Diagnosing Healthcare Assignments: A Year of Medical Interpreting for Deaf People in Austria and Germany

Patricia Brueck, Juliane Rode, Jens Hessmann, Britta Meinicke, Daniela Unruh, and Anja Bergmann

ABSTRACT

This chapter presents the insights of five practicing signed language interpreters into the conditions and factors that characterize professional interpreting in the medical field in Austria and Germany. To this purpose, a total of 142 healthcare assignments, completed by the five interpreters in 2012, were documented and analyzed. After considering general challenges offered by the medical setting and outlining field-specific conditions in Austria and Germany, we discuss recurrent features of medical encounters between deaf patients and hearing doctors that involve a signed language interpreter. The data presented here suggest that, more often than not, interpreters will encounter conditions that are conducive to the satisfactory outcome of healthcare assignments. However, a number of risks and potential stumbling blocks require the reflective practitioner to practice circumspection.

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Just like anyone else, deaf people need medical appointments, some of which may be of a routine nature, while others may involve severe health problems. Unlike most people, however, deaf people often rely on mediated communication in order to be able to access what may be very personal, sensitive consultations and treatments. In countries like Germany and Austria, this has given rise to social regulations that enable them to draw on the financial support necessary to employ the services of professional interpreters. Accompanying a deaf person to see a doctor is a standard feature in the wide range of public service interpreting assignments offered by most signed language interpreters in both countries. Depending on the circumstances, being involved as a third party in encounters between deaf patients and hearing doctors may be experienced as particularly challenging and emotionally trying. Since healthcare interpreting assignments deal with matters of immediate personal concern, they often involve dimensions of closeness and trust that go beyond the demands of many other settings.

This chapter reflects the experiences of five full-time signed language interpreters working in the medical field. We, the interpreters, are all female and professionally active in the western and southern regions of Germany and in the Vienna area in Austria. For the purposes of the study presented here, we tracked all of our healthcare assignments in 2012. These assignments aCCount for some 10-15% of our total assignments that year. All of the healthcare assignments that form the basis of this study are listed in the appendix; expressions like "A:006," for "assignment no. 6 in 2012" refer to this list.

The study continues efforts to enhance the research orientation of working professionals and encourage the evolution of a practice-oriented research community, as cultivated in the EUMASLI (European Master in Sign Language Interpreting) study program (Hessmann et al., 2011; cf. www.eumasli.eu). All five of us graduated from the EUMASLI program in 2011. For the purposes of this study, we continued our cooperation with one of the EUMASLI teachers in the collaborative spirit of the study program. We did not consider ourselves specialists in medical interpreting. Rather, as a routine part of a varied professional practice, the specific features of healthcare assignments may easily be overlooked, and accompanying a deaf person to the doctor becomes "just another job." Thus, this study started as an attempt to counter the lack of awareness and reflection that may develop with the routine handling of what more often than not is a sensitive kind of assignment. We decided to take stock: if success resides in the satisfaction of the participants and, more particularly, in enabling deaf patients to achieve the goals of obtaining medical advice and treatment, then what is it that contributes to the successful outcome of a medical assignment? Conversely, what are the aspects that are experienced as problematic and potentially detrimental to such success?

Here we try to answer these broad questions by looking at a year of collective experience in the medical field. With reference to the literature we first review relevant features that concern deaf people's access to the healthcare system and the special challenges that medical settings pre-

sent to signed language interpreters. We then provide background on the healthcare system in Germany and Austria as relevant to deaf people and characterize general aspects of our data. After that we describe (in some detail and with reference to particular assignments) the stepping-stones and stumbling blocks encountered in this one year of professional interpreting work in the medical field. In conclusion, we consider a number of limitations of this study and point out consequences for research as well as professional practice.

SIGNED LANGUAGE INTERPRETING IN THE HEALTHCARE SYSTEM

Deaf People's Access to the Healthcare System

Signed language interpreters generally work in a wide range of settings. They offer their services in almost any situation where deaf people encounter the hearing world. Assignments in the healthcare system are a routine part of the professional life of most signed language interpreters. Ideally, deaf people might prefer the services of a doctor who is competent in sign language (McKee et al., 2011), but, as a rule, one must have access to the dominant language in order to benefit from the services of the healthcare system. Therefore, deaf people need signed language interpreters if they are to be able to communicate in their natural language, given that the proficient use of one's own language is necessary for identity and self-esteem (Wedam, 2009, p. 185). That patients must be enabled to make informed decisions is universally acknowledged as a basic right (Gonzalez-Nava, 2009, p. 74). Moreover, the difficulties that deaf people encounter within the healthcare system underlines the importance of signed language interpretation to bridge gaps in communication between deaf patients and hearing medical staff and enable deaf patients to get all the information they need: "Interpreters for deaf people in medical settings are not a luxury or nicety but rather a service mandated by law" (Frishberg, 1990, p. 118).

Physicians often report significantly greater difficulties communicating with deaf patients than with their patients in general (Ralston, Zazove, & Gorenflo, 1996). In fact, many healthcare providers have unrealistic expectations regarding the use of spoken and written language by deaf people:

> [M]any health care workers expect deaf individuals to write notes in English that clearly express the thoughts or questions of the individual and to read lips perfectly. No other subset of Americans who use English as their second language are expected to do this, nor are they presumed to be retarded when they fail at these efforts. Deaf individuals, on the other hand, are expected to do both. (Harmer, 1999, p. 96, in reference to Lotke, 1995)

Similarly, in their study of observations by persons who are deaf or hard of hearing, Iezzoni et al. (2004) found that respondents perceive "that physicians do not fully recognize the implications of communication barriers and have fundamental misconceptions about effective communication modalities" (p. 360). Inquiring into the knowledge, beliefs, and practices of physicians, Ebert & Heckerling (1995) concluded that "although most physicians recognized the appropriateness of using sign language interpreters to communicate with deaf patients, only a minority used these interpreters in their practices" (p. 229). An analysis of the perceptions of 25 Brazilian signed language-using patients demonstrates "the existence of a scenario of incommunicability that discourages enlightened decision making by patients about their own health" (Pereira & Fortes, 2010, p. 36).

The ability to communicate accurately with a patient is "one of the most effective and least expensive tools in diagnosing and treating patients" (Swabey & Nicodemus, 2011, p. 243), considering that medical diagnoses are often based on a medical history recorded during a conversation between patient and doctor (Harmer, 1999, p. 75).

Byrne and Long (1976) identified six phases of a medical consultation:

- establishing the doctor-patient relationship
- finding out the reason for the patient's attendance
- a verbal or physical examination
- consideration of the patient's condition
- explanation of treatment or further investigation
- termination

All of these phases depend on rwo-way communication and on information passing berween the rwo parties involved. "Communication is often the most important feature of a successful relationship between a health care provider and ... patient" (Shipman, 2010, p. 434; cf. van Dulmen, 2011). Ir is therefore crucial to use interpreting services for an accurate and meaningful diagnosis and treatment of deaf patients.

However, "the magnitude of the problems posed by speaking through an interpreter" (Aranguri, Davidson, & Ramirez, 2006, p. 627) needs to be recognized.

Special Challenges of Medical Settings

One of the problems facing signed language interpreters in medical settings is the huge variety of situations such as initial medical consultations, medicaJ interviews, physical checkups, diagnoses, medical examinations, emergency room visits, in- and outpatient services, operations, healthcare education, explanations of treatments and prescriptions, and descriptions of discharge and follow-up care. Humphrey and Alcorn (1995) discuss settings in which interpreters are contracted for medical appointments that may take place in a neighborhood clinic or at a doctor's office. They mayaiso be called to interpret in a variety of laboratory or hospital procedures, which can range "from emergency room procedures to routine tests and surgicallpost-surgical events" (ibid., p. 308). Clearly, medical interpreting is nothing short of "diverse and unpredictable" (Napier, Locker McKee, & Goswell, 2006, p. 111).

Because of the huge variety of situations, the importance of accurate interpretation, the technical knowledge needed, and the emotional challenge involved, interpreting in healthcare settings is especially demanding (Tomassini, 2012). Interpreters in these settings should have a general knowledge of common illnesses, medical tests, treatments, procedures, and equipment. They also need to be familiar with human anatomy and the roles of various medical professionals (Napier, Locker McKee, & Goswell, 2006, p. 112; Humphrey and Alcorn, 1995, p. 311; Frishberg, 1990, p. 119). However, currently few interpreters have any specific medical training or background, and most of them have to rely solelyon their everyday experience and general knowledge, which may give rise to serious communication problems in a field characterized by specialized expertise and terminology (Gorjanc, 2009, p. 85; Napier, Locker McKee, & Goswell, 2010, p. 118f.).

In medical settings, doctors are often regarded as authority figures who ha ve their own ways of interacting with the client. However, the degree of participation of the patient may weil have an impact on physicians' patient-centered communication (Cegala & Post, 2009). One relevant aspect of interpreted interaction is the positioning of the participants in relation to each other, which can significantly influence the communicative setting not just in terms of physical proximity but also because the seating arrangement may imply a hierarchy among the parties involved (Felgner, 2009, p. 58). The "interpreter will need to tactfully negotiate where to position themselves in the doctor's space" (Napier, Locker McKee, & Goswell, 2010, p. 119). Still, it is virtually impossible to find an ideal placement that can be kept for the whole assignment (Humphrey & Alcorn, 1995, p. 309). Initially, the interpreter needs to be flexible and adjust her position, based on the type of examination, the size of the room, the visual needs of the patient, and the medical equipment. The interpreter must also be ready to reposition herself to stay in visual contact with the patient without being in the doctor's way (cf. Felgner, 2009, p. 59; Frishberg, 1990, p. 121).

For obvious reasons, healthcare assignments can be embarrassing for patient and interpreter alike (e.g., if the patient has to undress or expose private body parts), and interpreters must take care to respect the patient's privacy (Humphrey and Alcorn, 1995, p. 309; Frishberg, 1990, pp. 119-120). "[T]he trick is knowing how to maintain sightlines with the deaf client, without embarrassing them" (Napier, Locker McKee, & Goswell, 2010, p. 119). If the patient has to get undressed, interpreters should give instructions beforehand as clearly as possible and then avert their eyes for the undressing. If an interpreter is necessary für the examination itself, the interpreter should make sure that she sees the deaf client's face, while facing away from any sensitive body parts (ibid.).

