DOKUZ EYLÜL UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
DEPARTMENT OF TRANSLATION AND INTERPRETING
ENGLISH TRANSLATION AND INTERPRETING PROGRAM
MASTER'S THESIS

# HEALTHCARE INTERPRETING IN TURKEY: ROLE AND ETHICS FROM A SOCIOLOGICAL PERSPECTIVE

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İZMİR- 2017

**YÜKSEK LİSANS**
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|---|---|
| **Üniversite** | : Dokuz Eylül Üniversitesi |
| **Enstitü** | : Sosyal Bilimler Enstitüsü |
| **Adı ve Soyadı** | : OLCAY ŞENER |
| **Öğrenci No** | : 2015800565 |
| **Tez Başlığı** Perspective | : Healthcare Interpreting in Turkey: Role and Ethics From A Sociological |
| **Savunma Tarihi** | : 22/06/2017 |
| **Danışmanı** | : Yrd.Doç.Dr.Müge IŞIKLAR KOÇAK |

**JÜRİ ÜYELERİ**

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## DECLARATION

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22 /06 /2017

Olcay ŞENER

## ABSTRACT

**Master's Thesis**

**Healthcare Interpreting in Turkey:**
**Role and Ethics from a Sociological Perspective**

**Olcay ŞENER**

**Dokuz Eylül University**
**Graduate School of Social Sciences**
**Department of Translation and Interpreting**
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**The objective of this thesis is to analyze the role of the interpreters in relation to ethics in depth, providing an overview of the field based on real-life data, constituting an example of fieldwork in interpreting studies. The case study relies on the triangulation of several types of data (comparing and contrasting) and different research methods in order to provide a deeper understanding of the interpreter's role in Turkish healthcare settings. In accordance with fieldwork strategy, the focus is on naturally occurring data, as well as interviews with fourteen healthcare interpreters working in private hospitals in Turkey and five patients, participant observation and a total of twenty-seven audio-recordings of interactions between healthcare providers and patients in Istanbul, Izmir and Aydın. This study has shown that academic research on healthcare interpreting is scarce in Turkey, even though healthcare interpreting is commonly practiced and needed. Surprisingly, there is no association which has established codes of ethics and conduct for healthcare interpreters in Turkey, in contrast to developed countries which have made significant attempts to institutionalize the profession of community interpreting, including healthcare interpreting. Thus, this study also**

**aims at analysing the implications of this lack of codes of ethics and conduct and also national standards on the role of interpreters in healthcare settings in Turkey. The role of the interpreters in healthcare settings has been analyzed at two levels: during and beyond interpretation at micro and macro levels. Decisions and strategies taken or not taken by the interpreters during interpretation have been associated to the broader issues of role and ethics beyond interpretation at a macro level. These decisions and strategies related to role and ethics are analyzed through Bourdieu's concepts of "habitus" and "capital".**

**This study has revealed that the lack of an explicit job description and code of ethics/conduct in Turkey causes challenges in practice for healthcare providers and interpreters as well as patients and it implies a risk for the quality of service. The findings obtained also revealed that there may be a gap between what the interpreters say they do and what they do in real-life situations.**

**Keywords: Interpreting, Healthcare interpreting, Role of interpreters, Ethics, Habitus, Capital, Fieldwork, Case study**

## ÖZET

**Yüksek Lisans Tezi**

**Türkiye'de Hastane Çevirmenliği:**

**Sosyolojik Açıdan Rol ve Etik**

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**Mütercim-Tercümanlık Anabilim Dalı**

**İngilizce Mütercim-Tercümanlık Yüksek Lisans Programı**

**Bu tezin amacı, çevirmenin rolünü etik açıdan detaylı bir şekilde incelemek, gerçek hayattan alınan veriler doğrultusunda alanla ilgili genel bir bakış açısı ortaya koymak ve sözlü çeviri çalışmalarında bir saha çalışması örneği sunmaktır. Türkiye'de hastane çevirmenlerinin rolüne ilişkin derin bir analiz ortaya koyma amacıyla yürütülen bu vaka çalışması, birçok farklı türden verilerin üçlemesini (kıyaslama ve karşılaştırma) ve farklı araştırma yöntemlerini kapsamaktadır. Saha çalışması ile elde edilen veriler doğrultusunda gerçek ortamdan alınan bulgulara, on dört tercüman ve beş hastayla yapılan röportaja, ayrıca Istanbul, Izmir ve Aydın'daki toplam beş hastanede yapılan gözlem ile sağlık görevlileri ve hastalar arasında geçen toplam yirmi yedi görüşmenin ses kayıtlarına odaklanılmaktadır. Hastane çevirmenliği Türkiye'de sıklıkla kullanılan ve ihtiyaç duyulan bir meslek olmasına rağmen, Türkiye'de hastane çevirmenliğine ilişkin akademik çalışma son derece azdır. Diğer yandan, hastane çevirmenliği de dahil olmak üzere toplum çevirmenliğinin profesyonelleşmesi için önemli adımlar atan gelişmiş ülkelerin aksine Türkiye'de çevirmenin rolünü belirleyen etik kurallar yayımlayan herhangi bir dernek bulunmamaktadır. Bu sebeple bu çalışma, söz konusu etik kuralların ve standartların eksikliğinin uygulamada çevirmenin rolüne etkilerini analiz etmeyi hedeflemektedir. Hastane çevirmeninin rolü, çeviri sırasında ve çeviri ötesinde**

**mikro ve makro düzey olmak üzere toplam iki düzeyde incelenecektir. Çevirmenin çeviri sırasında mikro bağlamda aldığı veya almadığı karar ve stratejiler, çeviri ötesinde makro bağlamda rol ve etik ile bağdaştırılarak incelenecektir. Rol ve etik ile bağdaştırılacak olan çevirmenin kararları ve stratejileri Bourdieu'nun "habitus" ve "sermaye" kavramları çerçevesinde analiz edilecektir.**

**Bu çalışma, Türkiye'de etik kuralların ve belirli bir meslek tanımının eksikliğinin; hastane çalışanları, çevirmenler ve hastalar için zorluklar yarattığını ve verilen hizmetin kalitesini tehlikeye attığını ortaya koymaktadır. Bu çalışmadan elde edilen veriler sonucunda ise çevirmenlerin söyledikleri ve uyguladıkları arasında farklılıklar ortaya çıkabileceği gözlemlenmiştir.**

**Anahtar Kelimeler: Sözlü çeviri, Hastane çevirmenliği, Çevirmenin rolü, Etik, Habitus, Sermaye, Saha çalışması, Vaka çalışması**

**HEALTHCARE INTERPRETING IN TURKEY: ROLE AND ETHICS FROM A SOCIOLOGICAL PERSPECTIVE**

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## ABBREVIATIONS

| | |
|---|---|
| **ARC** | Disaster and Emergency Interpreting |
| **BSL** | British Sign Language |
| **CCHI** | The Certification Commission for Healthcare Interpreters |
| **CHIA** | California Healthcare Interpreting Association |
| **CODA** | A child of a deaf adult |
| **DGS** | Deutsche Gebaerdensprache |
| **EU** | European Union |
| **HIN** | Healthcare Interpretation Network |
| **ICE** | Interpretered Communicated Event |
| **IMIA** | International Medical Interpreters Association |
| **INT** | Improvements to NAATI Testing |
| **ITIA** | The Irish Translators' and Interpreters Association |
| **LSF** | Langua de Signes Française |
| **MMIA** | Massachusetts Medical Interpreters Association |
| **NAATI** | National Accreditation Authority for Translators and Interpreters |
| **NAJIT** | National Association of Judiciary Interpreters and Translators |
| **NBCMI** | The National Board of Certification for Medical Interpreters |
| **NCCA** | National Commission for Certifying Agencies (NCCA) |
| **NCIHC** | The National Council of Interpreting in Healthcare |
| **NRPSI** | The National Register of Public Service Interpreters |
| **NSGCIS** | National Standard Guide for Community Interpreting Services |

| | |
|---|---|
| **NSW HCS** | New South Whales Health Care Interpreter Service |
| **RID** | Registry of Interpreters for the Deaf |
| **TDI** | Türk İşaret Dili |
| **TIS** | Telephone Interpreter Service |
| **TRICC** | Training Intercultural and Bilingual Competencies in Health and Social Care |
| **U.S.A** | United States of America |
| **UK** | United Kingdom |

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## INTRODUCTION

Even though community interpreting is known as a young profession which is still developing, only recently drawing the attention of the academic world, it is actually the oldest type of interpreting in the world (Roberts, 1997: 7). In order to put emphasis on the term community interpreting, Slapp asks a simple question: "Is there any country in western Europe or in the whole world where only a single language is spoken? The answer is "no"" (Slapp, 2004: 11)[1]. Due to increasing migration rates between countries, for a variety of reasons such as vacation, education, work or even natural disasters, countries have become multicultural and multilingual, leading to a growing need for interpreters in social settings such as health, court, police stations, etc. and also the development of community interpreting as a profession around the world. Despite the controversy over the use of the term 'community interpreting' and its term variations such as ad hoc interpreting, cultural interpreting, public service interpreting, dialogue interpreting or community-based interpreting, the term community interpreting basically refers to providing interpreting services for minority groups who do not share the same language with the service providers of a society. Therefore, community interpreting is different from other types of interpreting, such as conference or escort interpreting, in that the services are provided to the residents of the community in which the interpreting takes place instead of providing interpreting services for conference delegates, diplomats or professionals travelling abroad to do business (Mikkelson, 2012). Over the years, considerable steps have been taken in the professionalisation of community interpreting (Mikkelson, 2012; Pöchhacker, 1999). As a result, countries have started establishing codes of ethics and conduct as well as standards (Bancroft, 2005).

In Turkey, the use of interpreters has been regulated in the Turkish Criminal Procedure Code. Dating back to 1929, the Code was amended and enacted in 2004 and has beeinforce since June 1, 2005. It is one of the main documents which provides the basis for the use of interpreters at courts.

[1] All translations are mine unless otherwise indicated.

***Cases where the presence of an interpreter is required*** [2]

*Article 202 – (1) If the accused or victim of the offense does not speak enough Turkish in order to express himself, the essential points of the accusation and the defense shall be translated by an interpreter appointed by the court.*

*(2) The essential points of the accusation and the defense shall be explained to the accused or to the victim, who is handicapped, in a manner that they can understand them.*

*(3) The provisions of this article are also applicable at hearings of the suspect, victim and witnesses in the investigation phase. The interpreter shall be appointed by the judge or the public prosecutor at this phase.*

In this Code, it is stated that an interpreter could be used if needed. However, there is no detailed information regarding the qualifications the court interpreters should have (Diriker and Tahir-Gürçağlar, 2004). Apart from court interpreters, it is also a fact that there is no certain code of ethics and conduct for healthcare interpreters in Turkey, in contrast to other developing countries who have established certain standards and codes of ethics and conduct. Therefore, the objective of this study is to analyze the implications of a lack of codes of ethics and conduct and of national standards on the role of interpreters in Turkish healthcare settings.

Although community interpreting has been applied in practice for a long time, it can be suggested that the Critical Link Conference, now known as Critical Link International, organized in 1995 in Canada, was a leading factor in the increased studies conducted on community interpreting settings. This conference led to increased academic studies focused on community interpreting, including healthcare interpreting (Pöchhacker, 1999: 125). As a consequence, studies on community interpreting quickly turned into a distinct research field. An issue to which greatest attention has been given by researchers is the role controversy of interpreters. An existing literature review has disclosed two opposite views on the issue of role, namely the 'conduit' or 'invisible'

[2] Translation has been excerpted from Beta Publishing House, Istanbul;2009

(Reddy, 1979; Fenton 1997) role, limiting the interpreters' role to conveying information and messages like a translation machine, and the 'mediator' role, at the end of other spectrum, facilitating communication during encounters between two parties (Bolden, 2000; Davidson, 2000; Angelelli, 2004; Hsieh, 2006). However, the current literature review shows that there has been a shift from the 'conduit' role towards a 'mediator' role.

Despite the wide range of studies on community interpreting -including healthcare interpreting -around the world, the range of research that focuses on community interpreting and healthcare interpreting is very limited in numbers in Turkey, even though Turkey can be counted among the countries where community interpreting has been developed and commonly practiced as a profession. Among the studies on community interpreting, Disaster and Emergency Interpreting (ARC)[3] is the most researched area under the category of community interpreting (See 1.3.1). However, aside from studies conducted on ARC, Diriker and Tahir- Gürçağlar have also published an article titled "Community Interpreting in Turkey" (Diriker and Tahir-Gürçağlar, 2004). In this article, Diriker and Tahir Gürçağlar (2004) aim to provide an insight into existing legal and administrative structures as well as practices with regard to interpreting in community settings in Turkey. Kahraman (2010) carried out a doctoral research on the role of community interpreters, specifically focusing on community interpreters working in asylum applications. In this research, Kahraman investigates the positions of interpreters in two stages. In the first stage of the study she analyzes the impact of socio-cultural and political changes around the world and in Turkey on the role of community interpreters. The second stage of the study includes an empirical evaluation, based on data obtained from face-to-face interviews and surveys.

Studies on healthcare interpreting in Turkey can be counted on the fingers of one hand. Thus, this present study aims at contributing towards filling this gap, providing an in-depth analysis of the interpreters' role in Turkish healthcare settings.

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3 Bulut and Kurultay, 2002; Kahraman, 2003; Doğan and Kahraman, 2011

Interpreting is a complex linguistic, social, cognitive and cultural process in which the interpreter is in most cases the only bilingual or bicultural individual who can bridge the gap between service providers and service users (Swabey and Mickelson, 2008: 51). The interpreter plays a fundamental role in situations such as education, legal and medical settings and has the potential to impact people's daily lives (ibid). Therefore, the choices and decisions taken or not taken by the interpreter may influence the consequences and communications between the parties involved. Focusing on the general role of the interpreter before, during and beyond interpretation, the actions and decision-making processes of the interpreter are significant for communication during treatment and therefore have the potential to influence the course and consequences of any treatment. Therefore, such a vital role should be defined by a code of ethics and conduct and by standards of practice, leaving no room for, or at least minimizing arbitrary and unprofessional behavior, violating the codes of ethics and standards of practice explained in detail in Chapter One (see 1.5).

Focusing at the language level, medical terminology is a unique feature and an important issue to be tackled in healthcare interpreting. The interpreter should not only possess an excellent knowledge of daily expressions and idioms but also specific knowledge of medical terminology (Creeze et al., 2015: 21). Moreover, the precision of an interpreter's work in medical matters relies heavily on terminology according to the Scientific Job Analysis conducted by the International Medical Interpreters Association (IMIA) in 2009. In this study, therefore, the issue of medical terminology and the strategies applied by the interpreters during interpretation were included in the research questions to be discussed in detail. However, the current study has also unveiled other factors such as psychological factors or institutional expectations which also determine the strategies and roles of interpreters during the interpretation process.

Based on observation of and research into the current situation, it is clear that the lack of an explicit job description and code of ethics and conduct, as well as standards of practice in Turkey causes challenges in practice for healthcare providers and interpreters as well as for patients. This implies a risk to the quality of service. Therefore, the other objective of this study is to explore the consequences of the lack of a clear job description and code of ethics and conduct, as well as standards of practice, and the role

of the interpreter in relation to ethics beyond interpretation in healthcare settings in Turkey.

In a nutshell, the data will be analyzed at two levels: during interpretation and beyond interpretation at micro and macro levels, leading to a better and richer description of the interpreter's role in this unique setting. The decisions taken by the interpreter during interpretation will be associated to broader issues of role and ethics at the macro level beyond interpretation.

With this aim in mind, the current study sets out to address the following, over-arching research question:

1. How does the role of the healthcare interpreter in Turkey manifest itself at both micro and macro levels?

Answers to this question are pursued through three more specific questions, as follows:

1. How do the interpreters under study handle medical terminology during the interactions? What kind of strategies do healthcare interpreters apply in order to deal with problems arising from medical terminology?
2. To what extent does a lack of a code of ethics and conduct for healthcare interpreters in Turkey affect the role of interpreters in healthcare settings? How is this disclosed during their daily practice?
3. What are the roles imposed on interpreters besides only interpreting i.e. translating between languages?

The data collected with a view to answering the research questions outlined above is described in detail and analyzed in Chapter 3. The abovementioned research questions will be answered through triangulation of data (comparing and contrasting), consisting of interviews with healthcare interpreters and patients, participant observation and recordings of the interpreter-mediated encounters between healthcare providers and patients.

As for the theoretical framework of this research, I will utilize Bourdieu's key concepts 'habitus' (Bourdieu, 1989, 1993) and 'capital' (Bourdieu, 1986, 1989, 1991 1992). The current study does not specifically aim to analyze the interpreters' habitus and capital, however decisions and strategies of the interpreters which constitute the role

of the healthcare interpreters will be analyzed with the help of Bourdieu's concepts habitus and capital, both during and beyond interpretation.

Investigating the questions mentioned above, the present thesis is broadly divided into three chapters. Chapter One deals with the descriptions and general information regarding basic concepts of community interpreting and healthcare interpreting both around the world and in Turkey. The second part of this chapter focuses on codes of ethics and conduct as well as standards of practice established by developed countries. Thus, this analysis of ethical principles will provide a basis for analyzing the role of interpreters in relation to ethics beyond interpretation.

Chapter Two consists of a literature review, theoretical framework and methodology of the study. The literature review focuses only on the studies conducted on healthcare interpreting around the world and in Turkey, since the main scope of this thesis is healthcare interpreting. Following the literature review, the theoretical framework and methodology will be introduced in this chapter.

Chapter Three introduces the main discussion of the study. The chapter starts with general background information about interpreters, patients as well as settings in which interpreting services have been provided. Following the general background information, data will be discussed under two sections. In the first section, the role of interpreters will be analyzed based on data obtained from interviews with fourteen healthcare interpreters working in private hospitals. In the second section of the chapter, data obtained from participant observation and audio-recordings which take place in authentic healthcare providers and patient encounters will be analyzed in detail. Each section ends with a discussion of findings from a Bourdieusian perspective.

The analysis of the data collected in order to address the above-mentioned research questions will lead to an in-depth understanding of the interpreter's role in relation to ethics in healthcare settings. The interpreters' self-perceptions of their roles, user perspectives and interpreter-mediated encounters reflects the gaps between what is said and what is done in this specific setting.

# CHAPTER ONE

# BACKGROUND TO THE STUDY

## 1.1. COMMUNITY INTERPRETING AS A CONCEPT

Globalization and modern modes of transportation have led to the increased movement of people between countries. People travel to other countries for education, work, holidays or for their health. They also do so to escape natural and man-made disasters (Corsellis, 2008: 1) Therefore, countries have become multilingual and multicultural, and people who are supposed to communicate in legal, healthcare and other public settings are sometimes unable to carry out this communication because of language barriers. As a result of this, community interpreting is developing as a profession around the world due to the increasing need for interpreters in social services.

Corsellis (2008) asserts that studies of interpreting carried out in the past focused primarily on the communication between people with different languages and cultures at an international level. However, the present and future will focus more on the communication between people with different languages and cultures *within* national borders and deal with the events of people's daily lives (Corsellis, 2008: 1)

Ozolins (2015:319) also stresses three major historical developments in the field of professional interpreting in community settings which have arisen, namely:

- the increasing movement of multilingual populations around the globe through migration, and host societies' responses to this,
- the growth in assertiveness of, and service provision for, Deaf communities,
- slowly evolving changes in attitudes and response to the presence of indigenous populations.

As for the definition of community interpreting, Hale (2007:30) defines community interpreting as "the type of interpreting that take place within one country's

own community, and within resident groups of that country". When it comes to Pöchhacker's definition, he defines community interpreting in more detail:

> *In the most general sense, community interpreting refers to interpreting in institutional settings of a given society in which public service providers and individual clients do not speak the same language.* (Pöchhacker, 1999:126)

However, there is controversy over the use of the word "*community*". For many countries, the word "community" in "community interpreting" is often associated with "unprofessional" or "unqualified" interpreters. Therefore, there are term variations used for community interpreting. It is referred to as "*cultural interpreting*" in Canada, "*public service interpreting*" in the UK, and "*community-based interpreting*" in Australia (Pöchhacker, 2004: 15, Corsellis, 2008).

Hale (2007) also explicitly expresses in her book that the use of the term "community interpreting" varies around the world.

> *[...] In some countries the term refers to ad hoc, unpaid interpreting conducted by volunteers (Dueñas González et al., 1991); in some it refers to the health and welfare sectors only (Pöchhacker, 1999); in others it is used more broadly to include all types of interpreting other than Conference Interpreting (Roberts, 1997; Ozolins,1998); and in countries such as Denmark, they are still struggling to find a term that suits their language and situation. Other labels that have been used are 'escort interpreting' (Mikkelson, nd), 'public service interpreting' (Valero Garcés, 2003a), 'cultural interpreting', 'ad hoc interpreting' (Roberts,1997), 'community-based interpreting'(Chesher et al.,2003), 'dialogue interpreting'(Mason,2001) and 'liaison interpreting' (Gentile et al., 1996; Erasmus, 2000).* (Hale, 2007: 28).

In contrast to the variations mentioned above, community interpreting is founded on a simple concept: giving voice to those who seek access to basic services but are not fluent speakers of the language of that society.

Community interpreting means interpreting a dialogue such as an interview, court hearing, negotiation, inquiry, a conversation for solving or settling affairs and exchanging information, etc. between an authority or a private individual working in different institutions such as schools, hospitals, police stations or immigrant offices where community services are offered, and a client (Pöllabauer, 2002: 287). It takes place between two or more interlocutors and typical community interpreting settings are social services (such as welfare, housing, employment or schools); medical settings

(such as child care centres, hospitals, mental health clinics); or legal settings (such as prisons, police stations or probation offices).

The interpretation mode could be described as "*two way consecutive*" in most community interpreting settings, where each speaker is interpreted after two or three sentences uttered by the speaker into and out of each language by conversational turn. Whispered interpreting or "whispering" (also known as *chuchotage*) (Pöchhacker, 2004: 19) could be also used when needed. It is a type of simultaneous interpreting but without the booth, with the interpreter sitting next to a one or no more than a couple of listeners (Pöchhacker, 2004: 19) and interpreting through whispering as the speaker continues to speak without stopping for the interpreter. Corsellis (2008) gives court hearings as an example for such occasions when the other language speaker is not part of exchange or where long utterances should not be interrupted, or, when strong emotions are being expressed.

It is mostly carried out face-to-face, however, telephone or videoconference interpreting might be used as well.

Users of community interpreting are generally immigrants, asylum seekers, refugees and other minority groups in the host country (Pöllabauer, 2002: 287). Tourists travelling to other countries both for health issues or pleasure could be also included.

## 1.2. COMMUNITY INTERPRETING AROUND THE WORLD

According to Pöchhacker, one of the most remarkable developments in interpreting studies since the mid-1990s has been the emergence of community interpreting as an increasingly significant field of professional practice and academic research. (Pöchhacker and Shlesinger, 2007: 1). He asserts that community interpreting could be dated back to Antiquity and he exemplifies the use of interpreters for Aramaic-speaking Jews after the Babylonian exile or the role of interpreters in the provinces of the far-flung Roman Empire, and he further claims that community interpreters have been found at work in systems of colonial domination over the centuries. At this point, he exemplifies the court interpreters in 16$^{th}$ century Spain. (Pöchhacker, 1999: 128)

According to Pöllabauer, on the other hand, community interpreting is more developed in countries receiving immigrants such as U.S.A, Australia, Canada and Scandinavia (Sweden), etc. than in European countries (Pöllabauer, 2002: 289). These countries figured out much earlier the importance of providing quality interpreting services in order to help foreign people who do not share the host country's language to communicate effectively (ibid). Even though community interpreting has been provided for a long time, the nature of interpreting services varies according to the country. Therefore, preliminary efforts at community interpreting, especially healthcare interpreting, were made in the above-mentioned developed countries as a consequence of intense migration and its results (ibid). When this point is taken into account, it could be mentioned that modern developments in community interpreting took place particularly after the establishment of the Registry of Interpreters for the Deaf (RID) in the U.S.A in 1965 (Hertog, 2010). As stated by Pöchhacker (1999), U.S. government authorities provided for the rehabilitation of hearing-impaired and deaf individuals in order to (re)integrate them into society and the workforce. Thanks to the U.S. government authorities' endeavors, RID became a successful association and it launched an evaluation and certification system in the early 1970s in order to maintain a registry of qualified interpreters and has since certified more than 5,000 members as interpreters and/or transliterators (ibid). Apart from RID, there are several medical-interpreter associations which have played an important part in the development of the profession during the last decade of the twentieth century in the U.S (Angelelli, 2008: 156). For example, the establishment of the California Healthcare Interpreting Association (CHIA) and the Massachusetts Medical Interpreters Association (MMIA) (changed to the International Medical Interpreters Association (IMIA) in 2007) were established. These associations later published Codes of Ethics (CHIA, 2002; MMIA, 1995), and are currently discussing certification efforts (CHIA, 2004; MMIA 2006).

Moreover, National Association of Judiciary Interpreters and Translators (NAJIT) was founded as a non-profit organization in 1978. It promotes the highest professional standards in legal interpreting.

There are also associations contributing to the professionalization of community interpreting, especially healthcare interpreting in the United States. The Certification

Commission for Healthcare Interpreters (CCHI), for instance, offers two examinations to become a professional healthcare interpreter[4]:

- Core Certification Healthcare Interpreter™ examination (CoreCHI™) for interpreters of all languages
- Certified Healthcare Interpreter™ examination (CHI™) for Spanish, Arabic, & Mandarin interpreters

The National Board of Certification for Medical Interpreters (NBCMI) is another association which is a nationally recognized certifying body accredited by the National Commission for Certifying Agencies (NCCA). NBCMI offers a Certified Medical Interpreter (CMI) credential in six languages which are Spanish, Mandarin, Cantonese, Russian, Korean and Vietnamese[5].

Lastly, South Eastern Medical Interpreters Association (SEMIA) should be mentioned. SEMIA is a forum for medical interpreters enabling them to exchange useful information. SEMIA supports healthcare interpreter training, in order to enable limited English proficiency for marginalized communities to access to healthcare and other fundamental services. It also promotes professionalism and public awareness of the importance of providing quality interpreting services[6].

Australia, where there was a massive intake of immigrants of non-English speaking backgrounds after World War II, is another country heading the development of community interpreting as a profession for immigrants (Pöchhacker, 1999: 131). With a government policy which supported multilingualism and multiculturalism in the 1970s, the Department of Immigration established a Telephone Interpreter Service (TIS) in 1973 (ibid). Apart from TIS, there were a number of initiatives taken at the state level. For example, a quality interpreting service was provided in order to meet the communication needs of schools in Victoria (ibid). Additionally, the New South Whales

4 www. cchicertification.org/our-cchi-community/healthcare-interpreters
5 www.certifiedmedicalinterpreters.org
6 Retrieved from http://www.semia.org/

Health Care Interpreter Service (NSW HCIS) arose out of the Hospital Interpreter Program, which is now the largest language service in Australia after TIS (ibid).

A National Accreditation Authority for Translators and Interpreters (NAATI) is another important example showing that Australia is among the countries heading community interpreting in the world, by creating national standards and an accreditation system for interpreters in order to provide smooth communication between English-speaking and non-English speaking Australians in medical, government and other public services. NAATI is a company that belongs to nine state governments of Australia jointly. It was established in 1977 and it implemented a five-level proficiency standards system (ibid). However, after a revision made in 1993, the accreditation test is now given at four different levels: Paraprofessional Translator or Paraprofessional Interpreter, Professional Translator or Professional Interpreter, Advanced Translator or Conference Interpreter, and Advanced (Senior) Translator or Conference (Senior) Interpreter.

Apart from that, NAATI set up two different projects with a view to enhancing the standards of testing and certification in 2011 and in 2012, successively. In 2011, NAATI initiated the Improvements to NAATI Testing (INT) Project with the aim of improving the integrity and efficiency of the NAATI certification system.

In addition to this, NAATI has developed the Indigenous Interpreting Project with three objectives, which are:

- To increase the number of accredited Indigenous interpreters and examiners
- To increase the range of Indigenous languages for which there are accredited Indigenous interpreters
- To increase the accessibility of interpreting resources for Indigenous interpreters and organisations.

Apart from the pioneering achievements of U.S and Australia, Sweden is also a country making an impressive progress towards the professionalization of community interpreting (Pöchhacker, 1999: 130). Immigrants in Sweden have the legal right to

demand an interpreter, often referred to as a *dialogue interpreter;* whose costs are mostly met by institutions (Niska in Pöllabauer, 2002: 289). The government also established the *Code of Good Practice for Interpreting (God Tolksed),* to regulate interpreter-mediated encounters (ibid). Furthermore, there have also been certification courses for interpreters since 1968. Likewise, the University of Stockholm offers a curriculum course in the Institute for Interpretation and Translation Studies (ibid).

Canada also gained significant momentum in the development of community interpreting, which is referred to as *cultural interpreting,* in the 1990s (Pöchhacker, 1999: 134). However, community or *cultural* interpreting has been implemented on the provincial level rather than at a state level, in contrast to Sweden (ibid). Legal and medical interpreting services are provided for speakers of indigenous languages, and healthcare interpreter projects and certificate programs have also been developed (ibid).

