DIRECT VERSUS INDIRECT SPEECH IN COMMUNITY INTERPRETING:

DOES IT REALLY MATTER?

by

PATRICK MOORE

(Under the Direction of Sarah E. Blackwell)

ABSTRACT

This thesis analyzes interpreting as reported speech and attempts to discover whether it matters or not if interpreting is performed as direct or indirect speech. Traditionally, interpreter training prescribes direct speech. Because community interpreters may be untrained, many use indirect speech. Although direct speech is necessary in court interpreting, it may not be in medical interpreting. There has been little research done on this question and the results are inconclusive. In this study, mock interpreting sessions were videotaped and transcribed. Additionally, interpreters were surveyed via internet. All interpreters used direct speech, however the mock interpreting sessions demonstrate that the interpreting process has a tendency to introduce significant stylistic changes in the interpreted renditions, such as lengthening, shortening, changes in formality, and the omission of curse word and discourse markers. The majority of survey respondents express a strong preference for direct speech, with very few admitting to using indirect speech.

INDEX WORDS: Reported speech, Direct speech, Indirect speech, Community interpreting, Interpreting

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PATRICK MOORE

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PATRICK MOORE

Major Professor: Dr. Sarah E. Blackwell

Committee: Dr. Marlyse Baptista
                    Dr. Hildebrando Ruiz

Electronic Version Approved:

Maureen Grasso
Dean of the Graduate School
The University of Georgia
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DEDICATION

To Holly, whose encouragement and love continue to inspire me.

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Finally, I would like to again thank my wife, Holly. In addition to always telling me what I needed to hear (whether I wanted to or not), she has been a top-notch typographical and technical assistant.

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Chapter 1

Introduction

In this thesis I explore the question of whether or not interpreting in first person (direct speech) or third person (indirect speech) style makes a difference in community interpreting. In the academic literature that addresses this concept, first person style in interpreting is more commonly referred to as direct speech, and third person style is referred to as indirect speech (Bot 2005). I will use both of these sets of terms, although within the world of community interpreting, the terms 'first person' and 'third person' are much more commonly used (Roat et al. 1999: 35-37).

The orthodox method of interpreting is first person (Roat et al. 1999: 37). In other words, when someone says, for example, *Me llamo Carlos*, the interpreter would say *My name is Carlos*. Many interpreters working in different community interpreting contexts are not aware of this tradition in professional interpreting, or, if they are, they prefer to interpret in third person (Bot 2005). An interpreter who works in third person would take Carlos's utterance and render it as *He's Carlos* or *He says his name is Carlos* or *He said, "My name is Carlos"*, or a similar variation of these.

The tradition in professional interpreting strictly prescribes the use of the first person style (Dubslaff and Martinsen 2005: 211-212). Therefore, the use of third person style is controversial. In spite of this, some interpreters prefer it (Bot 2005, Dubslaff and Martinsen 2005). Because community interpreting settings are sometimes less formal than more traditional professional interpreting settings, one may wonder if it could be acceptable, under certain circumstances, for an interpreter to work in the third person. On the other hand, one may also wonder if there are other reasons besides tradition to interpret in first person. In other words, for

community interpreters, does it really matter whether they interpret in first person or in third person? In this study, I review some of the relevant literature on this question and describe a research project that attempts to answer this question. I also make some observations and possible recommendations for future research and for the future of the profession of community interpreting.

What is community interpreting?

It is impossible to listen to or read news reports right now in the United States without eventually coming across a discussion on immigration. Regardless of the opinions one may have, there is no denying that the U.S. is experiencing a massive and continuous wave of immigration that is having profound effects on our society (Guzmán 2001). One of these is the need for language interpreting in courts, doctors offices, hospitals, social service agencies, schools, and other places where perhaps one would not have in the past expected to find an interpreter. The name 'community interpreting' has been given as a blanket term for the interpreting done in all of these settings (Mikkelson 1996).

Several other countries, including some European nations and Australia, are also experiencing massive immigration, and in these places community interpreting has emerged as a new and still-evolving profession (Bancroft 2005). Community interpreters tend to work in hospitals, courts, medical clinics, psychotherapy clinics, social service agencies, schools, and other arenas that are grouped under the term 'community'. In response to the need for interpreters in these settings, those who interpret do not always have the language skills or the training that an interpreter normally would have (Bot 2005). As a result, a variety of policies have been proposed and enacted, and in some cases are still being debated.[1] The goal of these

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[1] Besides American Sign Language, In the United States there is really only a licensure program for court interpreting. The federal government has a court interpreter certification program. Additionally, many states have a

policies is to attempt to ensure that the interpreters who work in community settings are qualified to do so and have at least some training in interpreting (Bancroft 2005).

It should be obvious why the competence of community interpreters is so important. Two of the main arenas of community interpreting may be broadly labeled as medical and legal. Thus, it is not an exaggeration to say that faithful, competent, and accurate interpreting is a matter of life and death. For instance, in the medical arena, life and death situations may arise; however, because some states in the U.S. continue to use the death penalty for certain crimes, the legal arena also has the potential to produce life and death scenarios for a defendant who needs an interpreter. It is difficult, if not impossible, therefore, to overstate the importance of having qualified and competent interpreters available to those who need them. However, when the time comes for a court, hospital, or clinic to find an interpreter, there may not be one available, or those charged with locating one may not know how to find one. Also, since community interpreting is such an immature profession, standards have not been established in such a way that they are respected the way they are for other professions (Mikkelson 1997). In other words, it is possible to practice as a community interpreter, in some cases, without having demonstrated that one is competent to do so. In fact, as I have already explained, in many cases there is nothing in place that would permit someone to prove his or her competence as an interpreter. This stands in contrast to other professions (teaching in public schools, medicine, dentistry, law, etc.) where there is a specific academic program and also a professional credential requirement. Moreover, both the government and the public at large understand this, and recognize the credentials as necessary and valid. Unfortunately, sometimes those who act as interpreters may not be able to

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court interpreter certification program. In the state of Washington there is a certification program for community interpreters administered by the Washington Department of Social and Health Services (DSHS) used in conjunction with the Washington state administration of the Medicaid program to reimburse health care providers for the cost of hiring a qualified interpreter so long as they hire an interpreter that has the DSHS certification. As of this writing, several states are currently debating and developing medical interpreter certification programs.

truly interpret, or they may be ill-prepared to do so. Additionally, with the exception of legal interpreting, those who are qualified and competent do not yet have a credential they can obtain to demonstrate their competency in a way that is recognized by the public and the government.

To summarize, community interpreting is interpreting in settings that have traditionally been the realm of monolingual communication. These tend to be legal and medical environments, law enforcement scenarios, school settings, social service settings, but may include others. Community interpreting is a relatively new profession and is still evolving toward its maturity. It is easy to demonstrate that there is a serious and urgent need for interpreters in these settings. However, there is not always an economic demand for interpreters. This is partly due to budgetary limitations, but is also because community interpreting is not widely known or recognized as a profession, and outside of court interpreting, at least in the U.S., there is no professional credential available to community interpreters.[2]

Basic terminology

There are two crucial terms I would like to discuss briefly before continuing. They are interpreting/interpretation[3] and translation. It is not uncommon to see or hear the word translation or translator used when in fact what is really meant is interpreting, interpretation, or an interpreter. The difference is that translation refers to written texts and interpreting refers to speech (González et al. 1992: 295).

The difference between translating and interpreting is often most important to interpreters, who feel a special desire to explain it. This is no doubt due in no small part to the fact that, as González et al. (1992: 295) explain:

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[2] One may include the Washington state DSHS certification as some type of professional credential for community interpreters, although some have argued that it is not a medical interpreting certification.
[3] Interpretation is often used as the term to describe interpreting in academic literature about interpreting, although it is also referred to simply as interpreting.

> Translators have time to reflect and craft their output, whereas interpreters must instantaneously arrive at a target language equivalent, while at the same time searching for further input.

As Mikkelson (1999) has pointed out, sometimes judges have instructed court interpreters to simply translate and to not interpret. This instruction, although it may reflect a well-meaning concern for the role of the interpreter, demonstrates that the judge does not understand this basic terminology.

On the other hand, it is not possible to talk about interpreting without also discussing translation. In an abstract sense, they are two tasks that are very similar. Interpreting may be considered a subset of translation, or at very least, intimately related to translation. Additionally, there is a mode of interpreting known as sight translation (González et al. 1992: 401). This is when the interpreter is given a short written text to translate on the spot by reading it aloud in the target language.[4] More fundamentally, we may speak of translation not only as the translation of written texts, but also the mental process of translation that both translators and interpreters engage in while performing their work (González et al. 1992: 295). Even if one wishes to emphasize the differences between translation and interpreting, they are closely related. Therefore, while I will attempt to be as precise as possible in my use of this terminology, I may use the term 'translation' while discussing the work done in interpreting when I am referring to the mental process of translation that all interpreters must do.

Relevance of this project

It may seem redundant, but I feel compelled to justify this thesis in terms of how it is relevant to the study of Spanish language and linguistics, and linguistics in general. In the U.S., Spanish is a language in high demand in community interpreting. It is therefore not difficult to

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[4] Of course, when performing a sight translation, it is recommended that the interpreter read the entire text before starting his rendition of it in the target language.

see that interpreting has a very real link to the study of the Spanish language in the U.S. Also, there are relatively few programs for interpreting studies in U.S. colleges and universities, although interpreting is an activity that is very closely related to the study of language.

Translation and interpreting are without a doubt two fields that would be considered possible applications of linguistic theory, and translation is usually listed along with SLA and second and foreign language instruction when applied linguistics is first explained in textbooks (Rees-Miller 2001: 638). Of course, the idea that linguistic theory may be applied beyond theoretical and structural studies, including whether it may be applied to translation, is one that Chomsky has notably disputed (Robinson 2003: 7). In spite of this, I am convinced that while translation and interpreting studies are multidisciplinary, they do need to also have a grounding in linguistics. Furthermore, translation and interpreting are also concerned with literary theory, communications studies, and cognitive sciences, to name only three different fields. However, more than any other academic discipline, linguistics is one that should inform translation and interpreting studies because they are fundamentally tasks that are done with language and that are performed on specific texts and utterances.

The little training currently available to community interpreters is sometimes rather limited in terms of its linguistic foundation. Overall, there is a preoccupation with vocabulary. Besides emphasizing the general cultural importance of language and some basic translation theory, i.e. to not translate 'word-for-word', there is precious little linguistics-related training given. In Chapter 3 we will see that in the practice of community interpreting there are ways in which training in general, and training grounded in linguistics in particular, will be of great benefit to the profession and those who rely on it. Given the current state of immigration in the U.S. and the foreseeable future, it would also be a great benefit to the profession of interpreting,

society at large, as well as to the academy, if there were more university-level training for interpreters available.

Research questions

In this study, I attempt to answer the question, "Does it really matter whether community interpreters interpret in first person or in third person?" Although this may be correctly characterized as a yes/no question, it is not a simple question at all. To put it in other words, if we observe, transcribe, and describe interpreted interactions, will we find general tendencies that make interpreting in first person preferable to doing so in third person, or vice-versa? Does interpreting in the third person have a tendency to introduce distortions or additions? Or, does interpreting in the third person produce, all other factors being equal, interpretation of more or less the same quality as interpreting in the first person? Bot's (2005) research on interpreted psychotherapy sessions in the Netherlands addresses this question, although it is not her only concern. While she concludes that first-person interpreting is best in order to limit the interpreter's influence on the conversation, her work is also concerned with interpreting psychotherapy sessions in general.

Dubslaff and Martinsen (2005) did a similar study in Denmark. They asked interpreters to interpret a mock doctor-patient interview. Their results were somewhat inconclusive, partly because the interpreters involved had difficulties with some of the medical terminology used. Because of HIPAA (the Health Insurance Portability and Accountability Act of 1996) and other privacy concerns, it would be extremely difficult to gain access to authentic medical interpreting sessions in the U.S. Therefore, for this study I conducted mock doctor-patient interviews, using actors and scripts. The interpreters who participated in these interviews interpreted the dialogs

and were video recorded. I intentionally left out technical and medical terminology in the

scripted dialogs so as to avoid the difficulties encountered by Dubslaff and Martinsen's subjects.

In the training of community interpreters, it is stressed that interpreting in first person is

of utmost importance, and that it is the standard practice for professional interpreters (Roat et al.

1999: 35). However, the origin of this standard is not explained. Therefore, another issue I

explore is precisely the origin of the first person standard in interpreting. One reason for this

practice that is frequently given is that it helps to facilitate the 'illusion' that the primary

participants in a conversation are communicating directly (Wadensjö 1997: 49), as if the

interpreter were not there. However, research on interpreting has demonstrated that this illusion

truly is just that. The interpreter does not simply act as a 'conduit' for information between the

primary participants, as is often asserted.

Another question I hope to answer is whether different kinds of discourse or content tend

to elicit renditions in first person or in third person from an interpreter. In discussing this with

other interpreters, we have concluded that certain types of conversations or certain types of

discourse or content do tend to make the interpreter render in the third person, even if he[5] would

normally use first person. If the interpreter feels some sort of embarrassment[6], even though it is

not for himself but for the primary speaker, or any sort of personal discomfort based on his

interpretation (something all interpreters must accept as a constant possibility inherent in their

profession), he may tend to render his interpretation in the third person. For example, if a

primary speaker answers "I don't know" to a question that everyone should be able to answer,

the interpreter might switch to third person. Other examples of speech that interpreters may find

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[5] I alternate using both male and female third person pronouns.
[6] It is true that a professional interpreter is trained to not take the conversations she interprets personally, and therefore should not worry about what is said, accept responsibility for it, or treat it as if they were her own words. Because community interpreting frequently relies on untrained interpreters, there is a greater chance that a community interpreter would not be aware of, or adhere to this ideal.

embarrassing are cursing, making a request, or rejecting a doctor's advice. In order to test this hypothesis, I have written some of these kinds of speech into my mock dialog scripts, so the interpreters who participate in the study will be forced to interpret them.

Another factor that may influence whether an interpreter works in first or third person could be whether primary speakers refer to themselves during the interpreted dialog. When the primary speaker is of the opposite sex of the interpreter, this becomes a potential source of trouble for the untrained interpreter. In this study we will be able to observe how these factors influence the choice of first or third person since there are multiple dialogs scripted, and there are both male and female characters in them.

Relevant literature

There is relatively little published research available, save for the aforementioned studies by Bot (2005) and Dubslaff and Martinsen (2005), that deal directly and specifically with the question of whether interpreting in first or third person truly makes a difference. Thus, I intend to examine their works rather closely in this thesis. Additionally, I review research by Berk-Seligson (1990) and Hale (2004), who have written books on court interpreting. Although I am focusing on medical interpreting their work is very relevant to this thesis because they demonstrate how interpreters affect the discourse in which they participate and are not simply 'conduits'.

The current study

This research consists of the recording, both audio and video, of interpreted conversations, and later transcribing and analyzing them to see if they will help shed light on the issue of first versus third person interpreting. Four scripts were prepared for four different

conversations. Each conversation is typical of one that a medical interpreter may be asked to interpret.[7] Each conversation script portrays a brief conversation between two people, one, a Spanish-speaking patient or family member, and the other, an English-speaking member of the hospital staff. Certain roles in these scripts prescribed either a male or female character, and the rest could be performed by a person of either gender. The script was performed by native speakers of Spanish for the Spanish-speaking characters, and by native speakers of English for the English-speaking characters. Each interpreter subject interpreted all four conversations and provided basic demographic information afterwards.

The current study also employed a survey to collect data about interpreters' opinions and ideas about interpreting, and to find out whether they use first or third person style and why. The survey was made available via internet. The survey data are every bit as important as the experimental data in that they attempt to uncover tendencies in first and third person style in community interpreting.

Overview

After discussing and analyzing the results of my data collection I discuss my recommendations for future research. This work may serve as the foundation for further studies while also contributing to the continued evolution and maturity of community interpreting as a profession. It is equally important that this work help pave the way for more university level research and instruction on translation and interpreting studies in the U.S.

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[7] In part, I base these dialogs on my experience as a medical interpreter at a hospital in Georgia.

Chapter 2

Interpreting as reported speech

Reported speech is the name given for what we do when we repeat what someone else has previously said. In other words, anytime someone quotes someone else, it is an instance of reported speech. Every citation I make in this thesis is also an example of reported speech. Before reviewing some of the literature that analyzes court and medical interpreting, I want to examine in greater detail exactly what is meant by the term reported speech. I will also briefly discuss the linguistic characteristics of reported speech and different types and theoretical models of reported speech. Additionally, I will discuss some objections to the traditional notions of reported speech and offer my response to them. Finally, I will show how interpreting is a special application of reported speech and relate this to the present study.

It should not be hard for us to think of examples of reported speech. For instance, an utterance can refer to a past utterance. Language can talk about language. This is not only a universal feature of natural language; it is also a requirement (Coulmas 1986: 2). Reported speech is ubiquitous; in English we even have a common name for reported speech in arguments: 'he said-she said'. The following examples contain instances of reported speech:

(1) He said, "I'm coming to the party."
(2) My mom said to use the coupon.

In the first example, there is a direct quotation. This is called direct speech, or sometimes direct reported speech (Bot 2005: 239).[8] The second only uses an indirect quotation; this is called indirect speech. Some propose a third (Portolés 2004: 220) or even a fourth (Vandelanotte 2004:

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[8] There are several different terms used to describe the different types of reported speech. There is even some disagreement as to whether reported speech should be called reported speech or not (Tannen 1989: 101). In community interpreting literature the different types of reported speech are usually referred to by naming the person reference associated with them: thus 'first person' for direct speech and 'third person' for indirect speech (Roat et al. 1999: 35).

490) category. These are meant to include examples of reported speech that mix direct and indirect speech. For my purposes I will not be examining in detail these mixed categories. However, in conversation, or in any kind of narration, it is not difficult to imagine a mixed reference. For example, we could expand (1) from above to say:

> (3) He said, "I'm coming to the party," and then later, he was like, no, he changed his mind.

In this example, the portion in quotation marks is direct speech, or first person style in community interpreting terminology, but the second part is indirect speech. Because I am ultimately concerned with how interpreters use reported speech it is sufficient to simply refer to these types of examples as mixed. Moreover, any indirect speech (third person style) in interpreting is considered unorthodox (Dubslaff and Martinsen 2005: 212), regardless of its particular subcategorization.

Characteristics of reported speech

Reported speech is characterized by a variety of traits which tend to place it in the realm of pragmatics more than any other linguistic subfield. The obvious feature of reported speech that makes it a pragmatic interest is its use of deictics. Looking back at example (3), there is person deixis in the quotation *I'm coming to the party*, and depending on the context, there may also be person deixis in the use of *he*. There is also temporal deixis in all of the verbs in the example. We can see that the deictic center shifts when using direct speech to that of the original speaker, a phenomenon we will discuss in slightly greater detail later on. Furthermore, reported speech is by its nature discourse about discourse, and thus it is metapragmatic. The speaker who does the reporting deliberately selects a previously uttered sample for some specific purpose based on his memory of said utterance (Collins 2001: 1-2). Direct speech, or the speech quoted in a direct quotation, will not be different in terms of syntax from any other utterance. Reported

speech may seem to have certain structures that are common to it, like the 'he/she said' in English. According to Collins (2001), however, there is a wider variety of structures used in reported speech, especially when viewed cross linguistically. Moreover, reported speech by its nature is not able to be completely understood outside of its discursive and deictic contexts. Therefore, an attempt to reduce the analysis of reported speech to mere structure or syntax is doomed to be woefully inadequate at best, and completely off target at worst (Collins 2001: 10-16).

Direct speech

Direct speech is commonly referred to as 'direct quotation' and is represented in written discourse by quotation marks. In oral discourse as in written discourse, a direct quote may be introduced by a reporting verb, such as *said* or *told*. In the absence of a reporting verb, oral discourse may make use of a pause before the citation, different intonations, imitating the original speaker's timbre or gestural clues to signal a portion of speech which is a direct quote (Portolés 2004: 218).

In direct speech there are two distinct deictic centers, although not always are both of them made explicit (Vandelanotte 2004: 491-492). First, there is the deictic center of the reporter. She is grounded in her own frame of reference, but as soon as the direct quoting begins, the deictic center shifts to that of the original speaker, the one being quoted. In those instances when there is no reporting verb, the only deictic center that is expressed is that of the original speaker, and not that of the reporter. In the following example, John's utterance, an example of direct speech, adopts the deictic center of Matt, the person whose speech he is reporting:

(5) [Wendy, to John]: What did Matt say?
     [John, answering Wendy] "I'm going to be there at 8:00."

Direct speech, sometimes called *oratio recta* (Coulmas 1986: 2), focuses on the original utterance that it is quoting. Although it may not always do so (and indeed we shall see later that in many cases it does nothing of the sort), direct speech attempts to preserve the original utterance as-is, word for word (Coulmas 1986: 3).

Indirect speech

Indirect speech, sometimes called *oratio obliqua* (Coulmas 1986: 2), by contrast is more focused on the person doing the reporting than the original speaker. In fact, in indirect speech the deictic center is the reporter.

(6)   He said he'd be there at 8:00.

This example, unlike (5), does not assume the vantage point of the person who said he'd be there; it merely reports it, maintaining the perspective of the person doing the reporting. Whereas direct speech attempts or purports to preserve the wording of the original utterance, indirect speech allows greater flexibility. It lets the reporter add information or comment on what is said (Coulmas 1986: 2).

The greater freedom of indirect speech, however, introduces the possibility of ambiguity. Coulmas (1986) uses a canonical example, also cited by Vandelanotte (2004), which makes reference to Oedipus:

(7)   Oedipus said that his mother was beautiful.

This example of indirect speech lends itself to at least two possible readings (Coulmas 1986: 3-4). The first possibility, known as the *de dicto* reading, is that Oedipus originally said something like, "My mother is beautiful" and this is what the reporter is meaning to say in (7). Another possibility is that Oedipus originally said, "My wife is beautiful" (or other equivalent

possibilities), and this is what the reporter is meaning to say. The second reading is known as the *de re* reading. It is not too difficult to invent other non-classical examples of this.

(8)   Johnny told Mark not to take his gun.

In this example of indirect speech *his* could be coreferential with *Johnny* or with *Mark* (or with someone else.) This type of ambiguity in reported speech may be a problem when it affects the primary interlocutors of an interpreted dialog.

Problems with the concept of reported speech

In our society, we rely on reported speech very heavily in our consumption of news reports of all varieties, as well as in other types of discourse, such as academic writing, legal and political discourse, and most notably translation and interpreting. When reported speech is direct, it is taken for granted that the citation is a faithful reproduction of the original utterance or text. This runs the risk of overlooking the fact that even though it may indeed be a faithful reproduction, it is still a report, and not the original. This may be a side effect of being a literate society. As Coulmas explains (1986: 13) by way of quoting Finnigan, who wrote about Limba (Sierra Leone) oral poetry:

> When I asked a Limba assistant to elucidate the words I could not catch fully while trying to transcribe taped stories, he could not be made to understand that I wanted the *exact* words on the tape. As far as he was concerned any comparable phrase with roughly the same meaning would do.

Thus, our ideas and expectations about what direct speech is and what is 'equal', 'the same', or 'faithful' in a reproduction are conditioned by society and variable.

This points to a problem with our notion of direct speech. As Coulmas (1986) notes, we tend to think of a faithful reproduction as being interchangeable with its original utterance or text. This may only be true in as much as it consists of the same words in the same order. However, that does not mean that they are equivalent. They may be described in terms of token

and type: they are different tokens of the same type (Coulmas 1986: 13). Nevertheless, they are still two different tokens. When one uses reported speech, it is often with a specific purpose in mind, and not merely to report. For example, I might offer a quotation from the President to convince you that my opinion about the President is correct and yours is wrong. Of course in doing so, the speech I am reporting is taken out of context, and potentially distorted. Therefore, even though the reproduction maybe faithful to the original, that does not mean they are the 'same' or 'equivalent'.

Tannen (1989) problematizes our notion of reported speech even further, dedicating an entire chapter to deconstructing it. For Tannen, the very idea of reported speech is not a valid one. Her primary reason for this assertion is that in many cases, what seems to be reported speech is something that was never previously said. Also, according to her analysis, the act of reporting speech puts it into a different context, and what is reproduced (if it is really reproducing something) belongs to the reporter, not to the original speaker (Tannen 1989: 101). Tannen says that by reporting speech, we are transforming it, and to illustrate this, she discusses a type of reported speech, reported criticism, that is, when someone repeats a criticism that was previously uttered in the absence of the person to whom the criticism is directed. Although it is not her main point, she makes an interesting cultural observation, namely, that in the U.S. we typically do not attribute the criticism to the reporter, thus recognizing that he is just reporting it. The opposite is true in Arabic society where to repeat a criticism is equal to stating a criticism (Tannen 1989: 105-106). However, Tannen demonstrates that when we repeat a criticism to someone who was not present to hear it, we change what was said, because if the person had been present to hear the original version, the criticism would not have been uttered, or it would have been expressed in a fundamentally different form. In other words, when you change the

context of a statement, you are changing the "spirit, nature and force" of the statement (Tannen 1989: 109-110).

What Tannen proposes therefore, is that we discard the 'reported speech' terminology and instead understand it as 'constructed dialog', similar to dialog produced in a novel or a dramatic work (1989: 110). She then goes on to analyze several different types of constructed dialog, and she analyzes some narratives from a few different cultural sources. All of Tannen's examples, while they do indeed demonstrate her contention that reported speech does not always report something that was said, consist exclusively of conversational and story-telling contexts. There are no examples provided from the more formal registers I mentioned earlier (journalism, academic writing, etc.). For instance, one of her examples illustrates the category which Tannen calls 'vague referents' (1989: 118):

(9)   He was sending me out to get the tools or whatever
        [imitating father] "Go get this
        and it looks like this and the other."

This is only one of several categories that she proposes of different types of constructed dialog. Indeed, it is very easy to understand that this person's father did not actually say, "Go get this and it looks like this and the other." Therefore, while this appears to be, in its form, an example of reported speech, in its substance what is 'reported' was never uttered by the person to whom it is attributed.

Another variety of constructed dialog that Tannen proposes is "dialogue representing what wasn't said" (1989: 111). She cites someone explaining something she never said because she felt she should not and could not say it:

(10)   You can't say, "Well Daddy I didn't HEAR you."

In this case the speaker is presenting something as a quotation although it was precisely that which was never said.

Yet another category that Tannen proposes is 'summarizing dialogue' in which a speaker repeats a summary of something that was said. Here is the example she gives (1989: 113):

(11)   and this man is essentially saying
        "We shouldn't be here
         because Imelda Marcos owns this restaurant."

In this example the speaker does not pretend to present a direct quote that is necessarily faithful and accurate to its source. These types of reported speech abound in our conversation and storytelling, and it may be helpful, as Tannen suggests, to think of them instead as constructed dialog.

Although I agree with Tannen, I use the terminology of reported speech, as I do think that there is a fundamental difference between reported speech which ostensibly attempts to report a previous utterance, and the many examples she gives of constructed dialog. In example (9), taken from a conversation, it is obvious that the girl, in imitating her father, does not actually believe that her father uttered those exact words, nor does she intend for her interlocutor to believe that either. Likewise, the speakers in (10) and (11) do not intend their quotations to be taken as words that were actually spoken. Instead they use discursive devices to give an impression of what was said, or what might be said, or what one is thinking; they are a means to an end.

The utilitarian nature of these kinds of utterances is taken for granted. As such, one could potentially make the argument that these conversational examples, while they have the formal appearance of reported speech, are something different than what reported speech actually is. For example, if the girl in (9) had said, "My father said, 'please bring me my small wrench,'" or "He told me to get his wrench," we would have something fundamentally different. In the 'vague

referents' example, what was actually said by the father is unimportant, and one can imagine a larger conversational context that has little if anything to do with what the father actually said. In these hypothetical examples however, the girl is actually trying to reproduce or represent what was actually said, instead of giving an impression of how her father speaks. In spite of this, as Tannen points out, a reported speech item is still separate from its original source, it belongs to a different context, and failure to realize or acknowledge this is quite problematic (1989: 133). Therefore, reported speech or constructed dialog must not be mistaken for the original utterance, even if it is a literal, verbatim reproduction of what was originally said. Nevertheless, I propose that there is a crucial difference between reported speech and Tannen's constructed dialog. In the former there is a conscious and overt effort to represent something previously said, while in the latter there may or may not be such an effort, and actually the exact form and content of what was said is less important. If we look to other types of discourse, such as the ones I listed before (journalism, academic writing, legal and political discourse, translation/interpreting), we will indeed see that the content and form of reported speech is important. When a speaker or author working in the aforementioned contexts uses reported speech, it is expected that he will make an effort to be precise and accurate and faithful to what was originally said. If not, he will be criticized for reporting something that was not said.

