...when all these are repeated every day, it is like automated. Apart from this, I was striving for having a talk with the patient and thus divert his/her attention away. [...]
[INT6]

[İ]şlemden önce mesela anestezi ile ilgili birazcık konuşmam gerekiyor çünkü birazcık acılı bir süreç o kısım. Bir 10 dakika falan dişini sıkması gerekiyor hastanın. ... yani bunlar da zaten her gün her gün tekrarlanınca artık otomatığe bağlandı gibi bir şey oldu. Onun dışında hastanın birazcık o süreçte dikkatini dağıtıp sohbet etmeye çalışıyordum. [...]]

After a while, this type of support seems to be perceived as naturally-occurring for the interpreter. In return, some of the patients give the interpreters the 'authority' to speak on their behalf. In the example below, INT9 declared that the patients could sometimes share information with them which they could not share with the doctors:

EX17:

[...] It is sometimes beyond interpreting because it is required to understand psychology of the patient. Some patients might share some information with you which s/he forgot to share with the doctor because of his/her excitement at that moment. ... it is required to be a good communicator and observer. [...]
These foreign patients sometimes have difficulties in expressing their feelings because of their psychology. They are in different country. It is required to understand their psychology and everything. In order to transfer the message correctly, it is necessary to internalize and conceive why they said so and what they really mean. It means that technical terms, culture and a variety of points as well as a comprehensive information can be included within this approach. You need to love what you do in this profession. It is required to concentrate on and to extract real meaning of a message and to transfer it to parties. It is such a profession. [INT9]

[...] Çeviri bilmekten de bazen ötesi olabiliyor çünkü o hastanın o psikolojisini anlamamız, o anda söylemediği- doktora heyecandan söyleyemediği şeyleri sizinle paylaşıyor hasta. ... iyi bir- çok iyi bir iletişim, çok iyi bir gözlemci olmak gerekiyor. [...] Bazen kendini ifade edemeyen- çok zaten hastanın psikolojisinden dolayı kendini ifade etmekte çok zorlanan ... bir grup bu hasta denilen yabancı hastalar. Başka bir ülkedeler. O psikolojiyi, her şeyi anlamak lazım. Orada neden öyle söylediğini, ne demek istediğini çok iyi özümsemek, çok iyi kavramak lazım ki doğru aktarabilmek için. Yani bunun içinde teknik terim, kültür, birçok şey giriyor. Çok kapsamlı bir bilgi de. Ama çok sevmek gerektiren bir iş. Bunu gerçekten- bu işi yapmak için çok severek konsantre olarak o andaki özü çıkarıp bekleyen yere gereken mesajı karşılıklı iletmek gerekiyor. Böyle bir iş.]

In addition to providing psychological support, INT9 also placed emphasis on the transfer of the sense of the message, cultural as well as medical knowledge. With the

emphasis on the medical knowledge, the interpreter might already position herself as an authority. However, more interestingly, as could be inferred from the example above, the patient accepts the interpreter as an “authority” by sharing the information which s/he cannot share with the doctor. In Goffman’s (1981) terms, the patients seem to accept the interpreter as a “principal”. This, in turn, could be regarded as an implication of the strong connection between the interpreter and the patient again.

Likewise, INT7 resembled his role to a “shadow” of the patient and listed the tasks he was responsible for, including the psychological support. However, besides the various types of support mentioned above, he raised a new topic for discussion and actually underscored directly the “in-betweenness” of the interpreter. The interpreter, on the one hand, is responsible for looking after the hospital’s interests, and on the other hand, showing an exact tenderness for the patient, which comes as an intuitive act. This gives rise to the shift between the interpreter’s ‘professional identity’ and ‘personal identity’:

EX18:

*[M]y job is not merely to interpret but most of it is composed of interpreting and providing communication between two people who cannot communicate directly. We are doing health tourism. That is, we bring patients directly to Turkey. Because we are the only ones who can speak foreign language, we become everything or **a shadow** of the patient. We take every single step together with the patient within the hospital. **We have a heart-to-heart conversation with the patient. It means that the patient addresses remarks to you because of interpreting. We are like a shadow of the patient.** [INT7]*

*[[İ]şim sadece çevirmenlik değil ama büyük bir kısmını sonuçta çeviri oluşturuyor, dil bilmeyen iki insan arasında iletişim kurmak. Sağlık turizmi yapıyoruz yani hastayı doğrudan Türkiye’ye biz getiriyoruz. Dilini yalnızca biz bildiğimiz için hastanın aslında her şeyi yani **gölgesi** gibi oluyoruz. Hastanede her adımı beraber atıyoruz. İletilmesi gereken her şeyi çeviriyoruz. **Sohbet ediyoruz, dertleşiyoruz. Yani çeviri- çevirmenlikten dolayı aslında hasta sadece sizi muhatap olarak kabul ediyor. Baya bir hastanın gölgesi pozisyonundayız.]***

In the excerpt above, INT7 indicates that it is among the tasks of the interpreter to bring the patient to Turkey and to follow the patient like a “shadow” in the hospital. All these could be considered as the tasks imposed on the interpreters by the users. However, the interpreter also went beyond his/her ‘professional identity’ and constituted a bilateral relationship with the patient. This alleged fact was also reiterated by INT5 who is responsible for the insurance claims of the patients, i.e., the financial

interests of the hospital. Yet, she behaves, on the other hand, as if she were a “counsellor” of the patient:

EX19:

*As a healthcare interpreter, ...well that is: a person who accompanies the patient, afterwards conducts paper works as if s/he were **a counsellor** for the patients. For the hospital I can say that I was like a mediator in order to manage insurance operations and of course to provide smooth communication with the patients. [INT5]*

*[Hastane çevirmeni olarak ... yani şöyle: hastalara, daha doğrusu yabancı hastalara eşlik eden, ardından da hani gerekli evrak işlerini yapan bir hani hastalar için bir **danışman** diyebilirim bir nevi. Hastane için de bu sigorta süreçlerinin yürüyebilmesi, hastaların tabi ki daha rahat iletişim kurabilmeleri için bir aracı gibiydim diyebilirim.]*

Lastly, INT4 looked from the hospital’s point of view and explained that they are the “representatives” of the hospital, implicitly pointing to the financial issues. Hence, the interpreters are then important agents representing and ‘advertising’ both their institution and the country:

EX20:

*[Y]ou are actually **the face of the hospital** for the patients obtaining foreign language services. ... that is why it is so important at this point. The hospital, if you are in a private hospital, how you treat to patients and how you communicate with them is very important in terms of both the prestige of the hospital and our country when they leave from Turkey, which stick in their minds. Therefore, I think that the interpreter should be a good representative. [INT4]*

*[[H]astanenin yabancı dil servisi hastaları için bir **yüzü oluyorsunuz**. ... o yüzden çok önemli bu anlamda. Hastane, eğer özel bir hastanedeyseniz hem hastanenin imajı açısından hem de Türkiye’den ayrıldıkları zaman ... ya ülkemiz için de akıllarında bir şeyler kalacaksa sizin nasıl davrandığınız, hastalarla nasıl iletişim kurduğunuzun bu bağlamda çok önemi oluyor. O yüzden iyi bir yani temsilci olması gerektiğini düşünüyorum ben.]*

All the examples cited above demonstrated that the interpreters adopt from time to time both an institution- oriented approach and a patient-oriented approach, moving back and forth between their ‘professional identity’ and ‘personal identity’, which will further be traced in the following sub-sections.

4.3.2.2. Users' Role Perceptions and Expectations from the Interpreters' Perspectives

This section focuses on the answers given to the question “What is the ‘role’ perception of users (doctors and hospital executives)? Do you think that your role as a healthcare interpreter is conceived correctly?”. The findings in this part will allow us to gain insight into users’ **expectancy norms** regarding the interpreters’ role from the interpreters’ perspective. Apart from three interpreters, all interpreters indicated that their role as a healthcare interpreter is not conceived correctly by the users within the hospital, drawing attention to the lack of awareness among the users. It also sheds light on the gap between the users’ perception and the interpreters’ perception of role. From the interpreters’ perspective, the users perceive the interpreters more as someone who could handle all kinds of responsibilities, related to task of interpreting or not. Thus, this approach caused the interpreters to perceive their role and profession “unreputable”.

INT2 indicated a general lack of awareness regarding the interpreting profession and the role of the interpreter within the hospital:

EX21:

I don't think that it is understood correctly since they still don't know the interpreter's qualifications, what the interpreter does and the process the interpreter deals with. Of course, there are also people who know it, but I cannot say that there is a complete awareness. [INT2]

[Tam olarak anlaşıldığını düşünmüyorum ben şahsen çünkü hala bir tercüman – yani tercümanın özelliklerini, tercümanın yaptığı işi, ortaya çıkardığı sürece hala hâkim değiller. Hâkim olanlar da var tabi ki de ama tam olarak bir farkındalık olduğunu söyleyemem.]

This lack of awareness can be seen when the tasks assumed by the interpreters are scrutinized, as clarified by INT1. Even though INT1 asserted that the users perceive his role as a “guide”, he actually tried to describe a more comprehensive meaning of that perception in a negative way. Under the title of a “guide”, the interpreter deals with all types of tasks within the hospital, which refer to an irrelevant and additional workload for the interpreter:

EX22:

*I don't think that it is understood correctly since it is presented and understood as if **healthcare interpreter were a guide or someone who deals with the hospital procedures**, not as an interpreter. Okay ... they say, “The interpreter knows*

everything about the patient”, for example. “We ask him/her”. If there is a procedure to be done, for instance, patient’s insurance procedures will be done or will be justified or anything like this, they say “Okay, the interpreter solves this.” You can say a “representative of the patient” or an “attorney of the patient”. **It means that every responsibility is imposed on the interpreter.** [INT1]
[Tam olarak doğru anlaşıldığını düşünmüyorum. Çünkü sadece tercüman değil de hastanın bir temsilcisi gibi ya da **rehber- hastane işlerini halleden birisi gibi** gösteriliyor- anlaşılıyor. Tamam ... “bu hastayla ilgili her şeyi tercüman bilir” mesela. “Ona dönelim”, “Ona şey edelim”. Bir işlem varsa, bir şey yapılacak mesela bir hastanın- yabancı- bazen yabancı hastanın yabancı sigortaları- onay alınacaksa ya da bir şey alınacaksa “Tamam, tercüman halleder.” Yani “hastanın temsilcisi” diyeceksiniz ya da “avukatı” gibi, “vekili” gibi. **Her şeyi hastaya- tercüme- tercümana- çevirmene yüklemek demek ya da yönlendirmek.]**

In addition to the tasks mentioned above, INT5 also included the interpreters’ support to the hospital in financial terms:

EX23:

[M]y job was not restricted to interpreting. Apart from that, it included calculation of hospital procedures or how can I say?... That is, it included **communicating with patients’ insurance companies in their country**. It was not only interpreting. First of all, it was required to know about patient’s health and math, and also calculation at some point.... We were not only interpreting, there were also expectations in addition to interpreting. [INT5]

[[Y]aptığım iş kesinlikle hani tamamen çevirmenlik sınırlarında kalmıyordu. Bunun dışında hani hastanenin hesaplarıyla ilgili olarak ya da ne bileyim ... yani **yurt dışındaki sigorta şirketleriyle birebir görüşme**. Hani ... sadece çevirmenlik dışında sağlık bilgisi ve hani ... biraz belki matematik, hesap bilgisi bile gerekiyordu bir noktada. ... yani sadece çevirmenlik yap- yapmıyorduk yani onun dışında beklentiler de vardı]

Like INT5, the statement of INT6 also exemplifies the users’ perception of the interpreter as an agent who shoulder the responsibility for all the issues within the hospital. According to him, the interpreter was called when there was no available staff at that moment. Besides admitting the “irrelevant” tasks within the hospital, INT6 also complained about the role imposed on them for the issues or problems that require more responsibility:

EX24:

*[T]hey are trying to overcome the problems occurred to their staff deficiencies with us. **It is not a problem to run an errand, but they asked for help when they had problems.** They didn't take into account that fact that we were actually interpreters. [INT6]*

*[[O]radaki kendi personel eksiklik- eksikliklerini bazen bizden faydalanarak tamamlamaya çalışıyorlar. **Ufak getir götür işleri sorun değil ama daha şey sorunları olduğu zaman yine bizden yardım bekliyorlardı.** Orada yani çevirmen olarak bulunduğumuzu pek dikkate almıyorlardı.]*

Likewise, INT12 went one step further by putting an emphasis on the fact that the interpreters are sometimes explicitly declared even as “scapegoats”, when something goes wrong with the patients:

EX25:

***There is an approach towards interpreters as such: If there is problem about the patient, the interpreter is involved in that problem.** Suppose that something went wrong directly about the patient, they ask “Who is the interpreter of that patient?” In fact, it might have occurred due to the patient's individual problems. They also try to impose that problem on the interpreter. That is, they try to impose all responsibilities on us. Other colleagues think that the interpreters have other responsibilities apart from our own roles. [INT12]*

***[Bizim hastanede aslında tercümanlara şu şekilde bir bakış var: Hasta ile ilgili bir problem varsa tercüman vardır.** Hani direk hasta ile ilgili en ufak bir şey oldu, “Bu hastanın tercümanı kim?” diye sorarlar. Halbuki belki de hastanın kişisel bir problemidir o. Kişisel problemi de artık tercümana yansıtmaya çalışırlar. Yani bütün yükü bize bindirmeye çalışırlar açıkçası hasta yani aslında bizim kendi bildiğimiz görevlerden daha da fazla görevlerimiz varmış gibi bir kaniya sahip diğer arkadaşlarımız.]*

According to the responses of the interpreters, the users' expectations from the interpreter to undertake all the responsibilities and also to take the blame on themselves if any problem occurs, are reflected on the doctor-patient interactions. For instance, INT3 contended that the doctors sometimes perceive the interpreter as a “translation machine” and speak accordingly. Instead of transmitting the core message, the doctors speak with long and complicated sentences, which obstructs the task of the interpreter during the interaction:

EX26:

[...] I don't think that they- especially the ones who have not worked with interpreters before, can understand the profession. First of all, they cannot understand your language capacity and... the fact that knowing a foreign language doesn't mean the capability of interpreting into/from that language.

Furthermore, they even sometimes might hinder both the interpreter and the other parties to obtain information by uttering long sentences instead of transmitting the core message by uttering short sentences. Therefore, I think that they don't know both... the profile of a healthcare interpreter and the profession of interpreting. [INT3]

[[...] Özellikle ... çevirmenle hiç çalışmamış insanların anlayabildiğini düşünmüyorum. Öncelikle dil kapasitenizi anlayamıyorlar ve ... yani bir dili konuşmakla çeviri yapmak arasındaki farkı bilmiyorlar. Onun dışında çeviri esnasında işte kısa cümleler ve özünü vermek yerine uzun cümleler ... kurarak işte hem tercümanı hem karşıdaki kişinin edinmesi gereken bilgiyi almasını biraz engelliyorlar. O yüzden hem ... çevirmeni tanımadıklarını düşünüyorum hem çeviri alanını tanımadıklarını düşünüyorum.]

INT3 in this statement explicitly dwells on the significance of the 'sense' of the message and the 'context'. The same approach was also adopted by INT10, indicating that they are treated as if they were a "Google Translate" or a "translation machine" during the interactions. In contrast to that perception, INT10 underlined the context they take into account while interpreting:

EX27:

*[I] think, unfortunately, that there are some deficiencies at this point. The interpreter's role is not understood correctly neither in our sector, nor in Turkey. I also feel its impact in the hospital because people only receive you as a "translation". **That means that they label you as a "robotics", but it actually involves feelings, context. You interpret by taking the context into account.** We also add something while interpreting in order to enable the parties to communicate smoothly. Well, the role here is not to conduct a robotic translation like Google Translate. What is crucial here is that the message should be transferred correctly after filtered by the interpreter in order to provide communication between doctor and patient. I don't think that they understand this point. They expect the interpreter to interpret literally from English into Turkish or vice versa. [INT10]*

*[[M]aalesef bu konuda bazı eksiklikler olduğunu düşünüyorum. Çevirmen rolü sadece bizim sektörde değil; Türkiye'de zaten tam olarak anlaşılmayan bir meslek bana göre. Hastanede de bunun etkilerini hissetmedim değil çünkü insanlar sadece çeviri gözüyle bakıyorlar. **Yani aslında sizin orada yaptığınız işi robotik bir iş olarak nitelendiriyorlar ama aslında daha fazla- sizde daha fazla- içinde bir duygu var, bir bağlam var.** O ortamı yine değerlendirip bir şeyler aktarıyorsunuz. Aktarırken de aynı zamanda kendinizden de bir şeyler katarak iki tarafında kolayca anlaşabilmesini sağlamaya çalışıyoruz. Yani burada aslında rol sadece robotik bir çeviri yapmak değil Google Translate gibi. Burada önemli olan hastayla doktor arasındaki uyumun sağlanabilmesi oradaki aktarımın çevirmenin süzgecinden geçirilerek en doğru şekilde aktarılması. Bunu anladıklarını düşünmüyorum. Onlar daha çok literal bir İngilizce -Türkçe tercümesi gibi bekliyorlar yani.]*

Another implication occurring due to a lack of awareness is the eye directions of the parties in the interactions. First of all, INT4 describes the ‘ideal’ gaze patterns of the parties below in which the doctor and the patient should look at each other while talking as also indicated in the literature. However, although she strived to position herself in the backwards, she said both the doctors and the patients were directly looking at her while talking. Hence, the eye directions of the parties make the interpreter get involved in the interactions:

EX28:

*... not actually. When we try to do our job, especially in professional terms,... we have to ignore some... principles. For example, while we were receiving education in this field, eye-contact- what was eye-contact in Turkish? Well, you need to have eye-contact with the patient. Same with the doctor. You need to remain in the background. But, ... **while the doctor was giving you information about the patient’s condition, s/he gazes at you.** Likewise, the patient gazes at you, while s/he is speaking about her/his condition. ... like this. This happened at the hospital: In the beginning, there wasn’t a perception as such. However, you need to deal with this issue step by step as an interpreter. You also need to deal with this issue by talking about it and demonstrating it. Because unfortunately there isn’t much awareness in this issue. [INT4]*

*[... açıkçası tam olarak değil. Özellikle profesyonel anlamda bu işi yapmaya çalıştığımızda ... bazı kuralları ... görmezden gelme durumunda kalıyorsunuz. Örneğin ... biz eğitim alırken bu alanda eye- contact yani göz ... yani ne denir? İşte göz göze gelmemeniz gerekiyor hastayla. Doktorla da aynı şekilde. Daha geri planda durmanız gerekiyor. Ama ... ya doktor da size hani durum- **hastanın durumunu anlatırken size bakıyor, hasta da aynı şekilde kendi durumunu anlatırken size bakıyor.** ... bu şekilde. Hastanede şöyle oldu: başta böyle bir algı hiç yoktu. Ancak siz yavaş yavaş bunu çevirmen olarak oturtmak da durumunda kalıyorsunuz. Anlattıkça, gösterdikçe nasıl olması gerektiği konusunda da bir mücadele vermek durumundasınız çünkü çok maalesef farkındalık yok bu anlamda.]*

Contrary to the interpreters quoted above, three interpreters, namely, INT7, INT8 and INT13 believe that their role is perceived correctly. They specifically dwell on the issue of language capacity and capabilities. Since they can eliminate the language barrier between the doctor and the patient, they are respected, and their role is well appreciated.

EX29:

I think that ((our role)) is perceived correctly. Because the patient coming from abroad cannot communicate with the parties and s/he can deal with all the procedures and health problems with the help of the interpreter. Therefore, both hospital executives and doctors as well as other health professionals cannot ignore the interpreter in order to help the patient. That is, they give particular importance to the interpreters. [INT8]

[Doğru anlaşıldığını düşünüyorum çünkü ... gerçekten yani yurt dışından gelen bir hasta hiçbir şekilde burada iletişim kuramazken bir kişi var ve çevirmen var ve bunun sayesinde orada sağlık sorunları neyse ...yani yapmak istediği işlem ne ise bunu rahatlıkla halledebiliyor. ... yönetim de sağlık personelleri de aslında diğer sağlık personelleri de tabi ki de o hastaya yardımcı olmak konusunda çevirmeni göz ardı edemiyorlar. Yani ön planda oluyor.]

Even though three interpreters accepted that their role is well comprehended and respected, there is an inclination between the vast majority of the interpreters that their role is not perceived by the users as perceived by the interpreters. In other words, according to their statements and examples, their role is not perceived correctly by the users. Thus, the possible impact of this finding on the interpreters' perception of prestige within the hospital will be traced in the following section.

4.3.2.3. Prestige/Position of the Healthcare Interpreters within the Hospital

After delving into the interpreters' self-perception of role and the users' perceptions of role from the interpreters' perspective, the focus of the present section is whether and how the interpreters perceive their position i.e. their prestige within the hospital. This section of analysis can be considered as the continuation of the previous one since it is directly related to the issues raised by the interpreters in the previous section. The responses of the interpreters uncovered different approaches embraced. While most of the interpreters, namely, 8 interpreters, reported that they do not consider their profession prestigious, 5 interpreters indicated that they are well respected within the hospital. The most repeated reason of this respect lies in the fact that the interpreters are crucial agents for the hospitals in financial terms.

On the other hand, the most mentioned reason leading to a lack of prestige is the additional tasks imposed on the interpreters by the users as also highlighted in the previous section (see section 4.3.2.1).

INT1, INT2 and INT5 explicitly stated that they feel uncomfortable with the users' approach towards the interpreters as they are expected to assume many other responsibilities. For example, INT1 asserted:

EX30:

In fact, they don't think the interpreters' profession as prestigious. They don't think that it is so important. They have an approach towards us as if we were a representative of the patient and say, "The interpreter deals with the patient's procedures". I can also give an example. For example, a wheelchair was needed, and you call and say, "The foreign patient needs wheelchair". They say "Well, why don't you send?". I am an interpreter there and I am not a bellboy. I don't despise bellboys here, but it is not my task there. Another example can be that they take the patient, for example. They say to me "Take the patient" or "Carry the patient's documents". There is not much respectability. [INT1]

[Aslında, açıkça o kadar da bir şey ... bir prestij bir şey görmüyorlar. Çok önemli bir şey görmüyorlar. İşte hani dediğim gibi ilk başta geliyor hastanın bir temsilcisi gibi işte "hastanın işini halleder" falan filan. Mesela bazen bir örnek de vereyim: Hasta diyelim ki ... tekerlekli sandalye falan isteniyor, şey ediyor. Arıyorsun işte yabancı hasta işte "aa, niye sen göndermiyorsun?" anlamında. Ben tercümanım burada, bellboy değilim ya da ... O, karşıdaki bellboy'u küçümseme anlamında değil ama o benim işim değil mesela. Ya da hastayı mesela bir yerden bir yere götürürken yatan hastayı götürüyorlar. "Sen götür" mesela ya da hastanın yanında giderken dosyası oluyor. "Sen taşı" mesela, falan filan. Bu anlamda işte biraz saygınlık yok sanki.]

The point INT1 wanted to underline here is that he was treated as an "errand boy" or a "maid of all work" who could deal with everything included within his role definition or not. The same approach was also felt by INT5. She complained that the executives expected her to translate their personal documents, even though it was not among her main tasks:

EX31:

I can say that the profession of interpreting doesn't receive a respect which it reserves.... Because, if you don't deal with a patient at that moment, they can ask you "Can you also deal with this?". Or, if the executives need a translation, they can ask you "Can you translate this document?", even if it is not among your responsibilities. Therefore, I think that it doesn't receive a respect deserved. Yet, I also don't think that we are otherized in the hospital. However, I don't think that we receive respect that we deserve. Especially in financial terms, when we take our salaries into account. [INT5]

[Yani çok hak ettiği yeri görmediğini söyleyebilirim açıkçası. ... çünkü hani eğer mesela hasta yoksa, gerekirse hani böyle işte "şu işi de yapar mısın?" falan hani böyle ya da yöneticilerin bir çeviriye ihtiyacı varsa, hiç senin görev tanımında olmasa bile hani sana gönderip, "Bunu da çevirir misin?" falan gibi böyle iş kakalama gibi. ... şey de vardı açıkçası. Hani- o yüzden çok görevine, mesleğine saygı- yani çok fazla, olması gerektiği kadar olduğunu düşünmüyorum. Ama yine de çok ötelendiğimizi düşünmüyorum hastanede ama. ...ama yine de hak ettiğimiz değeri gördüğümüzü düşünmüyorum açıkçası. Özellikle de maddi yönde hani. Aldığımız maaş bazında düşününce.]

INT5 also made it clear that the interpreters were not totally ‘excluded’ or ‘differed’. Rather, she thought that they did not receive the respect that their role deserved. Apart from the ‘irrelevant’ tasks imposed on them, INT9 dwelled on the reflections of the users’ lack of awareness on the interaction. According to her, she was perceived as an ‘invisible’ agent, rendering from one language into another automatically, namely, like a “translation machine”:

EX32:

It is not, of course, as it should be. We are perceived as if we were not there who provided an ...automatic rendition as a translation program does. [...] [INT9]

[Olması gerektiği gibi değil tabi. Yani orada yokmuşuz gibi, hani bir ... tele-otomatik çeviri, bir telefonda bir siz çeviri programı gibi görüyoruz. [...]]

Contrary to the approaches above, four interpreters advocated that their profession was regarded prestigious, mostly because of their support in bringing money to the hospital.

At this point, INT12 touched on a striking point, exemplifying the power the interpreters have not only for the doctors, but also for the executives and the hospital in general. In the statement below, first it becomes obvious that the interpreter benefitted from the privilege in financial terms because he is a ‘touchstone’ who helps the hospital and the doctors to earn money. He further claimed that if the doctor did not have a close relationship with the interpreter, then the interpreter might direct the patient to another doctor and enabled him/her to gain money. Thus, it can be inferred that the interpreter appears as a significant decision-maker in financial terms:

EX33:

Doctors and hospital executives- actually patients bring money to the hospital. Therefore, I can say that they grant privileges to the interpreters. Let me give an example. One of the staffs will get examined, for example, in the department of dermatology. The doctor might ask additional charge for that staff. I was examined in the dermatology department a few days ago. S/he didn’t ask me an additional charge because we are very close. Why? Because I bring patients to him/her.... It is also a fact. The doctor says, “I should be close with the interpreter and bring to me patients.” If the patient is foreign, they earn more when compared to Turkish patients. It is another fact. On the other hand, if they are not close with the interpreters, then you take the patients to another doctor or the patient doesn’t come at all. If there is no patient, - because the general directorate of the hospital is informed about the complaint of the patient about the situation such as “The patient isn’t satisfied”, then the general directorate doesn’t send

that patient to our hospital. Then, if we consider that the hospital has lost the patient, then the hospital executives complain about it. Therefore, all medical doctors try to have a good communication with the interpreters. [INT12]

[Doktorlar ve yönetim- aslında yabancı hastalar hastanenin büyük çoğunluğunun gelirini sağlıyor. O yüzden tercümanlara çok büyük bir ayrıcalık aslında var diyebilirim çünkü mesela herhangi bir personel bir bölüme- örnek vereyim dermatolojiye muayene olacak. Kendisi için hekim o personelle ilgilendiği zaman ondan fark alabiliyor ama ben mesela geçenlerde dermatolojiye muayene oldum. Benden fark almadı çünkü aramız çok iyi. Neden? Ben ona hasta getiriyorum. ... şimdi bu yanı da var. Hekimimiz diyor ki "Tercümanla aramı iyi tutayım. Bana hasta gelsin. Yabancı hasta gelince tabi Türk hastalardan daha da fazla şey oluyor, getirisi oluyor. Bir bu yandan var. Bir de aynı zamanda tercümanına iyi davranılmadığı zaman bu sefer de hekimle aranız iyi olmadığı için bu sefer zaman gidip başka hekime veriyoruz ya da hasta gelmiyor. Hasta gelmeyince- çünkü genel müdürlüğe şikâyet gidiyor "Hasta memnun olmadı" gibi. Hasta memnun olmayınca, genel müdüre şikâyet gidince genel müdürlük bu sefer hastanemize bu hastayı göndermiyor. Bu sefer hastane hasta kaybetmiş olduğuna kanaat getirirsek bu sefer yönetim de bundan şikâyetçi oluyor. O yüzden herkes tercümanlarla gayet iyi bir şekilde iyi bir tutum sergiliyor.]

This aspect was also verified by INT10, underscoring their important role in bringing money to the hospital:

EX34:

If we conceive interpreters only as interpreters- I mean, if we consider interpreters' prestige only as interpreters, then I can say that it is not very prestigious. You aren't appreciated only as an interpreter from the users' perspective. Having additional titles apart from being just an interpreter and taking additional responsibilities will increase your reputation. Right in the beginning, your position is already very important. If you are employed only as an interpreter, then people don't understand your value. They don't know how important it is because there aren't much people who are received language education. There aren't many experts in language. You interpret for the people who haven't received that education, but it is your job as an interpreter. However, the role of interpreters isn't much respected in our country. Particularly the hospital is a trade place. I was working at a private hospital. As I said, the time is money here. Everything comes from money. In such a place, the interpreter isn't considered important because s/he is only in the role of an interpreter, not in the role of a person who brings money to the hospital. S/he only provides service. Therefore, s/he doesn't receive the reputation that s/he deserves. At least, the hospital executives have this opinion. [INT10]

[Sadece hastane çevirmeni olarak bakarsak yani sadece çevirmen olarak bakarsak çok iyi görmüyorum maalesef. ... yani sadece çeviri yapmak insanların gözünde çok fazla değer arz etmiyor maalesef. Onun yerinde farklı title'lara sahip olmak, farklı sorumluluklar almak sizin saygınlığınızı artıracaktır. Zaten pozisyona girdiğiniz zaman ne pozisyonda girdiğiniz çok önemli ama çevirmen olarak- sadece çevirmen olarak girdiğiniz zaman maalesef insanlar bunun değerini anlayamıyorlar. Ne kadar önemli bir iş

olduğunu bilemiyorlar çünkü dil eğitimi alan çok fazla insan yok. Dil konusunda uzman olan çok fazla insan yok. Siz zaten uzman olmayan insanlara yapıyorsunuz ki çevirmen olarak rolünüz de bu ama maalesef ülkemizde çevirmen rolü çok fazla değer arz eden bir rol değil. Özellikle de hastane- ya da şöyle söyleyeyim: ticaret yapılan yerlerde- çünkü aslında hastane de bir ticaret yapılan bir yer- ben özel hastanede çalışıyordum. Burada dediğim gibi vakit nakittir. Her şey paradan dönüyor. Öyle bir yer olduğu zaman çevirmen maalesef çok önemli sayılmıyor çünkü çevirmen tek sadece çevirmen rolünde olduğu zaman aslında parayı getiren rol değil, sadece hizmet rolünde oluyor. O yüzden yeterli değere sahip olmuyor. Yani en azından patronun gözünde o şekilde.]

Here in this example, INT10 emphasized their role not as an interpreter, but as an agent who supplies money for the hospital, thus resembles the hospital to a business firm.

As a consequence, in this section it can be argued that there is a general view among the interpreters that they desire more reputation than they receive since their workload is worth being respected. On the other hand, the interpreters alleging that they are well respected mainly focus on the financial interests of the hospitals, which shows that they are respected not because of their competencies as “interpreters”, but because of their critical role in bringing money to the doctor and the hospital. The following section investigates what kind of responsibilities and tasks the interpreters have in the hospital.

4.3.2.4. Tasks and Responsibilities in Addition to Interpreting

Even though the interpreters already clarified that their tasks went beyond interpreting in the previous sections, they were also asked whether they had additional tasks besides the task of interpreting within the hospital. Thus, it is aimed to reinforce the understanding of the users’ role perceptions and expectations with the analysis of the interpreters’ answers to this question. All the interpreters, except one, admitted that they were busy with a wide array of responsibilities in the hospital. These include physical assistance to the patients and financial support for the hospitals in general.

For instance, INT1 implied that his tasks already commenced even before the patients arrived at the hospital since he was also responsible for organizing the transfer triangles of the patients and they continued even after the patients’ procedures were completed and they arrived at their country:

EX35:

Transfer of the patients. Getting in contact with the patients. Sending the patients' reports. Showing the results of the patients' investigation to the doctor by taking their documents.... Such kinds of things. Such procedures. Transfer of the patients. Their transfer from hotel to the airport, from airport to the hospital. Transfer between these circles. [INT1]

[Hastaların transferi. Hastalarla iletişim kurmak. Hastaların raporlarını göndermek. Hastaların ... raporlarını alıp da mesela gittikten sonra sonuçlarını alıp da hocalara göstermek. ... bu şeyler. Bu tür işlemler. Hastaların transferi. Otelden havalimanına, havalimanından hastaneye. Bu üçgen arasındaki transferleri.]