Interpreters often report that service providers and patients may have conflicting expectations as to the outcome of the consultation (Gonzalez-Nava, 2009, p. 72) as weIl as to the structure of the communication itself (Paulini, 2008, p. 95). While doctors generally expect short and pertinent answers to their questions, people from different cultural backgrounds, like Spanish or deaf people, tend to answer in a narrative style by telling a personal story (AngeleIli, 2004, p. 19). When patients' and doctors' cultural beliefs and values differ, establishing a cooperative partnership is impeded (Lee, 2002, cited in AngeleIli, 2004, p. 19). Disparities in cultural background leave ample room for "interlinguistic and intercultural mediation" (Pignataro, 2012). Mindess (1999) mentions substantial differences between hearing and deaf cultures and suggests techniques for cultural adjustment to compensate, such as skillful handling of the situation and elimination of misunderstandings to allow patients to control

the interaction themselves (p. 188). As Metzger's seminaI work (1999) has made clear, interpreters cannot afford to stay neutral but must be actively involved in the interaction if healthcare interpreting, or any other assignment, for that matter, is to succeed.

The Interpreter's Role in Healthcare Settings

Shortcomings of traditional models that propagate an ideal of "invisibility" and see interpreters as "conduits" or "machines" have long been recognized. Although "neutrality" is still a key term in many professional codes of ethics, medical interpreters' associations generally take into account that interpreting is just as much about cultural mediation and advocacy. The International Medical Interpreters Association (IMIA) states the following in its Code of Ethics:

> 7. Interpreters will engage in patient advocacy and in the intercultural mediation role of explaining cultural differences/practices to health care providers and patients only when appropriate and necessary for communication purposes, using professional judgment.
>
> 8. Interpreters will use skillful unobtrusive interventions so as not to interfere with the f10w of communication in a triadic medical setting. (http://www.imiaweb.org/codel)

A study by Angelelli (2003) and a survey by Tate and Turner (1997) found that interpreters' self-perceptions follow these lines, whereas other studies show that, when questioned, interpreters answered in the spirit of the conduit model, as implied by their professional codes, but acted differently in their daily work (Dysart-Gale, 2005; Hsieh, 2009). Interestingly, studies from Switzerland found that most of the doctors viewed interpreters as "translation machines" (Leanza, 2005; Singy & Guex, 2005). SimiIarly, in a Canadian study, Rosenberg, Leanza, and Seiler (2007) found that professional interpreters tended to be regarded as conduits or "cultural brokers," whiIe famiIy members were seen in a care-giving role.

Wadensjö studied medical interviews interpreted into spoken languages. She categorized interpreters' performances as "relaying" and "coordinating." The first category refers to interpreting in a narrow sense, that is, conveying what the participating parties intended to say, whereas the second category includes activities such as asking for clarification, prompting a response or turn at talk, and offering explanations (Wadensjö, 1992, pp. 18L).

With reference to signed language interpreting, the best-known discussion of the interpreter's role is found in Metzger (1999). In her study on healthcare interpreting, Metzger analyzes two types of discourse mediated by interpreters. One dataset came from role-plays in which students interpreted simulated medical interviews; the other set was taken from real medical interviews. Metzger found that interpreters actively participated in the communication and influenced the discourse in accordance with the participants' goals. More recently, Major (2013) stresses that healthcare interpreting is "relational practice"; professional interpreters can be shown to get actively involved in the f10w of interaction in order to maintain good relationships between all participants (see also Major, this volume).

AngeleIli (2004) observed and interviewed experienced spoken language interpreters working at the California Hope Hospital. She found that interpreters do not see themselves as invisible but get involved as "co-constructors to the interaction" (AngeleIli, 2004, p. 7). She proposed a continuum of visibility with a corresponding impact on the medical information involved. Interpreters in her study used a wide range of metaphors to describe their roles (ibid., pp. 130L). In his study of Spanish-English medical discourse with immigrants to the United States, Davidson (2000) found that interpreters were officially required to act as an "instrument," "saying all and only what has been said" (p. 400). In practice, however, interpreters are encouraged "to keep the interview short, and to keep patients 'on track'" (p. 401). In a note of criticism Davidson notes that the interpreters in his study in effeet "work as an extra gatekeeping layer through which patients must pass in order to receive medical care" (ibid.).

More recent attempts at modeling actual interpreting behavior and decision making recognize that interpreters cannot always act by the book but must respond f1exibly to the demands of specific situations. Based on interaction research on monolingual dialogues, where the dimensions of cooperation, enactment of roles, alignment, and accommodation figure prominently, Lee and Uewellyn-Jones (2011) postulate that "interpreters should make use of many of the same behaviors that the other participants make use of in an interaction, rather than calling upon some special interpreter-specific behaviors that might come across as strange and alien to the interlocutors" (p. 2).

Starting from this premise, Lee and Uewellyn-Jones's role space model identifies presentation of seH, interaction management, and alignment to deaf or hearing participants as the three dimensions that work together in the creation of actual interpreting behavior. One might predict that, in

healthcare assignments, relatively little self-presentation of the interpreter would coincide with high interaction management and a high level of alignment to deaf patients.

In another attempt at going beyond considerations of "right or wrong" and providing a realistic account of interpreting behavior, Rozanes (2013) suggests that interpreters tend to be protective about their goals and try to stay as much as possible in their "comfort zone." Healthcare assignments may weil pose challenges that put the dynamic equilibrium of the comfort zone at risk, but, as Rozanes asserts, it is challenges such as these that allow interpreters to grow as professionals.

Healthcare Interpreting Research in Austria and Germany

Only a few articles have been published dealing with signed language interpretation in healthcare settings in German-speaking countries. Those publications include two studies, one from 2001 and the other from 2012, both of which focus on the situation in Austria.

The older of the two studies (based on a questionnaire) analyzes the conversation practices of deaf patients in medical appointments. Deaf people from the Vienna area were asked about their experiences, their communication practices with doctors, and any problems they encountered when using interpreting services. The questionnaire was interpreted into signed language (Seeber, 2001). The more recent Austrian work is a qualitative interview study. Interviews were conducted with three deaf patients, one interpreter, and one doctor. They were asked about their experiences and communication strategies in medical assignments. The study also analyzes the extent of interpreter use and the challenges deaf people face when using an interpreter (Winkler, 2011).

As for Germany, we know of only a single study done in 1996 (Paulini, 2008). For this qualitative field study, 50 people with a hearing impairment were asked about their experiences in the healthcare field. These interviews took place in the course of two different workshops and via a communication forum. On the basis of the results of these interviews, Paulini formulated nine hypotheses that were tested in a follow-up questionnaire.

These studies are helpful in outlining basic aspects of how deaf people in Austria and Germany access the healthcare system. Our own study adds to this as yet small body of research and knowledge by presenting the views and experiences of interpreters who are professionally active in the healthcare field.

ONE YEAR OF SIGNED LANGUAGE INTERPRETING FOR DEAF PEOPLE IN THE GERMAN AND AUSTRIAN HEALTHCARE SYSTEM

This section describes the general situation of healthcare interpreting for deaf people in Germany and Austria and summarizes general aspects of the data that form the basis of our study.

General Situation

In Germany, deaf people are legally entitled to use signed language in medical appointments. The wording of the relevant Code of Social Law is as folIows:

> Hearing-impaired people have the right to use signed language in the execution of social services, particularly in medical examinations and treatments. The social service providers in charge are obliged to cover the costs incurred by the use of signed language and other communication aids. (German Code of Social Law *[Sozialgesetzbuch*], Book 1, §17)

This regulation, which went into effect in 2001, provides a basis for the reimbursement of signed language interpreting costs by the statutory health insurance programs. As a consequence, medical practitioners themselves are generally not directly involved in the provision and financing of signed language interpreters.

General regulations notwithstanding, some health insurance providers may refuse to cover the costs for interpreters at certain special appointments like preoperative discussions. In such cases deaf people must file a complaint and fight for their rights. Such appeals may weil be successful and may eventually compe! health insurance companies to cover interpreting costs. However, regulations do not apply in the same way in cases involving hospitalization because medical clinics must cover the costs for interpreting services from the case-based daily allowance that is provided by the deaf person's health insurance company. Private clinics are exempt from these regulations and decide for themselves whether to cover these costs, but even publically funded hospitals may try to minimize interpreting services in order to economize.

The situation in Austria is similar to that in Germany. A federal law passed in 2006 *(Bundesbehindertengleichstellungsgesetz)* requires all

public services, including services by associations or private companies funded with public money, to be accessible to people with disabilities. Apart from Carinthia,[1] all federal states cover the cost of interpreters at doctors' offices up to a maximum of €2,400 per year per client (including interpreting costs for other matters in their private lives, such as parent-teacher conferences).

Public hospitals and clinics are required to cover the costs of interpreting services out of their budgets, following the provisions of the 2006 law. Private clinics, exempt from the law, make their own determination whether to pay; some of them occasionally pay for some assignments, whereas others refuse payment altogether. In such cases, interpreting costs must be covered by the federal government, up to the aforementioned annuallimit of €2,400 per individual deaf person.

In addition, Austria has four publicly funded deaf clinics, in Graz, Linz, Salzburg, and Vienna. These clinics were established as apart of public hospitals run by the Roman Catholic Order of the Brothers Hospitallers. They provide medical, psychological, and social services by professionals in Austrian Sign Language (http://www.barmherzige-brueder.at).

General patterns of making use of interpreters are similar in both Austria and Germany. If deaf people need to see a doctor, they must first make an appointment. Often the deaf person will contact the medical interpreter first and ask her to make the appointment by telephone. Since the availability of interpreters is often a problem (cf. Parisé 1999, p. 67), many deaf clients will ask their regular interpreter to arrange an appointment according to the interpreter's availability. Alternatively, interpreters may be contacted through agencies, listings on the Internet, and so on (see the section titled "Procurement"). If deaf clients want to consult a medical specialist or a specialist clinic, their general practitioner will need to make a specialist referral.