Interpreting as a type of reported speech

This brings us to the focus of this discussion, interpreting as reported speech. Interpreting is a very special case of reported speech. First of all, when an interpreter does her work, everything the interpreter says is reported speech. Secondly, not only is everything reported speech, but it is also speech that has been translated. This point is self-evident but deserves mention. For example, a third grade teacher reading a story to his class is also creating a

discourse which consists entirely of reported speech, but it is not a translation. Third, the interpreter is present in the context of the original utterance. This must be so, even though the presence of the interpreter may be remote, as in an interpreting booth, or via telephone. If the interpreter is not present in some way in the context of the primary interlocutors, then interpreting is not possible. Moreover, if the interpreter were not present, translation via the oral/auditory channels would not be possible. It is true that if a transcript were available, a translation could be done, but in that case the activity ceases to be interpreting.

This leads to an interesting observation: the interpreter is like a deictic phantom. By constantly reporting the speech of others, the interpreter is constantly adopting a deictic center that is foreign to her. During interpreted dialogs (as opposed to the conference situation where the communication is primarily one way), the interpreter is constantly switching between the two or more deictic centers of the corresponding primary interlocutors. This should ideally be understood, even taken for granted, by the primary interlocutors in an interpreted dialog or discourse. Indeed, if it were not so, it would create problems for the interpreter because traditionally, interpreters use direct speech in their translated reproduction. To illustrate this, consider the classically peformative utterance in the following example from Robinson (2003) (originally given by Pym (1993)). Suppose at an international conference a man at a podium in front of the auditorium says into the microphone *I declare the meeting open*. Shortly thereafter the French interpreter should say *Je déclare ouverte la réunion*. It is the man at the microphone who has the authority to open the meeting, and it is his utterance that opens the meeting, not the interpreter's rendition (Robinson 2003: 43). Those participants listening to the French interpreter understand that they are not his words, but instead those of the man at the podium. It is further

implicit and understood that if the opposite were true, i.e., if the interpreter actually had the authority to open the meeting, then he would be at the podium instead. Here is another example:

> (12) judge: How do you plead?
> interpreter: *¿Cómo se declara usted?*
> defendant: *Me declaro culpable.*
> interpreter: I plead guilty.

Ideally, the Spanish speaker in this scenario understands that it is the judge asking the question, not the interpreter, and the judge understands it is the Spanish speaker who pleads guilty and not the interpreter.

Direct versus indirect speech in interpreting

In both of the previous examples, the interpreter is using direct speech. This is the norm in professional interpreting (Dubslaff and Martinsen 2005: 212). This is done for a variety of reasons. To me, it is intuitive to try to maintain the same voice and person reference as the original speaker. After all, a written translation does not begin with "The author wrote, ..." and then proceed to enclose the entire translation in quotation marks. The use of direct speech, however, has more important benefits. It is done to reinforce the fact that it is not the interpreter but instead the primary interlocutors who are communicating. If not for the primary interlocutors, there would be no interaction in the first place, and if there were no language barrier, the interpreter would not be there. Moreover, when a record of what is said is being recorded or transcribed, the record keepers will rely primarily, if not exclusively, on the interpreted renditions, and not on the original utterances of the minority language speaker. Therefore, in the U.S., direct speech is considered a requirement for legal/court interpreting (Zetterstrand 2004).

Even in non-legal contexts, direct speech is the preferred style for interpreting because it helps maintain "the illusion of a direct exchange between the monolingual parties" (Wadensjö

1997: 49). In fact, it is often asserted that direct speech allows the interpreter and primary interlocutors to avoid confusion with regard to who is speaking (Roat et al. 1999: 35). This is true because as we have seen, indirect speech is more susceptible to ambiguity. However, this is only true in practice if all participants in an interpreted dialog are aware of the fact that the interpreter will use direct speech, and that they may feel free to address each other directly, instead of addressing the interpreter. Wadensjö, quoting a story from another interpreter (1998: 239), provides a poignant example of what can happen when a primary interlocutor does not understand that the interpreter will use direct speech.

> "We have decided not to give you permission to stay in Sweden," says the police officer. I translate: "We have decided not to give you permission to stay in Sweden." The man rushes up to me and shouts in anger and despair: "And me, I always thought that you were my friend!"

In this example the minority language speaker mistakenly thinks that the *we* in the interpreter's translation refers to the interpreter plus the police officer, while in reality it refers to the police officer plus any other officials who made the decision together with him. Therefore, in order for direct speech to work as it is intended to in interpreted dialogs, it must be explained beforehand to the primary interlocutors, especially in community interpreting settings (Roat et al.1999: 56).

As discussed in the introduction, community interpreters are often untrained in interpreting, or have received very little training in it (Bot 2005: 238). As a result, many community interpreters prefer to interpret using reported speech instead of direct speech (Dubslaff and Martinsen 2005: 212). Because direct speech is prescribed by interpreter training (and is required in some contexts), indirect speech in interpreting is controversial. Indeed, the use of direct speech is viewed by some as "*the* sign of professionalism" (Bot 2005: 239, italics preserved from source). However, given the relative informality of some of the community arenas (legal notwithstanding), one wonders whether it really makes a difference whether the

interpreter uses direct or reported speech. Furthermore, if it is taken for granted that reported speech is *not* equivalent to its respective source, and that direct speech only provides an 'illusion' of direct exchange between primary interlocutors, then perhaps indirect speech may be acceptable for interpreting in some contexts.

In my research, I have only been able to find two studies which attempt to directly address the issue of direct versus reported speech in community interpreting. Bot (2005) and Dubslaff and Martinsen (2005) both attempt to analyze interpreted dialogs in a community interpreting context that they have recorded with the intention of shedding some light on this question. Both of these studies are somewhat inconclusive for different reasons. Bot asserts that while indirect speech may be acceptable, it should be avoided in favor of direct speech. Dubslaff and Martinsen's data do not offer much insight because the untrained interpreters whose work they analyzed were sidetracked by a more fundamental problem, which was unfamiliarity with medical terminology. It is clear to me that more research on this issue is needed, which is exactly what this thesis intends to provide.

Chapter 3

Previous research

In this chapter I review and discuss relevant literature on community interpreting. In particular I look at work by Berk-Seligson (1990) and Hale (2004) on court interpreting, and work by Bot (2005) and by Dubslaff and Martinson (2005) about medical and psychological interpreting, and I also make a distinction between court and medical interpreting.

Court interpreting

Although Mikkelson (1996) includes court, legal, and medical interpreting as possible types of community interpreting, I would like to emphasize the distinction between court and medical interpreting. In court interpreting the primary participants in conversations are often adversaries. Even when the primary participants in the conversation are not adversaries, the discourse has a specific purpose in courtroom proceedings, to attempt to prove or disprove something. In medical and other types of interpreting this is not necessarily so.

There are currently more and more in-depth studies available on court interpreting than on medical or other community interpreting. *The Bilingual Courtroom* by Susan Berk-Seligson (1990) and *The Discourse of Court Interpreting* by Sandra Hale (2004) both demonstrate how even those court interpreters who are considered competent inevitably affect the conversations they are interpreting. This is done by analyzing real data from court proceedings as well as obtaining data from mock jury experiments. Berk-Seligson's data comes from U.S. trials, while Hale's data comes from proceedings in Australia. Although these studies investigated court interpreting, they reveal general principles that should also apply to medical and other community interpreting.

Berk-Seligson was granted permission to observe and record official court proceedings for her study, and she also interviewed court interpreters and attorneys (1990: 43). Additionally she conducted experiments using mock juries and a modified version of 'verbal-guise technique' (1990: 155). For these experiments, two recordings were played to mock juries. Each recording was meant to be a Spanish-speaking witness testifying via an interpreter. The recordings were nearly identical except in one respect, for example, the presence or absence of the politeness marker *sir*. The experiment was also conducted to test the effects of hyperformality, hedging, active versus passive voice, and the impact of interpreter intrusiveness (1990: 155-197). The experiments grew out of her observation of court interpreters' work in which she was able to witness firsthand instances where "the court interpreter plays a far more active verbal role than the system actually realizes" (1990: 54). This is quite different than the theoretical ideal for the court interpreter, which imagines that she does her work without otherwise affecting the proceedings. The experiments that Berk-Seligson performed confirmed that court interpreters do have an effect on how the jury perceives the Spanish-speaking witness, and to some extent, how they may perceive an attorney (1990: 198).

It is not difficult to find examples in Berk-Seligson's data that support her claims. As she states (1990: 131):

> Specifically, the English interpretations (1) add hedges, (2) insert linguistic material that is perceived to be underlying or "understood" in the original utterances, (3) use uncontracted forms, (4) rephrase what the interpreter herself has just said in her interpretation, (5) add polite forms of address, and (6) add particles and hesitation forms. It is important to notice that most of these mechanisms turn out to be features of powerless testimony style.

The first example given (1990: 131, underlined text and italics are preserved from source) demonstrates an instance of the interpreter introducing a hedge in her English rendition that was not present in the original utterance:

> ATTORNEY: Approximately how many?
> INTERPRETER: *¿Aproximadamente cuántos?*
> WITNESS: *Un promedio de veintiuno.*
> INTERPRETER: <u>Uh, probably</u> an average of twenty-one <u>people</u>.

The interpreted rendition adds the hedge *probably* and also the hesitation *uh*, both of which are elements of a style of speech in courtroom testimony known as powerless style (1990:131). In other words, the interpreter has changed what was said and created an utterance that is less convincing than the original. This is problematic for obvious legal reasons, and is also a violation of the interpreters' code of ethics in that it may be characterized as a distortion of what is said or as having added something to what was originally said (Zetterstrand 2004). Another example is the use of uncontracted forms (1990: 135), in other words, saying for example *we have* instead of *we've*. This is part of a general tendency of the interpreters she observed to insert language not present in the source utterance. Here is another example from her data (1990: 135, underlined text preserved from source):

> ATTORNEY: Of what country are you a citizen?
> INTERPRETER: *¿De qué país es usted ciudadano?*
> WITNESS: *México.*
> INTERPRETER: <u>I am a citizen of</u> Mexico.

Berk-Seligson argues that this type of change produces a hyperformal style, which tends to elicit a negative evaluation of the witness from the jurors.

Powerless testimony style is a speaking style that tends to reflect less favorably on the speaker in terms of jurors' evaluation of him or her. Berk-Seligson, relying on previous research on courtroom discourse, defines the powerless style as a combination of different elements, which may include, among others, those previously cited (1990: 131): the use of hedges, hyperformality, repetition, polite forms of address, and hesitations. These were studied in the mock jury experiments. One of these examined the effect of politeness markers on the juror's

perception of the witness (Berk-Seligson 1990: 149-169). This was done by asking 551 people to act as mock jurors and listen to a recording of testimony given in Spanish and interpreted into English. Half of the participants heard the English version of testimony which contained a certain politeness marker, consisting of adding the word *sir* after a response. The other half heard the English rendition of the testimony without this politeness marker. The original Spanish testimony was identical for both recordings. The mock jurors were asked to give ratings on a scale of one to seven for different attributes of the Spanish speaking witness, which were intelligence, convincingness, competence, and trustworthiness.

Berk-Seligson cites previous research which determined that the powerless testimony style tends to give a negative impression of the witness to jurors with regard to his or her intelligence, competence, truthfulness, and trustworthiness. For this reason, she anticipated that the mock jurors would give low ratings for these traits for testimony in which the interpreter did use the politeness markers, thus producing a powerless style, in her English rendition. In this study, after listening to the recording, the subjects were asked to rate the witness on a scale of one to seven for the traits 'convincing', 'competent', 'intelligent', and 'trustworthy', with a score of one representing 'not at all' and seven representing the highest score possible for each trait (1990: 157-158). The results actually were to the contrary of what was expected (1990: 161-166). The testimony which contained politeness markers in the English rendition generated higher ratings by the mock jurors for the different witness traits. The pool of mock jurors included a significant number of Hispanics, and among these many were Spanish speakers of varying degrees of competence. Also some of the non-Hispanic mock jurors spoke or understood some Spanish. Berk-Seligson explains that even adjusting for ethnic, linguistic, and gender differences, all groups still rate the witness higher on the surveyed traits for the testimony which

contained the politeness markers in the English rendition. This may suggest that politeness alone is not sufficient to create the effect of powerless testimony style. More importantly, it does demonstrate that the court interpreter has a tremendous influence over juries' perception of the Spanish-speaking witness.

Hale's work is very similar to that of Berk-Seligson. Essentially, Hale demonstrates that in the Australian legal system, court interpreters affect courtroom discourse in similar ways, in that they change the discourse of the primary participants in courtroom conversations by introducing their own discourse in their interpretation (2004: 235). More specifically and importantly, Hale states (2004: 239):

> Whether consciously or not, interpreters tend to maintain accuracy of propositional content alone. This can include the omission of important discourse markers which have pragmatic significance, the omission or misinterpretation of tag questions in cross-examination where such are used as challenging devices, the omission or addition of what O'Barr (1982) calls 'powerless speech features' such as fillers, repetitions and hedges from the witnesses' speech, to name a few.

Hale reached her conclusions after observing court interpreters working in Australia, and also like Berk-Seligson, she performed experiments later to check her hypotheses, and her results did indeed support them (2004: 241). Additionally, Hale surveyed interpreters and found that her respondents were confused about the concepts of accuracy with regard to interpreting, as well as the role of the interpreter and knowledge of the legal system (2004: 242). The survey also asked the respondents to perform some translations, which showed the same tendencies as her data from actual courtroom interpretations. This suggests that in some cases, the mistranslations are intentional (2004: 242), which is disturbing, considering the consequences of the court interpreter's work.

In her study of court interpreters working in Australia working in Spanish and English, one of the observations that Hale made is that interpreters tend to omit or mistranslate discourse

markers (2004: 62). Discourse markers are invariable linguistic units that do not have a syntactic function, but instead serve to organize and guide discourse (Portolés 2004: 288). The absence of a discourse marker does not change the propositional content of what is said, and for that reason they may seem unimportant to interpreters, which would explain their omission (Hale 2004: 62). Despite this, discourse markers are chosen for a reason by the speakers who use them. One example from Hale's courtroom observations is the discourse marker *you see*. She states that in her data the discourse marker *you see* was omitted by the interpreters (2004: 80). It is explained that *you see* is used to signal 'proclaimed knowledge', to present new information, to convey the speaker's point of view, and to try to cause the listener to accept one's ideas more forcefully (2004: 79). Therefore, if an attorney uses the marker *you see* at the start of a question or statement, it should be considered essential, considering that the attorney is there to convince his audience of his point of view. Here is an example from her data (2004: 79, bold text and italics preserved from the original):

> Q- **You see, what I'm putting to you** is that he didn't as you say, set himself to the left at all, he was in front of you.
> Interpreter- *Yo lo que le digo que él ni siquiera se se se torció a la izquierda, él estaba frente a usted.*
> ('What I say is that he didn't even uh uh uh twist to the left, he was in front of you.')

Although most of the meaning seems to be preserved, certainly the questioner's utterance is more confrontational and accusational than the interpreter's rendition. It is true that it would be incorrect to say *usted ve* for *you see* in this context, and perhaps the interpreter, sensing this, and unable to think of a good equivalent in a timely manner, chooses to omit it (Hale 1990: 80). This corroborates Berk-Seligson's work on court interpreting and again demonstrates that interpreters tend to introduce changes from the source utterances in their renditions.

Hale also discusses speech style in courtroom testimony, particularly the issue of powerless speech style (2004: 90-95). The previous studies on speech styles in courtroom testimony have demonstrated that when witnesses frequently use certain linguistic elements such as hedges, hesitations, and polite forms, among others, those witnesses tend to be perceived by juries as less convincing, truthful, competent, intelligent, and trustworthy (Hale 2004: 92). Hale discovered in her courtroom data that interpreters produced 148% more hesitations in their renditions than what were present in the source utterances (2004: 96-97). This is probably due in part to the difficulty of interpreting, and the fact that some of these hesitations may be vocalized pauses during which the interpreter is buying time while formulating his rendition; in effect it is an unconscious cognitive strategy (2004: 101). In any case, the fact that there are more hesitation forms in the interpreted renditions than the original utterances does demonstrate that they are, in some cases at least, coming from the interpreters and not the primary participants in the conversation (2004: 97). Here is an example from Hale's data, bold text and italics preserved from original (2004: 103):

> **Original answers with author's translations**
> *a.1*
> A1- *Por el temor de que esto tuviera más grandes consecuencias.*
> (Because I was afraid this would have more serious consequences)
> *…*
> **Interpreter's renditions**
> *a.2*
> I- Because I thought that this **uh** could **uh** have **uh** more serious consequences.

The interpreter's rendition adds the *uh* hesitations, which are not present in the original utterance, and in doing so, produces a rendition in powerless testimony style.

In order to corroborate her hypotheses, Hale also performed matched guise experiments (2004: 144-145). They attempted to find out whether the original Spanish testimony would elicit responses from listeners similar to the interpreted English version, and whether a 'polished'

version of the original testimony would receive a more favorable evaluation than an accurate interpretation.

In one experiment a recording of an original testimony in Spanish was played for university students who were native speakers of Spanish, and the interpreter's English rendition of that testimony was played to English speaking university students (Hale 2004: 146). Hale then asked the students to rate the witness on credibility, competence, and intelligence by using a scale of one to five, with one representing the most of each trait and five the least. The results for this were somewhat mixed because there were brief recordings of text from four different witnesses and also from their respective interpreters, and thus the results were somewhat different for each of them, perhaps suggesting that other factors besides speech style play a role in the evaluation of these traits (2004: 152). The results for the third witness were most interesting. Hale states that in the interpretation of this testimony the interpreter "had made considerable additions of powerless speech style features" (2004: 152), and the results show that the Spanish speakers, who listened to the testimony in the original Spanish, rated this witness higher for credibility, competence, and intelligence than did the English speakers who heard the interpreted version. Again, these results show clearly that the interpreter does change how an audience perceives what is said.

In another experiment, Hale tested whether 'polished' versus 'unpolished' testimony made a difference in listeners' ratings on the witnesses credibility, competence, and intelligence (2004: 153). Two sets of recordings of testimony were prepared. Both were read by a native speaker of English with a 'standard English accent'. The difference was that one recording was an accurate translation of the original testimony. The other recording, the 'polished' one was stripped of discourse markers and other features that some might mistakenly deem unnecessary,

and by coincidence are also features of powerless style (2004: 153). The polished version

produced significantly higher ratings for competence, credibility, and intelligence (2004: 154).

Once again, this shows that interpreters do change fundamentally the perception of the speech

they interpret.

Pragmatics and interpreting

Both Berk-Seligson and Hale stress that pragmatics play a role in interpreting, which is

often overlooked, at least to a degree if not completely, in court interpreter training (Berk-

Seligson 1990: 2; Hale 2004: 5-7). Berk-Seligson defines pragmatics as "the use of language to

do things, focusing on what a person is doing with words in particular situations" (1990: 271).

Hale expands on this:

> It is important at this point to refer to Speech Act Theory, as advanced by Austin (1962)
> and later developed by Searle (1969). A speech act is a combination of three simultaneous
> acts: a locutionary act, which is the utterance itself, an illocutionary act, which is the
> communicative act, the intended meaning behind the utterance, and the perlocutionary act,
> which is the reaction the utterance produces in the listener (Hale 2004: 7).

The nature of courtroom discourse is argumentative and the relationship between the primary

participants in a courtroom conversation is often adversarial. Even when the adversarial nature is

not at the forefront, the purpose of almost all courtroom discourse is to try to convince its

audience of something, which, if successful, will have demonstrated what is meant by

illocutionary and perlocutionary speech acts. Therefore, it is especially important that

interpreters be aware of and recognize the importance of the pragmatic elements of speech and in

their interpreting. This also points to a crucial difference between court and medical interpreting:

it is taken for granted that a physician or nurse has a very different set of goals in mind for

communication with the patient or family member who is speaking via an interpreter than does

an attorney or judge for their communication with parties in a courtroom who are speaking via an interpreter.

Other problems with legal language

Even if pragmatic issues were not so important in court interpreting, there are plenty of other issues which complicate translating legal discourse. In some cases, there may not always be an exact match between different terms in two different languages. One good example of this is the terminology used to describe the crime of homicide. As Mikkelson (1995: 203) notes:

> Translating the various homicide-related terms into Spanish is problematic for a number of reasons. As noted above, every society has laws prohibiting the taking of human life; but each society in its own way, differentiates various acts of homicide according to the circumstances surrounding them, for the purpose of determining the severity of the penalty, and defines exceptions that exonerate the killer from culpability…The result is a confusing array of terms from which the court interpreter must choose the closest equivalent to a given English term (which, I suppose, is better than having no equivalent whatsoever, a circumstance that forces the interpreter to coin a new term).

The problematic nature of legal language and how it impacts interpreting goes beyond differences in cross-cultural semantics, however. Both English (Mikkelson 1998, 1999; Berk-Seligson 1990: 14-18) and Spanish legal language (Mikkelson 1998) are criticized for being unnecessarily complicated and extremely difficult to understand for those who are not legal professionals. Mikkelson (1999: 3) and Berk-Seligson (1990: 15-16) list several features which are often found in legal discourse which tend to make it very difficult to understand: use of technical vocabulary, use of common words with uncommon meanings, words of Latin origin, words of French origin, words from Old English, compound words composed of a combination of one word from Anglo-Saxon origin and another from either French or Latin, hyperformality, vagueness, and overprecision.

Considering the aforementioned nature of legal discourse, it is not surprising that at times, those who employ it may seek to use language in a way that deliberately obfuscates the

speaker's true meaning or intention. Thus, even for the lay person who is a native speaker of English, understanding what is happening in a courtroom conversation may not always be possible. The purpose of a court interpreter is not to assist the participant who does not speak English in any other way besides providing him or her the same opportunity to be present in the courtroom that an English speaker would have. "The role of the interpreter is to put non-English speakers on an equal footing with individuals who do speak English during their interactions with the judicial system" (Zetterstrand 2004: 2). To be on 'equal footing' does not imply that one will be more or less able to understand legal language. In some cases, this may be frustrating for an interpreter, since

> a faithful translation of a meaningless original should be equally meaningless in the target language, though it is excruciatingly painful for a competent translator to deliberately create a nonsensical text (Mikkelson 1998: 94).

In fact, the court interpreter is prohibited from attempting to go beyond interpreting. The National Association of Judiciary Interpreters and Translators (NAJIT) Code of Ethics states that court interpreters "shall limit their participation in those matters in which they serve to interpreting and translating" (Zetterstrand 2005: 2). This is another crucial difference between medical interpreting and court interpreting. In a medical interpreting situation, if the non-English speaker does not understand, and if the medical staff does not do something to remedy the lack of understanding, the interpreter is expected to intervene in some way to help ensure that the communication be truly understood (Roat et al. 1999: 47-49).

Medical interpreting

In my research I was unable to find studies on medical interpreting that match those of Hale and Berk-Seligson in terms of scope and depth. However, two studies address the same question addressed in this thesis. Dubslaff and Martinsen (2005) wrote about direct versus

indirect speech in untrained interpreters' work in medical settings. Their results seem somewhat tentative, and are overshadowed by the fact that the main characteristic of their interpreter-subjects' renditions is a manifest difficulty with medical terminology (2005: 232). This shows that despite the differences between medical and court interpreting, terminology is also important in medical interpreting. I was also able to find a study done by Bot (2005) that deals with direct versus indirect speech in untrained interpreters' work in a psychological setting. Her results are more definitive in that they show that the interpreter who used the most reporting verbs (*he said…*) tended to produce interpretations that were most divergent from their source utterances. Although this does not demonstrate that the use of third person per se was causing the distortion evident in his interpretations, Bot concluded that it would be best for interpreters to only use first person interpreting so as to limit their influence on the conversations they interpret (2005: 260).

Dubslaff and Martinsen's work on reported speech and medical interpreting

Dubslaff and Martinsen (2005) conducted a study in Denmark using four untrained Arabic interpreters. Two of the interpreters stated a preference for first person style, and the other two stated a preference for third person. The data was collected by administering an interpreting test in which two other people performed the part of the primary participants of the conversation by reading a script that simulated a doctor-patient interview (2005: 214). The interviews were scripted such that neither the doctor nor the patient would use the third person when they were referring to each other, although there was some use of an indefinite reference (e.g. *man/one*) (2005: 216-217).

Overall, Dubslaff and Martinsen found that even though direct speech, or first person style, is intended to facilitate direct communication between participants in an interpreted conversation, this effect is seriously reduced when the interpreter experiences difficulty with

medical terminology or concepts (2005: 232). This is demonstrated in an example from their data where the interpreter mistranslates "blood pressure" as "blood pressure disease" (2005: 227), which resulted in a misunderstanding between the doctor and patient, and also resulted in unnecessary conversation between the interpreter and the doctor, and the interpreter and the patient.

There was a more subtle shift in perspective than that between first and third person, which each of their interpreter-subjects performed at least once. This was a shift from an indefinite reference (*man/one*) to a personal one (*you*) (2005: 223-224). At one point in the script the doctor says, "There are many things one can do oneself…", and it is interpreted by one of their subjects as "There are some other things e:r you can use yourself…" According to Dubslaff and Martinsen, the switch from *one* to *you* is a show of solidarity with the patient as someone who speaks their mother tongue or dominant language (2005: 224). This shows how the interpreter's mental perception of his relationship to the primary participants in the conversation influences what type of reference he uses in the actual interpretation.

Elsewhere in their data, Dubslaff and Martinsen show that the interpreter may use a third person reference to achieve the opposite, a distancing effect (2005: 222-223). For instance, in one example the doctor and patient are discussing the patient's parents as part of his medical history, and at this point the patient explains that his mother is dead. In the interpreted rendition, in the middle of an interpretation performed in first person, the interpreter introduces a reporting verb with third person reference: "… he says that" (2005: 222). In this interpretation the interpreter was supposed to be repeating what the patient said previously regarding how the mother died, but instead seems to be unsure of either the nature of her death or of what was said:

> (.)/ he says that(.) / I don't know what the disease is but it is an artery which has got clotted to the heart. That is what I understood of it. (2005: 222).

The interpreter inserts this third person reference and reporting verb *he says* to distance herself from what is said since she has doubts about it. This is an attempt to disclaim the responsibility for any miscommunications that may result (2005: 223).

An advantage of this experimental design is that it allows the researchers to obtain their data without worrying about violating patients' privacy or dealing with any of the other dangers present in an authentic medical environment. It is for these reasons that I chose to use mock dialogs, scripted in advance, for my study. Dubslaff and Martinsen reveal that interpreters have a tendency to change indefinite references to personal references at times, which show solidarity with the participant to whom they refer. They also demonstrate that when interpreters do switch from first to third person, it may be because they want to distance themselves from what is being said. However, because of the relatively small data set (only four interpreters and only the one mock dialog) and the problems the interpreters had with vocabulary and medical concepts, as well as the lack of other research on this topic, there is certainly plenty of room for further study of the question of first versus third person interpreting in medical contexts.

Bot's research on interpreting in a psychological context

Bot's article (2005) is based on research done on the work of interpreters in psychotherapy sessions in the Netherlands. In these sessions, the therapist is a speaker of Dutch. The patients speak Dari and Persian. The three interpreters whose work is analyzed in this article also speak Dari and Persian as their mother tongues and Dutch as their second language. The psychotherapy sessions were video taped and the conversations were transcribed, translated, and then analyzed. Bot comes to the conclusion that interpreting in third person, i.e. using reported speech, even though it is proscribed by most if not all interpreter training programs, is not

necessarily as bad a practice as the proponents of the first person standard suggest (2005: 259), although she ultimately agrees that it is best if interpreters work in first person (2005: 260).

The three interpreters in Bot's study had little training in interpreting (2005: 238). They were employed by an official state agency, the Dutch Interpreter and Translation Center. In order to work as interpreters, they had to agree to a code of conduct and pass proficiency exams in both their mother tongue and second language, as well as successfully complete an exam on "general knowledge of the countries involved, a memory test and role plays" (Bot 2005: 238).

The question of whether the interpreter is interpreting in first person or third person is important because, among other things,

> users of interpreter services believe the interpretation to be good when they note that interpreters render the translation in the first person, and seem to treat the retention of the perspective of person as *the* sign of professionalism (Bot 2005: 239, italics preserved from source).

Despite this, in my experience, it is interpreter trainers and some interpreters who think this way, not the 'users' of interpreters (doctors and other medical staff, judges, lawyers, participants in interpreted telephone conversations, etc.), who are almost always unaware of this aspect of interpreting. In fact, it is very common for those primary speakers to address the interpreter directly rather than the other primary speaker, and to continue to do so even after it is explained to them that this is unnecessary because the interpreter is interpreting in first person. This in turn encourages the interpreter to work in third person (Hale 2004: 237). However, I have included this citation because Bot is absolutely correct that interpreting in first person is presented as '*the* sign of professionalism' in training for community interpreters. Nevertheless, it is not uncommon for community interpreters, with the exception of court interpreters, to interpret in third person.