In the same manner, in addition to organizing the transfers of the patients mentioned by INT1 above, INT9 listed a number of duties she carried out in the hospital, including the financial bargain done with the insurance company of the patients to advocate the hospital's interests:

EX36:

Registration of the patients, if the fee isn't received correctly, calling the fee center, reaching the person representing the patient's country, finding the correct price by negotiating with her/him, giving a regional discount, if there is any, a lot of thing like this. I also help the patient's pharmacist to communicate, because the pharmacist cannot speak foreign language. The hospital doesn't provide service for this. International hospital might be providing such services, but I haven't encountered. Also, the transfer of the patient. Dealing with return transfer of the patient by getting in contact with the related person. There are a lot of extra duties. It is not limited to interpreting. [INT9]

[Hastanın sürekli girişinden kayıttın- kayıttı, ücret alınması ... doğru alınmadıysa ücret merkezi aramak, merkezde onun temsilcisi olduğu ülkenin ... ülkesini temsil eden kişiye ulaşmak. Onunla tekrar müzakere edip doğru fiyatı bulmak, bölge indirimi varsa onu yapmak, ...bunun gibi birçok şey. Bazen eczanesine tabi öyle şeylere de yardım ettiğim çok oluyor. Eczane bilmiyor çünkü. Hastanenin böyle bir servisi yok. ... uluslararası vardır hani sabit şeylerde belki vardır ama ... benim karşılaştığım birçok alanda- sonra transferi. Dönüş transferini ilgili kişiye iletip transferini sağlamak. Birçok ekstra şeyleri de oluyor. Sadece tercüme değil.]

Attending the hospital's interests in financial terms was also put forth by INT3:

EX37:

[...] I am dealing with the insurance claims of the patients. I am dealing with all the patients' insurance processes, if the patient is Turkish and has a foreign insurance or s/he is foreign and has a foreign insurance, or s/he is a foreign and a Turkish insurance. I am dealing with their preliminary approvals and payments until the accounts are closed. [INT3]

[...] Hastaların sigorta işlemleriyle ilgileniyorum. Türkse- Türkse ve yabancı sigortalıysa veya yabancı ve yabancı sigortalıysa ve yabancıysa ve Türk sigortalıysa, bunların hepsiyle ben ilgileniyorum. Ön onayları, onayları. Ödemelerin takibine kadar, hesapların hepsi kapanana kadar ben takip ediyorum.]

Like INT9 above, INT3 also touched upon their critical role in advocating the financial interests of the hospital by following the payment procedures. Besides financial perspective, INT5 directly associated her role to that of a ‘hospital attendant’ or a ‘relative of the patient’ because she was following the patients wherever they went. She indicated that the patients could not even go to the toilets without the interpreters, which demonstrates how they actually depend on the interpreters:

EX38:

*[T]o accompany the patient, of course. Taking them everywhere, to the tests, even to the toilets. Once I had an experience about that. Well, I left the patient upstairs. I was occupied downstairs. We were waiting for the doctor to call us. The doctor could also speak English, therefore I thought that leaving the patient alone upstairs would not be a problem. They called me from the upstairs, from the Department of Internal Medicine. They told me that the patient was telling something to them, and they could not understand it. I wanted to talk to the patient on the phone. The patient only wanted to go to the toilets and was asking where the toilets were. The staff could even not tell where the toilets were. That’s why, you become a person who **accompanies the patient** as if you were **a relative of the patient**. Apart from that, the hospital expected us to deal with insurance claims of the patients. [...] [INT5]*

*[[Z]aten hastaya eşlik etmek bir kere. Oradan oraya götürmek, tahlile götürmek en nihayetinde tuvaletin yerini bile sorsa- hatta böyle bir şey başıma bile geldi. Şey, hastayı yukarıda bıraktım. Aşağıda yapmam gereken bir iş vardı. Doktorun çağırmasını bekliyorduk. Doktor da İngilizce konuşuyordu, o yüzden çok sorun olmayacağını düşündüm. Üst kattan telefonla aradılar beni, dahiliyeden işte. Bir şey söylüyor hasta, anlamıyoruz diye. Hastayı işte telefona istedim. Tuvalete gitmek istiyordu sadece. Tuvaletin yerini soruyordu. Onun yerini bile tarif edememişti yani böyle. ... yani şey, **hastanın eşlikçisi gibi** oluyorsun. Sanki yakınıymış gibi, **hasta yakınıymış gibi**. Onun dışında tabi hastanenin beklentisi ... ayrıca sigortayla ilgili süreçler de var. [...]]*

The similar responses and examples could be multiplied here. However, interestingly, two interpreters- INT7 and INT10- remarked that they were employed as “operation specialist” and also work for the department of “sales marketing”, rather than as an “interpreter”. Even those titles alone imply additional responsibilities on the interpreters’ shoulders, such as doing marketing research, listening to the patients’ requests and creating solutions, organizing their flight tickets and transfers, etc.:

EX39:

*I am working at the department of “**sales marketing**”. In fact, interpreting constitutes only a part of my job. I think this case is all the same in most hospitals. There are not many hospitals and departments in Izmir, but the case is the same in most hospitals because the target receiver is health tourism patients. Therefore, my main responsibility is regarding sales marketing, which includes getting in contact with the patient, listening to their requests and afterwards offering them price, responding, informing, helping them while purchasing flight*

ticket We also arrange their appointments by informing them regarding which airport they should come on which dates. We arrange their appointments and hotels. We also deal with their transfers between the airport, hotel and the hospital. The patients get in contact only with us from the hospital before coming to Turkey. After returning their countries, we also get in contact with them. If they need to ask something to a doctor, they pose their questions to us. We ask to the doctor and then inform them. We are also involved in the follow-up process, after they return to their countries after their operation. [INT7]

[[S]atış pazarlama bölümündeyim aslında tercümanlık dediğim gibi işin sadece bir kısmı. Bu zaten sanıyorum çoğu hastanede de bu şekildedir. İzmir’de çok fazla hastane de yok gerçi böyle departmanlar ama çoğu hastanede bu şekilde oluyor çünkü erek kitle sağlık turizmi hastası ... bunun... yani bu nedenle üstlendiğim görevler öncelikle satış pazarlama kısmı. Yani hastayla ilk olarak diyaloga geçme, hastanın isteklerini dinleme, sonrasında ona bir fiyat teklifi sunma, yanıt verme, bilgilendirme sağlama, uçak biletleri bakarken ona destek olma, hangi-işte hava alanından alması gerektiğini, hangi tarihleri alacağını randevusunu ayarlıyoruz. Otellerini biz ayarlıyoruz. Bunun dışından havalimanı hastane ve kalacağı adres arasında transferlerini biz yapıyoruz. Hastaya gelmeden önce hastanın tek muhatap kişisi biziz hastaneden, gittikten sonra da yine aynı şekilde doktora bir şey danışması gerekiyorsa bize soruyor. Biz doktora sorup hastaya söylüyoruz. Yani post-op dediğimiz ameliyat sonrası hasta ülkesine döndükten sonra takibinde de yer alıyoruz.]

As seen above, interpreting constitutes just a small part of the whole process. She admits that her main responsibility entails the tasks pertaining to the sales marketing department, which has nothing to do with interpreting. Similarly, INT10 touched upon his responsibilities as an “operation specialist” in the hospital, indicating similar responsibilities such as doing marketing research again, making agreements with the agencies and hotels, writing texts and translating them for the advertisement of the hospital:

EX40:

[...] I was employed as an operation specialist. [...] I have actually a number of responsibilities under the title “operation specialist”. Let me explain: There has been a health tourism trend abroad in recent years. Some processes need to be managed here. I was managing this process. I was a mediator. So, what is it? Making agreements with agencies, agency research, market research, making an agreement with hotels, organizing transfers, marketing, preparing marketing advertisements, making statements there, posts in the website, etc. All these included in my job. [...] Interpreting, in fact, constitutes a large part of all my responsibilities because all are related to language. You conduct all these responsibilities with your language competence. Thus, interpreting is also included in this process. For example, when you write a text for advertisement, you also translate it or when you write an informative text in the website, for instance, I was writing, these texts needed to be translated into three languages. Thus, you translate them. You give them to graphic designer. S/he arranges texts and uploads in the website. Actually, texts belong to you. You both create it and translate it. [INT10]

[[...] operasyon uzmanı olarak işe alındım. [...] Operasyon uzmanı olarak aslında birçok görevimiz var. Mesela şöyle anlatayım: yurt dışında biliyorsunuz son yıllarda bir sağlık turizmi trendi var. Burada bazı süreçlerin yönetilmesi gerekiyor. Ben bu süreç yönetimini yapan kişiydim. Buradaki ara bulucuydum. Yani nedir bu? Acentalarla olan anlaşmalar, acenta araştırması, piyasa araştırması, otellerle yapılan anlaşmalar, transferlerin ayarlanması, onun dışında satış kısmı, pazarlama reklamların hazırlanması, oradaki demeçlerin verilmesi, sitelerdeki yazılar vs. bunların hepsi var içinde. [...] Çeviri aslında bunun büyük bir kısmını oluşturuyor çünkü tamamen dille bağdaşık bir süreç. ... yani dilinizi kullanarak yapıyorsunuz. O yüzden çeviri bu işin içinde var. Mesela siz reklam için bir metin yazdığınız zaman onun çevirisini de kendiniz yapıyorsunuz ya da sitede bir bilgilendirme yazısı yazdığınız zaman sitedeki yazıları, atıyorum ben yazıyordum, onların yine üç dile çevrilmesi gerekiyor. E siz yapıyorsunuz. Siteye yani onları yazıyorsunuz düz bir metin olarak. Grafikere veriyorsunuz. O kendisi ayarlayıp siteye yüklüyor. Aslında yazdığımız şey aslında sizin yazınız, hem de sizin çeviriniz aynı zamanda.]

The responses of INT7 and INT10 put the statements manifested above about the financial interests of the hospitals on the table again. The interpreters come forward as important agents in facilitating not only the interactions, but also advocating the financial interests of the hospital by dealing with the insurance claims of the patients, bargaining and following the financial procedure of the hospital. The interpreters also come forward with their assistance to the patient before, during and after their examinations in the hospital. Even in the ‘post-op’ process- a process after the patient’s operation- the interpreter continues to play a crucial role in coordinating the communication between the parties. However, this could increase the burden of the interpreters, which, in return, affects the interpreted interactions as well as the service quality of the interpreters. For the very same reason, the issue of ‘quality’ will be scrutinized in the following section.

4.3.3. Quality

Another important issue addressed in this study is ‘quality’. Two questions were asked to the interpreters regarding the issue of quality: 1) Do you think that your interpreting performance is of high quality? and 2) What do you think a high-quality healthcare interpreting means? What are the most important quality criteria in healthcare interpreting according to you? Interpreters’ responses will serve to shed light on their perceptions of quality criteria. In their answers to the question on their perceptions of quality criteria, the interpreters listed a number of criteria; therefore, it is very hard to present sharply circumscribed categories. Nevertheless, three main

factors emerged indicating high quality in healthcare settings: *Accuracy and completeness of information* (6 interpreters), *experience in the field* (5 interpreters) and *(medical) terminology* (5 interpreters). Following these three criteria, the interpreters placed emphasis also on the “personal characteristics” including providing support for the patient such as showing empathy, a sociable personality, and the sense of responsibility, knowledge on culture and language, professionalism, confidentiality, and coherence. Interestingly, aside from those criteria, 4 interpreters admitted that their renditions are of high quality since they receive complaints from neither hospital executives or doctors, nor the patients. This shows a lack of control mechanism with regard to quality standards. Moreover, the interpreters still continue to take care of both the users’ and the patients’ interests in the interactions, assuming again the roles of “facilitator” and “advocator”. The implications and examples with respect to the above-mentioned quality criteria will be demonstrated and discussed under the main categories “Accuracy and completeness of Information”, “Experience in the field”, and “Terminology”.

4.3.3.1. Accuracy and Completeness of Information

The criteria “accuracy and completeness of information” was among the top priorities of the interpreters remarked. INT3 expressed undoubtedly that the most important quality criterion is transferring an accurate message by saying, “Quality interpreting means is, first of all, to transfer an accurate message. I think that it is the most important criterion” [Çevirmenliğin kaliteli olması demek, 1) doğru mesajın aktarılması demek. En önemlisi bu bence.]. In the same manner, INT5 supported that mutual understanding between the doctor and the patient must be ensured. In this regard, the interpreter plays an important role:

EX41:

[I]t is very important that patient understands exactly what the doctor says. It is also so important that every utterance of the patient should be understood by the doctor. [...] Quality refers to the fact that both parties fully understand each other. [...] [INT5]

[[H]astanın doktorun dediğini tam anlaması çok önemli. Bir de hastanın her söylediğinin doktora mutlaka ulaşmış olması çok önemli. [...] önemli olan mesajı doğru yere tam anlamıyla ulaştırabilmek. Kalitenin şeyi- bu bence. Her iki taraf da anladı mı birbirini tam olarak. [...]]

On the same issue, in addition to the emphasis on the accurate transfer of the message, INT9 further pointed to the transfer of the ‘sense’ of the message, saying that deviation from the core message or omitting anything might pose a risk for the procedures of the patients. She additionally emphasized the sense of responsibility as an important quality criterion as well:

EX 42:

[...] The interpreter should have full knowledge of his/her profession, love his/her profession and undertake its responsibility. S/he needs to feel its **responsibility** ... and do it accurately. Quality interpreting ... refers to transferring message accurately. In this regard, the interpreter should feel his/her deficiencies. **S/he should transfer the sense of the message** and should be curious. S/he should not miss anything, should not omit anything. S/he should try to conduct procedures ... by doing his/her best. [INT9]

[...] Alanına hâkim olacak çevirmen, kesinlikle işi severek ve sorumluluğuyla yapacak. **Sorumluluğu** hissedecek. ... doğru- doğru yapacak. Kaliteli çeviri ... mesajı doğru iletecek ve bunu hissedecek, eksiklerini hissedecek. **Tam olarak özünü olması gereken şekilde aktaracak** ve meraklı olacak. Yani bir şey kaçırmayacak, atlamayacak. Tam hakkını vererek ... işlemlerin doğru yürütmesi için çalışacak.]

Even though INT9 focused on the completeness of information without omissions, she did not mean word-for-word or literal translations. Rather, the ‘sense’ is the most important point. In addition, the interpreter should also improve himself/herself so as to provide smooth service for the parties, which emphasizes the ethical principle “professionalism”. On the other hand, by underlining the importance of the accurate and completeness of information, INT10 also brought up the financial issue of the profession and commented on the gap between the users’ and the interpreters’ role perceptions. Although the users focused more on financial gain, INT10 revealed a more patient-oriented approach in the example below by referring back to the need of taking the responsibility of the patient which could be analyzed as a part of personal characteristics as handled above:

EX 43:

Quality of interpreting in healthcare interpreting might refer to... financial gains from the hospital’s perspective; however, health is the important issue to be taken into account from the interpreter’s perspective. Thus, the interpreting performance should be as clear and accurate as possible. **The most important criterion is to give the core message.** ... apart from that, it entails the process right from the beginning until it is over, it is not only about interpreting. You undertake the responsibility of the patient and you need to be with the patient at every moment because anything can happen anywhere. Taking this **responsibility** enable the interpreter to conduct his/her job more properly. [INT10]

*[Hastane çevirmenliğinde çevirmenin kaliteli olması ... **hastaneye göre burada para döngüsü oluşabilir ama çevirmene göre önemli olması gereken şey burada sağlıktır.** O yüzden yapılan çevirinin olabildiğince net ve yanlış anlaşılmalardan veya bariz hatalardan uzak olması gerekiyor. **Burada net mesajı vermek en önemli kriter.** ... onun dışında bu baştan sona bir süreç olduğu için sadece çeviri gözüyle bakmamak lazım. Hastanın sorumluluğunu siz alıyorsunuz ve her anında yanında olmanız gerekiyor çünkü çevirmenin nereden çıkacağı- hastanede nerede çıkacağı belli olmuyor. Her an- her an her şey olabilir. Bu sorumluluğu alabilmek bir çevirmene bu meslekte daha iyi yapacaktır.]*

INT10's views were reiterated by INT12, who summarized the whole process with regard to "accuracy and completeness of information". If the procedure of the patient could not be completed because of insufficient or incomplete information provided to the patient, the interpreter falls to the position of the "scapegoat" again. Thus, s/he believes that s/he has room for maneuver to defend herself/himself against the accusations, if s/he explains everything and conveys every piece of information given by the parties:

EX44:

*[Q]uality criteria include, first of all, **transferring the message accurately**.... When you convey the message accurately, the patient's procedures are conducted quickly, and nothing is hindered because the patient accepted the procedures to be done.... Therefore, the patient does not complain about the procedures done. The patient says, "I already knew the interventions to be done like this." Informing the patient before the procedure regarding the possible complications after the operation enables to conduct smooth process. Otherwise, the patient says, "I have not been informed about it. Why did it happen?" and complains to the hospital management, which extends the process. Then everybody starts blaming the others and the process slows down. Discharge of the patient is delayed.... Therefore, an accurate interpretation enables the process in the hospital to progress quickly. Otherwise, if there occurs a problem, the hospital generally dissatisfies about the situation and says "Why has the patient not been discharged from the hospital? Because his/her procedures were completed, but the interpreter has not completed yet." [INT12]*

*[[K]alite kriterleri bir **şeyi doğru aktarmak** en başında. ... bir şeyi doğru aktardığınız zaman en azından hastanın süreci çabuk ilerliyor ve hiçbir şekilde hiçbir şey aksamıyor çünkü hasta her yapılan şeyi kabul etmiş oluyor ve ...yapılan müdahaleler sonucunda hasta herhangi bir şikâyetle bulunmuyor. Hasta diyor ki "Ben zaten bunun böyle olacağını biliyordum.". Önceden hastanın bilgilendirmesi, ameliyattan gelişen komplikasyonlar hakkında hastanın bilgi sahibi olması ... bu sefer bu süreçte her şeyi kolaylaştırıyor. Öbür türlü "Ben bundan haberdar olmamıştım, neden böyle oldu?" deyip yönetime şikâyet ediliyor. Süreç daha da çok uzuyor. Bu sefer herkes birilerini suçlamaya çalışıyor ve süreç yavaşlıyor. Hastanın taburculuğu gecikiyor. ... o yüzden tercümenin doğru olması hastanedeki sürecin hızlı ilerlemesine yardımcı oluyor. Öbür türlü tercüme konusunda bir problem olursa hastane genelde memnun olmuyor. Tabi yani hastadan- "hasta neden taburcu olmadı hala çünkü bu yapılmıştı da ama tercüman yapmadı henüz" gibi bir sonuçlar da olabiliyor bazen.]*

Even though the abovementioned examples clearly reveal the fact that the interpreters attribute a lot of importance to accuracy and completeness of information, they also indicated further issues indirectly such as professionalism and responsibility. Those hints give us critical details as regards the users' role perceptions in general, which will be discussed in detail at the end of the chapter. The next issue elaborated on by the interpreters is the 'experience in the field'.

4.3.3.2. Experience in the Field

In addition to other qualifications, one of the main quality criteria which was highlighted by the majority of the interpreters is having experience in the field. INT1 believed that he provided a high quality of interpreting service because he has experience in this field. Yet, it is the language knowledge which helps to strengthen the service provided by him because being able to speak two languages is an advantage especially in rendering the medical terms during the interpreting process:

EX 45:

I personally find my interpreting service as a high quality since I have experience. Moreover, I am capable of speaking two languages- English and Arabic. Since most medical terms arise from English, I believe that I provide a quality interpreting service by especially benefitting from the advantage of having two languages, while interpreting of transferring a case to the patient. [INT1]

[Ben kendi adıma evet kaliteli buluyorum çünkü yeterince ... tecrübeye sahibim. Artı iki dile sahip olduğum için -İngilizce ve Arapça- çoğu tıbbi terimler İngilizceden geldiği için bir ... çeviri yaparken ya da bir vakayı bir hastalığı anlatırken ... iki dilin getirdiği avantajı kullanarak daha kaliteli tercüme yaptığıma inanıyorum.]

A similar response was explicitly described by INT7 who also agreed on the importance of language level and the experience in the field. Even though he indicated that he received training in medical terms, his remarks highlighted that experience matters more than theoretical knowledge regarding the field, which might direct us to the gap between the theory and practice in interpreting:

EX46:

[I] think I provide a quality of interpreting service because I have sufficient language level. [...] [I] have a good command of medical translation. It means

that I have observed everything. You can perceive the hospital as a factory floor. I have also received medical translation lecture at the university. But everything hangs in the air. When you observe an operation, for instance, I also had a chance to be present at an operation. You have better command of knowledge when you see the organ called the liver, that is, the organ you know in more than one language, while observing at an operation. You know everything then. You know the method. Then all the words you have learnt do not hang in the air, you learn them. [INT7]

[D]il bilgim yeterli olduğu için aslında kaliteli buluyorum [...] [T]ıp çevirisine hakimim yani her şeyi çok iyi gözlemledim. Hastanenin içi biraz zaten şey gibi-mutfak gibi düşünebilirsiniz. Üniversitede de tıp çevirmenliği dersi aldım ama her şey havada kalıyor. Fakat bir ameliyata girdiğinizde- mesela birkaç ameliyata da girdim. Ameliyata girdiğinizde her şeyi gözlemlerken işte karaciğer denilen organı yani birkaç dille bildiğiniz organı gördüğünüz zaman çok daha hâkim oluyorsunuz. Her şeyi biliyorsunuz. Yöntemi biliyorsunuz. O zaman o bütün kelimeler havada kalmaktan çıkıyor öğreniyorsunuz.

INT9 also placed emphasis on the importance of experience in the field by clearly indicating that she had lack of self-confidence and was afraid of working in healthcare settings before. However, working in the field and acquiring experience enabled her to make the decision to continue working as a healthcare interpreter. When the fact that INT9 graduated from French translation and interpreting department is taken into account, it is reasonable to say that theoretical knowledge alone does not seem to be sufficient in achieving high quality service in healthcare interpreting. Thus, her views supplement the answer of INT7 above since from their point of view, this theoretical background needs to be bolstered by the experience:

EX47:

[I] worked for 2 years in a Turkish company in Algeria. I was dealing with all hospital procedures of over thousand Turkish workers, which was really hard especially in a foreign country. I was interpreting between Turkish and a foreign language. Having this experience and positive feedbacks helped me to overcome all my fears and concerns. [...] [INT9]

[[Y]urtdışında 2 yıl ... bir Türk şirketinde çalıştım ben Cezayir'de. ... ve Türk hastalar-bın küsur Türk işçilerin bütün hastane işlemleri- yabancı bir ülkede üstelik, çok zordu. ... orada tamamen artık bir de yabancı dile- Türkçeden yabancı dile- ... bu tecrübeyi yaptığımda geri dönüşlerden dolayı dedim ki hiç ... artık o, benim bütün korkularımı, kaygılarımı aşmama sebep oldu. [...]]

The experience and the user satisfaction as well as feedback from the users, accordingly, as understood from the statement above, helped her to continue to work in this sector. The experience helped the interpreter to obtain competences on the different matters as well. As clarified by INT6, he started to perceive himself competent enough to provide medical information with the experience he gained:

EX48:

[...] At one point, I started seeing approximately 500 head photos. Then, I started to be able to make decisions myself about which procedure and how many sessions the patients will need. Thus, the experience becomes important at some point. [...] [INT6]

[[...] Bir yerden sonra gün içinde yaklaşık belki 500 tane falan kafa fotoğrafı görüyordum. Bir yerden sonra artık kendim karar verebilmeye başladım bu kişinin hangi işleme kaç seansta ihtiyacı olacağına. O yüzden yani tecrübe önemli oluyor bir yerden sonra. [...]]

As implied above, experience in the field also enable the interpreter to obtain or to claim the ‘authority’ during the interactions. All in all, the answers show that experience is an important criterion in easing the decision-making process of the interpreters specifically in critical cases. However, terminology was also uttered as among the important criteria, which will be demonstrated below.

4.3.3.3. Terminology

Another factor touched upon by the interpreters as a quality criterion during the interviews was terminological knowledge. INT2, for example, based the quality interpreting service on the terminology knowledge. His response further revealed that a wide array of terms in a variety of medical specialties might raise difficulties in precise interpretation. Thus, terminology was perceived as a criterion which enhances quality and effectiveness of the service provided:

EX49:

[S]ince there are patients coming to different specialties, you cannot always interpret adequately and effectively. It is due to a lack of terminological knowledge, a lack of knowledge of special terms of that specialty. [INT2]

[[Ç]ok farklı branşlar olduğu için her zaman çok yeterli ve çok etkili bir çeviri yapamayabiliyorsunuz. Bu da bunun tek şeyi de- eksik olunan nokta da o branşa ait ... terminoloji, o branşa ait özel kelimeleri bilmemekten kaynaklanıyor.]

Showing a similar tendency towards quality, INT8 also paid attention to the use of correct terminology. He said that he could better help the patient if he knew the correct terms:

EX50:

*[F]irst of all, I can say **correct terminology**. When you know correct terminology,... you can help the patient more effectively and the procedure can be executed appropriately. Because, as I said earlier, health issues are sensitive in nature. It is required to know what is exactly done. For example, if blood*

sample is taken from the patient, the procedure is obvious, and I can say that it should be done accordingly. [INT8]

[[İ]lk olarak **hani doğru terminolojiyi söyleyebilirim**. Doğru terminolojiyi çünkü bildiğiniz zaman ... hastaya da daha iyi yardımcı olabilirsiniz ve doğru işlemler yapılıyor aslında çünkü dediğim gibi en başta sağlık hassas bir konu. Gerçekten ne yapıldığını net bir şekilde bilmek gerekiyor. İşte hastadan ne bileyim kan örneği alınacak ise bu bellidir zaten ve ona göre işlem yapılması gerekiyor, ona göre yol izlenmesi gerekiyor diyebilirim.]

Likewise, INT3 indicated that she improved herself because she worked for the patients coming for the same departments, thus, she associated her competence with the terminology knowledge she acquired over time, which, could be related to the experience as well:

EX51:

[N]ow I am only dealing with the patients coming for obesity surgery. We have a... network providing this service. The patients are merely coming for obesity surgeries. Therefore, **I am more acquainted with the medical terms**. That's why, I am confident on this topic. Well, while I was working at another hospital, there were patients mainly coming to the departments of orthopedics and urology. Therefore, I am also good at those areas. However, I am less qualified, for example for the department of dermatology. [...] [INT3]

[[Ş]u an mesela ben sadece obezite cerrahisi ile ilgili hastalara bakıyorum. O şekilde bir ... ağımız var. Sadece bunun için geliyor hastalar. **O yüzden terminolojiye daha fazla alıştım**. O yüzden bu konuda kendime güveniyorum. ... diğer hastanedeyken de ortopedi çok fazla geliyordu ve üroloji çok fazla geliyordu. O yüzden o konularda iyiyim. Ama mesela bir cildiyede daha yetersiz hissediyorum kendimi. [...]]

In addition to the emphasis on the experience in the previous sub-section (See Section 4.3.3.2.), INT1 also focused on the terminology knowledge. However, further focus was indirectly on the need of showing empathy towards the patients:

EX52:

The most important quality criterion... is to **learn medical terms**,... the second one is to comprehend the interpreting more than a profession. Rather, it is required to help the patient during his/her treatment process **and to provide psychological support**. [INT1]

[En önemli kalite kriteri ... **tıbbi terimler öğrenilmesi**, ... ikincisi tercüme-tercümanlık mesleğini bir meslek olup hem meslek hem de bir ... hastanın sadece bir meslekten çok da bir hastanın tedavisinde yardımcı olmak ya da bir destek sağlamak, **psikolojik destek** gibi aynı zamanda hani. Tedaviyi- tedaviye bir destek gibi görülmesi lazım.]

When the interpreters' answers given for the quality criteria are examined in general, it can be said that there is no single criterion highlighted. Instead, all the criteria mentioned and underscored by the interpreters are interconnected and enrich one another.

Another remarkable point stepped forth in this section is that the interpreters continuously highlight the cruciality of personal characteristics again in addition to the three main categories explained. Those include having the sense of responsibility, showing empathy and supporting the patient. In this vein, INT1, for instance, both underlined the experience in the field, medical terminology knowledge as well as empathy or support for the patient. Likewise, both INT9 and INT10 emphasized accuracy and completeness of information as well as the importance of having the required responsibility for the patient. All these actually put forth the way they place importance on the context and adopt their role in accordance with the context. On the other hand, three interpreters based their quality criteria on user satisfaction and explained that since they did not receive any complaints from the hospital staff or the patients, they evaluated their service as quality.

4.3.4. Interpreter's Involvement

The issue of involvement was another topic for discussion with the interpreters. With regard to interpreter's involvement, the interpreters were asked whether and how they interfere with the interpreting process. All the interpreters, except one, underlined that they had to get involved in the process and impinged on the situation. These interventions, according to the interpreters, are caused by mainly two reasons, which are *content* and *style* of the speech. Ten interpreters admitted that they are sometimes involved in the communication with regard to content of the speech, i.e. the information given by the parties, including correcting the parties, reminding the parties if there is missing information, confirming, omitting or adding information. Intervening in the interaction specifically in relation to the content of the speech proves that the interpreter takes the authority during the encounter, rather than acting as a conduit. Interference with the process regarding the style of the speech includes, on the other hand, involvement with regard to *fluency* and *speed of the speech*. Two out of thirteen interpreters stated that they sometimes requested the doctor to speak slowly or to divide his/her speech into shorter parts in order that the interpreters could provide an accurate and complete transfer of the message. All the examples will be analyzed under two sub-headings "*content of the speech*" and "*style of the speech*" to

demonstrate how the interpreters adopt the “facilitator” and the “advocator” roles for both the doctors and the patients.

4.3.4.1. Content of the Speech

Upon the question whether and how the interpreters intervene in the communication, ten interpreters indicated that they have to be involved in the process because of the content of the speech. For example, INT1, INT9 and INT12 admitted that they intervened in the conversation when one of the parties did not understand what was delivered. INT1 explained:

EX53:

While the doctor tries to explain something, s/he misunderstands a word, which might be a wordplay or something. Then I interfere and say, “No, this is not the case. The patient means this” [INT1]

[Doktor bir şey anlatmaya çalışırken, doktor bir şeyi yanlış anlıyor. O şeyi tekrar onu bir şekilde kelime oyunu- kelime oynaması mesela oynuyor ya da şey oluyor. “Yok hocam, bu böyle değil. Bu böyle oldu” demek anlamında.]

Apart from that, the most recurring example given by the interpreters that required their interventions during the interpreting process was to remind the patients a piece of information they forgot to say to the doctor. INT9 highlighted that the countries the patients come from affect the way they express their complaints, and especially exemplified the African patients for those situations. Therefore, the interpreters intervened and reminded the information which was delivered to the interpreter before the consultation started with the doctor. By doing so, the interpreter takes the authority and therefore these cases especially provide critical insights into how the authority is distributed between the parties during the interactions:

EX54:

While interpreting, yes, which might be caused by the patient’s difficulty of expressing herself/himself. [...] You know the patient’s all complaints from doctor-patient consultation conducted before. However, the patient might not give... correct answer to the doctor’s question because of the excitement, misunderstanding of the question, being abroad... or feeling fatigue. [...] Then, I ask a question to the patient, “You had such conversation with the doctor before” in order to convey the correct message to the doctor and to provide smooth communication between the parties, and the patients react by noticing, “Oh, yes”. In such situations I have to interfere. [...] [INT9]

[Çeviri sırasında, evet. Bu da hastanın ifade güçlüğünden kaynaklanan ani durumlar olabilir. [...] Daha önceki bir hasta- doktorla yapılan çeviri sırasında bütün rahatsızlığını biliyorsunuz. Ama hasta ya heyecandan ya başka sebeplerle idrak edemediği için, başka ülkede olmanın belki verdiği ... bir şeyle- yorgunlukla belki de

bir diğer muayenesinde sorulan soruya ...doğru cevap vermeyebiliyor. [...] Hastayı doktora doğru bilgi vermek adına, durumuyla ilgili ... doğru iletişimi geçirmek adına hastaya tekrar soru sorup “Siz daha önce muayenede böyle bir konuşma geçmiştii” deyince, “Aa, evet” diye uyanabiliyorlar. Yani böyle durumlarda yapmam gerekebiliyor. [...]]