## 1.3. COMMUNITY INTERPRETING IN TURKEY

Turkey has become a multilingual and multicultural country by accommodating people with different cultural backgrounds, religions and ethnicities. People with different ethnicities may need to communicate in public settings and therefore may have difficulties understanding the host country's language. Currently, communication barriers are frequently encountered with Syrians. Today, Turkey hosts 2.85 million Syrian refugees[7] fleeing from war or disasters in their countries. Hosting 2.85 million Syrians, Turkey has become a crucial harbor for many of them to shelter in.

However, the refugees who have fled from their own country have encountered one of the most basic problems: a language barrier. Consequently, they have had difficulties in communicating in a variety of settings including legal, health and social settings. Therefore, interpretation services are offered for refugees in order to help them communicate effectively in the abovementioned settings in Turkey as well.

7 (2017) UNHCR Syria Regional Refugee Response, Retrieved from http://data.unhcr.org/syrianrefugees/country.php?id=224

Apart from these, there are also outstanding community interpreting services including Emergency and Disaster Interpreting (ARC) and sign language interpreting services explained further below.

### 1.3.1. Emergency and Disaster Interpreting (ARC) in Turkey

Turkey is located in a region susceptible to natural disasters such as earthquakes (Doğan and Kahraman, 2011: 61). Previously Turkey was not well equipped to respond in an effective and timely manner to natural disasters and therefore support was sought from foreign search and rescue teams (SAR) (ibid: 63). Since there was no team of interpreters who could enable communication with these teams coming from abroad, and especially after the 1999 earthquake, Department of Translation and Interpreting and Department of Foreign Languages Training at Istanbul University initiated training programmes for voluntary interpreters who were willing to provide interpretation services for foreign search and rescue teams (ibid).

As stated by Doğan and Kahraman (2011), the objective of this training programme was to provide translation and interpreting services in order to help the foreign search and rescue teams communicate effectively with officials and the authorities (ibid:65).

The Translation Studies Department at Istanbul University first started training interpreters to act in emergency and disaster situations in 2000 (ibid:66). Secondly, the Department of Translation and Interpreting at Hacettepe University also launched training for voluntary translators and interpreters in 2001. Then Okan University in Istanbul, Dokuz Eylul University in Izmir, Onsekiz Mart University in Canakkale, Sakarya University in Sakarya followed by training voluntary translators and interpreters (ibid).

ARC has organized two different training programmes: The first one is the Basic ARC Programme, encompassing 100 hours of training modules, including topics such as the geomorphological basis of earthquakes, the architectural basis of buildings and their behavior during earthquakes, the formation of other disasters, disaster management and related regulations, psychological traumas related to disasters, communication as a part of disaster management, wireless radio communication training, international aid during

disasters, international and national organizations dealing with disaster management, community interpreting, field knowledge and terminology; 18 hours of first aid and 30 hours of civil defense after the "Scenario Practices" in which all the basic terms, knowledge and skills were put to test and practiced and on-site drills were conducted (ibid). The second type of training is a Volunteers' Seminar where the voluntary interpreters are given brief and general information about the training modules of Basic ARC Training Programme within just one day (ibid).

Kurultay and Bulut assert that ARC is the only such organization in the world (Kurultay and Bulut, 2012: 88). They further assert that ARC has adopted more active roles in its development process, namely:

*Waiting in a state of emergency readiness
*Active preparation for and the provision of interpretation services in disasters

Therefore, it could be concluded that ARC is a successful organization, providing service within the scope of community interpreting in Turkey.

### 1.3.2. Sign Language Interpreting Services in Turkey

Sign languages are visual-gestural languages and generally used by hearing-impaired people who use signs to communicate with each other (Bontempo, 2015: 112). Sign languages have their own grammar rules and lexicon which vary according to the community (ibid). Therefore, it could be alleged that sign languages are not universal.

Moreover, national and regional sign languages generally have acronyms (ibid: 113). For example; DGS is Deutsche Gebaerdensprache (German Sign Language), BSL is British Sign Language and LSF is Langua de Signes Française (French Sign Language) and TDI is Türk İşaret Dili (Turkish Sign Language).

Sign language interpreting, on the other hand, aims to enable communication between two parties who do not share the same language. It is generally carried out between signed and spoken language users i.e, between the hearing-impaired and those who have no hearing disorders.

Zeynep Oral asserts that in countries such as U.S.A and Australia, sign language interpreting was accepted as a distinct profession and those countries started to determine the criteria for interpreters (Oral, 2015: 208). Likewise, training on sign language interpreting in France started in the 1980s. As for Turkey, it is a fact that there is a need for professional sign language interpreters, as there are many hearing-impaired and deaf people living in Turkey. However, there is no academic sign language training program at graduate and/or undergraduate level for interpreters.

Oral reiterates that every country has its own sign language system, reflecting culture, world view and the discourse of the society to which the hearing-impaired people belong. Turkish Sign Language (TID) also has its own grammar, vocabulary, phonetics and forms of expression (ibid). The Ministry of Family and Social Policies initiated an in-service training program for sign language interpreters, in order to raise awareness of the development of sign language interpreting as a profession in Turkey (ibid). The training program on the development of sign language interpreting as a profession included community interpreting, sign language interpreting linguistics, research on Turkish Sign Language (TID), interpreting, code of ethics in sign language interpreting etc. and took place between the dates of 28 September- 2 October 2016 (ibid).

Hearing-impaired people communicate with other people through interpretation by their relatives (ibid). Although their parents are hearing-impaired, children who can speak and hear are called as "a child of a deaf adult" (CODA) in English (ibid).

Therefore, sign language interpreting is mostly carried out by CODAs either voluntarily or not, as there are not many paid interpreters in social service settings such as schools, courts, hospitals, etc. in Turkey.

## 1.4. HEALTHCARE INTERPRETING AS A SUB-BRANCH OF COMMUNITY INTERPRETING

*"Healthcare interpreting" or "medical interpreting"* refers to the type of interpreting which takes place in healthcare settings. The term *"medical interpreting"* was used more frequently in the early years of the field, while *"healthcare interpreting"* has been used more recently because the field encompasses interactions which are not strictly

medical in nature, such as rehabilitation and mental health (Roat and Creeze, 2015: 237). However, both terms i.e. medical interpreting and healthcare interpreting are used interchangeably in practice (ibid).

*Healthcare interpreting*, *medical interpreting* or *hospital interpreting* (Pöchhacker, 2004: 15) are different labels; however, all refer to the same concept: the use of an interpreter in healthcare settings for foreign patients, including immigrants, guest workers, refugees, tourists, etc. to communicate with healthcare providers such as medical doctors, nurses, physical therapists, or speech pathologists, to name but a few (Tebble, 1999: 179-180).

Favaron (2010: 9) describes healthcare interpreting "as a type of (human) interpreting, both spoken and signed, that occurs in an intra-social setting, more specifically in healthcare, where a (usually) semi-professional or (sometimes) natural interpreter uses the (short) consecutive mode to interpret face-to-face talk between an individual speaking a migrant language and an institutional representative."

Healthcare interpreters interpret both for inpatients and outpatients in healthcare settings. Those healthcare settings include hospitals, clinics, skilled nursing centers, mental health centers, public health departments, inpatient and out-patient settings, emergency rooms, primary care, specialty care, pharmacy, rehabilitation centers, school-based clinics, rural and urban settings and even prisons (Roat and Creeze, 2015: 244).

As stated above, healthcare interpreters provide services in person, i.e. face-to-face, by meeting healthcare providers and patients at health facilities. However, healthcare interpreters may sometimes interpret over the phone or via videoconferencing. Moreover, healthcare interpreters may work as full-time staff interpreters or as freelancers.

Staff interpreters work based on a given schedule, however, they may also work in shifts in emergency cases. Roat and Creeze (2015) indicate the negative and positive aspects of working as staff interpreters. Its negative aspects are that staff interpreters have generally stressful work schedules in uncomfortable conditions and they may also encounter dissatisfied patients and healthcare providers. On the other hand, its positive aspects are that staff interpreters may have the security of a full-time job, predictability of assignments and they may perceive themselves as an integral part of the healthcare team (Roat and Creeze, 2015: 244). On the other hand, working as a staff interpreter at the hospital can also be advantageous, both for the hospital and the interpreter, since the staff

interpreter will be familiar with working conditions and the processes in the hospital. However, the interpretation process could be more challenging for an interpreter who is not affiliated to the hospital (Zimmerman, 2000: 28-29).

Freelance interpreters, on the other hand, are called in as independent business people who interpret in a variety of settings including legal, healthcare, social services, etc. (ibid). Freelance interpreters may enjoy freedom and flexibility in choosing the assignments they would like to work at (ibid). Speaking of the healthcare settings in Turkey, it has been observed that both staff interpreters and freelance interpreters are recruited in private and state hospitals.

Apart from staff and freelance interpreters, Wadensjö (1998) states that community interpreting was once performed only by volunteers, *ad hoc* bilinguals, relatives or even children. However, she further asserts that this type of interpreting has developed into a profession during the past few decades. Speaking of interpreting in police stations in Spain, Herraez and Rubio (2008) likewise exemplify *ad hoc* interpreting services and assert that one reason might be a lack of knowledge at the institutions about what an interpreter is and what they do. According to them, it is often thought that an interpreter is a person who could speak at least two languages.

Likewise, healthcare interpreting was an *ad hoc* activity prior to the 1970s according to Creeze and Roat (2015), rendered by relatives of a patient, including children or at times even by cleaners! The reason for this kind of activity is the perception that people who are able to speak two languages could interpret between themselves (ibid: 238). However, Creeze and Roat (2015) also assert that healthcare interpreting has come a long way from ad hoc activity towards professionalization.

### 1.4.1. Healthcare Interpreting in Turkey

Healthcare settings are another type of setting where community interpreting takes place in Turkey. This is because Turkey is, on one hand, an attractive destination to take a vacation for many tourists and, on the other hand, a destination for health tourism. i.e. there are many tourists coming to Turkey for operations such as hair transplantation, cosmetic surgery, etc. In these cases, people who do not speak the language of the host country need interpreters to communicate in healthcare settings. Therefore, many private

hospitals recruit interpreters who enable communication between healthcare providers and patients. As a consequence, it could be claimed that Turkey is also among the countries where community interpreting is developing as a profession, due to the increasing need for interpreters.

Conversely, communication barriers also occur in state hospitals, especially with refugees, as was explained in the above section (see 1.3). Interviews were carried out with two medical doctors who work in the neurology department in the state hospital in Izmir. Even though the present study focuses on the interpretation services provided in private hospitals, the perspectives of medical doctors working especially in state hospitals in Turkey have been included because of the communication problems they face. Ten main questions were addressed to medical doctors regarding their work experience and communication challenges with foreigners living in Turkey who do not speak Turkish. Both interviews lasted approximately five minutes and were audio-recorded and transcribed later. Consequently, a general overview regarding healthcare interpreting in state hospitals has also been included in the study. According to the interviews carried out with two medical doctors working in a state hospital in Turkey, the most frequently encountered communication problem is with the Syrians living in Turkey, or citizens from the Eastern region of Turkey who do not speak Turkish. Working in the neurology department for two and four years respectively, the doctors explained that they could not communicate with the refugees because of the language barrier and lack of staff interpreters in the hospital. Therefore, they even ask security staff who speak Arabic or Kurdish for help. One doctor notes that they typically seek one of the relatives of the patient in the first place, in order to diagnose the illness. This clearly indicates that ad hoc interpreting is still commonly used in Turkey in healthcare settings, especially in state hospitals which provide services for refugees.

However, Creeze (2013) addresses the possibility of censoring of information given to the patient by the healthcare provider, because of the fact that the untrained ad hoc interpreter does not want the patient to learn about their medical condition (Creeze, 2013: 19). For instance, there are taboo words, such as 'cancer', in some cultures. Such interpreters may also distort the course and consequences of the treatment process due to a lack of knowledge of medical conditions and terminology.

Consequently, Creeze advocates that healthcare professionals should not use untrained ad hoc interpreters, because they would not adhere to a code of ethics and conduct or a standard of practice:

> *[T]hey may (amongst other things):*
> *– not maintain accuracy, but leave out things they do not understand, change information or add information they feel should have been included;*
> *– not maintain strict confidentiality;*
> *– not maintain impartiality: they may be tempted to take sides with either party (the client or the professional) and 'interpret' what they want the other party to hear, rather than what was really said;*
> *– not disclose any possible conflict of interest (including any personal connections with the patient);*
> *– offer advice to the client, which may include giving the client the answers to a test the client is taking (e.g. when they are interpreting for someone who is taking their driver's licence test!);*
> *– not be able to provide the healthcare practitioner with cultural background information, as they may not be aware of, or able to elucidate, differences between their own culture and that of the host country;*
> *– not be able to brief the professional on the 'triangle of communication' and the need to use the 'first person singular';*
> *– not be able to use the correct interpreting technique or to explain to both client and professional about the various interpreting techniques which can be used.*
> (Creeze, 2013: 19)

Consequently, the use of non-professional interpreters may impact the patient's health and the quality of the service negatively.

## 1.5. THE ISSUE OF ETHICS, NATIONAL STANDARDS AND ROLE IN HEALTHCARE SETTINGS IN DEVELOPED COUNTRIES

Coming from the Greek, the term "ethics" refers to "a set of principles of right conducts" (The American Heritage Dictionary of the English Language). Consequently,

ethical behavior refers to behavior that corresponds to the accepted principles expressing what is considered right and wrong.

Healthcare interpreting which is a sub-branch of community interpreting, on the other hand, takes place in settings where the private health issues of patients are discussed. Most healthcare interactions are dyadic, taking place between two parties, i.e. the healthcare provider and the patient. However, when these parties do not share the same language, the presence of an interpreter is needed. Consequently, the interaction between healthcare provider and the patient becomes triadic (healthcare provider-interpreter-patient). In these situations, healthcare interpreters witness the patients' private stories and they assist them in communicating in their daily lives. At this point it could be said that professional conduct is of the utmost importance in healthcare settings, since any unprofessional behavior of interpreters may lead to challenges in communication. Therefore, it is crucial for healthcare interpreters to adhere strictly to the code of ethics and conduct as well as standards of practice.

On the other hand, in an interpreter-mediated medical encounter, the presence of an interpreter may change the power dynamics of the dyadic relationship between the healthcare provider and the patient. Since the interpreter is the only person who understands both languages, they uphold tremendous power. Moreover, the interpreter has an identity with their own individual beliefs, background, culture norms and feelings. Therefore, both the healthcare provider and the patient have to trust that the interpreter will not misuse the power they hold. They need to trust that the interpreter will interpret faithfully what both parties utter, without adding their own comments or feelings (IMIA, 2007: 17). "It is the function of a code of ethics to guide the interpreter on how to wield that power" (Edwards in IMIA, 2007: 17). A code of ethics provides guidelines and standards to follow, creating consistency and lessening arbitrariness in the choices interpreters make in solving the dilemmas they face (Gonzalez et. al. in IMIA, 2007: 17).

According to Inghilleri (2012), codes of ethics and codes of practice are generally perceived by all parties in an interpreted interaction as serving both a practical and an ethical purpose.

> *From a language perspective, such codes are seen to limit the potential for misunderstanding and guarantee that interpretations are true and accurate. From an ethical perspective, they are deemed to provide the necessary ground rules for ethical conduct primarily through the maintenance of 'neutrality' and the 'faithful' reproduction of original utterances- the adherence to truth.* (İnghilleri, 2012: 27)

A code of ethics and standards helps interpreters make critical decisions such as whether to summarize or not (Bancroft, 2015: 227-8). Without such published ethics and standards, community interpreters often have to make decisions "on the fly" guided by their intuition and training (ibid). However, it should also be noted that not all interpreters working in community settings have training in professional interpreting. Therefore, ethics and standards also contribute to clarifying hotly debated issues, such as whether community interpreters should "change register" by simplifying the utterances of service provider to help service users understand the message more easily (ibid).

As the profession of healthcare interpreting has evolved and matured around the world, the importance of constituting shared knowledge as to what is appropriate and what is ethical practice in the field has become imperative (NCIHC, 2005). To this end, associations in a variety of countries have developed a set of principles or a code of ethics and conduct as well as standards of practice, which will be reviewed in detail below.

Here are some examples of ethics and standards followed by community interpreters, including healthcare interpreters:

- The California Healthcare Interpreting Association (CHIA) (United States)
- The National Council of Interpreting in Healthcare (NCIHC) (United States)
- The International Medical Interpreters Association (IMIA) (United States)
- New South Whales Healthcare Interpreting Services (NSW HCIS) (Australia)
- The Irish Translators' and Interpreters Association (ITIA) (Ireland)
- The National Register of Public Service Interpreters (NRPSI) (United Kingdom)
- Healthcare Interpretation Network (HIN) (Canada)

145 community interpreting and standards documents (including healthcare or legal interpreting ethics) reviewed in 11 languages from 25 countries around the world

(Bancroft, 2005) shows the degree to which there is near-universal agreement on three ethical principles. These are *confidentiality*, *accuracy* and *impartiality*. Other common principles adopted internationally are *professionalism*, *honesty*, *professional development* and *professional solidarity*. Less consensus, on the other hand, is reached on the principles related to the interpreter's role and scope of practice, such as *cultural mediation* and *advocacy* (Bancroft, 2015: 228). A review of codes of ethics and standards in community interpreting associations[8] (primarily healthcare interpreting associations) also shows a common approach to the findings of Bancroft (2005). The common ethical and standards principles could be listed as following:

- *Accuracy*
- *Confidentiality*
- *Impartiality*
- *Respect*
- *Professionalism*
- *Professional Development*

With the principle of *accuracy*, the healthcare interpreter is expected to render the message accurately by conveying the spirit, content and cultural context of the message in source language into the target language, making it possible for the participant in the interaction to communicate effectively. National Standard Guide for Community Interpreting Services (NSGCIS) of Canada (Healthcare Interpretation Network (HIN)) states *accuracy* as an ethical principle:

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[8] National Council of Interpreting in Healthcare (NCIHC) (United States)
- California Healthcare Interpreting Association (CHIA) (United States)
- New South Whales (NSW) (Australia)
- International Medical Interpreters Association (IMIA) (United States)
-The Irish Translators' and Interpreters Association (ITIA) (Ireland)
-National Register of Public Service Interpreters (United Kingdom)

See www.inboxtranslation.com/resources/professional-associations-translators-interpreters for further detail (accessed 04/01/2017). These are the pioneer associations in the field of community interpreting an These are the pioneer associations in the field of community interpreting and healthcare interpreting whose codes of ethics and standard of practice I analyzed.

*Interpreters strive to render all messages in their entirety accurately, as faithfully as possible and to the best of their ability without addition, distortion, omission or embellishment of the meaning.* (NSGCIS, 2007: 13)

The principle of *confidentiality* refers to honoring the privacy of the healthcare interaction and maintaining trust by keeping all the information gathered during the interaction hidden. Healthcare interpreters are also supposed to strive to maintain *impartiality* by refraining from counseling, advising or projecting personal biases or judgments. The National Council of Interpreting in Healthcare (NCIHC), for instance, implies impartiality by exemplifying:

9. **The interpreter does not allow personal judgments or cultural values to influence objectivity.**
For example, an interpreter does not reveal personal feelings through words, tone of voice or body language.

**10. The interpreter discloses potential conflicts of interest, withdrawing from assignments if necessary.**
For example, an interpreter avoids interpreting for a family member or a close friend. (NCIHC, 2005:6)

The Irish Translators' and Interpreters' Association (ITIA) also emphasizes the principle of *impartiality* by stating:

*The community interpreter will inform the beneficiaries and users prior to the communication process that everything said during the exchange will be interpreted, even when they say something not meant for interpretation.*
(ITIA, 2009: 2)

*Respect* is another principle which needs to be taken into account. The interpreter should strive to support mutually respectful relationships between all the parties involved. Moreover, interpreters should act in a professional and ethical manner by respecting *professionalism* and *integrity. Professional development* also plays an important role. The interpreter is expected to further their knowledge and skills by carrying out independent studies, participating in the conferences related to their profession, and conducting actual interpreting practice.

Slatyer and Chesher (2007:140-141) argue that, on the other hand, codes of ethics, codes of practice as well as standards also explicitly designate the boundaries of

the role of the interpreter. For instance, IMIA, NSW and CHIA predicate the role of the interpreter before, during and after the interpretation very clearly. Therefore, it could be indicated that codes of ethics and standards limit the role of the interpreter. Alongside that, both NCHIC (2004) and CHIA (2002) set out four roles for the interpreter on the issues of roles and interventions, namely (Ozolins, 2015: 322):

- *Message converter*
- *Message clarifier*
- *Cultural clarifier*
- *Patient advocate*

The *Message converter* role means that the interpreter listens to both parties, observes their body language, and transmits the meaning of all messages uttered in one language to another by refraining from unnecessary additions, omissions, or changes in meaning (CHIA, 2002: 42). Within this scope, the interpreter must manage the flow of communication between all the parties included. However, the guidance also gives the interpreter the right to intervene both verbally and nonverbally if necessary. Such occasions could take place when parties speak too fast or do not give the interpreter sufficient time to interpret (ibid).

With the *message clarifier* role, the interpreter is expected to alert parties of possible misunderstandings. The CHIA standard, therefore, authorizes the interpreter in the case of misunderstanding:

> *When there is evidence that any of the parties, including the interpreter, may be confused by a word or phrase, interpreters may need to:*
> *a. Interrupt the communication process with a word, comment, or a gesture to the party currently speaking.*
> *b. Alert the parties that the interpreter is seeing signs of confusion from one or more of the parties and identify the confusing word or concept.*
> *c. Request or assist the speaker of a word or concept unfamiliar to the listener or interpreter to restate or describe the unfamiliar word or concept.*
> *d. Explore ways to assist speakers to describe concepts using analogies, or "word pictures" when there are no linguistic equivalents in either language.*
>
> (CHIA, 2002: 42)

In the *culture clarifier* role, the emphasis is on the culture. Culture is regarded as a component which is inseparable from language by indicating that concepts and words may exist in one language but not another (ibid: 43). Especially in medical settings, medical terms that do not have a corresponding word in the target language may lead to misunderstandings. Therefore, the interpreter plays a fundamental role in bridging this gap, hence the *culture clarifier* role. The interpreter removes the possible misunderstanding caused by the cultural differences.

The *Patient advocacy* role is another role designated for interpreters. The CHIA standards recognize that non-English speakers may be unfamiliar with U.S healthcare system services available and/or their healthcare rights (ibid:45). Because of this, patients with limited English proficiency may have difficulties advocating their own individual rights. Therefore, the interpreters are the ones who advocate their rights on behalf of them when a problem occurs. However, this role does not assign the interpreters full authority, either. It states that the interpreters should balance this role of patient advocacy by taking into account the ethics of patient autonomy and impartiality (ibid: 46). To this end, standards also guide the interpreters to consider the ethical decision-making process. *Patient advocacy* refers to suggestions about the patient's needs for follow-up appointments or informing the patient how to lodge a complaint with the U.S Department of Health and Human Services Office for Civil Rights (ibid). However, the CHIA also suggests potential risks and benefits of the patient advocacy role in cases of controversy.

However, the Canadian code *National Standard Guide for Community Interpreting Services* (NSGCIS), which is based on standards of practice developed by the Language Interpretation Training Program for Ontario Colleges (LITP) and is endorsed *inter alia* by Canada's Healthcare Interpretation Network (HIN), presents an explicitly opposing view to the *patient advocacy* role:

> *Unlike CHIA, NCIHC and IMIA (International Medical Interpreters Association) standards, the LITP Standards of Practice do not endorse cultural brokering and advocacy. ... the LITP Standards of Practice differs in purpose as it is intended to be a broad guide for interpreting in several settings, and not exclusive to the health care setting.* (NSGCIS, 2007:21)

In the same vein, emphasizing the interpreter's role as a "faciliator", ITIA also opposes the advocacy role:

> *[...] A community interpreter;*
> *-should never act on behalf of the user and should never speak on behalf of either party;*
> *- is not employed by the beneficiary and should not act as their advocate.*
> (ITIA, 2009:1)

Therefore, it clearly reveals the controversy asserted by Bancroft (2005) around the issue of cultural mediation and advocacy.

When the above-mentioned ethical principles and standards of practice are taken into account, it is a fact that there is a gap about the code of ethics and conduct as well as standards of practice to be applied by healthcare interpreters in Turkey, which might have implications in practice.

## 1.6. SUMMARY

This chapter has offered descriptions of the main concepts which comprise the basis for the thesis. First, the description of the term community interpreting and its term variations as well as its general features have been put forward. After laying the conceptual foundations, associations and their activities which led to the development of community interpreting around the world have been analyzed. As Pöllabauer (2002: 289) indicates, community interpreting is more developed in countries receiving massive numbers of immigrants such as the U.S.A, Australia, Canada, Scandinavia, etc. when compared to European countries. Thus, associations have been established much earlier in these countries than in European countries. They have also developed certification programs, codes of ethics as well as standards of practice which define the role of community interpreters, including healthcare interpreters, in order to provide a professional service for receivers. Following the detailed analysis of these associations' activities and codes of ethics and conduct, it has become evident that there is no association which has established codes of ethics and conduct for healthcare interpreters. However, it is important to mention that in the field of conference interpreting and sign language interpreting there are associations such as TKDT (The Conference Interpreters

Association of Turkey) for conference interpreters and The Association of Turkish Sign Language Interpreters for sign language interpreters in Turkey.

This chapter has also provided general information regarding community interpreting services such as ARC (Emergency and Disaster Interpreting), sign language interpreting services and healthcare interpreting services as a sub-branch of community interpreting in Turkey. Although the focus of the current study is private hospitals, it is important to mention at this point that communication barriers are encountered with Syrians and citizens coming from the eastern part of Turkey according to the findings obtained through the interviews with doctors in state hospitals. Therefore, they asserted that they seek help from the patients' relatives or even from security staff working in the hospital, which reveals that ad hoc interpreting still prevails in Turkey. Following the general information, the codes of ethics as well as standards of practice developed by the abovementioned countries have been analyzed in detail. According to the analysis, it has become evident that there is a gap regarding the codes of ethics and conduct as well as in the standards of practice to be applied by healthcare interpreters in Turkey, when compared with the above-mentioned developed countries' standards and ethical principles. This gap might have implications in practice. The codes of ethics and conduct as well as standards of practice will also underlie the discussion of the strategies and decisions taken by the interpreters both during and beyond interpretation process in the following chapters.

The next chapter will provide the literature review on the role of interpreters in healthcare settings, theoretical framework and methodology which will be employed in this study.

# CHAPTER TWO

# LITERATURE REVIEW, THEORETICAL FRAMEWORK AND METHODOLOGY

This chapter focuses on selected scholarly studies on the issue of role and ethics in healthcare interpreting. These selected studies on healthcare interpreting are analyzed under two classifications: those from around the world and those in Turkey.
The second part constitutes the theoretical framework of this research, which is mainly comprised of Pierre Bourdieu's concepts "habitus" and "capital".
In the last section of this chapter a methodological framework is introduced in detail.

## 2.1. APPROACHES TO COMMUNITY INTERPRETING AROUND THE WORLD

Until recently, studies in the field of interpreting studies have focused on cognitive and psycholinguistic aspects of simultaneous conference interpreting. Interpreting in community settings started to attract scholars' attention only after 1990s. (Diriker and Tahir-Gürçağlar, 2004: 75)

Regarding studies in community interpreting, a landmark event in the development of community interpreting including healthcare interpreting was the first international congress organized at Geneva Park, near Toronto in Canada in 1995, called *The Critical Link: Interpreters in the Community. First International Conference on Interpreting in Legal, Health, and Social Service Settings.* This conference marked the historic beginning of Critical Link Conferences, now known as Critical Link International. Later Critical Link Conferences, which took place in Vancouver (1998), Montreal (2001), Stockholm (2004), Sydney (2007), Birmingham (2010), Toronto (2013) and Edinburgh (2016), also contributed to research on community interpreting. Critical Link International hosts the largest international conference in the field, held every three years, resulting in a publication consisting of conference proceedings, which is among the significant publications in this field. This conference also led to an

increasing interest in academic research on community interpreting, including healthcare interpreting.

The issue of role is one of the most prevailing topics in interpreting studies, including community interpreting. Many scholars have conducted research on the role of interpreters in a variety of settings, including court interpreting[9], interpreting in police stations[10], interpreting in asylum hearings[11]and sign language interpreting[12]. However, the literature review in this study is mainly based on research into the role of interpreters and ethics in healthcare interpreting from the selected studies around the world. This also constitutes the main focus of this study.

### 2.1.1. Research on the Interpreters' Role and Ethics in Healthcare Settings

The healthcare interpreter's role is one of the most debated issues among academics. According to Hale, the main reason for the debate has been the lack of uniformity evident in the practice of community interpreters (Hale, 2011).

Gentile et al. (1996:30) define the concept of "role" as a social science construct which is used to explain behavior and examine attitudes between at least two participants in any social situation. Accepting the interpreter's role both as vicarious (being performed on somebody else's behalf) and in effect a double role (being performed for two clients), Gentile et al. describe components which affect the role of interpreters. These components could be listed as *contextual factors*, *status differential* between clients and *language issues.* Apart from those components, they also highlight the interpreters' ability to empathize with each interlocutor in turn at each exchange.