All three of the interpreters in this study use reported speech of one type or another in their interpretation (2005: 244-245). One of them interprets the patient's words in first person,

but when rendering the therapist's speech starts with *he says* and then goes into a first person interpretation. This interpreter explains that he does it this way because the therapist understands how interpreting works while the patient may not. The other two interpreters add *he says* to their renditions more often, both when interpreting the therapist's words as well as the patient's. When asked why, the interpreters could not give a specific reason other than that it just felt 'natural' to do so. Thus, the interpreters, by adding *he says* or *she says* before their rendition, are making clear their role in the conversation.

In her analysis of her recordings and transcriptions, Bot (2005) discovers that many times an interpreter will use multiple reporting verbs ("he/she said") when interpreting a single conversational turn. Sometimes it is evident (2005: 251) that the interpreter does this in response to a difficult to translate conversational turn, in order to have time to think and gain a few more seconds to do so. She notices (2005: 257) that the interpreters in her study use multiple reporting verbs more frequently when interpreting what the therapist says. This may occur because the therapist's speech would be more difficult to translate than the client's if the therapist uses certain jargon or a more formal speech style, which we might expect from a therapist. Also, the therapist in this study is speaking Dutch, which is not the interpreters' first language, and this in turn may create additional difficulties.

The three interpreters that participated in the study seem to have different patterns to their use of reporting verbs and multiple reporting verbs (2005: 258-259). One interpreter interprets in first person when translating the client's speech to the therapist, but uses a reporting verb before interpreting the therapist's speech in first person to the client. An example of the latter would be to say: "he says 'I went to school'" (Bot 2005: 246). Another interpreter mixes both first person interpreting and first person with reporting verbs. The third interpreter works in a different

pattern: he often uses multiple reporting verbs and interprets in third person, and also interprets in first person and third person with reporting verbs.

Bot sees many of the uses of reporting verbs as a way to build mental space between the interpreter and the primary speaker, whether it be a therapist or a client (2005: 258). She does not see an inherent harm to the translation done by the interpreters in using reporting verbs; however, if they are used very frequently, they become redundant. Moreover, she does not believe that using reporting verbs should be included as part of the definition of 'good interpreting practice' (2005: 259). As she notes, there is much resistance from professional interpreters, regardless of their specialty, to the idea that it may be harmless or acceptable to interpret in third person. More importantly, Bot stresses that her Interpreter Three, who uses multiple reporting verbs and indirect representation the most, does produce renditions that in effect lose information and contribute to misunderstanding between therapist and client (2005: 259). Thus, she concludes that although interpreting in third person does not always have a negative influence on interpreting, one should strive to limit this influence.

In the training of community interpreters the importance of interpreting in first person is emphasized (Roat et al. 1999: 35). However, there is little background or justification for this, outside of the legal arena, other than it is the tradition of professional interpreting, and that it allows the interpreter to act as a 'conduit'. Still, there are some community interpreters who are experienced, but prefer to work in third person. Therefore, this question needs further investigation.

Another important point is that the first person interpreting prescription assumes that the primary speakers also understand how the interpreting will work (Bot 2005: 240). This is frequently not so (Wadensjö 1998: 239). Even when the interpreter has time to explain how it

will work, the persons involved do not necessarily work within that framework afterwards, i.e., they speak to the interpreter directly, instead of speaking to the other person as if the interpreter weren't there, which is how they are 'supposed' to do it.

Even though in the U.S., we supposedly do not treat the person who repeats criticism the same as someone who actually speaks it (Tannen 1989: 105-106), I find that interpreters are less comfortable interpreting criticisms than they are interpreting more neutral speech. In fact, any utterance that may cause some embarrassment, may tend to influence an otherwise orthodox interpreter to render the utterance in third person. This could be anything: a confrontational question, a swear word, an insult, an expression of not knowing something that most people 'should' know, an expression of folk belief that a scientific-thinking person would not accept, etc. An interpreter who normally works in first person may tend to switch to third person at these moments in a dialog to distance herself from what was said.

Bot criticizes the conduit metaphor harshly (2005: 243-245). In interpreting studies the interpreter is sometimes described as a 'conduit' (Wadensjö 1998: 7-9). What this means is that the interpreter is expected to translate what was said by repeating it in the target language without changing it, without adding to it, nor subtracting from it. The conduit metaphor has caused the interpreter to be traditionally viewed as a person performing a mechanistic task, as if he were the linguistic equivalent of a telephone that interprets. This metaphor is at best problematic, and at worst fundamentally wrong. It is not possible to translate or interpret something without affecting it somehow (Robinson 2003: 86). That is not to say that competent interpreters produce inaccurate interpretations, but that by doing so they inevitably leave their mark on it one way or another. Even if a human could be like a machine (which is suggested if we take the conduit metaphor literally) it might not be any different. A telephone may have noise

on the line, preventing you from hearing the other person well, even if they are speaking clearly.

A photocopier makes copies that may seem 'perfect', but upon closer inspection, small lines and

dots are revealed that do not exist on the original document. Therefore, even under the best

circumstances, when the best interpreters are doing their best work, the conduit model is quite

misleading.

The question of whether the interpreter is producing renditions which are correct

interpretations of the source utterance is of utmost importance. One example from Bot's data of

interpreting in third person shows a rendition that is divergent from the source utterance. Here is

the English gloss of the patient's turn (2005: 249):

> my brother was ill, I went to visit my brother, he had many complaints, I went to see him,
> my own leg also was not well, this part was totally scratched, very much so that I could not
> walk, I went to the house of my brother, about three weeks I stayed, they have helped me a
> little, I have not used my leg at all, I only rested a bit

This is the English gloss of the interpreter's rendition (2005: 249):

> yes, two reasons, firstly he had gone to his brother, we eh because brother was ill and that
> was eh good support for him when mister was with him and second he had himself a lot of
> trouble with his leg and he is gone to Amsterdam so he did not have to use that artificial leg
> for a while, three weeks long

The real problem here is a lack of correspondence in meaning and information between the

source utterance and the interpreted rendition. It would be, or so it seems, possible to interpret

faithfully and accurately in third person. That is, I don't think interpreting in third person in itself

causes an interpreter to produce renditions that are divergent.

Ultimately, I agree with Bot's conclusion that an interpreter should try to limit her

influence, and one way to do this is to work in first person (2005: 260). Past work, such as that of

Berk-Seligson (1990) and Hale (2004), demonstrates clearly that the interpreter always plays a

crucial role in the conversations he interprets. Bot's Interpreter Three is the one who uses the

most reporting verbs and third person references. She describes his work as follows: "These sessions also show a large percentage of divergent renditions" (2005: 260). However, the diergent renditions may not be simply due to the fact that he works in third person: since he uses so many reporting verbs, he is already adding speech absent from the source utterance. Therefore, if he would learn to use first person, it may help him to be more accurate in his interpreting. Some interpreters resist this because they simply prefer third person. One wonders if this may not be such a problem, as long as they are careful and consistent, and are not interpreting in a court or other legal setting.

Chapter 4

Methods of data collection

In order to collect authentic data for this study (i.e. spontaneous speech), it would be necessary to observe, and record interpreted dialogs in their natural setting. For my purposes, ideally, these would be in a medical setting of some kind. Due to HIPAA and other privacy concerns, this would not be very practical considering the nature and scope of this thesis. Instead, I created mock dialogs to be interpreted and used a survey.

The mock dialogs were interpreted by volunteer interpreter subjects, following a procedure similar to the one described in Dubslaff and Martinsen (2005). It was hoped that by keeping the content of the dialogs relatively free from technical vocabulary, the difficulties these researchers encountered would be avoided in the present study.

The second method of data collection involved a survey that was made available via internet. It was announced on the National Council on Interpreting in Health Care (NCIHC) e-mail listserv and respondents were able to click a link in that message to go to the survey site. The purpose of the survey was to ask interpreters what they thought about first versus third person interpreting.

Rationale

I expected the interpreter-subjects at certain moments to shift to third person even if they normally would work in first person. This was based on Dubslaff and Martinsen's observation that any time an interpreter wishes to distance herself from what a primary participant says, there is a greater likelihood that she will render her interpretations in third person (2005: 200, 223). Berk-Seligson (1990: 65-66) also notes that there is a 'temptation' to shift to third person if the interpreter is worried that those listening may think her renditions are actually her own words or

if what she is saying may sound 'stupid' or 'incompetent'. Therefore, whenever the interpreter may be more self-conscious or embarrassed for any reason, there is a greater possibility that she will shift to third person style.

The scripted dialogs

The mock interpreting was done with four short dialogs (see Appendices A-D). These are bilingual dialogs meant to reflect a typical interpreted conversation in a hospital setting. The hospital staff are English speakers, and the patients or guests are Spanish speakers. I solicited volunteers to read/perform these parts. Whenever possible, native speakers of English read the English speaking roles, and native speakers of Spanish read the Spanish speaking roles. Male speakers read those roles that are designated as male speakers, and female speakers read those roles that are designated as females, except in Session 2, when I had to read all English-speaking parts and a male native speaker of Spanish had to read all Spanish-speaking parts. However, we did not change the scripts in any way for this session. I did this because I hypothesized that when the interpreter and primary speakers are not of the same gender then there may be a greater tendency to use third person style.

Volunteer interpreters were solicited to participate as subjects in this pilot experiment. The only requirements for their participation besides being able to interpret was that they not be personally acquainted with the primary researcher or be aware of the research questions before they participated.

The four different dialogs were scripted with the intent that at various points in the conversation the interpreter might feel a compulsion to use the third person, even if she normally works in first person. The first dialog was an Emergency Room (ER) triage interview. It was meant to be a realistic portrayal of a conversation between a male patient and an ER nurse when

the patient first enters the hospital and is examined by the nurse to assess his status and the urgency of his situation. During this dialog, I expected the following parts to be more likely to induce third person interpreting from even those who work in first person: when the patient gestures his lower right abdominal area as part of his response to one of the nurse's questions, and when the patient responds to the question about his medical history at first by saying that his visit was the first time he'd been to a hospital "here", and then when he says he doesn't know what "chronic disease" means. This is because the interpreter may not know how to convey the gesture while still rendering a complete interpretation, and because the interpreter may feel embarrassed when the patient is unable to answer a question on its first asking.

The second dialog was between a hospital registrar and the mother of a female patient. It was meant to be a realistic conversation during the registration process in a hospital. I anticipated that the interpreter would be more likely to use third person when the mother says she doesn't know her date of birth, her address, her phone number, and when she says that she doesn't have an identification card. I expected this because the interpreter might be embarrassed or feel uncomfortable during those parts of the conversation, and may wish to distance himself from them. I base this on personal experience as well as Dubslaff and Martinsen's observations (2005: 223).

The third dialog was between a male patient and a physician. This conversation was supposed to be an authentic representation of one that could occur when an ER physician is giving some advice to a patient about quitting smoking. I expected that the interpreter would be more likely to use third person when the patient rejects the physician's advice, and especially when the patient's speech takes on a hostile tone and when he curses, since the interpreter might feel uncomfortable during these parts and wish to distance himself from them.

The fourth dialog was between a female patient and a cashier. This dialog was meant to be a realistic conversation that might occur just before the patient leaves the ER. The cashier is attempting to get payment and insurance information. When the patient does not have insurance or a payment, a financial assistance application is offered. I expected the interpreter to be more likely to use third person when the patient was surprised by the amount of the payment she was asked for, and when she requested that they "have mercy" on her. Again, I would expect an interpreter to feel some discomfort during these parts of the conversation and possibly to want to distance herself from them.

Actors

Volunteers were solicited to perform the conversations scripted in each dialog. Ideally, I wanted native speakers of English to read the hospital staff roles, and native speakers of Spanish to read the roles of the Spanish-speaking patients and guests. If a volunteer actor were bilingual and did not have an accent that would very readily identify him or her as a 'foreign' speaker to most people, then it would be possible for him or her to read roles in either language. If it was not possible to have actors that met these specifications, I did not expect interpreters to interpret differently than they otherwise would. Instead, I simply hoped to create as authentic of a scenario as was possible. In Session 2 only two actors, a native speaker of Spanish and I, read all parts scripted; however, the resulting interpretations did not seem to be affected by this.

The volunteer actors met the primary researcher to discuss their participation before the recording sessions with the interpreter-subjects. The actors were made aware of the purpose of the study, with the caveat that it was absolutely necessary that they not divulge this information to any of the interpreters. The actors did not need to memorize their lines, but were asked to read their respective lines from a script while not allowing the interpreter to see them. Moreover, they

were asked to read their lines as though they were performing them. In other words, they were to perform a dramatic reading. The actors were asked to look over the scripts first, so that when they performed them during the mock interpreting sessions, they would be able to read them smoothly and without any mistakes. The actors were instructed to pause after each conversational turn to allow the interpreter to interpret it.

Interpreters

Spanish interpreters were solicited to volunteer as subjects for this portion of the study. There were two qualifying requirements for the interpreter-subjects. One was that they must not be personally acquainted with the primary researcher. The other was that they must not have been aware of the research question until after their participation. Ideally, the subject-interpreters would have had experience as medical interpreters, but as long as they had some experience as an interpreter it was considered sufficient. They did not need to have had any training in interpreting. It was explained to each subject-interpreter that she was going to interpret four brief dialogs, each of which consisted of a conversation between a Spanish-speaking patient or guest and an English-speaking member of the hospital staff. It was explained that each speaker would pause after each conversational turn to allow the interpreter to interpret it. The interpreter was welcome to take notes as needed, as is the norm for the consecutive interpreting mode[9], and was provided with paper and pen or pencil to do so if desired.

Equipment and studio

The mock interpreting sessions were recorded using video equipment provided by the University of Georgia Language Resource Center (LRC). The sessions were conducted and recorded in the studio available at the LRC. The video camera has its own built-in microphone

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[9] Consecutive interpreting, or consecutive interpretation is the mode of interpreting in which the interpreter waits until the primary speaker has finished what he is saying before delivering her interpretation (González et al. 1992: 379).

that provided synchronized audio. The resulting recordings were digitized and stored on computer hard drive and DVD for archive purposes. Any and all original tapes were re-used and thus recorded over by LRC staff.

The sessions

Before beginning each session, each interpreter-subject was asked to sign the required consent form. The interpreter was assigned a number which corresponded to his or her order with relation to the other subjects. In other words, the first interpreter was assigned 1, the second was 2, and so on. In order to further identify each interpreter, this number was followed by M or F to indicate the subject's gender. The interpreter-subjects filled out a demographic information sheet (Appendix E) before their sessions. This paper was marked with the subject's number.

Before actually staging and recording the mock dialogs and their interpretation, the interpreter was asked to simply interpret as she[10] normally would. The interpreter was informed that she would interpret four separate conversations, each of which only involved two primary speakers and was relatively brief. The interpreter was given an opportunity to ask questions. After the questions were answered (if there were any), the actors and the interpreter took their places in the studio.

The LRC assistant director, Dr. Gary Baker, assisted with the video recording. The two actors were seated on either side of the interpreter. The actors faced each other, with their profiles to the camera, and the interpreter faced the camera. There was a brief break between each dialog to change actors if necessary, and to allow the interpreter to pause. Recording did not stop during these breaks.

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[10] All three interpreter-subjects in this study were female.

Debriefing

After each session was over, the interpreter-subject had to be debriefed. Essentially this was to inform her of the true nature of the study, which was to investigate whether interpreting in first person versus interpreting in third person makes a difference or not. The primary researcher conducted the debriefing. The content of this discussion is contained in the debriefing script (Appendix F). At this time the subject was given another opportunity to ask any questions she may have had.

The survey

Data was collected using a survey, the content of which can seen in Appendix G. The survey asks interpreters for some information about their background and current practice in the profession, as well as their thoughts and opinions on person reference in interpreting. The interpreter-subjects in the mock interpreting sessions were asked to take this survey on paper after they were debriefed. The survey was also made available via internet for other interpreters to take who did not participate in the mock dialog sessions.

After the mock dialog sessions were completed, survey respondents were solicited outside of the pool of interpreter-subjects by posting a link to the survey to the NCIHC e-mail listserv, and by making the website available via other means to other interpreters. The respondents could be interpreters of any language. It was important to not let an interpreter-subject take the survey until after she had interpreted the mock dialogs, because the survey would make her aware of the research question. It is for this reason that the survey was not made available to other respondents until after the mock interpreting sessions had been completed. Additionally, I entered the mock interpreting sessions subjects' responses from the paper version of the survey to the internet version of the survey, so that their responses would also be included.

Chapter 5

Results and analysis

The data collected demonstrate an overwhelming preference for interpreting in first person. All three interpreter-subjects worked in first person. Although it was hypothesized that the interpreters would use third person in their interpreting, and that this practice would show whether doing so makes a difference or not, it is hoped that the data collected will shed light on some linguistic problems in community interpreting, regardless of the research question. In this chapter, I will discuss some of the most salient features of the mock interpreting sessions based on their transcriptions.

Almost all of the survey respondents expressed a preference for first person style interpreting, but there were a few who did express a preference for third person. Their responses to the survey's open-ended questions, as well as others' responses to those questions, are also explored in this chapter.

Mock interpreting sessions

There were three mock interpreting sessions. Each interpreter-subject was female. The interpreter in Session 1 (Interpreter 1) was a native speaker of English, the interpreter in Session 2 (Interpreter 2) was a native speaker of Spanish, and the interpreter in Session 3 (Interpreter 3) was a native speaker of Portuguese. All three interpreters worked in first person, and there were virtually no shifts to third person, though these had been expected. One of the interpreters did use third person references to refer to a primary speaker, but only in two separate renditions. Additionally, there were other noteworthy features in the interpreted dialogs which deserve commentary. First, there were several instances of a change from a personal to impersonal reference or vice-versa by the interpreters. Second, there were some interesting differences in the

interpreters' uses of *tú* and *usted* to refer to the Spanish-speaking primary participants. Also,

there were a variety of stylistic changes observed similar to those observed by Berk-Seligson

(1990), including the reducing and extending of the length and content of source utterances.

Another stylistic change was the omission of curse words. Finally, similar to the findings of Hale

(2004), there was a tendency to omit discourse markers.

Third person references

There were only two instances of third person references and both occurred in Session 2.

In the first example, the interpreter is narrating a gesture that the patient is performing:[11]

> (13) P4: Bueno, antes s me dolía todo el estómago, pero ahora me duele más (.)[12] por aquí.
> ((*Patient gestures using left hand indicating the region between left hip bone and belly button on his left side.*))
> I2: um (.) It used to hurt my whole stomach, but now it hurts about (.) here, where he's showing.

In the second instance, the interpreter has simply switched to an indirect speech style:

> (14) S4: Hello. Please have a: seat over here, I'm going ta do your registration.
> I2: Hola. Por favor siéntese aquí la- va- ella va:cer la registración.

In general, deictic references seem to influence these shifts to third person. In (13) the interpreter

is faced with the task of interpreting an utterance accompanied by a gesture. This is problematic

for a variety of reasons. Since the gesture is non-verbal, it would be left out of a translation of

what the patient expressed with words, but it is important because it is shows the nurse where he

hurts. One possible solution would be to simply leave the gesture out of the interpreted rendition

since the English speaker most likely saw the gesture, but, to do so would run the risk of leaving

out essential communication if the intended recipient did not see it. Another option would be for

the interpreter to mimic the gesture in a respectful way. However, even if done respectfully, it

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[11] In the transcriptions the letter P (patient) represents the Spanish-speaking primary participant, I represents the interpreter, and S (staff) represents the English-speaking primary participant.
[12] Jeffersonian transcription notations are used (Jefferson 2004). For further explanation see Appendix H.

still may be misunderstood as a type of mocking. More importantly, if the interpreter makes a mistake in her imitation of the original gesture, it may cause a misunderstanding. By describing the gesture and calling attention to it, as this interpreter did, she avoided the risks of the other two solutions, but did not introduce speech that was not part of the primary speaker's original utterance.

In (14) the interpreter switches to third person style, and this is the only time she does it. This could be a typical distancing of oneself from what the primary speaker said (Dubslaff and Martinsen 2005: 200, 223). It is as if she wants to emphasize that it is the registrar who will do the registration and not the interpreter. If the other primary speaker is not sure how interpreting is supposed to work, or if there is any doubt about the source of speech, there may be a misunderstanding about who is actually doing what (Wadensjö 1998: 239). This could also be an unintended shift that the interpreter performed unconsciously under the pressure to render an interpretation as quickly as possible. Interpreting is a relatively complex process and requires the interpreter to perform many different mental tasks simultaneously (González et al. 1992:318-322). It is not surprising, therefore, that an interpreter may sometimes make this type of shift even if it is not her normal practice. Looking back at the transcription, right before she makes the third person reference, she starts a word then cuts herself off twice, which indicates that there may have been some processing issues affecting her performance.

Changes from personal to impersonal references and vice-versa

Although there were only two previously cited uses of third person references to address the primary speakers during the mock interpreting sessions, there were several instances of a change from a personal reference in the source utterance to an impersonal one in the interpreted rendition, and vice-versa. This type of change happens when in the source utterance there is a

personal pronoun or other personal reference that is omitted in the interpretation by shifting the focus to an impersonal reference or inanimate entity, or vice-versa. The following is an example from Session 1:

(15) S1: When did you start having this pain?
      I1: Cuándo empezó el dolor?

In the source utterance, the nurse addresses the patient directly. This is eliminated in the interpretation, which refers instead to the pain. The reverse may also occur as in the example below, also from Session 1:

(16) P1: uh Qué signifíc- qué quiere (decir que) eso?
      I1: What do you mean?

This time, the source utterance refers to *eso*, which means *that*. In her rendition, the interpreter personalizes the question by referring deictically to the nurse.

All three interpreters did this at least twice. Interpreter 1 introduced these changes a total of four times, three of them being in the direction of personal to impersonal as in (15), and one being impersonal to personal as in (16). Interpreter 2 also made four of these changes, and in the same proportion: three personal to impersonal, and one impersonal to personal. Interpreter 3 made only two of these changes, both of them impersonal to personal.

Two of the changes introduced by interpreter 2 are identical to those of interpreter 1. The first is when the patient asks the nurse what a word meant. Here is Interpreter 2's rendition, which is comparable to (16):

(17) P4: Qué quiere decir eso?
      I2: Um (.) what do you mean?

This also happens is in Dialog 4 of Session 1 which is between a patient and a hospital cashier, when the patient expresses surprise at the amount of money she will be charged. Here is that excerpt from Session 1:

(18) P2: Híjole: eso se me hace mucho. Por qué cobran tanto?
     I1: Geez seems like a lot to me. Why's it cost so much?

In the source utterance the patient is asking why *they/you all* charge so much, but in her rendition, Interpreter 1 has changed it to an impersonal question. Here is the same excerpt from Session 2:

(19) P4: Hí:jole. Eso se me hace mucho. Por qué me cobran tanto?
     I2: That's a lot of money. How come it's so expensive?

Again, Interpreter 2 has changed the reference from *they/you all* in the source to just *it* in her rendition.

Interpreter 3 only introduced two of these changes in her renditions and they both were in the direction of impersonal to personal. Here is the first example taken from Dialog 2:

(20) S5: Any ID with photo (i)n- on it?
     I3: ah: Tiene alguna idenfi- identidentificación que tenga su foto?

The registrar refers to an *ID* and *it*, while the interpreter refers to *your picture*. The second occurrence is from Dialog 4:

(21) S4: That is just (.) what the hospital charges. I don't know how that is determined. Ih-
     I3: Esto es sólo lo que el hospital ah le va a cobrar ah I don't know- yo no sé cómo (.) ellos cobran.

There are actually two changes here. First, the interpreter adds the pronoun *le* which does not correspond to the source utterance; she says what the hospital is going to charge 'you' instead of just what the hospital charges. Second, whereas the cashier simply says *I don't know how that is determined*, the interpreter says 'I don't know how they charge'.

These changes are similar to those described by Dubslaff and Martinsen (2005: 223-224) in that their subjects changed the indefinite *man/one* to the personal *you*. They theorized that their interpreters performed this change as a show of solidarity with the patient. In the examples found in my data I can not say for certain that that is also happening here. Example (20), *ID with*

photo on it to *identificación que tenga **su** foto* is the only change from impersonal to personal which is directed to the patient. Although it may be a show of solidarity, it may also be an attempt by the interpreter to clarify the message by making it more specific. The other changes in the direction of impersonal to personal made reference to the staff or to the larger institution of the hospital. Examples (16) and (17) involve the patient's asking a nurse what she meant by a certain word, although the source utterances may be understood as asking what the word itself means: *¿Qué quiere decir eso?* versus *What do you mean?* This could be an attempt to shift the responsibility of knowing what is meant from the patient to the nurse, who should have the responsibility of communicating in a way that is understandable. In (21) the *you* and *they* are absent from the source utterance. Although the cashier does not explicitly refer to herself as part of the hospital in her utterance: *that is just what the hospital charges; I don't know how that is determined*, it is taken for granted, and her concise reply does not explicitly separate herself from the hospital either. The interpreter, who is caught in the middle of a cashier and patient who are discussing payment, may have added *ellos* to place a further distance between herself and the institution which is actually billing the patient.

The changes that go in the other direction, from personal to impersonal, are similar to the third person references observed by Dubslaff and Martinsen (2005: 222-223), which achieve a distancing effect. In example (15), the interpreter's rendition, *Cuándo empezó el dolor?,* is a less personal way of asking the question about pain. Without more data, it is difficult to conclude that, in fact, the interpreter intends to distance herself by using a non-personal reference. Examples (18) and (19) demonstrate the distancing effect more clearly. The question that the patient asks may be taken as somewhat confrontational, and to ask *why does it cost so much*

instead of *why do they/you all charge so much* is a less personal and more mitigated or indirect way of asking for the interpreter.

I believe that some, if not all, of these examples may also be motivated simply by the pressure of interpreting and by the cognitive processing involved. There is a constant pressure of time, and if the interpreter pauses or delays, it may call into question her competence. Therefore, there is always the possibility that the changes we observe in the transcription may also have been simply introduced as a side effect of this process. Another factor is the fact that Spanish and English don't always have equivalent structures. For example, it's impossible to have a subject that is not explicit in English, as in (18) and (19)'s question, *por qué cobran tanto?*, whereas in Spanish it is perfectly normal. Thus, it may make more sense to translate it as *why does it cost so much?*, even though the Spanish speaker may have been thinking of the hospital as doing the charging. I asked several colleagues who are native speakers of Spanish their opinion on who or what would be the subject of *¿Por qué cobran tanto?* and the results were not unanimous. Most said that it would be *ellos*, with some emphasizing that this would refer to the hospital staff or administration, and others saying that it was an impersonal third person plural reference. A few said the subject should be *ustedes*, understanding that this included the cashier. A couple people said that both were valid readings of the utterance. It seems to me that if the question is understood to have an impersonal subject, then rendering it as 'Why does it cost so much?' seems quite reasonable.

Tú versus *usted*

Spanish uses a system of address that does not correspond neatly to *you* in English. That is, one must choose either *tú* or *usted*. Brown and Gilman (1960) describe their usage as reflecting power and solidarity. In other words, the *tú* forms may be used for addressees with

whom the speaker is on a more or less equal level, whereas the *usted* forms are used for

addressees that are above the speaker in terms of social hierarchy (Portolés 2004: 119). These

pronouns are an example of social deixis, which refers to the use of linguistic elements that

signify the social relationships between speakers (Levinson 1983: 89). This creates a potential

problem for Spanish interpreters if they are not careful or if they are unsure which form to use.

Both legal and medical interpreting contexts tend to use respectful language and in Spanish, the

use of *usted* to address the Spanish speakers would be most appropriate.

In the mock interpreting sessions the three interpreters used *usted* forms most of the time.

Interpreter 1 used *tú* forms the most for a total of twelve times. Interpreter 2 used *tú* forms two

times, and Interpreter 3 used *tú* forms seven times. All of the remaining references to *you* in

Spanish were *usted* forms. The *tú* forms that were produced deserve commentary because they

are so few and one may wonder why they were used at all. For Interpreter 1 and Interpreter 3

they were most likely errors since Spanish is not their native language. For interpreter 2 they

may have been a show of solidarity with the Spanish speaker.

Interpreter 1 used *tú* forms more than the other two interpreters. In some of these they

were the only type of address used. For example,

(22) S1: Hello, do you need to see the doctor today?
I1: Buenos días, necesitas ver al doctor hoy?

In some instances Interpreter 1 mixed *usted* and *tú* references in the same rendition. For example,

(23) S1: It's possible it could be somewhat serious but the doctor will tell you (.) an:d
answer any other questions you have.
I1: Es posible que puede ser grave pero el doctor va a hablar más contigo y va a (.)
um va a (.) responder a: cualquieres preguntas tiene usted.