Usually the deaf dient and the interpreter will meet at the doctor's office or the clinic at the appointed time. They will register at the front desk, then wait in the waiting room until being brought in to see the doctor or other medical staff for consultation, examination, or treatment. If a follow-up appointment is necessary, this is arranged at the front desk after the consultation.

Overall, increasing numbers of deaf people in both countries are taking advantage of their legal right and book a signed language interpreter when they have scheduled a medical appointment. However, as this study confirms, the use of interpreters is often limited to meetings with medical specialists, whereas general practitioners are frequently consulted without an interpreter. This may be due to a number of reasons, including already established long-term, trusting relationships between general practitioners and deaf patients; the use of family members, friends, or healthcare staff members as interpreters; or, in some cases, a general practitioner who is skilled in signed language. Another reason may be that a deaf person who sees a medical specialist rather than a general practitioner has a more complicated problem that needs detailed clarification and more specialized language. In such cases, deaf patients may prefer to bring in an interpreter to make sure they understand all of the details and are able to ask questions.

Assignments and Clients

In this section we outline the general characteristics of the assignments and the deaf dients involved in the 142 instances of medical interpreting in 2012 that form the basis of this study. A complete list of these assignments and more specific, relevant details appear in appendix 1.

HEALTHCARE ASSIGNMENTS

The whole dataset consists of 142 assignments for 60 patients that cover general practitioners (3%), public medical officers (1%), and 16 special medical areas (96%) (see figure 1).

The fact that 96% of all assignments are with medical specialists is striking. As mentioned earlier, this may be due to a number of reasons, including the fact that deaf patients may prefer to use an interpreter when seeing a specialist to avoid miscommunication but use other ways of communicating with their general practitioners (see the later section on procurement).

The most frequented specialties were the following:

- internal medicine (18%, induding vascular medicine, cardiology, diabetology, gastrology, nephrology, and colorectal surgery)
- ophthalmologists (15%)
- gynecologists and orthopedists (11% each)

The high percentage of visits to ophthalmologists may be related to the fact that deaf people crucially rely on their eyes. Therefore, they may be particularly sensitive to problems connected with sight. Of special note is that three assignments consisted of repeated otolaryngological examinations of

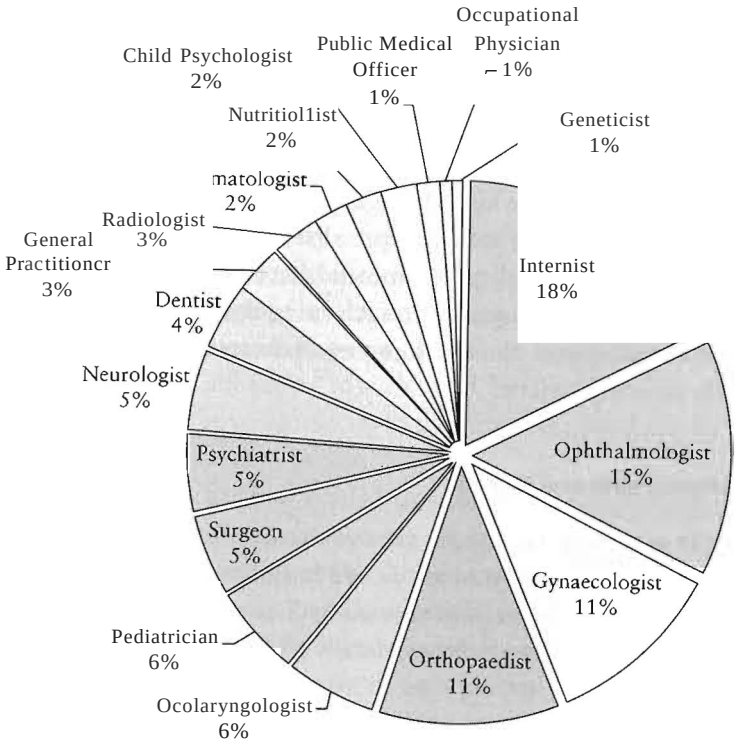

FIGURE 1. *Assigmnents by medical area.*

a young deaf woman suffering from persistent headaches after cochlear implantation (A:050, A:090, A:095).

Ninety-one (64%) of the assignments were considered to be of moderate or "normal" urgency, 18% were classified as particularly urgent (25), and 18% were of low urgency (26). Urgent cases included a case of epilepsy (A:028), cataract surgery (A:029), and suspected rubella during pregnancy (A:055). Cases of low urgency involved routine checkups, follow-up visits, and so on (e.g. A:010, A:039, A:047). Most of the assignments were planned and arranged beforehand and not spontaneous. As far as we know from our daily work, generally only a few interpreting assignments are emergency cases in a narrow sense because, first, both countries have a shortage of signed language interpreters, and, second, hospitals and doctors may not even try to find an interpreter if immediate medical action is called for. Worse, hospitals and doctors may not even be aware of the possibility of contracting an interpreter or, if they do, may not know how to do so. Some hospitals may draw on various deaf staff

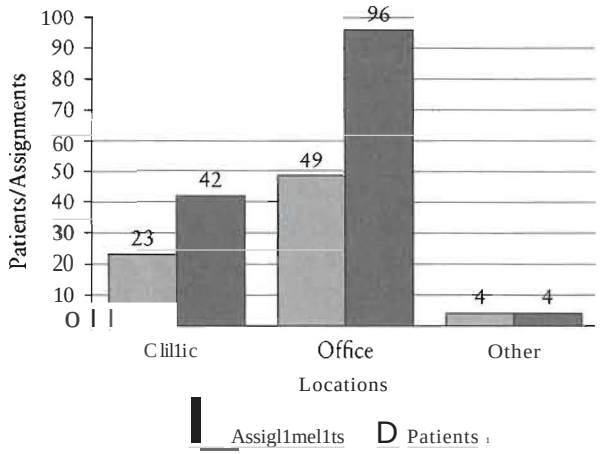

FIGURE 2. *Patients and assignments by location.*

members, who might be cleaning personnel or part of facility management, because they are deaf rather than because they have any medical interpreting competence (cf. Meyer, 2009, p. 144).

As figure 2 shows, 96, or 67.6%, of all assignments took place at doctors' offices, and only 42, or 29.6%, were at clinics. The remaining 4, or 2.8%, took place at offices where doctors examined the health status of the clients or their children in relation to decisions concerning school entry, retirement, disability allowances, and so on (see, for instance, A:027, A:100, A:129). The relationship between the number of patients and the number of assignments is very similar for both major types of location (1:1.8 for clinics, 1:2.0 for offices).2

DEAF PATIENTS

The patients were classified into six age groups. Figure 3 illustrates the numbers by patients and by assignments.

Figure 3 gives some indication of the distribution of patients to interpreters. Whereas in the age groups 30-39 and over 50, each deaf patient had, on average, two medical interpreting appointments; in the age groups 20-29 and 40--49, only a small number of deaf patients account for all of the assignments. Overall, the distribution of age groups seems to confirm the generalist approach practiced by most signed language interpreters: none of the interpreters in this sampie reported a preference for any particular age group. Rather, assignments are accepted and carried out as they come in.

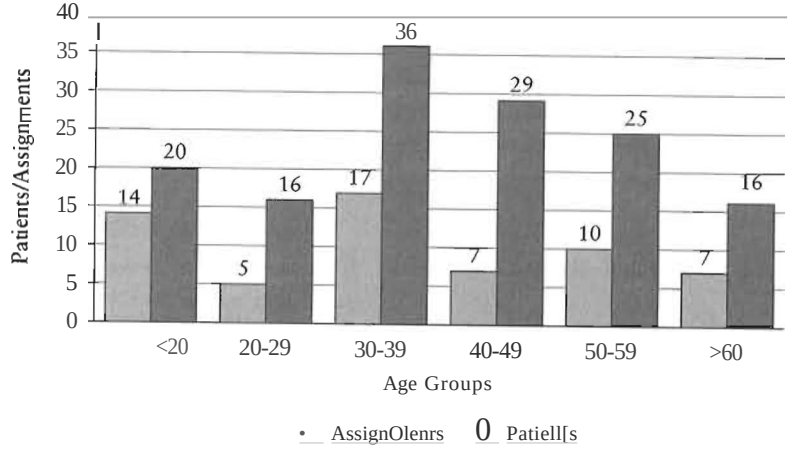

FIGURE 3. *Patients and assignments per age group.*

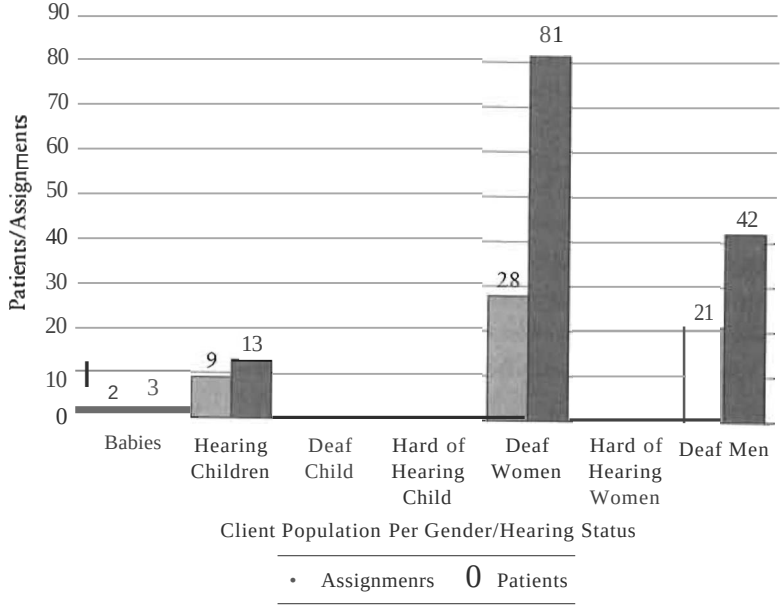

FIGURE 4· *Patients and assignments by hearing status and gender.*

Patients were further categorized by their gender and hearing status. Figure 4 compares the number of patients and assignments in seven categories: babies, hearing children, deaf children, hard of hearing children, deaf women, hard of hearing women, and deaf men.