A similar point was also put forth by INT3 and INT4, respectively, pointing to the position they get within the hospital. The examples which will be provided below also exemplify how the patients perceive the interpreter:

EX55:

[S]ince I am in communication with the patient just from the beginning, s/he explains his/her all complaints to me first. Afterwards, s/he explains to the doctor. S/he explains to me like, “I am going to tell this and this”. If s/he forgets something to tell the doctor, I am reminding her/him- not to the doctor- by saying, “You told this to me. Would you also like to ask it to the doctor?”. I interfere in such situations. [...] [INT3]

[[H]astayla ilk geldiğinden itibaren iletişim kurduğum için işte öncesinde bana anlatıyor. Daha sonra doktora anlatıyor. İşte “Şunu şunu soracağım”, “Şunu şunu da söyleyeceğim” diye. Bana söyleyip doktora söylemediği bir şey olursa ben kendisine hatırlatma- doktora değil de- kendisine hatırlatma, “Bana böyle böyle bir şey söylemişsiniz, onu da sormak ister misiniz?” diye. O şekilde müdahale ediyorum. [...]]

According to the statements of INT3 above, the patient perceives the interpreter as an authority and shares information with the interpreter even before s/he talks to the doctor. Likewise, INT4 implied that she was talking to the patient before the patient informed the doctor, which justifies the ‘authority’ given to the interpreter again:

EX56:

[...] The patients give us some important information in a conversation we had before the consultation... and they might sometimes forget to explain to the doctor. I repeat it again to the patient by asking, “There was a case you told me about. Would you like to ask?”. ...If the patient says “Yes”, I was pointing it to the doctor. [...] [INT4]

[[...] Özellikle girmeden önce hastayla yaptığımız konuşmalarda ... bazı önemli noktalar olabiliyor ve içeri girdiklerinde doktora söylemeyi unutabiliyorlar. Ben tekrar hastaya soruyorum “böyle de bir durum vardı, dile getirelim mi?” diye. ... “evet” dediği zaman ben de açıkçası dile getiriyordum. [...]]

The examples above reflected the dynamics of the power relations between the parties. First, the patients conceive the interpreter as someone who possess the authority, or the information needed. In return, the interpreter advocates his/her rights when s/he forgets to tell something important to the doctor. Then, the interpreter takes the floor to facilitate the patient’s process by advocating his/her rights. By interfering and reminding a piece of information to the parties in general, the interpreters go beyond their “interpreter role” and act as a “facilitator” and “advocator”. Yet, it would

be wrong – or at least incomplete - to say that the interpreter merely adopts the patient-oriented approach by advocating their rights. In some cases, the interpreters indicated that they acted in complete contrast to the abovementioned examples by advocating the institution's or the doctors' rights.

For instance, three interpreters illustrated that they either omitted or added some information to the original speech when they deemed necessary. INT7 is among those interpreters who gave a remarkable example by indicating that she took initiatives at some points and omitted some information given by the doctor in order to protect the financial interests of the hospital:

EX57:

*[I]t sometimes might to take initiative. How can I explain it? ... for example, we sometimes might decide not to convey the information which might worry the patients. For example, plastic surgeries are performed very often.... The doctor, at that moment, unwittingly or because the patient cannot understand Turkish, says that “**The patient does not get a positive result**”. **We cannot interpret this sentence because there is also a financial dimension**. Thus, I cannot say that I interpret everything hundred percent. However, I have to transfer all information the patient needs to know about the surgery. I take such initiatives and interfere with the process. [INT7]*

*[[İ]nisiyatif kullanmak gerekebiliyor bazen ... nasıl anlatsam bunu yani mesela hastayı endişe ettirecek şeyleri bazen inisiyatif kullanarak söyleyemeyebiliyoruz. Mesela estetik ameliyatları çok sık yapılıyor. ... doktor o sırada hani gayri ihtiyari ya da hasta- hastanın dili bilmediğini gayet iyi bilerek “**Bu hasta hiç iyi sonuç almaz**” diyor ama bunu çeviremeyiz çünkü işin bir de ticari boyutu var. Bu yüzden tamamen her şeyi yüzde yüz çeviriyorum diyemem ama ameliyatla ilgili bilinmesi gereken her şeyi anlatmak durumundayım. Böyle inisiyatif kullanıyorum, bu tarz müdahalelerde bulunuyorum.]*

As manifested above, the financial perspective of the sector comes to the fore again. INT7's claims show that financial interests of the hospital navigate both the interpreter's role and the strategies employed during interpreting process. By omitting the doctor's negative estimations regarding the surgery, the interpreter acts as a part of a team of the institution and aligns with the institution. By doing so, the interpreter also takes away the patient's right to knowledge acquisition, which might also jeopardy the patient's health. In that case, gaining money subordinates the health outcomes of the patient.

In contrast to omissions, two interpreters (INT10 and INT13) claimed that they extended the information given by the parties to enhance their understanding in a particular situation. They said that they tried to sort things out both for the doctor and

the patient, taking their expectations and interests into account, which also highlights the “in-betweenness” of the interpreter again:

EX58:

[...] There is a patient here and his/her psychology is important. The doctor has a different type of psychology. The time is so valuable for the doctor, but this is not the case for the patient. The patient wants to hear a more detailed information. S/he asks questions from different perspectives. S/he has many points to touch on. However, the doctor focuses only on the answer. While I was trying to receive a clear answer from the doctor, I was also transferring the information given by the doctor to the patient. While I was transferring the information to the patient, I was giving more details to the patient instead of giving just one answer. For example, if the doctor asked a single question to the patient, I was not asking a single question. I was asking a couple of questions to the patient while interpreting. By doing so, I could receive the answers faster and could inform the doctor if there is a different case because the doctor might ask that question again or forgets to ask. You actually help the parties in that way, too. [...] [INT10]

[[...] Burada bir hasta var. Hastanın bir psikolojisi var. Doktorun ayrı bir psikolojisi var. Doktor için vakit nakit demek maalesef ama hasta için öyle değil. Hasta daha detaylı anlatmak istiyor. Birçok yerden giriyor, söylemek istediği birçok şey var. Doktor sadece net bir cevaba bakıyor. Ben o net cevabı almayı çalışırken aynı zamanda hastanın anlattığı şeyleri de doktora aktarıyordum ve doktordan da ... sadece tek bir cevap olarak değil hastaya detaylandırarak anlatıyordum. Yani hastaya mesela doktor tek bir sorduğu zaman ben tek bir soru sormuyordum. Birkaç soru soruyordum. O şekilde cevapları daha hızlı bir şekilde alıp doktora eğer farklı durum varsa onu da aktarmış olabiliyordum çünkü doktor daha sonrasında yine bunu sorabiliyor ya da sormayı unutabiliyor. Bir yandan aslında o konuda da yardımcı olmuş oluyorsunuz. [...]

According to the statement of the interpreter above, the doctor has a limited time, which lead to the abridgement of the speech. However, the patient wants to get more information. The interpreter here plays “facilitator” and “advocator” roles by filling this gap. INT10’s views were reiterated by INT13, who explained that she also gave more detailed information to the patients by giving examples from their cultures and countries. Thus, the interpreter steps forth by filling the information gap.

Last but not least, INT12 had a clear number of strategies in mind. He said that while he protected the patient’s rights in some cases, he had to meet the doctor’s expectations in others. For example, he informed the patients regarding the doctors’ principles before going into examination:

EX59:

If the patient does not understand or the doctor says something short and the patient does not understand it, we can intervene and say, “Professor, our patient did not understand. Could you please repeat the sentence in a more understandable way?”. Or one of our doctors pays a lot of attention to where

the patient sits or to whom s/he looks at while talking. Some of the doctors have obsessions that the patient should not look at the interpreter while talking. We tell these to the patients before going to examination and we say, “You need to do these. You want to go into examination”, etc. [...] [INT12]

[Hasta eğer anlamadıysa veya doktor kısa bir şekilde bir şey söylediyse hasta anlamadıysa biz “Hocam hastamız anlamadı. Tekrar daha açık bir şekilde söyler misiniz?” diye kendimiz müdahale edebiliyoruz bazen veya bir hocamız mesela çok dikkat eder benim hastam şuraya oturmalı, işte benim hastam bana bakmalı konuşurken tercümana bakmamalı gibi bazı hocalarımızın bir takıntıları oluyor. Bunları biz muayeneye girmeden önce hastaya müdahale ederek hastaya söylüyoruz. Diyoruz ki “Şunları yapmanız lazım, bunları yapmanız lazım. Muayeneye girmek istiyorsunuz” gibisinden. [...]]

Therefore, the interpreter strives to thread a thin line between the two parties and to make easier the process for both parties.

4.3.4.2. Style of the Speech

Another reason causing the interpreter’s involvement is style of the speech. In other words, fluency and speed of the speech. Two out of thirteen interpreters emphasized that they had to interrupt and requested the doctor to either speak slowly or to shorten his/her sentences in order to interpret accurately and completely. Although small in number, these two examples support the data discussed in the previous sections not only about the role perceptions of the users, but also the impact of their perceptions on the interpreting process during the interactions.

In this regard, INT2 stated that the doctors perceive the interpreters as “translation machine” and talk so fast. As a result, the interpreter feels obligatory to intervene in the process and to remind his/her profession’s requirements:

EX60:

[T]hey could sometimes perceive us as machines and speak so fast or without giving a break. Thus, we interrupt in those situations. They speak and we request the doctor like, “I can interpret the information you have given so far. I can tell the patient. Afterwards, we can ask questions.”. Apart from those situations, we do not interrupt much, actually. We only intervene because of the speech... or style of the speech. [INT2]

[[Y]ani bizi açıkçası makine gibi görüp çok hızlı konuşabiliyorlar. Ya da böyle es vermeden konuşabiliyorlar. O şeylerde genelde müdahalemiz o şekilde oluyor. Konuşuyorlar. Doktor beyden rica ediyoruz. “Ben buraya kadar çevireyim. Hastaya anlatalım. Sonrasında sorularını alalım.” O şekilde. Başka müdahale ettiğimiz bir durum olmuyor açıkçası. Sadece konuşma hızı ya da ... konuşma düzeniyle alakalı.]

In the same manner, INT5 also put emphasis on the doctor's speech speed by referring to indirectly the doctor's perception of "translation machine" again:

EX61:

*[I]f the doctor spoke so long, I had to interrupt the doctor and say, "Professor, let me interpret what you have said. Then you can go on explaining". [INT5]
[[D]oktoru çok uzun süre konuşursa hani "Hocam, bir çevireyim. Ondan sonra devam edeyim, devam edelim olur mu?" falan gibi bazı durumlarda müdahale etmem gerekti.]*

As revealed by the explanations above, it becomes obvious that style of the speech, i.e. fluency and the speed of the speech, is also an important element affecting the interpreter's performance. In those situations, the interpreters need to make themselves visible so that they could do their job properly. The fact that the doctors speak so long or so fast could be perceived as an indicator of the unawareness of the doctors regarding the interpreting profession.

In brief, the interpreters expressed that they had to intervene in the process to 'facilitate' and to 'advocate' the interests of both parties. However, their intervention as regards to the speech speed also indicate a gap between the role perceptions of the users and the interpreters.

4.3.5. Positioning of the Interpreter

According to the guide published by The National Council on Interpreting in Health Care (NCIHC), physical positioning of healthcare interpreters is a decisive factor in terms of doctor- patient relationship. It is underlined that the relationship between doctor and patient gains more strength, when they directly speak to each other, instead of speaking to the interpreter. Thus, the interpreter should be aware of the impact of his/her positioning on the interactions and remain in the background during doctor- patient encounters.⁸ In order to elicit the interpreters' awareness regarding their potential impact on the interactions, they are asked how the interpreter should position herself/himself during the interactions. According to their remarks, the most repeated positioning option revealed is the triangle position in which the

⁸ Accessed the information on the website on 2th March, 2021
<https://www.ncihc.org/assets/documents/workingpapers/NCIHC%20Working%20Paper%20-%20Guide%20to%20Interpreter%20Positioning%20in%20Health%20Care%20Settings.pdf>

interpreter stands in an equal distance both to the doctor and the patient. One of the reasons for triangle position is the importance attached to eye contact during the interactions. However, there are different positioning tendencies advocating that the interpreter should either be close to the doctor or to the patient, or even distanced from both.

INT1 is among the interpreters supporting an equidistant positioning and indicated the following:

EX62:

[...] ((The interpreter)) should see both the doctor and the patient directly because it [...] eye contact and gestures are so important while I am explaining something. [INT1]

[...] Hastayı da birebir görmesi lazım doktoru da birebir görmesi lazım çünkü burada göz teması, elle anlatım çoğu zaman- hani ben elle anlatırken şey ederken [...] el-kol hareketi, göz- kaş çok önemli gerçekten.]

A similar approach was also shared by INT3 and INT9 advocating an equidistant and triangle position because of the importance of eye contact. For example, INT3 explained:

EX63:

In an equidistant both to the doctor... and the patient. This is already taught in the lectures at the university. There is a triangle position... in which the interpreter stands close neither to the doctor nor to the patient. S/he stands in the middle of them, connecting them to each other. That's why I always say, "It is more important that the patient looks at the doctor, and the doctor looks at the patient, not me". I am always paying attention to that point. [...] [INT3]

[Hem doktora ... hem de hastaya eşit mesafede olacak şekilde. Zaten bu, derslerde de işleniyor. Bu üçgen stili var. ... ne hastaya çok yakın ne doktora çok yakın. İkisinin arasında sadece bir bağ gibi durarak. Bu yüzden zaten şey diyorum "Hastanın bana bakması değil, doktora bakması; doktorun hastaya bakması daha önemli". Ona dikkat etmeye çalışıyorum mutlaka. [...]]

In the excerpt above, INT3 put emphasis on gaze directions of the parties and believes that the doctor and the patient should directly talk to each other by gazing at each other instead of talking directly to the interpreter. Therefore, positioning of the parties comes to the fore as a focal point having impact on the interaction. However, there were also different opinions regarding the position of the interpreter supporting to be close to the doctor, to the patient, or to be far away from both. For instance, instead of an equidistant position, 2 interpreters expressed that they should be close to the doctor,

which shows a tendency towards taking side with the institution. INT 6 gave a striking example at this point:

EX64:

[I]n fact you are not a mediator. You represent the hospital and the doctor as a hospital staff member. Therefore, I do not support to be in an equidistant as a “mediator”. Instead, I am of the opinion that the interpreter should be close to the doctor. [INT6]

[[A]slında çok aracı değilsiniz. Hastane personeli olarak hastaneyi ve doktoru temsil ediyorsunuz. Bu yüzden bir “mediator” gibi arada oturmak çok değil-bana göre doktorun yanında yer almalı çevirmen.]

As could be inferred from the statements above, INT6 demonstrates an alignment with the hospital. INT6 perceives him as a part of the hospital team. However, by doing so, he might move away from a “neutral agent” violating impartiality principle from the patient’s perspective and destroy the patient’s confidentiality. In contrast to this view, two interpreters supported to be close to the patient. It is indeed interesting that there seems to be no consensus among the interpreters on the issue of positioning. One of them is INT13 indicating that:

EX65:

[...] I prefer to stand next to the patient. I mean, of course, I sit next to the patient and converse with him/her, when the examinations take too long. However, I generally sit next to the patient in a way that we could converse and answer his/her questions. Yet, I prefer to stand next to the patient rather than sit close to him/her. [INT13]

[[...] Ben yatağının yanında dikilmeyi tercih ediyorum. Yani hani tabi tetkiklerde uzun sürdüğü zaman bazen koltukta yanında oturup muhabbet ediyorum ama genelde hastaya dönük oturup bir şekilde hani konuşmaya devam edip ya da sorularına devam edebileceğimiz şekilde oturuyorum. Ama genelde ben her hastanın yanında dikilmeyi hani yakınında olmayı tercih ediyorum oturmaktan çok aslında.]

INT13 approached the issue of positioning of the interpreter from a different angle and indicated that the interpreter should be close to the patient.

The responses of the interpreters demonstrate that most of the interpreters showed a tendency towards locating in the middle of both parties, i.e. doctor and patient. It is possible to argue pros and cons for the interaction resulted from each positions of the interpreters. The physical intimacy of the interpreter to the parties might be perceived as violating impartiality principle, taking a part to each side as stated above. However, it might also a positive effect, especially for the patient’s side.

The patient might feel more comfortable, if the interpreter stands close to him/her during the interactions. Even though most of the interpreters indicated that the interpreter should be in the middle of the parties as a neutral agent, it might also have negative impact on the interaction, as referred by the NCIHC. According to the guideline of NCIHC, the interpreter's positioning in the middle might hinder direct communication between doctor and patient, since both of them might be disposed to gaze at the interpreter, instead of gazing at each other, which makes the interpreter more involved and visible participant in the interaction.

On the other hand, the doctors' preferences and expectations as an important participant of triadic interaction regarding the interpreters' seating position during the interaction might also be determining. Thus, the same question regarding how the interpreter should position himself/herself during the interactions were asked to the doctors and the hospital executives.

4.4. DISCUSSION

In order to make a comparison with the opinions of the users, the interpreters' responses were analyzed under different sub-titles in accordance with the **expectancy norms** and the **professional norms**. Primary focus was on five main topics: eligibility, role, quality, involvement and positioning of the interpreter. Especially the responses explicated by the interpreters during the interviews provided a rich description of the picture of the healthcare settings by revealing both their own as well as the users' perceptions of role comparatively.

Both the answers given by the users, namely, the doctors and the hospital executives- and by the interpreters revealed an undeniable gap between the **role perceptions** of the users and the interpreters, and this gap is reflected in the examples presented for the analysis of the sub-sections in this chapter. The users are found to perceive the interpreter more as an agent who, first of all, conducts all financial procedures. It is realized by the interpreters by protecting the financial interests of the hospitals, dealing with insurance claims of the patients, finding patients to the hospital by doing marketing research and advertisements, and finally providing the patient satisfaction. Apart from the agent who conducts financial procedures, the interpreters

are also perceived as “wildcard characters” who could deal with all types of responsibilities including helping the patients to accompany them to everywhere, to fill out their forms, etc., which were also underscored both by the doctors and the executives in the results of the questionnaires (see Section 3.3.1.2.). These responsibilities could either be related to the task of the interpreting or not, which all make the interpreter as “errand boy” or “a maid of all work”. However, in stark contrast to the users, the interpreters perceive themselves as “facilitators” and/or “advocators” both for the users -the doctors and the executives- and the patients. The interpreters are recruited mainly by the hospital, work for the hospital, need to protect their interests and meet their expectations. On the other hand, the interpreters focus on the ‘context’ where they provide renditions and as a consequence, develop a strong connection with the patient as an intuitive act. Even though both the users and the interpreters provided similar responses to each other in the **eligibility** part, the interpreters additionally elaborated on the importance of the personal characteristics such as having the sense of responsibility, a sociable personality, and showing empathy. By realizing these characteristics, namely, providing psychological support for the patient, taking their responsibilities, showing empathy towards them and developing a strong relationship with them, the interpreters specifically strive to enable the patient to obtain proper medication, proper treatment, to get surgery or examination without feeling any pain and to leave the hospital safe and sound. To this end, it could be indicated that they facilitate the patients’ procedures and advocate their rights and interests. One of those implications of this approach of the interpreters could be the fact that the interpreters perceive the patient as a “minor” who could do nothing without the help of the interpreter, including going to the toilets. It also refers to the power imbalance between the parties, which is again a striking distinction between conference interpreting settings and community interpreting settings. For the very same reason, the interpreter might adopt a patient-oriented approach from time to time, which, in turn, refers to the shift between his/her “professional identity” towards “personal identity”.

The **role gap** could also be detected in the part where the interpreters’ self-perception of prestige within the hospital (see Section 4.3.2.3). The users’ perception of the interpreters as “wildcard characters” who are generally expected to carry out all

tasks makes the most of the interpreters feel that their profession is not prestigious, and they are not granted the prestige they think they deserve. Even the ones who feel their profession is prestigious evaluated their value on the basis of financial gains. According to their statements, they are respected because they are perceived as having a potential for increasing the hospital's and the doctor's financial income.

In the same manner, this role gap between the users and the interpreters are also reflected on their answers to the **quality** criteria. As obtained from the results of the questionnaires, the doctors' top priority is "fidelity to the original speech", while the executives' is "completeness of information", both of which could be related to each other in sense. The interpreters listed the quality criteria which they find important in parallel with the users', and "completeness of information" is the criterion on which both the users and the interpreters agreed. Even though they seem to have met on the common ground by attaching importance to the 'completeness of information', the implicit implications are actually different because the users and the interpreters described the "accuracy" in different terms. Thus, they seem to interpret accuracy very differently. While the doctors and the executives seem to be more inclined towards the understanding of the "accuracy" as 'word-for-word' or 'literal translation', which further lead to their perception of the interpreter as a "translation machine", the interpreters seem to focus more on the transfer of the 'sense' of the message, thus, they declared that they make additions, omissions, and explicitations when they see necessary.

The above-mentioned role gap also has an impact on the interpreting strategies, causing to the interpreter's **involvement** during the interactions. The interpreters asserted that they sometimes feel obliged to intervene in the interaction to stop or to slow the doctor's speech down, when the doctors utter long and complicated sentences and speak fast just because they perceive the interpreter as a "translation machine" or a "translation program" who renders the words and sentences automatically from one language into another. Moreover, the interpreters also said that they intervene in the interaction not only to advocate the patients' rights, but also the doctors' rights in order to provide smooth communication and mutual understanding between the parties. By doing so, the interpreters facilitate the process for both the doctors and the patients.

The last category handled in this section was the **positioning** of the interpreter during the interactions. It was put forth that positioning could be a triggering factor affecting or shaping the interpreter's role. In this sense, the interpreter's self-awareness on where to stand is of great importance. Likewise, the users' preferences- especially the doctors'- might be a determining factor on the interpreter, thus, affecting the role of the interpreter as well. The majority of the users clearly predicated that the interpreter should be in an equal distance to both parties. The factual background of this preference might be their inclination to view the interpreter as a neutral, impartial agent, and a conduit. Although some of them advocated being closer to the patient, or to the doctor because s/he feels as a part of hospital team, there was also a common idea that the interpreter should be in a triangle position where the interpreter stands in an equal distance to both parties. The main reason of this approach was the importance of gaze / eye contact of the parties. They advocated that the doctor and the patient should directly gaze at each other, rather than at the interpreter. The gaze directions of the parties in authentic settings will be discussed in the next chapter more in detail.

To sum up, the answers obtained from the doctors and the executives through the questionnaires were compared and contrasted with the answers of the interpreters through the interviews, and a gap between their perceptions regarding the interpreter's role come to fore. While, the users perceive the interpreters more as agents as "wildcard characters" or "a maid of all work", the interpreters perceive themselves as "facilitators" and "advocators" for both the users and the patients. The interpreters meet the user expectations, in theoretical terms, the **expectancy norms** determined by the users, with their 'professional identity' by facilitating and advocating their rights and interests. However, on the other hand, they emphasize certain personal characteristics as a factor intrinsically related to the healthcare context and the importance of creating a personal relationship with the patients by broadening their professional boundaries, which demonstrate how they shift from their professional identities towards personal identities. Striking enough, some of the patients seem to accept the facilitator and the advocator role of the interpreter since they even sometimes share information with the interpreters which they could not share with the doctors. This indicates how they set a strong relationship with the interpreters as their facilitators and advocates.

Even though the discourse of the users and the interpreters revealed a role gap in their perceptions, how the interpreters act and which roles they adopt in real-life situations will be examined in the next chapter (Chapter 5). With this aim in mind, the next chapter relies on the data obtained from participant observation and audio-recordings of interpreter-mediated doctor and patient encounters. The data taken from real life situations will provide a more concrete picture in this unique setting by enriching the discussions and present a more specific insight into power dynamics in triadic interactions.



CHAPTER FIVE

ANALYSIS OF PARTICIPANT OBSERVATION AND AUDIO-RECORDINGS OF INTERPRETER-MEDIATED INTERACTIONS

This chapter analyses the interactional aspects of healthcare interpreting in Turkey, drawing on the power dynamics between the participants in the encounters. For this purpose, it attempts to demonstrate “not only to show how the interpreter participates but also, and mainly, how the interpreter’s behavior impacts on the participation of other interactants” (Pöchhacker, 2012: 58). Audio-recordings and observations of four interpreter-mediated doctor-patient interactions elicited various role shifts that the interpreter went through, which were triggered by the non-conforming forms of address and the gaze patterns of the participants. For the sake of providing a clear picture of the examples taken from the interactions, the analysis will entail progressive steps along a pathway leading from the analysis of ‘forms of address’ and ‘the gaze patterns’ of the participants to a ‘combination of thereof’, respectively. The analysis will be constructed on the combination of Goffman’s (1981) ‘participation framework’ (with the notions of hearers as ‘addressed’ and ‘unaddressed’ as well as ‘production format’ with the speaker roles as ‘principal’, ‘author’ and ‘animator’) and Wadensjö’s (1998) ‘reception format’ (with the listener modes as ‘responder’, ‘recapitulator’ and ‘reporter’) . At this point, it is worthy to note that especially Merlini and Favaron’s (2003, 2005) analysis was a source of inspiration, which provided an essential guide for this section.

Bearing in mind the objectives of the study, selected examples are demonstrated as excerpts entailing the original utterances, the interpreted utterances, and the back-translation of the Turkish utterances into English by the author. To ensure confidentiality, the participants have been coded as follows: “Dr” stands for the doctor, “I” for the interpreter, “P” for the patient, and “D” for the dietician.

This section begins with the depiction of the interactions including descriptions of the four interactions whose audio-recordings and observation notes constitute the data to be analyzed, and the positioning arrangements of the participants in each interaction with pros and cons. Following the detailed information with regard to the

interactions and participants, the data will be analyzed in line with the objective of the study.

5.1. DEPICTING THE INTERACTIONS

In what follows, I intend to demonstrate a table encompassing the information regarding place, date, duration, participants and purpose of the interactions and to depict the seating arrangements of the participants in the interactions in detail.

Table 1: Description of the Interactions

	INTERACTION 1	INTERACTION 2	INTERACTION 3	INTERACTION 4
PLACE	IZMIR	IZMIR	IZMIR	IZMIR
DATE	01.07.2020	02.07.2020	02.07.2020	10.07.2020
DURATION	19'31"	16'48"	22'52"	23'14"
PARTICIPANTS	Doctor- Patient and Interpreter	Doctor- Patient and Interpreter	Dietician- Patient and Interpreter	Dietician- Patient and Interpreter
PURPOSE	Laparoscopic sleeve gastrectomy	Laparoscopic sleeve gastrectomy	Laparoscopic sleeve gastrectomy	Laparoscopic sleeve gastrectomy
LANGUAGE	German- Turkish	German- Turkish	German- Turkish	German- Turkish

A total of 4 interactions took place between July 1, 2020 and July 10, 2020 in Izmir and included two different patients who came to Turkey for laparoscopic sleeve gastrectomy. The interactions were between German and Turkish since one of the patients was native German, the other patient was from Kosovo; however, he spoke German because he was living in Germany. All the interactions were consecutively rendered from German into Turkish and vice versa by the same interpreter who worked as a freelancer. Her native language was Turkish. Although she was not professionally

trained as an interpreter, she could speak German since she lived in Germany for a long time.

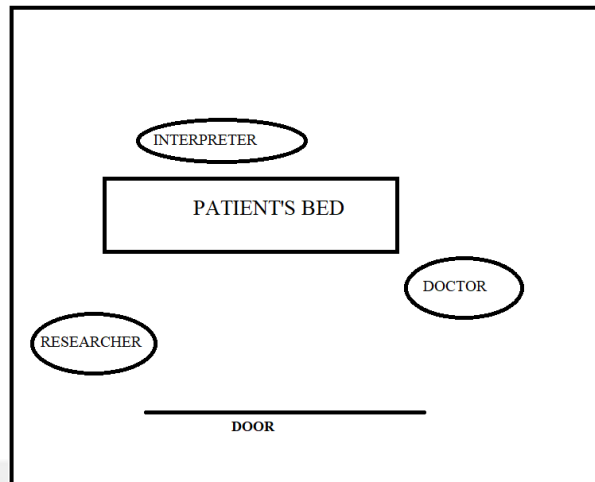
The first and the second interaction was about the doctor's medical visit after the patient's operation. In the interaction 3, the dietician visited the patient in order to inform her as to how she would take nourishment after the operation. The Interaction 4 took place between the Kosovan patient and the dietician. Just like in the Interaction 3, the dietician informed the patient regarding the nutrition.

5.1.1. Seating Arrangements of the Participants

In this section, in order to picture the setting where the interactions took place, sketches of positioning arrangements of the participants in each interaction are illustrated in the Figures 37- 41. The positioning of the participants might have an effect on the gaze directions, turn-taking allocations, thus, the power exerted in the interaction. Each schema of the positioning will be discussed in terms of its pros and cons.

In the Interaction 1, the interpreter was standing by the patient, while the patient was lying on the bed. At that moment, the doctor was standing on the right side of the patient, so the doctor could have direct eye contact both with the interpreter and the patient (see Figure 37). When this type of positioning where the interpreter stands next to the patient is analyzed from the patient's perspective, it could be argued that the patient might feel himself/herself much safer since the interpreter is the only person to whom s/he can complain about her/his problems. Physical proximity of the interpreter to the patient might make the patient perceive the interpreter as if s/he were closer to the patient – and perhaps on the patient's side – and strengthens the relationship between them. However, from the doctor's perspective it can be expounded as a loss of authority. In this interaction, the positioning of the triadic interaction seems to have given the interpreter more power and authority on the patient and the interaction over the other parties involved.

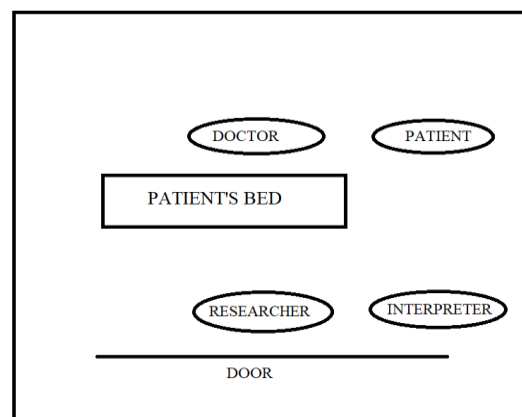
Figure 37: Depiction of seating arrangement in the Interaction 1



Source: Prepared by the Author.

Yet, this power and authority shifts to the doctor in the second interaction (see Figure 38). The next day, when the doctor visited the patient again, he stood closer to the patient, while the interpreter was closer to the researcher. All participants got a direct eye contact with each other. However, it is more probable that the doctor holds the authority, power, and control over the situation, given the positioning observed (see Figure 38).

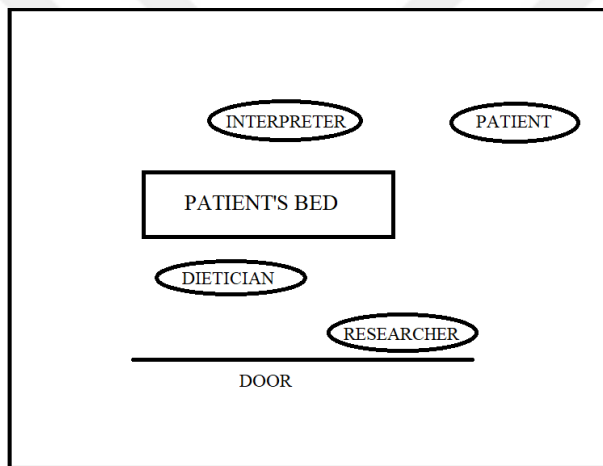
Figure 38: Depiction of seating arrangement in the Interaction 2



Source: Prepared by the Author.

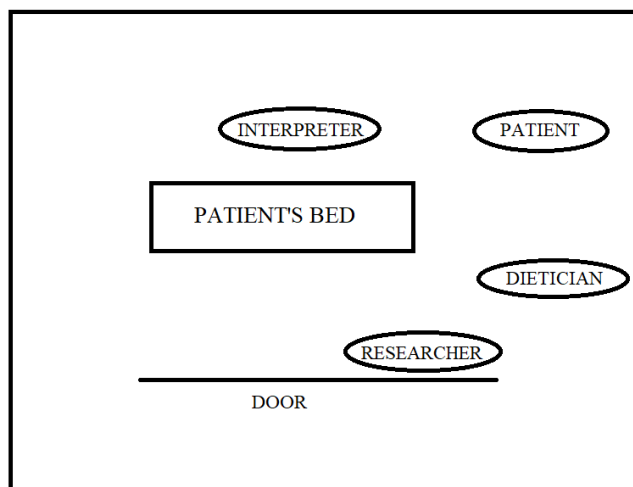
After the doctor had left the room, the dietician visited the patient on the same day. In this scenario in the Interaction 3, the interpreter was closer to the patient (see Figure 39). However, after a while, the dietician needed to come closer to the patient so as to provide better information regarding the nutrition for the patient (see Figure 40). The dietician's shift in the positioning might be the indicator of losing her power in the interaction. In order to regain this authority, she came closer to the patient (see Figure 40). In this way, she stood at the same proximity to the patient as the interpreter. Thus, by changing her position and coming closer, in fact she intervened at the unequal distance in the positioning to the patient.