Here the interpreter uses a *tú* form in *contigo* and an *usted* form in *tiene usted*. Interpreter 1's *tú*

forms occur in several different contexts, however at no point does she actually refer to the

patient as *tú*; the references are encoded in the verb conjugations used or in object pronoun forms. The interpreter also used imperative *tú* forms to request a repetition:

(24) I1: Por favor repite.

Interpreter 1 also used *tú* forms in verb phrases with subjunctive mood:

(25) S1: Okay ah I'm going to take your temperature and blood pressure then I want you to wait in the waiting room over there. ((*points with right index finger to area behind patient*))
I1: Voy a tomar su ah su presión y: su temperatura, y después quiero que:: esperes a allí ((*nods head to her left which coincides with the general direction the nurse pointed to which was behind the patient*)) en la sala.

At one point, the interpreter used a *tú* form in a clitic object pronoun attached to the end of an infinitive. In this example Interpreter 1 also uses a *tú* form in the verb phrase following the infinitive:

(26) S3: um (.) But I agree that no one can <u>force</u> you to do something you don't want to do.
I1: Pero estoy de acuerdo que nadie: um debe (.) forzarte um dejar algo cuando no quieres.

These examples provide one of each of the different contexts in which Interpreter 1 used *tú* forms.

Interpreter 2 only produced *tú* forms in her renditions twice. The first example is an indicative verb conjugation with the *tú* ending.

(27) S4: Not even a cell phone? How can that be?
I2: No tienes d- >ni siquiera< teléfono (.) móvil? celular?

This may be a show of solidarity with the Spanish speaker who is having to explain to a hospital registrar why she doesn't have a telephone. The other occurrence is a clitic pronoun placed before an indicative verb:

(28) S4: Very well then, <Mister Rodríguez. I think I understand>. I still ↑<u>wish</u> you'd quit smoking, but I ↑agree that no one can force you to do something that you <u>don't want to do.</u>

I2: Muy bien, yo lentiendo. Um (2) ah: (.) te entiendo lo que usted está diciendo, y, aunque me gustaría que dejara de fumar, tiene razón nadie le puede forzar a dejar del hábito.

It should be noted that the *te* in (28) is followed by three verb phrases which all use *usted* forms (*usted está diciendo, dejara de fumar, **le** puede forzar a dejar del hábito*). If this is a processing or performance error, it is odd considering that Interpreter 2 is a native speaker of Spanish. Again, it may be a temporary show of solidarity which would go well with the doctor's saying that he understands the patient.

Interpreter 3 used *tú* forms a total of seven times. Five of these involve a clitic object pronoun and two involve a possessive adjective. Both of the possessive adjective examples occur in utterances in which the interpreter asks similar questions of the patient. One asks her name:

(29) I3: And what is you- Oh. Cuál es tu nombre?

The other asks her phone number:

(30) I3: And- Y cuál es tu número de teléfono?

The remaining occurrences of *tú* references are clitic pronouns. All but one of these are mixed with *usted* forms, and all but one have a clitic pronoun preposed before a conjugated verb. The following excerpt has one instance of a preposed clitic *tú* form in the phrase *te va a responder*:

(31) S5: It is possible it could be somewhat serious but the doctor will let you know >that (he) can answer any questions you have<.
I3: Es posible que sea al:go se:rio pero:, el doctor te va a responder (cual)que pregunta que tenga.

The only instance of a postposed clitic, attached to an infinitive, occurs in the segment below:

(32) S5: Well, we have to have some way to contact you by phone, or at least in case the doctor needs to tell you something after you leave.
I3: Well, nosotros tenemos que tener por lo menos un número de teléfono en caso que el doctor necesite: decirte algo después que usted se va (.) se va(ya).

Finally, the only *tú* reference where there is not also an *usted* form in the same rendition appears in the following utterance:

(33) S4: And let you know by mail if you qualify, and, if so, at what level.
I3: Y- y te va a dejah saber por correo y: si sí en qué nivel.

Interpreter 3's renditions only show *tú* forms in possessive adjectives and clitic object pronouns.

The main reason why I find the uses of *tú* to be noteworthy is because the interpreter training for Spanish interpreters in the U.S. that is available advises interpreters to use *usted* in both legal and medical contexts. This is followed more often than not in the mock interpreting sessions. There is a temptation to suggest that the use of *tú* forms is another show of solidarity, since it has been shown that this is one of the normal uses of these forms (Brown and Gilman 1960). However, if this were so, it is very strange then, that the interpreters do not consistently use *tú* forms, because to use them and then stop using them may be understood as a sign of disrespect. (Brown and Gilman 1960: 280). Therefore, it is more likely that the use of *tú* forms here is accidental and due to the pressure of interpreting. Interpreters 1 and 3 produce *tú* forms that may be inappropriate or are simply performance errors because they are not native speakers and thus do not have sufficient proficiency to enable them to use the address forms correctly. This is supported by the fact that they produce more *tú* forms than Interpreter 2, a native speaker of Spanish.

Stylistic changes

Another prominent feature in the interpreted dialogs was the interpreters' introduction of changes in style in their renditions. The omission of curse words and a tendency to omit discourse markers were the two most notable examples of this. Besides these, other changes in style were observed, such as making an interpretation sound more or less formal, and producing

an interpretation that was reduced or expanded[13] in length and content. These stylistic changes

are similar to those observed by Berk-Seligson (1990) and Hale (2004), and may produce similar

effects on the primary participants. That is, the changes introduced in the discourse by the

interpreters may affect the addressee's perceptions of the other primary speaker.

One change observed was the interpreter producing a rendition that sounded more or less

formal than the source utterance by using words and phrases that are more or less common or

more or less marked. I base my judgments of formality on my knowledge and experience with

English as a native speaker. In Dialog 3 of Session 1, Interpreter 1 changes *discharge (a patient*

from the hospital) to just *salir*. The verb *salir* is less marked and not as formal as *discharge/dar*

de alta.

(34) S3: (hhh) I just wanted to talk to you about ↑one more thing before I discharge you
today.
I1: Quiero hablar de una una cosa más antes de:: um (.) sales hoy.

Most likely the interpreter does not know or can not remember the best way to translate

discharge; this is indicated by the pauses before she renders it as *sales*. Interpreter 2 produces a

change that results in the opposite effect, a rendition that sounds more formal than the original in

Dialog 1:

(35) P4: No sé. m: Tal vez un: un seis.
I2: Perhaps ↑six.

It is true that *tal vez* may be translated as *perhaps*; however it could also be translated as *maybe*.

The word *perhaps* is more formal than *maybe,* and the latter would be a better choice because the

patient is not speaking in an especially formal style. Another example of a change resulting in a

less formal rendition is from Session 3:

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[13] The terms 'reduced' and 'expanded' are taken from Wadensjö (1998: 106-108) who provides these as well as
others to give a taxonomy of interpreted renditions in terms of their closeness or divergence from the source
utterance.

(36) P1: Qué quiere decir eso?
      I3: What that means?

The translated question does not reflect the standard grammar of the original. Again, I would say this is likely due to processing and the pressure to interpret quickly. Additionally, it reflects the proficiency level of the interpreter, who is not a native speaker of English.[14] In Session 2, during Dialog 3, the interpreter translated *hola* as *hi* when the patient greets the doctor at the beginning of the conversation.

(37) P4: Hola doctor.
      I2: Hi doctor.

Although it would be a mistake to say that *hola* could not mean *hi*, the greeting *hello* is somewhat more formal than *hi*. When greeting a doctor, especially when uttering this title in the greeting, one would be much more likely to say *hello*.

These changes may have an effect on primary speakers' perceptions of each other (Berk-Seligson 1990: 198). Some of the examples (34-37) may be more likely than others to reveal such effects. Although a patient probably expects formal speech from a physician, the rendition in (34) still communicates the idea expressed in the source utterance. And in (36), I would expect the nurse to be very forgiving of the English rendition, especially if the interpreter is not a native speaker of English. However, *hi* is a less formal greeting than *hello*, as in (37), and it does not match up with addressing the physician by his title, *doctor*. The example that illustrates this kind of change most clearly is (35). It's not likely that a nurse who doesn't speak Spanish would understand *tal vez*, and the interpreter's rendition as *perhaps* is definitely more formal than the patient's style in this conversation. The consequences of this are completely different than in court interpreting, but they are not unimportant or meaningless, because medical staff do make

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[14] From my conversation with this interpreter, however, I would say she normally speaks at a higher proficiency than what this rendition may imply.

judgments about their patients based on how they speak, and these may have consequences for their care.

Another stylistic change observed in the mock interpreting sessions is a rendition that is reduced in length and content. Example (35) above illustrates such a change because the interpreter has omitted *no sé* from her rendition in English. Another reduced rendition is found in Session 1 when the patient answers a question about when his pain began:

(38) P1: ah: ah Apenas me empezó ayer.
      I1: um It started yesterday.

In her rendition, Interpreter 1 leaves out the adverb *apenas*, which could have been rendered as *just* in her interpretation. Interpreter 2 also did this in her rendition of this part of her session. She also produces a reduced rendition of the very first turn of Dialog 1, when she leaves out the greeting *hello*:

(39) S4: Hello. Do you need to see the doctor today?
      I2: Necesita(s) ver al doctor hoy día?

Without the *hello* greeting, the nurse's utterance may be understood as at least slightly less polite. Interpreter 3 also produces a reduced rendition near the end of Dialog 4 in example (33). The phrase *if you qualify* is missing from the interpretation.

I strongly suspect that the missing content in the interpreted renditions is simply forgotten by the interpreters. This is easy to do given the nature of the interpreting process, and it may be influenced also by a desire to save time and keep the interaction moving along quickly. It is also possible in (38) and (39) that the content that is omitted is considered to be less important than the rest of the utterance. Another alternative would be a prudent tendency to avoid word-for-word translation. The omission of *if you qualify* in (33) is more significant than the others in this group. A patient might understand the missing content based on the context of the conversation,

but there is no way to know for sure.

Expanded renditions are another stylistic change observed in the mock interpreting sessions. Interpreter 1 produces one of these in the third dialog when the patient's mother is repeating to the registrar that they have recently moved:

(40) P2: Bueno pues, es como le digo, acabamos de cambiarnos par acá.
I1: Well ih- it's like I told you, we just moved here (.) °we don't° (.) have everything yet.

Everything after the word *here* in the interpreter's rendition (*we don't have everything yet*) is information not contained in the source utterance. Interpreter 2 provides an expanded rendition at the end of Dialog 3, when the patient thanks the doctor after a heated discussion about smoking:

(41) P4: Bueno pues, le agradezco.
I2: Well thank you very much.

Although the patient does express gratitude, he does not say *very much*. Interpreter 3 also provides an expanded rendition in Dialog 2 when the registrar asks the patient's mother if she has insurance:

(42) S5: And do you have insurance?
I3: Usted tiene s- segura(n)za médica?

The interpreter adds *médica* to her rendition. This is also reduced in that the *and* from the beginning of the source utterance is omitted in the interpreter's rendition.

The expanded renditions are similar to the lengthened testimony observed by Berk-Seligson (1990: 131). In (40) the interpreter adds content that may have been thought to be understood by the primary speakers. They were discussing the Spanish-speaking family's not having a telephone, and although the Spanish-speaker did not say *we don't have everything yet*, she may have implied it. The addition in (42) of *médica* to describe the insurance should have been understood from the context of the conversation. The most significant example from this

group is (41), where the interpreter renders *le agradezco* as 'thank you very much'. In U.S. English, the phrase *thank you very much* is sometimes used sarcastically, if uttered with a certain intonation, especially after defending one's opinion in an argument. This is ironic because the addition of *very much* seems to be a secondary politeness marker or an intensifier of the politeness expressed. Berk-Seligson (1990: 138) explains that politeness is more important in Latin America than it is in the U.S. This interpreter is from Latin America and perhaps the addition of *very much* reflects this cultural tendency, and also a desire to ensure the patient is being as polite as possible.

Treatment of curse words

In my experience[15] there is a strong tendency to not translate curse words, or to translate them as weaker forms or euphemisms that may be more acceptable. Therefore I wrote some into the script of Dialog 3 to see how the interpreters would translate these expressions. Based on an interpreter's desire to distance oneself from those parts of the conversation that may make him feel uncomfortable, I predicted that at points in the conversation where these words occurred, the interpreter would switch to third person. Instead, none of the interpreter-subjects translated these words. Each had a different strategy for dealing with them that allowed the interpreter to continue working without including the curse words in her renditions.

Interpreter 1 had to ask the patient what some of the curse words meant, so I suspect she did not know how to translate them. Here is the stretch of conversation from Dialog 3 that contains the words in question:

(43) P3: Le voy a decir algo muy sinceramente. A mí me gusta hacer lo que me da la pu-pinche gana, y no me importa cuántas personas que me dicen que deje de fumar. No lo hago (.) a menos que yo quiera hacerlo.

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[15] When I am interpreting and the Spanish speaker says a curse word, my instinct is to try to find a way to not translate it or to use a weaker euphemism, even though this is contrary to what an interpreter is normally supposed to do. I have spoken with other interpreters about this who say they also experience this.

> I1: Discúlpame, pero qué de significa pinche eh-
> P3: uh:: Maldita gana.
> I1: um (basically) I'm gonna be honest with you (.) um everyone's told me to stop smoking but (.) I'm gonna: (.) I don't feel like it I'm gonna smoke when I- I'm gonna stop smoking when I feel like it.
> P3: Si no fumo, no me siento vivo. El fumar es un placer pues, chinga.
> I1: ((*laughter*)) If I don't smoke, I don't feel alive (.) Lo siento, qué significa chinga?
> P3: Maldición.
> I1: u:m (.) >I- it really bothers me when I stop<
> P3: La gente hoy en día está obsesionada por la salud. Un hombre debe poder fumar si quiere, qué fregados.
> I1: ((*slight laughter*)) People you're obsessed with health (.) with health um (1) ah a- and a man can smoke if he wants.

It is clear from her laughter and her understanding of the rest of what is said, as well as from her rendition, that she is aware that something is going on here, but it is not clear whether she understands the cursing. If she wanted to, she could have assumed the patient was cursing based on his answers to her questions, but she doesn't translate *maldita* or *maldición* either. It seems more likely to me that she simply was not familiar with any of these words, although it is also possible that she was uncomfortable introducing curse words into her interpretation.

Interpreter 2 was definitely uncomfortable with these words and did not translate them on purpose.

> (44) P4: <A mí me gusta hacer lo que me de la pinche gana, y no me importa cuántas personas que me dice- que me dicen que deje de fumar, o no lo haga- o no lo haga a menos que yo quieracerlo. S-
> I2: I like to do what I like to do:, and I don't like when people tell me- what to do or what (.) not to do.
> P4: Si no fumo no me siento vivo. El fumar es un placer pues chinga >la gente hoy en día está obsecionada por su salud. Un hombre debe poder fumar si quiere<. Qué fregaos.
> I2: If I feel like smoking, I should have the right to- smoke and I don't care- (.) what (.) other people think or (.) uh jus:t- stop um (.) bothering me with the subject.

This interpreter almost certainly understood the words and was able to translate them since she was a native speaker of Spanish. Her English was also very fluent, and she had university-level training in interpreting. Therefore, it is most likely that she chose to simply omit the cursing and

paraphrase what was said instead of translating the curse words. This is also supported by the

fact that in Dialog 4, she does not translate *híjole*, which is a slang exclamation from Mexico. It

may be translated as "darn, jeez, man" (Mikkelson 2000: 273), and is not vulgar.[16] However, I

suspect that because it sounds similar to *hijo de…*, some may think of it as a euphemism for that

expression. Here is the transcription from this part of Dialog 4 in Session 2:

(45) P4: Hí:jole. Eso se me hace mucho. Por qué me cobran tanto?
       I2: That's a lot of money. Home come it's so expensive?

The omission of *híjole* and the curse words from Dialog 3 demonstrates that this interpreter

preferred to not include these words in her renditions.

Interpreter 3 used a different strategy. She asked the Spanish-speaker to slow down at this

point in the conversation, and had him repeat what he said. Before providing her interpretation,

she asked the Spanish-speaker if he really wanted her to say all of that, in the way that he said it,

to the doctor. The patient told her yes, but she still did not translate the curse words.

(46) P1: Ah, le voy a decir algo muy sinceramente. A mí me gusta >hacer lo que me da la
       pinche< ga:na y no me importa cuántas personas que me digen que deje de fumar >no
       lo hago a menos que yo quiera hacerlo<. Si no fumo m- no me siento vivo el fumar es
       un placer, pues, chingá:, la gente hoy en día está obsesionada [por]
       I3:   [s:-]
       P1: la salud.
       I3: Señor Jodríguez, por favor, será que usted puede leer en corta: s frases, y más
          [dehpacio]
       P1: [Oh   ]
       I3: por favor?
       P1: Por supuesto, por supuesto.
       I3: Gracias.
       P1: Decía que- que le voy a decir algo muy sinceramente.
       I3: Ah (.) wanna tel- tell you something and sincerely.
       P1: A mí me gusta hacer lo que me da la pinche gana y no me importa cuántas
       personas me dicen que deje de fumar.
       I3: Seño Rodríguez, yo tengo que interpretar todo lo que usté dice. Usted quiere que
       yo diga lo que usted está diciendo así como está diciendo al doctor?
       P1: <Uh sí>, por favor.

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[16] In searching the internet I found a family-style Mexican restaurant in Puerto Rico named *Híjole* (http://hijole.com/).

> I3: Puede repetir entonce?
> P1: Sí, digo que a mí me gusta hacer lo que me da la pinche gana, y no me importa cuánta gente me dice que deje de fumar.
> I3: Uh:m- I wanna do whatever I feel like to do it, and I don- I don't care whatever people tell me, I don't gonna quit smoke.
> P1: Y que yo no voy a dejar de fumar a menos que quiera hacerlo.
> I3: And I'm not gonna quit smok in unless I wanted to do it.
> P1: Porque si no fumo, no no no me siento vivo.
> I3: Because if I don't smoke, I don't feel alive.
> P1: El fumar es un placer, y: hoy en día (.) la gente está obsesionada por la salud.
> I3: Ah: esmoke is a pleasure an: today people are obsess with uh smoke.
> P1: Y que un hombre debe poder fumar si quiere, >qué fregaos<.
> I3: e:ah and a man has to: smoke if h- he wants. I don't care.

I would suggest that saying *I don't care* and *I wanna do whatever I feel like* do come close to the spirit behind the cursing, but these renditions still omit these words.

The strategies for handling curse words in the mock interpreting sessions reflect a general discomfort with these words. This is why I predicted a shift to third person, so the interpreter would distance herself from what the primary speaker said. With the possible exception of Interpreter 1, who may not have completely understood what was said, the transcriptions show that these interpreters chose to omit part of what was said, and this too is a way of distancing oneself from what was said. Interpreter 3 gave herself a potential exit from whatever discomfort she felt by asking the patient if that is what he really wanted to say. Roat et al. (1999: 57) recommend informing the non-English speaker ahead of time, if possible, that everything he or she says will be translated. Thus, Interpreter 3 was, in effect, exercising this principle, to inform the primary speaker that everything he says will be translated, even though she didn't have a chance to inform him before the session. However, she then proceeded to omit the curse words.

Treatment of discourse markers

Discourse markers are linguistic elements that organize discourse and do not have a syntactic function in sentences (Portolés 1998: 25-26). Although many words and phrases that

are identified as discourse markers may function in other contexts as gramaticalized elements such as prepositions, conjunctions, interjections, adverbs, or others, discourse markers do not have these same functions and are not able to be substituted by seemingly equivalent words or phrases (Martín Zorraquino 1998: 26-28). Discourse markers are invariable (Martín Zorraquino 1998: 45). This means that, for example, they do not undergo morphological inflection for number, person, and gender, such as *bueno, buena, buenos, buenas*. For instance, some examples of discourse markers are *bueno* and *pues* in Spanish, and *okay* and *I mean* in English. Hale (2004: 62) found that in her study of court interpreting in Australia that interpreters tend to omit discourse markers. That tendency is reflected in the present study. I read the transcriptions of the mock interpreting sessions multiple times to identify common discourse markers in the source utterances and to observe how they were translated by the interpreters. Discourse markers found in the transcriptions were *bueno*, *pues*, *este*, and *es que* in Spanish, and *well*, *okay*, *I mean*, *like*, *basically*, *alright* and *(it's) that* in English. Interpreters 1 and 2 omitted more discourse markers than they translated. Interpreter 3 translated more than she omitted, but still omitted many. Since discourse markers help guide our discourse, omitting them may have meaningful consequences.

In the transcriptions of the mock interpreting sessions one can find examples of omitted discourse markers that may have communicated something important. The following is an example from Session 1, Dialog 2:

(47) P2: Bueno: (.) este: (.) es que no la sé de verdá.
       I1: The truth is that I don't really know.

The *bueno* here functions as what Portolés (2004: 288) calls a '*comentador*', which serves to introduce a new comment. It is also what Shiffrin calls a 'response marker' (1987: 102-103), which allows the speaker to utter an answer that may be in some way incongruent with the preceding conversation. The *este* and the pauses before and after it are definitely hesitations.

Omitting these from the interpretation does not capture the true spirit of what was said.

Interpreter 2 also omits this discourse marker and hesitation in her rendition of the same part of

Dialog 2. The following excerpt has another example from Session 2, Dialog 3:

(48) P4: Entiendo eso pues, pero pues, muchas personas me han dicho: ya me han dicho
eso pero >yo no quiero dejar de fumar<.
I2: I understand doctor, but, many people have already told me that but I don't want
to s:top smoking.

Here the two instances of *pues* are discourse markers. The first one may be a response marker or

comentador. The second one may be a response marker also or it may also be a '*conector*

consecutivo' (Portolés 2004: 289-290), or 'discourse connective' (Shiffrin 1987: 128), which

helps to join the parts of the utterance that come before and after it. The interpreter's rendition is

a more direct reply than the original utterance. Interpreters 1 and 3 did not translate *pues* in this

part of Dialog 3 either, although in theirs, there was only one *pues*. Interpreter 3 translated more

discourse markers than the others but still omitted many. Here is an example from Dialog 2, right

after the registrar asks the patient if she has any photo ID with her:

(49) P5: Es que no tengo ninguna.
I3: No I don't have any.

In this example *es que* is functioning as a discourse marker similar to the others here. It is a

response marker and a *comentador*. The patient wants the registrar to know that she understands

that she is expected to have an identification of some type with her even though she doesn't. This

has an effect of softening the blow caused by her answer, but it is absent from the interpreter's

rendition.

As with the other stylistic changes, discourse markers may be omitted in any given

rendition because the interpreter has forgotten part of the source utterance, and this is an inherent

risk to the interpretation process. It is also likely that the interpreter is not able to think of a good

translation in time and omits the discourse marker on purpose (Hale 2004: 80). Interpreters may tend to omit discourse markers at times also because they are thought to be unimportant to the main idea of what is said. However, discourse markers do organize and guide our conversations, and the English-speaking participants in the medical arena do make judgments about the patients and their family members based on how they speak, and some of them may have relevance to the patient's medical care (Roat et al. 1999: 85).

The survey

The results of the survey show almost unanimous support for first person interpreting. A summary of the survey responses is available in Appendix I. Of 122 respondents, 117 said that they interpret in first person, and five said they interpret in third person. All 115 respondents who answered the question asking whether they thought it made a difference whether the interpreter worked in first or third person said that yes, they thought it did make a difference. Twelve respondents answered the question, asking if they would be willing to switch to first person if research showed it was preferable, and nine of them answered yes.

Open-ended questions

The most interesting data in this section comes from the open-ended questions because those answers reveal the rationales behind interpreters' practices. These answers show that the topic of third person interpreting is somewhat of a taboo. Additionally they reveal that even interpreters who normally work in first person may sometimes interpret in third person. Most importantly, they show that in some cases, interpreters give the same or similar reasons to justify interpreting in third person as they do for first person. Almost all respondents agreed that it does make a difference whether an interpreter works in first or third person. Finally, several respondents made a reference to the conduit metaphor in explaining their rationale for first

person interpreting.

When asked to explain why they prefer the style they use, 119 of 122 respondents provided an answer. Many respondents expressed a very strict understanding of the first person standard. One interpreter simply said, "It is the professional way." Another respondent states emphatically:

> First person is truly the ONLY way to interpret. It allows for the interpreter to be a conduit and transparent. It is also less confusing and allows the patient and provider the ability to communicate seamlessly through the Interpreter. 3rd person is very confusing and looked down upon in the interpreting world - very elementary and unacceptable.

Another says, "First person interpretation is recommended by all professional standards of practice, whereas third person is strictly forbidden…" Based strictly on the survey responses, there appears to be no room for discussion of this standard.

Several of the interpreters who expressed a preference for first person interpreting explained that they may sometimes also work in third person. As one respondent stated:

> …I notice that it is harder to stick with the first person when I am interpreting for family members and in informal, non-professional situations. I tend to lean towards third person with family members.

Another said:

> I interpret in first person because it is generally required as a standard in some settings. In other settings, notably mental health, medical and some social service work I work in third person.

And yet another stated:

> Mostly first person, but sometimes have used third (if patient is a minor and is bilingual, brought up in US school system and answering without difficulty simple questions from provider) for mother who is monolingual and observing. Have also switched to third with elderly who seemed lost and stressed, after trying first the first person.

These are only three of several replies to Question 9 that express a more permissive attitude toward interpreting in third person.

Of the reasons given why first person interpreting is superior, it is most commonly said that it fosters a more direct and less confusing communication between the primary speakers. It turns out that these are also reasons given in support of their position by those who prefer third person interpreting. An interpreter who prefers first person said "It's less confusing. The doctor is more aware when I'm speaking versus the patient is speaking." Compare this with what an interpreter who prefers third person said:

> 1. I am able to interpret what is said, as it is said. 2. Communication between the parties is more direct and focused, and boundaries are readily clear regarding who is talking to whom (i.e. not to me).

Another response from an interpreter who works in third person argues that: "It just seems easier for the other person (nurse, doctor) to understand." Again, contrast this with the following response from an interpreter who works in third person:

> Although I was trained that first person is the best and most appropriate way to interpret, I often find myself using third person. I prefer it, and do not believe that patients or providers have problems with it. I wish there were a trend to have both be 'PC'.

This suggests that the question of whether to interpret in first or third person is also influenced by personal philosophy and preference.

Another frequent rationale given in support of first person interpreting is that it is consistent with the conduit metaphor. One respondent simply said, "The interpreter acts as a conduit." Another respondent wrote the following, which reflects this philosophy: "This is the formal setting as the interpreter is only 'the voice' and should be 'invisible'." Yet another respondent states:

> This is the accepted standard of practice. It allows for more 'invisibility' of the interpreter, because the listener understands that the interpreter is merely the conduit for the language…

The problem with these approaches to this issue is that even under the best of circumstances and while practicing first person interpreting, the interpreter is still present in the conversation and influencing it even if only in subtle ways.

The survey results show that there is indeed a strong preference among practicing interpreters for first person interpreting. I suspect that this was greatly influenced by the fact that the pool of respondents was mainly limited to NCIHC members, and most of the interpreters who responded have had some kind of training in interpreting. Furthermore, given the 'political incorrectness' of interpreting in third person, some respondents may have been hesitant to reply in favor of third person interpreting. I would argue that the many appeals to tradition and the conduit metaphor in favor of first person interpreting without thinking the issue over more deeply are an opportunity to further interpreter education by problematizing these assumptions and attempting to provide viable and more realistic alternatives to them.

Chapter 6

Discussion and conclusion

This thesis has described the issue of first person versus third person style in community interpreting (i.e. direct versus indirect speech) and investigated the question of whether it matters if an interpreter uses one style or the other. I have explained how interpreting is a type of reported speech and reviewed relevant literature from Berk-Seligson (1990), Hale (2004), Dubslaff and Martinsen (2005), and Bot (2005). These previous studies show that the interpreter plays a fundamental role in any interpreted encounter and that he tends to exert an influence on interpreted conversations. Data from the present study, consisting of mock interpreting sessions and a survey, indicate that interpreters tend to introduce a variety of changes in perspective and style to their renditions. Additionally, the survey results show that a majority of professional interpreters prefer first person interpreting.

Does it really matter?

One of the questions I hoped to answer was whether or not it really matters if community interpreters work in first or third person. It does matter a lot to interpreters, based on the survey responses, so for that reason alone the answer is *yes*. The research on interpreting shows that interpreters inevitably affect the conversations they interpret, and for that reason it is important also. If that is true, then even an interpreter working in first person exerts a tremendous influence over the conversations she interprets. Therefore, the question really is whether it may be shown empirically whether third person interpreting does this differently or more so than first person interpreting. The data collected is unable to answer this question.