Whether the interpreters should just translate or should adopt additional roles and responsibilities has also been one of the major controversial issues. The metaphor "conduit" was first used by Reddy (1976). Here the interpreter is viewed as an "invisible", a "language modem", a non-thinking linguistic "transferring machine" for

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9 Laster/Taylor, 1994; Berg-Seligson, 1990; Fenton, 1997; Mikkelson, 2000; Ibrahim, 2007; Jacobsen, 2002
10 Harraez/Rubio, 2008; Sauerwein, 2006
11 Pöllabauer, 2004
12 Metzger, 1999; Roy, 2000; Napier, 2002

speakers who do not share the same language when communicating with each other (Jiang, 2008: 52).

However, there are sociological and sociolinguistic approaches which stress the need for interpreters' active involvement in the encounters as "culture brokers", "advocators" or "conciliators". According to Slapp (2004), the community interpreter in the role of "culture broker" in healthcare settings not only tries to eliminate the language barriers and to point out the cultural problems to the doctor, but also tries to direct the conversation in order that the doctor can reach a mutually satisfactory diagnosis.

As one of the researchers who supports the idea that the interpreter is an active participant, Roberts (1997) holds that the problem in mediating communication between clients and service providers occurs not only due to linguistic differences, but also due to cultural differences, according to the Ontario Ministry of Citizenship. Moreover, the "client" of the community interpreter belongs invariably to a minority group whose language and culture are not understood by the majority group which organizes and offers the services. This is why, "community interpreting" has been labeled as "cultural interpreting":

> *We define interpreting as including the communication of conceptual and cultural factors that are relevant to the given interaction as part of the lingual transmission... This model of interpreting service was developed out of an awareness that communication is seriously impeded by insensitivity to the role of culture in the content and manner of communication, especially in formal interactions.*
> (Giovannini 1992 cited by Roberts, 1997: 12)

The role of "advocacy", on the other hand, refers to defending, pleading for or actively supporting the client. In other words, the community interpreter is seen as a guide and counselor as well as a power broker who works on behalf of his "underprivileged" client in which the interpreter "advices clients about rights and options in the situation" [...] "ensures that the client has all relevant information and controls the interaction"; and "challenges racially/culturally prejudiced statements or conclusions" on the part of the service providers (Giovannini 1992 cited by Roberts, 1997: 13).

Hsieh (2004: 172-178) distinguishes two types of healthcare interpreter's advocacy: *overt* advocacy and *covert* advocacy. In *overt* advocacy, interpreters essentially act on behalf of the patients. In other words, they may seek information, provide answers and request services *for* a patient *without* consulting with a patient. By doing so, interpreters make the patients invisible and make judgements about what services and resources are needed by the patients. In *covert* advocacy, in contrast to *overt* advocacy, interpreters use *covert* advocacy communicative strategies to be invisible and yet advocate for the patients.

However, Slapp (2004) indicates that this role of "advocacy" is also controversial in the situation where the interpreter has been employed by a hospital and the patients' interests' conflict with the hospital's interests. This perspective has been also cited by Roberts as "[...] It is difficult to be a helpmate to and even an advocate of those not speaking the language of the country and still to retain the objectivity and impartiality required to interpret well" (Roberts, 1997:21).

Slapp (2004) highlights that the community interpreter informs the patients about their legal rights; however, this does not give the interpreters full authorization to control the conversation which should take place between the primary parties i.e doctor and patient. The community interpreter should interpret every utterance of the parties, even though it would be easier to omit irrelevant ones. The interpreter does not have the right to support the doctor or the patient. S/he should stay neutral in every case (Dhawan et al. 1992 in Slapp 2004). Apart from interpreting, the interpreter may also have tasks such as making a phone call for the patient etc. Nevertheless, in this "friendly" role, the interpreter should be careful to preserve his/her neutrality.

In the same way, the role of "conduit" is also challenged by a number of scholars who support the active participation of the interpreter. Hsieh (2006), for instance, conducted empirical research on the non-conduit behaviours of healthcare interpreters. Describing the role "conduit" as an interpreting model that requires the interpreter to perform in a neutral, faithful and machine-like manner, Hsieh (2006) tackles the role conflicts encountered by healthcare interpreters. Based on the interview data, this study is of pivotal significance. Hsieh explains conflicts in healthcare interpreters' role performances, the causes of these conflicts and the strategies adopted by interpreters for

resolving these conflicts. Hsieh claims four sources of conflicts in role performances, which are a) others' communicative practices, b) changes in participant dynamics, c) institutional constraints, and d) unrealistic expectations. In brief, she indicates that these factors impact the "conduit" role of the interpreters, although these interpreters were trained to adopt a "conduit" role. Secondly, this study also reveals the impact of institutional policies and expectations on the role of the interpreters, since the expectations of parties involved in the interaction affect the way in which the role is both created, defined, and perceived, and are important factors influencing interpreting behavior.

Supporting the idea that interpreters are active participants in the interaction, i.e., specifically in the patient's history-taking procedure, Bolden (2000) speaks of two main approaches, which are "directly interpreted interaction" and "mediated interaction". In the directly interpreted interaction the interpreter *directly* interprets what has been said in the previous turn by the participants. The doctor and the patient address each other directly, rather than through an interpreter. According to Bolden, this approach is adopted by interpreters who embrace the role of "translating machine". In a mediated interaction, two interweaving conversations take place: one between the interpreter and the patient, the other one between the interpreter and the doctor (Bolden, 2000: 393). As a consequence of her study, Bolden reveals that the interpreters adapted their roles to the ongoing activity based on their understanding of the communicative goal to be achieved. Moreover, they conduct interpretations by basing them on their perception as to the usefullness of the information. However, this kind of involvement is perceived as a risk because the interpreters are not seen as medical experts, thus, this kind of intervention may lead to negative consequences for the patients who lack linguistic skills in the majority language.

Likewise, Angelelli (2004) conducted an ethnographic study about the role of the interpreter in a large Californian hospital which employed a team of English-Spanish medical interpreters between June 1999 and April 2001. Looking at the interpreters' role through the different lenses of social psychology, sociological theory and linguistic anthropology (2004: 26) and also collecting an amount of data using triangulation over the two-year time period, Angelelli discusses the interpreters' perspectives of their role in

medical encounters. Interpreters describe themselves by using metaphors such as *detectives*, *multi-purpose bridges*, *diamond connoisseurs*, and *miners* (Angelelli, 2004: 129-132). As a consequence, Angelelli illustrates that there is a tension between the prescribed invisible roles and the actual visible role. In other words, interpreters play an active role in medical encounters, unlike the interpreters' "invisible" perception.

In contrast, Angelelli (2006) also discusses how four roles of interpreters as *message converter*, *message clarifier*, *cultural clarifier* and *patient advocate* may contradict with the standards of the California Healthcare Interpreters Association (CHIA). Her study reveals the tensions related to the role, ethics and expectations of the healthcare interpreting profession, and she states:

> *The data seems to indicate that most interpreters make personal decisions about the roles they will assume during an interpretation session, based on the number and perceived importance of the interlocutors and the topic. They may choose to interpret everything, to explain why they are not interpreting certain utterances, or even to omit side conversations that they regard as not pertinent. [...] They believe themselves to be responsible for explaining intercultural differences and for educating parties and would like to see that responsibility stated in the professional code.* (Angelelli, 2006: 182-183)

Consequently, Angelelli suggests that the *standards* should be revised periodically to account for new findings in research on role, ethics, boundaries and expectations by laying emphasis on developing such standards.

Apart from that, a number of scholars such as Drennan & Swartz (1999), Leanza (2005) and Niska (2002), have attempted to develop role typologies for healthcare interpreters.

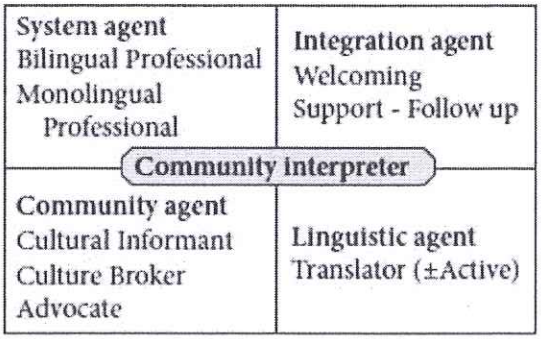
Drennan & Swartz differentiate four different roles of interpreters in South Africa which are a) '*language specialist*' within a multidisciplinary team with the inherent problems of fragmentation of care and confidentiality, b) "*culture specialist*' requiring a combination of highly skilled linguistic capabilities as well as cultural and clinical knowledge, c) '*patient advocate'* with the difficulty that intervening on behalf of the patient may lead to conflict with the health provider and/or questioning the clinical competence of a range of other professionals, d) *'institutional therapist'* with the inherent problem that interpreting is required in administrative situations such as

disciplinary hearings, salary negotiations etc., as well as clinical contexts which require extensive expertise and experience and may result in conflicts (Jiang, 2008: 57-58).

Based on a study of interpreter-mediated consultations in pediatric settings in Switzerland, Leanza (2005:170) describes her overview of community interpreter roles using Jalbert's typology (1998) which describes the interpreter as 1) *translator* with the mininal presence of the interpreter who facilitates the communication by not interfering with the parties, 2) *cultural informant* who helps, (e.g healthcare providers who understand the patient better by using his/her knowledge of cultural norms and values), 3) *cultural broker* or *cultural mediator,* who is also called as a negotiator between parties by coming up with explanations, enlarging or synthesizing the patients' and healthcare providers' utterances in order to help them communicate smoothly, 4) *advocate* who also defends the patient against the institution if value-conflict occurs, 5) *bilingual professional* when the interpreter is a healthcare professional, for example (Jalbert in Leanza, 2005: 170).

Within the scope of this typology, Leanza proposes her own role typology:

**Figure 1:** Community interpreter's role according to their relation to cultural difference



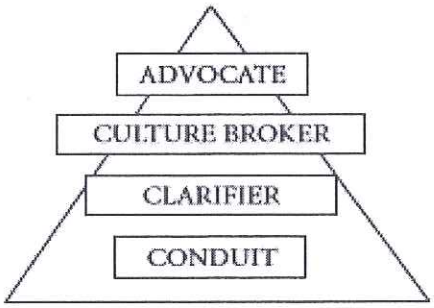

Source: Leanza, 2005: 29

As could be seen above, Leanza develops four different roles for interpreters which are *system agent*, *integration agent*, *community agent* and *linguistic agent*.

According to Niska, the role of the community interpreter is different from that of the conference interpreter. Securing satisfactory communication between professionals and clients who differ in social and cultural background, religious beliefs

and education levels are among the tasks of interpreters. According to the outcome of the survey, which was conducted within the scope of a European project in 1998, there appear to be two conflicting approaches to interpreters' role. These are the neutral "translator/ "linguistic interpreter" as opposed to the "advocate" / "cultural interpreter" (Niska, 2002: 137-138). Adopting a practical view of this topic, Niska explains the role of the interpreter using the following pyramid diagram:

**Figure 2**: Interpreter Roles




Source: Niska, 2002: 138

According to the pyramid, Niska explains that the interpreting task is mostly carried out at the "conduit" level, which means "just interpreting". However, Niska further explains that the interpreter has to give explanations or clarifications in the case of cultural differences or technical problems, taking the role of "cultural broker" and "clarifier". Regarding the two controversial roles of "cultural broker" and "advocacy", Niska indicates that the interpreter adopts the role of "advocacy" when s/he acts on behalf of the client outside the interpreting session (Niska, 2002: 138).

One of the recent studies on healthcare interpreting has been conducted by Souza (2016) in which she focuses on perspectives of professional healthcare interpreters. In her work she utilized both quantitative and qualitative design, obtaining data from four hundred and fifty-eight healthcare interpreters working in twenty-five countries. She utilized interview, survey, focus group, and essay as data collection method. Her work revealed that healthcare interpreters are acting as intercultural mediators beyond dealing with miscommunication between patients and healthcare providers due to a cultural

issue. Consequently, they act as welcomers, integration agents, community agents, bilingual professionals, cultural informants, and educators, all within the context of intercultural mediation.

## 2.2. APPROACHES TO COMMUNITY INTERPRETING AND HEALTHCARE INTERPRETING IN TURKEY

Even though community interpreting, including healthcare interpreting, is commonly practised in Turkey, there is little academic research on community interpreting[13] (See also Chapter 1) and healthcare interpreting. One reason for the lack of academic research could be the difficulty in obtaining permission to conduct research in various settings such as courts, hospitals, etc.

The first academic research on healthcare interpreting in Turkey was conducted by Ross and Dereboy (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 practices in public health institutions in eastern and south-eastern Anatolia as well as in Istanbul, it was observed that language is an important barrier in communication between doctor-patient encounters. Interviewing 54 patients and 46 ad hoc interpreters, it was concluded that nearly all patients interviewed did not speak Turkish, something which is common in most parts of Turkey, not just in Kurdish speaking parts. Moreover, according to the survey results, patients would prefer to have Kurdish-speaking doctors and also complained that the doctors did not understand the patients' perspectives when they didn't speak Turkish (TRICC, 2011). As a consequence, Ross and Dereboy suggest (i) assigning bilingual doctors to the region, (ii) providing doctors with language training, (iii) raising awareness, (iv) assigning Kurdish-speaking doctors to mostly Kurdish speaking areas and improving Kurdish competence of doctors, (v) making doctors more aware of the nature, process and challenges of mediated communication and (vi) training interpreters (Ross and Dereboy, 2009).

13 Bulut and Kurultay, 2002; Kahraman, 2003, 2010; Diriker and Tahir- Gürçağlar, 2004, Doğan and Kahraman, 2011

Addressing the need for trained medical interpreters at public health institutions in Turkey, Mine Güven (2014) argues distance learning (DL) would be 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 acting as 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). She suggests delivery of theoretical content through a distance learning mode as well as face-to-face practice guided by professional interpreter trainers and experts in the local/ethnic languages concerned.

As for suggestions for the future, Güven suggests that in-service training for health professionals could be offered in order to raise awareness and to explain the importance of working with interpreters, which could be a permanent solution. On the other hand, the above mentioned one-year certificate programme in medical interpreting for prospective interpreters could also be implemented through two-year vocational or four-year undergraduate translation and interpreting programmes in the form of a medical interpreting module (Güven, 2014: 10). Thirdly, a (non-thesis) MA programme in community interpreting training is also possible as an opportunity for prospective trainers of medical interpreting (Güven, 2014: 11).

Lastly, there have also been recent studies conducted on healthcare interpreting in Turkey including an MA thesis in Sakarya University in 2015 and a book published in 2016. In her MA thesis titled "Küresel Hareketlilik Etkisinde Türkiye'de Sağlık Çevirmenliği Uygulamaları: Çevirmen Görüşlerine Dayalı Bir Uygulama" (Healthcare Interpreting Practices Under The Influence Of Global Mobility: A Case Study From the Interpreters' Perspective), Öztürk aims at giving an overview about healthcare interpreting services, mainly healthcare interpreting services provided for medical tourism. She states three major aims to be covered in her thesis, namely, a) to give an overview about interpreting service quality and the interpreters' profile, b) to include the interpreters' perspectives about their profession, and c) to put forward the interprers' experiences as well as to contribute to the development of the profession in Turkey. Data was collected through interviews with healthcare interpreters. Even though it provides

valuable data about the profession and the interpreters' perspectives, fieldwork is more enhanced when observation and analysis of real-life data is included, since data provided only from interviews with interpreters might be misleading. As in the present thesis, it is possible that what interpreters say they do in interviews might contradict what they actually do in real-life situations (See Chapter 3).

Recent work published by Dilek Turan (2016) titled "Sağlık Hizmetlerinde Sözlü Çeviri" (Interpreting In Healthcare Services) aims at analysing the profession of interpreting in healthcare settings from academic, judicial, social and administrative perspectives, and makes suggestions about the interpreting services in Turkey. Putting emphasis on the lack of clear job descriptions for community interpreters, Turan (2016, 229) offers two solutions:

> *[...] First, raising awareness of institutions about community interpreting as a profession and recruiting trained, professional interpreters and if possible, trained interpreters who have had education specificially in community interpreting, instead of recruiting untrained interpreters only with language skills. Second, enabling universities who offer training in Translation and Interpreting Departments to include community interpreting lectures in more detail.* (Turan, 2016: 229)

> *"[...]Birincisi, kurum ve kruuluşların istihdamlarında çevirmenliği özel bir mesleki alan olarak görmelerinin sağlanması ve çeviri hizmetlerini farklı alanlarda eğitim almış ancak dil bilen mevcut personele yaptırmak yerine, alanda eğitim almış ve tercihen toplum çevirmenliği ve kamu hizmeti çevirmenliği konularında da özel olarak eğitilmiş ya da kendini eğitmiş kişileri seçmelerinin sağlanması; ikincisi mütercim-tercümanlık konusunda eğitim verilen bölümlerin müfredatlarında bu konunun daha derin ele alınmasıdır."*

It is clear that raising awareness in institutions and focusing on community interpreting in education would be key steps towards enhancing community interpreting services in Turkey. However, first and foremost, an understanding of the current situation through detailed observation and analysis of the field is needed.

As a consequence, there is a shift from the interpreter's "conduit", "invisible", "translating machine" role into "active participant" role, when the studies around the world are taken into account. Most of the above mentioned studies suggest that interpreters play an active role in healthcare settings. Also, the perspective of studies on interpreting is focused more on sociological and sociolinguistic approaches dealing with the interpreters' role in relation to broader issues of context and ethics. Even though a

number of studies have been conducted on the role of interpreters in healthcare settings around the world, it is clear that there is little academic research on healthcare interpreting in Turkey and only a small percentage of these few studies have been conducted as case studies based on real-life data. Thus, this study focuses on the interpreter's role in these settings, and aims at conducting an in-depth analysis of the field based on real-life data in Turkey. This study could also be positioned in the existing literature in terms of its focus on role and ethics in healthcare settings from a sociological perspective.

## 2.3. THEORETICAL FRAMEWORK OF THE STUDY

Translation Studies has witnessed a number of "turns", from the "pragmatic turn" in linguistics in the 1960s and "cultural turn" in the 1990s, to the "sociological turn" and the "power turn" in the 2000s (Wolf, 2014: 7). Valero-Garces explains the "sociological turn" as:

> *[...] One of the results of this shift is that role of the agents involved in the translation process is brought into the foreground. Viewed from this perspective, any translation is necessarily bound up within social contexts: on the one hand, the act of translating, in all various stages, is undeniably carried out by individuals who belong to a social system; on the other, the translation phenomenon is inevitably linked to social institutions, which greatly determine the selection, production, and distribution of translation, and as a result the strategies adopted in the translation itself.* (Valero-Garces, 2012: 16).

In this thesis, the theoretical framework rests on Pierre Bourdieu's two central concepts "habitus" and "capital" which encompass the interpreter's role. In other words, these concepts are of considerable importance in analyzing the interpreter's decision-making process and thus in determining the interpreter's role, both during and beyond interpretation, from a sociological perspective.

### 2.3.1. Habitus

Pierre Bourdieu is one of the leading theorists of the twentieth century and his sociological approach has been employed across a number of disciplines. His sociological approach has also been applied to social sciences, including translation and

interpreting studies. According to Inghilleri, this interest in Bourdieu's work is part of a shift in translation studies from textual products toward an approach of translation and interpreting as social, cultural and political acts intrinsically connected to local and global relations of power and control (Inghilleri, 2005a: 125). She further explains that Bourdieu's social reproduction theory has been suggested in order to address the limitations of Toury's work *translatorial norms*, since Toury has been criticized for focusing only on the descriptive level and for lacking an adequate conceptualisation of the social nature of communicative practices, such as ones where translation is involved (Inghilleri, 2003: 244). Therefore, the use of Bourdieu's theory for translation and interpreting studies has been considered as part of the re-evaluation of the descriptive and polysystems approaches, which suggest a more powerful set of concepts rather than norms and conventions to describe socio-cultural constraints on acts of translation. Bourdieu's work, according to Inghilleri, has also made essential contributions to translation studies in an attempt to analyze the translators and interpreters themselves, notably, analyzing their critical role as social and cultural agents who actively participate in the production and reproduction of textual and discursive practices (Inghilleri, 2005a: 125-6).

Bourdieu defines *habitus* as:

> *[S]ystems of durable, transposable dispositions, structured structures predisposed to function as structuring structures, that is, as principles which generate and organize practices and representations that can be objectively adapted to their outcomes without presupposing a conscious aiming at ends or an express mastery of the operations necessary in order to attain them.* (Bourdieu, 1990: 53).

According to Bourdieu's definition of *habitus*, the dispositions produced by the habitus are "durable," which means that they last throughout an agents' lifetime. They are "transposable," which means that they may generate practices in multiple and diverse fields of activity. Lastly, they are "structured structures," which means that they incorporate the objective social conditions of their incalculation (Bourdieu, 1993: 5).

Karl Maton, on the other hand, interprets the term *habitus* as "*structured*" by one's past experiences and present conditions including family and educational background, while it is "*structuring*" by allowing one's present and future behaviors to

be shaped (Maton, 2008: 51). In other words, *habitus* engages in our ways of acting, thinking and being by bringing our history into the present, and it also affects how we make choices in certain ways (Maton, 2008: 52). Simply put, Maton summarizes *habitus* as "our aspirations and expectations, our sense of what is reasonable or unreasonable, likely or unlikely, our beliefs about what are the obvious actions to take and the natural way of doing them".

On the other hand, Bourdieu speaks of the relation between *habitus* and *field.* In *the Field of Cultural Production (1993),* Bourdieu defines the term *field* as a structured space with its own functioning rules and whose structures are determined by the relations between the positions of agents who occupy the field (Bourdieu, 1993:6). This relation between *habitus* and *field* has also been put forth in the equation of Bourdieu's *Theory of Practice:*

$$((habitus)(capital)) + field = practice$$

According to the equation mentioned above, practices do not occur only as a result of one's habitus, capital or field. It is the relation between these central concepts which are called "thinking tools" (Bourdieu & Wacquant, 1989: 50) which lead to practices.

### 2.3.2. Capital

Usually associated with the economic sphere and monetary exchange, the term "capital" is used in a broader sense by Bourdieu (Moore, 2008: 101). The accumulation of *capital* is of significance in consolidating and maintaining the agents' positions in a competitive field (Thomson, 2008: 69). According to Wacquant (1998):

> *a field is an arena of struggle through which agents and institutions seek to preserve or overturn the existing distribution of capital (manifested, in the scientific field, by the ranking of institutions, disciplines, theories, methods, topics, journals, and so on): it is a battlefield wherein the bases of identity and hierarchy are endlessly disputed over.* (Wacquant, 1998: 222)

Thus, agents struggle to bolster their position by enhancing their capital in the field. In an attempt to conceptualize the struggle and power relations of the agents in the

field, Bourdieu borrows the term "capital" from the language of economics (Bourdieu, 1991: 14-15). Bourdieu (1986) speaks of three forms of capital: cultural capital (e.g. goods such as pictures, books, etc., education and knowledge), economic capital (e.g. material and financial assets) and social capital (e.g. social relations). He also speaks of symbolic capital which is the form that the various species of capital assume when they are perceived and recognized as legitimate (Bourdieu, 1989: 17). Moreover, those forms of capital can be converted between each other (Bourdieu, 1991: 14). To give an example from the healthcare interpreters, with the acquirement of academic training in translation and interpreting, more specifically, in healthcare interpreting, an agent can more easily find a job in healthcare institutions. Thus s/he can convert her/his cultural capital into economic capital.

#### 2.3.2.1. Economic Capital

According to Bourdieu, economic capital (e.g. money) is "at the root of all other types of capital," or to put it another way, the different types of capital can all be derived from *economic capital* (Bourdieu, 1986: 53).

Liang (2010, 79) indicates that agents need economic capital with the aim of obtaining cultural capital, which is often time-consuming. Furthermore, economic capital is a necessity for cultural capital and symbolic capital. Therefore, economic capital underpins all the other forms of capital (Liang, 2010: 79).

In my case, in healthcare interpreting, the aspiration to acquire economic capital is also an important factor determining the role of the interpreters in healthcare settings. My study has clearly shown that agents in the field of healthcare interpreting hold the desire for economic capital to live on. In a similar manner, the desire of healthcare interpreters, healthcare providers as well as hospital executives to earn more money, i.e., to acquire *economic capital,* may even affect the interpreters' role during the interaction. In the following chapter, I will discuss how the role of the interpreters is affected by the aim of obtaining or even increasing their economic capital.

### 2.3.2.2. Cultural Capital

According to Bourdieu (1986: 47), cultural capital can manifest itself in three forms: in the *embodied* state, in the *objectified* state, and in the *institutionalized* state. In the form of *embodied* state, it exists in the form of long-lasting dispositions of the agents' minds and bodies within a habitus (Bourdieu, 1986: 47). This type of capital is incorporated in the agent's habitus, and it is acquired to a great extent through primary pedagogy, i.e. in early childhood (Siisiäinen, 2000). Comparing two types of capital, economic capital and cultural capital in the embodied form, Bourdieu emphasizes that economic capital can be acquired in a short period of time, whereas cultural capital in the *embodied* form cannot. For example, a roulette wheel offers an opportunity to win a lot of money in a short period, therefore, to change the agent's social status (Bourdieu, 1986: 46). However, this does not apply to cultural capital in the *embodied* form as it does to economic capital. Instead, acquisition of *embodied* form of cultural capital requires time for embodiment and incorporation:

> *The accumulation of cultural capital in the embodied state, i.e., in the form of what is called culture, cultivation, Bildung, presupposes a process of embodiment, incorporation, which, insofar as it implies a labor of inculcation and assimilation, costs time, time which must be invested personally by the investor.*
>
> (Bourdieu, 1986: 48)

The embodied form of cultural capital, thus, can be acquired through time unconsciously according to a given society, social class or period. Furthermore, this embodied capital, which can be turned into an agent's habitus, cannot be transmitted spontaneously to other agents by gift or bequest, exchange or talent (Bourdieu,1986: 48).

Cultural capital in the *objectified* form, on the other hand, might be seen as a kind of "raw material" (Moore, 2008: 106), referring to material products such as writings, paintings, instruments, etc. (Bourdieu, 1986: 50). These cultural material products can also be converted into economic capital. Indeed, these cultural products can be attained both materially, which presupposes economic capital, and symbolically, which presupposes cultural capital (ibid).

As for the *institutionalized* form of cultural capital, Bourdieu asserts that academic qualifications such as examinations, certificates or diplomas (Siisiäinen, 2000)

confer on the agents a conventional, constant and legally guaranteed value with respect to culture (Bourdieu, 1986:50). According to Bourdieu (1986:51), "it makes it possible to establish conversion rates between cultural capital and economic capital by guaranteeing the monetary value of a given academic capital." In this sense, it would not be wrong to suggest that the more academic or institutional qualifications an agent holds, the more economic capital can be obtained by the agent. Accordingly, in my case, in healthcare interpreting, it could be argued that the higher the academic degree an interpreter has in interpreting studies, the more possibilities s/he has to get a job in healthcare institutions. However, Bourdieu also claims that symbolic values enabled by academic qualifications depend on their scarcity (ibid). If the academic qualifications which the agent holds are prevalent, the agent may have less symbolic profit than was assumed (Bourdieu, 1986: 51; Liang, 2010:78). In the case of healthcare interpreting, for instance, Aguilar-Solano (2012) describes the academic qualifications or training of the interpreters in public service interpreting and the amount of economic capital in the field of public service interpreting:

> *In the case of public service interpreting in some countries such as Spain, the limited opportunities for acquiring a high degree of qualification and training in public service interpreting specifically have a direct impact on the amount of economic capital available in the field, since there is a lack of cultural capital in its institutionalised form, i.e. professional qualifications in public service interpreting, which is essential in most social fields.* (Augilar-Solano, 2012: 31-32)

The possible implications of a similar case cited by Aguilar- Solano, i.e. lack of academic training opportunities in Turkey in healthcare interpreting, will also be dealt with in detail in a later chapter.

Language skills, on the other hand, are viewed not only as a competence, but also as capital which enables the agent to have domination over other agents in the field and to control their capitals (Bourdieu, 1992: 58; Aguilar Solano, 2012: 32). Inghilleri (2003) also emphasizes the concepts of the linguistic and cultural capital of interpreters which could be acquired and differenly employed in different contexts. However, Bourdieu (1992) differentiates linguistic capital from cultural capital by including linguistic capital as a sub-type of cultural capital:

> *The laws of transmission of linguistic capital are a particular case of the laws of the legitimate transmission of cultural capital between the generations, and it may therefore be posited that the linguistic competence increased by academic criteria depends, like the other dimensions of cultural capital, on the level of education (measured in terms of qualifications obtained) and on the social trajectory.* (Bourdieu, 1992: 61)

Linguistic capital as a sub-type of cultural capital plays a crucial role, especially in interpreting studies, since most interpreters acquire a job thanks to their language skills. In the current study, healthcare interpreters, whether they are trained, professional interpreters or not, possess language skills which enable them to obtain jobs in hospitals.