Figure 39: Depiction of seating arrangement in the Interaction 3a



Source: Prepared by the Author.

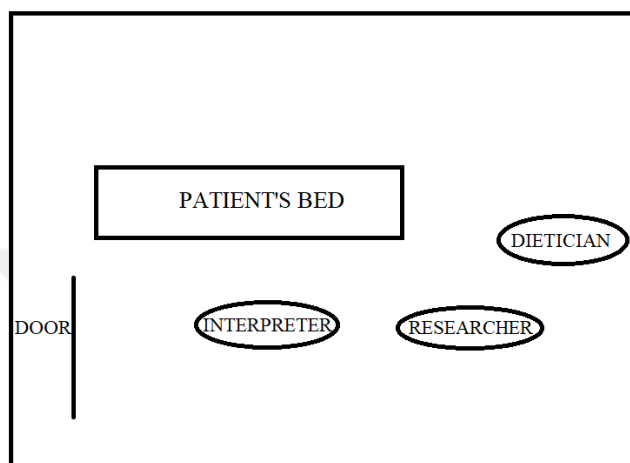
Figure 40: Depiction of seating arrangement in the Interaction 3b



Source: Prepared by the Author.

The last interaction took place between the dietician, a Kosovan patient and the interpreter. While the patient was lying on his bed, the interpreter, the researcher and the dietician were all close to each other and in equal distance to the patient (see Figure 41).

Figure 41: Depiction of seating arrangement in the Interaction 4



Source: Prepared by the Author.

Despite the fact that the interpreter was just in front of the patient, all the interactants could see each other directly in this scenario. The equal distance of both the dietician and the interpreter might have occurred because of their formal relationship with the patient.

The positioning of the participants might have an impact on the power relations between the participants. However, such an effect was not observed in this specific case since all the participants could have direct eye contact and were in equal distance to the patient.

5.2. 'ROLE SHIFTS' OF THE INTERPRETER

The corpus of this study revealed that there are non-conforming role distributions in the doctor-patient interactions. In theory, the interpreters are required to render the utterance in the way it was uttered in the source speech so as not to generate any additional distance (Hale, 2007: 44; Van de Mieeroop, 2012: 4). The same view was also echoed by Hanneke Bot (2005: 188) who indicates that “reporting

verbs and changing from 1st to 3rd person is generally assumed to be ‘wrong’”. Hale (2007: 39) further lays emphasis on the way the doctor addresses the patient especially in terms of power differentials. As for the gaze patterns, Davitti (2012: 165) points out that in many interpreting settings, the interpreters are still perceived as invisible agents who are expected to sit behind the parties so as to enable them to look at each other directly. For instance, Bot (2005: 132) maintains that the primary speakers- therapists and sometimes patients, are instructed to gaze at each other and not at the interpreter. “This instruction stems from the idea of the interpreter as a non-person, a translation-machine [...]” (Bot, 2005: 132). However, atypical ‘gaze patterns’ and ‘forms of address’ of the participants prevail in this corpus, which paved the way for atypical and unexpected ‘turn-taking allocations’ between the participants, which, in return, led to the ‘role shift’ of the interpreter from one to another. With an overall assessment, it will be attempted to provide an overview of the register, footing, eye-contact and in the end, a discussion of the power dynamics between the participants in the interactions. By doing so, I will try to broaden the understanding of the position of the interpreter within the complex power dynamics in triadic interactions in healthcare context in Turkey.

5.2.1. Analysis of ‘Forms of Address’ of the Participants

According to Straniero Sergio (1999: 309), modes of address and the use of pronouns are important interactional indicators in terms of footing i.e., the alignments of the participants. Hence, the following analysis will rely on how the participants address each other and whether or not they address the interpreter directly, as well as the interpreter’s answers as the following speaker and whether she utilizes direct or indirect speech. Accordingly, the extracts taken from the data in the present study showed that the doctor and the dietician used third-person singular “she/he” while referring to the patient, taking a distance from him/her. The interpreter was in return observed to directly refer to the patient as “you”, removing the distance while rendering to the patient. However, there was a consistent use of reported speech “he said/ she said” by the interpreter instead of abiding by the norm of speaking in the first person singular, while rendering the patient’s utterances to the doctor and vice versa.

In doing so, both the doctors and the interpreter were observed to have created distances during the communication from time to time and created two parallel conversations instead of triadic consultation (Hale, 2007:44). In Goffman's terms, those shifts also refer to two parallel participation frameworks as 'doctor-interpreter participation framework' and 'interpreter- patient participation framework' (Van de Mieeroop, 2012). Those shifts in the excerpts below are the indicators of the interpreter's 'reporter' or 'animator' role, revealing that the interpreter is only a 'sounding box' (Goffman, 1981) or an agent who 'memorized for repetition the words uttered' (Wadensjö, 1998) who does not undertake any responsibilities apart from just transferring the message uttered. With the doctor addressing the interpreter directly, the interpreter took the position of being the 'addressed listener' and was treated as the 'principal', while the patient fell on the position of an unaddressed participant by being excluded from the interaction.

The following excerpts only indicate the recurring patterns regarding how the parties address to each other. However, there are more than these excerpts examined in the sub-sections below which include not only the similar forms of address patterns, but also atypical turns taken by the parties, leading the interpreter to assume 'principal' and/or 'responder' roles. Therefore, the continuation of these excerpts will be further analyzed in "a combination of thereof" section.

Excerpt 1:

This instance was taken from the first interaction depicted above. After the operation, the doctor visited the patient and wanted to learn how the patient's general condition was.

1. Dr: How does **she** feel?
Kendini nasıl hissediyor?
2. I: How are **you** today?
Wie geht's dir heute?
3. P: Good. After taking a shower, I threw up twice. X Apart from this, I feel fine.
Gut. Also nach dem Duschen habe ich mich noch zweimal übergeben. X Aber sonst geht's mir gut.
4. I: **She** threw up twice after the shower. Apart from that, **she says** she feels fine. *Duştan sonra sadece 2 kere kusması gerekmiş. Yoksa genel olarak iyiyim diyor. [...]*

The doctor starts the interaction by referring to the patient in the third person “she” instead of “you”, thus addressing the interpreter directly in turn 1. As the doctor used “she”, he takes a distance from the patient. In return, while interpreting the doctor’s question to the patient, the interpreter eliminates the distance created by the doctor by referring to the patient as “you” (line 2). However, the interpreter also shifts to the third person singular while rendering the patient’s expressions to the doctor (line 4). Therefore, there seems to take place two parallel conversations first between the doctor and the interpreter, second between the interpreter and the patient. When approached in Goffman’s terms, there is a shift from the doctor- interpreter participation framework to the interpreter- patient participation framework. The same instance was observed in the Extract 2 below:

Excerpt 2:

Through the end of the encounter in the first interaction, the patient thanks the doctor who wants to answer back to the patient in German.

1. P: Thank you
Danke schön.
2. I: **She** thanks a lot.
Çok teşekkür ediyor.
3. Dr: What do we say in return?
Karşılığında ne deniyor?
4. I: You are welcome
Bitte schön.
5. Dr: You are welcome
Bitte schön.

This time it is the interpreter who keeps creating distance from the patient by referring her in the third person “she” while interpreting to the doctor (line 2). In this example, one can explicitly see that the patient is excluded from the interaction again. The interpreter persists her strategy of addressing the patient in the third person in the extract below. On the other hand, the doctor’s effort to speak in the patient’s language, thus constituting doctor-patient participation framework is quite obvious in turn 3.

Excerpt 3:

In this example, the doctor wants to obtain information about whether the patient allowed them to shoot a video for the social media.

1. Dr: Well, does **she** allow us to shoot a video in order to broadcast it on social media?
Peki, mesela yarın geldiğimizde ufak bir video çekmemize izin verir mi sosyal medyada yayınlamak üzere?
2. I: Ha well, **he asks** whether **we**- when **we** come tomorrow, whether **we** can shoot a video of you X about whether **you** are satisfied with the operation or what kind of experience **you** have during this process. A small, short one?
*Ha şey, **er fragt**, - ob **wir**- wenn **wir** morgen kommen, ob **wir** so ein kleines Video machen können von dir X ob **du** zufrieden bist mit der Operation oder was für Erfahrungen **du** hast in dieser Zeit. ein kleines, kurzes. [sic.]*
3. P: Okay, yes.
Okay, ja.

The doctor asks the interpreter directly whether the patient allows them to shoot a video to be broadcast on social media. The interpreter, in return, renders the doctor's question through reported speech (line 2). By preferring reported speech, the interpreter gives the impression of abdicating responsibility and assuming the role of a "reporter" or "animator" rather than a "principal". However, it is also equally interesting that in the same turn the interpreter uses first-person plural "we" by positioning herself as a part of the team, aligning with the doctor, which is in complete contrast to her use of reported speech.

As could be observed above, the interpreter pretends to assume solely the 'reporter' and the 'animator' role by distancing herself from what is said by the primary interlocutors, putting the responsibility on their shoulders. However, the excerpts in the following sub-sections will prove how the interpreter shifts from the roles of the 'reporter' and 'animator' to the roles of the 'principal' and 'responder'. These role shifts start to be unfolded in the subsequent section where the gaze patterns of the participants will be illustrated and discussed, which further lead the interpreter to take additional turns.

5.2.2. Analysis of Gaze Patterns of the Participants

This section focuses on gaze directions of primary parties during the interactions with the data obtained from the author's notes taken during observation process. Rossano (2012:2) indicates that the parties' gaze directions are important while they are speaking, especially taking into account "what kinds of social action they are performing during their conversation". In this regard, the video-recordings would provide more robust findings as regards the distribution of gaze directions of the parties while both speaking and listening because a single gaze pattern in a second would provide a crucially important data. Mondada (2016: 361) also emphasizes the importance of the detailed analysis of video-recordings and their transcripts which enable a "precise interpretation of the trajectories, temporalities and qualities of these multiple resources". Pöllabauer (2006: 239), on the other hand, approached from a different angle to the video-recordings:

"Video cameras [...] may be even more 'disturbing' to some subjects than audio recording equipment, as cameras may pose a stronger threat to the participants' privacy and may thus influence their behavior"

However, Mason (2012: 180) suggests a way to minimize the above-mentioned negative sides of the video-recordings by using a single, fixed camera, considering that the presence of the camera might be ignored after a short while.

Since I could not get the permission for a video-recording of the interactions, it is hoped to provide general view of the gaze patterns of the participants and to enrich the discussions about the role distributions of the parties. Likewise, Mason (2012:177) emphasizes the difficulties of obtaining video-recordings of authentic interactions and supports the view that even though the data are impoverished, it still provides invaluable insights into the role of the participants' gaze directions in the encounters. Even so, I am aware that the analysis based on video-recordings and eye-tracking machines would provide more valuable results in terms of gaze directions.

Observations of the gaze patterns of the parties produced remarkable findings in this study. In contrast to the prescribed gaze patterns in the literature (e.g. see Bot, 2005), the predominant patterns in the dataset of the current study showed that the primary parties- both the doctors and the patients- generally tend to gaze at the interpreter when in the speaking mode, which complements the data discussed above

in section 5.2.1. Direct gaze between the doctor and the patient was strictly limited. It shows that the interpreter being directly gazed by the primary interlocutors are then treated as an ‘addressed listener’ and thus, full-fledged and ratified participant in the interactions. That is to say, the primary interlocutors’ direct gazes at the interpreter verify their perception of the interpreter as a ‘principal’. This ‘authority’ given to the interpreter further incites the interpreter to take additional turns, resulting in the interpreter’s shifting from one role into another. The hints of the asymmetrical turn distributions could also be traced in the gaze behaviors of the parties below, although it will be discussed more in detail in the subsequent sub-section.

Moreover, it is of great importance to “distinguish gaze during speech from gaze during listening” (Mason, 2012: 184). Therefore, the main focus is on the question whether or not the primary interlocutors gaze directly at the interpreter while speaking. In addition to the speaker’s gaze patterns, gaze patterns of the listeners were also reflected in the analysis below, because all these patterns contribute to the role of the interpreter collectively. In this respect, it was found that the doctor and the dietician tended to gaze both at the interpreter and the patients evenly, while the patients kept gazing at the doctor and the dietician in the listening mode. Davitti (2012: 164) elaborates on the gaze shifts between the parties, indicating that the gaze shift from one party to another and vice versa might indicate a “monitoring function performed by gaze, mainly when in listener mode”. In this regard, Davitti’s (2012) assumption could be applied here in this corpus since all the four interactions entail instructions given by the doctors to the patients. Thus, the primary interlocutors- doctors and the patients- monitor the other one way or another. Yet, the ‘monitoring function of the gaze patterns’ of the doctors and the patients designate different objectives. The doctor and the dietician’s gazes at the interpreter and the patients evenly in their listener mode might signal that they ‘monitor’ the interpreter whether or not she conveys the core message. In search of clues from the patient’s body language such as facial expressions, gestures, etc., they, on the other side, ‘monitor’ the patient whether or not s/he comprehends the message. However, the patients’ gaze at the doctors in their listening mode might express an opposite opinion, which refutes Davitti’s (2012) assumption of monitoring function. Their repetitive glance at the doctors might not show that they ‘monitor’ the doctors. Rather, they might seem to perceive them as the

authority, thus monitoring the interpreter as to whether she transfers the accurate message or not. Therefore, it can be asserted even though the patients seem to perceive the interpreter as a ratified participant by gazing and speaking directly to her, their listening modes by directly glancing at the doctors appeared to be contradictory at this point.

The data obtained from the interactions will be analyzed and discussed separately. Furthermore, in the present section I benefitted from the gaze coding systems developed by Rossano (2012) for monolingual, dyadic interactions, and Davitti's (2012) adjusted coding system to mediated, triadic interactions. Samples of both Rossano's (2012) and Davitti's (2012) gaze encoding systems will be provided below in Figures 42 and 43.

Figure 42: Samples of Rossano's (2012) Gaze Coding Symbols

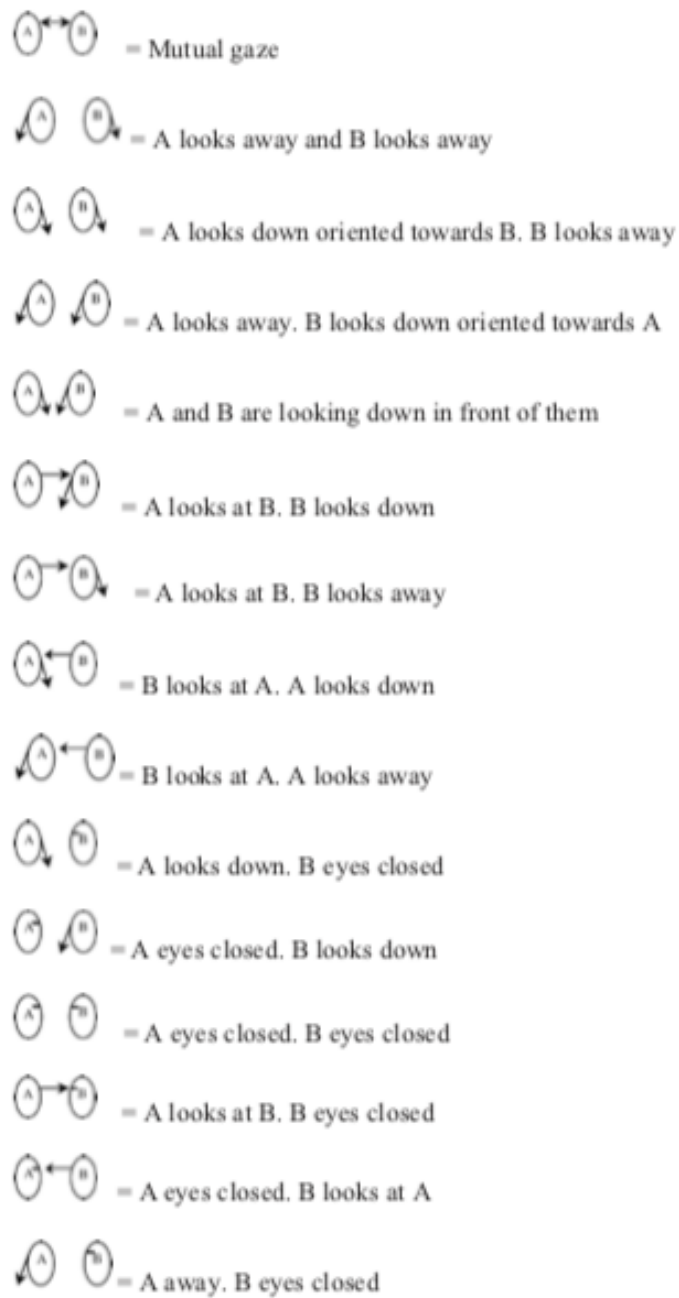
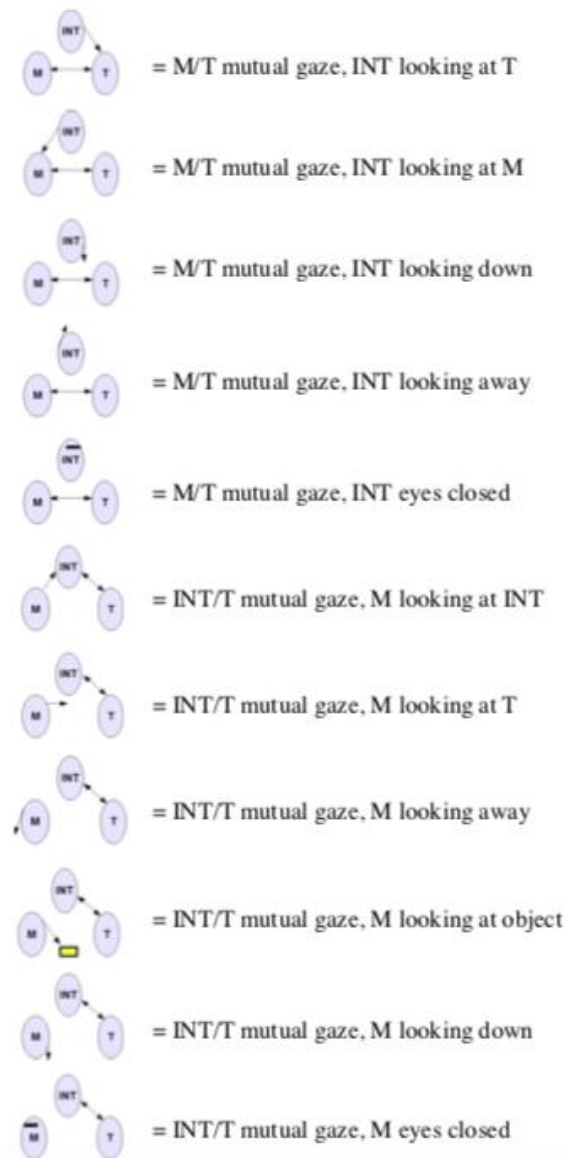


Figure 43: Samples of Davitti's (2012) gaze coding symbols



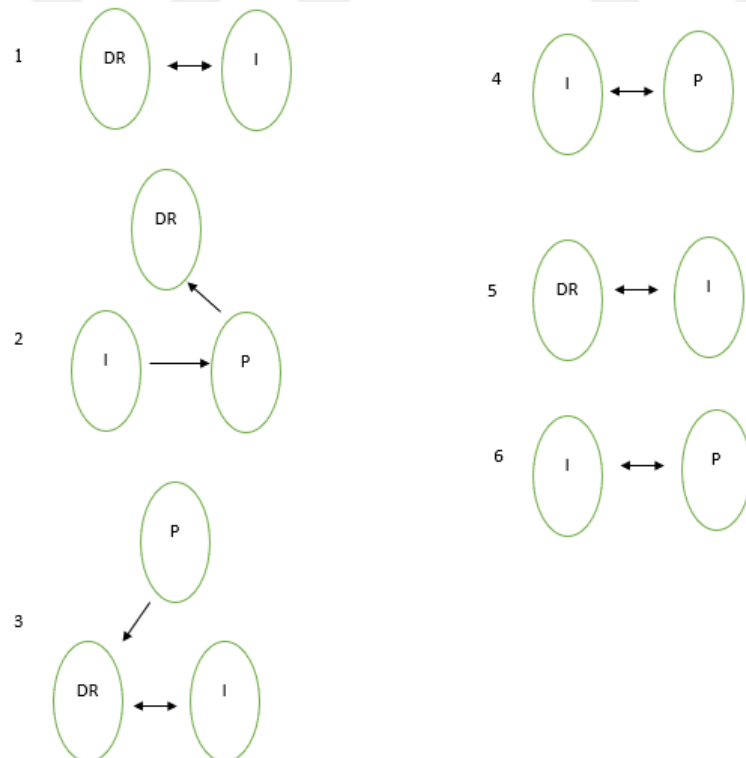
In order to simplify keeping track of the analysis, it is worth mentioning that each line refers to the turns taken by the parties and the parties located on the left side cycle represents the “speakers”. Moreover, the parties’ names were abbreviated as DR (doctor), P (patient), I (Interpreter), and D (dietician) in this analysis as well.

5.2.2.1. Gaze Patterns of the Participants in the Interaction 1

To exemplify the unexpected gaze directions of the parties, I introduce six excerpts taken from the first interaction which took place between the German patient and the doctor. The doctor visited the patient who had laparoscopic sleeve gastrectomy to learn about the general health condition of the patient. A high frequency was observed for the interpreter as being addressed as listener and thus, ratified participant by the primary parties who tended to look directly at the interpreter while speaking. What was striking and relatively rare is that there were a few instances captured where the parties- doctor and the patient- were directly looking at each other just as prescribed in the literature.

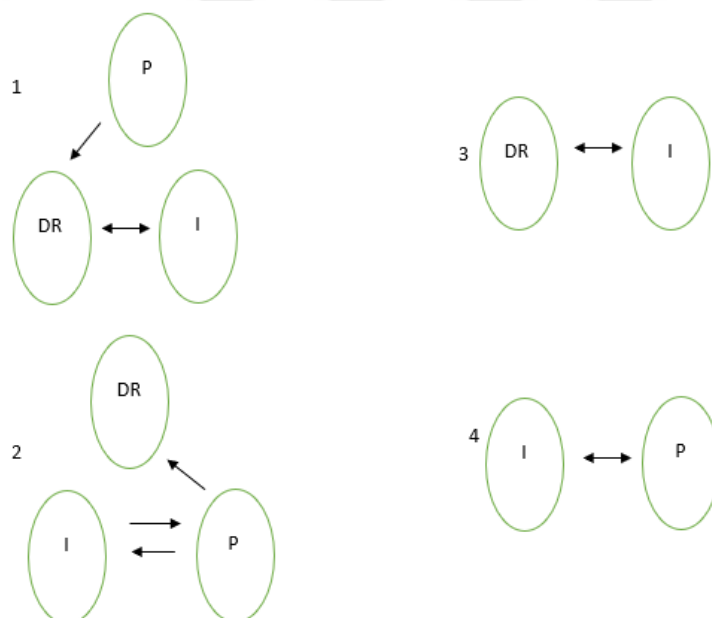
When it comes to listening mode of the primary interlocutors, the doctor exhibited more controlled gaze patterns between the patient and the interpreter, whereas the patient was overwhelmingly looking at the doctor when she was in the listener mode.

Extract 1:



This extract is a clear example revealing that the interpreter (I) is treated as a ratified participant by the doctor (DR), since he was continuously looking at the interpreter instead of gazing at the patient directly (P) (lines 1, 3 and 5). The interpreter was, presumably, rendering what the doctor said to the patient (lines 2, 4 and 6). Despite the fact that the interpreter is perceived and treated as an addressed listener and a ratified participant, the gaze behavior of the patient in the listening mode reveals the opposite because she tended to look at the doctor (line 3), even when she was an addressed listener (line 2). This might show that the ratified participant is the doctor from the patient's perspective.

Extract 2:



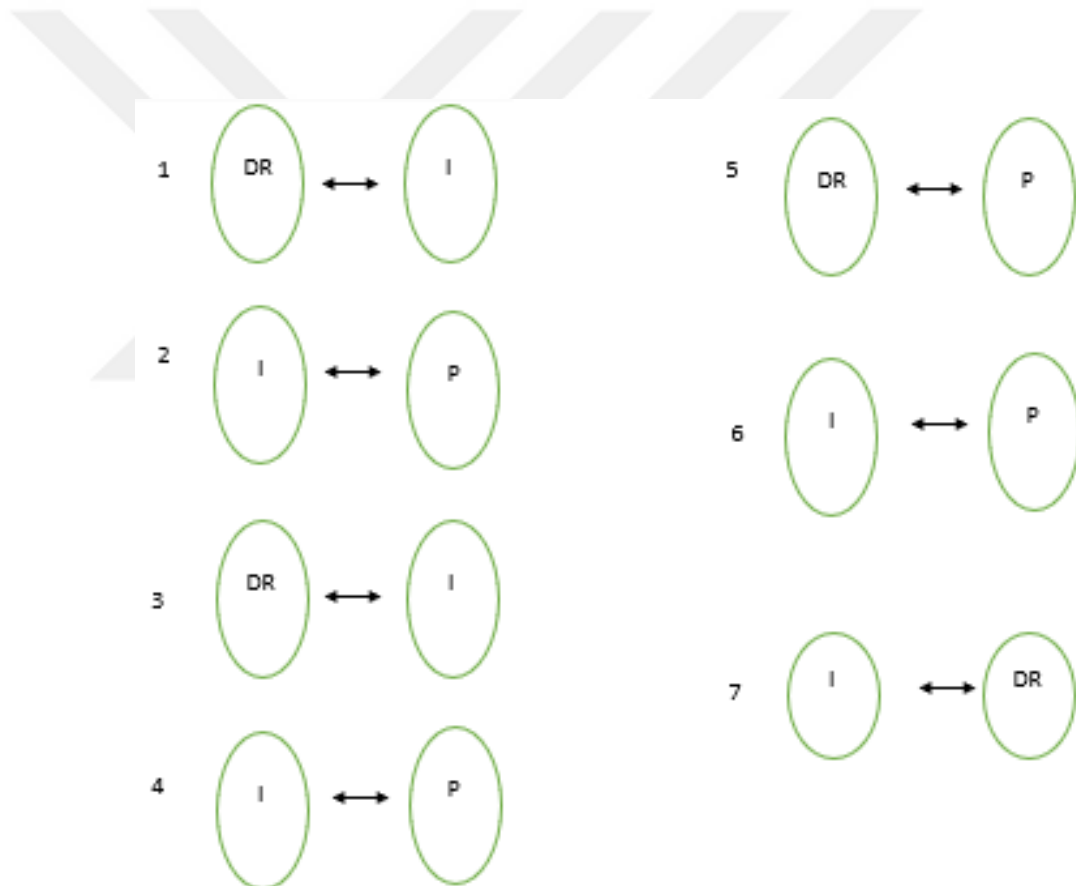
A similar pattern recurred in the second extract where the doctor (DR) spoke to the interpreter (I), gazing mutually directly at each other again (lines 1 and 3). The previous view of the patient seems to be valid in this example, since she showed a tendency towards gazing at the doctor while listening (lines 1 and 2). Even when she was directly gazed at and addressed by the interpreter, she was still alternating her gaze between the doctor and the interpreter (line 2).

Thus, one might say that this extract complements the previous one, and the patient seems to 'monitor' the interpreter by accepting the doctor as the authority,

while the doctor positions the interpreter as a ratified participant and gives her the authority.

Extract 3:

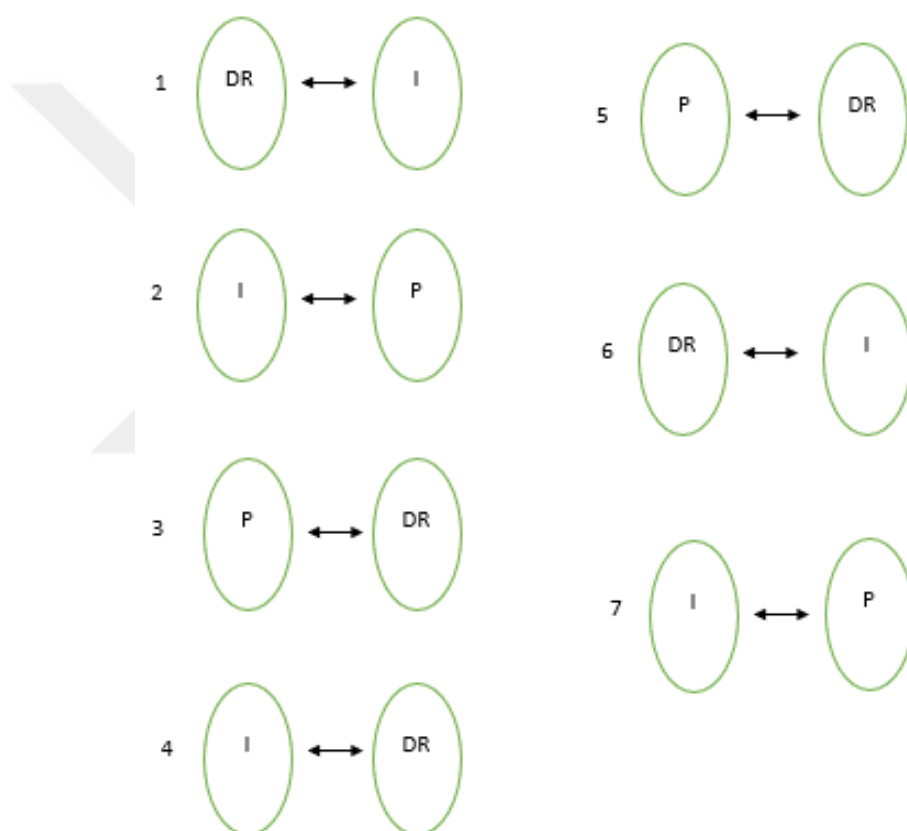
In the extract below, dual mutual gaze patterns were provided and analyzed. The doctor (DR) was observed to look at the interpreter as observed in the first two extracts above (see Extracts 1 and 2). However, there was an exception in this example. While the doctor was inclined to look at the interpreter while speaking (for instance line 1 and 3), he, for the first time, looked at the patient directly in the line 5 below.



In return for the doctor's direct gaze at the patient (line 5), the patient started gazing at the doctor in the Extract 4 below where the dual gaze patterns of the parties continued to be scrutinized.

Extract 4:

In the previous examples, the patient was observed to be looking at the doctor while she was in the listener mode. However, quite interestingly, she was observed to have spoken to the doctor directly below (lines 3 and 5). This might be interpreted as the positive reaction of the patient towards the doctor since the doctor was already observed to have gazed at her directly in the speaker mode above (see Extract 3 line 5).

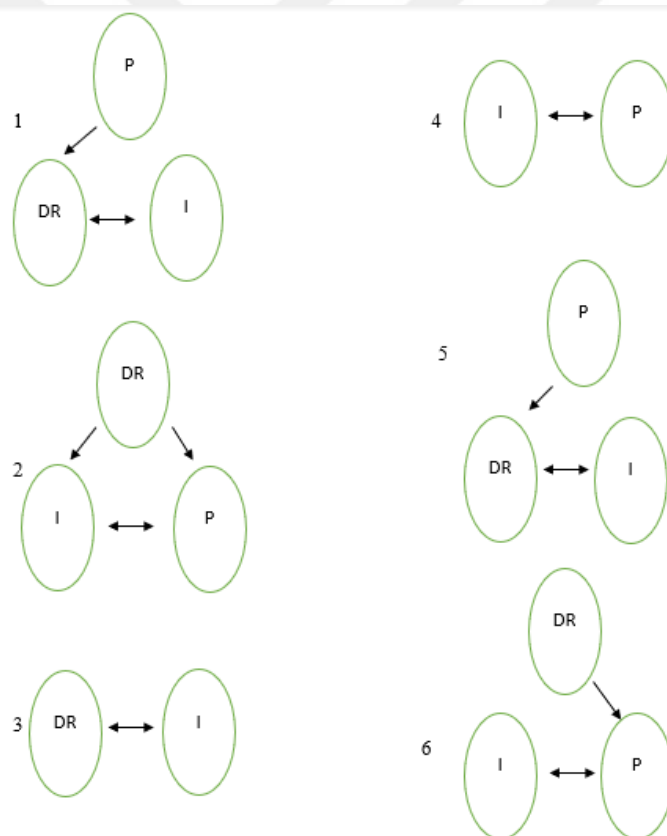


Even though the doctor was still glancing at the interpreter while talking (lines 1 and 6), in this example the patient was found to have glanced at the doctor directly (lines 3 and 5), still reinforcing the assumption that she regarded the doctor as the ‘authority’ in the interaction.