The origin of first person interpreting

In the literature reviewed in this thesis, the origin of first person interpreting is not explained. One possible explanation may be found in the tradition of written translation, which is also done in direct speech. That is, the translator does not begin by saying, *The author wrote, "..."* Another explanation may be found in the practice of simultaneous interpreting. There are different modes of interpreting, and the one most commonly used in medical interpreting is consecutive interpreting, during which each primary speaker utters his or her turn, and pauses for the interpreter to render his interpretation (González et al. 1992: 379). Simultaneous interpreting is when the interpreter and the primary speaker are speaking at the same time. To do this, the interpreter is listening and speaking at the same time, lagging behind the primary speaker by a few seconds (González et al. 1992: 359). It would be impossible for the interpreter to do this in third person; it must be done in first person. In community interpreting, simultaneous interpreting is used extensively in court interpreting, for those portions of the proceedings during which the person who needs the interpreter does not participate. Gaiba (1998) does identify the origin of this technique in modern interpreting as being developed for the Nuremburg Trials. For court interpreting it is also necessary that the interpreter work in first person since his words may be preserved as the record of what was said instead of those of the primary speaker. This has definitely influenced the preference for first person interpreting throughout community interpreting.

Do certain types of language, content, or style encourage third person interpreting?

I had also hoped to answer the question of whether certain types of discourse would tend to elicit a rendition in third person from the interpreter. The predictions that I made about this were not observed in the data. This suggests that other factors also influence whether an

interpreter may shift to third person style. Despite this, the transcriptions of the mock

interpreting sessions do show that interpreters treat curse words differently than the rest of the

interpreted conversation. There is a need for further research on this question.

The interpreter's participation

Some may read this or other studies that show how interpreters affect the conversations

they interpret and focus on these as 'mistakes'. My purpose in analyzing the interpreted dialogs

is not to highlight errors but simply to describe the process of interpreting. The past work on this

subject, as well as the present study, demonstrate that the interpreter inherently tends to produce

interpretations that differ from their source utterances. These differences may be crucial or they

may be inconsequential, depending on the context and circumstances. An interpreter is not a

passive agent; she is an active participant in the conversations she interprets (Wasdensjö 1998:

278-279). Ideally then, the interpreter should be aware of this aspect of the interpretation

process.

The data collected showed some similar results to those of Berk-Seligson (1990) and

Hale (2004) in terms of stylistic changes in interpreters' renditions. It seems that the

consequences of these would potentially be more serious in a legal context. However, that is not

to say they are not also important in medical contexts. Physicians, nurses, counselors, and other

medical staff do make judgments of their patients and the patients' family members based on

how they speak. These may have important consequences considering that a great deal of

information is obtained via interviewing their patients. Some of the same issues that arise in

courtroom discourse may also be important in medical interpreted conversations that involve law

enforcement, or when behavioral or psychiatric issues are involved. Roat et al. (1999: 24-25)

advise the medical interpreter to interpret everything that is said accurately, including "the spirit

of what is said." This means that the medical interpreter must adhere to the same rigorous standards as the legal interpreter.

The survey results show that some medical interpreters do perform consecutive interpretation in third person. These are professional interpreters who have had training. I have also worked with interpreters who prefer to work in third person. Therefore I am of two minds about this issue. On one hand, studies suggest that it is best to work in first person. On the other hand, however, an interpreter, in certain circumstances, may work in third person in a way that is appropriate and acceptable. I propose that in less formal, and non-legal contexts, it may at times be acceptable for an interpreter to work in third person while in consecutive mode. It would not be practical to attempt to work in third-person while in simultaneous mode, because it would likely be impossible for the interpreter to keep up with the primary speaker.

One of the two times when an interpreter-subject used third person in the present study was to describe a gesture that a patient performed. I believe this is a very good practice in the medical context.[17] An interpreter may also perform the gesture on himself, in a respectful, non-mocking way. However, this runs the risk of miscommunication if the interpreter makes a mistake in his reproduction of the gesture. The use of a third person reference is a relatively safe way to call attention to the gesture so the medical staff may observe it if they have not already. It is ironic that gestures present difficulty in interpretation since American Sign Language (ASL) interpreting is somewhat more mature of a profession in the U.S. than Spanish interpreting and that of other spoken languages. Perhaps ASL and ASL interpreting may be able to provide some guidelines for interpreting gestures for spoken language interpreters.

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[17] In my experience, court interpreters are trained to not attempt to translate gestures whatsoever, nor to mention them.

Another context in which it may be acceptable to interpret in third person is when there are more than just two primary speakers participating in the conversation, such as when family members of a patient are present. Several survey respondents mentioned this as a time when they do work in third person. This may allow the interpreter to interpret everything that is said and to do so in a way that explicitly marks who said what. Additionally, several survey respondents said they either work in third person for medical or mental health settings, or for consecutive interpreting mode. I would say that it is probably better to work in first person as much as possible in these settings. Third person references may be ambiguous, and if an interpreter is working in third person she must take pains to make explicit who said what. When working in first person it is taken for granted that the speech is coming from the primary speakers. The trouble with this, as some survey respondents pointed out, is that sometimes both professionals and patients forget this, refuse to work in this framework, are unaware of it, or do not understand it. Therefore, if the primary speakers' difficulty understanding the framework required for the interpreter working in first person is impeding successful communication, it may be necessary for the interpreter to switch to third person. However, I stress that the use of third person style interpreting should be very limited.

Conclusions

Interpreting in first person is preferable to interpreting in third person. First of all, in the simultaneous mode and in legal interpreting, it is the only option. Once an interpreter learns to work in first person, it is a simpler cognitive process than working in third person. All you have to do is repeat what was said, instead of shifting the deictic references constantly. First person interpretations are by definition, therefore, a more faithful reflection of their source utterances. Most importantly, in recognizing that the interpreter inherently leaves her mark on any

conversation she interprets, working in first person is a way to constrain that tendency (Bot 2005).

However, there is a contradiction here. If first person is preferable, why should we allow for limited use of third person? First of all, it is because we know it is impossible for the interpreter to not affect the conversation in some way even if he works in first person. This is shown by the stylistic changes introduced by interpreters in the current study, as well as in the work of Berk-Seligson (1990) and Hale (2004). Also, I believe that in medical contexts, it is acceptable to interpret gestures and remarks made by family members of patients by using third person references. The acceptability of third person interpreting could be limited to less formal and non-legal contexts, and of course, it really should only be used in consecutive interpreting. Although it is preferable that interpreters work in first person, some make compelling arguments for their use of third person. Among these are the need to clarify who said what if there are more than just two primary speakers, and when primary speakers refuse to accept or do not seem to understand how first person interpreting works. Moreover, those interpreters who prefer third person style say they do so for the same or similar reasons as those who advocate first person style: to make clear who said what and for the interpreter to be 'transparent'. Finally, because the need is so great for community interpreters, this question should at least be open for discussion so as to not alienate current or potential interpreters who may use third person.

Regardless of whether an interpreter works in first or third person, the present study does show that there is a tendency to produce renditions which differ in some ways from their corresponding source utterances. Interpreters sometimes change references that are personal to ones that refer to a non-person or inanimate entity or vice-versa. When Spanish and English are the two languages in use, the interpreter must choose between addressing the Spanish speaker as

either *tú* or *usted*. The data from this study show that although *usted* is more commonly used,

sometimes *tú* is used. The switches between *tú* and *usted* and between personal and non-personal

references may at times be caused by the pressure of having to interpret as quickly as possible, or

proficiency in either language, or it may be a show of solidarity with one primary speaker, or an

attempt to distance oneself from the topic of conversation. Interpreters also tended to produce

renditions that were shortened or lengthened when compared with their source utterance. This

may have been due to the pressure on the interpreter to work quickly, and in some cases the

changes may not have been of great consequence. Another change shown in the data is in the

treatment of curse words, which the interpreter tends to not translate or to translate as weaker

euphemisms. This is most likely due to the interpreter feeling uncomfortable repeating the curse

words. Finally, it was shown that there is a tendency for the interpreter to not translate discourse

markers. This again may be due to the complexity of interpreting and the need to do it quickly, or

the inability to think of an appropriate translation. All of these changes do have potential

consequences for how the other speaker(s) involved may perceive what is being said and how

they judge the primary speaker.

The Future

More research on these questions is needed. It may be possible with more data from

interpreters who actually work in third person to better answer the present study's research

questions. Interpreting in general is a field that is full of issues that are relevant to applied

linguistics, and community interpreting is very important for societies that are experiencing a

massive influx of immigrants who do not speak the majority languages. Also, with more

research, it may be easier to convince new interpreters to use first person, even if they might

prefer third person style.

Traditionally, the conduit metaphor has been used as a justification for the first person standard in community interpreting. Berk-Seligson (1990), Hale (2004), Roy (2000), and Robinson (2003) make powerful arguments against the notion that an interpreter or translator is able to perform his work as a mechanistic 'conduit'. Roy says it best:

> Assuming that two speakers truly do not know the other's language, the only participant who can logically maintain, adjust, and, if necessary, repair differences in structure and use is the interpreter. Because interpreters are the only bilinguals in those situations, the knowledge of different linguistic strategies and conversational control mechanisms resides in them alone. This means that the interpreter is an active, third participant with potential to influence both the direction and the outcome of the event, and that the event itself is intercultural and interpersonal rather than simply mechanical and technical (2002: 352).

Of course, the idea behind the conduit metaphor is not only a mechanistic symbol. The interpreter's fundamental role is to enable communication. This is more complex than what the conduit metaphor implies.

Let us therefore discard the conduit metaphor. Wadensjö (1998) describes interpreting, as 'dialogic', 'interaction', and a '*pas de trois*'. These are good starting points to develop a new metaphor to replace the old one. As the professionalization of community interpreting continues to evolve, I would like the question of interpreting in third person to cease to be a taboo, and to be discussed openly. We need to create better explanations of why first person interpreting is preferable and not just appeal to tradition. I also hope that more states in the U.S. and elsewhere continue to develop standards and certification for professional community interpreters. As this happens universities will need to provide courses that complement the limited training currently available.

Community interpreting is important for our societies because it meets an urgent need for communication that would otherwise be impossible. It is a service that benefits not only those who speak minority languages, but also the societies in which they are immersed. Therefore

community interpreters, trainers of interpreters, and researchers, must continue to help the

profession to grow and mature, and to insist on the highest professional and ethical standards for

its practice. I hope that this thesis may contribute to that ideal.

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Appendix A
Dialog 1 - ER Triage interview

Nurse: Hello. Do you need to see the doctor today?
Male patient: Sí. Creo que sí.
Nurse: Please have a seat here.
Male patient: Gracias.
Nurse: What brings you to the emergency room today?
Male patient: Bueno… pues me duele el estómago bien feo.
Nurse: When did you start having this pain?
Male patient: Apenas me empezó ayer.
Nurse: Where exactly do you hurt?
Male patient: Bueno… antes me dolía todo el estomago pero ahora me duele más por aquí.
[Patient gestures toward the region between the right hip bone and the belly button.]
Nurse: On a scale of zero to ten, with zero being no pain at all and ten being the worst pain
imaginable, how would you rate your pain right now?
Male patient: No sé… tal vez un seis.
Nurse: Have you had any other symptoms?
Male patient: Me sentía como que tenía calentura antes.
Nurse: Have you had nausea or vomited?
Male patient: Oh eso sí. No quería comer y luego tenía ascos.
Nurse: Did you vomit?
Male patient: No, pero me dieron ganas de vomitar.
Nurse: Do you have any history of serious medical problems?
Male patient: Pues… ésta es la primera vez que vengo al hospital aquí.
Nurse: I mean do you have or have you ever had any chronic disease?
Male patient: ¿Qué quiere decir eso?
Nurse: Like, for example, asthma, diabetes or any other disease?
Male patient: No, pues, mi mamá tenía diabetes pero yo no.
Nurse: Have you ever been hospitalized or had any surgeries?
Male patient: No. Bueno… cuando era niño se me rompió el brazo y tuve que ir al hospital. Pero
eso fue en México.
Nurse: Are you on any regular medications?
Male patient: A veces me tomo Advil si me duele la cabeza.
Nurse: I mean prescription medications.
Male patient. No. Eso no.
Nurse: Are you allergic to any medication?
Male patient: A la penicilina.
Nurse: Ok. I'm going to take your temperature and blood pressure. Then I want you to wait in
that waiting room over there. [Nurse points to an area behind the patient and to his left.]
Male patient: ¿Voy a tener que esperar mucho?
Nurse: It shouldn't be too long.
Male patient: ¿Es grave?
Nurse: It's possible it could be somewhat serious but the doctor will tell you that and answer any
other questions you have.
Male patient. Oh. Está bien. Gracias.

Appendix B
Dialog 2 - Registration

Registrar: Ms. Suárez?
Mother of girl patient: Sí, soy yo.
Registrar: Hello. Please have a seat over here, I'm going to do your registration.
Mother of girl patient: Bien.
Registrar: What is the patient's date of birth?
Mother of girl patient: Ella es del dieciséis de junio de dos mil uno.
Registrar: Ok. What is the patient's name?
Mother of girl patient: Araceli Suárez.
Registrar: We have an Araceli Suárez Saavedra in our system. Is that her?
Mother of girl patient: Sí. Es ella.
Registrar: And what is your name.
Mother of girl patient: María Carmen Suárez.
Registrar: And your date of birth?
Mother of girl patient: Bueno… este.. es que no la sé de verdad.
Registrar: You don't know your date of birth?
Mother of girl patient: No.
Registrar: Ok…What is your address?
Mother of girl patient: No me la sé.
Registrar: You don't know it?
Mother of girl patient: Es que acabamos de mudar. Luego viene mi esposo y él se la puede decir.
Registrar: Ok. And what is your phone number?
Mother of girl patient: No tenemos teléfono.
Registrar: You don't have a telephone?
Mother of girl patient: No.
Registrar: Not even a cell phone? How can that be?
Mother of girl patient: Bueno, pues. Es como le digo, acabamos de cambiarnos para acá.
Registrar: Well we have to have some way to contact you by phone at least in case the doctor needs to tell you something after you leave.
Mother of girl patient: Bueno… cuando venga mi esposo a lo mejor él le puede dar el número de su hermano. Él vive muy cerca de nosotros.
Registrar: Alright. Who is your daughter's regular doctor?
Mother of girl patient: La doctora Katrina.
Registrar: Dr. Katrina Sánchez?
Mother of girl patient: Sí.
Registrar: And do you have insurance?
Mother of girl patient: Na´ más el Medicaid.
Registrar: Ok. Please let me have your Medicaid card for a moment so that I can make a copy of it. I'll also need to make a copy of your drivers license.
Mother of girl patient: No tengo licencia.
Registrar: That's ok. Any I.D. with your photo will do.
Mother of girl patient: Es que no tengo ninguna. Antes tenía mi credencial para votar pero alguien me robó la cartera y ahora no tengo nada.

Registrar: That's alright. I need you to sign this form here, here and here, and then I'll get your Medicaid card back to you in just a minute and then you can return to the waiting room.
Mother of girl patient: Bien. Gracias.

Appendix C
Dialog 3 - Conversation with physician

Doctor: Hello again Mr. Rodríguez.

Male patient: Hola doctor.

Doctor: I just wanted to talk to you about one more thing before I discharge you today.

Male patient: Bien.

Doctor: It's very important that you stop smoking. Your symptoms are caused and made worse by your smoking. Even when you don't feel sick, smoking is very bad for your health and you will feel much better after you quit.

Male patient: Entiendo eso… pero… pues… muchas personas ya me han dicho eso pero yo no quiero dejar de fumar.

Doctor: And why is that?

Male patient: Porque me gusta. Y mi papá fumaba y él se murió hasta los noventa años, de viejo se murió.

Doctor: Be that as it may, it doesn't mean that you will live that long. And as long as you smoke your asthma and allergies will continue to bother you, and you are at risk for cancer, emphysema, heart problems and other diseases.

Male patient: Le voy a decir algo muy sinceramente. A mí me gusta hacer lo que me de la pinche gana y no me importa cuántas personas, que me dicen que deje de fumar, no lo hago a menos que yo quiera hacerlo. Si no fumo no me siento vivo. El fumar es un placer. Pues… ¡Chingá! La gente hoy en día está obsesionada por la salud. Un hombre debe poder fumar si quiere, ¡qué fregaos!.

Doctor: Alright… [sounds a little taken aback…] Very well then Mr. Rodríguez. I think I understand. I still wish you'd quit smoking, but I agree that no one can force you to do something you don't want to do.

Male patient: Bueno pues… le agradezco.

Appendix D
Dialog 4 - Conversation with cashier

Cashier: Ok, before you leave today, there are just a few things I need to go over with you.
Female patient: Está bien.
Cashier: I see here you have no insurance. Is that correct?
Female patient: Así es.
Cashier: Alright. We do ask our patients for payment at the time of service. That means we'd like you to pay now. The minimum charge for the hospital is $100. In addition to this, you will receive a separate bill from the Emergency Room physician as well as from other physicians if you received other services.
Female patient: Yo no tengo el dinero para pagar ahora.
Cashier. Ok. Do you think you will be able to pay, say, in two weeks?
Female patient: ¿Y cuánto será?
Cashier. Well, the charges aren't finalized yet. The minimum charge is $100, but it's possible you may be charged more depending on the services you received today.
Female patient. ¡Híjole! Eso se me hace mucho. ¿Por qué cobran tanto?
Cashier: That is just what the hospital charges, I don't know how that is determined. If you are interested there is a financial assistance form you can fill out.
Female patient: ¡Sí! Sí, eso me gustaría mucho; ojalá que me ayuden con eso.
Cashier: Here it is. One side is in English, and the other side is in Spanish. You only need to fill out one side, whichever language you feel most comfortable with.
Female patient: Muy bien. ¿Y luego qué hago?
Cashier: You will want to fill it out and return it to us as soon as possible. Our business office will make a decision based on your family's income.
Female patient: Ténganme consideración, por favor.
Cashier: Well, like I said, it's based on your income, and the business office will make their decision and let you know by mail if you qualify and if so, at what level.
Female patient: Muy bien. Gracias.

Appendix E
Demographic information of interpreter-subjects

1. Please indicate your gender: M   F

2. Age: _____

3. Native language _____

4. What country were you born in? _____

5. Do you work (i.e. are you paid to work as…) or do you volunteer as an interpreter? Or do you

do both? Please circle your answer:

WORK   VOLUNTEER   BOTH

Appendix F
Debriefing Script

Thank you for participation in our study, "Direct vs. indirect speech in community interpreting."

I would like to discuss with you in more detail the study that you just participated in. Do you have any questions right now?

As you probably know, for a scientific study to be valid, in some cases, not all research participants are made aware of the purpose of the study or other information until after they have finished participating. For example, to understand how a person would behave under everyday circumstances, it may be necessary to NOT tell that person what the purpose of the study is until after he/she has participated. This is because if the person knew that information, his/her participation in the study would be affected by that knowledge, and the results would no longer be valid.

In this particular study we are trying to see whether interpreting in first person (direct speech) or interpreting in third person (indirect speech) makes a difference in community interpreting. We did not tell you that this was the purpose of the study beforehand because we did not want you to change how you would normally interpret based on that information.

Now that we have explained this to you, do you agree to let the investigator to use the data that we collected from your participation in the study?

I hope you enjoyed this experience. If you have any questions or comments later, please feel free to contact me, . [*at this point we will provide sheet with contact names, addresses, telephone numbers, emails, for Principal Investigator, Patrick Moore, and for Faculty Sponsor, Dr. Sarah Blackwell.*]

Do you have any other questions or comments right now about anything you did today or anything we've talked about?

 Thank you again for your participation.

Appendix G
Survey (paper version)

By completing this survey you are voluntarily agreeing to participate in research related to person reference in community interpreting conducted by Patrick Moore from the Department of Romance Languages of the University of Georgia (706) 542-4068, under the direction of Dr. Sarah Blackwell (706) 542-3151. If you prefer not to answer any particular question you may simply leave it blank and skip it. Any information which is personal or could potentially identify you will be kept strictly confidential. If you have any questions or concerns you may contact Patrick Moore at the above phone number or via email at pkmoore@uga.edu .

1. Please circle your gender: Male   Female
2. Please write your age: _____
3. What languages do you speak? Please indicate the languages that you interpret.
_____
_____
_____
4. How long have you been interpreting? _____
5. What type(s) of interpreting do you do? Please circle all that apply and fill in the blank for "other" if your field is not listed.
Medical   Legal   Social Service   School
Conference   Political/Diplomatic   Other:_____
6. Do you have any formal training in interpreting? Yes   No
7. If you answered "Yes" to question 6, please describe the training that you have had:
_____
_____
_____

8. When you interpret, do you interpret in first person or third person? _____
(First person is when you say exactly what was said: For example, if the non-English speaker says "I am sick" you would repeat "I am sick" in your translation. Third person is when you would instead say "He/she said he/she's sick." or something similar)
9. Please explain briefly why you prefer the style that you answered in question 8.
_____
_____
_____
_____
_____
10. Do you think it makes a difference whether an interpreter interprets in first or in third person? Please explain why you think it does or it does not.
_____
_____
_____
_____
_____

11. If you answered "third person" to question 8, would you be willing to change your style to first person if there was research that showed that this was a better way to interpret?   Yes
No
12. Please explain why you would or would not be willing to change as asked in question 11.

_____
_____
_____
_____
_____

Appendix H
Glossary of transcription notations.

Taken from Jefferson (2004).

[	A *left bracket* indicates the point of overlap onset.
]	A *right bracket* indicates the point at which two overlapping utterances end.
=	*Equal signs* indicate no break or gap.
(0.0)	*Numbers in parenthesis* indicate elapsed time by tenths of seconds.
(.)	*A dot in parentheses* indicates a brief interval (± a tenth of a second) within or between utterances.
___	*Underscoring* indicates some form of stress, via pitch and/or amplitude. A short underscore indicates lighter stress than does a long underscore.
::	*Colons* indicate prolongation of the immediately prior sound. The longer the colon row, the longer the prolongation.
↑↓	*Arrows* indicate shifts into especially high or low pitch.
.,??	*Punctuation markers* are used to indicate *'the usual'*intonation.
WORD	*Upper case* indicates especially loud sounds relative to the surrounding talk.
ºwordº	*Degree signs* bracketing an utterance or utterance-part indicates that the sounds are softer than the surrounding talk.
<word	*A pre-positioned left carat* is a 'left push', indicating a hurried start; in effect, an utterance trying to have started a bit sooner than it actually did.
-	*A dash* indicates a cut-off.
> <	*Right/left carats* bracketing an utterance or utterance-part indicate that the bracketed material is speeded up, compared to the surrounding talk.
< >	*Left/right carats* bracketing an utterance or utterance-part indicate that the bracketed material is slowed down, compared to the surrounding talk.
.hhh	*A dot-prefixed row of 'h's* indicates an inbreath. Without the dot, the 'h's indicate the outbreath.
( )	*Empty parentheses* indicate that the transcriber was unable to get what was said. The length of the parenthesized space reflects the length of the ungotten talk.
(word)	*Parenthesized words and speaker* designations are especially dubious.
(( ))	*Doubled parentheses* contain transcriber's descriptions.

Appendix I
Summary of Survey results

1. Please select your gender:			
		Response Percent	Response Total
Male	▬▬▬▬▬	24%	29
Female	▬▬▬▬▬▬▬▬▬▬▬	76%	92
	Total Respondents		121
	(skipped this question)		1

2. Please enter your age:		
		Response Total
	Total Respondents	121
	(skipped this question)	1

3. What languages do you speak? Please indicate the languages that you interpret.		
		Response Total
	Total Respondents	122
	(skipped this question)	0

4. How long have you been interpreting?		
		Response Total
	Total Respondents	121
	(skipped this question)	1

5. What type(s) of interpreting do you do? Please select all that apply and fill in the blank for "other" if your field is not listed.			
		Response Percent	Response Total
Medical	▬▬▬▬▬▬▬▬▬▬▬▬▬▬	100%	122
Legal	▬▬▬▬▬	25.4%	31
Social Service	▬▬▬▬▬▬▬▬	48.4%	59
School	▬▬▬▬▬	27%	33
Conference	▬▬▬▬	19.7%	24
Political/Diplomatic	▪	2.5%	3
Other (please specify)	▬▬▬▬	24.6%	30
	Total Respondents		122
	(skipped this question)		0

6. Do you have any formal training in interpreting?			
		Response Percent	Response Total
Yes	▬▬▬▬▬▬▬▬▬▬▬▬	86.9%	106
No	▬▬▬	13.1%	16
	Total Respondents		122
	(skipped this question)		0

7. If you answered "Yes" to question 6, please describe the training that you have had:		
		Response Total
	Total Respondents	104
	(skipped this question)	18

8. When you interpret, do you interpret in first person or third person? (First person is when you say exactly what was said: For example, if the non-English speaker says "I am sick" you would repeat "I am sick" in your translation. Third person is when you would instead say "He/she said he/she's sick." or something similar.)		Response Percent	Response Total
First Person	▬▬▬▬▬▬▬▬	95.9%	117
Third Person	▬	4.1%	5
		Total Respondents	122
		(skipped this question)	0

9. Please explain briefly why you prefer the style that you answered in question 8.		
		Response Total
	Total Respondents	119
	(skipped this question)	3

10. Do you think it makes a difference whether an interpreter interprets in first or in third person? Please explain why you think it does or does not.		
		Response Total
	Total Respondents	115
	(skipped this question)	7

11. If you answered "third person" to question 8, would you be willing to change your interpreting style to first person if there was research that showed that this was a better way to interpret?		Response Percent	Response Total
Yes	▬▬▬▬▬▬▬	75%	9
No	▬▬▬	25%	3
		Total Respondents	12
		(skipped this question)	110

12. Please explain why you would or would not be willing to change as asked in question 11.		
		Response Total
	Total Respondents	4
	(skipped this question)	104

Appendix J
Detailed Survey results

3. What languages do you speak? Please indicate the languages that you interpret.		Response Percent	Response Total
Spanish	▬▬▬▬▬▬▬▬	76.2%	93
Japanese	▬▬	9%	11
American Sign Language	▬▬	8.2%	10
Portuguese	▬	5.7%	7
French	▬	4.9%	6
Russian	▬	4.9%	6
Italian	▬	4.1%	5
Arabic	▪	3.3%	4
Chinese	▪	1.6%	2
Somali	'	0.8%	1
German	'	0.8%	1
Polish	'	0.8%	1
Chaldean	'	0.8%	1
Farsi	'	0.8%	1
Assyrian	'	0.8%	1
Bosnian	'	0.8%	1
Serbo-Croatian	'	0.8%	1
Croatian	'	0.8%	1
Serbian	'	0.8%	1
Haitian Creole	'	0.8%	1
Total Respondents*			122
Languages Spoken			20
Respondents often listed more than one language. Total languages listed			155

Detailed responses from those respondents who said they interpret in third person:
(responses are pasted here 'as is'; any grammatical, spelling or typographical errors are preserved from original responses.)

Question 3

What languages do you speak? Please indicate the languages that you interpret.
1. Polish
2. English and Spanish. I interpret in both directions.
3. English and Spanish

4.	Spanish and French.
5.	English Spanish

Question 4

How long have you been interpreting?

1.	less than one year
2.	9 years
3.	6 years
4.	1 year
5.	30 + years

Question 5 (other)

What type(s) of interpreting do you do? Please select all that apply and fill in the blank for "other" if your field is not listed.

1.	business

Question 7

If you answered "Yes" to question 6, please describe the training that you have had:

1.	ATA Medical Translation and Interpreting Seminar Bridging the Gap Court interpretation workshop (Advanced) I & II (Mario Flores, instructor) Agnese Haury Institute for Court Interpretation and SSTI workshops for preparation for the oral portion of the federal certification exam for judiciary interpreters Indiana Court workshops for preparation for the IN State Certification Exam (have taught those as well)
2.	Bridging the Gap (40 hours), Court Interpreter Orientation and Written Exams
3.	24 hour course.

Question 9

Please explain briefly why you prefer the style that you answered in question 8.

1.	1. I am able to interpret what is said, as it is said. 2. Communication between the parties is more direct and focused, and boundaries are readily clear regarding who is talking to whom (i.e. not to me).
2.	I think 3rd person is clearer in a medical setting. I do not say "s/he said" before each phrase, just the statement made, for example: "Me duele la cabeza" / "His/Her head hurts".
3.	Although I was trained that first person is the best and most appropriate way to interpret, I often find myself using third person. I prefer it, and do not believe that patients or providers have problems with it. I wish there were a trend to have both be "PC"
4.	For consecutive interpretation I prefer third person. Even if you explain in advance that you are going to use the first person in your interpretation, both patients and providers get confused when you do so. There are ways of using the third person without having to say he/she said, etc.

Question 10

Do you think it makes a difference whether an interpreter interprets in first or in third person? Please explain why you think it does or does not.		