Fifty-one dients, or 81%, were deaf or hard of hearing persons; 12, or 19%, were deaf family members of hearing children or babies whose hearing status was not recorded. In about 12% of all cases, the deaf dient was the parent of a hearing, deaf, Or hard of hearing child who was the subject of the medical consultation. Assignments that involved female deaf patients account for 57% of all assignments, compared to 30% that involved deaf men. This difference is partly accounted for by the fact that deaf women have more assignments with the same interpreter than do men (2.7 vs. 2.1 assignments per person). It is perhaps the case that deaf women are more aware of their health and may therefore see doctors more regularly, but gender distribution in the profession of signed language interpreting mayaiso be a factor tO consider: Deaf men may prefer tO consult docrors on their own rather than rely on the services of a female interpreter.

Assignments were coded for two further broad factors that tend to complicate the work of interpreting. Nine of the 60 patients (23 assignments) displayed some kind of motoric, perceptual, or cognitive impairment. For example, spasms made the signing of one deaf patient difficult to understand (A:048), deaf patients' Usher syndrome needed particular attention (e.g., A:004, A:019, A:030), and one patient's mild dementia prompted frequent interventions by his deaf wife (A:092). Finally, a further 9 deaf patients (16 assignments) had amigrant background and had learned the national signed language as a foreign signed language with varying success (A:060, A:091, A:138).

All in all, even though coincidental to five interpreters' work in 2012, the assignments and deaf dients represented in our dataset seem to reflect quite adequately the range of tasks and challenges any signed language interpreter in Germany or Austria (and perhaps elsewhere) may expect.

STEPPING-STONES AND STUMBLING BLOCKS: 141 MEDICAL ASSIGNMENTS

The main goal of this srudy was to enabJe the participating practitioners to reflect on the experiences of professional signed language interpreting in the healthcare system and identify conditions that they consider supportive as opposed to factors that make their task difficult or stressful. In line with this broad intention of taking stock of interpreting experiences in the medical field, all of the 2012 assignments were recorded in a diary fashion: after each assignment the interpreter concerned noted down the basic facts of the assignment, gave a rough sketch of "how

it went," and commented on aspects that were perceived as "positive" or "negative." This rather loose format had it drawbacks since the level of detail that was recorded varied from interpreter to interpreter, and in some instances it proved difficult to verify particular aspects of the assignment from memory at a later date. We use extracts, translated from the original interpreters' notes, to illustrate particular cases.

For the purposes of analysis, all of oUf notes were entered into a database and evaluated with regard to a number of recurring features that we considered as distinctive components of medical interpreting assignments. Although the triad of patient, doctor, and interpreter is at the center of medical consultations, additional components contribute to the overall progression and success of an assignment. These components demonstrate the complexity of interpreting in healthcare environments, and their analysis is at the heart of our chapter:

- Procurement: Someone has to arrange for an interpreter. Given the way interpreters are generally procured in Austria and Germany (see the following section), this is often related to the degree of familiarity and the type of personal relationship that exists between deaf dients and interpreters.
- Medical staff: Besides doctors, other medical staff are generally also involved in an assignment, often as receptionists but also in conducting examinations and administering treatments.
- Waiting room interaction: More often than not, even with an appointment, patients have to wait before they can see the doctor. Interestingly, this time is rarely idly spent but rather may allow for crucial interaction between deaf patients and interpreters.
- Visually accessible environment: Care must often be taken during an appointment when arranging adequate lines of sight and negotiating seating arrangements.
- Doctors: All of the doctors in this study were hearing. Obviously their attitudes and behaviors crucially contribute to the success of the interpreted interaction.
- Patients: Patients in this study were deaf (induding a small number of patients who might be considered hard of hearing in audiological terms). In a number of cases, deaf clients accompanied their deaf or hearing children. Again, attitudes and behaviors of deaf patients contribute to the outcome of the consultation in obvious ways.
- Interpreters: The situation may prompt interpreters to react or get involved in different ways. Generally, more is involved than simply rendering messages.
- Escons: Quite commonly, deaf patients were accompanied to the appointment by other people. While a deaf mother may simply take a child to the doctor's office, more typically, accompanying people are related to the patient in a caregiving or supervisory role and may get involved in the interaction.
- Medical examinations: When they occur as part of the consultation, physical examinations, often involving the use of medical equipment, may pose particular challenges for the interpreter.
- Debriefing: Assignments may not end with the consultation but will often involve some kind of debriefing situation that allows for direct communication between deaf clients and interpreters.

In the following section we review each of the previously mentioned components of medical assignments with reference to oUf data in search of stepping-stones and stumbling blocks, that is, factors that contribute, on the one hand, to the success of the interpreted interaction and the satisfaction of the participants and, on the other, factors that complicate or impede this particular form of encounter between deaf people and the hearing world.

Procurement

As discussed earlier, healthcare assignments imply increased responsibility for the interpreter and a great deal of trust on the part of the deaf patient. A study about trust in interpreted primary-care consultations in the UK found that "trust was a prominent theme in almost all the narratives" of service users, interpreters, doctors, nurses, and receptionists (Robb & Greenhalgh, 2006, p. 434). Following Ian Greener's (2003) categories, Robb and Greenhalgh distinguish three types of trust. "Voluntary" trust has to be built up and comes into play when deaf people choose their interpreters; "coercive" trust mayaiso be relevant if the deaf person did not have a choice of interpreter. Third, "hegemonie" trust is established by the system and induces people to trust without knowing that they have any alternative (e.g., general trust in doctors).

A study of immigrants to the UK who needed spoken language interpreters for healthcare consultations consisted of 50 interviews in which

participants asked interviewees to give their opinion of interpreters in medical consultations (Edwards, Temple, & Alexander, 2005). The results showed that "trust emerged as a key feature in people's understandings and experiences of the process and ideals in needing and using interpreters" (ibid., p. 90).

Procurement patterns confirm the relevance of personal relationships between deaf dients and their interpreters. A 2013 study highlights the importance of choice: enabling deaf consumers to choose their interpreters creates the rapport and trust necessary for a successful interpreting assignment (Major, 2013, p. 269). Clearly, this is at work in our data as weil, where in 88% of all cases (125) dients had known their interpreters before the assignment, and in 80% of the assignments (114) it was the deaf person who direcdy contacted the interpreter.

When asked for the reasons for taking the same interpreter to all of her medical appointments, a deaf woman answered that it was organizationally advantageous because of the notorious scarcity of interpreters since the interpreter she is familiar with will prioritize her assignments or find areplacement when necessary. She added that she knew the interpreter weil, trusted her, and was satisfied with her performance (for similar responses by other deaf women see Steinberg et al., 2005). She stressed that the interpreter's knowledge of her health situation and her special needs was a huge advantage (A:064). This is how the interpreter in question described arrangements for an appointment at a gynecologist's office:

> I had already known the deaf person for some time and had interpreted for her occasionally. We had not been in contact for some months, when she contacted me via e-mail, asking me if I was available to interpret an assignment at the gynecologist for her. She gave me the name and contact details of the specialist and asked me to call his office to make an appointment at a time that would suit me, as she was much more flexible with her time than me. (A:064)

The interpreter emphasized that her background knowledge of the deaf patient's health situation and special needs was gready beneficial (on the problem of familiarity with the interpreter, cf. Parise, 1999, p. 71ff). In addition, the rapport between doctor and patient is of the utmost importance for the success of a medical communication (Major, 2013, p. 52f.). Clearly, good rapport between patient and interpreter is no less important.

Very few assignments were organized by hearing doctors (5, or 3.5%), while 14.8% (21) were organized by others, such as family members, caregivers, social workers, or other signed language interpreters. Only 12% of the 142 assignments (17) were new encounters, in which the interpreter and the patient met for the first time, and most of these had been arranged by a third party or an agency. In very few exceptional cases, deaf clients contacted a previously unknown interpreter themselves, for instance, by sending an email to a list of interpreters. More generally, contact between deaf dients and interpreters was established directly by sending brief informal emails or text messages or using messaging services like WhatsApp. A total of 60 deaf people, more than half of whom had two or more assignments with the same interpreter, were involved in the 142 assignments. Some interpreters had regular dients with up to nine medical assignments in 2012.

The procurement system in Austria and Germany can be criticized for imposing much of the burden of organizing interpreting services on the deaf dient. However, given a choice, deaf persons will understandably follow a preference for choosing a familiar and trusted interpreter for a sensitive setting such as health care.