Extract 5:

Differently from the previous examples, this extract reveals a bit more variety by focusing on both dual and triadic gaze patterns between the parties.

The doctor was unsurprisingly looking at the interpreter (lines 1, 3 and 5) in the speaker mode and the patient persisted directing her gaze at the doctor continuously in the listening mode (lines 1 and 5). What comes as striking in this example is that the doctor kept shifting his gaze between the interpreter and the patient while he was listening the rendition of the interpreter in line 2. Thus, the constant gaze shift of the doctor from the interpreter to the patient might demonstrate that he wanted to keep the power at hand. Thus, he was, on the one hand, looking at the interpreter while she was rendering with the aim of monitoring her renditions.

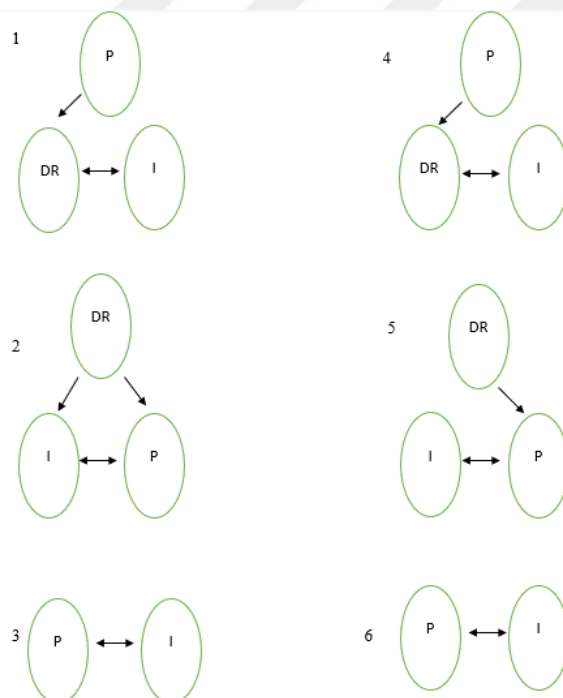


He was, on the other hand, glancing at the patient, which might indicate the doctor's endeavors to figure out whether the patient was understanding or not. This amounts to the 'monitoring function of the gaze' again, since the doctor seems to strive to monitor the parties.

Similar results were gathered in the following example in the Extract 6 below, bolstering the assumptions put forth here.

Extract 6:

In this extract, both primary parties were predominantly glancing at the interpreter in speaking mode, keeping on giving her the authority in the interaction. The doctor already showed his tendency towards addressing the interpreter in previous examples. However, what is more interesting is that the patient was also observed to have gazed at the interpreter in the speaking mode (lines 3 and 6). What is controversial at this point is that, even though the patient seemed to treat the interpreter as a ratified participant by gazing directly at her when she was in speaking mode, she exhibited contrasting gaze behavior when in listener mode by shifting her gaze towards the doctor while listening (lines 1 and 4).



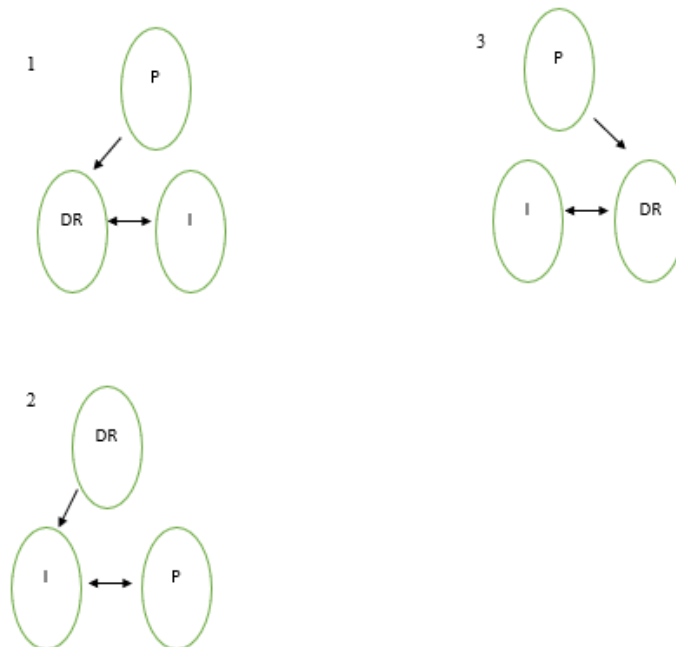
All these gaze patterns analyzed in this subsection will be compared with the data obtained in the second, the third and the fourth interactions below.

5.2.2.2. Gaze Patterns of Participants in the Interaction 2

In this section, a total of 9 extracts will be presented taken from the Interaction 2 which was between the same doctor, patient and the interpreter as asserted above in the first interaction.

In this dataset, the gaze patterns of the doctor were almost the same as the first interaction where he mostly directed his gaze at the interpreter while speaking. The patient, on the contrary, displayed a different gaze direction in this interaction than observed in the first interaction in that she was observed to have always looked at the interpreter in the speaker mode in the Interaction 2. However, their gaze patterns ranged in their listening mode. For example, whereas the doctor was observed to have more casted his glances at the interpreter, the patient was gazing at the doctor in their listening mode. Thus, the ‘monitoring function of gaze’ expressed by Davitti (2012: 164) is still valid from the doctor’s perspective who keeps looking at the interpreter while listening. The doctor, on the other hand, was treated as the ‘authority’ by the patient who directed her gaze at the doctor in her listening mode.

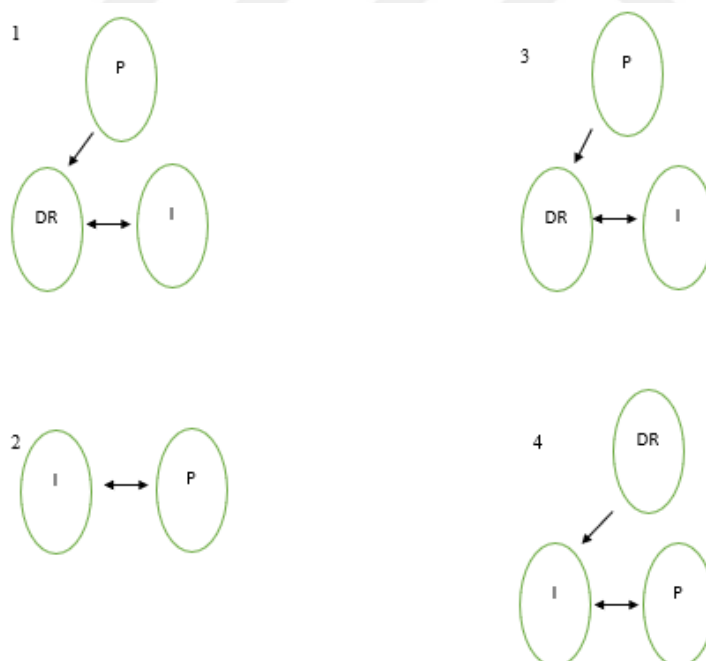
Extract 7:



In this extract, the doctor was gazing directly at the interpreter while speaking (line 1). When he shifted towards the listening mode, he insisted on gazing at and monitoring the interpreter (line 2). Apart from being a ratified listener in the second line, the patient's eyes were on the doctor when she was in the listener mode (lines 1 and 3). Regardless of whether the doctor is a speaker (line 1) or an addressed listener (line 3), the patient unchangeably looked at the doctor with the probable aim of verifying the message conveyed by the interpreter.

Extract 8:

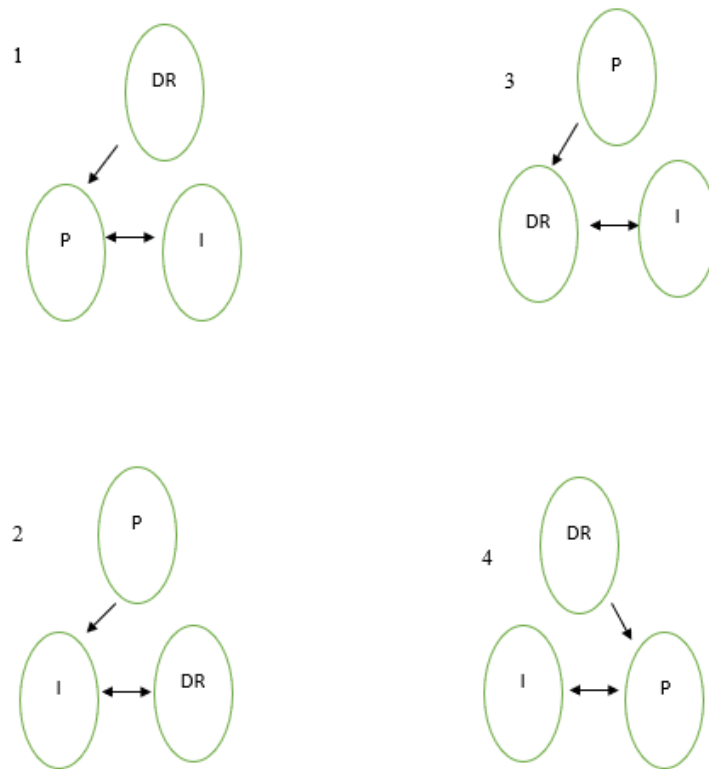
Similar gaze patterns were attained in the following example. The interpreter kept being treated as a ratified participant by the doctor who glanced at the interpreter while speaking (lines 1 and 3). As shown in the previous example, the doctor was still looking at the interpreter while he was listening to the renditions of the interpreter (line 4). The patient also kept providing the same gaze patterns by gazing at the doctor when in the listener mode (lines 1 and 3).



Extract 9:

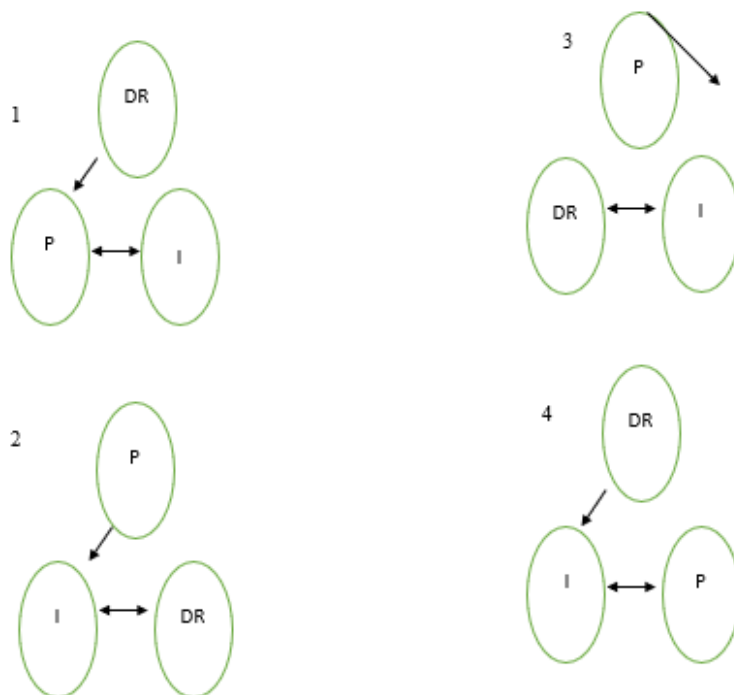
Not surprisingly, both primary parties were observed to have looked at the interpreter while speaking (lines 1 and 3). What is surprising is that, while the doctor

was observed to have looked at the interpreter in the listening mode as demonstrated in previous examples (see Extracts 7 and 8), he displayed a different gaze direction pattern in this example by looking at the patient while listening (lines 1 and 4). Likewise, the patient displayed a fluctuant gaze pattern by shifting her gaze between the interpreter and the doctor in the listening mode (lines 2 and 3).



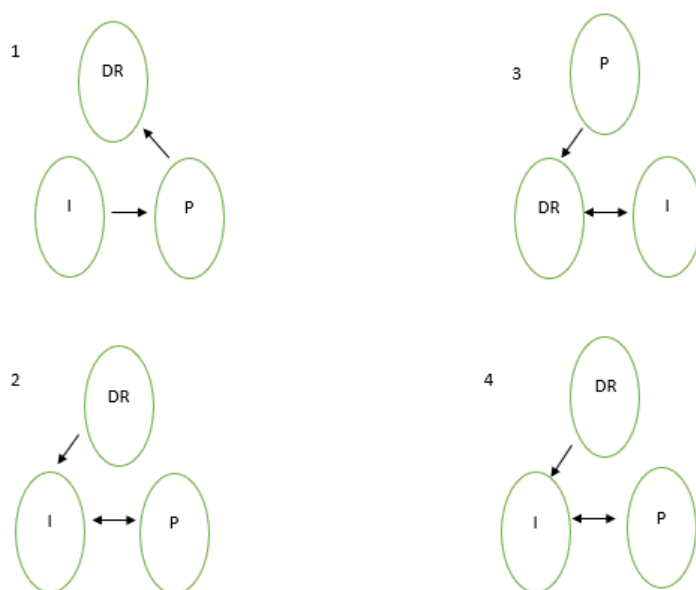
Extract 10:

Apart from the direct gaze of the doctor and the patient at the interpreter while speaking (lines 1 and 3), the doctor exhibited a varying gaze pattern this time, gazing first at the patient in the first line, then at the interpreter in the fourth line. Differently from the other examples, it can also be seen that the patient was talking on the phone, thus looking away from both the doctor and the interpreter (line 3). At that moment, the doctor was directly gazing at the interpreter in speaking mode.



Extract 11:

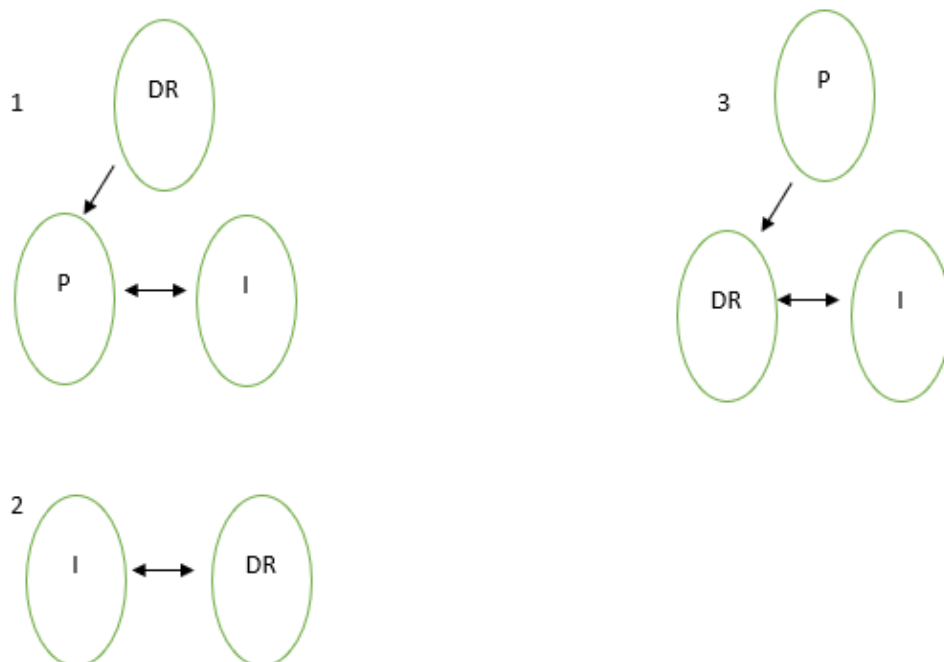
This extract seems to demonstrate the general finding as regards the gaze patterns of the participants obtained in the second interaction. The doctor, as in the previous examples, directed his gaze at the interpreter while speaking, which comes as no surprise (line 3).



When it comes to listening modes of the doctor and the patient, it could be asserted that both of them presented stable patterns in that the doctor was glancing at the interpreter (lines 2 and 4), whereas the latter was glancing at the doctor even when she was directly addressed by the interpreter in the first line (lines 1 and 3). The interpreter seems to be perceived as a ratified participant, but still her renditions seem to be monitored by the doctor. From the patient's point of view, the doctor comes forward as the authority, thus the interpreter still seems to be monitored by the patient.

Extract 12:

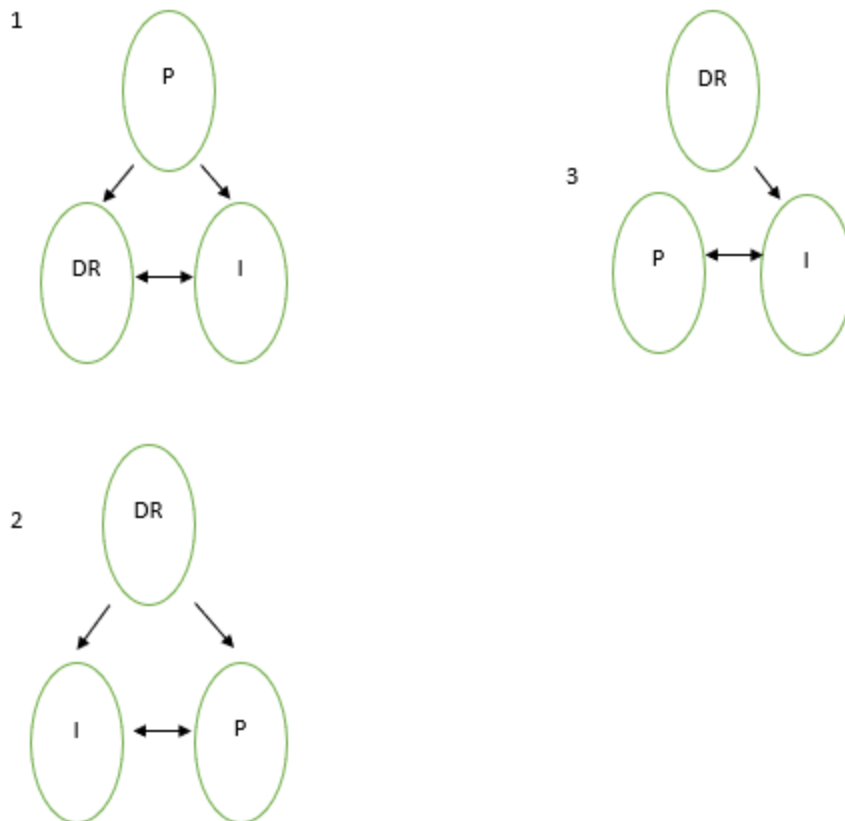
The interpreter, as always, was treated again as a ratified participant both by the patient (line 1) and the doctor (line 3) who directly gazed at her while speaking. Differently from the previous extract, the doctor here seems to control the patient instead of the interpreter as he gazed at the patient while listening (line 1).



However, the monitoring function was valid for the patient this time. As a response, the patient also gazed at the doctor (line 3).

Extract 13:

It is a crystal- clear fact that the interpreter was treated as the authority, a full-fledged participant again by both the doctor and the patient (lines 1 and 3) because both participants spoke directly by looking at the interpreter, which indicates their perception of the interpreter as the authority.



What changed between the interactions was the listening modes of the participants. In this example, quite interestingly, both the patient and the doctor shifted their gaze between the other two participants (lines 1 and 2). By doing so, the patient also seemed to monitor the interaction.

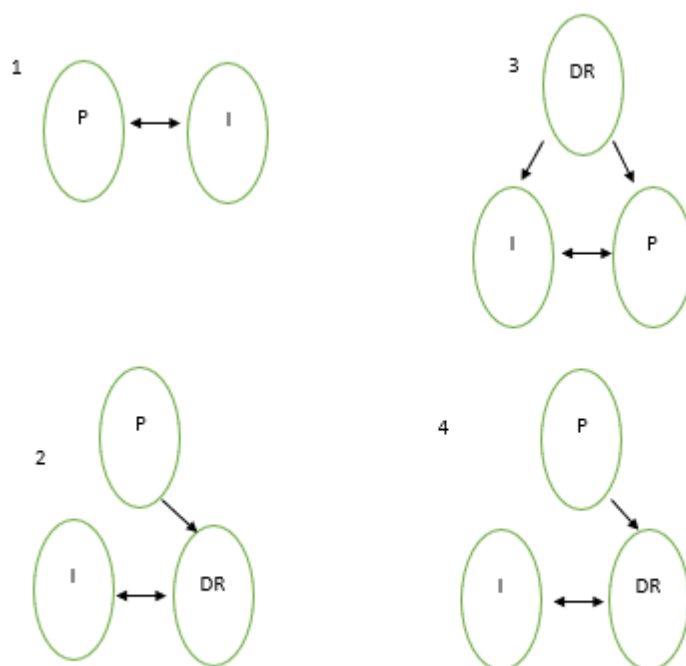
Extract 14:

Needless to say, in addition to the interpreter's being treated as a ratified participant (line 1), the patient's gaze kept serving as the monitoring function in the first line of the interaction. She even shifted her gaze at the researcher as well.



Extract 15:

In the last example of the Interaction 2, the patient was still looking at the interpreter while speaking (line 1). When she switched back to the listening mode, she was glancing at the doctor, thus authorizing him, even when the speaker was not the doctor himself (lines 2 and 4). The contradiction regarding who the ratified participant in the interaction has showed up again.



When all the examples are considered together, it becomes clear that both the doctor and the patient maintains sustained gaze with the interpreter in their speaking modes, which makes the interpreter a full-fledged participant in the interaction. Even

though the gaze behaviors of the participants change in each extract in the Interaction 2 above, the general tendencies of the doctor and the patient in their listening modes are as follows: The doctor was inclined to look at the interpreter, when she was rendering the utterances to the patient, with the possible aim of monitoring her renditions. On the other hand, the patient was observed to have looked at the doctor, with the possible aim of confirming the accuracy of information. It, thus, shows the discrepancy between the patient's gaze in her speaking mode and listening mode. Because the patient's gaze direction shows that the patient in this part of the data seems to authorize the doctor in the listening mode, while she authorized the interpreter in the speaking mode. Even though she treats the interpreter as an authority by directly gazing at and speaking to the interpreter, she reveals her lack of trust on the interpreter in terms of the transfer of medical knowledge while listening.

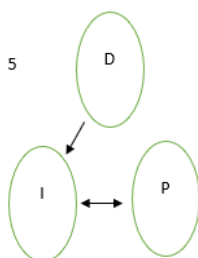
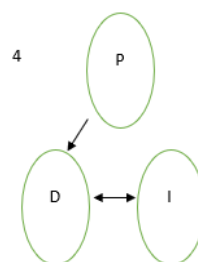
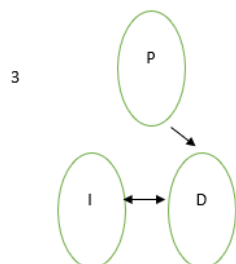
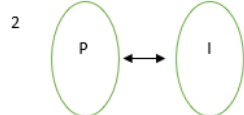
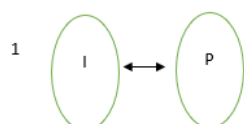
5.2.2.3. Gaze Patterns of Participants in the Interactions 3 and 4

This section includes the analysis of gaze patterns obtained from the Interaction 3 and 4 together. While the Interaction 3 took place between the dietician, a German patient and the interpreter, the Interaction 4 was between the same dietician, a Kosovan patient and the interpreter. In this interaction, less gaze patterns occurred in number, when compared to the first two interactions. For that reason, a total number of 6 patterns gathered from both the Interaction 3 and 4 were taken and analyzed together, respectively.

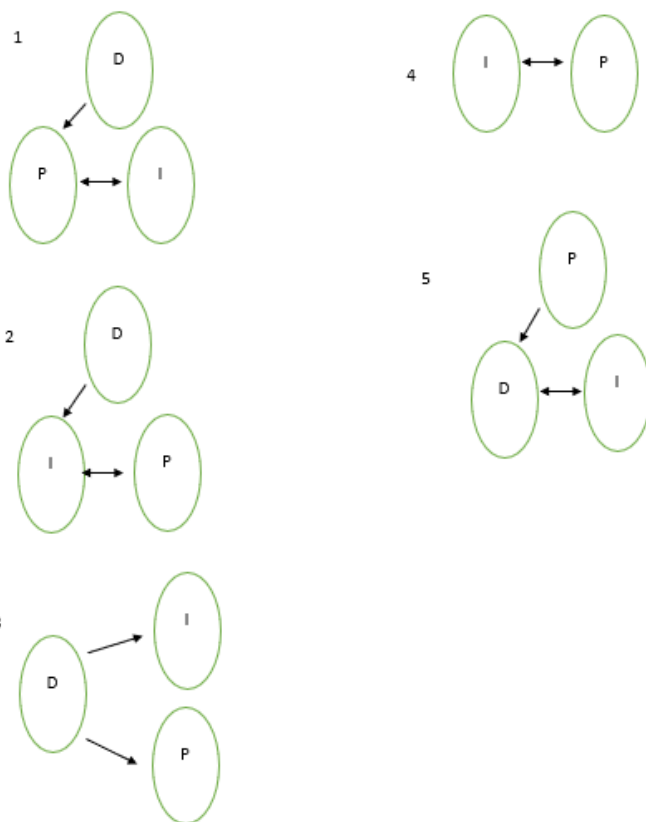
Both interactions showed similar gaze patterns of the participants, specifically in the speaker mode. It is revealed that both dietician and the patient perceived the interpreter as a ratified participant since they were prone to consistently look at the interpreter while speaking. Even though there were almost no cues noted regarding the listener mode of the participants in the Interaction 4, the patient was observed to have gazed at the dietician, whereas the dietician displayed more stabilized gaze patterns while listening in the Interaction 3.

Extract 16:

In this example, it is quite obvious that both the dietician and the patient perceive the interpreter as an ‘authority’ and a ratified participant since they directly looked at her while speaking (lines 2 and 4). However, the interpreter continues to be ‘monitored’ both by the patient gazing at the dietician (lines 3 and 4) and the doctor gazing at the interpreter (line 5) while listening.

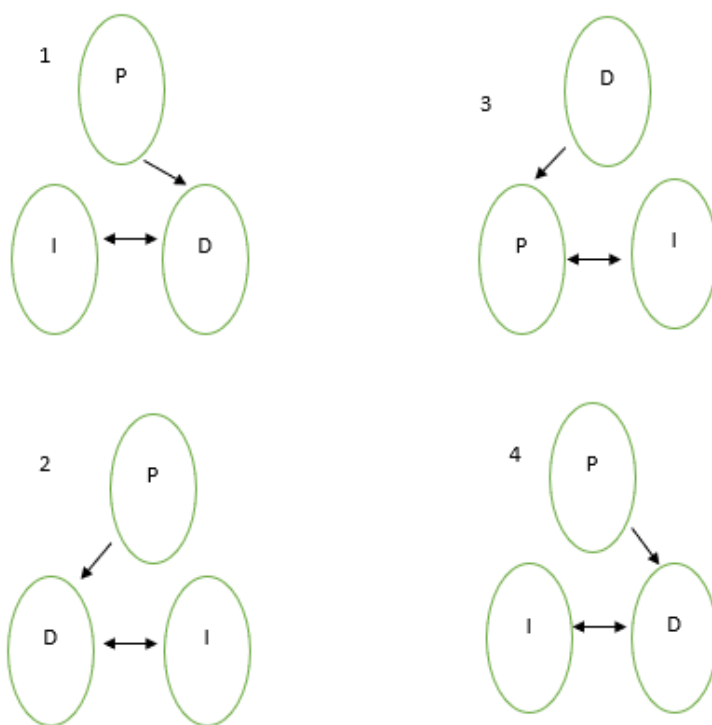


Extract 17:



When it comes to this extract, the patient seems to continue perceiving the interpreter as the authority since she was directly speaking to the interpreter (line 1) and kept monitoring her by looking at the dietician while listening (line 5). The gaze behavior in the second line is especially remarkable since it seems that the interpreter responds directly to the patient by gazing at her, which might also be evaluated as a hint of an additional turn taken by the interpreter.

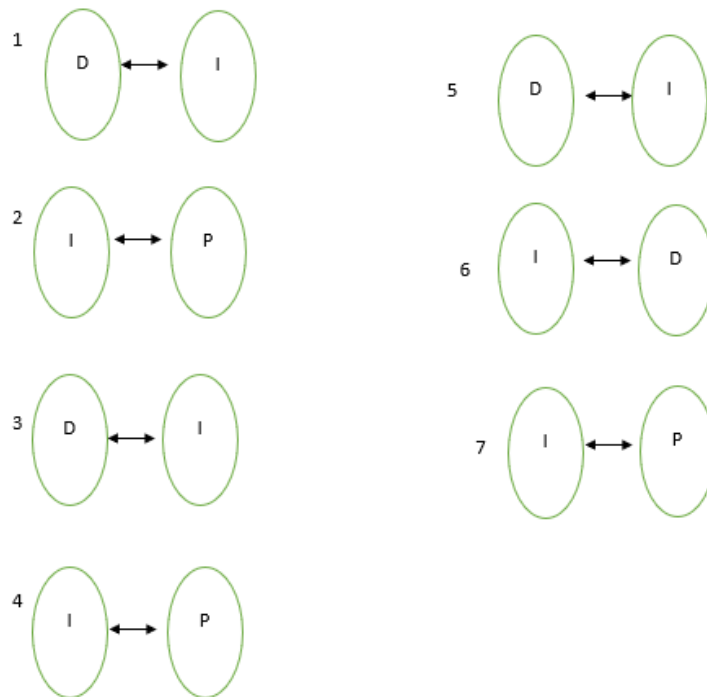
Extract 18:



The interpreter becomes prominent as a ratified participant by being directly gazed by both the dietician and the patient (lines 2 and 3), whereas the dietician comes to the fore as the authority by the patient who continued looking at the doctor in her listening mode.

Extract 19:

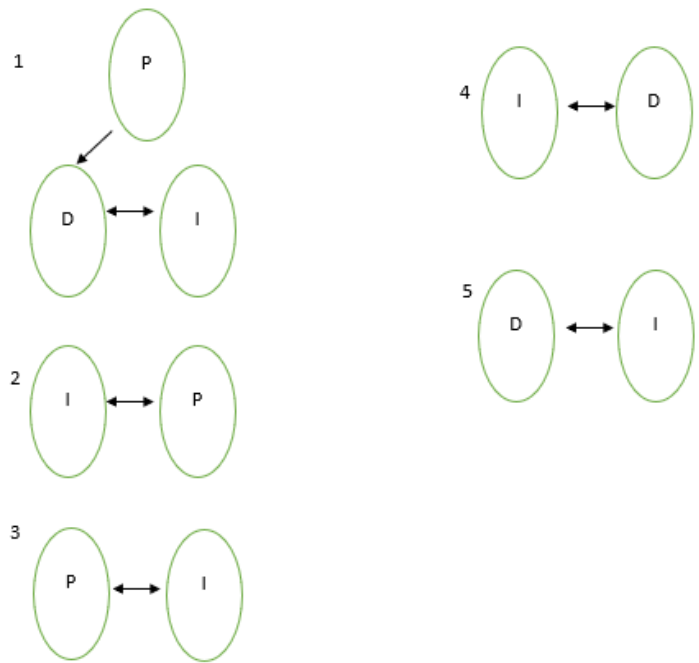
The following 3 examples belong to the Interaction 4 which took place between the dietician and the Kosovan patient, and this extract mainly focuses on dual gaze patterns of the participants.