1.	Yes, the main reason for me is that when the interpreter uses the first person (having first explained to all that is what s/he is doing), communication between the parties is direct, not through me. It is also much more efficient: you skip all of the "tell him this" "she says", avoids confusion regarding who is being talked about.
2.	I think it depends on the kind of session or setting in which you are interpreting. If it's a forensic interview for a child abuse investigation, then first person would be best to make sure it's clear who is speaking, since the case may end up in court. Psychiatric evaluations would be another good time to use first person. To me, third person works better in typical medical settings because there is less chance that the patient or provider will be confused about the information being relayed (e.g. taking a medical history, giving instructions, etc.). I've had it happen that patients think I am the one giving the instructions, diagnosis, etc. when I use first person, which is what led me to use third person instead, without the reported speech component (i.e. "S/he said...").
3.	There is obviously a difference, but I don't think it ends up having a determinable effect on quality care. I'm sure experts in the matter would disagree with me!
4.	Pretty much for the same reasons above. Doing it in the third person seems more natural to me and those for whom I am interpreting. I think that the only time it does make a difference, because of the nature of the encounter, is when you are interpreting during a psychiatric evaluation, when you have to use simultaneous mode instead of consecutive.

Question 12

Please explain why you would or would not be willing to change as asked in question 11.

1.	If there was research to support using first person I would be willing to change my style. I think there is also a need for patient/provider education about how interpreters work to make communication more effective.
2.	I suppose I often find that patients want to speak and look at the interpreter and this forces him/her to act as an advocate as well. Although this puts the interpreter in a compromised position professionally, I do think that there is a degree of empathy that can only be offered by the interpreter as he/she is truly the one communicating with the patient. AGain, I'm sure many would disagree...
3.	I have read a lot about both modes, have used both modes in the past, and in our setting, which is a large hospital/outpatient services organization, we have all opted for third person for consecutive interpretation, and first person for simultaneous interpretation (mainly for psychiatric evalutions).

Detailed responses to open-ended questions from all respndents

Question 9

Please explain briefly why you prefer the style that you answered in question 8.

1.	Because as a interpreter I'm the client's voice.
2.	I was trained like that, plus while doing an interpretation it is easier not to think about who is saying what, and keep track of who is speaking. If I interpret in first person I don't have to keep track or "explain" who is talking.
3.	I used to translate in third person, but it felt very impersonal and strange to me. Doctors tended to look at me, not the patient, and to not really interact much with the patient at all. After I switched to first person, I'm not sure if the doctors' behavious changed, but I felt better at being more inclusive myself.
4.	This is what Bridging the Gap emphazize to do because it's like the patient is speaking with the doctor instead of there been a thrid person
5.	In a medical setting (specially critical medical emergencies)a consecutive and/or simultaneous interpretation is best to use.
6.	Because it keeps the interpretation transparent. And also, I have found that the healthcare provider likes it better and there are less clarifying questions .
7.	I was trained to interpret specifically in this manner.
8.	I do not have a preference. I use what it is commonly used by my employer at the time. Most medical doctors insist that the first person be used.
9.	Because it conveys the message as if I wasn't there, so the focus is the patient and

	provider and the issue in question. I explain to the patients and not so often to the providers that I am their voice to communicate with each other and noting else. Everything said in the room while in my presence will be interpreted...
10.	1st person interpretation reduces my "presence" in the interpretation encounter, therefore promoting a better patient-provider relationship. Also simplifies the interpretation in its direct, two-way dynamic instead of a more complex triangulation.
11.	It conveys direct communication between client and provider. Another reason why I prefer 1st person, to the person who is receiving the information that is being interpreting, the interpreter is "invisible". Therefore it feels like only the interviewer and the interviewee are present in the conversation.
12.	It's less confusing. The doctor is more aware when I'm speaking versus the patient is speaking.
13.	It is the professional way
14.	I learned to use the first persono in interpreter training. Although a little awkward in the beginning, I am convinced it is the correct way to interpret.
15.	Interpreter should always speak in 1st person when voicing the non-English speaking person. When interpreter refers to him/herself, he says "the interpreter would like to say ...", for ex.
16.	Interpreting in First person allows the conversation to flow naturally instead of adding a "third" person in the exchange. I would like to add that is important to inform both parties that you will be using that type of interpretation so you don't confuse them and request that both parties use it too.
17.	INTERPRETERS, REPEATS EXACTLY WHAT IS SAID
18.	more direct, less prone to distortion
19.	It takes less time and it is more clear. It helps client and provider have direct communication.
20.	It is easier to do and is the instruction received in the training.
21.	Because that is the correct way to interpret. You are the voice of the person you are interpreting for.
22.	Interpreting in the first person allows direct communication between patient and provider, teacher and parent, etc. The use of the third person is limited to the interpreter's interventions, to clarify. This makes it easier for all parties to know "whose voice is being heard".
23.	it is less confusing and clear
24.	I interpret in first person because it is generally required as a standard in some settings.

	In other settings, notably mental health, medical and some social service work I work in third person.
25.	it is alot easier and you are interpreting what the pt. is saying.
26.	I USUALLY use 1st person but not always. I prefer this style with most adult patients because it takes the interpreter out of the scenario and seems to make things less confusing. When interpreting for children and the elderly, I use third person when speaking in Spanish but 1st person when speaking (their responses) in English.
27.	That is the way I have always been taught from the beginning of my career in professional interpretation. I notice that it is harder to stick with the first person when I am interpreting for family members and in informal, non-professional situations. I tend to lean towards third person with family members.
28.	My purpose is to facilitate communications between the patient and health care provider without additions/deletions, keeping myself as "invisible" as possible. Also, most training that I have received encourages first person as preferable.
29.	it makes facilitates comunication directly between health care provider & patient the interpreter is invisible, it there only to facility comunication between them
30.	It makes more sense and it eases communication by diminishing confusion.
31.	The interpreter is uttering exactly what is being said exactly the way it is said and I feel that this keeps the message very clear and precise, and it eliminates "tell him/her, he says/ she says.
32.	the focus of interpretation is the patient not the interpreter. more efficient and exact
33.	It is the industry standard in my profession as well as permitting both parties to interact directly while minimizing the interpreter's impact on the communication process. I will only go to third person when, for some reason (i.e. cognitive impairment of either party), the communication process is not flowing smoothly or making sense.
34.	It provides for clearer communication and establishes the patient-provider relationship as such. It eliminates any implication of the interpreter "giving their version."
35.	Interpreter must serve as a voice only, therefore the use of third person is inappropriate. Also it is the matter of preserving clarity of the record in legal proceedings.
36.	FOr em, the goal is to ensure interaction between/among the parties involved. Using first person tends to foster this; using trhid person tends to make it seem like I am one of the participants/interlocutors.
37.	First person is truly the ONLY way to interpret. It allows for the interpreter to be a conduit and transparent. It is also less confusing and allows the patient and provider the ability to communicate seamlessly through the Interpreter. 3rd person is very confusing and looked down upon in the interpreting world - very elementary and unacceptable.

38.	I do it because it's the way you're supposed to do it and I agree with it.
39.	To avoid confusion
40.	I interpret in first person, when patient is alone with the provider/s. If family members are present and participate in discussions or I'm trying to explain cultural differences I prefer to interpret in third person. Interpretation in first person is faster and during training it was recommended to use first person.
41.	I was trained this way.
42.	It make easier.(shorter)
43.	I guess that is what I learned and I like it. It is easier not to get everybody confused.
44.	It is more proffesional and less likely to be misunderstood
45.	It is more precise. However, depending of the situation I might use the third person keeping "transparency" when I use either one of them.
46.	it make s more sense, since it is not the interperter talking
47.	makes interpretation more accurate, better suited for medical setting
48.	Less confusion, take less time by not having to say "the doctor said" "the patient said".
49.	It's less confusing, encourages direct interaction between the parties and allows the interpreter to be less "involved", it's more expedient
50.	In all of my training, I have been trained to use the first person. It's less intrusive & very direct between patient & provider.
51.	One major goal of the interpeter is to support the physician/patient therapeutic relationship. In most cases they feel more contected and pay more attention to each other whe I interpret in the 1st person (I form). In my hospital the staff are used to this high quality style of interpretation, so I seldom have to explain it. When not to: If patients are demented or otherwise confused and do not understand after a brief explaination I will switch to : 'the doctor says, "I want to send you for an X-ray".'
52.	I believe that is the correct way to interpreter, this was the way I Was tought.
53.	really there should be a both box. I personaly like first person cause you go into an acting stage exp. patient says "coño me rompi la pierna your job is to use the same remarks and or expressions such as DAMNIT I BROKE MY LEG!!! the dr. nows how bad it is and also its a faster less confusing method. third person will slow the process down cause you keep repeating the same thing over and over again such as he/she says in the begining of every interpretation. The reason why I say both,if theres a third person such as a son or daughter in the room that buts in to the conversation you also have to interpret for the care giver so you go into third person such as " papi tiene mucho dolor de pecho desde anoche" son says dad has a lot of chest pain since last

	night.
54.	I was trained to interpret in the third person at CSU Long Beach.
55.	it aids in assuming the persona of the speaker so that the message can be fully transmitted including emotions, inflections, not only language...
56.	Because it leaves the interpreter out of the conversation, helps to keep the flow of the conversation as to there is no doubt who is speaking. It helps at all times to keep the transparency in the exchanges.
57.	Because the doctor can understand EXACTLY what the patient is feeling, and how is he feeling it.
58.	The purpose of the interpreter is to be as transparent as possible, serving only as a bridge betweeen the two communicating parties. I interpret in the first person because I want to reflect exactly was said, as if the two parties were talking without me there.
59.	I think it is the most professional way of interpreting. I only use 3rd person if the client requests so or if the LEP person is getting confused by the use of 1st person.
60.	Mostly first person, but sometimes have used third (if patient is a minor and is bilingual, brought up in US school system and answering without difficulty simple questions from provider) for mother who is monolingual and observing. Have also switched to third with elderly who seemed lost and stressed, after trying first the first person
61.	That is the proper way of interpretation.
62.	I prefer to interpret in first person for two reasons. It is easier for me and the communication flows better. Also I feel more connected with the person I am interpreting for than just "saying what she/he is saying"
63.	Avoid confussion
64.	To minimize confusion as to who says what; to interpret accurately; to "link" the parties that I'm interpreting for; to render a faithful version of what was said; to minimize my role as interpreter;
65.	Wearing the person shoes convey more sense of what he cognitively said or trying to convey the message. In addition it presents what is happing now in front of the provider. Some people and this due to culture and level of health education try to tell you a past feeling which might not exist now.
66.	It maintains the differentiation between the interpreter's voice and the speakers voice and keeps the speakers cued to eachother as the sources of the utterances.
67.	I do not prefer necessarily the first person. I believe that it depends on the situation in which the interpreter is found. For example, some providers/patients may find it easier and less confusing to use the third person, and in medical interpreting, having both provider and patient understand correctly to the best possible degree is the most

	important part of the job. That means that even though we are trained to use first person normally, I take each situation under consideration first.
68.	It avoids confusion for both the pt. and provider. It promotes a relationship between the pt and provider. It makes it easier for the interpreter to speak as the interpreter if necesary in clarifications, etc.
69.	1. I am able to interpret what is said, as it is said. 2. Communication between the parties is more direct and focused, and boundaries are readily clear regarding who is talking to whom (i.e. not to me).
70.	The use of third person is more accurate and precise. It avoids confusion. It allows the two parties to have direct communication through the interpreter.
71.	This is the formal setting as the interpreter is only "the voice" and should be "invissible".
72.	That is the best and most exact way to interpret
73.	It is easier and it is the way it is suppossed to be done.
74.	It clarifies who is being spoken about or to. Instead of having to clarify who "he" Iws. (ie. the speaker, someone else in the room, relative, etc) Also, the goal is for the interpreter to be invisible. For the people conversing to give attention to eachother instead of bringing in a third party...that just gets distacting and can totally change the dynamics of the conversation. It is the biggest compliment to be unnoticed.
75.	This is the style that was taught and enforced
76.	It is easy to interpret what it is said as it is said withouth changing anything. Also makes comunnications more direct. In some situations, it is dificult for the interpreter to keep using the first person (ej, interpreting for a child molester) . I will understand to use the third perdon to put emotional and professional distance.
77.	Maintains a better flow: Helps maintain the interpreter in the background, with the focus on the speakers; the interpretation is direct speech, without any need to add pronoun conversion to the interpreting task.
78.	Because it is the right way to do it. This how one is taught to interpret. First person interpreting promotes communicationand decreases confusion
79.	If done professionally and correctly, this style is less intrusive to the situation. It promotes appropriate reporte between the communicators and distances the interpreter. Lessens the chance that a dependent relationship with develop between the interprter and either communicators.
80.	There can be some misunderstanding at times, but it keeps the communication clearly between the client and the provider and not focused on the in-between person.
81.	I think 3rd person is clearer in a medical setting. I do not say "s/he said" before each

	phrase, just the statement made, for example: "Me duele la cabeza" / "His/Her head hurts".
82.	Using first person keeps the interpreter out of the session and encourages patient/provider communication.
83.	I am speaking as if I am the Deaf person. I am their voice.
84.	It makes sense to me. At firt I used 3rd person, and once I learned, and thought about it . . . in a way it shortens the session by not using verbage such as, "the doctor says" or "the patient says." You just go straight to the heart of the matter. In the beginning I would slip back into 3rd person a lot, but it happens very seldom now.
85.	It reinforces the relation between the parties involved, and embodies the role of the interpreter, which is to be a "transparent window", in the interchange, not an active participant.
86.	Encourages direct patient/provider interaction. Easier to stay in the background. If interpreter adheres to her/his role and maintains trasparency, there's a better chance for effective communication to take place.
87.	It keeps me focused on what the patient is saying.
88.	This allows direct communication and has laways been the standard in the field of interpreting
89.	I think interpreting this way makes us more transparent, and hopefully helps both patient and provider feel as if they were talking directly to each other and not through an interpreter
90.	It is in accordance to the National Interpreting Standards and I have to maintain transparency while interpreting. I am there to voice what the provider and patient are trying to express.
91.	This is the accepted standard of practice. It allows for more "invisibility" of the interpreter, because the listener understands that the interpreter is merely the conduit for the language, and not the person whose thoughts are being expressed. Also, by using first person, the voice of the one who is speaking is perfectly clear, and the listener will tend to focus their eyes on the speaker, rather than the interpreter. It eliminates confusion when the speaker is conveying what he or she ehard someone else say. (See below)
92.	I prefer the first person for many reasons: 1)Interpreting is exhausting. Simply repeating what the client said, word for word, is easier. 2) There are many practices that interpreters use to take themselves out of the communication equation. As much as they are necessary for verbal communication to be possible at times, an interpreter's job is mainly to facilitate a conversation between two or more individuals. The first person keeps the interpreter out of the conversation by reinforcing the power of the client's voice as opposed to their own. 3) The main reason that I prefer the first person is exactly

	for reasons of power. As an interpreter, I am not meant to be a party in the conversation. My presence is already established by my body. To further reinforce my presence and necessity through linguistical manipulation that subliminally posits me as the interpreter would be to abuse the situation for my own recognition and gain.
93.	It is more polite the doctor to address directly to the patient, and the interpreter is just a voice to facilitate the interaction between doctor/patient.
94.	A clear interpretation. I believe is less confusion for me and de Doctor. I believe Interpreter in the room is invisible and using the FIRST PERSON help us to be more clear in our job.
95.	I believe that it allows patient and provider to relate better in first person -- provider does not say "Ask him . . ." or "Ask her . . ." From a linguistics perspective, it is quicker and easier because you you are not saying things like "The doctor wants to know . . ." and from my perspective it helps by not having to change verb conjugations.
96.	to avoid the confussion.
97.	you don't have to think about what is said. I started out working in third person, but through time and discovery found that first person stays true to the message and allows the relationship to grow between provider and patient.
98.	Because it is the norm of interpreting for over 100 years all over the world in all settings. It allows for less confusion, easier interpretation, and more direct communication. Sometimes third person can be misconstrued, if the first person utterance includes third person speech. For these and more reasons, interpreters around the world established first person as the standard. I was in the translation and interpreting field before interpreting in the US, where it is a younger field, specially community interpreting.
99.	Although I was trained that first person is the best and most appropriate way to interpret, I often find myself using third person. I prefer it, and do not believe that patients or providers have problems with it. I wish there were a trend to have both be "PC"
100.	I think it's imperative that the hearing person needs to learn to speak directly to the patient and develop a therapeutic alliance with the patient, not the interpreter. By using the third person, one only perpetuates the disconnect and I think promotes disrespect even if it's inadvertent.
101.	based on my trianing and work experiences.
102.	That is the best way to allow that connection between the people that I am interpreting for. That is the way I have been taught to do in Medical Interpreting.
103.	First it is the words of the parties that I am interpreting for and not my words. By doing it this way it is giving them "Ownership" of the meeting/words.
104.	Although there is a little confusion at first because sometimes it seems that you are the

	one that is talking the patient/clients picks right up-- I do a pre-session and I explain that to make it easier for the patient/client.
105.	Since the interpreter is supposed to be transparent during interpretation you just interprete what you hear without any intervention from his/her person.
106.	It's more accurate, in first person you express the real emotions/feelings of the speaker - It's less time consuming. I switch to 3rd person only when it's appropriate
107.	Less confusing, easier to express the speaker's tone of sprit as close as possible.
108.	For consecutive interpretation I prefer third person. Even if you explain in advance that you are going to use the first person in your interpretation, both patients and providers get confused when you do so. There are ways of using the third person without having to say he/she said, etc.
109.	It relates the message in its original context, conveying more meaning.
110.	I do not speak about the person, I speak for them
111.	The interpreter acts as a conduit.
112.	1. First person is more accurate (from observation and informal study). 2. Use of first person encourages a bond between the patient and provider. 3. First person interpretation helps the interpreter carry all the meta-linguistic data, including mood, intent, etc. 4. Use of first person keeps the interpreter in an appropriate role. 5. After clear explanation in an introduction about the mode being used, clients respond directly to one another and have less confusion about who is speaking. 6. First person is easier once an interpreter is trained on it: direct statements tend to be more clear and precise compared to their third person counterparts.
113.	It was the way I was taught, plus keeps the patient focused on the doctor/staff.
114.	For me, first person has become more natural. I started in the third person but because of the standard that leans towards 1st person I practiced and now use that almost exclusively. I still occasionally use third person or reported speech if I feel there is a need to clarify.
115.	It just seems easier for the other person(nurse,doctor) to understand.
116.	1) More accurate 2) Faster 3) Keeps the focus off me 4) Lets the people for whom I'm interpreting "hear" each other's voices 5) Reinforces that the people for whom I'm interpreting are talking to each other, not to me, so I get fewer comments or requests directed to me.
117.	There is less confusion in the long run; it is the professional standard, it's just easier and more fluid.
118.	First person interpretation is recommended by all professional standards of practice, whereas third person is strictly forbidden (see NAJIT position paper, or contact me for a

	copy: [e-mail address deleted]). First person enables direct communication to take place between the two parties, whereas third person (aka reported speech or indirect interpretation) can lead to confusion, prolonged conversations and frustration. In addition, third person is more likely to entice the interpreter to violate ethical principles and step out of the role of the interpreter.
119.	It achieves a more accurate and direct communication of the speaker's words. It lessens the number of analytical steps the interpreter has to go through (i.e., converting "I" to "he/she") It makes for fewer words to interpret (no "he says that..." It is the professional norm in the interpreting field, from conference, to medical to legal to community.

Question 10

Do you think it makes a difference whether an interpreter interprets in first or in third person? Please explain why you think it does or does not.

1.	Yes. Because it is better for the communication between two people that speak different

	man/woman".
11.	Not so much about context, but it makes the process go faster.
12.	Of course it does! It is a lot less confusing. (of course you should explain this to the patient to avoid confusion)
13.	Yes, if you interpret in the third person, you tend to become more than interpreter (or conduit) and to take control of the encounter.
14.	Interpreter is just a voice communicating the 2 people who do not speak the same language. He should speak as if the non-English speaking person was speaking himself.
15.	Yes, using the 3rd person is longer and it includes an additional person in the conversation that delays the rendering of the message.
16.	YES, IT COULD CHANGE THE MEANING OF A SENTENCE
17.	it does, ref answer #9
18.	It does makes a difference if intereperter interprets in first person. The message is better communicated since the non-english speaker feels as provider is talking to them not that she/he is telling her story to interpeter and then interpreter tells story to provider.
19.	Yes, it makes a difference. The interpreter is the communication link between the parties. This communication should be as close as possible to the parties talking directly to each other. More than anything it should eliminate ambiguities. If the interpreter has any doubt and needs clarification she/he can say "The interpreter would like clarification" thus identifying clearly who is speaking and has the doubt.
20.	If the person you are interpreting for says "I am sick", and you say "she is sick", you are not saying the same thing. It does make a difference.
21.	As I explained before, using the first person, after explaining to both parties that you are going to interpret in such form, facilitates a direct communication between the parties. Using the third person may also encourage side conversations between doctor&interpreter, between patient&interpreter.
22.	Yes, same reason as above
23.	To me it seems that third person interpreting preserves the truth of the situation; that it preserves and ascribes authorship honestly. First person is supposed to make it seem the parties are in direct contact and often I have found that one or both of them are not able to sustain this fiction.
24.	you have to make it clear that you will be interpreting as first person to the provider. Its les confusing. than we get to HE said SHE said.
25.	See answer above. I do like first person when possible because I feel like it allows patient and provider to connect more. There are some visits where there is more of a

	team approach so if the interpreter is participating in the discussion then 3rd person could come in handy here. Or, if a bunch of providers are talking to each other in high medical lingo 3rd person plus summarizing the conversation works well. Overall though, 3rd person seems to make things longer to say.
26.	Yes, it does make a difference. It helps avoid confusion (provided both parties know your role...importance of pre-session) regarding who is speaking; it encourages a direct interaction/relationship between the two parties. Also interpreting in 1st person is a sign that the interpreter has formal training in the profession.
27.	I prefer 1st person, because it encourages the relationship between patient and caregiver, rather than the relationship between the interpreter and patient. 3rd person can cause triangulation between the parties, and encourage more side conversations with the interpreter who is then expected to advocate for 1 party or the other. However, with children or patients with dementia, for example, I sometimes switch to 3rd person, because they have a harder time tracking what my role is.
28.	yes, it makes a great diference! I think I answer this in # 9 the interpreter needs not to interfeer with comunication only to facilitate it.
29.	It separates the interpreter from the encounter allowing for transparency.
30.	I think that it does make a difference because in third person the communication becomes like a triangle where the communication should be directly between the provider and his client. The interpreter is only there to facilitate this communication.
31.	the first person gives the patient importance and value
32.	see above
33.	I think it makes a huge difference because the communication flow is much smoother and it establishes direct communication between the patient and the provider without it seeming as though there is an outsider.
34.	Yes, stated above.
35.	Se above
36.	Yes it makes a huge difference. If the interpreter is using first person - they are transparent - being only the voice - the patient and provider are able to look at each other and speak back and forth through the interpreter. If they are using 3rd person it tell her this - he says that tell him this she says that - it takes way too long and it calls too much attention to the interperter and the interpreting instead of the patient and his or her issues and or what the provider is trying to find out.
37.	I have to admit that at times, in medical settings, I use "he" or "she" when referring to the medical provider. I mostly do this when I sense that the patient is a bit lost and finds the situation odd. Don't shoot me, I know it's not right, but at the time, I feel it's the best for the patient. I don't take those liberties in any other setting.

38.	I believe it does. Third person might cause confusion.
39.	See above. During one appointment quite often I interpret in first and third person (to explain some cultural differences or traditions I have to switch to third person so provider and patient would not be confused. It does not make any difference for me.
40.	Yes, I think it makes difference. First person indicates more transparency in communication between the parties.
41.	it does not make any different because you are only interpret for a person whom is trying to communicate with another person is not you.
42.	Less confusion
43.	Yes- it makes the interpreter as transparent as possible
44.	It does. Nevertheless, the interpreter has to be clear during the pre-session to explain both parties how the interpretation is going to be performed; without the pre-session using the first person, can be confusing but easier to resolve. The use of first person is more accurate and the flow of the communication easier to control. It is also fair to say that for new interpreters or those without training is somehow difficult to get used to the use of the first person.
45.	I think so, because agoin we are not the ones speaking
46.	yes
47.	Yes, the interpreter should be transparent.
48.	Yes, for the above reasons. Saying "he/she says" sounds unprofessional also. It places more focus on the interpreter rather than the parties on each other. Third person invites the interpreter to sum up or add to what was said, and with first person you are quoting so you tend to be more accurate.
49.	It's less intrusive & very clear. Patient & provider speak directly to each other. I provide the interpretation...almost as if I were not there & they are speaking directing to one another.
50.	Third person calls too much attention to the interpreter, interruping the conversation with the interpeter's words He says, she says. Third person distances the 2 people you are interpreting form from each other and inserts the interpreter into the middle.
51.	Yes, i do think that makes a difference,because the doctor and the paciente will be more confortable with each other and i would try to be invisible.
52.	Yes, I believe that a good interpreter is one who has the least impact on the communication event. In other words, the session should proceed as though the interpreter were not there as much as possible. This is best accomplished through the 1st person. Also, an interpreter is less likely to "editorialize" the communication if he/she is interpreting exactly what is said in the 3rd person.

53.	Yes, it makes a great difference. By interpreting in first person the identity and voice of the individuals is kept and the interpreter's voice is only used to allow communication. Whe you use third person it is reported speech, hence a message that has been processed by the interpreter. Direct speech allows for no ommision or addition to what is being said which is the ideal intepreting situation. Also, the way someone speaks says a lot about its personality and individuality, these can get lost in reported speech.
54.	It does not make a difference, as long as the interpretation is accurate.
55.	Yes it does. First person allows more of the message to be communicated, rather than just a summarized "he/she said this."
56.	Yes, it makes a big diference.
57.	First is more efficient, once patient and doctor understand how it actually works. It can be awkward initially with patients who on top of that have rarely seen a doctor.
58.	Yes, it's important to avoid confusion.
59.	It does make a difference and avoid confusion. For example, if I am interpreting for a "Maria" that is refering to her sister (Laura) about something that her sister (Laura) said. Interpretation in Third person it would be...she said that her sister said...such and such...but in first person I only have to say...my sister said such and such....do you see what I mean?? I hope my example is helful.
60.	Of course. Otherwise is almost imposible to find out who is speaking. Especially when third parties are involved in the session.
61.	Yes- for the reasons stated above; if I interpret in 3rd person, I am placing langauge distance between the parties and I am not interpreting faithfully or accurately. In addition, I am placing the focus on me, rather than on the parties.
62.	Yes it does as answered in previous question #9
63.	Yes. For the reasons in answer 10 and it also distances the interpreter from direct involvement in the conversation.
64.	Yes, it does make a difference! See above!
65.	Yes, the main reason for me is that when the interpreter uses the first person (having first explained to all that is what s/he is doing), communication between the parties is direct, not through me. It is also much more efficient: you skip all of the "tell him this" "she says", avoids confusion regarding who is being talked about.
66.	Yes, definitely. Using first person is more accurate and precise; avoids confusion about who is talking about who. It allows the two partices to have direct communication through the interpreter.
67.	I think speaking in the first person does make a difference. 1. Easier 2. Faster 3. Less confussion 4. It's the proper way to do it to avoid misunderstanding and

	miscommunication. For example "the interpreter said....". It's important to have a "pre-session" with the provider as well as the patient/client to explain how the interpretation will be handled (in the first person), the interpreter will say exactly what is said as it was said w/o ommitting or adding.
68.	When you interpret any other way it could firstly be confusing and secondly it takes more time to say "he says, she says, etc.
69.	It could confuse the provider or patient if you do not prompt them that you will do so. It does make a difference, as I said it is easier, and to interpret, you can concentrate better when you think as yourself being the patient when you keep using first person than third person and keep repeating "she/he says"
70.	Yes. Explained above.
71.	1st person turns the attention to the patient instead of the interpreter it gets the provider to talk directly to the patient instead of saying tell the patient or ask him/her
72.	Yes. Firs person facilites a more direct and personal communcation between the parties. It a way makes the interpreter more invisible. It could be confusing at first for parties that are no familiar to profesional interpreters. In situations that are emotionally very charge can be hard for the interpreter. It is easier to maintain a porfeional distance when using the third person.
73.	I think use of the third person puts the interpreter in a more 'intrusive' position. Use of the first person helps you act as a channel, not a participant in the conversation. That said, there are occasions when I find the third person works better. E.g., many elderly patients and children simply can't grasp the notion of first-person interpretation.
74.	Yes, it does. First person increse invisibility of the interpreters. Promote clsoe communication between clients and increases accuracy
75.	Same as 9
76.	Yes. When using third person, the interpreter becomes the focus of attention and the LEP is talked about rather than talked to.
77.	I think it depends on the kind of session or setting in which you are interpreting. If it's a forensic interview for a child abuse investigation, then first person would be best to make sure it's clear who is speaking, since the case may end up in court. Psychiatric evaluations would be another good time to use first person. To me, third person works better in typical medical settings because there is less chance that the patient or provider will be confused about the information being relayed (e.g. taking a medical history, giving instructions, etc.). I've had it happen that patients think I am the one giving the instructions, diagnosis, etc. when I use first person, which is what led me to use third person instead, without the reported speech component (i.e. "S/he said...").
78.	As above, I think it should be the default style. It helps to avoid any confusion about who is doing the speaking, or whose words they are.