Communication with Medical Staff

In most cases, the initial contact at a dinic or a doctor's office is with a receptiotüst, whose attitude may have a considerable impact on the doctor's manner and on the dimate and tone of the consultation. Without regard to assignments in which deaf patients had no relevant contact with receptionists or other medical staff (51, or 36%) and in which receptionists were considered as neutral or matter of fact (21, or 15%), most receptionists (52, or 37%) were perceived as friendly, polite, and helpful, as in the following instance:

> I [the interpreter] arrive at the dentist some time before the assignment to be able to get to know the dient, as I have not met the deaf person before. On my arrival, I am warmly welcomed by the dentist's assistant, who seems to be relieved to see me. The assistant informs me that the deaf patient has already arrived. She explains that this is the first deaf patient they have had and that basic communication seems to work, but that she did not understand some details. She shows me to the waiting room, where I present myself to the patient. The patient is very excited

and immediately starts to tell her life story and explain the reasons she has come to see the dentist. After a short wait, the assistant returns to tell the patient that it is her turn. During the whole assignment, the medical staff is very respectful and friendly with the deaf patient and me. (A:006)

In some cases (4, or 3%), the medical staff interaets directly with the deaf patient:

I [the interpreter] asked the assistant to explain the X-ray procedure to the patient by demonstrating it to her before starting the actual examination. The assistant follows my advice and has the patient go through the procedure without really switching on the X-ray machine. In this way, the patient is weil informed and feels more at ease with the procedure. (A:018)

In 8 cases (6%), rather than addressing the deaf person, the medical staff tried to interact with the interpreter by discussing aspects of her work or signed language in general. This might have been prompted by what the staff member perceived as a parallel in status and function. Thus, the receptionist in the following example may have considered the interpreter to be in a supportive role similar to her own:

A patient who is under guardianship sees her ophthalmologist regulady. The receptionist knows me [the interpreter] and her because we have been there many times. The receptionist considers me to be her hard-working colleague and prefers to bond with me and not with the patient, who is obviously mentally deficient. Every time the patient and I see the doctor, the receptionist treats me with a lot of consideration and asks how my day was, if I had problems in my profession and so on. I always feel burdened by her attention, but the patient does not seem to be bothered, and the receptionist's attitude seems to have some advantages: we do not have to wait long before we see the doctor, [and] there is no problem with changing appointments when necessary. (A:030)

In only 7% of the assignments (10) were the medical personnel unable to deal with the situation, which had a negative impact on the assignment. Some of them did not understand the need for a signed language interpreter (cf. Frishberg, 1990, p. 119):

When I [the interpreter] arrive, the patient is already registering. I present myself to the registration staff. The receptionist presents the deaf patient with a form that needs to be filled in. She starts to explain the form to the patient and asks me not to interpret. Because the patient does not understand the receptionist's explanations, she makes eye contaet with me, which angers the receptionist, who wants the patient to communicate with her and seems to feel disturbed by my presence. I intervene and explain to the receptionist the lack of eye contact (in order to follow the instructions the patient must look at the form and cannot maintain eye contact with the receptionist), but the receptionist is not really convinced. The medical assistant in the examination room has no experience with interpreting, either, and mocks the patient about being two people with the same name ("Oh, I have two Ms. Millers here, do I?"). (A:102)

In two cases the medical staff had a negative and arrogant attitude:

The assignment is at a group practice where several doctors worle The waiting room is huge and very crowded. There are several examination rooms, and the patients are calied in by the doctors themselves. When registering, the patient and I [her interpreter] are treated with little respect. The staff seems to be stressed and to have little patience for the deaf patient.They do not care about her difficulties with sitting for a long time (she has recently had surgery) and tell her that there is no way to affect the order in which patients see the doctors. (A:089)

The influence of the surrounding medical staff on the tone of a medical consultation should not be underestimated, but all in all, the personnel encountered during our study seemed to be able to deal quite weil with deaf patients and their interpreters. Where possible, most of them were welcoming and tried to give good service to the deaf patient. A few, however, were unfriendly; some, even hostile. Ir is possible that these staff members feIt challenged by the presence of an interpreter, but a lack of kindness may, of course, be caused by many things, some of which may be explained by the demands of daily work in a medical institution.

Waiting Room

As we have emphasized, the successful completion of healthcare interpreting assignments crucially depends on the relationship between the interpreter and the deaf client. "[E]xperienced interpreters engage in and actively facilitate relational work to such a degree that it should be considered an integral part of the healthcare interpreter's role" (Major, 2013, p. xiii). Clearly, relational work must start before the actual contact with

the doctor. In fact, our data show that most of the relational work is done in the waiting room before the consultation, if not during preceding assignments. In 49% of the healthcare assignments (69), the interpreter and the deaf patient use the time in the waiting room to reestablish their relationship and prepare for the upcoming consultation:

> When I [the interpreter] arrive at the hospital, the dient and her husband have already passed registration and are waiting for admission. I have known her for a long time and have already interpreted for her several times. She uses the waiting time to brief me about her reason to be there. We reestablish our relationship by chatting because we have not had contact for some time. (A:012)

In 6% (9) of the cases, the interpreter can be regarded as a support person who has become a confidante by having regularly interpreted for the dient. The interpreter may have known the deaf person as a friend before the assignment:

> I [the interpreter] and the patient have had private contact and are weil known to each other. While we are waiting for admission, the patient teils me her life story and expands on her current problems. I switch into "friend mode" and try to give her advice. Before admission, the patient teils me that she needs to ask the doctor for a prescription for a certain medicine. At the end of the consultation, I remind the patient of the prescription. She signs to me that she doesn't dare ask the doctor. Hence, I "interpret" the request to the doctor. (A:046)

In this case, the interpreter takes the initiative and reminds the deaf person of what she has planned to do. In another case (A:103) the interpreter finds herself acting as a confidante because of the lack of family or friends to support the deaf dient, who is undergoing an operation. She takes the patient home afterward.

If there is a briefing for the interpreter (67%, or 95 cases), as a rule, it is given by the deaf dient (58.5%, 83 cases, of which 13 are new encounters). Occasionally it is the person escorting the deaf patient who briefs the interpreter (5%, 7 cases). In only 3.5% of the cases (5) is the interpreter briefed by the doctor or an assistant because the deaf patient has not yet arrived or is late:

> The patient arrives late because he had trouble finding the dinic in the huge hospital. In the meantime, I [the interpreter] make use of the waiting time to ask the docror for a short briefing and to explain the SLI [sign language interpreter] process to him. After the patient's arrival, I also get a briefing by hirn. He gives me detailed information about his illness and the prognosis that has been given to him. (A:085)

Only 12% (17) of the 142 assignments were new encounters between the interpreter and the dient. Generally, waiting time was used for getting to know each other and briefing the interpreter about the upcoming assignment. This may be a vital procedure:

> In the waiting room I [the interpreter] realize that the deaf person does not use fingerspelling correctly when she tries to explain the symptoms that made her come to see the doctor ... Finally, we agree on a sign for the term the patient needs to use to explain her symptoms to the doctor to enable fluent communication between me and her. (A:051)

As in this case, getting to know each other and establishing a common base of communication with the deaf dient may be essential for the success of the triangular communication in a stressful situation.

Waiting time in dinics or doctor's offices may, of course, be excessive (this was reported for 22, or 15%, of the assignments in both settings). However, more generally, time that may appear to be idly spent is in fact used to procure vital information and develop rapport between deaf dients and interpreters, which is crucial for handling the subsequent encounter between patients and doctors.

Creating a Visually Accessible Environment

In his discussion of the influence of nonverbal and paraverbal factors on the quality of interpreter-mediated interactions in medical settings, Felgner (2009, pp. 58-65) stresses the importance of creating a visually accessible environment because the interpreter's position in the room may have a considerable impact on the interpreted communication. The situation is even more complicated for signed languages: deaf patients and interpreters need to have eye contact, they need to be able to observe the doctor, who may give visual information, and the deaf patient should be able to make eye contact with the doctor as much as possible ro help establish good doctor-patient rapport. The deaf patient's visual needs require interpreters to be flexible, adapt to the situation, and change position if necessary, especially during physical examinations and

the use of special equipment. Occasionally, it may be necessary to adopt unusual positions, such as sitting on desks or bending down to make eye contact with a patient who is lying on an examination table.

In medical settings, patients and their escorts tend to sit down before the start of the consultation. Therefore, the spatial arrangement is likely to be fixed for all of the participants throughout most of the event. In most cases, the doctor and the patient will be sitting in chairs. A chair is often provided for the interpreter and may be next to the doctor, beside the doctor's desk, or next to the patient. In most cases, the interpreter will try to choose her own position. Usually deaf clients intervene only if they cannot see the interpreter well. Our data reveal only one case in which the interpreter and the patient discuss and agree upon the interpreter's position before the start of the consultation (A:OI0). In 36% of the assignments (51 cases) the interpreters reported having chosen their position themselves, either by asking the doctor whether it was okay to move a chair next to the doctor or next to the doctor's desk or simply by sitting down or standing where they thought it best:[3] "When called in, the patient enters the examination room first, I follow ... She introduces herself. I introduce myself and ask for a place next to the doctor. He agrees without hesitation, and the communication goes on smoothly" (A:012).

Generally, proceeding like this meets with the doctor's tacit approval, though two doctors in this study rejected the interpreter's request for a position next to the doctor. In the preferred constellation, the interpreter takes a seat beside the doctor's desk, while the deaf patient is seated facing the doctor's desk. This "triangle" is also best for spoken language interpreting because all three parties have equal eye contact with each other, and no one is excluded (Haenel, 2001, p. 315).

Occasionally, clear-sighted doctors who are familiar with the interpreting environment will have provided a chair next to themselves for the interpreter before the start of the consultation (8, or 5.6% of the assignments). Some doctors will tell the interpreter where to get a chair or where to sit (3 cases reported). In a single case, the position assigned to the interpreter by an accompanying social worker caused a problem:

> At one medical assignment I was the last person who entered the consultation room. The doctor was friendly, but the social worker who accompanied the deaf client decided who was to sit where. I came to sit next to the social worker, and the deaf client sat next to the doctor. I asked the patient whether she wanted to change seats, but she declined. Maybe I was not clear enough with my reasons. The deaf client was sitting on a swivel chair so she could change eye contact between the doctor and me. She decided to lip-read from the doctor, leaving me to interpret mostly consecutively. (A:017)

Most doctors seems to be familiar with or to adapt well to the interpreting environment. Only a minority (3 cases, or 2.1%) felt disturbed by the presence of the interpreter and the interpreter's movements. One such case occurred at a dentist's office: "[H]e treats two teeth and is obviously irritated by my presence. He seems to be disturbed by my 'dancing' to stay in the view of the patient" (A:I05).

Special positioning may be needed when the deaf patient undergoes an examination (cf. Frishberg, 1990, pp. 120-121). This was recorded in three cases, at a dentist's (A:I05), a gynecologist's (A:135), and a radiologist's office (A:079), where patients needed to follow instructions meticulously while at the same time adopting positions that impeded visual communication. Further visual conditions such as glaring light or an insufficiently lit room need to be taken into account, especially if the patients have a visual impairment. Thirteen, or 9.2%, of the assignments involved patients with sight disorders (e.g., related to Usher's syndrome), which meant that options for the interpreter's position were even more limited.