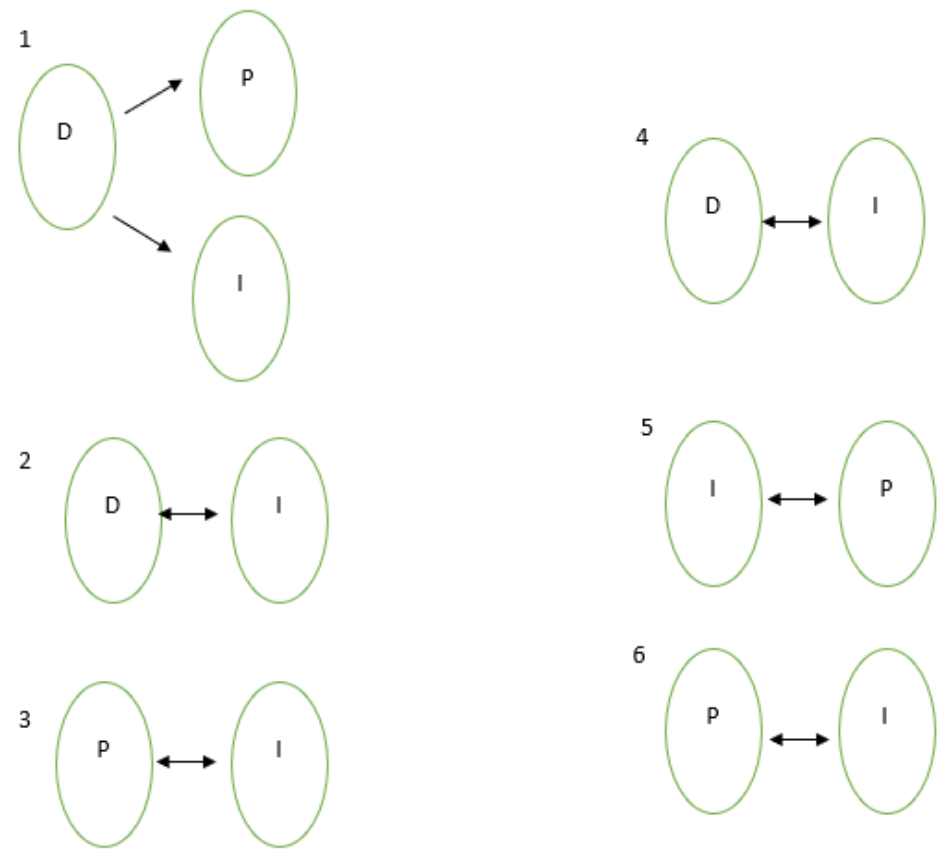
This example is also a strong indicator of the interpreter as an addressed listener with the direct gazes of the dietician (lines 1, 3 and 5). However, it is interesting enough that the interpreter seems to take an additional turn in line 6, instead of directing the utterances made by the dietician in line 5 to the patient. Even a single gaze pattern like this is strong enough to bolster these assumptions.

Extract 20:

This extract consists of single triadic gaze patterns and dual ones. From the gaze movements of the parties below, one might assert that the dietician explains something to the interpreter (line 1), which was rendered by the interpreter to the patient (line 2). However, the striking point is that the patient seems to answer back to the interpreter in line 3, which proves the ratified position of the interpreter.



Extract 21:



In the last gaze pattern, in addition to the direct gaze movement towards the interpreter, the dietician also strives to shift her gaze between the interpreter and the patient (line 1), which might prevent excluding the patient totally from the interaction. However, the patient keeps gazing at the interpreter (lines 3 and 6).

All the examples above demonstrate the fact that the doctor, the dietician and the patients predominantly look at the interpreter while speaking, thus ratifying the interpreter as a full-fledged participant in the interaction. This shows that the interpreter can also be counted as one of the primary interlocutors. In other words, all the instances of the doctors and the patients gazing directly at each other, as prescribed in the literature, are very limited in my corpus. Therefore, the gaze patterns, in addition to the forms of address of the participants, seem to offer a natural opportunity for the interpreter to commence speaking i.e. to take an extra turn, which lead to the shift in her roles during the interactions.

5.2.3. A Combination of Thereof

This section relies on the role shifts of the interpreter from ‘animator’/ ‘reporter’ to ‘principal’/ ‘responder’ triggered by the common factors of non-conforming forms of address and gaze patterns of the participants discussed above. To provide an overview of the forms of address to be analyzed below, the doctor and the dietician are far more likely to formulate his/her questions or instructions regarding the patient’s health conditions in the third person singular ‘she’ and ‘he’, thus constituting a doctor/dietician- interpreter participation framework or doctor/dietician- interpreter dyad by excluding the patient from the framework. The interpreter was, on the other hand, seldom observed to take over this approach since she was inclined to move to a second- person reference ‘you’ while rendering the utterances of the doctor/dietician, leading to interpreter- patient participation framework or interpreter- patient dyad. Furthermore, the interpreter was also observed to render with the quotative ‘he/she says’ (see Section 5.2.1). Even though the interpreter seems to muddle through the responsibility with the use of ‘he/she says’ assuming the role of “animator” or “reporter”, in some instances she shifted to roles of “responder” and “principal” by taking initiatives to ask for clarifications, explanations, offer help or

give instructions, thus answering or speaking on behalf of the patient and the doctor/dietician. Thus, almost all instances which will be tackled below clearly demonstrate how the interpreter shifts from the role of “reporter” or “animator” to the role of “responder” and “principal”. Exemplifying from the speech pathology, Merlini and Favaron (2005: 271) indicate two main turn- takings of the parties as follows:

1. Speech pathologist’s question- Interpreter’s translation- Patient’s answer
2. Patient’s answer- Interpreter’s translation- Speech pathologist’s assessment/ Speech pathologist’s next question.

As could be seen above easily, the only task of the interpreter is to render the utterances of the parties. However, in this study, the interpreter breaks this turn-taking system and takes additional turns when she assumes principal and responder roles in the examples below.

5.2.3.1 *Principal* role of the interpreter

During the encounters, there are several instances where the interpreter speaks either on behalf of the doctor/dietician or the patient, thus assuming the role of “principal”. These examples demonstrate how the interpreter shifts from being an animator/ reporter to a principal.

The Extract 1 below occurred right at the beginning of the Interaction 2 where the doctor, the interpreter and the researcher visited the patient’s room after the patient’s operation. The doctor greeted the patient in her language, which might indicate the effort made by the doctor to create the doctor- patient participation framework. However, as opposed to the expected turn- taking allocation, the interpreter sustained the conversation with the patient:

Extract 1:

- 1 Dr: Hello
Hallo
2 P: Hello
Hallo.
3 I: **How are you?**
Wie geht's dir?
4 P: Good, thank you.
Gut, danke.
5 I: **We** are here again.
Wir sind wieder da.

As a “principal” i.e. owner of the words, the interpreter asks how the patient is and says that “we are here again”, reflecting her language superiority over the doctor, thus turning this superiority into her own authority in the communication. This dialogue that has occurred right at the beginning of the encounter reveals that even though the interpreter visits the patient together with the doctor, she actually seems to have captured the power over the communication.

The interpreter appears to maintain her language superiority by asking a question to the patient in the following example. Through the end of the encounter, the interpreter asks whether the patient has a question to ask on her own responsibility, thus behaving as if she had the answer needed:

Extract 2:

- 1 I: **Do you have anything to ask?**
Hast du irgendwelche Fragen?
2 DR: If she has any questions
Varsa soracağı şeyler.
3 P: ...
4 I: **It was very sudden, right?**
Es ist so plötzlich, ne? (sic.)
5 P: Yes
Ja
6 I: **It was very sudden.**
Çok ani oldu ya.

As could be seen above, the interpreter spontaneously poses a question to the patient, which is followed by the doctor (lines 1 and 2). What is more, when the patient stays silent, the interpreter rationalizes why the patient might keep quiet (line 4), then explaining it to the doctor in line 6. When this dialogue that has taken place mostly between the interpreter and the patient is analyzed, the extract above seems to

demonstrate that the interpreter positions herself as the only participant who holds the authority asking a question and finding a possible solution.

Extract 3:

- 1 D: Does **she** have a question?
Kendisinin sormak istediği bir şey var mı?
- 2 I: Do **you** have a question?
Hast du eine Frage?
- 3 P: Not actually.
Ne, momentan nicht. (sic.)
- 4 I: **She says** she does not have a question [now].
Şu [anda yok diyor.
- 5 P: [Everything is well explained. Thank you.
[Alles gut erklärt. Danke schön. (sic.)
- 6 I: **I have already explained her. Now it is again ...**
Ben daha önce de anlattım biraz da. Şimdi bir daha şey oldu.

On the contrary, the same question is asked by the dietician in the Interaction 3, which is then rendered by the interpreter to the patient in line 2. This example is especially remarkable because of two reasons. First, the shift from dietician-interpreter framework to the interpreter-patient framework could easily be traced in lines 1 and 2. Whereas the dietician refers to the patient in the third person and distances herself from the patient, the interpreter directly refers to the patient, thus constituting interpreter-patient participation framework. What is more striking is that the interpreter first renders the utterance of the dietician with the use of reported speech “she says” (line 4) in the role of “animator/ reporter”, thus evading the responsibility of the utterance. However, she shifts to the role of “principal” in the following lines in two ways: First, the patient thanked the dietician for providing a clear explanation; however, the interpreter omitted this part of the answer and instead, she preferred to comment on the situation. By omitting the compliment of the patient, the interpreter hid an important information from the dietician. Secondly, leaving the responsibility in turn 4, the interpreter this time takes the responsibility by attributing the fact that the patient has understood everything very clearly to herself. It clearly shows that while the interpreter seems to be afraid of being responsible for something negative, she is observed to take the responsibility of the positive result without a second thought.

The doctor in the subsequent example indicates that the operation date of the patient depended on her COVID-19 test results. If her test results could have been

accessed much later, she would have been operated much later. Besides conveying this message to the patient, the interpreter consoles the patient by commenting on her situation, thus assuming the role of “principal” again:

Extract 4:

- 1 DR: [...] If **her** test results of Corona had concluded later, she would have been operated much later.
[...] Korona testi daha geç çıksaydı, daha geç ameliyata girecekti.
- 2 I: **Yes, okay.** When **your** test results had come much later, then you must have been undergone an operation much later. **That’s why, ... this is so exceptional time. This is stressful for you. But you left it behind you. Ja genau.** *Wenn dein Test später fertig da waere, dann müsstest du später operiert werden. Deswegen, - das war eine Ausnahmezeit. Es ist stressig für dich. Aber so hast du es hinter dir.*
- 3 I: **Anyway, I said that it is over. She recovered at least.**
Neyse bitti gitti diyorum yani artık kurtuldu yani en azından.

In this example, the interpreter is also seen to remove the distance created by the doctor who referred to the patient in the third person singular “she”. However, the interpreter does not persist the doctor’s approach and referred directly to the patient in the second person singular “you”, shifting from “the doctor- interpreter participation framework” to “the interpreter- patient participation framework”. Interestingly, the interpreter is observed to move the communication forward by commenting on the patient’s condition with a view to relieving her, thus shifting to the “principal” role instead of being a reporter/animator (line 2).

The next extract takes place between the dietician and the patient where the dietician commences to give instructions as regards the nutrition after the operation. The interpreter, as expected, starts rendering the utterance of the dietician. Soon afterwards, the mobile phone of the dietician ringed. At that moment, the interpreter goes beyond her role as an “interpreter”, posing a question to the patient herself again:

Extract 5:

- 1 D: Now, after the nutrition. **We** will have 15-day liquid period.
Şimdi, ameliyat sonrası beslenmemiz. 15 gün sıvı dönemimiz olacak.
- 2 I: **You** will have only liquid nourishment period during 15 days. **With tiny pieces or something like that.**
Sie werden jetzt nach der Operation 15 tagelang nur flüssiges zu sich nehmen. Auch mit kleinem Teilchen oder so.

- 3 P: Yes.
Ja.
MOBILE PHONE OF THE DIETICIAN RINGS
- 4 I: **How was Shake? Did you drink well?**
Wie geht's mit dem Shake? Haben Sie ihn gut vertragen?
- 5 P: Yes, but Ayran was better.
Ja, aber mehr geht's Ayran. [sic.]
- 6 I: Ayran better?
Ayran besser?
- 7 P: Yes
Ja.

Adopting a contrasting approach to the previous example where the doctor excluded the patient by referring to her as „she”, the dietician above refers to the patient as “we”, aligning herself with the patient. Instead of constituting dietician- interpreter framework as exemplified above, the dietician here surprisingly constructs dietician- patient participation framework. When the interpreter directly addresses the patient as “you”, she shifts the framework to the interpreter- patient participation framework. However, it is also apparent that the interpreter generates utterances two times on her own. First of all, the interpreter makes an addition to the instruction given by the dietician to the patient in line 2. Despite the fact that the dietician merely touches upon the importance of liquid consumption, the interpreter further adds that the liquid could include “tiny pieces” in order to give more detailed information in line 3. This might come from the experience the interpreter has gained from the doctor on the previous day. More strikingly, while the dietician is on the phone, the interpreter asks a question to the patient to presumably show her experience to the patient, thus authorizing herself by speaking on behalf of the dietician (line 4). By directly posing a question to the patient, the interpreter falls into the “principal” role.

The interpreter maintains the same strategy in the following example, authorizing herself by asking a direct question to the dietician:

Extract 6:

- 1 I: **We** will give a list, won't we?
Liste falan da vereceğiz zaten değil mi?
- 2 D: List will be given, of course.
Liste de verilecek tabii.
- 3 I: **You** will also have a list in German regarding what **you** need to eat.
Du kriegst auch eine Liste auf Deutsch, was du essen darfst.

4 P: Perfect.
Perfekt.

Here the interpreter authorizes and aligns herself with the dietician, asking whether they will provide a list to the patient in the first turn. The only exception is that the interpreter first confirms its accuracy with the dietician, then tells the patient in turn 3. In the Extract 7 below, the interpreter still behaves as a team by keeping aligning with the doctor and the dietician. Furthermore, she assumes the “principal” role by expanding the information given by the doctor, with the possible aim of facilitating communication and clarifying some confusion, if occurs any.

Extract 7:

- 1 DR: The dietitian will come. You will talk about nutrition.
Ondan sonra, beslenmeyi zaten diyetisyen gelecek. Konuşacaksınız onunla.
- 2 I: **Our dietitian** will come. **She is not here.** When she comes here, **we** will talk again. **Because I think that he ((the doctor)) has to go to the operation now.**
Unsere Diätassistentin kommt. Sie ist noch nicht da. Wir sprechen da nochmal, wenn sie da ist. Weil er muss, glaube ich, vielleicht zur Operation gleich.

This extract is taken from the Interaction 2 where the doctor gives some information in the post-op period for the patient. The first interesting point is that the interpreter behaves as a team by using first person plural „we”, aligning herself with the hospital, which is quite unusual, while the dietician comes to the forefront by aligning herself with the patient. After that, even though the doctor only says that the dietician will provide information regarding the nutrition, the interpreter widens the information given by the doctor by indicating that “[the dietician] is not here” and “I think the doctor has to go the operation now” in line 2. The reason why the interpreter provides more detailed information might be because of the willingness of the interpreter not to leave any room for confusion on the patient’s mind.

In all these examples above, the instances where the interpreter holds complete authority and assumes the role of principal were analyzed. These instances also cleared how the interpreter, on the one hand, strives to distance herself by rendering with the use of reported speech, thus assuming the role of “animator/reporter”, whereas on the other hand, she shifts to the role of principal by commenting on the situation

and providing additional information. Apart from that, she was also observed to assume the “responder” role by either responding to the doctor/dietician or the patients with the aim of again providing tangible information to the patient, which will be scrutinized below.

5.2.3.2. Responder Role of The Interpreter

In addition to the role of principal, the interpreter also comes forward with her “responder” role by responding either to the doctor/dietician or the patients directly. Some instances even entail both the “principal” and the “responder” roles of the interpreter. In the following two extracts the interpreter could be traced as assuming the role of “responder”. The main objective to respond the parties is to confirm the parties. Yet, the interpreter also attracts the attention by giving direct answer including medical information.

The patient states that she has two questions in the Interaction 2. The Extract 8 and 9 below explain the patient’s questions and the answers accordingly. It appears that the interpreter prefers to stay behind by mostly conveying the utterances with the use of reported speech.

Extract 8:

- 1 P: I have two more questions.
Ich habe auch noch 2 Fragen.
- 2 I: **She** has two more questions.
2 tane sorusu var.
- 3 P: Today I had headache at noon. What will I do if I have headache at home?
Will I use medicine or what should I do best?
Heute mittags hatte ich Kopfschmerzen. Was mache ich, wenn ich zu Hause Kopfschmerzen bekomme? Sollte ich Medikamente nehmen? Oder was soll ich am besten tun?
- 4 I: **Okay. She** had headache at noon today. **She** asks what she can do. If **she** has headache at home, [what **she** can do
Okay. Bugün biraz başı ağrımış öğlen de. Ona karşı ne yapabilirim diyor. Hani evde falan başım ağrırsa [nasıl bir şey yapayım?
- 5 DR: [So, **she** can take painkiller pills, the small ones.
[Şöyle, ağrı kesici hap, küçüklerinden içebilir.
- 6 I: Hmm [**you** can
Hmm [du kannst
- 7 DR: Well, small in [size.
[Yani boyut olarak küçüklerinden.
- 8 I: **Okay.** So small hmm pills, if **you** have painkiller or something. But [small.

- Tamam.** So kleine ... Tabletten, wenn **du** so hast, Schmerzmittel oder so.
Aber [kleine (sic.)
- 9 P: [Yes, but X can I make them smaller?
[Ja, aber X kann ich die kleiner machen?
- 10 I: [Ha...
[Ha...
- 11 DR: [Or **she** can divide it.
[Ya da bölebilir.
- 12 I: **Ha, yes, okay. You** can make them [smaller, yes.
Ha, aynen okay. Die kannst **du** [kleiner machen, genau.
- 13 P: [Okay, super
[Okay, super.
- 14 DR: But this is for the first month. After a month, **she** can take every pill.
Bu ama ilk 1 ay. 1 aydan sonra her hapi içebilir.
- 15 I: Na, this is only for this first month that **you** should make smaller. **He says that** after a month, you can swallow them normally.
Na, das ist nur es für diesen ersten Monat, dass **du** etwas kleiner machen musst. Nach einem Monat kannst du die normal schlucken, **sagt er.** (sic.)
- 16 P: Super.
Super.
- 17 I: **No problem.**
Das kein Problem.

In this excerpt, the patient explains that she has a headache and is afraid of having a headache again at home, thus asking for a possible solution. In response to this question, the doctor indicates that the patient could take small pills. Even after a month, as stated by the doctor, she could take all types of pills. This sensitive question is rendered and answered by the interpreter and the doctor in the third person singular, actually detaching the patient from the interaction. Furthermore, the interpreter seems to assume the “reporter/animater” role by specifically rendering with “he says that” in line 15, thus she seemingly refrains from taking any responsibility because of the intense medical information transfer. However, from time to time, she has to shift to the role of “responder” with the aim of convincing the parties that she has understood the message (lines 4, 8 and 12).

The Extract 9 is the continuation of the Extract 8 where the patient asks her second question to the doctor.

Extract 9:

- 1 DR: Second question?
İkinci soru?
- 2 I: Second question?
dann zweite Frage? (Laughing)
- 3 P: My mother asked. When she cooks broth from chicken or beef for me, she will pour it off. Well, only the liquid.
... meine Mutter hat gefragt. Wenn sie... frische Brühe für mich kocht, ... vom Hühnchen oder vom Rind. Das gießt sie ab. Also nur das flüssige.
- 4 I: **Exactly.**
genau.
- 5 P: But, when she cooks, can she include tiny pieces or something in it?
Aber wenn sie die kocht, ist ja dann auch Porree oder so mit drin, darf man das?
- 6 I: ... **I think 15 days not, but.** [Well ...
... ich glaube fünfzehn Tage nicht aber. Şey [böyle...
- 7 P: [Well, pour only the liquid.
[Also nur die Brühe abkippen.
- 8 I: **Hı hı. She says** if her mother cooks something like soup, well, meat or chicken. Will it be a problem if pieces of meat or chicken are included in it? Or should we only take the liquid?
Hı hı. Çorba tarzı bir şey yaparsa annem diyor şey yani et ya da tavuk tarzı. Onun parçaları falan olursa içinde sorun olur mu diyor. Yoksa sadece sıvısını mı alalım diyor.
- 9 DR: Only liquid during the first 15 days.
İlk 15 gün sadece sıvısı.
- 10 I: **He means** that the first 15 days only liquid. After 15 days, maybe a little bit piece. [But
Er meint die ersten fünfzehn Tage nur das flüssige, nach fünfzehn Tagen vielleicht ein bisschen von den Teilchen. Aber [die
- 11 P: [But may I drink broth, fresh?
[Aber die Brühe darf ich trinken? Die frische?
- 12 I: [Yes. **Soup and etc. You can drink everything.** X
[Ja. Suppen und so darfst du alles trinken. X
- 13 P: Cold or warm? Of course, I am not allowed to drink hot, but can it be warm?
kalt oder lauwarm? Also heiß ist klar darf ich nicht, aber darf es lauwarm sein?
- 14 I: But it can be warm, can't it? Not hot, but warm?
Ilık olabilir ama değil mi? Sıcak [değil ama ılık?
- 15 DR: It can be.
[Olur.
- 16 I: Yes, **you** are allowed to drink warm.
Ja ja, lauwarm darfst du.
- 17 DR: **You** will also talk with dietitian about them in detail now.
Zaten diyetisyen ile güzel konuşacaksınız onları şimdi.
- 18 I: Ha, dietitian will explain **us** in detail. Actually, **you** can ask about the nutrition.
Ha, Diätassistentin erzählt uns das gleich detailliert. Also du kannst nachfragen mit der Ernährung.

In this example, the patient asks whether her mother could include tiny pieces of meat or chicken in the soup. However, in this case, the interpreter directly responds to the patient in order to provide or confirm the medical information given by the patient. For example, the patient remarks that she should only drink the liquid, which is confirmed by the interpreter in line 4. Yet, the patient further asks whether it could be a problem if her mother includes tiny pieces into the soup in line 5. The interpreter shows tendency towards replying the patient's question again, possibly because she has already obtained information as regards to the nutrition in previous encounters. Therefore, she shows no hesitation in uttering what she knows in lines 6 and 12, even though she prefers to use reported speech again in conveying the utterances of the parties in lines 8 and 10. Startlingly, the alignment of the interpreter with the patient in line 18 by utilizing "us" seems to be triggered by the informal style of the doctor in line 17. Even though the interpreter looks as if she and the patient were a team, it becomes obvious in the subsequent excerpt that the interpreter behaves as if she were the mere authority in the room:

Extract 10:

- 1 DR: Now, we will have liquid nourishment during the first 15 days.
Şimdi zaten kabaca ilk 15 gün sıvı besleneceğiz.
- 2 I: **Hı hı. I have already said it to her.**
Hı hı, onu da söylemiştim.
- 3 DR: Puree during the first half of the 15th day, we will start solid food in the first month. Our Turkish tea or normal black tea and coffee are forbidden during a month.
15. günün birinci yarısında püre, 1. ayda katı gıdalara geçiyoruz. İşte bizim Türk çayı veya işte normal siyah çay ve kahve 1 ay yasak.
- 4 I: **Ha okay. I said to you that** 15 days are only liquid X. Afterwards, you will start solid ... let me say, food, slowly. But this Turkish tea and coffee is forbidden during a month. (sic.)
Ha okay. Also, Ich habe dir gesagt, 15 Tage flüssig X. Danach fängst du an langsam mit härterem Essen, sag mal. Aber dieser türkische Tee – X normalerweise trinken wir türkische Tee- und Kaffee ist ein Monat verboten. (sic.)
- 5 P: Okay.
Okay

The doctor is giving instructions regarding the nutrition in the post-op period. The moment he starts explaining, the interpreter says that she has already provided that information to the patient in line 2. Although she is observed to be prone to use reported speech in the previous examples, she comes forward by directly indicating that “I said to you that”, taking the responsibility of the information in this excerpt in line 4. Thus, the interpreter takes up the position of the “principal”. Adopting the same strategy, the interpreter shares the responsibility of the information with the doctor, aligning herself with the doctor as a team in the Extract 11 below:

Extract 11:

- 1 P: But normal tea bags are also allowed, right? Normal bag fruit teas.
Ganz normale Teebeutel sind aber auch erlaubt, ne? Ganz normale Fruchtetee Beutel. (sic.)
- 2 I: Ha well, fres- I said fresh- there are tea bags.
Ha şey, ta- taze demişim- bu sallama çaylar var ya.
- 3 D: Hı hı.
Hı hı.
- 4 I: Herbal tea, fruit tea. Are they allowed?
Bitki çayı, meyve çayları. Onlara [izin veriliyor mu?
- 5 D: Yes. **She** can drink herbal tea, but coffee and normal black tea are forbidden.
[Olur. Bitki çayları içebilir ama kahve ve normal siyah çay yok.
- 6 I: Ha, **we already said it. She asked yesterday.** Actually, no tea and no coffee.
Ha, onu söylemiştik. Dün sormuştu. Also kein Tee und kein Kaffee.

Even though the doctor has explained what is allowed and what is not in the interaction a day before, the patient wants to be sure again about drinking herbal tea in line 1. The dietician’s answer consolidates the information provided by the doctor in line 5. Surprisingly, the interpreter, who aligns with the patient in the previous dialogue, now again aligns with the doctor, indicating “We already said. She asked yesterday” in line 6. This approach adopted by the interpreter in this example overlaps with the dietician’s use of third person singular in line 5, which together distance the patient from the interaction. Moreover, the interpreter makes an implicit omission disregarding the patient’s main question in line 1. Rather, she emphasizes what is forbidden, possibly assuming that the patient already knows the answer in line 6. She sustains her alignment with the dietician in the following extract.

Extract 12:

- 1 D: Here is **her** nutrition. It is in German.
Bu da beslenmesi. Almanca.
- 2 I: **Okay. Ah, super.**
Okay. Ah super.
- 3 D: **Tell her that, too.**
Onu da söyle.
- 4 I: Here is **your** nutrition plan. **We** will now explain **you** once again. But it is also stated in German.
*Hier ist **dein** Ernährungsplan. **Wir** erklären dir das jetzt noch einmal. Aber es steht auch auf Deutsch darauf.*

A PHONE RINGS

- 5 I: Here is **your** nutrition plan. **We** will explain you once again. But you can also read it again, it is written in German.
*Also hier ist **dein** Ernährungsplan. **Wir** erklären ihn dir jetzt erstmal. Aber **du** kannst es auch später wieder nachlesen. Auf Deutsch geschrieben. (sic.)*
- 6 P: Perfect, super. Thank you.
Perfekt. Super. Danke schön.
- 7 I: **Okay.**
Tamamdir.

The dietician indicates that the patient would also obtain a nutrition list written in German, of which the interpreter is very pleased (line 2). When the dietician notices that the interpreter might be prone to omit that information, she considers it necessary to remind the interpreter to render that information to the patient (line 3). The interpreter keeps aligning with the dietician, explaining to the patient that “We will explain you once again” in turn 4. The pronoun choice of the interpreter implicitly demonstrates how she authorizes herself in the communication. At the end of the dialogue in line 7, the interpreter responds to the dietician by confirming that the message is already conveyed to the patient.

In the extracts 13 and 14 below, the interpreter prefers to respond to the doctor in order to obtain and then convey more detailed information to the patient.

Extract 13:

- 1 DR: Now, I am also adding these: I am now writing out a prescription. There will be 2 medicines in this prescription. One of them is pill, a capsule.

Şimdi benim ekstra söyleyeceğim şunlar: Şimdi bir reçete yazacağım. O reçetede 2 tane ilaç olacak. Biri hap, kapsül şeklinde.

2 I: **Okay.**

Tamam.

3 DR: **She** will take a pill on an empty stomach every morning.

Her sabah aç karnına 1 tane içecek.

4 I: **Okay. Is it a vitamin pill?**

Tamam. O vitamin hapı mı oluyor?

5 DR: No, gastroprotective.

Yok, mide koruyucu.

6 I: **Ha, okay.**

Ha, tamam.

7 DR: There are 30 pills in it.

İçinde 30 tane var.

8 I: **Okay.**

Tamam.

9 DR: **She** will take gastroprotective pill again, when she comes back to Germany. She will use 3 months in total. The one that I prescribe will be used for a month.

Almanya'ya gittiğinde mide koruyucu hap alsın yine. Toplamda 3 ay kullanacak. Bu kez yazdığım 1 aylık.

10 I: **Ha, she will buy for 2 months, too.**

Ha 2 aylık daha alacak.

11 DR: **She** will buy for 2 months, too

2 aylık daha alacak.

12 I: **I understood, okay.** You will have prescription with medicine that you should use afterwards.

Anladım, tamam. Du kriegst wahrscheinlich Rezepte mit Medikamenten, die du benutzen musst, nachher. (sic.)

13 P: Hı hı.

Hı hı.

14 I: **He** will prescribe now. There will be tablet in it. They are for 30 days capsules. You have to swallow every day.

Er verschreibt sie dir auch gleich. Da ist eine Tablette drin. Diese für 30 Tage Kapseln. Du musst jeden Tag eine davon schlucken. (sic.)

15 P: In the morning, at noon, and in the evenings?

Morgens, mittags und abends?

16 I: **No, once a day.** Is it once a day, right?

Nein, einmal am Tag. *Günde 1 tane değil mi?*

17 DR: Once a day. [In the morning on an empty stomach, in the morning on an empty stomach.

Günde 1. [Sabah aç, sabah aç.

18 P: [But does it matter whether I take in the morning, at noon or in the evenings?

[Aber egal ob morgens, oder mittags oder abends?

19 I: **In the morning, when you are still- actually before you eat, you should swallow it. And when you are in Germany, you have to buy one. X It is a gastroprotective pill.**

morgens, wenn du noch- also bevor du gegessen hast, musst du die schlucken. Und wenn du in Deutschland bist, musst du noch eine kaufen. X Das ist eine Magenschutztablette. (sic.)

- 20 P: Yes
Ja.
- 21 I: You have to buy the new one for 2 months again when you are in Germany. You have to use it only 3 months totally.
In Deutschland musst du eine neue kaufen für zwei Monate noch einmal. Insgesamt nur drei Monate musst du die benutzen. (sic.)
- 22 I: **Okay.**
Tamam.

In the long excerpt above, the interpreter responds to the parties multiple times, all of which have different objectives. The interpreter is continuously seen to respond to the doctor either so as to obtain more detailed data regarding the medicine or to confirm the doctor with “**Okay**”, “**Ha, okay**”, etc., thus constituting the doctor-interpreter framework between the lines 1 and 12. For example, when the doctor explains that he will prescribe a medicine, the interpreter asks a further question whether it is a vitamin pill. Likewise, the interpreter also responds to the patient, providing medical information in turn 16, even though she then tries to confirm its accuracy. In sum, it means that the interpreter here assumes the “responder” role, first of all, in order to delve into the knowledge regarding the medicine (lines 2, 6 and 8) and secondly, to convince the doctor that she has understood it (line 12). Then, she elaborately explains what she has learnt from the doctor.

The Extract 14 is the continuation of the Extract 13 where the doctor keeps giving instructions about the medication. As in the previous example, the interpreter keeps asking further questions to the doctor, thus also keeps speaking on behalf of the patient, which leads her to assume the responder role again.

Extract 14:

- 1 R: The second one is anticoagulant thrombosis needle.
İkincisi de kan sulandırıcı Tromboz iğnesi.
- 2 I: **Hı hı.**
Hı hı.
- 3 DR: ... Thrombosis needle every evening at 9-10 o'clock...
... Tromboz iğnesini her akşam 9- 10'da ...
- 4 I: **Hı hı.**
Hı hı.
- 5 DR:... 10 days. Once a day. I will prescribe the needle. I will prescribe
10 needles. **She** will have with her. Every evening...
... 10 gün. Günde 1 tane. İğneden yazacağım zaten. Toplam 10 tane yazacağım. Onunla beraber gidecek. Her akşam...

- 6 I: **Will she start after coming back?**
Gittikten sonra mı başlasın ona?
- 7 DR: Tomorrow I will have it made and send her.
Yarın ben onu yaptırır gönderirim sabahtan.
- 8 I: **Okay**
Tamam.
- 9 DR: **She** will make it even from 9 am to 9 am every day.
Hatta sabah 9'dan 9'a yapsın o.
- 10 I: **Okay she will [do it in the mornings.**
Tamam. Sabahları [yapsın.
- 11 DR: I will have it done [tomorrow morning.
[Yarın sabah 9'da yaptırırım.
- 12 I: **Okay**
Tamam.
- 13 DR: Then, on Saturday at 9, on Sunday at 9 o'clock. There are 10
needles. It lasts 10 days.
Sonra Cumartesi 9, Pazar 9 diye. 10 tane. 10 günlük o zaten.
- 14 I: **Okay.** And **you** will also have needle. Thrombosis needle. You have
to make inject it every morning at 9 am. Actually, he will start
tomorrow by injecting here for you (sic.)
Tamam. *Und noch eine Spritze kriegst du. Die Thrombosespritze. Die
musst du jeden Tag morgens um 9 Uhr machen. Also morgen fängt er
schon damit an, wenn er es sich hier macht also für dich schon mal
(sic.)*
- 15 P: Okay
Okay.
- 16 I: **You** have to use it during 9 days at 9 am in the morning. For
example, if you start at 9 am, the rest of them will also be injected at 9
am.
*Du musst die nächsten 9 Tagen noch benutzen um 9 Uhr morgen. Zum
Beispiel wenn du um 9 anfängst, also die Reste auch um 9 Uhr. (sic.)*
- 17 P: Good
Gut.
- 18 I: **Okay**
Okay.