#### 2.3.2.3. Social Capital

Bourdieu describes *social capital* as "the sum of resources, actual or virtual, that accrue to an individual or a group by possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition" (Bourdieu & Wacquant, 1992: 119). Bourdieu further indicates that the acquaintance and recognition might also be attained through the membership of a group. This, in turn, provides the agents "credentials" which entitle them to credit (Bourdieu, 1986: 51). For example, voluntary associations, trade unions, political parties, etc., are modern examples where an agent can possess social capital (Siisiäinen, 2000).

Social capital, according to Bourdieu, does not only depend on the social capital possessed by the agent, but also on the size of the social capital possessed by other agents in the network:

> *The volume of the social capital possessed by a given agent thus depends on the size of the network of connections he can effectively mobilize and on the volume of the capital (economic, cultural or symbolic) possessed in his own right by each of those to whom he is connected.* (Bourdieu, 1986:51)

Unlike cultural capital in *objectified* form or economic capital, social capital is not a natural or social given. Rather, it takes time to accumulate and requires a continuous effort at institutions (Bourdieu, 1986: 52). Furthermore, Bourdieu (1986: 52) also points out that the introduction of a new member into a family, a club, etc., might put its fines, boundaries, identity, etc., in danger, which also might be a reason why it is time-consuming.

For example, "The Conference Interpreters Association of Turkey" which was founded in 1969 in Istanbul, is the only prestigious association for conference interpreters in Turkey. Therefore, being a member of such a prestigious association enables the interpreter to acquire both economic capital and symbolic capital through relationships with experienced conference interpreters and more job opportunities. However, as Bourdieu (1986) states, contacting and constituting connections with such prestigious groups, takes time and effort. Membership conditions of the above-mentioned prestigious association verify Bourdieu's argument[14].

Without membership of this association, it is also harder to get a job as an interpreter compared to a translator, since a translator could acquire a text online to translate. Even though it is possible for a translator to manifest his/her skills in translation through a sample text, this is not the case for acquiring jobs in the field of interpreting. An interpreter's chance of acquiring a job, in contrast to translators, depends highly on the references they have acquired from other agents, institutions, and interpreters which constitute the interpreting network within the translation and interpreting market. In other words, it means that an interpreter needs to have social capital to some extent, which may enable an interpreter to start a career as an interpreter and enhance his/her social capital within the translation and interpreting market.

#### 2.3.2.4. Symbolic Capital

According to Bourdieu, symbolic capital is "nothing other than capital, in whatever form, when perceived by an agent endowed with categories of perception arising from the internalization (embodiment) of the structure of the distribution, i.e. when it is known and recognized as self-evident" (Bourdieu 1985, 204 in Siisiäinen, 2000). Bourdieu also asserts that symbolic capital is the form by which the various kinds of capital, namely, economic, cultural and social capital, are perceived and recognized as legitimate (Bourdieu, 1985:17). Moreover, symbolic capital exists only in the "eyes of the other," while economic and cultural capital have their own modes of existence such as money, certificates or diplomas (Siisiäinen, 2000). It means that symbolic capital cannot be either incorporated into habitus, not institutionalized and objectified, unlike

[14] See www.tktd.org/uyelik

economic and cultural capital. Likewise, Gouanvic notes that symbolic capital cannot be acquired by heritage. Rather, it can be obtained by recognition (Gouanvic, 2005:161). Thus, it is this recognition possessed by the agent which leads to the imposition of a recognition on other agents' minds, views, etc. (Bourdieu, 1985:23).

Therefore, this type of capital is important for healthcare interpreters. Healthcare interpreters in this network might get symbolic capital through work experience, competence in both languages and in the healthcare area as well as in medical terminology. From the same perspective, Valero Garces explains:

> *[...] We can find a professional Tr/In whose symbolic capital is formed by professional experience, traditional knowledge of the cultures (history, customs, etc), personal observations, knowledge of the history of conference interpreting, and knowledge of interpreting training curricula with particular reference to "classical standards of quality". However, we can also find a Tr/In whose symbolic capital is formed by practice in specific settings (e.g healthcare setting accompanying relatives), without any sort of academic training in T&I, but with a deep linguistic and cultural knowledge of the client's language and culture he serves and interacts with, and who belongs to the same minority ethnic group.* (Valero-Garces, 2012:20-21)

Therefore, it could be argued that even healthcare interpreters with no formal, academic training in healthcare interpreting settings, might acquire symbolic capital through their language skills and work experience.

Healthcare interpreters with symbolic capital might, therefore, sometimes determine their own interpreting strategies independently from healthcare providers, since the interpreters are in most cases the only agent who can understand both languages and enable communication. However, in other cases, healthcare providers and hospital executives have the final say when the hierarchy in the hospital is taken into consideration. (See Chapter 3).

## 2.4. BOURDIEU'S CONCEPTS IN INTERPRETING STUDIES

For a long time, the main focus of interpreting studies has been the cognitive, psycholinguistic and neurolinguistic factors in simultaneous conference interpreting (Grbc, 2014: 285). Even though there is little research on the sociological aspects of interpreting studies, there are a number of scholars who have recognized the significance

of both social context and the individual influence of the agents in interpreting situations (ibid). There are a variety of researchers who have applied Bourdieu's concepts "field", "habitus", "capital" and "illusio" within translation studies (e.g. Simeoni, 1998; Hermans 1999; Gouanvic, 2005) and interpreting studies (e.g. Inghilleri, 2003, 2005a, 2005b; Angelelli, 2004; Valero-Garces, 2010; Eraslan, 2011, Aguilar-Solano, 2012) both around the world and in Turkey.

In the current literature review, the shift in the interpreter's role from the "conduit", "invisible" role towards a more "interactive", "co-participant" role has been emphasized. However, the questions *"why do the interpreters make these choices?"* and *"what triggers their participation?"* should be also investigated (Angellelli, 2004).

Asserting that the interpreter's role is constrained by the institution and the society where the interaction takes place, Angellelli (2004) speaks of three levels at which the interpreter's agent is present: interpersonal, institutional and societal. She further claims that the interpreter's role in an interpreted communicated event (ICE) could be understood through three main bodies of knowledge, which are 1) social theory; 2) sociological theory; and 3) linguistic anthropology (Angellelli, 2004: 26).

According to Angellelli (2004), the lens of social theory helps us understand an interpreted communicated event (ICE) in a broader sense, and it also enables us to evaluate the participants within an institution and society.

> *According to Bourdieu's theory of practice, each ICE is shaped not only by its participants but also by the past, present, and future dispositions that each participant brings to the encounter (e.g. doctors examining patients; patients seeking assistance; interpreters offering linguistic and cultural competence)*
> (Angellelli, 2004: 27).

Therefore, this sociological theory explains how an interaction is connected to objective structures to which it owes its form, which produce the dispositions *(habitus)* of the interacting agents (ibid).

She asserts that like any agent within a society who works in an institution, the interpreter is no exception, since the interpreter also has a *"habitus"* which affects his/her decisions and behaviors. Therefore, it helps us analyze the interpreter and the

evidence of their interpersonal role in a bigger context, reflecting their tendencies and limitations (Angelelli, 2004: 29).

In a similar vein, Angelelli states that social theory and sociological theory help us recognize how an interpreting event and its participants are socially bound and constrained. Furthermore, these theories, i.e. social theory and sociological theory, also help us analyze the interpreter within an interaction where s/he participates and in turn, the interaction within the bigger picture where it is embedded (Angellelli, 2004:32-3).

Taking Toury's model of norms as the starting point of her study, Inghilleri (2003) examines the micro-macro relationship within the context and culture of interpreting activity by drawing on Bourdieu's concepts "habitus" and "field". Even though her study draws on the particular context of "the interpreted political asylum interview", she notes that the same theoretical methodology could be applied to other interpreting contexts as well. Inghilleri (2003) uses data which was reported in Anker's (1991) study as her starting point for her research on the investigations of interpreting norms at both a theoretical and methodological level. In the study, two types of interpreters, *staff interpreters* who had no formal interpreting training, and *contract interpreters* who were certified with credentials, are compared. Staff interpreters are imposed by judges to interpret literally without any omission or addition. In other words, they are imposed to adopt "conduit norm". However, this approach has led to difficulties in interpreting especially regional terms and to misinterpretations (Inghilleri, 2003: 256-257). Contract interpreters, on the other hand, made deliberate decisions including making omissions or additions, using third person and conversing with their clients before a response was interpreted (Inghilleri, 2003:258). Consequently, Inghilleri asserts that the decision of the interpreters to adopt conduit or advocate roles results from the interpreters' qualifications, experience or the cultural understanding of the applicants. However, the impact of these factors on the interpreters' decision-making process is also related to field, habitus and norms prevailing in the interpreting context itself. Thus, the relationship between the interpreter and the social world play a significant role in designating the decisions, strategies and possible outcomes (Inghilleri, 2003: 259-261).

Valero-Garces (2012) is another researcher who has employed Bourdieu's sociological approach to interpreting studies. Aiming to analyze the quality of

communication of the foreign-born population in Spain, which has increased in the last decades of the 20th century and the beginning of the 21st century, Valero-Garces analyzes three types of data. This data came from questionnaires filled out by professional interpreters regarding their mode of interpreting and their reactions in specific cases; excerpts which have been taken from reports on internships compiled by students at the University of Alcala; and excerpts from real medical encounters in healthcare centres. From Bourdieu's sociological perspective, she concludes that the interpreter constitutes part of a social network which can be seen as far beyond the act of interpreting. In other words, the interpreter always acts within a certain context in a specific field (Valero-Garces, 2012: 32). Therefore, the interpreter's decisions such as additions, omissions, etc. must not be seen as errors. Rather, the interpreter must adhere to the social, personal, institutional, cultural limitations of the moment (Valero-Garces, 2012: 32).

Despite the fact that there are a number of studies which have applied a sociological approach and used Bourdieu's concepts in interpreting studies around the world, there are only a few studies conducted from a sociological perspective in interpreting studies in Turkey.

Even though Diriker (2001) has not employed specifically Bourdieu's concepts, she is the first researcher to have taken a sociological approach in Turkey which deserves to be mentioned. She employs a sociological approach in her doctoral dissertation titled "De-/Re-Contextualising Simultaneous Interpreting: Interpreters In The Ivory Tower?". She aims at analyzing the relationship between the presence and performance of conference interpreters and the socio-cultural and interactional context around them. With this aim, she analyzes the socio-cultural and interactional context of conference interpreters by focusing on a particular conference which was held on "Heidegger and Arendt: Metaphysics and Politics" at the Boğaziçi University in Istanbul on 29-30 May, 2000.

Following her research, Eraslan (2011) conducts a study applying Bourdieu's concept "habitus" in her doctoral dissertation. She analyzes the role of interpreters in consecutive interpreting in the EU context on the basis of Goffman's social interaction model as well as Bourdieu's concept "habitus". She concludes that there is a gap between what the interpreters say they do and what they actually do in real-life situations. This

finding reinforces the view that contradictions might occur between the initial or acquired habitus of interpreters and norms of interpreting in interpreter training and practice.

Based on the abovementioned discussions, the current study employs Bourdieu's concepts "habitus" and "capital" in analyzing the role of healthcare interpreters both at micro and macro levels during and beyond interpretation.

## 2.5. METHODOLOGICAL FRAMEWORK

This section covers the methodological framework of the study. Firstly, I will explain the ethnographic research and case study as the research methods of the current study. Secondly, I will focus on the data collection process, consisting of interviews, participant observation and audio-recordings of authentic healthcare provider-patient encounters.

### 2.5.1. Ethnographic Research as a Qualitative Research Method

One of the most prevalent methods used in Interpreting Studies, ethnography is defined by Hale and Napier (2013: 84) as "the study of a social group or individual or individuals representative of that group, based on direct recording of the behaviour and "voices" of the participants by the researcher over a period of time". Spradley, on the other hand, describes ethnography as "the work of describing a culture" (Spradley, 1979: 3).

The objective of ethnographic research is more likely to be to interpret (sic) what the researcher sees and thus create a local theory from "the ground" ( i.e. the data) up (to the theory) (Hale and Napier, 2013: 85). According to Hammersley (1990:2), the main features of the ethnographic method include studying people's behaviour in an everyday context rather than under conditions which have been created by the researcher (i.e. experiments); data is gathered from a variety of sources, particularly by observation and/or relatively informal conversation. Ethnographic research is, therefore, labour-intensive and requires time, energy and resources (Hale and Napier, 2013: 85).

Claiming that ethnographic methods are based on watching and asking, Hale and Napier (2013: 87-88) include some methods that can be utilized as part of ethnographic studies, such as participant (immersed) or non-participant (distance) observation; formal or informal reflective/prospective in-depth audio or video-recorded interviews; focus group discussions; the keeping of diaries or field notes taken during observations or experiences. Dickinson also explains from the same perspective:

> *Ethnographic methods include observation of workplace interactions, collecting documentary evidence, and interviews with practitioners. Both audio- and video-recording can be used, in conjunction with observation, in order to capture the finer details of the interaction.* (Dickinson, 2010: 92)

Some of the studies that have employed ethnographic research methods include Angelelli (2004), in medical interpreting settings, Berg-Seligson (1990), in courtroom interpreting settings and Dickinson (2010), in sign language interpreting settings, to name just a few.

Angelelli (2004) explored the role of interpreters in a public Northern California Hospital called "California Hope", a pseudonym utilised by the author in order to maintain the anonymity of the institution. She monitored ten interpreters and collected data from 392 ICEs during a period of twenty-two months, by employing ethnographic research methods, namely observation, audio-recordings of face-to-face and over-the-speakerphone interpreted sessions, semi-structured interviews with interpreters and managers, artifacts as well as an interpreter interpersonal role inventory (IPRI) survey. She asserts that it was the first ethnographic study in bilingual medical settings (Angelelli, 2004: 4)

Berg-Seligson is another researcher who utilized ethnographic research in her work titled "The Bilingual Courtroom: The Court Interpreters In The Judicial Process" (1990). She collected data over a seven-month period in courtrooms in the United States and studied the work of Spanish-English interpreters. Her research consists of the triangulation of data; observation, audio-recordings of 114 hours of courtroom interpreting and interviews with interpreters and attorneys (Hale and Napier, 2013:93). It is also a sociolinguistic study which takes into account the sociological factors affecting how language is used (and interpreted) in courtrooms (Hale and Napier, 2013).

By using a linguistic ethnographic approach in her PhD thesis called "Interpreting in a Community of Practice A Sociolinguistic Study of the Signed Language Interpreter's Role in Workplace Discourse", Jules Dickinson (2010) sets out to explore the role of sign language interpreters (SLI) in the workplace, which is a setting that presents challenges in the issues of role, boundaries and interaction with deaf and hearing employees. Her main objective in the thesis was to determine how primary participants understand the role of the SLI, and how this influences the dynamics of everyday interaction. However, as she indicates, special attention was given to norms of discourse and shared repertoires within a workplace Community of Practice (CofP). A detailed description of the interpreting process was thus generated from the data collected through the use of questionnaires, practitioner journals, video-recorded interpreted interactions which were gathered in workplace settings and video playback interviews.

Another important point which should be underlined is the issue of the generalizability of findings in ethnographic research methods. Hale and Napier (2013:91) imply that ethnographers cannot make claims regarding the generalizability of the findings, since the findings focus on one specific group or individual. It is the duty of the researcher to interpret the data and help others compare this with their own findings in order to decide to what extent their findings might be applied to other groups or contexts. And Hale and Napier (2013) further exemplifies:

> *For example, the findings from a study of how interpreters perceive their role in Country A may not be necessarily apply to other interpreters' perceptions in Country B. For this reason, it is very important that as much detail as possible about the context is provided in the ethnographic account, so that others have a basis for comparison.* (Hale and Napier, 2013:91)

In the light of this fact, it is important to note that the findings obtained in the current study do not infer that interpreting procedures and interpreters' decisions are all the same or similar in all private hospitals in Turkey, even though various data sources have been used in the present study. Thus, the aim is not to generalize, rather to gain an in-depth understanding of the daily practice of a specific group in accordance with ethnographic research principles.

As can be seen in the abovementioned studies, ethnographic research is commonly applied in Interpreting Studies as a research methodology. Thus, this study can also be evaluated under the title of ethnographic studies and as a case study as well. It should also be noted that case studies can be used as an ethnographic research method. However, not all case studies are necessarily defined under ethnographic research.

### 2.5.2. Why Case Study?

This study can also be conceived as a case study adopting fieldwork strategy as it focuses on a specific case and analyzes the *field* in which the case is embedded. In the book "Introducing Interpreting Studies" (2004), Franz Pöchhacker explains *fieldwork* as "collecting data on people or occurrences in their real-life context, often conceptualised as studying a unique "case" (case study) (Pöchhacker, 2004:63). A case study, on the other hand, can be defined as "an exploration of a 'bounded system' or a case (or multiple cases) over time, through detailed, in-depth data collection involving multiple sources of information rich in context" (Creswell, 1998: 61).

Case studies have commonly been applied in Interpreting Studies in a range of settings such as sign language interpreting settings (Roy, 2000), courtroom interpreting settings (Jacobsen, 2008) and medical, mental health and legal settings (Wadensjö, 1998).

The study of Roy (2000) "Interpreting As a Discourse Process" is based on a case study of an American Sign Language interpreter who mediates a meeting between a deaf graduate student who uses American Sign Language and a university professor who speaks American English. In her work, Roy (2000) examines how an interpreter manages the discourse process between two participants who do not share the same language. Furthermore, she indicates three objectives of her work: to offer a definition of interpreted events in general, based on a discourse framework; to describe, analyze, and interpret the turn-taking exchanges in one interpreted event; and to discuss, from analysis of one role performance, an interpreter's role as it is performed in interaction with others (Roy, 2000: 3-4).

Wadensjö's work (1998) also presents an example of a case study carried out in legal, medical and social service settings. As for the content of the book, she explains:

> *This book is about interpreter-mediated conversation as a mode of communication, about interpreters and their responsibilities, about what they do, what they think they should do and what others expect them to do in face-to-face, institutional encounters.* (Wadensjö, 1998: 2)

With this aim, she conducts a detailed discourse analysis of Swedish interpreters, using audio-recordings of institutional, interpreter-mediated encounters as the main method i.e. primary data. Interviews, participant observation, fieldnotes and written sources obtained by interpreters, institutions and others form the basis of the complementary background information, i.e. secondary data.

Jacobsen applies a case study in her PhD thesis (2002) titled " Pragmatic Meaning in Court Interpreting: An Empirical Study Of Additions In Consecutively Interpreted Question-Answer Dialogues". The thesis analyses consecutively interpreted question-answer dialogues in a courtroom setting, an activity commonly referred to as court interpreting.

The case in this study, on the other hand, can be characterised as interpreting in Turkish healthcare settings, i.e. in hospitals. In order to analyse the case under this study, a variety of methods has been employed through triangulation of data including *interviews* with healthcare interpreters and patients; *participant observation*; and *audio-recordings* of healthcare provider- patient encounters, which will be explained in detail in this chapter. Triangulation of data was conducted through the comparison and contrast of the above-mentioned data in the specific setting under study in order to seek similarities and differences, if any, between what interpreters claim to do and what they actually do in practice. The analysis is expected to contribute significantly to forming the 'big picture' in this specific setting, and relating the findings to the broader issues of ethics and role.

### 2.5.3. Data Collection Methods

Pöchhacker (2004:64) indicates that the basic data collection methods could be summarised as "*watch*", "*ask*" and "*record*" in research on interpreting. More

specifically, these labels could correspond to participant observation, semi-structured interviews and documentary materials such as audio-recordings of authentic healthcare provider-patient encounters. According to Pöchhacker, multiple sources of data, i.e.,"*triangulation*" - collecting data from more than one source- are particularly valuable in qualitative research in Interpreting Studies (Pöchhacker, 2004: 64). Thus, preference was given to triangulation of data in the current study in order to provide both a broader view and a deeper understanding of the role of the interpreter in Turkish healthcare settings.

#### 2.5.3.1. Interviews

During the data collection process, I interviewed fourteen interpreters who work in private hospitals in Istanbul, Izmir and Aydın in Turkey as well as five patients who have been operated on in private hospitals in Izmir and Aydın in order to include the patients' perspectives on the interpretation services they have acquired in Turkey.

Hale and Napier (2013: 90) emphasize the importance of including a set of criteria for choosing the participants, the interviewees in this study, which represent the different features of the group.

> *For example, in an interpreting context, if you decide to use three participants, you may select one interpreter who has completed a formal interpreter education programme, one interpreter who is self-taught and has never had any training and an interpreting student. Or you may select participants as representatives of different stakeholders, for example, an interpreter, a minority language client and an interpreting agency.* (Hale and Napier, 2013: 90).

With this aim in mind, I tried to include speakers of different languages and native interpreters to have a broader overview of the field, while selecting the interpreters to conduct interviews. Therefore, I included not only the interpreters working in English but also those working in French, Spanish, Arabic, Greek, Italian, German and Kurdish. The language variety will shed light on different aspects related to different languages in the interpreters' decision-making process. Apart from native or bilingual interpreters who speak two languages at the level of their mother tongue, some of the interpreters have two or three working languages. Even though I included interpreters with different languages, these languages could be studied separately.

In accessing the interpreters, both personal and professional contacts have been used. My personal contacts enabled me to access to other interpreters working in private hospitals. I also accessed to healthcare interpreters online. However, it was challenging since some interpreters refused to give an interview. Thefore, some of them even did not give an answer.

All interviews with interpreters were conducted face-to-face in Istanbul, Izmir and Aydın, except one interview which was conducted via Skype, with an interpreter based in Izmir.[15]

All healthcare interpreters were sent a consent form via e-mail, in order to inform them of the objective and the scope of the study.

Semi-structured interviews were conducted with healthcare interpreters. In other words, open-ended questions were addressed, so that they could express their opinions and experience freely. Thirty-one questions were asked, which led to a lot of discussion during the interviews with the interpreters. The four titles under which the questions were asked were "General Qualifications of Interpreters", "Interpreter's Role", "Terminology" and "Ethics". All interviews were audio-recorded and have been fully transcribed. The interviews lasted between 12 minutes and 43 minutes. However, finding enough time for an interview with interpreters was problematic, since interpreters work intensively. Four interpreters spared time for an interview outside of their workplace. The interviews with the rest of the interpreters were conducted in the hospitals; therefore, interviews were interrupted from time to time.

Apart from the interpreters' perspectives, semi- structured interviews were conducted with the patients in order to analyze user satisfaction and their perspective on the role of interpreters in Turkey. Interviews with patients were carried out in the hospitals where observation and audio-recordings had been obtained. In order to gain an understanding of the user perspective, three open-ended questions were posed to the patients:

1. Have you ever used interpretation service in Turkey before?
2. Are interpretation services necessary for smooth communication during patient-doctor encounters?

[15] Interviews will be published on http://kisi.deu.edu.tr/olcay.sener/

3. Have you encountered any difficulties, such as in understanding the renderings of the interpreter or the explanations of a doctor during the encounter?

Through the answers of the patients who have received treatment in Turkey, I intended to gain insight into the user perspective on healthcare interpreting in Turkey.

The interviews conducted with five patients were also recorded and fully transcribed. However, the duration of interviews with the patients lasted only one or two minutes, in comparison to the healthcare interpreters' interviews.

As Hale and Napier (2013) suggest, different participants' perspectives were included in order to have a broader overview. Thus, not only the interpreters', but also the patients' perspectives have been included in the study.

#### 2.5.3.2. Participant Observation

Participant observation is also a common method in ethnographic research where the researcher observes the behaviour(s) of a certain group or individual and takes notes (Hale, 2007: 231). Therefore, participant observation is the second method employed in the current study to collect data. According to Silverman (2001: 14), the aim of observation is to gather information from firsthand sources about social processes in a "naturally occurring "context like any observational study. By the same token, Spradley (1979: 32) asserts that in ethnographic research participant observation could be applied as a strategy both for listening to people and for watching them in natural settings. Therefore, the aim of using a participant observation method in this study was to observe the whole interpretation process of interpreters in their working environment. In other words, the objective was to observe what the interpreters actually do, contrary to what they say they do.

After approval by hospital executives, I began to collect data through participant observation in summer 2016. With an interpreter who interpreted for the patient in two different private hospitals, I observed a total of four interpreters in five different private hospitals. Thus, I had the chance to participate in the interpreter-mediated encounters and to observe the overall interpretation process. During the observation process, I also took notes to keep track of the encounters on the behaviors of participants, nonverbal

communication and the reactions of the participants. I especially noted what the interpreters do during and besides the interpretation process.

#### 2.5.3.3 Audio-recordings of Interpreter-Mediated Encounters

As stated above, the interpreter-mediated interactions between healthcare providers and patients were audio-recorded. Consent was requested from the hospital executives as well as patients and healthcare providers. Upon obtaining consent, I could obtain a total of 27 audio-recordings by five interpreters working in the above-mentioned private hospitals in Izmir, Aydın and Istanbul, during the summer of 2016. Four interpreters out of five interpreters are the ones whose actual performances I could observe. In addition to the audio-recordings of these four interpreters' interpretations, I could also obtain audio-recording of an interpreter without observing his performance during the interactions. Therefore, I could obtain a total of five interpreters' audio-recordings.

The language combinations in the encounters between healthcare providers and patients were English-Turkish and German-Turkish. The English and German encounters were audio-recorded. Parts of the German-Turkish encounters have been translated into English by the author.

As a consequence, data obtained from participant observations and interviews will be backed by a detailed analysis of these recordings, providing an overall perspective of the field, which paints a rich description of the role and the profession in Turkey.

##### 2.5.3.3.1. The Author's Presence as a Researcher during the Encounters and the Issue of Confidentiality

It is significant to note that the presence of the researcher during the interactions and the use of an audio-recording device might have an impact on the interactions taking place (Aguilar-Solano, 2012: 82). In this respect, it is pivotal to stay as passive as possible during the interactions. Therefore, I attempted to minimize my intervention during the interactions between healthcare providers and patients.

One of the main challenges in conducting research in interpreting studies is to obtain recordings of authentic encounters. This could be the reason why there are a few studies based on real-life data in interpreting studies in Turkey. In this study it was extremely difficult to get a chance to be present during healthcare provider and patient encounters and to observe the whole interpretation process. It was also difficult to record these encounters because of patients' confidentiality. In the beginning, a lot of private hospitals rejected my request to conduct a study, even though I clearly indicated that none of the interpreters', patients' and hospitals' names as well as conversations between healthcare providers and patients will be published explicitly. However, in the end I could get permission to observe and record the encounters, provided that all interpreters', patients' and hospitals' names were not written explicitly. Therefore, all interpreter names, as well as hospital and patient names, are used as anonymous names, such as "Interpreter A" for confidentiality reasons. Moreover, only some parts of the conversations which are related to the main discussion of this study will be explained in the analysis chapter explicitly (Chapter 3). The rest of the conversations between healthcare providers and patients will not be published explicitly, in order to respect the patients' and hospitals' confidentiality.

Before attending the encounters, medical doctors were informed about the purpose of the study and the presence of the researcher. Therefore, my presence during the encounters did not raise any problems for medical doctors, interpreters or patients. On the contrary, most patients tried to contribute to my study to some extent by expressing their opinions freely. Even though my presence during the encounters does not seem to have affected the interpreters' performance, it should be noted that observer's paradox might occur.

To sum up, consent forms which include the objective of the study were submitted to healthcare interpreters before the interviews. Consent was also requested and obtained by hospital executives for observing and audio-recording the encounters.

## 2.6. SUMMARY

Chapter Two consists of a literature review in healthcare interpreting studies, the theoretical framework and the methodology of the thesis. This chapter starts with the literature review of the studies conducted in healthcare interpreting. Since the current study focuses on the role of interpreters in the healthcare setting, the literature review has been restricted to the studies conducted on the role of healthcare interpreters. My research has shown that there is a shift from a "conduit", "non-participant", "invisible" role towards an "active", "participatory", "visible" role. However, the current study does not discuss whether the healthcare interpreters are active or not, rather, what are their roles in relation to ethics at the macro level.

This chapter has also used Bourdieu's central concepts "capital" and "habitus" as well as a detailed analysis of the forms and types of capital. Strategies and decisions taken by interpreters during interpretation will be analyzed in light of the interpreters' habitus and capital. Therefore, these concepts are pivotal in the current study in the analysis part. In addition to the detailed explanation of Bourdieu's concepts, selected scholarly studies which have drawn on Bourdieu's concepts in interpreting studies, have also been scrutinized.

Following the theoretical framework, the methodology applied in the study has been focused on. Attention was first given to an insight into the description and examples of ethnographic studies and case studies. Afterwards, I provided information about the data collection methods which are comprised of triangulation of data i.e. interviews with healthcare interpreters and patients, observation and audio-recordings taken in real-life situations.

In the next chapter, also applying Bourdieu's concepts of habitus and capital discussed in this chapter, I will analyze the role of interpreters in relation to ethics as a broader issue at a macro level in the light of strategies and decisions taken by interpreters during interactions.

# CHAPTER THREE

# ROLE FROM THE INTERPRETERS' PERSPECTIVE AND INTERPRETER-MEDIATED INTERACTIONS

The present chapter is comprised of two main discussion parts. The first part deals with the interpreters' role from the interpreters' perspective gathered through interviews with interpreters and patients. Data obtained from interviews will be analysed in sections considered relevant to the objectives of the study. It begins with general descriptions of settings and participants in the study and ends with a discussion of the findings obtained by the interviews. The second part, on the other hand, includes the data obtained from participant observation and audio-recordings taken from interpreter-mediated interactions. The findings will be analysed in terms of Bourdieu's concepts habitus and capital at the end of the part.