Occasionally (two cases), the consultation room itself may have a negative impact. It may simply be too small to allow for optimal positioning and adequate lines of sight:

> The problematic spatial arrangement is due to the fact that the doctor sits behind his desk, which is covered by stacks of papers to his right and left. Because of these barriers I have to sit next to the patient in front of the desk, opposite the doctor. I cannot sit next to the doctor or in one corner of a triangle. It does not feel professional and is a clear disadvantage for my interpreting. (A:124)

To summarize, although establishing clear lines of sight is crucial for signed communication, difficulty with this is rarely an insurmountable problem. A certain measure of clarification or negotiation may indeed be necessary, but, with few exceptions, hearing parties seem to understand and accept that the spatial arrangement must allow visual communication. Generally, interpreters can choose their spatial position comfortably and establish a suitable place in the triangular relation between the three main participants.

Hearing Doctors

In their reports, interpreters rated the doctors' overall behavior as "positive," "negative," or "unremarkable" to allow for an analysis of person-related factors that were perceived as either beneficial or detrimental to the interpreting situation. Of all of the assignments, 78 cases (55%) were rated as positive, and only 22 (15%) as negative.[4]

Initially, we suspected that a doctor's lack of experience with and knowledge of interpreted interaction with deaf people might prompt negative perceptions. There seems to be some truth in this since in just over half of the negatively evaluated cases (13) the doctor and deaf patient were meeting for the first time. However, not having met before does not, in and of itself, determine the outcome of the interaction. Rather, it seems that doctors' attitudes need to be considered: in 15 of the 22 negatively rated assignments, interpreters commented on what they perceived as condescending behavior by the doctor, lack of respect for the patient, or disregard for the deaf person as an interlocutor regardless of whether the doctors and patients had known each other before. In a few extreme cases, the deaf patients were not taken seriously or were even treated as if they were objects:

> The receptionist comes to take the patient to an eye test. To me [the interpreter]: "We do not need interpreting service. So far it's always gone pretty weil. The patient knows what to do." Then she stops speaking and starts to use only gestures to communicate with the deaf patient. The deaf patient reads numbers in the eye test aloud, and the receptionists talks to her like to a child. The ophthalmologist shows up and starts talking to me. "5he has always come alone. 5he can lip-read perfectly. Are you family?" "No. I'm the interpreter." Then he draws elose to the patient's face and speaks in telegraphic style. The patient does not understand at all and looks at me. I interpret. The ophthalmologist looks at me, copies me, and seems to be proud. He stops speaking and uses only gestures to communicate with the patient. After the examination, the doctor wants to say good-bye, but first, the deaf patient mentions blurred vision and headaches while reading. The doctor answers that it is ophthalmic migraine, turns around, and is about to leave the room. He turns his back on an obviously terrified patient. 5he asks for elarification; I do the voice-over, which is ignored by the doctor, and the doctor turns around and waves good-bye to uso (A:059)

In four cases, it was the doctor's moody, willful, or authoritarian behavior that was perceived as negative and impeding communication between doctor and patient (A:032, A:051, A:059, A:105). Lack of empathy may be a further reason that interpreters experienced a situation as negative. In extreme cases, lack of empathy made the doctor misuse the interpreter as a bearer of bad news and the caregiver of a patient in despair:

> The physician teils me [the interpreter], "So good that you are here today!" Ir turns out that a tumor has been diagnosed, and the physician needs to tell the patient. For obvious reasons, the patient is very upset. The doctor is not responsive at all, ignores her psychological condition, and refers her to a colorectal surgeon. The woman struggles to keep back her tears. The doctor remarks that the tumor was tiny and that he was glad to have discovered it at such an early stage. The patient's questions are answered only minimally. He hands over the letter of referral for the hospital and asks her to take a copy of the pathology findings for the hospital's information . . . I am left with the feeling that the doctor is glad he did not have to deliver the diagnosis on his own. Apparently, he attributes to me (as a woman? as confidante?) the role of empathetic company. When we leave the office, he thanks me for having been there. (A:073)

Lack of time, as weil as the pressure that institutional structures exert on doctors, are both detrimental to the success of medical consultations (Angelelli, 2004; Felgner, 2009, p. 59). In 18 (12.7%) of the assignments, the interpreters reported time pressure as a negative influence. The doctors could not really concentrate and seemed primarily interested in getting rid of the patients. In one case, a dentist did not even finish his explanations and abruptly left the room without even saying good-bye:

> The elient asks some informed questions, which are not all answered by the doctor, who is distracted. The doctor performs the treatment in a casual way. When the patient asks a more complicated question, the doctor answers, but he disappears into the next room before he has finished his answer, leaving the patient and me entirely perplexed. He does not even return to say good-bye to the patient. (A:078)

Interestingly, none of the interpreters was under the impression that negative experiences were caused by a lack of confidence in their abilities,

as Hsieh, Ju, & Kong (2010) found in their study of in-house interpreters and doc[Qrs working within hierarchically structured hospitals. One reason for this difference may be that freelance interpreters in Austria or Germany are not perceived as belonging to the doctor's team, so that neither competition nor hierarchical relations are involved.

In positively rated assignments, doctors were often familiar with the overall situation and knew either the deaf patient (49 cases) or both the deaf patient and the interpreter (34 cases). However, as might be expected, positive behavior does not depend on familiarity: 27 cases of a first encounter between a doctor, a deaf patient, and the patient's interpreter were also rated positively. Again, attitudes appear to be crucial. Thus, consultations were regarded positively when doctors treated the patient with respect, took time to fully answer the patients' questions, or adjusted to the patients' communicative needs by either using visual materials to illustrate their explanations (e.g., A:034) or attempting to communicate as directly as possible with the patient (e.g., A:016).

The following example illustrates a situation in which the doctors treated the deaf mother of a newborn patient with respect. They understood her concerns and showed interest in her by asking questions about signed language:

> The doctors are empathetic. They first look at all the data in their chart, then examine the baby. They ask the deaf mother how weil she had made it through the previous night and then explain to her in detail why oxygen is so important for the newborn. They make sure that the mother knows what to do at home. After all the medical issues are settled, they start to show their interest in signed language and ask the deaf mother some questions. (A:033)

In some instances a doctor's effons to communicate directly with the deaf patient can be evaluated as another way of showing respect:

> The neurologist speaks slowly and dearly in order to give the deaf patient the opportunity to lip-read. The patient is lip-reading, but as soon as she starts having trouble doing so, she looks at me [the interpreter]. For general small talk ("Howare you? Are you tired?") direct communication is sufficient; for detailed medical information, interpretation is used. (A:016)

If direct communication is either impossible or limited, doctors may use models, pictures, radiographs, CT images, paintings, and so on to illustrate their explanations or to explain medical treatments. Often such strategies have a positive effect:

> The Deaf patient goes to an orthodontist because her dental prosthesis fits so badly that she cannot eat without severe problems. When describing her painful situation, the patient starts to cry and tears run down her cheeks. The doctor gives her the time she needs to regain her composure, answers her questions, and then suggests and discusses different options for areplacement. While doing so, the orthodomist shows different catalogues and models to make her explanations as visual and dear as possible. (A:017)

In a few cases, prescient doctors used email to inform their deaf patients in advance of the consultation about what they might expect and how they might prepare for their visit to the office.

All in all, even though unpleasant encounters with disrespectful, intimidating, or overly stressed doctors did occur, positive impressions prevailed. Familiarity with the panicular needs of deaf people as weil as with the interpreting situation dearly helps but is not necessary. If doctors are cognizant and respectful of the needs of deaf patients, their efforts go a long way toward creating an atmosphere that feels supportive and helpful to both the interpreters and, as one might suspect, the deaf patients.

Deaf Patients

Now we take a doser look at a number of cases that interpreters found noteworthy: in 13, or 9.2%, of all of the assignments, deaf patients expressed their dissatisfaction with the medical communication; in 35, or 24.6%, of all of the assignments, patiems' behavior was regarded as "proactive"; and in 15, or 10.6%, of the cases interpreters labeled the patient as "difficult."

The data support three main reasons for deaf dients' dissatisfaction with a medical appoimment. They may feel that they have received inadequate explanation or that a diagnosis is given without sufficient clarification (5 cases; for instance, see A:059, quoted earlier; cf. Paulini, 2008, p. 94). A situation in which there was confusion about the flow of communication and the roles of the people present was also perceived as unsatisfactory:

> The doctor comes to call us into his office and is surprised: "Oh, three people? Why's that?" The patient explains: "I am deaf and need an

interpreter to interpret for me. This is the interpreter with her trainee." The interpretation of this utterance is accompanied by pointing at the respective people, so it should be clear who is who. But the doctor still has problems understanding. Doctor: "So, who is hearing? You are deaf, aren't you?" Deaf patient: "No, this is my interpreter. She is hearing, I am deaf." The doctor still cannot figure out who is who. His irritation doesn't seem to subside ... In the middle of the examination it starts again. The doctor asks again who is who and why we are there. The deaf patient starts to be annoyed. (A:027)

However, in a few cases, dissatisfaction mayaiso reflect on the patient, who may suffer from misguided expectations, which gives rises to disappointment when the doctor does not prescribe the preferred medicine (e.g., A:099). In a rather special case, an older doctor gave reason for dissatisfaction when he made salacious comments about his young female patient (A:080).