Here the doctor indicates that the patient will also have an injection. The interpreter again makes an attempt to extend the information provided by the doctor by asking him when the patient should start injecting the needle in line 6. The doctor explains that he will inject the first needle, then the patient should inject it by at precisely the same time in the upcoming days (lines 7 and 9). These question- answer turns where the interpreter assumes the responder role leads to the doctor- interpreter framework, distancing the patient from the framework. Yet, the interpreter's effort to include the patient in the interaction is also obvious since she directly refers to the patient as "you" while conveying the detailed information she obtained from the doctor. In brief, two objectives which caused the interpreter to assume responder role

come to the forefront: to enrich the information, and to confirm the parties as regards the information conveyed.

Extract 15:

- 1 DR: Now the cigarette. ... first of all it damages lungs. That's known by everyone, not only by doctors.
Şimdi sigara şöyle: ... bir: akciğerlere zararı var. Bunu sadece doktor değil, herkes biliyor.
- 2 I: **Of course.**
E tabi canım.
- 3 DR: The second: The stitches in stomach. There are wounds there. The cigarette might retard the recovery of those wounds.
iki: midedeki dikişler, orada yaralar var sonuçta. Onların iyileşmesini biraz daha geciktirebilir.
- 4 I: **Haa. It might prolong the process.**
Haa. Süreci biraz uzatabilir.
- 5 DR: Well, nothing happens %90 if she smokes. But it is better if she doesn't smoke. It is a recommendation. I am recommending it.
Yani %90'ın üzerinde hiçbir şey olmaz içmesi. Ama, hani içmese iyi olur, tavsiye. Ben onu tavsiye olarak söylüyorum.
- 6 I: **She will try to resist as long as she can.**
Tutabildiği kadar tutmaya çalışsın.
- 7 DR: She will resist as long as she can.
Tutabildiği kadar tutsun.
- 8 I: Hı hı. **He says that** we know- **he means** it is harmful for the body. But **he also thinks that** there are wounds now. It might prolong the recovery process of those wounds, if you smoke. But, if **you** smoke, nothing happens %90. But try to smoke as little as possible or ...
Hı hı. Also er sagt, dass es wir wissen – ja das ist- er gemeint ungesund für den Körper. Aber auch an der Meinung, dass sind die Wunden jetzt. Das kann sein, dass die Wunden sich ein bisschen langsamer heilen, wenn du rauchst. Aber, also wird zum 90 Prozent passiert nichts, wenn du rauchst. Aber versuch so wenig wie möglich zu Rauchen... (sic.)
- 9 P: I actually can smoke a few. X
Also, ich kann gerne weniger rauchen. X

This excerpt still takes place between the same patient and the doctor in the Interaction 2. In this extract, the doctor underlines the negative impacts of smoking and adds that if the patient goes on smoking, it might prolong the healing process of the wounds. The interpreter seems to feel obliged to respond to the doctor for confirming his opinion in turn 2. Upon learning the negative impacts of the cigarette, she strives to find a solution and presents it to the doctor on behalf of the patient in turn 6, indicating that the patient should resist to smoking as far as she could. However, even though she answers the doctor on behalf of the patient as a “responder”, she abstains from speaking in the first person and highlights that the utterances belong to

the doctor in turn 8 where she says “**He says that** we know- **he means** it is harmful for the body. But **he also thinks that** there are wounds now. [...]”, thus shifting to the “reporter/ animator” role.

Extract 16:

- 1 P: When can I drink coffee again? Caffeine- free or?
Ab wann darf ich wieder Kaffee trinken? koffeinfreier, oder?
- 2 I: [When?
Ne zamandan [itibaren?
- 3 DR: It is forbidden during a [month.
[Bir ay yasak.
- 4 I: **She can’t drink caffeine-free coffee, either.**
Kafeinsiz falan da içemiyor.
- 5 DR: No, it is forbidden during a month.
Yok, 1 ay yasak.
- 6 I: After a month **you** can.
Nach einem Monat darfst du.
- 7 P: Should it be normal coffee or caffeine-free?
normaler Kaffee oder auch koffeinfreier egal?
- 8 I: [Normal
[Normal
- 9 DR: It makes no difference. She can also drink caffeinated coffee.
[Fark etmez. Kafeinli de içebilir.
- 10 I: It doesn’t matter. **He says that** you can drink both of them
*Es egal. Kannst du beides trinken, **sagt er.***

In this excerpt above, the patient asks when she can start drinking coffee again and what type of coffee she can drink (line 1). Since the word “coffee” (Kaffee) in the first line might sound familiar from English, the doctor understands the question partially and answers that it is forbidden for a month, when the interpreter just started rendering the patient’s question in line 2. However, the interpreter seems to avoid any room for doubt, and she wants to ascertain that the patient should also not drink caffeine-free coffee in turn 4 where she directly replies to the doctor. Surprisingly, she does not transfer that knowledge to the patient in that the patient has to ask whether she can drink caffeine-free coffee after a month (line 7). Then, the interpreter renders the message with a reported speech “he says”, underlining that she is not the source of that information.

Extract 17:

- 1 D: Now the 15-day period after the operation- we will have only liquid
nourishment period for 15 days.
*Şimdi ameliyatımızdan sonraki 15 günlük dönemimiz- sadece 15 gün sıvı
beslenme dönemimiz olacak.*
- 2 I: **Hı hı.** Well, the first 15 days only liquid nourishment.
Hı hı. Also die ersten 15 Tage ist nur flüssige Ernährung.
- 3 D: **We** do not have many choices. We have limited options. **She** can drink
water, protein shake. ...
*Sıvı beslenme dönemimizde çok fazla alternatifimiz yok. Kısıtlı
alternatiflerimiz var. Su içebiliyor, protein shake'i. ...*
- 4 I: **Soup.**
Çorba.
- 5 D: [...] Water, protein shake ...
[...] Su, protein shake ...
- 6 I: **Something like soup**
Çorba tarzı.
- 7 D: Fresh- squeezed fruit juices. There won't be fruits containing acid. It
might be carrot juice. It might be apple juice. It might be peach juice. It might
be apricot juice. After crushing out, she will water them down. She won't use
intense, pure fruits in the beginning.
*Taze sıkılmış meyve suları. Asitli meyveler olmayacak içerisinde. Havuç suyu
olabilir. Elma suyu olabilir. Şeftali suyu olabilir. Kayısı suyu olabilir. Bunları
sıktıktan sonra sularını, hafif de sulandırarak. Sadece yoğun, saf meyve
olmasın ilk zamanlar.*
- 8 I: **Well, she won't use the ones bought from the market, right?**
Şey o marketten alınanlar [olmuyor değil mi?
- 9 D: No. We only give %100 natural apple juice at the hospital. After coming
home, we want fresh-squeezed juices.
*[Değil. Yüzde yüz doğal elma suyunu hastane ortamında sadece veriyoruz.
Eve gittikten sonra taze sıkılmış istiyoruz.*
- 10 I: **Okay. Okay.** During this 15-day period, in the 15-day period **you** actually
don't have many choices regarding what you should eat or drink. You can **of
course** drink water. You can drink shake. And you can drink only natural, fresh-
squeezed fruit juices. But you should take X from the juice. But you are not
allowed to drink mineral fruits. For example. **Apple juice, right?** Apple juice.
Tamam. Okay. Also in diesen 15 Tagen- die ersten 15 Tage hast du eigentlich
nicht viel zur Auswahl, was du essen oder trinken darfst. Also Wasser darfst du
natürlich trinken. Den Shake sollst du trinken. Und nur naturell, selbst
gepresste ... Früchte- Früchte Säfte darfst du trinken. Aber bei denen solltest
du dieses X ausholen aus dem Saft. Aber keine mineralischen Früchte darfst du
benutzen. Also zum Beispiel. **Elma suyu değil mi?** [Apfelsaft.
- 11 D: Apple juice, carrot juice, peach juice, apricot juice
[Elma suyu, havuç suyu, şeftali suyu, kayısı suyu.
- 12 I: Carrot juice, ... nectarine juice or apricot juice. You can drink such things.
But you have to press [yourself].
*Karotten Wasser, ... Nektarine Wasser oder Aprikosen Wasser. Solche
Sachen darfst du trinken. Aber du musst [selber pressen. (sic.)*
- 13 D: No acidic juice.
[Asitliler yok.
- 14 I: **The acidic ones are orange, right?**

Asitliler şey değil mi? Portakal

- 15 D: Orange, ananas, kiwi, raw tomato juice. These are forbidden.
Portakal, ananas, kivi, çiğ domates suyu. Bunlar yok.
- 16 I: Also kiwi, orange and etc. These are all mineral fruits you shouldn't use.
also Kiwi, ... Orangen und so. Das sind alles mineralische Früchte, die darfst du nicht benutzen. (sic.)

In this example, as in many other examples throughout these interactions in this section, the interpreter is again observed to have given a voice to the patient by directly answering back to the dietician on behalf of the patient, thus assuming the role of “responder” again. The issue is regarding nutrition and the dietician states that the patient would have a 15-day period when she has to consume merely liquid. While she is counting the liquid alternatives, the interpreter intervenes in her turns two times by adding the “soup” as an alternative for the patient, trying to be insistently accepted by the dietician in turns 4 and 6. Upon the dietician’s explanations, the interpreter asks the dietician for an explicitation whether the patient could buy those liquid alternatives from the market (line 8), and answers back as “**Okay**” in turn 10, which sounds like a confirmation, indicating that she has understood the prior utterance. However, when she starts rendering the alternatives, it turns out that she could not memorize all the alternatives and asks for a repetition in turns 10 and 14, leading her to the “responder” role again.

The following section focuses on the instances where the interpreter assumes both “principal” and “responder” roles.

5.2.3.3. Both *Principal* and *Responder* roles of the interpreter

During the interactions, it became obvious that the interpreter assumes both “principal” and “responder” roles together. The following excerpt includes the answers of the interpreter to the doctor and also her comments on the instruction given by the doctor.

Extract 18:

- 1 DR: There is nothing for her to do today. **She** can go down to canteen. Provided that **she** wears a mask. Of course, **she** will wash her hands every time she comes from outside. This is our routine.
Bugün yapacağı bir şey yok. Aşağı kantine inebilir. Ama maskesini takmak şartıyla. Muhakkak her dışarıdan gelince ellerini yıkayacak. Bu, rutin şeylerimiz zaten.
- 2 I: **We are already used to those, yes.**

- 3 **Onlara zaten alıştık artık, evet.**
DR: **She** will continue to drink water in small swallows.
Suyuna yine yudum yudum devam edecek.
- 4 I: **Okay.**
Tamam.
- 5 DR: Tomorrow morning ...
Yarın sabah ...
- 6 I: **Her shake...**
Shake'ini...
- 7 DR: Shake, Ayran, apple juice. I will bring them tomorrow here.
Shake, ayran, elma suyu. Ben onları getireceğim buraya.
- 8 I: **Ha, good.**
Ha, iyi.
- 9 DR: Well, for example, from her shake- shake is half-liter. **She** needs to finish it in a day, in 24 hours. He can also drink Ayran in addition to it.
İşte mesela, shake'inden- shake'i yarım litre oluyor. Onu bir günde yani 24 saatte bitirmesi lazım. Onun yanında ayran içebilir.
- 10 I: **Ha, she asked about Ayran before.**
Ha ayranı sormuştu daha önce.
- 11 DR: In addition to that, I will bring apple juice. **She** can drink apple juice.
Onun yanında, ben elma suyu getiririm. Elma suyu içebilir.
- 12 I: **Hı hı.**
Hı hı.
- 13 DR: In addition to that, **she** can drink water. It means that **she** has 4 beverages.
Onun yanında su içebilir. Yani içeceği 4 tane.
- 14 I: **Ha, as much as she wants- as much as she can drink.**
Ha, istediği kadar- içebildiği kadar.
- 15 DR: As much as **she** can drink. As much as her stomach allows.
İçebildiği kadar. Mide izin verdiği kadar.
- 16 I: Ha. **He** will bring you a shake tomorrow morning **as I said**. Ayran and apple juice and so on.
Ha. Also er bringt dir morgen früh wie gesagt ein Shake, Ayran und Apfelsaft usw. dazu.
- 17 P: Yes. Can I drink Ayran tomorrow?
Ja, darf ich morgen Ayran trinken?
- 18 I: **Yes, of course.**
Ja, klar.
- 19 P: Super.
Super.
- 20 I: X You shouldn't overextend but you can drink from everything. You should drink your shake in a day. It is only 0.5 liter. **Not so much**. But you should drink during a day. You can drink the rest of them as you like.
X Du solltest dich nicht überfordern aber du darfst von allem was trinken davon. Den Shake musst du nur an einem Tag austrinken. Das ist nur eine 0.5 Liter Flasche. Nicht sehr viel. Aber das solltest du auf den ganzen Tag austeilen oder so. Aber die Reste kannst du trinken wie du willst. (sic.)
- 21 P: Okay.
Okay.
- 22 I: X How **you** want.
X Wie **du** möchtest.

In this first example of this section, it can be seen that there is a doctor- patient dyad between the lines 1 and 16. It shows that the interpreter continuously gives answers to the doctor for various reasons. For instance, the doctor states that “There is nothing for her to do today. **She** can go down to canteen. Provided that **she** wears a mask. Of course, **she** will wash her hands every time she comes from outside. This is our routine” in the first turn which also shows that the patient was distanced again. Then, the interpreter answers that “**We are already used to those, yes.**”, which might implicitly display that the interpreter also perceived herself as an authority by acquiring enough information. She also attempts to show her knowledge, as also revealed in the Extract 17 above, by offering an option as “Shake” in turn 6, completing the doctor’s prior utterance in turn 5. Interestingly enough, the interpreter uses a statement like “as I said” while rendering the instructions given by the doctor to the patient in turn 16. Thus, the interpreter seems to behave as if she possessed the information needed. In addition to that, the interpreter here is also observed to assume the “responder” role, responding to the doctor for confirmation again either by stating “Okay” (line 4), “Ha, good” (line 8), “Hı hı” (line 12), and by repeating the doctor’s utterance as “**Ha, as much as she wants- as much as she can drink.**” in turn 14. However, when the doctor says that the patient should drink 0.5-liter water in a day, she makes an addition “Not so much” as a comment, which possibly exemplifies the zeal of the interpreter to motivate the patient, thus assuming the “principal” role, i.e. owner of the words.

Extract 19:

- 1 DR: But **she** can drink herbal tea.
Ama bitki çayları içebilir.
- 2 I: **Exactly. You** can drink normal herbal tea.
genau. Normal- Normale Kräutertees kannst du trinken.
- 3 P: Fruit tea?
Früchtetee?
- 4 I: **Yes.** Fruit teas are also okay, right?
Ja. Meyve çayları oluyor değil mi?
- 5 DR: **She** does not mean Ictea by saying „Früchtetee“, right? The ones which are cold and sugared.
“Früchtetee” derken bu Ictea’lerden bahsetmiyor değil mi? O şekerli hazır soğuk olanlardan?
- 6 I: **You** do not mean Lipton Ictea or something?
Du meinst nicht so Lipton Eistee oder so?
- 7 P: No, bag fruit tea.
Nein. Früchte Beuteltee.

- 8 I: Ha, no no. **She** is talking about tea bag.
Ha, yok yok. Sallama çaydan bahsediyor.
- 9 DR: Okay
Olur.
- 10 I: Yes, they are okay. **He** allows tea bag fruit tea. **No black tea and you do not drink coffee.**
Jaja, die gehen auch. Kräuter- Früchtetee alles erlaubt er. No schwarzer Tee und trinkst nicht Kaffee X.

The role shift of the interpreter from being “animator/reporter” to “responder” and “principal” could easily be traced in this example. Before these utterances given in this excerpt, the doctor sorted some prohibitions. Then, in this part of the dialogue, he adds that the patient could drink herbal teas. In the second turn, where the interpreter starts interpreting to the patient, she first confirms what the doctor said as “**exactly**”. However, it can be stated that the interpreter confirms the doctor not because of showing that she has understood the message as occurred in another examples, but because of confirming the accuracy of the information provided by the doctor in the first turn. Then, the patient asks a further question to the interpreter, which is answered and confirmed by the interpreter again in turns 3 and 4, which associates to the “responder” role of the interpreter directly. While the interpreter implicitly gives some cues regarding that she perceives herself as the authority, she shows an explicit tendency towards not assuming the responsibility as regards the accuracy of the medical information. One of its indicators could be seen in turn 10 where the interpreter uses the pronoun “**he**”, indicating that the doctor allows the patient to drink herbal teas; therefore, the interpreter might actually point to the doctor as the one who is responsible for the utterance. However, the interpreter also displays a concrete contrast behavior which paves the way for her shift from being “animator/reporter” to the “principal” in the last turn where the interpreter decides to remind the patient that she should not drink black tea and coffee as an addition to the doctor’s utterance. It might also be an indicator of the confusion that the interpreter, on the one hand, perceives herself as an authority, thus assuming the principal and responder roles, she, on the other hand, seems to be afraid of undertaking the responsibility of the instructions given to the patient, thus assuming the “reporter/animator” roles.

Extract 20:

- 1 DR: But I am also saying that alcohol is forbidden during 6 months.
Ama şunu da söyleyeyim: Alkol 6 ay yasak.
- 2 I: Alcohol is forbidden during 6 months
Alkohol ist 6 Monate verboten.
- 3 P: That's not a problem.
Das kein Problem.
- 4 I: **She says that that's not a problem. She is addicted to the cigarette. She desires so badly. I also said that she might not be so addicted after an operation. But she says, ["I desire"]**
O sorun değil diyor. Sigaraya çok düşkün de. Çok aşırı arıyor yani. Ben de demiştim ameliyattan sonra istemezsin belki demiştim ama ["Çekiyor canım"] diyor.
- 5 DR: [It might turn her stomach.
[Biraz bulantı yapabilir.
- 6 I: Ha, you might have nausea after the cigarette.
Ha, es kann sein, dass du ein bisschen Übelkeit nach den Zigaretten haben kannst.
- 7 P: Okay
Okay.
- 8 I: **Well, you will take a risk.**
Also, du musst ein Risiko eingehen.
- 9 P: X Exactly.
X Genau.
- 10 I: **Yes. Well, alcohol is okay. As said, try to smoke as little as possible.**
Ja. Also, Alkohol ist okay. Zigarett wie gesagt, versuch einfach so wenig wie möglich.

The doctor previously warned the patient about smoking as rarely as possible (See Extract 15). However, in this extract, he lays special emphasis on the alcohol consumption, indicating that the patient should certainly not drink alcohol during a 6-month period (line 1). After conveying this warning of the doctor and the answer of the patient again by specifically using “**she says that that's not a problem**” in turn 4, she makes an addition to the previous utterances of the primary interlocutors “**She is addicted to the cigarette. She desires so badly. I also said that she might not be so addicted after an operation. But she says, “I desire”** in a manner to advocate the patient. This endeavor of the interpreter might also indicate us how the interpreter and the patient constitute a close relationship, thus encouraging the interpreter to speak on behalf of the patient. In addition to the doctor's second warning about nausea, the interpreter seems to have authorized herself by giving a second warning to the patient as “**Well, you will take a risk.**” in turn 8. Even so, in the last turn, the interpreter makes a repetition as a summarization “**Also, Alkohol ist okay. Zigarett wie gesagt, versuch einfach wenig wie möglich**“, thus assuming the “principal” role.

Extract 21:

- 1 DR: **She** can inject it herself. It has a gray cover. **She** will take the cover off.
Kendi yapabilir. Onun gri bir kapağı var. Kapağını çıkartıyor.
- 2 I: **Hı hı.**
Hı hı.
- 3 DR: Its needle is so small.
İğnesi çok küçük.
- 4 I: **Hı hı.**
Hı hı.
- 5 DR: From the exterior part of the leg.
Bacağın dış tarafından.
- 6 I: **He shows you how you have to do it.**
Er zeigt dir, wie du das machen musst.
- 7 P: **I, myself?**
Ich selber?
- 8 I: **Yes**
Ja.
- 9 P: I have never done it before. My mother had to do it [once].
Das habe ich noch nie gemacht. [Auch damals X musste meine Mutter es selber machen.
- 10 DR: [Does **she** say that she can't inject?
[Yapamam mı diyor?
- 11 I: Someone else injected it.
Başkasına yaptırmış.
- 12 DR: Then someone else will inject it.
O zaman başkasına yaptıracak.
- 13 I: **Can your mother maybe make it?**
kann deine Mutter das vielleicht machen?
- 14 P: Yes, it is no problem.
Ja. Das ist kein Problem.
- 15 I: **Her** mother could make it.
Annesi yapabilirmiş.
- 16 DR: Okay
Tamam.

In this example, the doctor describes how the patient could inject the thrombosis injection by herself that was previously mentioned (see Extract 14 for detailed dialogue). While the doctor is describing and showing how the needle could be used, the interpreter is seen to answer the doctor to confirm him, saying continuously “**hı hı**” in the second and the fourth turns, which presumably indicate that the interpreter has understood the message. Then, spontaneously, the interpreter turns to the patient and says, “**He shows you how you have to do it.**” in turn 6 and commences the interpreter- the patient framework, which might, in turn, urge the

patient to ask a question to the interpreter and the interpreter to answer back to the patient, thus assuming the “responder” role. The patient seems to be quite puzzled when she heard that she should inject the needle by herself. Hence, towards the end of the dialogue, the interpreter attempts to find a solution for this confusion and asks the patient whether her mother could inject it, shifting to the “principal” role.

Extract 22:

- 1 DR: For example **she** will leave early in the morning on Saturday.
Mesela cumartesi günü sabah erken gidecek şeye, havaalanına.
- 2 I: **Ha, yes.**
Ha evet.
- 3 DR: **She** will inject it while departing from the hotel- from the room.
Then she will get on a plane.
Otelden, oda- odadan çıkarken yapsın, öyle uçağa binsin.
- 4 I: **She will try the first needle then. She says that she can't inject it, but she will try at least (Laughing).**
İlkini bir denesin o zaman. Yapamam diyor ama bir denesin en azından.
- 5 I: Because you depart in the morning on Saturday, and you might be alone in the morning before you fly. I think that you should try to inject it by yourself. **You might achieve it. Your mother can inject the rest of them (sic.)**
weil du faerhst am Morgen an und am Samstag bist du ja vielleicht alleine morgens, bevor du fliegst. Da musst du es, glaube ich einmal, selber versuchen. Vielleicht schaffst du es ja eine Spritze zu machen. Den Rest kann deine Mutter machen (sic.)
- 6 DR: Then **she** will inject it from exterior part of her leg. It will be easier.
O zaman kendi bacağının dışından yapar. Daha rahat olur.
- 7 I: **He says that** injecting from the leg is easier. You can inject it from the leg.
Am Bein ist es einfacher, sagt er. Kannst du es am Bein machen.
- 8 P: Yes.
Ja.

This dialogue occurred right after the Extract 21 discussed above. The doctor suggests that the patient should inject the needle before getting on a plane. The interpreter is seen to have two times responded the doctor in the second and the fourth turns. First, in the second turn, the interpreter confirms the doctor and then in the fourth turn speaks on behalf of the patient in a way that could advocate her. Even though the patient clearly expressed that she could not do it herself, the interpreter seems to believe in the patient and feels free to encourage her. Thus, the interpreter also shares her positive conviction with the doctor. Then, apart from rendering what was said by

the doctor to the patient, the interpreter also explicitly encourages her, indicating “**You might achieve it.**” in turn 5 and continues to advocate her by indicating, “**Your mother can inject the rest of them**” in the same turn. Despite the evident courage and zeal of the interpreter to encourage the patient and advocate her by assuming “principal” role, she earnestly seems to reject the responsibility of the utterance(s), thus shifting to the “reporter/animater” role with her pronoun use, emphasizing “**He says that** injecting from the leg is easier” in turn 7.

5.3. DISCUSSION

From the overall analysis based on recorded and observed interpreter-mediated doctor/dietician and patient encounters in this study, it is revealed that the interpreter assumes various roles and shifts from one role into another. A closer examination of the interpreter’s interpreting performance during the interactions demonstrates that the interpreter tends to render the utterance(s) of the parties with the reported speech “she says that”/ “he says that”, thus, in Goffman’s (1981) terms, assuming the role of “animater” or in Wadensjö’s (1998) terms “reporter”, which means that she is the participant who only transfers what is being said by the primary interlocutors, not the “owner of the words”. Intentionally or unintentionally, this strategy preferred by the interpreter shows that she flees from the responsibility behind the utterances since all four interactions mainly rely on the medical instructions given by the doctor and the dietician regarding the nutrition during the post-op period. Thus, it seems plausible that the interpreter might not want to take over its responsibility.

On the other hand, this analysis also points to the fact that the interpreter speaks on behalf of the doctor/dietician and/or the patient or gives responds on behalf of them, assuming the roles of “principal” and “responder”, respectively. Such intervention made it clear that the interpreter perceives herself as an ‘authority’ in the interaction, which proves quite the opposite of her assumed “reporter”/ “animater” roles. However, there are two main factors triggering the interpreter’s shifts from the reporter/animater to the principal and responder roles. The first factor is atypical forms of address utilized by the parties. Even though it is accepted and expected from the primary parties to directly refer to each other, both the doctor and the dietician were observed

to be prone to refer to the patient in the third person singular “s/he”, thus distancing him/her from the framework and involving the interpreter as a primary party. The second triggering factor is atypical gaze patterns of the parties. It is accepted as a norm that the primary parties should directly look at each other as if the interpreter were not available at that encounter. However, both the doctor/dietician and the patients were generally found out to speak directly looking at the interpreter. Hence, the interpreter who is directly referred to and looked at by the parties seems to be perceived as a full-fledged ratified participant in the interaction. The interpreter who grasped these cues from the parties also appear to have an authority sufficient to intervene in the communication, thus taking ownership and control of the messages. These principal and responder roles assumed by the interpreters were mostly intended for confirmation, explicitation for more detailed information and advocacy of the parties. Thus, it can safely be said that these role shifts of the interpreter do not seem to harm the interaction, deteriorate the service quality including the interpreting service, rather, she comes to the forefront as an important agent bridging the gaps between the parties and coordinating the interaction as Wadensjö (1998) suggests.

CONCLUSION

This final part of the thesis provides a general overview of the research objectives, main findings, as well as the discussions guided by the theoretical concepts of Chesterman's *norm* and Goffman's (1961) *participation framework*. At the end of this chapter, limitations of the study will also be acknowledged.

Interestingly, a substantial group of scholars have taken an interactionalist approach (Wadensjö, 1995, 1998) to the investigation of interpreters as active participants, not only in conference settings, but also in community settings. Turkey attracts many tourists, both as an important vacation destination, and for healthcare services such as hair transplantation and cosmetic surgery. For this very reason, there is a rapidly-growing need for interpreters who facilitate communication between healthcare providers and patients, and the profession of community interpreting, in this case healthcare interpreting, is becoming ever more visible. Scholarly interest in healthcare settings is also increasing correspondingly (see the section 1.3. for the detailed review of the studies in Turkey). Against this backdrop, this study set out to explore the role of healthcare interpreters within the interactional dynamics in triadic encounters in Turkey. Role can be defined as a "cluster of behaviours shared between a group of individuals fulfilling the same position in society and as a pattern of behaviour expected by other societal segments" (Havighurst and Neugarten, 1962 in Aranda, 2020: 23). In this definition, role can be regarded as "strategies" and "behaviours" of the interpreter. It can further be understood that role also depends on others' expectations. Thus, this study is a comprehensive investigation of how the interpreter's role shapes and is shaped within the interactional dynamics, from three different stakeholder perspectives- namely medical doctors, hospital executives and the interpreters- with additional data on the interpreter's performance in authentic doctor- patient encounters.

Since the study focuses on interpreter- mediated interactions and the relational networks of the participants in healthcare settings, a comprehensive summary of research studies on the issue of role, both internationally and in Turkey, was reviewed in **Chapter 1**. The studies revealed valuable insight into turn allocation and role distribution not only from verbal output of the interpreter, but also from non-verbal

instruments. As the role is also based on user expectations and perceptions, a variety of studies also focused on user perspectives.

After discussing the scholarly works in Chapter 1, **Chapter 2** constituted the foundations of the thesis' methodology and theoretical framework. This case study was based on fieldwork, adopting a mixed- method approach. The role of the interpreter was extrapolated through a triangulation of various ethnographic data collection methods i.e. questionnaire data from 22 medical doctors and 11 hospital executives, interviews with 13 healthcare interpreters, as well as participant observation and audio- recordings of interpreter- mediated consultations. The expectations and perceptions of role of the healthcare interpreters were elicited with questionnaires of 23 items for hospital executives and 25 items for doctors. Secondly, semi- structured interviews conducted with the interpreters revealed their self-perception of role, and their perceived role image of the users. The quantitative analysis of the data from the doctor and executive questionnaires was supplemented with the qualitative analysis of the interview results. The findings from these two data sets were triangulated with the analysis of participant observations and audio-recordings of interpreted encounters.

This approach led to two-fold findings. First, the discursive statements of the key actors involved in the encounters were determined, and comparative analysis was conducted of convergences and divergences between different views, expectations and perceptions on the role of the interpreters. My intention here was to explore from a theoretical perspective the *expectancy norms* of the users and the *professional* or *process norms* applied by the interpreters.

In the second stage of the analysis, the focus was on naturally- occurring data, which consisted mainly of the field notes of the participant observation and the audio-recordings of four interpreter-mediated doctor and patient encounters. More specifically, within complex interactional dynamics, the role of the interpreter was explored through analysing participants' forms of address, turn-takings and gaze patterns, in accordance with Goffman's (1981) *participation framework* and the concept of *footing*. Verbal and non-verbal data, as well as discourse- based materials were integrated into the discussions, with the aim of widening the scope of the analysis and advancing our understanding of the complex relations in healthcare consultations

in Turkey. Taking such an approach, this thesis can be considered to align with the **dialogic discourse- based interaction (DI) paradigm** (Pöchhacker, 2004: 79). However, as further indicated by Pöchhacker (2004: 79), **DI paradigm** shares common ground with **target- text-oriented translation- theoretical approach (TT paradigm)**, such as “functionalist concern with (inter)action and mediation, and the interest in translational norms” (Pöchhacker, 2004: 79). This is because of the mutually supportive contributions of the two theoretical concepts applied in this study, while the triangulated research methods ensure complementary data in the analysis.

In analyzing the users’ perceptions and expectations, I categorized the answers into the sub- headings of “eligibility”, “role”, “quality” and “positioning of the interpreter”, which focused intentionally on the *expectancy norms* determined by the users in **Chapter 3**. When taking into consideration the degree of importance attached to the eligibility criteria by the doctors and the executives, the results clearly revealed that despite some meeting points on common ground, there were also points of divergence. The most outstanding divergence concerns the ‘eligibility’ section. To cite an example, although “language competence” was regarded as by far the most important eligibility criterion by both groups, the doctors stressed “medical terminology” and “training in the field” as more important criteria, while the executives stressed “cultural background knowledge” and “experience in the field”. The hospital executives’ choices might point to their much stronger institution-oriented approach. Precisely because of that, they expect the interpreters to be superior in terms of cultural knowledge than both the patient and the doctor, and through their experience in the field, they could reinforce patient satisfaction, and promote hospital profitability.

The second sub-heading was ‘role’, in regard to which my analysis detected inconsistencies in both the doctors’ and the executives’ answers. These contradictory findings might, in my view, point to confusion. On the one hand, the users have an ideal image of the interpreters, as depicted in the literature, as ‘conduits’, “non-persons” and “translation machines” (Bot, 2007: 82). In reality, however, they expect the interpreters to take up a more active position. These conflicting views were similarly reflected in other sub- categories. This part was complicated by four interrelated questions posed to the users, which sometimes resulted in contradictory

statements. When asked to define the task of the interpreter, majority of the doctors and the executives asserted that the interpreter ‘always interprets only what the participants (healthcare providers and patients) say exactly, without any additions or omissions’. This answer gives impression that the interpreters are expected to make word-for-word renditions as invisible participants in the encounters. However, when asked to define the role of the interpreter, a higher percentage of users depicted the interpreter as an active participant controlling and shaping the communication, which contradicts the earlier statement. This confusion grew as more questions were asked. For instance, when asked what they expected from interpreters, 77.27% of the doctors and 90.91% of the executives indicated multiple responsibilities, such as dealing with the patients’ procedures, tests, forms, etc. in addition to the main task. Even so, the doctors asserted they perceived the status of the interpreters only as ‘language experts’. This is another point of divergence with the executives, who reinforced their position by regarding the interpreter not only as ‘an expert with his/her medical terminology and language knowledge’, but also as a member of a hospital staff, dealing with a variety of tasks within the hospital.