79.	Yes, I believe the medical professional is more inclined to speak directly to the deaf person and make more of a personal connection to that person. As an interpreter, I become more invisible in the process.
80.	First person personalizes the communication and interaction between provider, and patient. There is nothing wrong with interpreting in third person, it is like participating in a gossip like conversation.
81.	Please see my response to No. 9....
82.	There is; see above. The "he said" "she said" truly triadic interaction will definitely take a lot longer and increases chances for miscommunication
83.	The few times that I've used third person I noticed that I was inclined to summarize. Also, I feel that speaking in first person makes the interaction more about the patient. I've also noticed that providers are not as likely to establish eye contact or speak directly to the patient if I speak in 3rd person.
84.	Absolutely. 3rd person adds lots of confusion and impedes direct communication. It creates the sense that the interpreter is a full party to the interaction as opposed to the commnunication link between two parties
85.	Yes, for reasons stated above although sometimes people get confused when you speak in first person.
86.	Yes. When interpreting in the third person, you are not truly capturing the message that is being given. I explain to both provider and interpreter that when I use "I," I am acting as the other party.
87.	Absolutely!! Interpreting in the third person should only be used in rare instances, which means that I RARELY use it. Third person adds another layer of complexity to the discourse. Let's use the example of when a male speaker says in reference to something he witnessed, "He told her to leave the books on the floor." If I interpret this in first person, the listener understands that the person for whom I am interpreting witnessed that another man told a female to leave the books on the floor. But, if I interpret this in third person, it comes out as, "He said he told her to leave the books on the floor." This interpretation is ambiguous now: Which "he" said and which "he" told her?? It could mean that the person for whom I am interpreting told her, or that another man told her.
88.	I certainly do think that use of the first and third person are quite different. The first person encourages each party to speak to the other and not to me. If my client says, "I am sick," and I interpret that as, "He is sick," then I am effectively positioning myself as a third party who becomes part of the conversation and not merely a facilitator. Not only do I take on a role in the actual conversation at hand, but I become an entity who can take sides. Thus, I become an advocate as well. Use of the third person assumes two more roles than use of the first--that of party to the conversation and possible advocate for a party. At times, this can become quite cumbersome.
89.	Yes, because it makes a more acurate interpretation

90.	It does. Make a huge different on the interpretation. When I use the THIRD person it create a confusion on (she said this....) (I NEED YOU TO PAUSE PLEASE) Who need the pause me or the patiece? FIRST PERSON IS clear and profesional.
91.	See #9, and also saves time for interpreter, provider, and patient.
92.	yes, for the first person, you are repeating exact word of the speaker in that case the interpreter is transparent. but the third person you may create confusion.
93.	As stated earlier, in first person you are allowing the rapport to build between the primary players in the interaction and you are able to remain as neutral as possible.
94.	Huge, see above. One is the professional way to do it, the other (third person) is how lay people do it because they don't understand the reasons stated above. In legal, for example, you need to have the exact utteration of the speaker, and third person taints that.
95.	There is obviously a difference, but I don't think it ends up having a determinable effect on quality care. I'm sure experts in the matter would disagree with me!
96.	Answered in #9
97.	It promotes a better rapport between the speakers to use 1st person in the languages I work in; I realize that some other languages may have different constructs and in those cases maybe 3rd person would be best.
98.	Yes. It allows the interpreter to not for the lack of better phrasing be in sight.
99.	By not doing it fist person takes away ownership.
100.	I think it is more confusing to use 3rd person because you end up she said, he said, she said--and it can get confusing.
101.	In the begining of the interpretation I always make it clear that I am goin to interpret in 1st person so there will not be any confusion. I think 1st person is much more simple because you take the place of that person and makes it more personal.
102.	Yes it does. Most new interpreters interpret in 3rd person,it takes a while for them to grasp and feel comfortable using the 1st person. Interjecting "s/he says" all the time ruins the grammar/syntaxis and flow. In real life it's time consuming,it adds unnecessary words
103.	Yes, it makes a difference. Medical interpreters are prefered to speak in 1st person for accuracy reason.No adding, no omitting.
104.	Pretty much for the same reasons above. Doing it in the third person seems more natural to me and those for whom I am interpreting. I think that the only time it does make a difference, because of the nature of the encounter, is when you are interpreting during a psychiatric evaluation, when you have to use simultaneous mode instead of consecutive.

105.	Yes, third person interpretations belittle the speakers and takes the message out of context.
106.	The interpreter should not speak about the patient. Third person interpretation is speaking about the patient.
107.	Yes. Using the first person, it is clear the words are those of the speaker (person being interpreted) and not those of the interpreter.
108.	Absolutely! See the above answers. Please consider our role is to be as transparent as possible. Third person simply cannot accomplish this as we are "always in the picture" with its use. Use of third person also solicits questions or remarks, such as "Did he/she REALLY say that?" or "Wow, he is really _____."--comments they are not intending to have interpreted, but by our role we must.
109.	I think it does make a difference in that it keeps the interpreter out of the picture, so to speak, and keeps the focus on the medical staff.
110.	I think that the first person avoids some confusion and no mental tricks are needed to change pronouns. I have read some research that suggests that when something is offensive or could be confused interpreters tend to attribute the utterance in a third person way. I find myself doing this also. "I think you are a bad doctor." he said. I think that is natural for me to distance myself from those utterances. Is that unprofessiona? Hard to say.
111.	We are being used as their voices. We are speaking for them. Also takes less time and seems easier for the persons we are interpreting for to understand. Especially the physisians and nurses.
112.	Yes. Use of the first person has the benefits mentioned above: faster, keeps focus on interpreter, lets speakers hear each other's voices and emphasizes that the conversation is between them (not with the interpreter). Interpreters who use third person are more likely to have people speak to them directly, making requests of them and expecting them to mediate the conversation instead of interpret it.
113.	Yes absolutely. Given that use of the first person is the professional standard, anytime someone uses reported speech it makes look bad as a profession; lack of cohesiveness. Use of third person leads to more confusion and makes the session run longer. First person is more efficient and probably leads to better outcomes and overall patient satisfaction (I have no real evidence to support this theory, just my intuition).
114.	Definitely. 3rd person is normally used by non-professional interpreters who are normally ad-hoc and have not been professionally trained. It is what is "natural" to them, because they are essentially describing what the other person is saying instead of interpreting their words exactly as they were stated. It makes a tremendous difference on the quality of the interpretation.
115.	Absolutely - it is much more faithful representation of what the speaker says. In community settings it can help to promote a better relationship between the client and

provider because there is no distance superimposed with "he said that...". It helps educate the speakers as to how to work with a professional interpreter. That said, it can cause confusion in some cases, as with children, large groups and the elderly. The interpreter must be able to analyze the situation and choose the best mode.

Question 12

Please explain why you would or would not be willing to change as asked in question 11.

1.	I answered "yes" because I always want to be as effective as possible, but I am very skeptical that third person interpretataion is better.

13.	I have read a lot about both modes, have used both modes in the past, and in our setting, which is a large hospital/outpatient services organization, we have all opted for third person for consecutive interpretation, and first person for simultaneous interpretation (mainly for psychiatric evalutions).
14.	Most professional standards of practice recommend first person. If there are interpreters out there not using first person, chances are they have not been properly trained. There are some exceptions. For example, telephone interpreters for some companies are trained to interpret all calls in third person, (it increases the number of billable minutes and prolongs the conversation by a substantial amount of time). However, other telephone interpreters are trained to interpret professionally in first person. In emergency settings, such as 911 calls, it may be necessary in certain instances to use reported speech, but there are ways of doing so that still implement good practices and enable the interpreter to continue on in first person.

Appendix K

Transcriptions of mock interpreting sessions

Session 1

Dialog 1 - ER Triage interview

S1: Hello, do you need to see the doctor today?

I1: Buenos días, necesitas ver al doctor hoy?

P1: ahm (.) Sí creo que sí.

I1: Yes, I think so.

S1: Please have a seat here.

I1: Por favor siéntese aquí.

P1: Gracias.

((*Patient and nurse sit down.*))

(3)

I1:Thank you

((*laughter*))

S1: What brings you to the emergency room today?

P1: [ah:]

I1: [Por] qué está aquí en ah la sala de emergencias hoy?

P1: ah Bueno pues, me duele el estómago bien feo.

I1: Well, my my stomach hurts real bad.

S1: When did you start having this pain?

I1: Cuándo empezó el dolor?

S1: Where exactly do you hurt?

I1: Dónde exactamente está el dolor?

P1: ah:: Bueno ba- antes me dolía todo el estómago pero ahora me duele: me duele más (.) por aquí ((*Patient gestures with right arm and hand to indicate the region between the rigt hip bone and belly button.*))

I1: Before, all of my stomach hurt. But now, it hurts more (.) here. ((*Interpreter touches right hand to right side of belly.*))

S1: Okay. (1) On a scale of zero to ten, with zero being no pain at all, and ten being the worst pain imaginable, how would you rate your pain right now?

I1: En una (.) escala supongo de uno a:: diez.

P1: uh [huh]

I1:   [uh] Un uno ah siendo u- no no mucho dolor-

P1: Uh huh.

I1: Y diez siendo dolor (.hhh) dolor más f- fuerte que se imagine- imaginable ah: qué tipo (.) qué número sería su dolor?

P1: ah o: No sé ah tal vez un seis.

I1: I don't know, I guess a six.

S1: Have you had any other symptoms?

I1: Ha tenido más síntomas?

P1: Bueno me me sentía como que tenía calentura antes.

I1: Por favor repite.

P1: Sí, digo que me sentía como que tenía (.) calentura.

I1: <I felt like I had a fever before.
S1: Okay (.) have you had nausea or vomited?
I1: Ha tenido náuseas o ha vomitando?
P1: oh [m-]
I1:   [(ah)]
P1: Eso sí. No no quería comer, y luogo tenía ascos.
I1: n- Repita otra vez, lo siento.
P1: Sí, digo que no: que no quería comer y que luogo tenía (.) tenía ascos.
I1: Yeah, e: I didn't want to eat before and um (.) I (.) kinda (.) felt (.) um (.) it felt a little bad later.
S1: Did you vomit?
I1: Ha vomitando? O ha vomitado?
P1: uh: No, pero me dieron ganas de vomitar.
I1: Um I didn't but I kinda felt like vomiting.
S1: Do you have any history of serious medical problems?
I1: Tiene usted una historia de problemas serios eh medicales?
P1: Pue:s uh ésta es la primera vez que vengo al hospital aquí.
I1: This is the first time that I've been to the hospital here.
S1: I mean do you have any- or do you have or have you ever had any chronic disease?
I1: L- lo que quieres quiero decir es tiene una enfermedad o ah (.) o ha teni- ha tenido una enfermedad muy serio en el pasado?
P1: uh Qué signifíc- qué quiere (decir que) eso?
I1: What do you mean?
S1: Like for example, asthma, diabetes, or any other disease?
I1: Por ejemplo asma, diabetes, o otro enfermedad
P1: No, pues mi mamá tenía diabetes pero: pero yo no.
I1: um (.) I- I not sure but no (.) °I (don't) think so°.
S1: uh Have you ever been hospitalized or had any surgeries?
I1: Ha estado en el hospital antes o ha tenido eh cirugías?
P1: ah:: No. Bueno, cuando era niño: se me rompió el brazo y tuve que ir al hospital pero eso eso fue en México.
I1: um Otra vez, qué qué rom romp (beh:) qué [rompó?]
P1:   [sí   ] El brazo.
I1: El brazo (.) uh I broke my arm when I was a kid but this was in Mexico.
S1: Okay. um Are you on any regular med- medications?
I1: Está tomando (.) medicamientos?
P1: uh: A veces me tomo Advil (.) si me duele la cabeza.
I1: Sometimes I take Advil if my head hurts.
S1: I mean prescription medications.
I1: ih Lo que quiero decir es uh medicamientos uh (1) ((*lip smacking sound*)) del doctor prescriptivas.
P1: ah No, no, eso no.
I1: No, no, this no.
S1: Are you allergic to any medication?
I1: Tiene alergías a algún medicamientos?
P1: A la penecilina.

I1: ah To penicillin.
S1: Okay ah I'm going to take your temperature and blood pressure then I want you to wait in the waiting room over there. ((*points with right index finger to area behind patient*))
I1: Voy a tomar su ah su presión y: su temperatura, y después quiero que:: esperes a allí ((*nods head to her left which coincides with the general direction the nurse pointed to which was behind the patient*)) en la sala.
P1: ah: Voy a tener que esperar mucho?
I1: Will I have to wait for a long time?
S1: It shouldn't be too long.
I1: No: uh no no debe pasar mucho tiempo.
P1: Es gravea?
I1: Is is is it serious?
S1: It's possible it could be somewhat serious but the doctor will tell you (.) an:d answer any other questions you have.
I1: Es posible que puede ser grave pero el doctor va a hablar más contigo y va a (.) um va a (.) responder a: cualquieres preguntas tiene usted.
P1: Oh, está bien, gracias.
I1: (This is) good thanks.

Dialog 2 - Registration
S2: Miss Suárez?
I1: [(S-)]
P2: [Sí soy] yo.
S2: ah Please have a seat over here. I'm gonna do your registration.
I1: Por favor siéntese aquí. Voy a: a registrate.

((*Registrar and Ms. Suárez sit down.*))
P2: Bien.
I1: Okay
S2: uh:m What is the patient's date of birth?
I1: Cuál es e- la fehca de: nacido del paciente?
P2: Ella es del dieciséis de junio de dos mil uno.
I1: She was born on um June twenty-six (.) two thousand one.
S2: Okay (.) ah what's the patient's name?
I1: Y cuál es su nombre?
P2: Araceli Suárez.
I1: Araceli Suárez.
S2: Okay (.) um (.) we have an Araceli Suárez Saavedra in our system (.) [is that] her?
I1:   [tenem-] Tenemos en una en nuestra sistema una Aribeles (.) cuál es? Aribeles Suárez San- Sarbeda?
S2: Saavedra.
I1: uh:m En nuestra sistema (.) esto es ella?
P2: Sí es ella.
I1: Yeah that's her.
S2: A:nd what is your name?
I1: Y cuál es su nombre?
P2: María Carmen Suárez.

I1: María Carmen Suárez.
S2: A:nd your date of birth.
I1: Y: su fecha de nacido?
P2: Bueno: (.) este: (.) es que no la sé de verdá.
I1: The truth is that I don't really know.
S2: uh:m You don't know your date of birth?
I1: No- no sabe usted su fecha de nacido?
P2: No.
I1: No.
S2: Okay: ah: what's your address?
I1: Pues uh cuál e- cuál es su dirección?
P2: No me la sé.
I1: I don't know.
S2: You don't know it?
I1: N- n- no sabe usted?
P2: Es que acabamos de mudar, y luego viene mi esposo, y él se la puede decir.
I1: uhm (.) Por favor repita otra vez.
P2: Es que acabamos de mudar, y luego viene mi esposo, y él la puede decir.
I1: Acabamos? Puede explicar un poco más (.) esa palabra?
P2: n- ah (.) Recién nos mudamos
I1: Oh, we've recently moved, um, and my husband's coming later and he'd be able to tell you.
S2: uh:m Okay (.) and what is your phone number?
P2: (i=)
I1: =Y cuál es su número de teléfono?
P2: No tenemos teléfono.
I1: We don't have a telephone.
S2: Okay (.) uh:m (3) not even a cell phone? ha- how is that possible?
I1: No- ((*laughter*)) no número celular? cómo es posible?
P2: Bueno pues, es como le digo, acabamos de cambiarnos par acá.
I1: Well ih- it's like I told you, we just moved here (.) °we don't° (.) have everything yet.
S2: uh:m (.) Well we have to have some way to contact you by phone at least in the case of (.) the doctor needs to tell you something after you leave.
I1: Pues necesitamos una manera de con- um de: hablar (.) con usted (.) um por teléfono (.) aun si es: solamente que el doctor necesita con con usted después de la cita.
P2: Bueno cuando venga mi esposo a lo mejor él le puede dar. (eh-)
I1: Well, when my husband comes um hopefully he'll be able to tell you.
P2: Él vive muy cerca de nosotros.
I1: He lives very close to us.
S2: Alright, um who is your daughter's regular daughter?[18]
I1: r- Regular doctor ?
P2: (yeah) ((*very quiet laughter*))
S1: dau- uh (.) Doctor (.) (who's) your daughter's regular doctor?
I1: ((*laughter*)) pues quién es el doctor regular de su: hija?
P2: La doctora Katrina.

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[18] During this session, the script contained an error so that it actually read "…who is your daughter's regular daughter" instead of "regular doctor."

I1: Doctor Katrina.
S2: ah (.) Doctor Katrina Sánchez?
I1: Doctor doctor Katrina Sánchez?
P2: Sí .
I1: Yes.
S2: um (.) And >do you have insurance<?
I1: Usted tiene seguro?
P2: Na más el Medicaid.
I1: uh No more than Medicare
S2: Okay (.) uh:m please let me have your medicaid card for- for a moment so that I can make a copy of it. I also need to make a copy of your drivers license.
I1: Por favor necesito su tarjeta de medicaid para copiarlo y también necesito su: ah su licencia de conducir (.) ahm para hacer copia.
P2: No tengo licencia.
I1: I don't have a license °a drivers license°.
S2: That's okay, any ID with your photo will do.
I1: Está bien cualquier ah identificación con una foto (.) está bien.
P2: Es que no tengo ninguna. Antes tenía mi credencial para votar pero alguien me robó la cartera y ahora no tengo nada.
I1: Is that I (.) don't have any ID. I used to have my voting card but somebody: stole it from me and >now I don't have anything<.
S2: That's okay (.) I need you to sign this form here, here, and here. ((*Registrar points to three spots on Ms. Suárez's script to correspond with the imaginary lines where she would sign. Ms. Suárez imitates this gesture playfully.*)) ((*quiet laughter from interpreter*)) And then I'll get your Medicaid card back to you in just a minute. And then you can return to the waiting room.
I1: Está bien (.) ah Pues necesito que:: ah (.) que usted firme aquí aquí aquí ((*points toward Ms. Suárez's script to indicate same general area that the Registrar previously indicated.*)) (.) uhm y: voy a re a- voy a entregar otra vez su: tarjeta de Medicaid en un momento (.) y:: hasta hasta es tiempo (.) por favor espere aquí en la sala.
P2: Bien, gracias.
I1: Thanks.

Dialog 3 - Conversation with physician
S3: ((*clears throat*)) Hello again, Mister Rodríguez.
I1: uh Hola Señor Sodríguez.
P3: Hola doctor.
I1: Hi doctor.
S3: (hhh) I just wanted to talk to you about ↑one more thing before I discharge you today.
I1: Quiero hablar de una una cosa más antes de:: um (.) sales hoy.
P3: Bien.
I1: Okay.

S3: It's very important that you stop smoking. [Your-]

I1:   [uh-   ] Es muy importante que: deja de fumar.

S3: Your symptoms are caused, a: and made worse by your smoking. Even when you don't feel sick, smoking is very bad for you.

I1: Sus síntomas es- s- oh (.) I'm sorry (.) could you repeat what you said?

S3: uhah: Yeah. Your symptoms are caused and made (.) worse by your smoking.

I1: Okay. Sus síntomas uh están causados y: están uh peorando por su fumando.

S3: Even when you (.) don't feel sick smoking is very bad for your health, and you will feel much better after you quit.

I1: Aun cuando no: no se siente: mal uh f- uh fumar es muy mal para su salud, y va a sentir muchísimo más uh mejor cuando dejas de fumar.

P3: <Entiendo eso pero, pues>, muchas personas ya me han dicho eso pero no quiero dejar de fumar.

I1: I understand, but (1) a lot of people have told me that I need to quit smoking, but I don't ↑want to.

S3: And why is that?

I1: Por qué no?

P3: Porque me gusta >y (ppá) fumaba y él se murió hasta que tenía noventa años de viejo se murió<.

I1: um (hhh) ((*laughter*)) Repita por favor otra vez.

P3: eh Me gusta fumar.

I1: Sí.

P3: Y mi papá fumaba. Y él se murió hasta que tenía noventa años, de viejo se murió.

I1: Well I like to smoke, and I have a friend who (.) (who)s been smoking for ninety years so he shoulda died. But he's still uhlround.

S3: Be that as it may it doesn't mean that you will live that long.

P3: [uh-]

I1: [um] (1) S::i es (eh) (.) quizás es verdad pero: (.) ese no significa que va va a vivir por tanto tiempo.

S3: And as long as you smoke, your asthma and allergies will continue to bother you ah-

I1: y (.) si está fumando (.) su alergías y su asma va: a seguir uh molestándole.

S3: And you are at risk for cancer, emphysema, heart problems, and other diseases

I1: Y tiene riesgos para enfesema, uh problemas del corazón (.) uh (.) it was heart disease, um emphysema and-

S3: Yeah, cancer and other problems.

I1: Cáncer y otros problemas.

P3: Le voy a decir algo muy sinceramente. A mí me gusta hacer lo que me da la pu- pinche gana, y no me importa cuántas personas que me dicen que deje de fumar. No lo hago (.) a menos que yo quiera hacerlo.

I1: Discúlpame, pero qué de significa pinche eh-

P3: uh:: Maldita gana.

I1: um (basically) I'm gonna be honest with you (.) um everyone's told me to stop smoking but (.) I'm gonna: (.) I don't feel like it I'm gonna smoke when I- I'm gonna stop smoking when I feel like it.

P3: Si no fumo, no me siento vivo. El fumar es un placer pues, chinga.

I1: ((*laughter*)) If I don't smoke, I don't feel alive (.) Lo siento, qué significa chinga?

P3: Maldición.

I1: u:m (.) >I- it really bothers me when I stop<

P3: La gente hoy en día está obsesionada por la salud. Un hombre debe poder fumar si quiere, qué fregados.

I1: ((*slight laughter*)) People you're obsessed with health (.) with health um (1) ah a- and a man can smoke if he wants.

S3: <Alright> (.) wh- very well mister Rodríguez ah I think I understand ah I still wish you'd quit smoking but I-

I1: Bien señor Rodríguez, creo que entiendo pero (.) um (.) aunque todavía (.) espero que: uh >dejes de fumar<.

S3: um (.) But I agree that no one can force you to do something you don't want to do.

I1: Pero estoy de acuerdo que nadie: um debe (.) forzarte um dejar algo cuando no quieres.

P3: Bueno pues, le agradezco.

I1: Well thanks I (.) I appreciate it.

Dialog 4 - Conversation with cashier

S3: Okay, before you leave today, there are just a few things I need to go over with you.

I1: <Antes de salir hoy (.) uh hay algunas cosas que necesito: a- hablar contigo.

P2: Está bien.

I1: Okay.

S3: I see here that you have no insurance is that correct ?

P2: [Así-]

I1: [Veo] que no- (.) um veo que no tiene usted seguro es verdad?

P2: Así es.

I1: Yes.

S3: Alright, um we do ask our patients for payment at the time of service. That means that we'd like you to pay now.

I1: Preguntamos de nuestros pacientes por el ah (.) m: (.) el dinero (.) al tiempo de servicio. E- este significa que necesitimo- necesitamos que usted pague ahora.

S3: uhm This mini- the minimum charge for the hospital is one hundred dollars. In addition to this you will receive a separate bill f:rom the emergency room physician, as well as from other physicians if you received other services.

I1: Bueno el car- la carga mínima del hospital es cien dólares y: can you repeat the rest (.) for me?

S3: After what point?

I1: After uhm (.) the one hundred dollars part.

S3: eh In addition to this ah: you will receive a separate bill from the emergency room physician <as well as> from other physicians ah: if you >received other services<.

I1: En adición va:: va: a vamos a (.) enviar (.) unas um (.) tch tch unas cuentas de um de:l physis- del doctor (.) de la sala de emergencias y también de otros doctores si: ha tenido otros servicios.

P2: Yo no tengo el dinero para pagar ahora.

I1: I don't have the money to pay now.

S3: O:↑kay um do you think you'll be able to pay say in two weeks?

I1: Bueno piensa (uh) usted que (.) puede uh puede pagar en dos semanas?

P2: Y cuánto será?

I1: um How much would it be?

S3: (.hhh) uh:m Well the charges aren't finalized yet. The minimum charge is a hundred dollars, but it's <u>possible</u> you may be charged <u>more</u> depending on the services you received today.

I1: Pues las cargas no son final ah ora el- >la carga mínimo< es cien dólares. Pero, puede ser más de i- depende de los servicios que ha recibido hoy.

P2: Híjole: eso se me hace mucho. Por qué cobran tanto?

I1: Geez seems like a lot to me. Why's it cost so much?

S3: That is just what the hospital charges. I don't know how that is determined.

I1: Esto es lo que carga el hospial o lo que equiere ah el hospital. No sé cómo (.) ellos (.) ah (.)no (b-) no sé cómo ellos hacen eso

S3: If you are interested there is a financial assistance form you can fill out.

I1: Si tiene interés (.) hay una forma de ah de (.) ayuda financial que: puede ah °puede hacer (.) usted°.

P2: <u>Sí sí</u> eso me gustaría mucho. Ojalá que me ayuden con es(o).

I1: Yeah I'd like that a lot. I hope they can help me with this.

S3: Aright <u>here</u> it is. On one side uh: (.) one side is in English and the other side is in Spanish.

I1: Aquí está °y° este lado está en inglés y este lado español.

S3: You only need to fill out one side, whichever language you feel most comfortable with.

I1: Sólo necesita hacer un: la:do (.) uh cualquier (.) uh idoma es más cómodo para usted.

P2: Muy bien. Y luego qué hago?

I1: Good and later what do I do?

S3: You will want to fill it out and return it to us as soon as possible. Our business office will make a decision based on your family's income.

I1: Necesita hacerlo y:: en:tregarlo (.) tan uh- tan pronto como sea posible (.) °ah-° could you repeat the part after (.) as soon as possible?

S3: >Oh yeah<. Our business office will make a decision based on your family's income.

I1: Nuestre- nuestra oficina de: negocios va: a hacer una decisión basado en el uh (eh) dinero ah de su familia.

P2: Téngame consideración por favor.

I1: Teng- tenga su: cuál?

P2: Téngame consideración por favor.

I1: Alright I'll think about it please (I have).

S3: Well like I said it's it's based on your income and the business office will make their decision and let you know by mail ah if you qualify, and if so at what level.

I1: Como dijo yo es: ah domo <u>dije</u> yo es: está basado en el ah (.) >(yo) no sé< (.) el nivel financial de su familia y:: um (.) Could you repeat the last part that you said?

S3: uhm (.) eh- The business office will make their decision and let you know by mail uh if you qualify, and if so at what level.

I1: el: ah La oficina de negocios va: a um va a contactarse (.) <u>por</u> um por carta y: si (.) usted (.) uh tiene las cualificaciones para eso vamo- va:n van a decirte a cuál nivel (.) puede tener la ayuda.

P2: Muy bien, gracias.

I1: Thanks.

Session 2

Dialog 1 - ER Triage interview

S4: Hello. Do you need to see the doctor today?

I2: Necesita(s) ver al doctor hoy día?

P4: Sí, creo que sí.

I2: I think so.

S4: Please, have a seat here.

I2: Por favor siéntese aquí.

P4: Gracias.

I2: Thank you.

S4: What (.) brings you to the emergency room today?

I2: Por qué viene a la sala de emergencia?

P4: Bueno pues, m:e duele el estómago bien feo.

I2: I have a stomich ache.

S4: When did you start having this pain?

I2: Cuándo empezó a tener loh dolores?

P4: Ah: apenas me empezó ayer.

I2: I: started yesterday.

S4: Where exactly do you hurt?

I2: Um (.) dónde le duele exactamente?

P4: Bueno, antes s me dolía todo el estómago, pero ahora me duele más (.) por aquí. ((*Patient gestures using left hand indicating the region between left hip bone and belly button on his left side.*))

I2: um (.) It used to hurt my whole stomach, but now it hurts about (.) here, where he's showing.

S4: Okay, on a scale of zero to ten, with zero being no pain at all, and ten being the worst pain imaginable, how would you rate your pain right now?

I2: (Si dada) una ehcala de cero a diez, donde cero (.) no tiene casi nada dolor y diez es un dolor que (.) ya no puede aguantar, cómo e- qué le daría el dolor que tiene?

P4: No sé. m: Tal vez un: un seis.

I2: Perhaps ↑six.

S4: Have you had any other symptoms?