Clients were labeled as "proactive" when they took the initiative and tried to control the communication at certain points. Twenty-four, or 40%, of the clients were considered proactive in 24.6% of the assignments (35). However, this included quite ordinary behavior, such as introducing themselves and their interpreters (12 cases, or 8.5%), asking questions (13, or 9.2%), or trying to influence the communication (8 instances, or 5.6%). For the interpreters, such behavior appeared to be "proactive" against a background of what they perceived as the often unassertive or even diffident behavior of deaf patients. In contrast, interpreters experienced it as helpful if a deaf dient took control of the communication and acted autonomously, as was the case with a deaf mother who was interacting with a pediatrician who was inexperienced in dealing with deaf people and an interpreter (A:047). In one case (A:079), the doctor, fascinated by the interpreting process, which was new to hirn, engaged the interpreter in conversation. Quite rightly, the deaf patient insisted on knowing everything that passed between the two hearing people. Even proactive deaf patients were not always successful in their attempts to get what they wanted, and sometimes it took great assertiveness to worm answers out of a doctor:

The mother [of a deaf child] uses the opportunity to repeat some questions she had already asked during the previous visit because there had been no interpreter present then. The doctor explains in a very cursory way and keeps referring to the leaflet he had given them at the last visit. The mother explains that it is important for her to get the information directly from hirn due to her difficulties in fully understanding written information ... In the end, the doctor gives in and gives the necessary information to the parents. (A:087)

Interpreters considered patients to be difficult mainly when the patients demonstrated an obvious mismatch of communication cultures or a lack of knowledge about communication rules in the hearing world (12 cases, or 8.5%). Some deaf patients repeatedly interrupted the doctor (A:067) or would not stop talking even after the doctor had clearly brought the consultation to a close (A:117). Some patients complained and made demands without acknowledging that the doctor had already made an effort to accommodate their wishes (A:104). Communication culture could also have been an issue when escorts were present, for instance, when husband and wife disagreed and argued in front of the doctor (A:130) or when the hearing mother and her deaf adult daughter spoke at the same time (A:104). Another difficult situation arose when a deaf patient refused to cooperate with the doctor, came unprepared, questioned the usefulness of the procedure, and did not accept the doctor's advice (A:040). Occasionally the lack of signing skills or the unskilled use of fingerspelling can also cause problems (3 cases):

She speils the word using the finger alphabet. I [the interpreter] do not understand. She repeats herself and is irritated when I still do not get it. She writes the word on a piece of paper. I visualize the letters she had spelled and realize why I had not understood her. She mixed up the letters of the finger alphabet. We agree on a sign for the word. I keep in mind that the finger alphabet is useless because she mixes up the letters. (A:051)

To summarize, deaf patients were dissatisfied for good reason with some of their doctors' behavior, they tended to lack assertiveness, and the interpreters perceived active participation as helpful. However, on occasion, difficulties arose when deaf patients disregarded the communication rules of the hearing world.

Interpreters

Next we consider a number of cases in which interpreters described their own behavior as "proactive." Because our data do not allow for any detailed discourse analysis, this assessment has to be taken with a

grain of salt. There is no simple opposition here between "staying neutral" and "getting involved" (see earlier section titled "The interpreter's role in healthcare settings"). Rather, a classification as proactive implied a degree of involvement that the interpreter considered as particularly pronounced and exceeding the demands of more commonly experienced situations. This was the case in 28, or 19.7%, of all the assignments.

In about one-third of these cases of pronounced activity, the interpreter's intervention was prompted by the need to create suitable conditions for the interpreting tasks. For instance, the interpreter might have asked for a change in the position of achair (A:062), intervened to shorten the waiting time (A:103, A:109), or instructed medical staff about how to proceed during an examination (A:018, A:079):

> X-ray of the neck. Beforehand, the doctor explains what is going to happen. The X-ray technician asks me [the interpreter] for help and explains how to stand and how to wait for the X-ray.... I interpret her instructions concerning the posture to be adopted by the patient. The X-ray technician is not yet perfectly satisfied and repeats several times the posture the patient should adopt. I suggest to the X-ray technician: "You can guide her gently into the right position. I am sure it is ok for her." (A:113)

In five cases the interpreter intervened when faced with ignorance on the part of a doctor or staff member concerning deaf patients or the interpreting process (see, for instance, A:102, quoted earlier). In four situations, the interpreter tried to stop patronizing or dominating behavior by the hearing doctor or staff member, as in the following case:

> I [the interpreter] am at the doctor's office before the patient arrives. I inform the receptionist that I am the interpreter for patient XYZ. The receptionist replies that I can stay in the waiting room and that they would call me when I am needed. Irespond that the deaf person should decide if she wants me to be with her. When the deaf person arrives, I inform her about the conversation I had with the receptionist. I ask her to decide if I should accompany her or not. She answers, "You come with me!" (A:123)

In four assignments the interpreter became an advocate because of the diffidence or insecurity of the deaf person in interacting with hearing people or the doctor (see A:046, quoted earlier). In one case, the interpreter intervened to make sure that the patient understood the doctor's instructions. Realizing that the client had not fully understood, she decided to repeat the doctor's instructions after the end of the consultation:

> The doctor explains to the patient how to use the medicine, then says good-bye and asks the receptionist for a follow-up appointment for the next examination. Now the patient and I are leaving the doctor's office. I ask her if she has understood the doctor's explanations-she says no. Therefore, I repeat the explanations and instructions the doctor had given. In the end, she teils me that she has finally understood. (A:061)

Finally, in a specialized field such as medicine it is not surprising to find that an inconsiderate use of jargon may prompt the interpreter to intervene:

> The deaf couple and I [the interpreter] meet in the waiting room. The husband explains the reason for the appointment. lt is the first time the doctor has had deaf patients, and I am the first interpreter he has had to deal with. The doctor only uses the technical language of his profession.lt is too much of achallenge for me. At one point, I have to interrupt the doctor and ask for clarification. (A:034)

All in all, the interpreters feit convinced that the interventions described here were necessary and contributed to successful and satisfying appointments by helping to clarify the message or support the deaf clients in asserting their rights to complete information.

Medical Examinations

Not every medical consultation involves a distinct physical examination, and those that do may not necessarily involve much communication. Of all of the recorded assignments, 37, or 26%, included an examination that was considered to be of interest in terms of interpretation, though often the main question was whether to interpret. Thus, in 20 instances the medical examination took place without the interpreter being present. Most of these were routine procedures that required no explanations: "He [the doctor] shows her [the patient] to the changing room. She already knows the procedure. I take a seat in the hallway and hear phrases like 'Does it hurt?' 'Ouch!' and 'Already done!' Back to the changing room, all of this has been routine for both of them" (A:127).

In a number of such cases, instructions were given and interpreted first, and then the interpreter left the room for the examination to take place, either because the examination was particularly intimate or because no visual contact with the patient was possible:

> The deaf patient undergoes an MRI. He is lying on his back. His head is fixed because he needs to stay immobile for the whole procedure. I ask the medical staff to give important information beforehand because communication will become difficult as soon as the patient is immobilized. The medical staff adapts easily to my request and gives all the information needed before the procedure starts. (A:079)

Where intimate examinations require the interpreter's presence, her discretion is called for: "When the patient is undressing and dressing, I avoid looking . . . The doctor examines her breasts. I look into the patient's eyes, avoiding looking at her breasts. Turning away was not an option for me because of the necessity to communicate" (A:043).

When interpreters are present in medical examinations, they often have to change their position during the procedure. In a few cases, interpreters reported that medical equipment obstructed their view. Adapting positions may occasionally irritate a doctor or, in one case, even the patient:

> The vision test is tricky: the hearing daughter is sining on the deaf mother's lap. I position myself in the mother's field of view so that she can see me, and the daughter can see the eye chart. The daughter answers the ophthalmologist's questions in spoken German, while I interpret into signed language. Unfortunately, the daughter can see me, which irritates her. I try to change my position but find no better place because of the size of the room and the equipment. (A:015)

As reported here, medical examinations pose achallenge to the interpreter's flexibility and discretion. Spatial conditions may be such as to cause problems, and the physical examination itself may give reason for discomfort. Still, although irritations cannot always be avoided, more generally this seems an aspect of healthcare interpreting that most interpreters can deal with quite confidently.

Escorts

Quite frequently, in 39, or 27.5%, of the assignments, deaf patients were accompanied by a third person who might get involved in or otherwise influence the situation. On occasion, such a presence can be beneficial. For instance, when an elderly deaf man who displayed early symptoms of Alzheimer's was not able to recount his medical history, the accompanying deaf wife took over the task of informing the doctor (A:092). In another case, the patient knew very linie German Sign Language, and his partner, who had lived in Germany for a number of years, acted as a relay interpreter. She also seemed to know her partner's medical history better than the patient himself. Having an additional person in the interpreting chain required detailed monitoring by the interpreter, but the escort's assistance was appreciated by both the interpreter and the doctor:

> The doctor is young, businesslike, and in a rush and asks about the patient's symptoms and previous illnesses. The patient barely understands me. His partner acts as a relay or simply answers the questions herself. She explains everything to him using her own signs. Managing the conversation is difficult. The doctor talks to me, the deaf woman answers, signs with the patient. I abandon the attempt to tell the doctor to talk to him directly. I interpret, sometimes signing two to three times until I am sure that both have understood. I check what the deaf woman signs to her partner, to be sure what she signs is correet . . . I am glad that the deaf woman is present, she can explain the symptoms better than the patient himself. (A:118)

Generally, more problematic were situations that involved the presence of hearing relatives. Doctors tended to choose the "easy option" and talk to the hearing person, neglecting the deaf patient. Hearing relatives may be too accustomed to interfering in the lives of their deaf children or siblings to notice:

> In the waiting room and during the consultation the grandmother is very dominant. She cares very much for the child and is apparently in charge of her often while the parents are working. The psychologist is very friendly. At the beginning, she includes the parents, but in the course of the conversation she drifts more in the direction of the grandmother. The parents more or less become spectators and just follow the conversation. (A:056)

A patient and an escort may quarrel, interrupt each other, or talk all at once, creating achallenge to make sense of the conversation for doctor and interpreter alike: "At the doctor's office, mother and daughter often talk at the same time, also to each other. I steer a lot, signing

what the mother says, doing voiceovers when she uses horne signs with the daughter" (A:I04).

The presence of a social worker, caregiver, or custodian may deflect the doctor's attention from the deaf patient, but some such third parties differed in their degree of involvement in the situation. In some instances, a caregiver would "take over" (e.g., A:028, A:076, A:133), whereas others displayed a professional behavior, staying in the background and providing useful information (e.g., A:025, A:133).