## 3.1. HEALTH TOURISM OR TOURIST HEALTH IN TURKEY?

Turkey is one of most popular destinations for tourists for health issues, since treatment prices are much lower when compared to other European or Arab countries. Therefore, many tourists prefer to come to Turkey for a variety of operations such as plastic surgery, hair transplantation, etc. In the light of this fact, at the outset, the objective of this research was to analyse the role of interpreters who work for the tourists/patients coming to Turkey within the scope of health tourism. For this reason, I first attempted to conduct interviews with healthcare interpreters working in private hospitals which provide such operations for tourists. However, data obtained from my initial interviews with healthcare interpreters has revealed that these interpreters do not provide interpretation services only for tourists coming for health issues. The preliminary findings suggest that interpretation services are provided for three types of "foreigners" in Turkey: a) foreigners who come to Turkey specifically for health issues, b) foreigners who live in Turkey but who do not speak Turkish well, and c) foreigners who come to Turkey for a vacation and who need interpretation service in hospitals in emergency cases. In addition, I have found out that there are two different concepts used

in healthcare settings in Turkey, namely, "health tourism" and "tourist health", which need to be differentiated. While health tourism refers to travelling to another country for health reasons, tourist health refers to medical treatments provided to patients in the cases of emergency during their stay in Turkey. As for the interpretation services they provide, while large-scale private hospitals provide interpretation services for all three types of patients mentioned above, it has been observed that small-scale hospitals provide interpretation services only for patients in emergency situations. In this study, interviews have been conducted with interpreters working in both large-scale and small-scale hospitals and who interpret for all three kinds of tourists/patients mentioned above. Observations and audio-recordings have also been obtained at small-scale and large-scale hospitals.

## 3.2. SETTING: PRIVATE HOSPITALS IN TURKEY

This study specifically focuses on interpreters working in private hospitals in Turkey. In this respect, research has been carried out to elicit data regarding the role of interpreters by including both types of hospitals mentioned above. In this study, interviews have been conducted with interpreters working in both large-scale and small-scale hospitals, whereas observation and audio-recordings have been obtained in three small-scale hospitals which provide interpretation services only in emergency cases for foreign patients, and were also conducted in one large-scale hospital.

In total, ten different private hospitals where interpreters provide services have been included in the study. Five hospitals out of these ten hospitals could be categorised as "large-scale" hospitals in which all kinds of treatments are provided for patients. Two of them are located in Istanbul, two hospitals are located in Izmir, while the remaining one is located in Aydın. Approximately 36 interpreters work in the two hospitals in Istanbul, and offer interpretation services in a number of languages including German, English, Russian, Arabic, Romanian; while another two large-scale hospitals in Izmir have only two interpreters working in English and French, and the other hospital in Aydın has three interpreters, working in English and French as well. This is despite the

fact that these hospitals in Aydın and Izmir also provide operation options for patients which include foreign patients.

Aside from these hospitals, one private hospital included in the study specifically provides services for hair transplantation and encompasses a large patient cohort from all over the world. Thus, it employs ten staff interpreters working in nine languages which are English, Italian, Spanish, French, Swedish, Russian, Norwegian, German and Romanian.

The other four hospitals which could be described as small-scale hospitals do not provide such surgeries. They only provide health services both for foreign and local patients. However, they also have a high inpatient bed capacity (approximately 92 beds) and also offer other types of operations (such as EKG, X-ray, MR, emergency maintenance, intensive care unit, neonatal intensive care unit) both for foreign and local patients.

They also employ between three and seven staff interpreters who work in different language pairs.

## 3.3. PARTICIPANTS

The current study includes fourteen healthcare interpreters and five patients. In order to gain a deeper understanding of the role of the interpreters and interpretation services, participants in this study will be dealt with in detail, in sub-sections.

### 3.3.1. Interpreters

Undoubtedly, the interpreters' role in the interactions in healthcare settings is crucial in communication. Therefore, their background information will also shed light on the analysis of their role. First, brief information will be provided on their background, before analysing them in sections in detail.

As explained in the previous chapter, I restricted this study only to the interpreters working in private hospitals. All fourteen interpreters involved in the study work as full-time staff interpreters. More importantly, three of them (Interpreter D, Interpreter K and Interpreter N) were the interpreters whose actual performance during

interpretation has been analysed in the present study. In addition to this, all except one of the interpreters (Interpreter I) are male. Other information will be dealt with under the titles 'Language Pairs', 'Education" and 'Experience'.

#### 3.3.1.1. Language Pairs

Interpreters work in different language pairs. Among the interpreters I interviewed, a total of nine interpreters work in a single language pair. It means that seven of them (Interpreter A, B, C, E, K and N) have the language combination of English and Turkish, while one interpreter (Interpreter G) works in Arabic-Turkish and one interpreter (Interpreter D) has the language combination of German and Turkish.

Additionally, three interpreters are capable of speaking more than one language, namely two interpreters interpret between German, English and Turkish, while one interpreter interprets between English, French and Turkish.

Except for the interpreters working in a couple of language pairs, native interpreters i.e., interpreters who have two mother languages, have been also included in the study. One interpreter (Interpreter F) has Kurdish and Turkish as his mother languages and works between Kurdish, Turkish and English. One interpreter (Interpreter H), on the other hand, has Italian and Turkish as his mother languages. Consequently, he works between Italian, Turkish, Spanish and English.

Perspectives of interpreters who work in different languages will also contribute to understanding the interpreters' role.

#### 3.3.1.2. Education

Among fourteen interpreters, only five interpreters (Interpreter F, Interpreter I, Interpreter J, Interpreter L, and Interpreter M) hold a BA degree in the field of translation and interpreting. Two of them (Interpreters F and J) gained their bachelor's degree at the English Translation and Interpreting Department at Istanbul University, while one interpreter (Interpreter M) studied at the German Translation and Interpreting Department at the same university in Istanbul. Apart from these interpreters, one interpreter (Interpreter L) graduated from the German-English and Turkish Translation and Interpreting Department at Dokuz Eylul University in Izmir, while the other

interpreter (Interpreter I) graduated from the French Translation and Interpreting Department at Hacettepe University in Ankara.

The remaining nine interpreters (Interpreter A, Interpreter B, Interpreter C, Interpreter D, Interpreter E, Interpreter G, Interpreter H, Interpreter K, and Interpreter N), do not have any educational background in the field of translation and interpreting. Consequently, it can be concluded that five interpreters out of fourteen involved in the study have an academic background and the other nine interpreters lack an academic background in translation and interpreting studies. Other interpreters assert that they either live abroad or graduated with a university degree in a foreign language. Thus, it could be suggested that they might have an inclination to foreign languages, since they either graduated from university with a foreign language or lived and were raised abroad. What Bourdieu defines as the embodied form of cultural capital, might, thus be the reason why the interpreters have started working in the health sector as an interpreter. However, lack of training, especially in translation and interpreting studies, may have negative implications for their work in hospitals as well, affecting their decisions and role during the interpretation process.

#### 3.3.1.3. Work Experience

The interpreters' professional background and experience range from three months to ten years. The most experienced interpreter is the Interpreter B, who has been working in the health sector for ten years.

As for work experience, all interpreters have indicated that they had had some experience in translation or interpreting before working in the health sector. Some interpreters who have an educational background in this field, have explicitly explained their work experiences in detail. For example, Interpreter I worked as a trainee in the parliament. Apart from that, she worked at an exhibition in Izmir where she also interpreted in meetings during the exhibition. Another interpreter (Interpreter L) also worked as an interpreter at the exhibition. Likewise, Interpreter M completed his traineeship in a hospital and also worked in a tourism company.

However, there are also interpreters who lack an educational background in a translation and interpreting department but have had experience in the sector. For

example, Interpreter K studied tourist guiding and worked as a tourist guide before he started working in the hospital. The native interpreter (Interpreter H), in contrast, has asserted that he has been working since he was 14 years old. He has indicated that he has worked both as a tourist guide and also conducted interpretations for companies.

As a consequence, it could be suggested that the work experiences of the interpreters may have had positive implications for their career as a healthcare interpreter. Here they could learn how to cope with the difficulties and problems which they faced, even though they have not had professional education in the interpreting field. On the other hand, it may also have had negative implications for conducting their jobs, leading to violations of ethics, which will be explained in the following parts of this chapter.

### 3.3.2. Patients

Four patients out of five whom I interviewed were working on a ship, except one patient who came from Germany. All of these four patients consulted an ophthalmologist for a variety of reasons.

The first patient was working as marketing manager on the ship and she came to see the doctor because of having a stye in the eye. The second patient was forty-three years old and came to the doctor with complaints of severe headaches and blurriness in the eye. The third patient was working as a cook on board and came to the doctor with a complaint of redness in the eye. The last patient was working on the ship as a lighting technician. He was thirty-eight years old and he applied to an ophthalmologist to have new glasses. Their encounters with the doctor lasted totally thirty-seven minutes. After they completed their consultations with the doctor, they waited for the interpreter to provide their medications in a cafe.

Another patient came from Germany to take a vacation in Turkey. She was forty-nine years old. She had a dental abscess; therefore, she had severe toothache. On the first day she was given serum. On the second day she was transferred to one of the large-scale hospitals in Izmir.

Even though I conducted interviews with five patients, analysis of those interviews have not been included in the study as a sub-section. Interviews with the

patients unveiled that they are satisfied with the interpretation service they held in Turkey. They think that interpreters play a pivotal role in enabling communication. However, interviews with the patients disclosed that they do not question whether the interpreters are partial or not, or, interpret accurately. In other words, they are not well aware of the importance of interpreters' role during the interactions. They only perceive the interpreters as an important mediator in terms of communicating with healthcare providers.

## 3.4. ANALYSIS OF INTERVIEWS WITH THE INTERPRETERS

Interviews were held with a total of fourteen healthcare interpreters in order to gain a deeper understanding regarding the role of interpreters. The interpreters' responses will be discussed under several titles.

### 3.4.1. Role

Unlike developed countries such as Australia, Sweden, Canada or the U.S.A, where community interpreting has become institutionalized as a profession, one cannot talk about such an institutionalization in this field of healthcare interpreting in Turkey. Accordingly, there are no codes of ethics and conduct or standards which define the role of healthcare interpreters in Turkey. Despite its common use in Turkey, very little is currently known regarding the interpreters' role between healthcare providers and patients. Aiming at unravelling the role of healthcare interpreters in Turkey, one of the questions which was posed to the interpreters regarding their role was whether they had other responsibilities and tasks apart from interpreting in the hospital. All the interpreters explained that they were also busy performing other tasks apart from just interpreting, including accompanying the patients in the hospital and conducting their all hospital procedures, etc. Interpreter B talked about their interpreting process with the patients as follows:

> *Our job description includes accompanying the patients from the minute they enter the hospital until the minute they leave because you are the only person with whom the patients can make themselves understood. Therefore, we cannot leave them alone or say "Okay, I am done with interpreting. You can*

*do whatever you want now." Rather, we try to make them comfortable and accompany them to their hotel or plane. (Interpreter B)*

"Bizim görev tanımımızda hastayla ilk temasa geçilip hasta taburcu oluncaya kadar hastayla birlikte, yanında olmak var. Çünkü hastanın tek sorabileceği ve dert yanabileceği kişi sizsiniz. Böyle olunca da hastayı yalnız bırakmak veya "ben işimi bitirdim, çevirisini yaptım. Artık naparsa yapsın" zihniyeti değil; onu rahat ettirip, en doğru şekilde oteline veya transfer edilecekse uçağına kadar eşlik etmek."

Likewise, Interpreter G emphasizes their interpretation load in the hospital during a day:

*We do not leave the patient alone from the minute they enter the hospital. We help them communicate in every department in the hospital- even with the secretary. Even if the patient makes a payment or gets an appointment from another department, we help them communicate. In other words, patients begin their procedures with the interpreter from the minute they enter the hospital and they are with us in whatever department, branch or doctor until they leave the hospital. (Interpreter G).*

"Hasta hastaneye girdiği sürece onu hiçbir şekilde yalnız bırakmıyoruz. Sürekli onunla beraber hangi bölüm olursa- sekreterle dahi diyaloğunu biz sağlıyoruz. Hasta ödeme yapacak olsa ya da şunu yapacak olsa ya da farklı bir bölümden randevu alacak olsa dahi bunu biz gerçekleştiriyoruz. Yani hasta içeri girince tercümanla beraber başlıyor. Çıkana kadar tercümanla beraber nereye gidecekse, hangi bölüm, hangi branş, hangi doktorsa çıkana kadar bizimle beraber gezer."

According to the comments of these interpreters, it could be understood that they not only provide communication between the patients and healthcare providers, but also deal with all of their procedures in the hospital by accompanying them within the hospital as if they were the patient's guide.

Furthermore, some interpreters gave striking examples regarding their responsibilities within the hospital. Apart from their workload in the hospital as explained above, interpreters asserted that they even help the patients physically as well:

*[...] My title was medical interpreter, however, there was a half-sheet job description for us. I also provided nursing care for the patients because it was required. [...] For example, a patient came to the dental clinic even though the dental clinic was closed at that time. A medical doctor was called, however, someone was needed to provide nursing care. Since all the nurses were busy at that time, I was helping to hold the hose since I was there. This was not included in my job description, however, I was doing this*

*as my job requires it. In this way, I was feeling comfortable with a clear conscience in order not to leave the doctor in a difficult situation and also to meet the patient's satisfaction since they are our clients at the same time. (Interpreter L)*

"[...] Ünvanım tıbbi çevirmen ama görev tanımım gerçekten yarım sayfaydı ve ben orada görevim içinde hemşirelik bile yaptım. Gerekiyordu. [...] Diş polikliniği açık değil doktoru çağırmamız gerekiyor. Doktor çağrılıyor ama hemşiresi burada olmadığı için birisinin hemşirelik yapması gerekiyor. O sırada tüm hemşireler dolu olduğu için, ben de ortamda olduğum için hastanın ağzına ben hortumu tutuyordum mesela. Bu aslında görev tanımım içinde değil ama mesleğim gereği ben yapıyordum kendimi vicdanen rahat hissediyordum. Çünkü doktoru zor durumda bırakmamak adına hem de hastaya -sonuçta hasta aynı zamanda bizim müşterimiz- onun da memnuniyeti sağlamak önceliğimiz olduğu için "

According to the statements above, patients' satisfaction is also a determining factor for the interpreter's role. The interpreter also assumes additional responsibilities and tasks in order to help the medical staff and also the patients, even though he is aware that it is not within the scope of his duty. Expectations and needs within the hospital, as well as the aspiration to provide patient satisfaction, play an important role in shaping the role of the interpreter. Thus, the interpreter is expected and assigned more responsibilities than his job description.

In parallel with the remarks above, Interpreter I also details all kinds of work tasks they have, including physical assistance to the patient:

*Our job includes helping the patient wear their overshoes, pushing their chairs, settling them in the chairs and picking them up, taking their arms, holding their bags, putting on their trousers, cleaning up their ultrasound gel in the navel... All kinds of responsibilities... Also accompanying them to the toilets... You are the only person dealing with the patient as if you were a hospital attendant or a nurse. You are the patient's mouth; thus, it is not like you have a choice to say "Stay here" or "Go to that department". It is like dealing with your own procedures.*

*(Interpreter I)*

"Yaptığımız işler ayaklarına galoş giydirmeden tutun, sedyelerini ittirmedir, tekerlekli sandalyelerine oturup kaldırma, koluna girme, yardımcı olma, çantalarını tutma, pantolonunu giydirme, göbeğinin ultrason jelini silme... Her türlü akla gelebilecek her şeyde... Tuvalete kadar eşlik etmeden tut aynı bir refakatçi gibi, hasta bakıcı gibi birebir sensin. Onun ağzı olduğun için

kesinlikle "Siz burada durun" ya da "Siz şuraya gidin" deme lüksü olmuyor. Tamamen sen hareket ediyormuşsun gibi oluyor."

The comments of the interpreters above provide particular insight into the workload they have in the hospital. Related to this example, Interpreter I and Interpreter L implied that their role in these situations is similar to that of a hospital attendant or a nurse. A similar perspective was explicitly stated by Interpreter N, even carrying his role one step further, explaining that they also provide medical assistance for the patients in addition to physical assistance:

*[...] Standing by the patient, helping them in their hospital procedures [...] There are even times when we perform gastric lavage. We even sometimes enter into the surgery room with foreign patients. This is of course caused by the need for an interpretation service, however, it is sometimes necessary to accompany the patient to the X-ray department due to the lack of staff at that time. Since the patient is foreign, we help them settle in the chair and take them out of the department. We encounter such situations; therefore, we have to help them in these situations. (Interpreter N)*

"[...] Hastanın yanında olma, işlemlerinde yardımcı olma...Mide bile yıkadığımız oluyor. Yabancı hastada ameliyathaneye girdiğimiz oluyor. Tabi bunlar genellikle çeviri için ama bazen hani mesela hastayı röntgene indirmek gerekiyor personel olmuyor burada. Yabancı hasta olduğu için yine biz indiriyoruz. Tekerlekli sandalyeye oturtup biz indiriyoruz. Böyle şeyler oluyor illaki yardım etmek durumunda kalıyorsunuz."

As understood by the comment of Interpreter N, they even provide medical services for patients, such as performing "gastric lavage", which might have negative implications for the patient's health. Even though Interpreter I commented that he had studied in the medical department at the university, specifically regarding health management skills, structures of health facilities and financial issues in health facilities, providing medical assistance such as "gastric lavage" is far beyond the interpreter's training and capacity. Likewise, considering the fact that Interpreter I and Interpreter L have a university degree in translation and interpreting, their medical or physical assistance to the patients might do harm to the patients, since they have not acquired medical training in order to be able to provide this kind of assistance.

In a similar vein, Interpreter K, N and J further indicated that they also deal with insurance procedures for the patients, whether they are foreign or local patients, after the patients' treatment is over. The interpreters also carry out insurance procedures for Turkish patients living abroad, even though no interpretation service is needed and provided. Likewise, they sometimes accompany VIP patients such as hotel owners or executives, in their hospital procedures, although no interpretation service is required. Interpreter K summarises the whole interpretation process in detail:

> *[...] We have a multifunctional team. [...] We need to diagnose the illness of patients and send them to the relevant department. After determining which doctor and which department should be visited, we make decisions with the doctors on whether the patient needs further examination or screening, laboratory or a stay in the hospital. To repeat, we do not only provide a interpretation service. We also conduct insurance procedures for the patients after their discharge, informing their affiliated institute, preparing their reports through the information gathered from their doctors as well as coordinating other departments. Carrying out the patients' daily examinations, interpreting during their daily or ongoing medical visits by the doctors, informing them regarding their current health condition, and updating their insurance and lastly, preparing their forms before discharging and also preparing the patients for a discharge, preparing their service scheme and billing are among our responsibilities within the hospital.*
> *At the same time, we also accompany VIP patients- either foreign or local- who work in our contracted hotels in the region and we also deal with the patients' transfer, sometimes, even including me. (Interpreter K)*

> "[...] Ekip olarak çok işlevsel bir yapıya sahibiz. [...] İlk önce bizim bu hastanın nasıl bir rahatsızlığa sahip olduğunu bilip, öğrenip hastayı ona göre sevk etmemiz gerekiyor. Buraya geldikten sonra hangi doktorun, hangi bölümün kendisini görmesi gerektiği ya da yapılan muayenenin ardından ne tür ileri tetkik ve görüntüleme, labaratuvar ya da tedavi amaçlı yatışa alınması gerektiğine de doktorlarla beraber koordineli bir şekilde karar veriliyor. Sadece çeviri değil- tekrar etmek gerekiyorsa- hastanın yatırıldıktan sonra sigortacılık işlemleri, bağlı bulunduğu kurumun haberdar edilmesi, raporunun doktorlardan alınan bilgiler doğrultusunda hazırlanması ve ayrıca hastanenin içindeki diğer bölüm ve departmanların da koordineli şekilde hayata geçirilmesi de bizim görevimiz açıkçası. [...]Buraya gelen hastaların aynı zamanda günlük yapılacak tetkikleri, sabah ve akşam olmak üzere doktorların kendilerini vizite esnasında çevirilerin yapılması, hastaların durumları hakkında bilgilendirilmesi ve aynı zamanda sigortalarının da günlük güncellenmelerinin yapılması. Son olarak da hasta çıkmadan önce formlarının hazır hale getirilip taburculuğa hazırlanması, hizmet dökümlerinin oluşturulması ve son olarak da faturalandırma gibi

departman olarak görevlerimiz söz konusu. Aynı zamanda bölge itibariyle anlaşmalı olduğumuz otellerin makam bünyesinde çalışan makam sahibi insanlara yapılan yardım- yabancı, Türk. Hastaların kimi zaman kendim de dahil olmak üzere transferi."

As seen above, interpreters also welcome and send the patients to related departments as well as preparing forms for discharge, billing and insurance.

As Interpreter K summarises, there is no job restriction for the interpreters. They deal with a variety of responsibilities apart from interpreting, some of which might lead to negative consequences for the patients' health safety.

All interpreters, on the other hand, also mentioned that they also do written translations within hospital. For example, Interpreter L said that he translated some test results, MR results or X-ray results. Interpreter L and N indicated that they also prepare medical reports in addition to translations.

There are also interpreters who have other titles and positions in the hospital. For instance, Interpreter A mentions that he is also a corporate communication executive and Interpreter H works as a marketing manager in the hospital. He explains that he accompanies the patients as well as coordinates who will accompany the patients. Similarly, Interpreter I works in the In-network provider department of the hospital, although she was previously recruited for carrying out interpretations in the hospital. The findings obtained from the interviews with interpreters reveal that interpreters assume various roles involving different tasks at a time, related both to language as well as health issues and procedures.

### 3.4.2. Empathy

Psychological factors, according to the interpreters' answers, play a pivotal role in determining their strategies during interactions in healthcare settings. These should not be underestimated in terms of the patients' psychology. In this regard, Interpreter A especially emphasizes the significance of empathy, suggesting that:

*[...] Training could be provided regarding patient psychology. For instance, getting them to feel as if they have received a treatment abroad, as an exercise in empathy. Because- how can I express- one feels safer in an*

*environment where one's mother language is spoken since s/he can then communicate directly. Training could be provided regarding raising awareness on this topic. (Interpreter A)*

"[...] Hastaların psikolojik durumuyla ilgili bir bilgilendirme eğitimi verilebilir. Örneğin kendilerinin de bir yabancı ülkede tedavi gördüklerini hissetmeleri, empati şeklinde. Çünkü insan- nasıl söyleyebilirim- ana dilinin olduğu yerde daha kendini daha güvende hissedebiliyor. Çünkü direk olarak iletişim kurabiliyorsunuz. Bunun farkındalığıyla ilgili bir empati eğitimi verilebilir."

Sharing a similar approach to empathy, two interpreters, B and C, mention the importance of caring for the patients. To give an example, Interpreter C indicates that he perceives his role as more than a guide:

*I am not only an interpreter here. How can I say- I do not perceive my job merely as a guide, either. I regard myself being at the side of the patient. I do not only attempt to help patients in medical terms, but in a variety of things, because it is of paramount importance in terms of a patient's psychology.*
*(Interpreter C)*

"Şimdi aslında bir çevirmen değilim ben burada. Ben- nasıl söyleyeyim- yani rehber olarak kendimi görmüyorum. Ben hastanın burada sağ kolu olarak görüyorum kendimi. O sadece tıbbi konuda değil, birçok konuda yardım etmeye çalışıyorum. Çünkü hastanın moral motivasyonu açısından bu önemli."

In his answer, this interpreter relates his role as being more than an interpreter or a guide. In this example, the interpreter embraces a "helper" role, which is one of the most controversial issues in interpreting studies.

With regard to the difficulties caused by the setting in which the interpreting process takes place mentioned above, other interpreters also talked about their strategies. They indicated that they adopt some strategies because of the psychological situation of the patients. For example, Interpreter F states that he interprets using different phrases in risky cases such as cancer. In addition to the statements of the two interpreters, B and C, Interpreter F approaches the issue from the interpreters' psychological perspective by indicating that he develops strategies according to his own psychological state in these

kinds of risky cases. Regarding the difficulties of working as a healthcare interpreter, he further explains:

> *Difficulties of the job... First of all, you are affected psychologically a lot. Second, you should not exceed some limits. I mean our communication with patients, our role in providing communication between patient- doctor relationship or sometimes between patient- hospital. This is the limit which should not be exceeded that I talk about. This is very risky. It may do harm both to you and the patient. It is the major problem and disadvantage of being a healthcare interpreter. (Interpreter F)*

> "Zorlukları, ilk olarak psikolojik olarak çok etkileniyorsunuz. İkincisi belli bir sınırı aşmamanız gerekiyor. Yani hastayla olan iletişiminiz, hasta-doktor arasındaki iletişimdeki göreviniz- o sınırı, bazen hasta-hastane arasındaki iletişiminiz- bazen o sınırı aşabiliyorsunuz. Bu çok büyük bir risk. Bu hem size hem hastaya zarar verebilecek bir risk aslında. Temel olarak en büyük sıkıntı bence bu. Dezavantajı da bu."

In the answer above, the interpreter admits that he should act professionally by hiding his feelings towards the patient. However, he underscores the heart-breaking cases that he faces, which also affect his psychology, strategies and, thus, his role, due to the nature of the setting. Interpreter K, in a similar vein, lays emphasis on the psychological perspective of being a healthcare interpreter, which affects his strategies during the interpretation process:

> *[...] My medical director particularly tells me not to interrupt by saying "You are not a medical doctor. Do not interrupt the decisions taken by doctor. Do not add anything from you which will be written." However, I cannot stand this. Because I am very sensitive at this point, I add my own opinions and interrupt by taking responsibility in the communication between the doctor and the patient at that point when it is needed. We need to inform the relatives when a patient's partner passes away, which is unfortunately a distressing situation. It is also our responsibility to share good news when the patient revives, for instance. Of course, we do not encounter such situations so often. However, as we share the joy of carrying the patient from intensive care to a normal room, we unfortunately also share bad news with the relatives of the patient while carrying the dead patient to the morgue. We face such situations, indeed. (Interpreter K)*

> "[...] Medikal direktörüm özellikle rica ediyor. "Sen doktor değilsin. Doktordan aldığın bilgiyi çevir. Doktorun verdiği ya da aldığı kararlara müdahil olma. Yazılacak şeylere ekstra bir mana ya da kendinden bir şey

> katma." Fakat ben buna dayanamıyorum açıkçası. Çünkü benim gerçekten hassas olduğum mevzu şu: O anda müdahil olunması gereken ne varsa ben sorumluluğumu kullanıp genelde doktorla hasta arasındaki iletişime kendi düşüncelerimi katıyorum. Bir hastanın eşinin vefat ettiğinde – bu maalesef üzücü bir durum- bizim paylaşmamız gerekebiliyor. Yine hastanın hayata döndüğü, iyi olduğu güzel durumların da paylaşılması bizim görevimiz. Tabi ki bu durumlara çok sıklıkla karşılaşılmıyor. Ama yoğun bakım ünitesinde olan bir hastanın normal odaya çıkartılırkenki sevinci paylaştığımız gibi yine vefat eden bir hastanın morga taşınması esnasında aileye verilmesi gereken bilgiler de maalesef bizden geçiyor. Bu tür durumlarla da karşılaşabiliyoruz açıkçası."

Interpreter K asserts that especially when the patients are in fear or panic, it is required to show empathy towards the patient. Moreover, he also indicates that even though the hospital requests the interpreter not to intervene in the communication, he clearly states that he takes responsibility and intervenes in the communication, in order to show empathy to the patient.

All the remarks given by the interpreters above explicitly show that interpreters show empathy for the patients, due to the setting in which interpreting takes place. Even though the interpreter asserts that this could violate professionalism and do harm for both parties, he has to take the emotional and psychological perspective into consideration. Thus, the setting in my study healthcare setting, seems to be an important factor in designating the strategies employed. From the Bourdieusian perspective, interpreters' showing empathy to patients could be regarded as the embodied form of interpreters' habitus, which affects role in this specific setting.

### 3.4.3. Ethics

Another question dealt with ethics, which also constitutes the main discussion of the study. One of the objectives of this study is to explore the implications of a lack of codes of ethics and conduct for healthcare interpreters in Turkey. With this aim in mind, three questions were posed to the interpreters, aiming at revealing to what extent they have been informed about ethical principles and are aware of these principles. Regarding the principles, eight interpreters out of fourteen interpreters said that they had been informed about ethical principles, indicating that they are aware of the principles.

However, when all of their answers during the interview are analysed, some conflicting cases seem to occur. Apart from the direct answers given by the interpreters, other comments and arguments related to these comments deduced from the interviews will be discussed in this part. The discussion here will also be dealt with in the analysis of the audio-recordings and observation.

One of the points tackled by the interpreters that I would like to touch upon is the financial perspective of the sector. Interpreter K explicitly highlights the financial perspective of the sector by indicating that they have to make the hospital earn money, even though they deal with the health sector. At this point, Interpreter L gives a conspicuous example. He asserts that he also has the task of persuading the patient to undergo further examinations. This is because if the patient stays for a longer time period in the hospital, this would be rewarding for the hospital in financial terms. Therefore, the executives of the hospital expect the interpreter to persuade the patient to stay at the hospital, even though the health condition of the patient does not necessitate a longer stay.