The users continued to repeat these clusters of conflicting ideas when determining their ‘quality’ criteria. This category is another topic where they diverged; when asked to rank the quality criteria in terms of importance, the primary criterion was “fidelity to the original speech” for the doctors and “completeness of information” for the executives. In a sense, these relate to each other, as both criteria seem to regard the interpreters as invisible agents, forbidden to make any additions, omissions or make changes in the words of the primary interlocutors. In this scenario, the interpreter is perceived as a translation- machine who is automatically rendering the words, rather than the sense. This is again contradictory; both the doctors and the executives already depicted interpreters as active participants who could control and shape the interaction, as well as assume responsibility for a variety of tasks, a position which allows them considerable freedom.

The responses of the users also give hints regarding the authority given to the interpreter during the encounters. While the two user groups referred to the similar criterion for the first ranking, they can be differentiated by their remaining rankings. The doctors ranked the criteria “correct terminology usage” and “fluent delivery” as

the third and the fourth important criteria respectively, but the executives ranked them second and the third respectively, i.e. the doctors have lower expectations of the interpreters' command of terminology, since they themselves have the authority. As long as the interpreter transfers the message completely and faithfully, the fluency and the terminology are not so important. In contrast, by ranking "correct terminology usage" second and "fluent delivery" third, the executives showed that they perceive the interpreter as an authority in regard to both terminology knowledge and fluency in the renditions.

The last sub-section in this category was "positioning of the interpreter". The vast majority of the doctors and all the executives indicated that the interpreter should be in the middle position, in relation to the doctor and the patient. This confirms that the interpreter is seen as the invisible, uninvolved participant in the encounters. These inconsistencies point to the lack of coherence of views over the question "What should they expect from the interpreter?" and "What do they expect the interpreter to do in real- life?".

However, in **Chapter 4**, the results of the semi- structured interviews conducted with 13 healthcare interpreters allowed more palpable findings regarding their self- perception of role. Responses analyzed under the categories of "eligibility", "role", "quality", "interpreter's involvement" as well as "positioning of the interpreter" clearly showed that the interpreters attached more importance to the context than the users. In accordance with the contextual requirements, they feel sometimes obliged to act intuitively, and move beyond their 'professional boundaries'. Accordingly, they highlighted the need of improving personal qualities in addition to the professional skills.

Evidence of the emphasis on the context first emerges in the 'eligibility' part. Most interpreters, i.e., 10, advocated that the interpreters in healthcare settings require certain personal characteristics, such as *having a sociable personality or empathy, the sense of responsibility and being patient*. Language and medical terminology knowledge are also highlighted as important eligibility criteria in healthcare setting, as clearly expected.

The context, according to their accounts, also affects their role. As a result of their specific context, they feel more than just "interpreters". In addition to an

interpreter- patient relationship, they sometimes establish a special tie with the patient, which resembles an interpreter- close friend or relative relationship. Thus, they asserted that they also provide psychological advocacy, and a need to show empathy when the patient is in pain, leading to a perception of their role as “counsellor”, “advocator”, or “representative”. This tendency is seen in their emphasis, when discussing the “quality” criteria in the setting, on the importance of personal characteristics, in addition to ‘accuracy and completeness of information’, “experience in the field”, and “terminology”.

When comparing the responses of the users and the interpreters, a **role gap** was detected in their perceptions. The users were found to perceive the interpreter as an agent responsible, first of all, for financial procedures of the hospital, such as dealing with patients’ insurance claims, doing marketing research, etc. Furthermore, the interpreters are expected to assume a number of tasks and responsibilities, not necessarily related to interpreting, which makes the interpreter seem a “maid of all work”. In complete contrast, the interpreters perceive themselves as a “facilitator” and/or “advocate” for both sides. On the one hand, they see themselves as protecting the hospital’s interests and meeting the expectations imposed on them, and on the other, facilitating and advocating the patients’ rights by constantly shifting between their professional and personal boundaries. In line with the contextual and situational factors, my study demonstrated an occasional inclination towards a patient- oriented approach. This might originate from the power imbalance between the parties, which is the main distinction between conference and community settings. The distinctions in role definitions, the interpreters implied, does not make their profession prestigious. Even those describing their job at the hospital as prestigious, related this prestige to the financial gain of the hospital rather than to their own position. Some interpreters revealed that only if they increase the hospital profits, are they regarded and treated as important actors. Holding a position as an interpreter, as indicated, does not bring any particular status within the hospital.

The above-mentioned role gap can also be observed in the ‘quality’ section of the analysis. As stated before, the doctors’ primary quality criterion was “fidelity to the original speech”, and the executives’ was “completeness of information”, and these could be related to each other. The interpreters also put much emphasis on the transfer

of the full message, and its accuracy. Even though all three groups appear to give a similar answer to this question, it is evident that the actual meanings underlying their choices are different. The doctors and the executives refer to the “accuracy” as word-for-word translation without additions or omissions; in contrast, the interpreters revealed a sense-based approach, focusing on the core meaning of the message, indicating that these parties’ rather different understandings of the term “accuracy”.

This word-for-word approach also highlighted the interpreters’ occasional need to intervene in the communication, especially as regards the style of the speech. When the doctors perceive the interpreters as mere computers or translation machines, they may speak without pause, and the interpreters may feel the need to slow or interrupt the conversation, to provide smoother communication between the parties.

Despite all those different role definitions and perceptions, the interpreters accepted that they were bound to undertake various non-interpreting tasks, such as working in the areas of “operation specialist” or “sales department”, dealing with insurance claims and payments, transfers from/to airport, hotel and hospital, registrations of the patients, etc. Thus, in theoretical terms, they conform to the users’ **expectancy norms**.

Lastly, **Chapter 5** examined the fieldwork data. The performance of the interpreter in actual settings was scrutinized so as to provide a more comprehensive and holistic understanding of the nature of the relational dynamics in healthcare context.

The data obtained from the direct observation and the audio-recordings consisted of four interpreter-mediated doctor-dietician-patient encounters. Direct observation of the encounters is crucial for examining the non-verbal features such as gaze patterns in this study. All the observed encounters involved interpreting consecutively between German and Turkish by the same interpreter. The interpreter had no formal interpreter-training, but was a Turkish speaker born and raised in Germany. All patients had undergone laparoscopic sleeve gastrectomy, and the encounters with the doctor and the dietician consisted of briefings regarding the post-operation period.

The focus in this part was the role of interpreter, regarding the forms of address, gaze behaviours, and turn-takings of the primary interlocutors. The findings

demonstrated that the interpreter alternated between different roles during the encounters; these 'role shifts' were found to be triggered by two main factors: participants' non-conforming forms of address, and non-conforming gaze patterns. It seemed to me to be quite common in this corpus that both the doctor and the dietician referred to the patient in the third- person singular "she" or "he", thus creating a distance between them (Van de Mieeroop, 2012; Hale, 2007). The interpreter strived to narrow this distance by referring to the patient in the second- person singular "you", but she was frequently observed to have violated the norm of speaking in the first-person singular "I", while rendering the utterances of the parties. After this, she switched to transferring messages with the use of quotative "she/he says". Thus, the interpreter took on the role of a "reporter" or an "animator", who is only a "sounding box" (Goffman, 1981) or an agent who "memorized for repetition the words uttered" (Wadensjö, 1998), thus absolving herself of the responsibility for the content of the message.

In the same manner, gaze behavior analysis revealed, remarkably, that all the interlocutors- the doctor, dietician and the patients, mostly addressed the interpreter, instead of directly speaking to each other. By directly attending to the interpreter, the primary parties allowed for and accepted the interpreter as an "addressed" listener and a full- fledged participant in the interaction, thus attributing to her the role of "principal". By being directly addressed the interpreter feels it is natural to take an extra turn, and to commence speaking. Thus, the interpreter, from time to time, took the initiative to act for either the doctor/dietician or the patients, posing questions or responding on their behalf in order to make a clarification, confirmation, extra explanation, or to offer help, leading to the assumption of the roles of "principal" and/or "responder". On the one hand, the interpreter attempted to avoid responsibility for the message with the use of "s/he says", but on the other, displayed an involved attitude by initiating a conversation, asking questions or answering the parties, thus shifting back-and-forth between the "reporter" and "animator" roles and the "principal" and "responder" roles.

All in all, this study yielded valuable findings. First of all, this study brought to light discrepancies between the users' and the interpreters' perception of role and how these affect interpreters' strategies and role in practice. At this point, it can be

argued that role is shaped by various factors, among which are user expectations. Interpreters meet the expectations of the users, in theoretical terms, the expectancy norms determined by the doctors and the executives, thus showing the decisive role of user expectations and perceptions in shaping the role of the interpreters. Another factor is 'context', which was frequently highlighted by the interpreters. Contextual and situational requirements caused the interpreters to move beyond their professional boundaries, and act intuitively especially towards the patients. Interpreters provide psychological assistance, showing empathy, creating a close relationship with the patients, advocating for them. Correspondingly, the patients allow the interpreters to create a room for maneuver, and this can be regarded as an important indication of the interpreters' ability to shape their own role, thus reinforcing their "principal" role in Goffman's (1981) terms.

The interpreter was also observed to sustain this strategy in real-life situations. With her particular pronoun choice, "you", while addressing the patient, and quotative use of "s/he says" while rendering the utterances of the parties to each other, the interpreter reinforces her own "principal" role, in addition to the triggering factors incited by the primary interlocutors, as discussed in detail in Chapter 5 above. In doing so, the interpreter proved her role as a "ratified" participant in the interaction, coordinating and controlling the flow. This was also confirmed by the data obtained from the stakeholders. The interpreter, as expected, and as described by the users, is "ratified" by participants, playing an active role during the encounters, as opposed to their "non-person" image.

Last but not least, the data clearly showed that the gaze patterns of the parties underlined in this thesis seem to be independent from the seating arrangements (see Figures 37- 41, for a schematic representation of the entire seating arrangements of the participants in the interactions). In contrast to Wadensjö's (2001) findings, this thesis revealed that participants' gaze patterns were not affected by proximity to the patient. The interpreter was closer to the patient in the first interaction, while the doctor was closer to the patient in the Interaction 2, but the results of their gaze directions were unchanged. It can therefore be deduced that the seating position has no primary impact on the role of the interpreter.

This thesis aims to cast light on the role of the interpreter within a socio-cultural and situational context, and can be regarded as a step toward enriching the understanding of healthcare interpreting practice in Turkey. It can also be acknowledged that this innovative study brings together rich clusters of ethnographic data collection methods comprising of audio-recordings, participant observation, questionnaires, and interviews, highlighting the benefits and drawback of each. Nevertheless, the biggest limitation of this study is a lack of analysis of video-recordings of the gaze patterns of the participants. Analysis of eye tracking of the participants with special technical equipment could have brought more detailed and concrete results, because a single gaze direction could signal deeper meanings. Yet, it is anticipated that this study will trigger further research on both the verbal and non-verbal features of the healthcare interpreting setting in Turkey.

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APPENDICES

Appendix 1: The Approval of the Ethical Board of the Rectorate of Dokuz Eylül University



**T.C.
DOKUZ EYLÜL ÜNİVERSİTESİ REKTÖRLÜĞÜ
HUKUK MÜŞAVİRLİĞİ**

29 Eylül 2020

Sayı : 87347630/42104268/ **4150**
Konu : Etik Kurul İzni Hak.

SOSYAL BİLİMLER ENSTİTÜSÜ MÜDÜRLÜĞÜNE

İlgi :24.08.2020 tarihli ve 57485104-302-15-06/5122 sayılı yazınız.

İlgide kayıtlı yazınıza istinaden Sosyal ve Beşeri Bilimler Araştırma ve Yayın Etik Kurulunun 25.09.2020 tarihli toplantısında alınan 1 sayılı karar ile Enstitünüz Mütercim Tercümanlık Anabilim Dalı doktora programı öğrencisi Olcay ŞENER'in yürütücüsü olduğu "Türkiye'de Hastane Çevirmenliği ve Çevirmenin Rolüne İlişkin Kullanıcı Algısı ve Beklentileri" konulu doktora tezinde uygulayacağı anketin etik açıdan uygun olduğuna karar verilmiştir.

Bilgilerinizi ve gereğini rica ederim.

Prof. Dr. Nükhet HOTAR
Rektör

1.10.2020/42104268
Cumhuriyet Bulvarı No:144 Alsancak/İZMİR/TÜRKİYE
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Appendix 2: Consent Form for the Interviewee

BİLGİLENDİRME FORMU (CONSENT FORM)

Bu çalışma Dokuz Eylül Üniversitesi Sosyal Bilimler Enstitüsü Mütercim Tercümanlık Anabilim Dalı Çeviribilim Doktora programı kapsamında Dr. Öğr. Üyesi Şeyda KINCAL ve Prof. Dr. Ebru DİRİKER'in danışmanlığında yürütülen Araş. Gör. Olcay ŞENER ERKİRTAY'ın hastane çevirmenliği ve çevirmenleri üzerine yapılan doktora tez araştırmasının bir parçasıdır.

Çalışmanın bilimsel niteliği sebebiyle yapılacak olan görüşmede ses kaydı alınacaktır. Alınan ses kaydı yalnızca araştırmacı Olcay Şener Erkirtay tarafından bu tez çalışması ve ilgili akademik çalışmaların hazırlanmasında kullanılacaktır. Tüm katılımcıların ismi anonim kalacak olup, hiçbir kurum/kuruluş ve katılımcının ismi açıkça belirtilmeyecektir. Cevaplarınız Türkiye'de hastane çevirmenliği mesleği ve hastane çevirmenlerinin rolüne ilişkin genel bir bakış açısını ortaya koymak üzere değerlendirilecektir.

Göstereceğiniz ilgi ve yardımlarınız için teşekkür ederim.

Appendix 3: Consent Form for Participant Observation and Audio-Recordings

ONAM FORMU

Bu çalışma Dokuz Eylül Üniversitesi Sosyal Bilimler Enstitüsü Mütercim Tercümanlık Anabilim Dalı Çeviribilim Doktora programı kapsamında yürütülmektedir.

Bu form ile, amaçları tarafıma ayrıntılı olarak açıklanmış bilimsel çalışmada kullanılmak üzere katıldığım görüşmede ses kaydı alması için araştırmacıya izin verdiğimi beyan ederim.

Alınan ses kaydı ve görüşmeden elde edilen notlar yalnızca bu tez çalışması ve ilintili akademik çalışmaların hazırlanmasında kullanılacaktır.

Adınız, soyadınız ve çalıştığınız kurumun adı gizli tutulacak olup, hiçbir yayında açıkça paylaşılmayacaktır.

CONSENT FORM

This study is conducted within the framework of Translation Studies Ph.D Programme, Department of Translation and Interpreting Studies at Social Sciences Institute of Dokuz Eylul University.

I voluntarily give my consent to the researcher to record my voice to be used in a research, the objective of which was explained to in details, prior to the encounter.

The recorded voice and the notes taken during the encounter will only be used for this and the related research.

Your name, surname and the institution you work will be kept confidential and will not be published explicitly in the research.

Appendix 4: Interview Questions for Healthcare Interpreters

TERCÜMANLAR İÇİN RÖPORTAJ SORULARI:

1. Kaç yaşındasınız?
2. Hangi diller arasında çeviri yapıyorsunuz?
3. Dil seviyeniz nedir?
4. Eğitim durumunuz nedir?
5. Kaç yıldır bu alanda (hastane çevirmenliği) çeviri yapıyorsunuz?
6. Daha önce çeviri/ tercümanlık eğitimi aldınız mı?
7. Çeviri yaptığınız dili nasıl öğrendiniz?
8. Günde yaklaşık kaç saat çeviri yapıyorsunuz?
9. Hastane tarafından size tercümanlık ve/veya tıbbi terimler hakkında eğitim verildi mi?
10. İşe alım sürecinizi tanımlayabilir misiniz? Çeviriyle veya medikal bilgi/terimlerle ilgili bir sınava (tıbbi) tabi tutulduunuz mu? Sizden dil bilginize dair bir belge /sertifika istendi mi?
11. Hastane çevirmeni olarak rolünüzü nasıl tanımlarsınız?
12. Sizce hastaların ve hastane personelinin (doktor, hemşire ve yönetim) çevirmen rolü algısı nedir? Çevirmen olarak rolünüzün diğer taraflar tarafından doğru anlaşıldığını düşünüyor musunuz?
13. Çeviri esnasında müdahale etmeniz gereken durumlar oluyor mu? Oluyorsa ne sıklıkla? Açıklayabilir misiniz? Örnek verebilir misiniz?
14. Sizce hastane çevirmenliği alanında çalışan çevirmenlerin sahip olması gereken en önemli özellikler nelerdir?
15. Hastane çevirmenliği dışında üstlendiğiniz başka sorumluluklar var mıdır? (Örneğin hastaların işlemleriyle ilgilenmek, başvuru, tahlil sonuçları, form doldurma, vb.)
16. Hastane çevirmeninin saygınlığını/prestijini/konumunu nasıl görüyorsunuz?
17. Sizin hastane çevirmeni olarak birlikte çalıştığınız diğer taraflardan beklentileriniz nelerdir?

18. Tarafların (hasta, hastane yönetimi, doktor, vb.) sizden çevirmen olarak beklentileri nelerdir? Bu beklentileri tam anlamıyla karşıladığınızı düşünüyor musunuz?
19. Sağlık personeli ile tercümanlar arasında sizce iş birliği mevcut mu? Sizce birlikte çalıştığınız taraflar çevirmenlik mesleğiyle ilgili yeterli bilgiye sahip mi veya bilgilendirilmeli mi?
20. Verdiğiniz çeviri hizmetini kaliteli buluyor musunuz? Neden?
21. Hastane çevirmenliğinin kaliteli olması sizce ne anlama geliyor? Sizce hastane çevirmenliğinde en önemli kalite kriterleri hangileridir?
22. Çeviri esnasında özellikle dikkat ettiğiniz durumlar/ unsurlar hangileridir?
23. Çeviri sırasında tarafların size çevirinizin içeriği (örneğin medikal bilgiler, terimler) veya formu (örneğin akıcılık, hız) müdahale ettiği oluyor mu?
24. Sizce çevirmenin oturma pozisyonu nasıl olmalıdır?
25. Tarafların beden dilini ve jest, mimik, bakış, vb. gibi sözel olmayan (nonverbal) unsurları çeviriyor musunuz? Beden dilinin de çevrilmesi gerektiğini düşünüyor musunuz? Neden?
26. Çeviri sırasında duygusal açıdan zorlandığınız durumlarla karşılaşılıyor musunuz? Evet ise bu durumla nasıl başa çıkıyorsunuz? Örnek verebilir misiniz?
27. Neden bu mesleği tercih ettiniz ve bu meslekte devam etmeyi düşünür müsünüz?

Appendix 5: Questionnaire for Hospital Executives

Bu anket Dokuz Eylül Üniversitesi Sosyal Bilimler Enstitüsü Mütercim Tercümanlık Anabilim Dalı Çeviribilim Doktora programı kapsamında Dr. Öğr. Üyesi Şeyda KINCAL ve Prof. Dr. Ebru DİRİKER'in danışmanlığında yürütülen Olcay ŞENER ERKIRTAY'ın hastane çevirmenliği ve çevirmenleri üzerine yapılan doktora tez araştırmanın parçasıdır. Tüm katılımcıların isimleri anonim kalacak olup, hiçbir kurum/kuruluş ve katılımcının ismi açıkça belirtilmeyecektir. Cevaplarınız Türkiye'de hastane çevirmenliği mesleği ve hastane çevirmenlerinin rolüne ilişkin genel bakış açısını ortaya koymak üzere değerlendirilecektir.

Göstereceğiniz ilgi ve yardımlarınız için teşekkür ederim.

- 1) Cinsiyetiniz
 - a) Kadın
 - b) Erkek
- 2) Lütfen yaşınızı belirtiniz.
-
- 3) Hangi dilleri biliyorsunuz?
 - a) İngilizce
 - b) Almanca
 - c) Diğer (Lütfen belirtiniz)
 - d) Bilmiyorum
- 4) Dil bilginiz hangi düzeydedir?
 - a) Başlangıç
 - b) Orta
 - c) İleri seviye
 - d) Anadil düzeyinde
- 5) Kaç yıldır yöneticilik yapıyorsunuz?
 - a) 1-3 yıl arası
 - b) 3-5 yıl arası

- c) 5 – 10 yıl arası
- d) 10 yıldan fazla

6) Çevirmen işe alımında çevirmeni yabancı dil sınavına (yazılı ve/veya sözlü) tabi tutuyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

7) Çevirmen işe alımında çevirmeni medikal terminoloji sınavına tabi tutuyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

8) Çevirmen işe alımında çevirmeni sözlü sınava (mülakat) tabi tutuyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

9) Çevirmen işe alımında çevirmenden dil belgesi talep ediyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

10) Çevirmen işe alımında kriterlerinizi sıralayabilir misiniz?

(0= En az önemli, 1= Az önemli, 2= Orta düzeyde önemli, 3=Çok önemli, 4= En önemli)

- a) Dil yetkinliği
- b) Tercümanlık eğitimi almış olması
- c) Medikal terminoloji bilgisi
- d) Kültürel unsurlara hakimiyet
- e) Aynı sektörde deneyim

f) Diğer (lütfen puanıyla birlikte belirtiniz)

11) Aşağıdaki kalite kriterlerini 0 ile 4 arasında puanlayabilir misiniz?

(0= En az önemli, 1= Az önemli, 2= Orta düzeyde önemli, 3=Çok önemli, 4= En önemli)

- a) Bilginin tamlığı
- b) Orijinal konuşmaya sadık kalma
- c) Akıcı aktarım
- d) Doğru terim/ terminoloji kullanımı
- e) Diğer (lütfen puanıyla birlikte belirtiniz)

12) Çevirmenin görevini aşağıdaki maddelerden hangisi/ hangileri ile tanımlarsınız?

- a) Çevirmen, doktor veya hastanın söylediklerine hiçbir şey eklemeyen veya çıkarmadan olduğu gibi aktarmalıdır.
- b) Çevirmen sadece gerekli durumlarda ekleme, çıkarma, açıklama, vb. yapmalıdır.
- c) Çevirmen hastayla doktor arasındaki görüşmede konuşmaya özgürce ekleme- çıkarma, açıklama, vb. yapabilir.

13) Çevirmenin rolünü aşağıdaki maddelerden hangisi ile tanımlarsınız?

- a) Çevirmen, hasta ve doktor (sağlık personeli) arasındaki görüşme esnasında görüşmeyi koordine eden ve şekillendiren aktif bir katılımcıdır.
- b) Çevirmen, sadece konuşmacıların (hasta ve doktor/ sağlık personeli) kelimelerini ve cümlelerini olduğu gibi aktaran nötr birisidir.

14) Çevirmenden beklentiniz nedir?

- a) Sadece doktor/sağlık personeli ve hasta arasında çeviri yapması
- b) Çeviri harici konularda da destek sağlaması (Örneğin; form doldurma, sigorta işlemleri, danışmanlık, vb)

15) Hastanede çeviri hizmetiyle ilgili ne kadar sıklıkla sıkıntı/ şikayetle karşılaştınız?

- a) Her zaman
- b) Çoğu zaman
- c) Arada bir
- d) Hiçbir zaman

16) Sizce çevirmen doktor ve hastanın kullandığı jest ve mimikleri taklit etmeli midir?

- a. Evet
- b. Hayır
- c. Emin değilim

17) Sizce çevirmen doktor/ sağlık personeli ve hastanın ses tonunu taklit etmeli midir?

- a) Evet
- b) Hayır
- c) Emin değilim

18) Sizce çevirmenin oturma pozisyonu nasıl olmalıdır?

- a) Hastaya daha yakın
- b) Doktora/ Sağlık personeline daha yakın
- c) İkisinden de uzak
- d) İkisinin de ortası

19) Sizce çevirmen çeviri sırasında gerektiği durumlarda hastalara empati göstermeli midir?

- a) Evet
- b) Hayır

20) Çevirmenin hastalara empati göstermesinin hasta tedavi sürecini/ tedavisini olumsuz etkileyeceğini düşünüyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

21) Çevirmenin hastalara empati göstermesinin hasta tedavi sürecini olumlu etkileyeceğini düşünüyor musunuz?

- a) Evet
- b) Hayır
- c) Bazen

22) Hastane içerisinde çevirmenin statüsünü nasıl görüyorsunuz?

- a) Terim ve tıbbi bilgisiyle uzman statüsünde
- b) Dil konusunda uzman statüsünde (sadece çevirmen olarak)
- c) Hastane içerisindeki işlemlere destek sağlayan personel
- d) Hepsi

23) İşe alım sürecinde herhangi bir yasal mevzuatı göz önünde bulunduruyor musunuz?

- a) Evet
- b) Hayır

Hastane çevirmenliği ve çevirmenlerle ilgili ankette belirtilmeyen eklemek istedikleriniz varsa lütfen belirtiniz.

Appendix 6: Questionnaire for Medical Doctors

Bu anket Dokuz Eylül Üniversitesi Sosyal Bilimler Enstitüsü Mütercim Tercümanlık Anabilim Dalı Çeviribilim Doktora programı kapsamında Dr. Öğr. Üyesi Şeyda KINCAL ve Prof. Dr. Ebru DİRİKER danışmanlığında yürütülen Olcay ŞENER ERKIRTAY'ın hastane çevirmenliği ve çevirmenleri üzerine yapılan doktora tez araştırmanın parçasıdır. Tüm katılımcıların isimleri anonim kalacak olup, hiçbir kurum/kuruluş ve katılımcının ismi açıkça belirtilmeyecektir. Cevaplarınız Türkiye'de hastane çevirmenliği mesleği ve hastane çevirmenlerinin rolüne ilişkin genel bakış açısını ortaya koymak üzere değerlendirilecektir.

Göstereceğiniz ilgi ve yardımlarınız için teşekkür ederim.

1. Cinsiyetiniz
 - a) Kadın
 - b) Erkek.
2. Lütfen yaşınızı belirtiniz.
-
3. Hangi dilleri biliyorsunuz?
 - a) İngilizce
 - b) Almanca
 - c) Diğer (...)
 - d) Bilmiyorum
4. Yabancı dil bilginiz hangi düzeydedir?
 - a) Başlangıç
 - b) Orta
 - c) İleri seviye
 - d) Ana dil düzeyinde

5. Ne kadar sıklıkla yabancı hastayla karşılaşıyorsunuz?
- a) Her zaman
 - b) Çoğu zaman
 - c) Arada bir
 - d) Hiçbir zaman
6. Ne kadar sıklıkla çevirmen aracılığıyla hastayla iletişim kuruyorsunuz?
- a) Her zaman
 - b) Çoğu zaman
 - c) Arada bir
 - d) Hiçbir zaman
7. Hastalarla iletişiminizde çevirmenin önemli rol oynadığını düşünüyor musunuz?
- a) Evet
 - b) Hayır
 - c) Bazen
8. Çevirmenin çeviri sırasında etik ilkelere uyduğunu düşünüyor musunuz?
- a) Evet
 - b) Hayır
 - c) Bazen
 - d) Hiçbir zaman
9. Çevirmenin çeviri hizmetinin kaliteli olduğunu düşünüyor musunuz?
- a) Evet
 - b) Hayır
 - c) Bazen
10. Aşağıdaki kalite kriterlerini 0 ile 4 arasında puanlayabilir misiniz?
(0= En az önemli, 1= Az önemli, 2= Orta düzeyde önemli, 3=Çok önemli, 4= En önemli)

- a) Bilginin tamlığı
- b) Orijinal konuşmaya sadık kalma
- c) Akıcı aktarım
- d) Doğru terim/ terminoloji kullanımı
- e) Diğer (lütfen puanıyla birlikte belirtiniz)

11. Çevirmenin görevini aşağıdaki maddelerden hangisi/ hangileri ile tanımlarsınız?

- a) Çevirmen, doktor veya hastanın söylediklerine hiçbir şey eklemekten veya çıkarmadan olduğu gibi aktarmalıdır.
- b) Çevirmen sadece gerekli durumlarda ekleme, çıkarma, açıklama, vb. yapmalıdır.
- c) Çevirmen hastayla doktor arasındaki görüşmede konuşmaya özgürce ekleme- çıkarma, açıklama, vb. yapabilir.

12. Çevirmenin rolünü aşağıdaki maddelerden hangisi ile tanımlarsınız?

- a) Çevirmen, hasta ve doktor (sağlık personeli) arasındaki görüşme esnasında görüşmeyi koordine eden ve şekillendiren aktif bir katılımcıdır.
- b) Çevirmen, sadece konuşmacıların (hasta ve doktor/ sağlık personeli) kelimelerini olduğu gibi aktaran nötr birisidir.

13. Hastane çevirmeninden beklediğiniz özellikleri önemine göre puanlayabilir misiniz? (0= En az önemli, 1= Az önemli, 2= Orta düzeyde önemli, 3=Çok önemli, 4= En önemli)

- a) Dil yetkinliği
- b) Tercümanlık eğitimi almış olması
- c) Medikal terminoloji bilgisi
- d) Kültürel unsurlara hakimiyet
- e) Aynı sektörde deneyim

f) Diğer (ltfen puanıyla birlikte belirtiniz)

14. evirmenden beklentiniz nedir?

- a.) Sadece eviri yapması
- b.) eviri harici konularda da destek saęlaması (Hasta işlemleri, başvuru, tahlil, form doldurma, vb)

15. evirmenin tıbbi terim bilgisine sahip olmasını bekler misiniz?

- a) Evet
- b) Hayır

16. Aldığınız eviri hizmetinden kaynaklanan herhangi bir sıkıntıyla karşılaştınız mı?

- a) Evet
- b) Hayır
- c) Bilmiyorum

17. Yabancı hastalarla iletişiminizi saęlama konusunda evirmenin eviri hizmeti yeterli mi?

- a) Evet
- b) Hayır
- c) Bazen

18. Sizce evirmen, doktor/ saęlık personeli ve hastanın kullandığı jest ve mimikleri taklit etmeli midir?

- a) Evet
- b) Hayır
- c) Emin deęilim

19. Sizce çevirmen, doktor/ sağlık personeli ve hastanın ses tonunu taklit etmeli midir?

- a) Evet
- b) Hayır
- c) Emin değilim

20. Sizce çevirmenin oturma pozisyonu nasıl olmalıdır?

- a) Hastaya daha yakın
- b) Doktora/ Sağlık personeline daha yakın
- c) İkisinden de uzak
- d) İkisinin de ortası

21. Sizce çevirmen tıp ve çevirmenlik konusunda eğitim almalı mıdır?

- a) Evet
- b) Hayır
- c) Emin değilim

22. Gerekli durumlarda çevirmenin empati yapması gerektiğini düşünüyor musunuz?

- a) Evet
- b) Hayır
- c) Emin değilim

23. Hastane içerisinde çevirmenin statüsünü nasıl görüyorsunuz?

- a) Terim ve tıbbi bilgisiyle uzman statüsünde
- b) Dil konusunda uzman statüsünde (sadece çevirmen olarak)
- c) Hastane içerisindeki işlemlere destek sağlayan personel statüsünde
- d) Hepsi

24. Tedavi/ teşhis sürecindeki kararlara çevirmenin müdahil olmasını bekler misiniz?

- a) Evet
- b) Hayır
- c) Bazen

25. Hastanede çevirmenlerle birlikte çalışma konusunda yeterli ölçüde bilgilendirildiğinizi düşünüyor musunuz?

- a) Evet
- b) Hayır

Katılımınız için teşekkürler. Hastane çevirmenliği mesleği ve çevirmenlerle ilgili olarak ankette belirtilmemiş olan eklemek istediğiniz düşünceleri lütfen ekleyiniz.

Appendix 7: Transcription Convention

(Adapted from Du Bois et.al, 1993: 45- 89)

- [Square brackets indicate the onset of overlapping speech.
- ... A sequence of three dots represents pauses.
- X Capital X represent inaudible passage.
- (()) A pair of double parentheses contains the transcriber's comment.