Accompanied by the escort, apart of the deaf patient's life enters the interpreting situation. The effeet may be helpful at times, but more often than not it complicates the interaction or creates an imbalance in the relationship between the hearing and deaf parties and thus poses areal challenge to the interpreter and the deaf patient, who is the focus of the interpreter's attention.

Debriefing

Healthcare assignments may effectively be concluded when the consultation ends. In fact, in 81, or 57%, of all cases, the reporting interpreters did not consider what happened after the consultation worth documenting, and even when something was reported, it was often considered unremarkable (26 cases). In most of the remaining 35 cases, the deaf client and the interpreter used the time following the appointment to exchange their opinions of the consultation. Thus, if a doctor had not administered the expected treatment or had behaved **in** an unexpected, negative way, this became a topic of discussion:

> Outside the office, the deaf patient teils me that she is surprised by the way the doctor had talked to her and even more that her GP recommended this doctor to her. She has experienced his way of talking as rude and asks me for my impression. I tell her that I had the same feeling. We discuss alternatives. Finally, she decides to wait for the results and consult a different cardiologist next time, if necessary. (A:071)

In another case, the exchange was initiated by the deaf patient, who wanted to express her satisfaction: "After the consultation, the patient is very happy and satisfied. She feels she has been taken seriously and treated with respect by the doctor. She wants to know if I share her opinion and asks for my feedback" (A:124).

In 6 cases, the situation was used for clarification. The initiative may be taken by the interpreter, who feels responsible for the complete delivery of the message (as in A:061, quoted earlier), or by the deaf patient:

> After the appointment the deaf patient asks me for clarification. There was a detail he didn't understand. I have more time now than in the situation itself. I sign as visually and clearly as I can to explain why the sternum needs to be cut open. He got a lot of paperwork he has to deal with, so I offer some help, if needed. He declines and teils me that his daughter will do that. (A:116)

In another 6 cases, the interpreter made phone calls for the deaf patient to arrange follow-up assignments with other doctors or specialists: "She asks me to call another specialist. I wonder if she wants to hire her usual interpreter. No, she wants me to interpret the assignment because it is easier for her. I call the specialist and make an appointment (no interpretation)" (A:043).

Occasionally (4 cases) the interpreter accompanied the patient to a drugstore nearby or, in a case involving surgery, back home:

> All the nurses know the patient weil because he already had his other hand operated on. One of the nurses asks me to see the patient home after the operation. I agree. After the surgery, I do so. I'm glad that everything went weil. I had a double role which contradicts any code of conduct: jumping back and forth from interpreter to escort and back again. (A:I03)

In only two cases, adebriefing in the narrow sense of the word took place. Here the interpreter's strategies were discussed, and decisions were made concerning modifications for follow-up assignments:

> In the street I have a short discussion with the couple, who want to know why I interrupted the doctor. They expect me just to interpret. I try to explain that I needed to ask for clarification to be able to translate. The patient isn't satisfied. For the next time, we agree that I will ask if I do not understand but will simultaneously use signed German so that the deaf clients can follow the conversation. (A:034)

When significant interaction between deaf clients and interpreters takes place after the consultation, it may be to clarify something or to undertake some small service for the deaf person. That the interpreting process itself is not more often the subject of discussion may be

unexpected. However, it is hardly surprising that the medical experience the deaf client and the interpreter have just been through together is a natural focus of their exchange.

Summary

We have reviewed the medical interpreting that took place as part of the daily professional practice of five signed language interpreters in Germany and Austria in 2012. Clearly, any of the various aspects of healthcare assignments that we have considered may turn out to be problematic and present achallenge to the interpreter. Healthcare assignments may concern medical problems of a critical nature, which put an emotional burden on the interpreter. Deaf patients and interpreters may encounter unfriendly or even hostile medical staff. They may be rushed through aseries of consultations and treatments, or their patience may be tried by spending long hours in the waiting *raom.* It may be hard to create adequate spatial arrangements either because of physical conditions that make visual communication difficult or because of a lack of understanding or empathy on the part of the doctor. Doctors may lack the time, patience, or the will to treat deaf patients with the respect they, like any other patient, deserve. Deaf patients may have unrealistic expectations or may not be aware of problems created by communication styles that alienate hearing interlocutors. In addition, they may be accompanied by relatives or caregivers whose well-intentioned interventions may be misplaced. Interpreters may feel they need to take action in order to bring messages across or support deaf clients in asserting their rights to complete information. After the consultation, interpreters may face dissatisfied, irritated, or helpless patients in need of clarification and assistance.

All of these complicating factors did OCCur in our data, and interpreters will do weil to anticipate the possibility of such problems. However, the overall picrure that we have painted is more balanced and, all in all, more positive. Encounters between deaf clients and interpreters in the waiting room often provide welcome opportunities to exchange information and establish the kind of personal relationship that is crucial for successful cooperation. In many cases, medical staff members are supportive and may go out of their way to ofter good service to deaf patients. More often than not, the triangular spatial arrangements that are conducive to visual communication can be established as a matter of course. Even when doctors have no previous experience with deaf patients or interpreted consultations, many of them invest time and patience and treat their deaf patients with due attention and respect. **In** such situations deaf patients may confidently assert their rights and cooperate with circumspection and understanding. At times, an accompanying third person may turn out to contribute vital information during the consultation. Medical cxaminations may be negotiated tactfully and carried out adequately even when interpreted communication is not feasible. Debriefing situations often serve to resolve uncertainties and allow deaf patients and interpreters to reach a common understanding of the preceding medical encounter.

Healthcare interpreting takes place in situations that vary according to general interactive patterns that occur between layperson and specialist, consulter and consultant, deaf and hearing people. On the basis of the experiences that we have reported here, it would seem that interpreters have reason to be confident that, generally, they will encounter circumstances that are conducive to the satisfactory outcome of medical assignments. However, enough risks and stumbling blocks remain to prompt the reflective practitioner to practice circumspection and prudence.

CONCLUSION

As we pointed out at the beginning of this chapter, creating aspace for reflection was a major aim of this study, which has served to heighten our awareness of aspects of our work that are often blurred by the routine handling of day-to-day assignments. The resulting picture is informative and rich in descriptive detail though not rigorous in its attention to structural conditions and overall patterns.

One aspect that emerges clearly is the particular role that close relationships between deaf clients and interpreters play in healthcare assignments. This partly reflects general conditions of the medical setting, where immediate personal concerns are of prime importance. The particular circumstances in which healthcare assignments take place in Germany and Austria seem to be conducive to the development of trusted relationships, too: in the great majority of cases, it is the deaf clients or their representative who contract the interpreter. Most deaf clients know their interpreters before the assignment and can draw on established relationships. As a rule, it is the deaf patients who brief the interpreter and explain their views and goals.

From the point of view of hearing doccors, this elose relationship between deaf patients and interpreters is often taken for granted, and the interpreter is seen as an aide or assistant to the deaf patient. At times, such a view may cause imbalances and interactive problems, but it seems to reflect something real: while, as most recent commentators have stressed, the interpreter is involved as an active participant in a "triadic" conversation of three parties, the interactive triangle is not equilateral. Rather, the interpreter will give precedence to achieving the deaf elients' goals. We, as the interpreters involved in this study, were not overtly concerned about following the rules and regulations of a professional code of conduct. Rather, we attempted to follow a course of action that, in any particular situation, seemed humanely appropriate and in the best interest of the deaf elients. Any more specific application is beyond the scope of this chapter, but, generally speaking, such an approach to the professional task seems to be in line with more recent attempts to account for interpreting behavior and decision making in interactive models that transcend earlier conceptions of "interpreting roles" (see earlier, the seetion titled "The Interpreter's Role in Healthcare Settings," and, in particular, the discussion of Lee and Llewellyn-Jones's [2011] role space model or Rozanes's [2013] notion of a comfort zoning process).

Although the data of this study are revealing in certain respects, they lack some of the detail that would allow for more finely tuned analyses. As a first attempt at taking stock of relevant interpreting experiences, analytical criteria established at the outset of this study were left deliberately vague and open. All of the assignments were recorded rather loosely in the form of minutes written from memory. Not all of these minutes covered the same kind and the same level of detail. In some cases it proved difficult or impossible co reconstruct critical elements of a particular assignment at a later date. More detailed inquiries into any of the aspects of the overall picture that we have painted here with rather bold brushstrokes will do weil to be selective in their analytical focus and work on the basis of preestablished sets of observational criteria. More generally, our views need co be complemented by the perspectives and experiences of other participants in medical settings. In particular, it needs to be determined whether deaf patients share the largely rather positive views outlined here and confirm our impression that interpreting enables deaf patients co take an active role as major participants in medical encounters. The results of such inquiries will inform the training of signed language interpreters and provide a basis for developing awareness-raising strategies directed at medical staff as weil as deaf patients.

Acknowledging the limitations of this study does not preelude us from reaching a preliminary diagnosis of healthcare interpreting for deaf people, as currently practiced in Austria and Germany. It is a challenging, often rewarding, professional task that brings interpreters into elose personal contact with their deaf elients. Insight and experience will help interpreters avoid some of the most obvious stumbling blocks and, in the interest of deaf people, make good use of all the available stepping-stones.

NOTES

1. As the federal governmenr of Carinthia has a very tight budget, it refuses ro cover interpreting costs for docrors' consultations. The interpreters' association has found alternative funding with the regional health insurance companies who pay berrer rates than government authorities in other federal countries. There are no personal budgets, deaf clients in Carinthia get all interpreting they may need for their health care.
2. Patient numbers do not add up to 60, as some patients had several appointments in different locations.
3. Ofren the particulars of the seating arrangement were not recorded in the interpreters' notes. From subsequent discussions, we deduce that what we are describing here is a general practice.
4. Twenry-five cases were considered unremarkable. The remaining assignments include a handful of cases in which either no relevant docror-patient interaction was involved (e.g., A:005, A:023, A:039) or the docror's behavior was of special interest but was not classified as either positive or negative (e.g., A:OIO: the doctor started using the patienr's native spoken language, which was unknown ro the interpreter; A:093: the docror tried ro communicate in signed German; A:079: the doctor was thrilled by the interpreting and kept asking the interpreter interested questions).

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