> *Since their health is in question and the hospital is private, the patient is sometimes encouraged to stay in hospital because of financial reasons, even though it is not required for the patient's health. We are expected to persuade the patient in that situation. The medical doctor evaluates the results and we interpret them to the patient. However, we need to utter additional remarks. For example, the patient has an infection at the rate of 5% in the blood. However, it does not necessitate staying in hospital. Nevertheless, we have to interpret it in a way that the patient should stay in hospital. We do of course, because the medical doctor wants us to do so. Otherwise, we do not utter such remarks unless the doctor tells us to say them. We interpret according to the doctors' and the hospital's working procedure. However, we sometimes interpret unethical decisions as the job requires. (Interpreter L)*

> "Sağlık söz konusu olduğu için ve hastane özel olduğu için bazı durumlarda hasta gerçekten yatmaması gerektiği halde maddi kar güdüldüğü için hastaya yatması gerektiği söyleniyor ve bizden de bunu ikna etmek...ikna edici olmamız gerekiyor. O yüzden sonuçları açıklarken... sonuçların yorumları doktor tarafından yapılıyor, biz bunu çevirip hastaya bildiriyoruz. Mesela bunu bildirirken ilave şeyler söylememiz gerekiyor. Mesela diyelim ki kanındaki enfeksiyon oranı... % 5 lik bir enfeksiyon oranı var kanında ama bu hastaneye yatmasını gerektiren bir durum değil. Ama biz bunu hastaneye yatmanız gerekiyormuş gibi söylemek zorunda kalıyoruz ama bunu da tabi ki doktor söylediği için iletiyoruz. Aksi taktirde doktor bize bunu hastaneye

yatırmayalım dediği zaman biz böyle bir şey söylemiyoruz. Yine doktorların ve hastanenin çalışma prosedürüne göre hareket ediyorsun ama bazı etik olmayan şeyleri de meslek gereği mecburen çeviriyorsun."

He clearly highlights that he is well aware that it is not an ethical situation. However, he has to act and persuade the patients according to the hospital's working procedures and expectations. At the other end of the spectrum, Interpreter I gives another example from a financial perspective. The hospital executives sometimes do not want the patient to occupy a bed or a room at the hospital because of their contracted companies' requests, although it is better for the patient to stay in terms of their health condition. In this case, the interpreter conveys the doctor's decision to the patient regarding not staying at the hospital, which might have serious consequences for the patient's well-being.

*I would like to add something regarding ethics. The patients, coming from ships, come to hospital with a severe stomach ache such as a urinary tract infection or appendix ache. Those patients who are not tourists, rather are crew members of the ship, should be present on that ship, unlike the tourists. They cannot go out and visit the city as the tourists. They have to work on that ship because they have contracts. Therefore, companies do not want those crew members to have a rest. Thus, they inform the hospitals right at the beginning regarding the least days for resting. Indeed, it is not ethical behaviour. Those patients have to stay at the hospital for a week or have an operation. They should not get on board and travel. They do not have urgent cases, but they can feel restless. Although medicines could partially reduce the ache, doctors have to write "Okay, they can travel. Two days off is enough". I remember this case. Actually, I was in deep sorrow and they get on the board with severe ache. (Interpreter I)*

"Etikle ilgili de bir şey söyleyeceğim. Bu gemiden gelen hastalar mesela gerçekten ciddi bir karın ağrısıyla geliyorlar. Mesela idrar yolu enfeksiyonu oluyor ya da apandis ağrısı. Gerçekten o işçinin – turist gemisindeki turistin, hastanın değil de geminin mürettebatı mesela. O, gemide olmak zorunda. İnip diğer turistler gibi çıkıp gezemez. Orada iş yerinde çalışmak zorunda, sözleşmesi var. Genellikle şirketler yatsın, istirahat etsin, dinlensin istemez. O yüzden doktorlar en az ne kadar dinlenme verilecekse o kadar verilsin diye baştan söylenir bu. Aslında etik değil bence. Hastanın aslında 1 hafta boyunca dinlenmesi gerekiyor ya da ameliyat olması gerekiyor. Tekrar o gemiye binip yolculuğa çıkmaması gerekiyor. Acil bir durum değil ama rahatsız hissediyor. İlaçlar kısmen kesse bile doktorlar bazen "Tamam, seyahat edebilir. 2 günlük izin yeter" diye yazmak zorunda kalıyorlar. Onu

hatırlıyorum. Aslında içim kan ağlaya ağlaya, adam ağrısından öle öle biniyor gemiye."

In addition to this comment, she also states that foreign patients are given privileges compared to local patients, since they make the hospital money. The hospital, in that case, perceives the patient as a "client" making money for the hospital. As a consequence, they emphasize the opposite case, which again amounts to the same thing. Although interpreters L and I, are fully aware that these cases are not ethical, they have to act and interpret in a way that they are expected. Thus, it would not be wrong, in my view, to suggest that hospital expectations and procedures shape the strategies and role of the interpreters. In other words, expectations and procedures of hospitals form the part of habitus of the interpreters.

Another point, which could be problematic in terms of ethics, is that the interpreter acts as if he were the healthcare provider, not being aware of its negative implications. For instance, Interpreter N indicates that he persuades patients to stay at the hospital not because of financial reasons but to help the patients who refuse to stay at the hospital and have a treatment.

*[...] For example, a child patient comes to the hospital. S/he is three-year-old but is sick. Vascular access should be established. Intravenous treatment should be provided, however, the relatives of the patient do not accept the treatment for fear that the child could get hurt. In those cases, we have to add something from ourselves in addition to the doctor's statements. For example, we can tell them that tablet treatment cannot solve the problem in a short period of time and that the patient should absolutely take medicinal treatment intravenously in a faster way, they have to endure the pain, etc. without consulting the doctor. The doctor tells us that vascular access will be established. We are trying to persuade the patient by adding something from ourselves. (Interpreter N)*

"[...] Mesela bazen mesela çocuk hasta geliyor 3 yaşında ama hasta, damar yolu açılması lazım, intravenous tedavi uygulanması lazım fakat ailesi çocuğun canı yanacak diye kabul etmiyor ama bu durumlarda doktorun söylediğine binaen bizim de birkaç bir şey söylememiz gerekiyor. Mesela tablet tedavisinin, hap tedavisinin sorunu kısa sürede çözemeyeceğini, hastanın mutlaka damardan hızlı bir şekilde iyileştirici tedavi alması gerektiğini, acıya biraz dayanmaları gerektiğini falan bunları tabi doktora

sormadan söyleyebiliyoruz. Sonuçta doktor bize damar yolu açılacağını söylemiş biz orada kendimizden bir şeyler katarak ikna etmeye çalışıyoruz."

In such a case, the interpreter acts as a medical doctor rather than an interpreter, by informing the patient about possible consequences of the treatment without consulting the doctor, which might have serious consequences for the patient's wellbeing. In the same manner, Interpreter L expresses the same strategy in order to persuade the patient. He explains that he makes additions from himself when he needs to persuade the patient by explaining, for example "Your infection rate is too high in your blood. This might lead to gangrene in the future. Or your arm might be cut, etc.". Or if the patient has a headache, the interpreter makes explanations such as "If you have headache, it could be the result of being without water, or of having cancer". Interpreter M explicitly claims that he has gained medical knowledge through work experience over time, therefore, he perceives it his right to intervene in the patient's treatment process by giving medical information to patients. He states that he makes additions regarding possible symptoms, findings or treatment of the patients' illnesses without informing or consulting the doctor. However, no matter how much medical knowledge and terminology the interpreters possess, giving medical information, unlike facilitating the communication by applying a variety of strategies, could have a major effect on patients' health. Therefore, those kinds of strategies, namely additions and omissions, are problematic in terms of patients' health conditions. Moreover, these interpreters act as institutional staff and side with the hospital. Therefore, they also violate the principle of impartiality.

The interpreters were also asked whether they have been informed about ethical principles and asked if they have affiliated to any association. Even though eight interpreters have stated that they have been informed regarding ethical principles, my research also disclosed striking results. For instance, Interpreter E asserts that he has not been informed professionally, thus, he employs his own ethical principles and he further indicates that he attempts not to make mistakes and to help as much as he can.

The affiliation of interpreters to professional associations could be relevant information at this point. Twelve interpreters out of fourteen are not affiliated to any associations regarding translation and interpreting. Only two interpreters, who have a

graduate degree in translation and interpreting, are affiliated to associations. Interpreter M is a member of the Translation and Interpreting Association (Cev-Der) and ARC. Interpreter J also asserts that he is a registered interpreter of the Istanbul Administration of Justice. It is clear that most interpreters are not members of any translation and interpreting association, which might also be considered as a factor in terms of awareness – or lack of it- regarding ethical principles, besides the educational and academic background.

### 3.4.4. Terminology

The strategies related to the medical terminology problem specifically employed during interaction by the interpreters was another topic discussed in the interview. One of the main qualities on which almost all interpreters lay particular emphasis during the interviews is a good knowledge of medical terminology. The interviews with healthcare interpreters have shown that excepting two hospitals, one private hospital providing specifically hair transplantation service and one small-scale hospital, none of the hospitals provide their own particular terminology for the interpreters. Moreover, none of the interpreters, except five interpreters who have studied translation and interpreting, have any special training in the medical field, including training in the use of medical terminology. One conspicuous example is given by the Interpreter L regarding his recruitment process.

> *[...] In the recruitment process, I had oral and written interviews. During the interview- before the interview I was prepared, however, questions were posed from daily language. Thus, I did not have any difficulties during the interview. (Interpreter L)*

> "[...] Hastaneye işe alınırken sözlü ve yazılı mülakata girdim. Mülakat sırasında- ben mülakata girmeden önce hazırlanmıştım ama genellikle günlük konuşma dilinden sorular sorulduğu için mülakatta herhangi bir sıkıntı yaşamadım."

The comment of Interpreter L indicates that knowledge of medical terminology is not a prerequisite for the hospital. Considering the number of interpreters who had training in the field of translation and interpreting, it could be argued that hospitals do

not take the training in interpreting and medical terminology as an important factor in this specific setting, which might constitute a basis for a violation of the principle of *professionalism*. On the contrary, almost all interpreters share very similar opinions regarding medical knowledge, including medical terminology knowledge, which is of paramount importance for the interpreter to acquire in this unique setting. They all underline the importance of training in terms of medical terminology.

For instance, Interpreter M puts forward as a prerequisite before starting to work in health sector that they should have a good understanding of medical terminology:

> *[...] Since terms in healthcare settings might be quite different, for example it can be easily understood when the terms "stomach" or "gallbladder surgery"are interpreted literally. However, if the doctor utilizes the term "cholecystectomy" instead of utilizing the term "gallbladder surgery" and I do not understand this Latin term, it might lead to problems in the interpretation process. It might cause miscommunication. Thus, I am of the view that it is required to have basic medical knowledge, so to say, to be a "lay medical doctor". This is what we do now. As our job requires, we are deemed to be a "lay medical doctor", i.e. uncertified doctor. (Interpreter M)*

> "[...] Tıbbi dildeki kelimeler çok daha farklı olabileceği için- örneğin mide kelimesi ya da safra kesesinin alınması ameliyatı birebir hastaya çevrildiğinde anlaşılabilir ama doktor bana "safra kesesi ameliyatı lazım" yerine "cholecystotomy lazım" derse ve ben bu kelimenin anlamını bilmiyorsam bu, çeviri sürecinde bir sıkıntı yaratacaktır. Bir iletişim kopukluğuna sebep olacaktır. Dolayısıyla tıbbi alanda da temel bazı şeyleri bilmek gerektiğine, tabiri caizze "alaylı doktor" olmak gerektiğine inanıyorum. Biz şuanda bu durumu yaşıyoruz zaten. Şuanda yağtığımız iş gereği alaylı doktor yani diplomasız doktor sayılıyoruz. İncelediğimiz hasta dosyalarına istinaden az çok bilgi sahibi oluyoruz böylece."

With the remarks given above, Interpreter M defines his role as a "lay medical doctor", underlining the importance of acquiring medical knowledge and terminology to some extent. He believes that it would lead to problems in the interaction if he did not have a full command of terminology. According to his remarks, something might be lacking and even lost in the communication.

Similarly, emphasizing particular training in the field of translation and interpreting, especially in terms of medical terminology, Interpreter K defines his role as a "bridge" between the healthcare providers and patients:

*[...] But in healthcare settings, when the medical perspective is taken into account, your job focuses totally on internalising the fact that the patient is in trouble both physically and mentally. Therefore, it already includes a problem within it. This should be transmitted to the doctor, which totally refers to the "bridging" role because any minor mistake might lead to misunderstanding, thus, to problems for the patient's health. Therefore, it is an important factor in medical terminology as well as at a grammatical level. (Interpreter K)*

"[...] Ama hastaneye geldiğimizde, işin medikal boyutunu ele aldığımız zaman yaptığınız iş tamamen oraya gelen hastanın öncelikle fiziksel, daha sonra mental açıdan sıkıntıda olduğunu az çok özümseyip, ona göre kendi içinde bulunduğu zaten bir sıkıntı söz konusu oluyor. Bunu doktora aktarmanız gerekiyor ki bu tamamıyla bir köprü görevi. Çünkü burada yapacağınız en küçük bir hata, o çevirinin tamamıyla yerle bir olması, hasta bazında çok büyük sıkıntılara yol açmasına sebebiyet verebilir. O yüzden gerek medikal bazda, gerekse terminoloji açısından gerek de gramer düzeyi açısından bu gerekli bir etmen."

Mishler (1984), on the other hand, develops two concepts regarding medical terminology, which are "voice of medicine" and "voice of the lifeword". "Voice of medicine" refers to "technical" interest, and expresses a "scientific attitude" (Bolden, 2000: 395), while "voice of the lifeword" refers to the patients' complaints and their impact on their daily life. According to Mishler (1984), "voice of the lifeword" refers to reports and descriptions of the worlds of everyday life expressed from the perspective of a natural attitude. The interaction between healthcare provider and patient is described as a dialectic between the voices of the lifeword and of medicine; thus, it involves conflict and struggle between two different domains of meaning (Mishler in Turan, 2016: 81). These different attitudes also affect the language they use.

In parallel with the findings of Mishler, my study also reveals the similar approach in terms of terminology usage of the two parties. Another discussion during the interviews was on whether there is a difference in language usage between the healthcare provider and the patients during interactions. In the interviews conducted, almost all interpreters indicated that medical doctors and patients use different languages. In other words, when the healthcare providers use Latin terms, patients generally use daily language in telling their medical histories to the healthcare providers. Interpreter B exemplifies this difference as in the following:

[I] *am reiterating. There are a lot of Latin terms in the health sector. [...] Another point is abbreviations. In other words, the doctor gives "YDT" as a diagnosis. "YDT". But you do not know what "YDT" is. But it refers to "Yumuşak Doku Zedelenmesi". What does it refer to in English? "Soft Tissue Injury", for instance. When the doctor tells you such abbreviations...because he says "YDT", "AGE" -akut-gastro-enterit. Let me say "diarrhea" in Turkish. The doctor tells you this term and leaves the room. When you search the term as "AGE" or as "YDT" online, you cannot find anything. It depends certainly on your memorisation. (Interpreter B)*

"[Y]ine yineliyorum: Sağlıkta aşırı derecede Latince kelime var. [...] Bir diğer şey de kısaltmalar. Yani doktor size diyor ki "YDT" diyor teşhis olarak. "YDT". Ama "YDT" nedir bilmiyorsunuz, ama kısaltması "Yumuşak Doku Travması". İngilizcesi ne? "Soft Tissue Injury" mesela. Bu şekilde bu kısaltmaları doktor size söylediğinde- çünkü doktor "YDT" der, "AGE"- akut-gastro-enterit. Yani bildiğimiz Türkçesi "ishal" diyelim. Doktor bunu söyler. Aradan çıkar gider. Siz bunu AGE yazdığınızda bir şey bulamazsınız ya da YDT yazdığınızda orada bir şey bulamazsınız. Belli bir şekilde ezbere dayanmış oluyor."

In the answer given above, the interpreter underlines the abbreviations used by doctors in addition to Latin terms and puts emphasis on the importance of acquiring a background in medical terminology, since it is not always possible to find these medical terms online readily at the moment of interaction.

In respect to language difference, Interpreter K explains by underscoring his role in eliminating the above-mentioned differences between healthcare provider and patient:

[...] *When we interpret simple language used by patients such as "My ear hurts", "There is a tingle within my ear" or expressions for headache or any complaints which might occur in the body, the doctor gives feedback by using totally medical language. In this sense, our role during interaction comes to the fore." (Interpreter K).*

"[...] Bizde de işte "Kulağım ağrıyor", "Kulağımın içinde çınlama var", ya da baş ağrısının tabirleri, anlatımları ya da tasfirleri, ya da ne bileyim vücutta oluşabilecek herhangi bir şikayetin tamamiyle normal bir dille aktarımı olduğu gibi misafirlerimizin kullandığı basit dili biz doktora şikayet bazda aktardığımızda doktor geribildirimi tamamiyle tıp ağzıyla yapıyor. Bu manada da bizim üstlendiğimiz rol yine keza ön plana çıkıyor."

As explained by the interpreters themselves, they play an important role in bridging this gap by eliminating language barriers between the parties. The interpreters should understand both languages, i.e. Latin versions with abbreviations and daily language, and convert these languages into each other smoothly. It means that interpreters provide interpretation both between cultures and languages i.e. they provide "interlingual" interpretation, firstly from the Latin into another language, then into the language of the healthcare provider. Thus, acquiring medical terminology knowledge in this field comes to the fore. However, it is not an easy job in every case according to the interpreters. Healthcare interpreters have explicitly elucidated that they do not always understand the "voice of medicine" i.e. Latin terms and abbreviations. By the same token, patients do not always understand the expressions used by the interpreters. In this respect, Interpreter L explains this difficulty by exemplifying the term "stool example":

> *[...] For example, the patient has to give a stool for examination. The doctor tells you that the patient has to give stool sample and leaves the room. Then you explain to the patient what the doctor said and the patient does not understand the term. You say "stool sample", but they do not understand. You try to say the term more politely because you have to be polite as well. You try to explain the term in the most polite way. Finally I say "poop" in order that they could understand it. They still could not understand. The patient once even asked "Is this one for shit?", which refers to "Will I put my shit within it?". It shows that you sometimes explain the term at that level as well. (Interpreter L)*

> "[...] Mesela gayta tahlili vermesi lazım- dışkı tahlili vermesi lazım. Bunu doktor sana söylüyor gidiyor "bunları bunları vermeli" diye, sen bunları doktor gittikten sonra açıklıyorsun. Anlamıyorlar. "stool example" diyorsun, anlamıyorlar. Kibarlaştırmaya çalışıyorsun çünkü kibar olmak zorundasın. Karşı tarafa en kibar yoldan anlatmaya çalışıyorsun, "poop" diyorum hani en son "poop" anlasın diye. Hala anlamıyor. Adam birinde şey demişti bir kere "is this one for shit?" demişti hani "Bunun içine kakamı mı koyacağım?" diye. Yani o kadar o seviyeye kadar yani inmek zorunda kalabiliyorsunuz bazen.

With this example, the interpreter mentions that they sometimes find themselves in an awkward situation, while trying to explain a term to the patients. In the example given above, it could be deduced that interpreters could also have difficulties in

informing the patients even when they use daily language to express what the doctor has said.

Likewise, Interpreter J puts emphasis on explaining the term used in daily language.

> *[P]atient sometimes has a difficulty in understanding medical terms- let me say daily medical terms. Then I try to explain by simplifying the term as far as possible. For instance, when I should say "Balgam" (phlegm), I cannot say "flame" or "mucus". Then, I try to explain by using the terms "liquid" or "solid liquid", etc. However, I try to explain as far as I can explain. Thus, body language comes into play. (Interpreter J)*

> "[H]astanın gerek genel İngilizcesi gerek tıbbi anlamındaki- hani günlük tıp diyeyim- onu anlaması bazen sıkıntı olabiliyor. Artık iyice basitleştirerek anlatmaya çalışıyorum. Balgam diyeceğim- flame diyemiyorum, mucus diyemiyorum. Artık "liquid", "solid liquid" falan bir şeyler uydurmaya çalışıyorum. Ama işte anlatabildiğim kadarıyla. Beden dili de devreye giriyor öyle olunca."

Here the interpreter indicates the terminology problem and his solution when faced with it. He, in addition to the remarks of Interpreter L, indicates that he even utilizes body language in order to help the patient understand the term.[16]

There were also contrary arguments mentioned by some interpreters that they do not often encounter difficulties with the terminology. Interpreter H gave the reason that he is bilingual both in Italian and Turkish. Since Latin and Italian languages have a similar root, he explained that he does not have problems in interpreting into Italian. However, all the rest of interpreters, except for these contrary arguments of four interpreters, expressed the point that to some extent they had difficulties in terms of medical terminology. Thus, the interpreters were asked what they prefer when they encounter medical terms. Along with the answers of all interpreters regarding their strategies employed during interaction, the most prevalent strategies could be summarized as follows:

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[16] All these problems are related to textual methods within translation studies. However, interpreters'decisions when faced with terminology problems are important in terms of interpreters' role and ethics in healthcare settings. Therefore, the issue of terminology and the interpreters' strategies have been included in the study and analyzed in detail.

1. When the interpreter does not understand Latin terms, s/he asks for a repetition or explanation from the doctor in order to be able to explain the term to the patient;
2. When the patient does not understand the expressions used by the interpreter, the interpreter uses *simplification*, *explicitation*, *addition* and *body language*.

Medical terminology problems, which are a specific issue in healthcare settings, might occur due to the lack of available vocabulary sources for healthcare interpreters, thus, a lack of healthcare interpreters' medical terminology knowledge. Even though interpreters claim that they have increased their medical terminology knowledge through work experience over time, the learning process might be risky in terms of patient health.

Based on a Bourdieusian perspective, on the other hand, Valero Garces indicates that the act of interpreting is not only a textual reproduction, it is instead consciously or unconsciously linked to the surrounding environment (Valero Garces, 2012: 18). Likewise, Inghilleri implies that the relationship between interpreter and the social world plays a significant role in determining the decisions and strategies applied by the interpreters (Inghilleri, 2003: 261). When the abovementioned strategies are taken into account, it could be suggested that interpreters play an active role during interpretation by intervening in the communication. Such intervening might also involve omissions of important terms and phrases which could include crucial information for the treatment. However, similar to the findings of Valero-Garces (2012), the strategies explained above are not deemed as an error, rather as a necessity within this specific field, from a sociological approach. In other words, the setting in which the interpreter works designates their strategies. The psychological aspect of working in hospital is another factor which plays a crucial role in the interpreters' strategies. This specific setting is demanding in terms of physical and mental strength and it requires showing empathy to the patients, which constitutes the discussion of the section below.

## 3.5. ANALYSIS OF FINDINGS FROM A BOURDIEUSIAN PERSPECTIVE

The review of existing literature indicates that there are no codes of ethics and conduct in the field of healthcare interpreting in Turkey. The examples described above in section 3.4.1 clearly show that there is no clear job description for healthcare interpreters either. Almost all interpreters deal with a number of tasks apart from interpreting and are under a lot of pressure. Interpreter J apparently criticizes this work load:

> *[W]hat I have realized is that the job has been on the rise, especially for the last five or six years in Turkey because health tourism has been on the rise. Thus, the job has no association. Thus, the job has not yet been recognized. Besides, we are recruited not as an interpreter, but as an "International Patient Authority" or as a "Team leader" in our institution. It differs from the patient admission department with foreign language knowledge. [...] Of course, they request something from us. When they request, you think about your job description, suspecting whether it is encompassed within our job description. Then you think about carrying out what has been requested in order to make them leave or you do not carry out, thus, you have a quarrel because of it. There is indeed no job restriction. You have to carry out all requests in your language. (Interpreter J)*

> "[B]enim gördüğüm özellikle son beş- altı yıldır yükselen bir şey Türkiye'de çünkü sağlık turizmi çok yükselen bir şey. Yani o yüzdendir ki özellikle bir sendikaları yok. O yüzdendir ki daha çok tanınmayan, çok hani bir oturtulmamış bir şey. Zaten bizim adımız çevirmen olarak geçmiyor bizim kurumda, "Uluslarası hasta hizmetleri yetkilisi" diye geçiyor veya "ekip lideri" olarak geçiyor. Bu da hasta kabulün yabancı dil bileni olarak algılanıyor. [...] Tabi bizden bir şey istiyorlar bu benim görev tanımımda mı değil mi yani onu düşünüyorsun bir şey istendiğinde. Sonra aman yapayım da çekilsin ya da yapmıyorsun onun kavgasını veriyorsun. Görev tanımının sınırları yok gerçekten. Gerçekten yok. Senin dilinle ilgili bir şey varsa sen onu yapmak zorundasın gibi bir şey nerdeyse."

In his remarks, Interpreter J also underlines the uncertainty of the job title as they are recruited not as an interpreter, rather as an "International Patient Authority" or "Guide". In the same vein, Interpreter K also compliments Interpreter J's argument by stating that they make up their title as "Foreign Public Relations Department" in their

hospital. Even this title and the lack of codes of ethics and conduct in Turkey reveal that the interpreter's role deserves further exploration and discussion.

The interviews have provided more specific information on the interpreters' role. However, it is also clear that their roles are influenced by a variety of factors such as setting and expectations. The role of interpreters could be also elaborated by basing them on Bourdieu's concepts habitus and capital. From a Bourdieusian perspective, for instance, it could be suggested that interpreters have a burden laid on them and all interpreters could deal with these burdens and responsibilities in order to gain economic capital, i.e. to earn money. Besides, expectations of hospital executives also form part of the interpreters' habitus and their actual role, which helps them increase their economic capital. Therefore, the interpreter, for instance, has to persuade the patients in order to help the hospital increase their economic capital. Or likewise, as interpreter I explains, the hospital abides by the expectations of its contracted companies from which the hospital earns money. In such cases, the interpreters have to act according to the expectations of the hospitals. However, they violate the principle of *impartiality* by siding with the hospital.

Among the responsibilities conferred on the interpreters, physical and particularly medical assistance to the patients also results in violating the principle of *professionalism*, since the interpreters who provide such kind of assistance have not acquired medical training. From the same perspective, informing patients without consulting doctors might also violate the principle of *professionalism*, since medical doctors and interpreters do not have medical knowledge at the same level. In other words, these interpreters' academic qualifications, an institutionalized state of cultural capital, in terms of medical knowledge to inform and guide the patient, are not at the same level as the medical doctors'. Therefore, giving medical information to the patient might risk the patient's health.

The findings I obtained in the study, on the other hand, do not overlap Bourdieu's claim that academic qualifications, in other words an institutionalized state of cultural capital, may ensure economic capital (Bourdieu, 1986: 50-51). Considering the fact that only five interpreters out of fourteen interpreters have been trained in a translation and interpreting department and also there is recruitment of interpreters who have no training

either in a translation and interpreting department or in the medical field without knowing medical terminology, it suggests that academic qualifications including medical terminology knowledge, do not always necessarily make the interpreters eligible for hospitals in contrast to Bourdieu's arguments. It means, in other words, the institutionalized state of cultural capital in Turkish healthcare settings may not always be converted into economic capital. Unlike cultural capital in its institutionalized state, I would claim that linguistic capital as a sub-type of cultural capital is converted into economic capital since interpreters are recruited thanks to their foreign languages. However, ignoring the lack of medical terminology knowledge and training in translation and interpreting department to recruit might also be the reason for violating the principle of professionalism, because lack of training in these issues might influence the strategies and roles of interpreters negatively.

Last, but not least, some interpreters also were critical of the fact that they do not have the prestige and respect that they deserve. Interpreter M, for example, said that nurses sometimes behave badly to the interpreters. Moreover, their job is sometimes despised. Along the same line, Interpreter J explains that their job is not well understood; therefore, they can sometimes be exposed to different behaviours from different people.

> *[...]Sometimes people do not understand what an interpreter does; therefore, we could feel bad from time to time. You could encounter with different behaviours from different people. For example, you are not busy with interpreting at that time. For example, you are dealing with insurance of a Turkish patient. The patient waits for something from you and when s/he behaves in a bossy manner, you could find it odd. (Interpreter J)*

> [...] Bazen insanlar çevirmenin tam olarak ne olduğunu tam bilmiyor ve insan kötü hissedebiliyor bazen. Hep böyle farklı muameleye maruz kalabiliyorsunuz farklı insanlar tarafından. Mesela çeviriyle ilgili bir iş yapmıyorsunuz o sırada. Mesela Türk hastanın yabancı sigortası var. Sizden bir şey bekliyor. Ve size böyle buyurgan bir tavırda bulunduğunda insan yadırgıyor.

Apart from the remarks above, Interpreter M further specifies that although today the situation is getting better, previously doctors reprimanded interpreters in front of patients when the interpreter made a mistake. Therefore, Interpreter M asserts that this

caused a lack of confidence from the patients, since patients could understand that something had gone wrong. Or in the case of any problem between doctor and patient occurring, the interpreter is the one who is responsible for this problem, according to Interpreter M. Thus, the interpreters have to persuade both sides since the interpreters seem guilty whatever the reason is.

Consequently, according to Bourdieu, symbolic capital is perceived as prestige and renown and it is "the most valuable form of accumulation in a society" (Bourdieu, 1977: 179). In healthcare interpreting, it is possible to assert that these interpreters who are of the opinion that their job is not attributed the value it deserves by the hospital personnel, have not acquired much symbolic capital, i.e. prestige in the hospital.

Because of these negative working conditions for healthcare interpreters, almost all interpreters, except for three, are not satisfied with the salary they receive. Almost all interpreters agree with the fact they should be paid more. Therefore, it could be concluded that most interpreters do not acquire economic capital at a desired level either.

## 3.6. ANALYSIS OF OBSERVATION AND AUDIO-RECORDINGS IN THE INTERACTIONS

The present section focuses on the data obtained from observation and audio-recordings taken from real-life situations in healthcare settings. In order to supplement the data obtained from interviews, observation of four interpreters' actual performances and audio-recordings of five interpreters' interpretations have been included in the study. The phrases in the excerpts relevant to the discussion in that section are highlighted and discussed following the excerpt. In these excerpts the participants, i.e. interpreters, healthcare providers, patients as well as the researcher will be denoted using an abbreviated form. The letter "I" stands for an interpreter, "P" stands for the word patient, "N" stands for a nurse and, "D" stands for the word doctor, while "R" is for the word researcher.

The following categories comprise of instances during the interaction in which the interpreters play an active role.The active role of interpreters will be discussed in relation to ethics, thus, the instances relevant to the research questions stated in

Introduction will be analyzed in detail. A total of 27 audio-recordings of five interpreters have been included. 11 audio-recordings out of 27 audio-recordings are in German, and six audio-recordings include doctor and patient direct conversations in the interpreter's presence, but without interpretation, while seven audio-recordings include conversations between healthcare interpreters and patients without the presence of healthcare providers.

### 3.6.1. Interpreter showing empathy

The excerpts below are taken from an interaction between an ophthalmalogist and a patient and one excerpt is taken from an interaction between interpreter and patient who came to Turkey to take a vacation from Germany. Therefore, the encounters were in the language combinations of German and Turkish. Since the patient had a dental abscess and severe tooth ache, she was conveyed to one of the large-scale hospitals in Izmir for further examinations. In the excerpts below in this category, the interpreter is giving emotional support to the patient both pyhsically and verbally.

Excerpt 1:

D2: [...] Because we will dismantle the bridge on Monday. We will clean out the nerves located under her tooth.
[[...]Çünkü köprüyü sökeceğiz pazartesi günü. Altındaki dişlerin sinirini biz boşaltacağız.]
D1: She will go downstairs on Monday. We will immediately dismantle the bridge. We will have a look at least. She will get some relief from the toothache by Monday.
[Pazartesi günü hemen buradan aşağıya iner. Hemen köprüyü sökeriz. En azından bakarız. Pazartesiye kadar toparlanmış olur zaten.]
I: Okay, if everything is okay until Monday, then they will dismantle the bridge.
[Okay, bis Montag wenn Sie alles okay, dann ziehen Sie den Brücke raus.] [sic.]
D1: Then we will clean out the nerves. But at the same time her antibiotic treatment will continue.
[Sonra oradaki sinirleri temizleyeceğiz. Ama aynı zamanda antibiyotik tedavisi devam edecek.]
I: If the nerves- everything is cleaned, you will get some relief. But you have to stay here until Monday.
[Wenn die Nerven wird- alles abgesaubert, dann haben Sie beruhigt. Aber bis mOndat müssen Sie hier bleiben.] [sic.]
P: Does it 100% go?
[Das ist 100% das geht weg, oder?]
I: She asks if 100% goes.

[100%'ü gider mi diyor.]
D1: Of course, of course.
[Tabi tabi]
I: Of course, of course. **You are in safe hands here.**
[Naturlich,naturlich. **Hier sind Sie im sicheren Haende**]

Excerpt 2:

[...] I: **I am so close to you. I am always be with you, on the table.**
**[Ich bin so nah dir. Ich bin immer bei dir hier, an der Kühlschrank]**
P: Good
[Gut]

The first excerpt has been taken from an encounter between doctor and patient. In this excerpt, the interpreter makes additions in order to make the patient feel comfortable by emphasizing that she is in safe hands there. After the encounter came to the end, the interpreter had to come back to the hospital in which he worked. However, before leaving the hospital and the patient alone, he tried to relieve the patient with his utterances. Through the end of the conversation, he emphasizes that the patient can reach him whenever she wants. At another point, the interpreter also makes an explanation to one of the patients whose situation was worse.

Excerpt 3:

P: A wonderful vacation.
[Eine schöne Urlaub].
I: **Yes, there is also worse than yours. I had a patient. She came to Turkey for 10 days. She fell down the stairs on the first day she came. Left side was totally broken. She stayed 15 or 20 days at the hospital.**
[Ja, es gibt auch noch schlimmere. Ich habe eine Patientin gehabt. Sie kam für 10 Tage Türkei. Auch an dem Tag, wo sie gekommen ist, sie fallen von den Treppe runter. Linke Seite komple kaputt, abgebrochen. 15 oder 20 Tage lag sie im Krankenhaus].
[sic.]
P: But 10 days were for a vacation.
[Das ist- aber 10 Tage war für Urlaub].
I: **Yes, 10 days were for a vacation. (Laughing) She stayed 20 days at the hospital. There are also such patients. When you get over it, you have at least 6-7 days left.**
[Ja, 10 Tage war Urlaub. 20 Tage lag sie im Krankenhaus. Es gibt auch solchende.]
Mindestens wenn du hast... wenn du das hinter dir hast, wenigstens hast du 6-7 Tagen.

Excerpt 4:

[...] **I am sorry for you. I do not know why, but I am really sorry for you. I am sorry for that young boy. I mean I see a lot of patients like you, everyday 20-30 patients. But you make me feel really sorry.**
[Du tuts mir wirklich leit. Warum weiss ich nicht aber du tuts mir wirklich leit. Diese junge Mann tut mir wirklich leit. Ich meine, so wie euch sehe ich taeglich 20-30 Patienten. Aber ihr tut mir wirklich leit].

In these excerpts above, the interpreter motivates the patient who was anxious and sad at that moment. She did not want to stay in the hospital since she was with her little boy alone. Thus, the interpreter's intervention is related to emotional support in the examples shown above. In addition to his verbal support, the interpreter was observed to show care for the patient. In the blood-letting procedure, the interpreter caressed the patient's hair and always reiterated that everything will be good and in the end he promised that she would leave the hospital safe and sound.

With his emotional support, the interpreter seems to violate the principle of impartiality by clearly showing his feelings to the patient. Showing emotional support or personal opinions have been opposed by some associations. For example, HIN clearly states that an interpreter does not get into an argument, give advice or talk about his/her own personal opinions (HIN, 2007: 15). Adopting the same approach, NSW also indicates that an interpreter does not give emotional support to patients (NSW, 2014: 11). Likewise, NCICH opposes this kind of intervention by an interpreter. In the Standards of Practice, it is determined that the interpreter does not reveal his personal feelings with this voice tone, utterances, or body language. However, the setting affects the interpreter's role, resulting in violating the principle of impartiality. Yet it should be noted that no negative perspective on the side of the patient has been observed. Instead, the patient was observed to have been relieved. Although providing emotional support could be controversial in terms of impartiality, it is true that it has positive impacts on the patients as observed above.

### 3.6.2. Interpreters omitting certain utterances

This category consists of omissions made by the interpreters, either intentionally or unintentionally. In other words, the interpreters hide information from the patients or the doctors.

The first excerpt in this category takes place during an encounter betwen an ophthalmalogist and a patient, who has a complaint of a stye in the eye.

Excerpt 5:

I: After the treatment...
[Tedavi olduktan sonra...]
D: Afterwards we will have to give her glasses.
[Sonra gözlük vermemiz lazım.]
I: It is possible that the optics degree might be changed.
[Gözlüğün derecesinin değiştirilme olasılığı...]
D: It is possible.
[Olasılığı var.]
D: Of course.
[Tabi canım.]
I: So, let me explain that. It happened, this one as a small cyst that really makes this side for the blurry. Okay? But after the medication and also the treatment you are going to get or take... okay? The doctor's suggestion is you have to change the left optics. Left one, okay? [sic.]
P: Change it?
I: It might, it might or may. Okay? But we have to wait for the medication at first. If it disappeared or ceased itself, we do not need to. But we can understand that while we just closed your right side...[sic.]
P: Yeah.
I: It has a little bit of a problem for now.
**P: What kind of medication is it?**
**I: He already prescribed.**

In the excerpt above, the doctor only remarks that it is possible to change their glasses. However, the interpreter explains the situation to the patient in a more detailed way. At the end of conversation, the patient wants to get information about the medicine she will utilize. When she asks a question about the medication, the interpreter omits the patient's question instead of directing the question to the doctor. However, omitting this kind of information may affect the patient's treatment process negatively. Thus, the

interpreter violates the principle of accuracy by not interpreting the question of the patient. In contrast, the interpreter omits the doctor's question in the excerpt below.

Exceprt 6:

D1: When did that operation happen?
[Ne zaman yapılmış o işlem?]
I: The patient had a dental bridge 3-4 months ago. Nerve was left, as you ... The doctor in Germany waited for the nerve to be dead. The air that it takes...
[Valla bundan 3-4 ay önce köprü yaptırmış. Sinir bırakılmış, siz de şey yaptınız. O sinirin ölmesini beklemiş Almanya'daki doktor. **Onun aldığı hava da ...]**
**D2: It is not air. Half of the nerve was taken and half of it was left.**
**[Hava değil. Sinirin yarısı alınmış yarısı alınmamış.]**
I: The patient said the same.
[İşte aynısı anlattı.]
D2: Because I have the film.
[Film elimde çünkü]

In the example above, there were two dental clinicians dealing with the patient. When the doctor asks a question regarding the patient's complaints, the interpreter answers on behalf of the patient by omitting the question of the doctor instead of interpreting it to the patient. Furthermore, while he is explaining the patient's complaints and health situation, the second doctor interrupts the interpreter and corrects him as could be seen in the emphasis above. From this example, it could be concluded that interpreters speaking on behalf of the patient and informing the doctors regarding the patient's medical complaints might mislead the doctors. If the doctors had not had the film of the patient's tooth, the misleading of the interpreter might affect the patient's treatment process negatively. By omitting the doctor's question, the interpreter also takes the patient's right to speak.

The third example in this category is directly between an interpreter and the patient who is about to get an MR. Before getting into the MR, the hospital gives the patient a Turkish document to be signed, encompassing possible risks, conditions, etc. Therefore, the Turkish document should be interpreted to the German patient by the interpreter, since it includes important information regarding factors which might affect the patient's health condition. However, the interpreter follows a different way, instead of interpreting the document.

Excerpt 7:

I: [...] And sign here. Everything is in Turkish here. You can not understand anything. But unfortunately this is it.
[[...]Und hier unterschriben. Da steht alles Turkish. Du kannst überhaupt nicht verstehen. Aber das ist leider so. ]
P: But what is it?
[Aber was ist das?]
T: Okay. You will now have a tomography.
[Okay. Sie bekommen jetzt eine Tomografie.]
P: What?
[Was was?]
T: You will have a computed tomography scan...
[Sie werden tomografiert... ]
P: X-Ray.
[Rontgen.]
I: Yes, from the mouth.
[jawohl, von den Mund.]
T: Yes.
[Ja.]
T: **During MR, if something goes wrong, but it cannot... something bad occurs, we make this as a precautionary measure. You will go into tomography. I have also never done this. I will do it for the first time with you. It takes 15 minutes. I cannot interpret everything.**
**[Bei Tomografie, wenn dir was schief geht- das kanns aber nicht... böses gehen aber, aus Vorsicht sein, machen wir das. Sie gehen jetzt in eine Tomografie rein. Das habe ich auch nie gemacht. Zum ersten mal bei Ihnen. Das dauert 15 Minuten. Ich kann nicht alles übersetzen.]**
P: Yes yes yes yes. Let's continue.
[Ja ja ja ja. Lass uns fortgehen.]

The excerpt above demonstrates that the interpreter refrains from interpreting a very important document to the patient by first explaining that the document is in Turkish. However, at the objection of the patient, the interpreter is obliged to interpret. After interpreting a couple of sentences, he says that he can not interpret everything and summarizes the whole document which includes pivotal information regarding the patient's health and safety. While signing the document, the patient says to herself "This is so funny. I am signing, but, I do not understand anything." According to the patient's comment, it is clear that the patient is not satisfied with the interpreter's attitude. Yet, the patient signed the document, even though she felt uncomfortable about the situation. For

this reason, not interpreting this kind of important information to the patient may lead to misinformation for the patient and this is a controversial issue in terms of ethics. As in the examples discussed above, the interpreter also violates the principle of *accuracy* by hiding medical information from the patient.

#### 3.6.2.1. Interpreters having conversation with healthcare providers

This sub-category consists of the conversation parts which are held between healthcare providers and interpreters regarding patients' illnesses and treatments. It is one of the recurring situations during my research which I would also like to emphasize.

The first excerpt occurs between a nurse and the interpreter, while the German patient gets an MR:

Excerpt 8:

N: I think she was in a vacation.
[Tatildeydi heralde.]
I: They came to have a vacation. She suffered so much, however.
[Tatile geldiler. Burnundan geldi tatil.]
[...]
N: Where is she from?
[Nereli?]
I: German.
[Alman]
[...]
I: If my wife had been a patient in this case... okay? I would not care too much. I would say "Go, do whatever you do".
[Şimdi bu durumda benim karım hasta olmuş olsa... tamam mı? bu kadar ilgilenmem, "Git" derim, "Ne yapıyorsan yap".]
R: Why?
[Niye?]
I: We deal with these people as if they were kids.
[E işte bunlarla bu kadar uğraşıyoruz çocuk gibi.]
N: Did she fall?
[Düşmüş mü?]
I: No, she had a dental bridge, tooth turned it into an abscess. She had the dental bridge in Germany. Here the tooth turned it into abscess. We have to care for these people as if they were our own people.
[Yok ya, köprü taktırmış, diş de apse yapmış. Almanya'da köprüyü taktırmış. Burada diş iltihaplanmış. Bunlarla kendi insanımız gibi ilgilenmek zorundayız.]

In this exemple, the nurse initiates a conversation with the interpreter by asking questions about the patient. Afterwards, the interpreter turns to the researcher at that moment, explaining that they have to care for patients as if the patients were from their own country. However, none of these conversations have been interpreted to the patient.

In the next example below, Interpreter K has a conversation with the doctor regarding the patient's health situation in the same way.

Excerpt 9:

P: And the doctor.. he used a needle. Also he tried to pop it.
D: Ehmm.. He wants to do something with a needle?
[Yani şey.. iğneyle şey yapmak istiyor heralde?]
I: A little thing... Had this already been performed in the.. at the ship or?
[Küçük bir şey.. Had this already been performed in the.. at the ship or..?]
P: He did it on the ship. He popped it.
I: He tried to pop or hole it with the help of a little needle.
[Gemide küçük bir iğne yardımıyla onu patlatmaya ya da delmeye çalışmış.]
P: But nothing...
D: Probably he could not be succesful.
[Muhtemelen başarılı olamamıştır heralde]
I: Nothing comes out.
P: Nothing came out.
I: Nothing came out [Repeat the patient's utterance]
I: Of course there was no [inaudible] or flix.
[Gelen herhangi bir [duyulamıyor] ya da akıntı olmamış tabi ki]
D: Of course, it did not come out.
[Gelmemiş tabi ki.]
I: Yes
[Evet]
D: It was obvious that he will not be succesful. Soon I will explain the reason, okay?
[Yani, başarısız olacağı aşikardı. Biraz sonra söylerim onun nedenini tamam?]
**I: Because he is unfortunately not an ophthalmologist.**
**[Göz doktoru olmadığı için maalesef.]**
**D: Of course, of course. Unfortunately.**
**[Tabi tabi, maalesef.]**
**I: He made an unsuccessful attempt.**
**[Başarısız bir girişimde bulunmuş.]**
**D: The rate of being unsuccessful is high.**
**[Başarısız olma şansı yüksek.]**
**I: Is it possible that the doctor thought is as a little abscess or acne?**
**[O küçük bir apse ya da akne olarak düşünmüş olabilir mi?]**
**D: A little... It is okay if he treats right in the beginning within 24 hours. After this time passes, a capsule covers there. Then there is no benefit.**

**[Küçük bir... en başlagıcında ilk 24 saatte müdahele ederse tamam. Orayı geçtikten sonra orayı kapsül sarıyor. O zaman hiç faydası olmuyor. ]**

As can be seen above, the interpreter and doctor have a conversation about the patient's previous doctor's intervention. Moreover, they discuss the reason why the previous doctor was unsuccessful in his intervention with the patient.

In this next case Interpreter D converses with a nurse regarding the patient's serum.

Excerpt 10:

I: How long does it take, Mrs. Nurse?
[Ne kadar sürer bu hemşire hanım?]
N: It does not take long.
[Çok uzun sürmez.]
I: Too- Please open it so that we do not wait long since we have also other patients, we are too busy. We are coming from another hospital.
[Fazla- açıverin biraz da fazla da beklemeyelim çünkü baya bir hasta da var yoğunuz çok, başka hastaneden geliyoruz biz.]
N: I see.
[Anladım.]
I: The patient already does not want to stay here.
[Zaten hanımefendi de yatmak istemiyor.]
N: Okay.
[Tamam.]

As seen in this excerpt, the interpreter requests that the nurse could open the serum up in order to tap and finish faster. However, it is important to note that all these conversations above take place in front of the patient. The interpreter again did not interpret the conversation they held with the nurse. However, this kind of omission might make the patient anxious about the situation since they do not understand anything going around them. During my observation, one of the patients came to me and requested from me to include the interpreters' above-mentioned attitude in the current study. He further asserted that when the interpreter talks with a doctor in Turkish and does not interpret these conversations into the patient's language, the patient gets irritated and feels uncomfortable. This has been already included in codes of ethics and national standards of a variety of associations. For instance, HIN clearly asserts that "The interpreter renders all utterances and written communication faithfully using the

same grammatical person as the speaker or writer. [...] The interpreter advises all parties that everything said in the encounter will be interpreted. If any party requests that the interpreter refrain from interpreting all utterances, the interpreter is obliged to inform all other parties of the request and seek direction." (HIN, 2007: 13). However, when the above-mentioned examples are analyzed, the interpreters refrain from interpreting even vital medical information for the patients. Thus, they violate the principle of accuracy. It can be also concluded that the interpreter in the first excerpt of this category also violates the principle of confidentiality, since he discloses the patient's private information both regarding her private and also medical situation. Rather, the interpreters are encouraged to keep confidentiality by respecting their privacy and holding the information they attain during encounters in confidence (HIN, 2007; CHIA, 2002; NCIHC, 2005). However, it is clear that the interpreters are not aware of this principle.

### 3.6.3. Interpreters acting as healthcare providers

This category deals with the instances in which interpreters act as a healthcare provider rather than as an interpreter, such as informing the patient's relatives regarding the patient's general health condition, or giving medical advice for the patients.

Excerpt 11:

D: "*Sıcak pansuman*" (Hot dressing). What will we say? What does "*pansuman*" (dressing) mean? Hot...
[Sıcak pansuman. Ne diyeceğiz? Pansuman neydi? Hot...]
I: Hot pack.
D: Hot pack.
I: You should also apply some hot packs.
D: Hot pack.
P: Hot pack?
D: It is very important. Ehmm maybe cotton...
P: Yeah.
D: And touch the hot water. Ehmm but you will say the following sentence. It should be a little bit hotter than the bath warmth she has.
[And touch the hot water. Şey yalnız bunu sen söyleyeceksin. Banyo yaptığı sıcaklığın biraz üstü olsun. ]
I: Than normal warmth. It should be a little bit hotter than recent and normal bath warmth. Okay?

[Üstünde. It should be a little bit hotter than recent and normal bath warmth. Okay?]
P: Okay.
I: A little bit...
P: Okay.
I: A higher level.
P: Okay.
**I: Okay? Pure the cotton or any kind clean tool to pour and rub on it. [sic.]**
**D: Now I will describe her.**
**[Ben tarif edeceğim şimdi ona.]**

In this excerpt, the doctor starts to talk about medicine and its application. After interpreting what the doctor has said, the interpreter initiates describing how the patient will apply the medicine. However, the doctor intervenes and says that he will start explaining the application method. Since the interpreter has no medical training in this field, his instructions might mislead the patient. The same interpreter also intervenes in the encounter by answering the patient's question himself, instead of directing it to the doctor.

Excerpt 12:

**P: It is not necessary to cut or drain?**
**I: Not, actually.**
**P: Okay, good.**
**I: Cut means a small operation, you do not need to do...**
P: No, I do not want. No.
D: Early. Very early for operation.
[Erken. Very early for operation.]
I: Yeah, just wait for the therapy.
D: It is medication is very important. [sic.]
P: Yeah. I would rather not have a cut.
D: From the very start, if it had been, a small operation could be done.
[İlk anda, olur olmaz eğer olmuş olsaydı olurdu ufak bir operayon.]
[No interpreting]

The interpreter in this example clearly interferes with the patient's question. First, the interpreter answers the patient's question. Afterwards the doctor gives an answer. Although both the interpreter and the doctor give the same answer, giving an answer by the interpreter regarding the patient's treatment procedure seems quite risky, since he does not have a command of the medical knowledge. In this excerpt, it seems as if there

were two doctors in the encounter, since both the interpreter and the doctor answer the patient's question. In addition to giving an answer to the patient's question, the interpreter also omits the doctor's detailed explanation regarding the patient's question at the end of the encounter.

During the observation process, it has also been observed that another interpreter informs the patient's relatives regarding the patient's current health situation. When the relatives of the patient who is in intensive care unit visit the hospital in order to get information regarding their current condition, the interpreter has received them and has given information about the patient such as "unconscious, but responds to stimulants". In the same way, relatives of the patient who is to be operated on for kidney stones, have come to the interpreter in order to ask whether their patient's operation would be that day. The interpreter has answered their questions and, moreover, directed them by giving a notice such as "The patient should go hungry tonight". Without informing and asking the patient's doctor, the interpreter's intervention in informing the patient directly might have negative consequences for the patient's health and mislead the patient. This situation is also prohibited in the national standards and also codes of ethics and conduct of associations. For example, the NSW explicitly states in the national standards that "healthcare interpreters do not assume the role of other health professionals" (NSW, 2014: 11). Likewise, the IMIA also asserts that " interpreters will not interject personal opinions or counsel patients" and " interpreters will not engage in interpretations that relate to issues outside the provision of health care services, unless qualified to do so". However, even though the interpreters in this part are not qualified in terms of medical knowledge, they provide medical information as well as counselling the patients.

## 3.7. ANALYSIS OF FINDINGS OBTAINED BY OBSERVATION AND AUDIO-RECORDINGS FROM A BOURDIEUSIAN PERSPECTIVE

The analysis in this part consists of data obtained by observation and a total number of 27 audio-recordings. As clearly seen from the excerpts above, data analyzed in this part supplements the findings of the interviews with interpreters and patients.

Empathy is one of the encountered issues during observation. Even though associations strictly prohibit interpreters from showing their feelings or personal

opinions, it has been observed that the interpreter has to sometimes show empathy in order to relieve the patient who is in a bad situation at that time. From a Bourdieusian approach, this situation could be the indicator that the habitus of the interpreter affects his role by leading him to adopt additional roles in addition to interpreting. Thus, the habitus of the interpreter leads to a violation of the principle of impartiality.

The second point encountered during my research process is the omissions made by the interpreter. The interpreters whose interpretation process has been observed and audio-recorded above have not acquired academic training in the department of translation and interpreting. When this fact is taken into consideration, it could be asserted that they lack cultural capital in its institutionalized state. Despite the fact that the current study does not merely focus on the impact of the interpreter's educational background on their decisions and role, it could be indeed suggested that their lack of cultural capital in its institutionalized form i.e. professional qualifications in interpreting, might have an impact on their decisions and thus, their role during the interpretation process. As a consequence, their decisions shown above clearly indicate that they are not aware of the criticality of the service they provide, since their omissions, particularly omissions regarding the patient's treatments or health conditions, might have direct outcomes for the patient's treatment process and health.

Another point which is tackled above is the cases where the interpreters act as healthcare providers by informing the patients and their relatives, or answering questions of the patient or providing medical information regarding the patient's health. However, as also concluded in the first part of this chapter, the interpreters do not have not any training in medicine. That means, from a Bourdieusian perspective, that the interpreters and the doctors do not have medical knowledge at the same level. In other words, their cultural capital in its institutionalized state is not the same. Thus, the fact that the interpreters provide medical information and guidance for the patients might pose a risk to the patients' health.

## 3.8. SUMMARY

This chapter consists of the analysis of two parts. In the first part, data obtained from interviews with both healthcare interpreters and patients have been analyzed. In the second part of this chapter, data gathered through observation and audio-recordings of the encounters has been analyzed. In the first part, interviews with healthcare interpreters have been discussed under the sub-titles of role, empathy, ethics and terminology. Apart from the interviews conducted with fourteen healthcare interpreters, interviews have been also conducted with five patients in order to have a broader user perspective on healthcare interpreting in Turkey. However, interviews with the patients have not been analyzed in detail as a sub-category in this study. Rather, I included the analysis of interviews with the healthcare interpreters. According to results of interviews with the patients, patients perceive interpreters as important mediators in terms of enabling communication between healthcare providers and patients. However, it became obvious that patients do not question whether interpreters' decisions are accurate or not, or, they are partial or not.

According to the results of the interviews from the interpreters' perspective, on the other hand, my study has revealed that interpreters also adopt additional roles such as providing physical and medical assistance for the patients, apart from just interpreting in hospitals. However, these roles imposed on interpreters have also indicated violations of principles of professionalism and impartiality when the codes of ethics and conduct as well as standards of practice developed by associations are taken into account. Moreover, this study has also opened up the factors affecting the interpreters' strategies and decisions during interpretation process. These factors have been analyzed under the sub-titles of *empathy* and *terminology*. Another sub-category of the first part has been the issue of *ethics*. In this category, decisions of the interpreters have been discussed in terms of ethics. Even though, the interpreters' role is related to ethics, violating some principles, it has been also concluded that patients are quite satisfied with the interpretation service they received in Turkey. At the end of the first part, these sub-categories playing an important role in determining the role of the interpreters during and beyond interpretation have been analyzed from a Bourdieusian perspective.

In the second part of this chapter, data obtained by observation and audio-recordings has been analyzed under the sub-titles of 'interpreters showing empathy', 'interpreters omitting certain utterances', and 'interpreters acting as healthcare providers'. According to the analysis of the second part, it has become apparent that data obtained from interviews complements the data obtained from observation and audio-recordings in order to give a detailed analysis regarding the role of healthcare interpreters in Turkey. Another finding of this chapter is the gap between what healthcare interpreters say they do, and what they actually do in real life situations. Although they claim that they are aware of the ethical principles in interpreting, in practice they violate principles such as impartiality, accuracy and professionalism. Also, the interviews with the patients revealed that patients are satisfied with the interpretation service they receive. However, the observation showed that there are cases where the patients are dissatisfied with the interpreters' refraining from interpreting some documents and conversing with healthcare providers in front of them in Turkish. Thus, contradictions are observed between different sources of data at certain cases, arising more questions in this field in relation to role and ethics.

## CONCLUSION

The objective of the present thesis is to analyze the role of healthcare interpreters in Turkish healthcare settings by focusing on the impact of a lack of codes of ethics and conduct as well as national standards for healthcare interpreters on the role of interpreters in practice in Turkey. The role of interpreters has been analyzed at two levels: micro and macro levels during and beyond interpretation. Strategies and decisions taken or not taken by the interpreters during interpretation have been associated with ethics at a macro level beyond interpretation. Constituting one of the most important fields within community interpreting, healthcare interpreting settings are among the most important settings. It was in the field of healthcare interpreting in which the earliest initiatives for the systematic provision of community interpreting services were taken in the 1970s and also it was healthcare interpreters who first established associations for community-based interpreting outside the judicial domain (Pöchhacker, 2006: 135). Among these associations, the International Medical Interpreters Association (former the Massachusetts Medical Interpreting Association MMIA) is the oldest to have developed an ethical code of conduct specifically for healthcare interpreters, which has since been translated and adopted in several countries. The California Healthcare Interpreters Association (CHIA), The National Council on Interpreters in Health Care (NCIHC), The Healthcare Interpretation Network (HIN), The New South Whales Healthcare Interpreting Services (NSW HCIS), The Irish Translators' and Interpreters Association (ITIA), and The National Register of Public Service Interpreters are also among associations which have developed ethical principles for community interpreters including healthcare interpreters. To this end, attention was first given to the analysis of codes of ethics and conduct as well as standards of practice of these associations which shed light on my analysis. In accordance with these ethical principles and standards, the role of healthcare interpreters in Turkey has been related to a broader issue of ethics at macro levels.

Data obtained from interviews with a total number of fourteen interpreters and five patients as well as participant observation and audio-recordings taken from real-life situations has provided the basis for the analysis regarding the role of interpreters.

Strategies regarding medical terminology problems during interpretation were among the main discussion topics. Additionally, it was also one of the main qualities on which all interpreters put special emphasis. This does not come as a surprise since an interpreter is expected to have a good knowledge of terminology related to the settings in which the interpreters work. Medical terminology knowledge in healthcare is no exception since it is about patient's lives. However, my study has also unveiled other factors which are pivotal in determining the role of interpreters during interpretation. These factors are the psychological aspect, leading to empathy, and hospitals' working procedures and expectations on the interpreters.

**Chapter One** consists of five main parts. In the first part I discussed the term community interpreting as a concept, its description, its various terms as well as some general background information about the profession. In the second part of the chapter I aimed to demonstrate the development of community interpreting as a profession around the world, mainly in developed countries such as U.S.A, Australia, Sweden and Canada, where community interpreting has been institutionalized by providing basic information regarding the leading associations and activities. In contrast to these analyzed associations, it has become apparent that there are currently no associations which provide a clear job description and role for interpreters in healthcare settings in Turkey. Thus, it was my main point of departure in this thesis. Although it has been claimed that community interpreting dates back to antiquity, modern developments in community interpreting are claimed to have started especially after the establishment of the Registry of Interpreters for the Deaf (RID) in the United States. Following the establishment of RID, a range of associations in a variety of settings in the U.S and other developed countries have also been listed. While the associations established have been taken as a focus in terms of developments around the world, activities that have been employed under community interpreting have been taken as a focal point in Turkey.

Following developments around the world and in Turkey, healthcare interpreting has been discussed as a concept, including general background information regarding the working conditions of healthcare interpreters. After defining healthcare interpreting as a concept, healthcare interpreting as a sub-branch of community interpreting in Turkey has

been analyzed. Even though the current study specifically focuses on the interpreting services provided in private hospitals in Turkey, current situation in state hospitals have been discussed as well. My research has revealed that currently one of the main language problems arises with Syrians in healthcare settings. Hosting 2.85 million Syrian refugees fleeing from disaster or war in their country, Turkey has become a crucial harbor for many of them to shelter in. However, language barriers are being encountered in a range of settings such as health, court, or other public settings. In order to unveil this language problem, semi-structured interviews have been carried out with two medical doctors working in the neurology department in a state hospital in Izmir. My research has thus far shown that the most frequently encountered problem with communication is with Syrians living in Turkey or citizens from the eastern part of Turkey who are not fluent in Turkish. Therefore, doctors even appeal for the help of security staff who can speak Kurdish or Arabic in their encounters with patients. One of these two doctors has also stated that they first look for relatives of patients in order to diagnose illnesses. Thus, it has become apparent that ad hoc interpreting still prevails in Turkey, specifically in state hospitals. Accordingly, they explicitly emphasize the need for staff interpreters in state hospitals.

In the last part of this chapter, I examined ethical principles and the standards of the associations. According to the analysis of seven community interpreting or healthcare interpreting associations in five countries, common ethical principles and standards for interpreters are accuracy, confidentiality, impartiality, respect, professionalism, and professional development. However, there are also controversial principles and roles on which universal agreement could be reached. These are the advocacy and cultural mediator role of interpreters. While some associations support the idea that an interpreter might also adopt advocacy or cultural mediator roles, there are also some associations which strictly forbid these kinds of roles. Above all, these ethical principles and standards will provide a basis for my main analysis in terms of the interpreters' role.

**Chapter Two** has a number of points to suggest regarding the literature review, theoretical framework and methodology of the study. At the beginning of this chapter, I

examined selected scholarly works on healthcare interpreting. Following the literature review on healthcare interpreting, the second section in this chapter was devoted to the theoretical framework, consisting of Bourdieu's sociological approach employed in the study. Pursuant to Bourdieu's key concepts, I explained the methodology I benefited from in this study.

In the first section of Chapter Two, I restricted my research to selected studies on healthcare interpreting, since the present study focuses on healthcare interpreting. My research on healthcare interpreting was completely based on scholarly research, scrutinizing the role of interpreters in healthcare settings. In the literature review, challenges have been put forward to the notion of the 'conduit', 'invisible', 'non-participatory' role of interpreters. This challenge has been shown in two ways. Firstly, role typologies which have been suggested for healthcare interpreters have been discussed. Secondly, case studies which analyze the active role of interpreters and oppose the role of interpreters like a machine translation have been analyzed. As a consequence, the shift from a 'conduit', 'invisible' and 'non-participatory' role to an 'active', 'visible', and 'participatory' role for interpreters has been put forward in healthcare settings. This kind of involvement has been supported by, for instance, an advocacy role, mediator role, etc. which creates a dilemma in terms of codes of ethics and standards. Therefore, it has also been claimed that codes of ethics of associations should be reviewed by taking into consideration real-life situations in practice.

In the second part of Chapter Two I introduced my theoretical framework. Bourdieu's sociological approach formed my theoretical framework for this research, and here I first introduced the concepts of 'habitus' and 'capital'. The preliminary objective of this study is not to focus on analyzing the interpreters' habitus and capital in detail. Instead, strategies and decisions taken or not taken by the interpreters during interpretation have been discussed, benefiting from Bourdieu's main concepts of habitus and capital. Thus, Bourdieu's concepts enabled me to analyze the role of interpreters adopted and/or imposed by the institutions. Before explaining these concepts, I gave brief information about Bourdieu's concept 'field' to ensure a holistic view of Bourdieu's sociological approach and a deeper understanding in the first section where I

explained the notion of habitus. In this regard, I aimed to give the relation between these three fundamental concepts of Bourdieu. Pursuant to information regarding the notion of habitus, I investigated the notion of capital, which plays a pivotal role in the analysis of my thesis. I elaborated on economic, cultural, social and symbolic capital with the relevant examples related to my research topic in detail with the aim of problematizing the role and position of interpreters in Turkish healthcare settings. In the last part of this section, I exemplified the use of Bourdieu's concepts in interpreting studies. My research has shown that his sociological approach and concepts have been more frequently used in translation studies, when compared to research in interpreting studies.

Chapter Two also included the methodology I benefited from in my study. I divided this section into three main sub-sections in order to present detailed background information. Attention was first given to information about ethnographic research and the case study as a qualitative research method. I included this part since these research methods clearly represent the process of data collection of my study. Following detailed information and sample studies for these research methods, I explained data collection methods, which I applied in order to attain data. Data was obtained from interviews, participant observation and audio-recordings of encounters between healthcare providers and patients enabled by the interpreters. This part was analyzed in detail as sub-sections. First, I analyzed the method of interview. Interviews were conducted with a total of fourteen interpreters working in ten private hospitals as well as five patients who have used interpretation services in Turkey, in order to have a broader overview of the profession. Interviews with both healthcare interpreters and patients were semi-structured with open-ended questions in order to enable them to explain their experience, ideas and issues raised during the interview process. Thus, it also helped me to collect an in-depth and comprehensive data through their answers on their role. The other two methods employed in the study were participant observation and audio-recordings of the encounters. As a consequence, upon the oral approval of hospital executives, I could seize the chance to participate in the encounters and to observe, and to record the actual role of interpreters in real-life situations and note naturally-occurring data by adopting a fieldwork strategy. Data obtained from interviews with healthcare interpreters and

patients has been supplemented by participant observation and audio-recording, enabling an in-depth analysis regarding the role of interpreters.

**Chapter Three** constitutes a significant part of the analysis in which I discussed the role of interpreters from the interpreters' and patients' perspective, obtained through the interviews. I organized this chapter into seven parts. As the current study analyzes the role of interpreters in healthcare settings, the notion of setting was discussed in detail in the first two sections.

My study revealed that there are two different notions in healthcare settings in Turkey. The first one is health *tourism* which refers to travelling to another country for health issues, such as hair transplantation surgery or cosmetic surgery, etc. The second is tourist health, referring to interpretation services provided for foreigners having come to Turkey for a vacation and needing an interpretation service in emergency cases at hospitals. Furthermore, three types of "foreigners" who need interpretation service in healthcare settings in Turkey have been observed: a) foreigners who come to Turkey specifically for health issues, b) foreigners who live in Turkey but who do not speak Turkish well, and c) foreigners who come to Turkey for a vacation and who need interpretation service in hospitals in emergency cases. My study has further revealed that while large-scale hospitals provide interpretation service for all three types of foreigners/patients, small-scale hospitals do not provide such interpretation services for the patients who come to Turkey within the scope of health tourism. Rather, they only provide interpretation service for the patients who reside in Turkey and the patients who come to Turkey for a vacation and need interpretation service in emergency cases. In the light of these findings, I could claim that both large-scale and small-scale hospitals have been included in the study. In other words, while interviews have been conducted with interpreters working in both large-scale and small-scale hospitals, observation and audio-recordings, except in one large-scale hospital, have all been obtained in three small-scale hospitals which provide interpretation services only in emergency cases for foreign patients. In total, data was gathered from ten different private hospitals located in Istanbul, Izmir and Aydın with different patient bed capacities.

After laying the foundations of the setting in which interactions take place, participants have been focused on in the third section. In this section, interpreters' background information was categorized and analyzed in sub-sections under the title of language pairs, education, and work experience. According to their responses, only five interpreters out of fourteen interpreters have an academic background in the form of a bachelor's degree in translation and interpreting. The remaining nine interpreters have neither an academic background in the department of translation and interpreting nor in the field of medicine. Thus, my study has clearly revealed that training in medical terminology and interpreting is not an issue for the hospitals, though five interpreters happen to be trained interpreters. Instead, all interpreters have been employed thanks to their language skills and knowledge rather than their academic background and field knowledge. To put it another way, my study suggests that most of these interpreters lack cultural capital in its institutionalized form. Therefore, the findings clearly revealed that cultural capital in its institutionalized form does not always convert into economic capital, unlike Bourdieu's arguments. Instead, linguistic capital as a sub-type of cultural capital has been turned into economic capital since interpreters' language knowledge has superseded their academic background in interpreting and field knowledge. Even though almost all interpreters have indicated that they improved themselves in terms of medical terminology knowledge through their work experience at the hospital, the process during which they gain experience might pose a risk to patients' wellbeing.

In the third section of this chapter, I analyzed the role of interpreters along with the issues of empathy, ethics and terminology. The statements relevant to the issue of role, empathy, ethics and terminology were extracted from the interviews and analyzed in sub-sections. Interviews with interpreters demonstrated that interpreters might adopt additional roles apart from interpreting in hospitals. It became apparent that all interpreters, for instance, are also busy with translating documents such as medical reports, surgery reports, etc. and also conducting the patients' insurance claims and all kinds of procedures within the hospital. Additionally, some interpreters also explained that they provide physical or even medical assistance for the patients. According to the statements of the interpreters, it became clear that interpreters are busy with other responsibilities under different titles such as 'corporate communication executive' or

'marketing manager'. All these roles explicitly show that there is no job description and restriction for interpreters in healthcare settings in Turkey. Some of the interpreters claim that the interpreters are employed as an 'international patient authority' or a 'guide', or for the department titled 'Foreign Public Relations Department'. Even these titles reveal the lack of awareness regarding the profession and role of interpreters in Turkey. In this regard, my study unveiled that there are responsibilities and burdens on interpreters in addition to the task of interpreting, which are beyond their scope. Thus, it could be claimed that all physical and medical assistance provided by the interpreters for the patients might pose a risk to the patients' health, since interpreters have not acquired an academic training in order to be able to provide such kinds of assistance. From a Bourdieusian approach, it could be argued that the interpreters lack an institutionalized form of cultural capital in terms of medical knowledge. In other words, the interpreters do not have the same medical knowledge as the doctors have. Therefore, this kind of assistance also leads to violations of the principles of professionalism. Nonetheless, it became clear that all interpreters undertake these responsibilities and tasks which are well beyond their capacities, in order to acquire economic capital, i.e. to earn money.

In this section, empathy was identified as another topic of debate. Some interpreters emphasised the psychological perspective of the profession, leading to a need to show empathy for the patients. However, my research suggest that this is one of the controversial issues in interpreting studies. While some associations include psychological factors in the role of interpreters, others strictly forbid this kind of intervention. Thus, it could be claimed that the interpreters violate the principle of professionalism and impartiality according to some associations' codes of ethics and conduct as well as standards. However, I would also argue that empathy shown by the interpreters could be tackled as an embodied form of habitus. Thus, habitus of the interpreters affects their roles, resulting in adopting additional roles apart from interpreting.

The following section encompasses a discussion on the decisions taken by the interpreters in relation to ethics. The present study revealed that some decisions of interpreters are controversial in terms of ethics. One of those decisions is related to the

financial interests of hospitals. In other words, the interpreters have to make decisions in line with the hospital's expectations and working conditions in order to acquire or even increase their economic capital. Thus, an aspiration of hospitals to acquire or increase economic capital affects the decisions and roles of interpreters during the interpretation process. As a consequence, it leads to a violation of impartiality, since the interpreters side with the hospitals.

Another question was about eliciting whether the interpreters are affiliated to any associations in the field of medicine or translation and interpreting. According to the findings of the study, most of the interpreters are not affiliated to any associations. Thus, this point could be also argued as one of the factors determining their decisions, which might lead to violating ethical principles. Some of the interpreters even explicitly indicated that their profession is underrated by other staff in the hospital. Or, the interpreters are the ones who are accused by both parties, namely, by healthcare providers and patients, when a problematic case occurs. Therefore, the interpreters also have a task to persuade both parties and to prove their innocence. From a Bourdieusian approach, it could be concluded that these interpreters lack symbolic capital, which is about power and prestige within the hospital. Because of all the negative sides of the profession and workload, most interpreters share the same view regarding their salary. Almost all interpreters touch on the fact that their profession deserves better salaries. Therefore, it is also clear that they do not acquire economic capital at a desired level.

Terminology was another topic discussed in this section. All interpreters laid an emphasis on a good knowledge of medical terminology. In the same manner, almost all interpreters indicated that they encounter terminological problems to some extent either in understanding the terms utilized by the doctors or in explaining expressions to the patients. Consequently, the study showed that the strategies employed by the interpreters are *simplification*, *explicitation*, *addition, omission* and *body language,* while the interpreters ask for a repetition or explanation when s/he does not understand the terms used by the doctor. From a sociological perspective, these kind of strategies, namely, additions, omissions, etc. are not perceived as an error. Rather, they are accepted as a necessity within this specific setting. However, it should be noted that omitting some

medical terms might also be problematic in terms of ethics, since the interpreter might omit important information concerning the patient's health.

However, regardless of all the negative findings in terms of the role of interpreters, interviews with the patients disclosed that all the patients are satisfied with the interpretation service they received in Turkey, as the interpreters are the only agents who enable their communication with healthcare providers. It has been further disclosed that patients do not question the interpreters' performance in detail.

The last discussion section of Chapter Three also focuses on the analysis through the data obtained from participant observation and audio-recordings. This section has been discussed under three sub-sections 'Interpreters showing empathy', 'Interpreters omitting certain utterances', and 'Interpreters acting as healthcare providers'. The data in this section has supplemented the analysis of interviews with interpreters and patients.

As in the case of interviews, the interpreters have been observed and audio-recorded while showing empathy both with their behaviours and also utterances. However, it is again a controversial issue in terms of ethical principles and role. However, the current study did not show any negative aspects of showing empathy. Instead, the patients have been observed as relieved.

In the following part, interpreters have been observed to omit certain utterances and two types of omissions have been observed and recorded. First, interpreters and healthcare providers have conversations about the patients' treatment and health conditions in front of the patient. Second, interpreters omit some utterances which are significant for the patients' well-being. In other words, the interpreters, intentionally or unintentionally hide information from both parties. By doing so, they violate the principle of accuracy and impartiality. The two interpreters whose actual performance was observed did not have an academic background in translation and interpreting. To put it another way, they lack cultural capital in an institutionalized state. Though my study does not specifically focus on the educational background of the interpreters, it could be argued in this case that these interpreters are not aware of their role as an interpreter and the criticality of the service they provide, since omissions of important utterances might pose a risk to the patients' health.

In the last section of Chapter Three, I scrutinised the interpreters acting as healthcare providers. Interpreters have been observed to have made a suggestion for the patients or answered on behalf of the doctor. However, the fact that these interpreters do not have medical knowledge at the same level as the doctors have, namely, they do not have the same cultural capital. Therefore, these kinds of interventions by the interpreters are quite risky. Furthermore, they violate the principle of professionalism.

To sum up, this study is planned as a case study, adopting fieldwork strategy in order to provide an in-depth analysis based on real-life data. Interpreters' roles have been analyzed at two levels: micro and macro levels during and beyond interpretation. The decisions taken and not taken by the interpreters have been related to an issue of ethics at a macro level beyond interpretation. Moreover, the role imposed on interpreters apart from interpreting has also been analyzed at a macro level besides interpretation. One of the most striking conclusions of this study is the contradictions observed between what the interpreters say they do and what they do in real life. Even though almost all interpreters explicitly indicated that they are well aware of the sensitive nature of the profession, the interpreters whose interpretation process has been observed and audio-recorded clearly disclosed that there is a lack of awareness regarding the profession and their role. However, I could further claim that there is also a lack of awareness on behalf of the hospitals. This claim has been proved by the fact that although healthcare interpreters are expected to have the relevant terminological knowledge, in my study it is has been noticed that almost none of the interpreters recruited have been expected and required to demonstrate this knowledge in addition to their interpreting background. It became obvious that the linguistic capital acquired by the interpreters played a more crucial role in attaining the job in a hospital than acquiring cultural capital in an institutionalized form. Apart from that, the factors determining the interpreters' role could be listed as hospital expectations and working procedures as well as setting. Consequently, five points which could be contradictory in terms of ethics have been put forward in this study. First, empathy has been put forward as an important factor designating the role of interpreters, which might constitute a contradiction in terms of ethics. The second point is the omissions of certain utterances which include medical information, made by the interpreters. Third, the role adopted by the interpreters as a

healthcare provider could be risky in terms of the patients' health. Fourth, different roles are imposed on interpreters, most of which are beyond their scope and capabilities. And the last category is that interpreters assume the responsibility to persuade patients.

The findings I obtained revealed that the interpreters in my study also do not act as a translation machine or conduit, rather the interpreters arise as active participants in the interaction. However, the interpreters are far beyond an active role, unlike the studies I scrutinised in the literature review. Rather, the interpreters in this study play an 'interventionalist' role, which might lead to violations of ethical principles and pose a risk to quality of service both for patients as well as healthcare providers.

They adopt different roles apart from interpreting most of which are far beyond their capabilities. Thus, these roles might lead to violations of impartiality, accuracy, and professionalism. Apart from the responsibilites imposed on interpreters, decisions and strategies which become part of the role of the interpreters during interpretation might affect the patients' treatment process and well-being. All these examples analyzed in detail in this study clearly reveal the significance of the analysis of decisions and strategies taken during interpretation in terms of ethics beyond interpretation. These examples also show that hospitals are not aware of the importance and criticality of interpretation service they provide as a hospital, since they recruit untrained interpreters who lack an academic background in translation and interpreting, and also in medical terms. The violation of some ethical principles might be an implication of this lack of awareness of hospitals. All these examples clearly reveal the role of interpreters and also show the possible implications of the lack of codes of ethics and conduct as well as national standards for healthcare interpreters in Turkey. However, it should be noted that lack of codes of ethics and conduct as well as standards for healthcare interpreters in Turkey might not be the only reason for these examples discussed in the study.

Also, the current study disclosed the gap in terms of patients' perspectives. Even though interviews with the patients showed that they are satisfied with the interpretation service they acquired in Turkey, it has been observed that there are also cases where the patients are dissatisfied with the interpreters' some decisions such as refraining from interpreting some documents or conversing with healthcare providers in front of them in

Turkish. This contradiction reveals the importance of further research on patients' perspectives in detail.

Consequently, decisions and strategies taken or not taken by interpreters during interpretation at a micro level have been analyzed in relation to role and ethics beyond interpretation at a macro level. Furthermore, the roles imposed on interpreters besides interpreting have also been analyzed in detail at a macro level.

My research also lead to a number of possibilities for further research in this field. One might be to investigate only patients' perspectives since this study put forward the gap in terms of patients' perspectives as mentioned above. Even though it is not within the scope of this thesis, patients' perspectives on interpretation service in Turkey might be studied in detail. Another research might be to discover whether gender plays a role in shaping the interpreters' role in healthcare settings. For example, impact of gender differences such as male doctor and female patient, or female doctor and male patient as well as female interpreter and male patient could be studied. Finally, interpretation needs and services in private and state hospitals in Turkey could be studied comparatively.

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# APPENDICES

**Appendix 1:** Consent Form

## KATILIMCI BİLGİLENDİRME FORMU (CONSENT FORM)

Hastane çevirmenliği başlığı altında çevirmenlerin doktor-hasta görüşmeleri sırasında yaşadığı sorunları ele alan ve Yrd. Doç. Dr. Şeyda ERASLAN tarafından yürütülen bu çalışma, Dokuz Eylül Üniversitesi Mütercim-Tercümanlık bölümü İngilizce Mütercim-Tercümanlık anabilim dalı yüksek lisans tezi kapsamında yapılmaktadır.

Çalışmanın amacı sağlık sektöründe hastane çevirmenliği yapan çevirmenlerin yukarıda da belirtildiği üzere doktor-hasta görüşmelerinde yaptıkları çeviri sırasında yaşadıkları sorunlar ve bu sorunları ortadan kaldırmak ve sağlıklı iletişimi sağlamak için uyguladıkları stratejileri ortaya çıkarmaktır.

Tezde çevirmen ve hastane isimleri anonim kalacak olup, hiçbir şekilde açıkça belirtilmeyecektir.

Katılımınız ve değerli görüşleriniz için teşekkür ederim.

**Appendix 2:** Interview questions for interpreters

**Interview Questions for Interpreters**

## GENEL NİTELİKLER

1. Hangi diller arasında çeviri yapıyorsunuz? Bu dillerden hangisi sizin anadilinizdir?
2. Daha önce sözlü veya yazılı çeviri deneyiminiz oldu mu?
3. Ne kadar süredir hastane çevirmenliği alanında çalışıyorsunuz?
4. Kadrolu mu yoksa serbest olarak mı çalışıyorsunuz?
5. Tercümanlık eğitimi aldınız mı? Çeviri eğitiminin daha iyi çeviri yapmak için gerekli olduğunu düşünüyor musunuz? Neden?
6. Sağlık/ hastane çevirmenliği konusunda ayrıca bir eğitimin gerekli olduğunu düşünüyor musunuz? Neden? Cevabınız evetse nasıl bir eğitim olmalı?
7. Belirli bir mesai saati içerisinde mi çalışıyorsunuz? Yoksa çalıştığınız saat aralığı değişkenlik gösteriyor mu?
8. Sadece işyerinde bulunduğunuz sürede mi çeviri yapıyorsunuz, yoksa işiniz için evden de çeviri yapıyor musunuz?
9. Sizin dışınızda işyerinizde çevirmen çalışıyor mu? Kadrolu mu serbest olarak mı?
10. Yaptığınız iş göz önüne alındığında yeterli maaşı aldığınızı düşünüyor musunuz?
11. Hastane içerisinde ayrıca yazılı çeviri de yapıyor musunuz?
12. Hastanede size ne sıklıkla sözlü çeviri için ihtiyaç duyuluyor? ( Ne kadar sıklıkla hasta geliyor?)
13. Doktor-hasta görüşmelerinde hangi çeviri yöntemini uyguluyorsunuz? (Ardıl çeviri mi, yani hasta/doktorun cümlesinin bitmesini bekleyip sonrasında dediğini aktarmak, yoksa fısıltı çeviri mi yani doktor/hasta konuşurken aynı anda mı çeviriyorsunuz?)

## ÇEVİRMENİN ROLÜ

14. Doktor ve hasta arasında iletişimi sağlamanın yanı sıra hastane içerisinde ayrıca başka görevler de yapıyor musunuz? Görev tanımınız çerçevesinde sizden beklenenler nelerdir? (Örneğin, hastaya refakat etme, hastane işlemlerinde yardımcı olma vb)
15. Doktor ve hasta arasındaki iletişimi sağlarken, mesajı aktarmanın yanı sıra müdahale etmeniz gereken durumlar oluyor mu? (Örneğin, doktorun söylediğini açıklama, çeviriyi tekrar etme vs.)
16. Söylenileni olduğu gibi eksiksiz bir şekilde mi aktarıyorsunuz yoksa özet şeklinde mi çeviriyorsunuz? Hangi durumlarda ve neden?

17. Genel olarak hangi durumlarda aktarımda güçlük çekiyorsunuz? Örnek verebilir misiniz?
18. Sizce bu alanda (hastane çevirmenliğinin) çalışmanın zorlukları/dezavantajları nelerdir?
19. Çeviriyi yaparken "Ben" diliyle mi çeviriyorsunuz yoksa dolaylı anlatım yoluyla mı çeviriyorsunuz? ( Örneğin, 'Hasta "Karnım ağrıyor" dedi'şeklinde mi yoksa "Karnım ağrıyor" diyerek mi, vb.)
20. Doktor, sağlık görevlisi ve hastayla iletişiminiz konusunda önceden bilgilendirildiniz mi? Doktorlar ve sağlık görevlileri bu konuda bilgilendirildi mi?
21. Çevirinin sağlıklı yürümesi için çevirmen(ler) ve hastane personeli arasında bir işbirliği mevcut mu? Bu işin bir ekip işi olduğu konusunda farkındalık yeterli mi? Değilse farkındalığı arttırmak için neler yapılabilir?

## TERMİNOLOJİ

22. Size hastane tarafından önceden herhangi bir terminoloji temin edildi mi? Veya kullanmanız gereken terimler hakkında bilgi verildi mi? Verilmediyse siz kendiniz herhangi bir terminoloji oluşturdunuz mu?
23. Sizin ve varsa meslektaşlarınızın kullandığı mevcut bir veritabanı, terimce veya sözlük var mı?
24. Doktorun çeviri sırasında terimlerle ilgili size müdahale ettiği oluyor mu? (Örneğin ".." terimi yerine "..." terimini kullan gibi)
25. Doktor ve hastanın kullandığı dil arasında farklılıklar var mı? (Örneğin, doktor Latince terimler kullanırken hastanın günlük dil kullanması) Sizden bu farklılıkları gidermeniz bekleniyor mu?
26. Doktor Latince bir terim kullandığında bu terimi Latince olarak mı hastaya aktarıyorsunuz yoksa hastanın dilindeki eşdeğer kelimeyi söylerek mi aktarıyorsunuz?
27. Terminoloji kaynaklı sorun yaşıyor musunuz? (Doktorun kullandığı terimi anlamama veya Latince terimi hastaya Latince aktardığınızda hastanın anlamaması gibi) Eğer bu tarz terminoloji kaynaklı sorunlar yaşıyorsanız bu sorunları ortadan kaldırmak ve iletişimi sağlamak için ne tür stratejiler uyguluyorsunuz? (Örneğin, ekleme, çıkarma, açıklama veya sadeleştirme, vb.)
28. Hastanın ülkesi, dili, ekonomik durumu vb. gibi unsurlar sizin çeviri stratejilerinizi ve kullandığınız terimleri etkiliyor mu? Açıklayabilir misiniz, örnek verebilir misiniz?

## ETİK

29.Hukuki açıdan sizi destekleyen herhangi bir kanun var mı?
30.Bağlı olduğunuz bir dernek var mı?

31.Sağlık çevirmeni olarak uymanız gereken etik kurallar ve etik sorumluluğunuzu biliyor musunuz? Eğitiminiz veya iş yaşamınızda bu konuda yeterli derecede bilgilendirildiniz mi?

**SONUÇ :**

Size sormak istediğim sorular bu kadar. Sizin ayrıca mesleğinizle ilgili eklemek istediğiniz şeyler var mı?
Katıldığınız ve vakit ayırdığınız için teşekkür ederim.

**Appendix 3**: Interview questions for doctors

1. Kaç yaşındasınız?
2. Branşınız nedir?
3.Kaç yıldır doktor olarak çalışıyorsunuz?
4. En çok hangi ülke vatandaşları ile iletişim konusunda sorun yaşıyorsunuz?
5.Günde ortalama kaç tane yabancı hasta geliyor?
6. Hastanede tercüman istihdam ediliyor mu? Eğer yoksa, tercümanın olmadığı durumlarda yabancı hastalarla iletişimi nasıl sağlıyorsunuz?
7. Hastaların akrabaları vs. hatta çocukların çeviri yaptığı durumlar oluyor mu? Örnek verebilir misiniz, açıklayabilir misiniz? Ve bu tarz çevirileri nasıl değerlendiriyorsunuz? (Sizce tedaviye olumlu/olumsuz etkileri nelerdir?)
8. Sizce iletişimi sağlamak için profesyonel tercüman gerekli mi yoksa hasta yakınlarının yaptığı çeviriler de yeterli oluyor mu?
9. İletişimin sağlanamamasına bağlı olarak yaşadığınız herhangi bir olumsuz vaka var mı?
10. Bu iletişim sorununu ortadan kaldırmak için sizce yapılması gerekenler nelerdir?

**Appendix 4**: Interview questions for Patients

1. Have you ever used interpretation service in Turkey before?
2. Are interpretation services necessary for smooth communication during patient-doctor encounters?
3. Have you encountered any difficulties such as understanding the renderings of interpreter or explanations of doctor during the encounter with the doctor?