I2: Tiene otras síntomas?

P4: ((*clears throat*)) Me sentía como que tenía calentura antes.

I2: I felt hot before.

S4: Have you had nausea or vomited?

I2: Se ha sentido con náuseas o ha tenido vómitos?=

P4: =Oh sí sí eso sí. No quería comer y luego tenía: m (.) ascos.

I2: I d- um: (.) I felt both, and I didn't want to eat, and (.) felt (.) like um (.) nauseous.

S4: Did you vomit?

I2: Vomitó?

P4: No, pero me: dieron gana de vomitar.

I2: No, but I felt like throwing up.

S4: Do you have any history of serious medical problems?

I2: Tiene en historia de- de problemah medicoh serios?

P4: Pue:s (.) ésta es la primera vez que vengo al hospital aquí.

I2: Is the first time I come to the hospital here.

S4: I mean, do you have or have you ever had, <any chronic disease>?

I2: Tiene o ha tenido algún- algún enfermedad crónica?

P4: Qué quiere decir eso?
I2: Um (.) what do you mean?
S4: Like for example, asthma, diabetes, or any other disease?
I2: Por ejemplo, asma, diabetes, o cualquier otra (.) enfermedad (.) de:se tipo?
P4: No pues, mi mamá tenía diabetes pero ↑yo no.
I2: My mom had diabetes but I (.) don't (.) have (.) °diabetes°.
S4: Have you ever been hospitalized? Or, had any surgeries?
I2: Ha estado alguna vez hospitalizado o ha tenido >alguna< cirugía?
P4: No. Bueno, cuando era niño: >se me rompió el brazo y tuvo que ir< al: hospital. Pero eso fuen México.
I2: Ahm. No, not really. When I was a kid, I broke my arm (ah) I had to go to the hospital. (1) But that was in Mexico.
S4: Are ↑ you on any regular med- medications?
I2: Está tomando (oh) remedios*?*
P4: A veces me tomo Advil y si me- si me duele la cabeza.
I2: If I have a headache I take Advil.
S4: I mean, prescription medications.
I2: Agún remedioh que la ya ha ci- ah- citado ah (.) o recetado el médico?
P4: No, eso no.
I2: No.
S4: Are you allergic to any medication?
I2: Tiene algo de alergia a:lgúnh (.) remedio?
P4: A la penecilina
I2: ((*in Spanish*)) Penecili- ((*switches to English*)) Penecillin.
S4: ↑Okay. I'm going to take your temperature and your blood pressure. Then, I want you to wait in that waiting room over there. ((*points by extending arm and right index finger, indicating the area behind and to the left of patient*))
I2: um (.) Le voy a tomar la temperatura y le voy a (.) ah medir la presión y despúes quiero que (.) vaya a- (.) a la sala por allá ya (.) y esperar.
P4: Voy a tener que esperar mucho?
I2: Uhm gonna have to wait too long? ((*indicates area roughly behind and to the left of the patient by pointing with left hand, arm close to chest, and a waving motion with right hand*))
S4: It shouldn't be too: long.
I2: No (de)berí- no debería demorarse mucho.
P4: Y es grave?
I2: Is it- (.) How serious is it?
S4: It's <possible it could be somewhat serious>, (.) but the doctor will tell you that, and answer any other questions you have.
I2: Pue: que sea un poco grave pero el doctor (da) a dar rehpuesta suh preguntas
P4: eh- Está bien, gracias.
I2: ↑Okay, thank you.

Dialog 2 - Registration
S4: Ms. Suárez?
P4: Sí soy yo.
I2: That's me.

S4: Hello. Please have a: seat over here, I'm going ta do your registration.
I2: Hola. Por favor siéntese aquí la- va- ella va:cer la registración.
P4: Bien.
I2: Okay.
S4: What is the patient's date of birth?
I2: Cuál es la fecha nacimiento del paciente?
P4: Ella es del dieciséis de junio de dos mil uno.
I2: June sixteen, two thousand one.
S4: ↑°Okay°. What is the patient's name?
I2: El nombre de paciente?
P4: Araceli Suárez.
I2: Araceli Suárez. Do you need me to spell that?
S4: m::: We ↑have an (.) <Araceli Suárez Saavedra> (.) in our system, is that her?
I2: El: >segundo apellido< (e-) Saavedra?
P4: Sí. Es ella.
I2: Yes. That's correct.
S4: An:d, what is your name?
I2: Cuál es su nombre?
P4: María Carmen Suárez.
S4: And (.) ye:r date of brith?
I2: Y su fecha de nacimiento?
P4: Bueno: este (.) es que no la sé la verdad.
I2: I don't really know it.
S4: You don't know your date of birth?
I2: No sabe su fecha nacimiento?
P4: No.
S4: Okay. What is your address?
I2: Dirección?
P4: No me la sé.
I2: I don't know it.
S4: You don't know it?
I2: °No se la sabe°?
P4: Es que (a)cabamos de mudar. eh- Luego viene mi esposo y él se la puede decir.
I2: We just moved here. So, when my hah- my husband gets here, he can tell you (.) the address.
P4: Okay. A:n:d what i:s your phone number?
I2: Cuál es su número telefónico?
P4: m: No tenemos (.) teléfono.
I2: We don't have a phone number.
S4: You don't have a telephone?
I2: (.) No tien teléfono?
P4: No.
I2: No.
S4: Not even a cell phone? How can that be?
I2: No tienes d- >ni siquiera< teléfono (.) móvil? celular?
P4: Bueno (.) pues (.) como le digo, >a(ca)bamos de cambiarnos par-acá<.
I2: Like I tell you, we just moved here. °So ( )°.

S4: Well, wh- we hafta have< (.) some way to contact you (.) <by <u>phone</u> at least> (.) in case the doctor (.) needs to tell you something after you leave.

I2: Temos que ah tener un número de contacto por si >necesitamos< llamarle o si el doctor necesita decirle algo (.) dehpueh que ustedes se vayan de aquí.

S4: Bueno, cuando venga mi esposo a lo mejor él: le puede dar el <número> de su hermano. Él vive muy cerca de nosotros.

I2: When my husband gets here, be- perhaps he can give you uh: <his brother's phone number>. He lives (.) pretty close to us.

S4: Alright. Who is your daughter's regular doctor?

I2: Quién es el doctor de cabeza de su hija?

P4: La doctora Katrina.

S4: Doctor: Katrina: Sánchez?

I2: Doc- Doctora Katrina Sánchez?

P4: Sí.

I2: Yes.

S4: And do you have insurance?

I2: Do you have ah- Tiene seguro de salud?

P4: No más el Medicaid.

I2: uhm (.) Just Medicaid.

S4: Okay. Please let me have your Medicaid card for a moment so that I can make a copy of it. I'll also need to make a copy of your driver's license.

I2: Necesito la tarjeta de aseguranza Medicaid para >hacer una copia una fotocopia<, y también la: (.) hacer una copia de su licencia de conducir.

P4: No tengo (mi licen-) mi licencia.

I2: I don't have a driver's licence.

S4: That's okay, any ID wilth your photo will do.

I2: Tiene cualquier otro tipo de identificación con su foto=   [fotografía   ] ?

P4:   =Es [que no tengo] no tengo ninguna. Antes (.) tenía mi credencial para votar pero >alguien me robó la cartera y (ya) no tengo nada<.

I2: I don't have anything with me, ah somebody stole my (.) wallet, um before I used to have the (1) uhm (.) (folders likely), but °I don't have that, since they stole my wallet°.

S4: That's alright, I need you to sign this form <here, here, and here ((*points at three different spaces on table as if indicating signature lines on form.*)) and then> I'll get your meda- ca- medicaid card back to you in just a minute, and then you kin return to the waiting room.

I2: Okay, necesito que firme en e(s)toh tres ↑lugarez y: (1) le voy a devolver la tarjeta de medicaid en un minuto y >que necesito después que se siente y a-< a ehperar, en la sala de e(s)perah.

P4: Bien, gracias.

I2: ↑Okay.

Dialog 3 - Conversation with physician

S4: Hello again, Mister Rodríguez.

I2: Señor Rodríguez, hola.

P4: Hola doctor.

I2: Hi doctor.

S4: <I just wanted> to talk to you about one more thing before I discharge you today.

I2: °go ahead° ((*makes circular motion gesture with left hand*))

S4: I just wanted to ta=

I2:   =OH Go ahead, I mean, keep going (hhh) ((*makes circular motion gesture with left hand*))=   [(would) ((*claps once*) (when)] out of the hospital

S4:   =That's it. [uh, I just-   ]

I2: ((*claps once*)) I just go a little longer ((*gestures by moving palms of hands slightly while facing each other as if representing a measurement or about to clap*)) ok=

S4: =I just wanted (.) to >talk to you about one more thing before I discharge you today<.

I2: Quiero decirle ah:m que lem- quiero conversar con uhted algo más antes de- de (en)viarlo a la casa=

P4: =bien=

I2: =de darle de alta.

P4: Bien.

I2: Okay.

S4: It's very important (.) that you stop smoking. [Yers-]

I2:   [Muy] importante que deje de fumar.=

S4: =Your symptoms are caused and made worse by your smoking.

I2: Los síntomas que tiene s- son caus>ados< por el cigarilloh por fumar y quis- que se van a empeorar (.) >debi(d)o a que está fumando<.

S4: Even when you don't feel sick, smoking is very bad for your health, and you will feel much better after (.) you quit.

I2: Aun si no se siente enfermo, el fumar le ha eh muy da(ñ)ino para su salud, y se va a sentir mucho mejor si deja de fumar.

P4: Entiendo eso pues, pero pues, muchas personas me han dicho: ya me han dicho eso pero >yo no quiero dejar de fumar<.

I2: I understand doctor, but, many people have already told me that but I don't want to s:top smoking.

S4: And why is that?

I2: Por qué?

P4: >Porque me gusta: y mi papá fumaba y él se murió hasta los noventa: años. De viejo se murió.

I2: Because I like it, I enjoy smoking, and my dad used to smoke and he died (.) he was about ninety, in his nineties when he died.

S4: Be that as it may, it doesn't mean that you will live that long, and as long as you smoke, your asthmuh: and allergies >will continue to bother you<, and, you are at risk for cancer, emphysema, heart problems, and other diseases.

I2: Aunque- (1) Can you repeat that be- ((*laughter*))

S4: Be that as it may, it doesn't mean that you will live that long.

I2: Okay, >Pese que suscedid(a) con su papá, bueno, no significa que usted viviría< tan- tanto tiempo.

S4: And, as long as you smoke, your asthma and alergies will continue to bother you, and you are at risk for cancer, emphysema, heart problems, and other diseases.

I2: Y: si continúa fumando, va: tener s- va a continua- va a seguir teniendo problemas con su <asma> (1) y:: va a tener (.) >probablemente otros problemas< como problemah de corazón, ahm (1) emfasima (   ) ahm (2) what else did you say doctor?=

S4: =um=

I2: =Heart problems? [( )and what else?]
S4:   [Heart problems   ] and other diseases.
I2: Otros- otras um (.) enfermedades.
P4: <Le voy a decir algo muy sinceramente.
I2: Let me be (.) ah ↓honest with you.
P4: <A mí me gusta hacer lo que me de la pinche gana, y no me importa cuántas personas que me dice- que me dicen que deje de fumar, o no lo haga- o no lo haga a menos que yo quieracerlo. S-
I2: I like to do what I like to do:, and I don't like when people tell me- what to do or what (.) not to do.
P4: Si no fumo no me siento vivo. El fumar es un placer pues chinga >la gente hoy en día está obsecionada por su salud. Un hombre debe poder fumar si quiere<. Qué fregaos.
I2: If I feel like smoking, I should have the right to- smoke and I don't care- (.) what (.) other people think or (.) uh jus:t- stop um (.) bothering me with the subject.
S4: Very well then, <Mister Rodríguez. I think I understand>. I still ↑<u>wish</u> you'd quit smoking, but I ↑agree that no one can force you to do something that you <u>don't want to do.</u>
I2: Muy bien, yo lentiendo. Um (2) ah: (.) te entiendo lo que usted está diciendo, y, aunque me gustaría que dejara de fumar, tiene razón nadie le puede forzar a dejar del hábito.
P4: Bueno pues, le agradezco.
I2: Well thank you very much.

Dialog 4 - Conversation with cashier
S4: Okay, before you leave toda- today, there are just a few things I need to go over with you.
I2: Antes de que se vaya, tenemoh que repasar unah cosas.
P4: Ta bien.
I2: ↑Okay.
S4: I see here that you have no insurance. Is that correct?
P4: Así eh- eh-
I2: ((*laughter*)) <Verdad que no tiene se- aseguranza esta- eh es verdad?
P4: Así es.
I2: That's right.
S4: W- Alright. We <u>do</u> ask our patients for payment (.) at the time of service. That means, we'd like you to pay now. Th-
I2: Le pedimoh a nuestroh pacienteh que: paguen, ahm que cancele su deuda, al momento des-de: recibir el servicio. O sea, no por tenía que- que pudiera pagar hoy.
S4: The minimum charge for the hospital here (.) is: (.) one hundred dollars.
I2: El cargo mínimo por- por de ehtar en el hospital es cien dólares.
S4: In addition to this, you will receive a separate bill from the emergency room physician, as well as from other physcicians, if you received other services.
I2: Además de esto, de- va a recibir una cuenta por separado de- de parte del doctor de la sala de emergencia >y todoh loh otroh doctoreh< que haya vihto.
P4: <Yo no tengo el dinero para pagar ahora.
I2: I don't have the money to pay right now.
S4: Okay. Do you think you will be able to pay, say, in two weeks?
I2: Cree uhted que pueda pagar de aquí a dos semanas?
P4: Y:m cuánto será?

S4: [Well-]
I2: [About] how much?
S4: Well, the charges aren't finalized yet. The minimum charge is one hundred dollars, but, it's possible you may be charged more depending on the services you received today.
I2: No tenemoh la cuenta final todavía. La car- El cargo mínimo (.) es cien dólares pero puede que hara sea mucho más dependiendo de las cosas (.) los servicios que recibió hoy día.
P4: Hí:jole. Eso se me hace mucho. Por qué me cobran tanto?
I2: That's a lot of money. How come it's so expensive?
S4: That is just what the hospital charges. I don't know (.) how that is determined. If you are interested, there is uh: financial assistance form you can fill out.
I2: Eso eh lo que cobra eh el hospital yo no sé cuánto- por- ah:m- no sé cómo llegan a esa conclusión pero si- si quiere hacer máh preguntas, hay un (.) formulario de: de ayuda financiera que usted puede llenar.
P4: Sí, sí, eso me gustaría mucho.
I2: I would be interested in that.
P4: Ojalá que me ayuden con eso.
I2: I hope- um I can receive help with that.
S4: Here it is, one side is in English, the other side is in Spanish. [Ye-]
I2:   [Aquí] está el formulario, un lado e(s)tá en español y el otro lado (en) inglés.
S4: You only need to fill out one side, whichever language you feel most comfortable with.
I2: Sólo necesita llenar uno de loh lados, el- no los dos y: en cualquer- en el idioma que se sienta más cómodo.
P4: Muy bien, y luego qué hago?
I2: And then, what do I need to do after that?
S4: You will want to fill it out and return it to us as soon as possible.
I2: Ahm (.) debe llenarlo y devolver- devolvernoh- nolo- devol- devolver ((*laugh*)) lo a nosotros ah lo antes posible.
S4: Our business office will make a decision based on your family's income.
I2: Nuehtra oficina de finanzah va as- >tomar una decisión< basa(d)a- basándose en: cuánto gana to- el la famila cuánto es eh la entrada por el hogar.
P4: Téngame consideración por favor.
I2: Ah please (3) °téngame consideración° ah (.) I dunno (3) sure ((*laughter*))
S4: Well, like I said, it's based on your income, and the business office will make their decision and let you know by mail if you qualify, and if so, at what level.
I2: Bueno, cómo le dije, esto se basa en: la entrada (.) por (to-) el hogar así que depende cuánto gane, allí donde hacen la decisión de cuánto (.) y cómo va a pagar.
P4: Muy bien, gracias.
I2: Okay thank you.

Session 3
Dialog 1 - ER Triage interview
S5: Hello. Do you need to see the doctor today?
I3: Hola. Usted necesita ver el doctor hoy?
P1: Sí, creo que sí.
I3: Yes, I think so.

S5: Please have a seat.
I3: Por favor siéntese.
P1: ah gracias.
I3: Thank you.
S5: What brings you to the emergency room today?
I3: Qué lo trae hoy al- a: la emergencia hoy?
P1: Ah: bueno pues:, me duele el estómago bien feo.
I3: I:: have a really bad- uh my- my stomach hurts really bad.
S5: When did you start having this pain?
I3: Cuándo usted empezó a tener este dolor?
P1: ah- Apenas me empezó ayer.
I3: Just started yesterday.
S5: Where exactly do you hurt?
I3: Ah adónde exactamente siente (eh) dolor?
P1: Bueno:, antes (.) me dolía todo el estómago, pero ahora me duele más (.) por aquí. ((*using right hand, patient gestures indicating his right side between hip and belly button*))
I3: Well, before ah, all my stomach hurts but now it's jus(t) over here. ((*gestures using right hand indicating right side near belly button level*))
S5: On a scale of zero to ten, with zero being no pain at all and ten being the worst pain imagineable, how would you rate your pain right now?
I3: En una escala de uno ah a diez, ese uno no teniendo mucho dolor y diez mucho dolor, cómo ste siente el dolor ahora?
P1: ah: No sé. Tal vez: (.) un seis.
I3: I don't know maybe six.
S5: Do you have any other symptoms?
I3: Usted tiene otros síntomas?
P1: Ah:m >me sentía como que tenía calentura antes<.
I3: I felt like I had a fever before.
S5: Have you had nausea or vomited?
I3: Uste: ah: sentió ganah de vomitar o estaba (1) °nauseous° o estaba (.) te- tenendo gana de vomitar?
P1: Ah- o eso sí sí. No quería comer, y luego tenía- tenía ascos.
I3: Ah yes, yes. I- I didn't want to (.) ate ah before <an:d then> I felt like (3) (c)ah the interpreter would like to ask, can you repeat the <last word, it's> nauseous?
P1: No que tenía (.) ((*moves torso and head and gestures with right hand from mouth as if to illustrate vomiting*)) [ascos.]
I3:   [agruras] the(n)- agruras, yeah. Um uh- I didn't (.) want to eat before, and then I- I really felt like I- I had to vomit.
S5: Did you vomit?
I3: Usted vomitó?
P1: No. Pero me dieron ganas de vomitar.
I3: Na- No, but I had- I had a feeling that I- I want to.
S5: Do you have any history of serious medical problems?
I3: Usted tiene historia de:: uh problemas medicos serios?
P1: Pue:s:, ésta es la primera vez que vengo al hospital aquí.
I3: ah- Well, this is the first time that I come to the hospital here.

S5: I mean, do you ha:f, or have you ever had any chronic diseases?

I3: Ah: Lo que es es usted ya tuvo o tiene alguna enfermeda(d) crónica

P1: Qué quiere decir eso?

I3: What that means?

S5: Like for example asthma, diabetes, or any other disease?

I3: Por ezemplo, la asma, la diabetes, o otra enfermedad.

P1: No. Pues:, mi mamá tenía diabetes pero- pero yo no.

I3: Ah- No. My mother had a- ((*Spanish pronunciation*)) dia- ((*English pronunciation*)) diabetes, but not me.

S5: Have you ever been hospitalized or had any surgeries?

I3: A- Usted ya fue hospitalizado tuvo una cirugía

P1: No bueno cuando- cuando era niño se me rompió el brazo, y tuve que ir al hospital pero eso fue en México.

I3: No. When I was a ki:d ah broke my arm, but this was: uh ((Spanish pronunciation)) en México.

S5: °m:° (.) Are you on any regular medications?

I3: Usted te- toma un medicamentoh regularmente?

P1: A veces me tomo- me tomo Advil, si me duele la cabeza.

I3: Sometimes I take Advil, when I fell ah a headache.

S5: I mean prescription medications.

I3: eh- Lo que quiero decir eh un:- una medicación ah prescrita.

P1: Ah no no. Eso no.

I3: No, no. Not this.

S5: Are you allergic to any medications?

I3: Usted tiene alergia a alguna medicación?

P1: A la penecilina.

I3: La pe- ah(m)- Yes, (ah-) the: ah- ((*more like Spanish than English pronunciation*)) pelícilin.

S5: Okay. I am gonna- t- to take your temperature ((*smiles; tone of voice and timbre sound like speaker is amused, as if about to laugh; interpreter also smiles and laughs a bit*)) and blood pressure. Then I want you to wait in the waiting room over there. ((*speaker points to her right which is to the patient's left*))

I3: Okay I'm going ta- Okay- Yo voy a tomar su temperatura <y su ah:> presión sanguín>ea< y usted tiene que esperar en el otro- la otra sala.

P1: Voy a tener que esperar mucho?

I3: I'm gonna (.) ah need to wait a lot *?*

S5: It shouldn't be too long.

I3: No:- n- no debe ser- por mucho tiempo.

P1: Es grave?

I3: I(t)s serious?

S5: It is possible it could be somewhat serious but the doctor will let you know >that (he) can answer any questions you have<.

I3: Es posible que sea al:go se:rio pero:, el doctor te va a responder (cual)que pregunta que tenga.

P1: Oh. me- Está bien. Gracias.

I3: Okay, thank you.

Dialog 2 - Registration
S5: Miss Suárez
I3: Señora Suárez
P5: Sí soy yo.
I3: (Yes th-) that's me.
S5: Hello. Please have a seat over here.=
I3: =Hi-
S5: I am going-
I3: I'm sorry.
S5: Please have a seat over here. I am going to do your registration.
I3: Usted se puede sentar aquí yo voy a hacer su ge:stración.
P5: Ah bien.
I3: °Okay°.
S5: What is the patient's date of birth?
I3: Cuál eh la fecha de nacimiento de: del paciente?
P5: Eh:: ella es del dieciséis de junio de dos mil uno.
(3)
I3: Ah: July sixteen, two thousand one.
S5: °Okay°. What is the patient's name?
I3: Cuál eh nombre de(l) paciente?
P5: Araceli Suárez.
I3: Araceli Suárez.
S5: °Okay°, we have an Araceli Suárez Sraaveda in our system. Is that her?
I3: We have ah Araceli- Can you repeat the name please? Nurse?
S5: Saavedra.
I3: Saavedra en eh n- nuestro sistema. Es- es ella?
P5: Sí, si. Es ella.
I3: Yes, yes, that's her.
S5: And what is your name?
I3: And what is you- Oh. Cuál es tu nombre?
P5: María Carmen Suárez.
I3: María Carmen Suárez.
S5: (Yeah). ((*laughter*)) And your date of birth?
I3: Y su fecha de nacimiento?
P5: Ah: Bueno eh:s- °es que no la se (.) de verdad°.
I3: Well, ah yes um that I- I don't know.
S5: You don't know your date of birth?
I3: Usted no sa be: su fecha de nacimiento?
P5: N:o
I3: No.
S5: ↑Okay, what is your address?
I3: Está bien. Cuá- Cuál es su dirección?
P5: °No me la sé°.
I3: °I don't know°.
S5: You don't know it?
I3: Usted no sabe?

P5: Eh- es que >nos acabamos de mudar<.
I3: I(t)s jus that we just moved.
P5: Luego viene mi esposo y el se la pued(a) decir.
I3: Ah My husband is just coming and he can tell you.
S5: And what is your phone number?
I3: And- Y cuál es tu número de teléfono?
P5: No tenemos teléfono.
I3: We don't have a phone.
S5: You don't have a phone?
I3: Usted no tiene un teléfono?
P5: No.
I3: No.
S5: Not even a cell pho:n: ? How can that be?
I3: Ah Ni (u)n teléfono celular? Cómo puede ser eso?
P5: Bueno pues, es- es como le digo, acabamos de cambiarnos par acá.
I3: Well, it's just the way that I t- I already told you. We just moved here.
S5: Well, we have to have some way to contact you by phone, or at least in case the doctor needs to tell you something after you leave.
I3: Well, nosotros tenemos que tener por lo menos un número de teléfono en caso que el doctor necesite: decirte algo después que usted se va (.) se va(ya).
P5: Bueno, cuando venga mi esposo a lo mejor él le puede dar el número de su hermano.
I3: Well, when my husband cah- comes ah he can give you: (.) his brother's number.
P5: Él vive cerca de nosotros.
I3: He lives close to us.
S5: Alright. Who is your daughter's regular doctor?
I3: Okay. eh Está bien. uh Quién es el ah: médico de cabecera de su hi(ja).
P5: La doctora Katrina.
I3: The doctor Katrina.
S5: Doctor Katrina Sánchez?
I3: Katrina Sánchez?
P5: Sí.
I3: Yes.
S5: And do you have insurance?
I3: Usted tiene s- segura(n)za médica?
P5: Nada más el Medicaid.
I3: Eh just the >Medicaid<.
S5: Okay. Please let me have your Medicaid card for a moment so that I can make a copy of it.
I=
I3: =Po- I'm- Perdon. Por favor, puedo tener su tarjeta de Medicaid que yo- tengo que hacer- puedo hacer una copia.
S5: I will also need to make a copy of your drivers license.
I3: Y también tengo que hacer una copia de su licencia de manejar.
P5: No tengo licencia.
I3: I don't have (a) license.
S5: That's [ok-   ]
I3:   [drivers] license=

S5: =That's okay. Any [i-   ]
I3:   [está-] está bien.
S5: Any ID with photo (i)n- on it?
I3: ah: Tiene alguna idenfi- identidentificación que tenga su foto?
P5: Es que no tengo ninguna.
I3: No I don't have any.
P5: Antes tenía mi credencial para votar pero alguien me robó la cartera, y ahora no tengo nada.
I3: Before I- I had m- a card to vote, but then ah::m somebody stole my purse, and now I don't have anything.
S5: That's alright.
I3: Está bien.
S5: I need you to sign this form here, and here, ((*points at paper in front of Ms. Suárez as if indicating a signature line*)) and then I'll get you to Medicaid- I'll get your Medicaid card back to you in just a minute and then you can return to the waiting room.
I3: Uh Yo necesito que usted firme aquí e aquí (.) y: necesito um (.) ah excuse me nurse, could you repeat (.) again what you just said?
S5: And I'll ge:t(h)- and your Medic(h) cay car back- <u>card</u> back to you in just a minute, and then you can return to the waiting room.
I3: Ah >Yo necesito que usted firme aquí (y) aquí< entonce te doy de regreso su: tarjeta de Medicaid, y usted puede regresar a la sala de espera.
P5: Bien, gracias.
I3: Okay, thank you.

Dialog 3 - Conversation with physician
S4: Hello ↑again, Mister Rodríguez.
I3: Hola más una vez, Señor Mu- Rodríguez.
P1: Hola doctor.
I3: Uh Hello doctor.
S4: I just wanted ta talk to you about <one more thing> (.) before I discharge you today.
I3: Yo sólo tengo que: hablar con usté: sobre una cosa más ante que uste(d) se puede ir hoy.
P1: Oh, bien.
I3: Okay.
S4: It's very important (.) that you stop smoking.
I3: Es muy importante que usted deje de fumar.
S4: Your symptoms are caused (.) and (.) made worse by your smoking.
I3: Su síntomaz e- ah: estám empeorando e:- ea e quedándose más peor porque usted fuma.
S4: Even when you don't feel sick, smoking is very bad (.) for your health, and you will feel much better (.) after you quit.
I3: Ah:, mi- mihmo cuando usted no se sienta: mal, es vere- muy importante que usted no: no deje- >no fuma< um scuse me=
S4: =um hm=
I3: =doctor, can you repeat that again?
S4: Even when you <u>don't</u> feel sick, smoking is very bad for your health (.) <u>a:nd</u> you will feel much better after you quit.
I3: ah- uh- uh- mismo que usted no se sienta mal, ez uh muy importante que usted deje de fumar el fumar es uh: (.) muy malo para su saúde- para su salud (1) I stuck in the the

[last part]

S4: [And you] will feel much better after you quit.

I3: Y usted se va a sentir mejor uh después de que usted deje de fumar.

P1: Um Entiendo eso pero (.) pues:, muchas personas ya me han dicho eso pero yo no quiero dejar de fumar.

I3: I understand that. uh A lot of people told me that but I don <u>wanna</u> (.) ah quit.

S4: And why is that?

I3: Y por qué es eso?

P1: Porque me gusta:, y mi papá fumaba y él se murió hasta los noventa años. >De viejo se murió<.

I3: E:h Because I ↑like it and my father die(d) at ninety years old and he was a smoker, and he djie because he was old.

S4: <Be that (.) as it may>, it doesn't mean that <u>you</u> will live that long.

I3: Uh Pe- >pero eso no significa que <u>usted</u> va a vivir< ah: tanto com cua- así.

S4: And, as long as you smoke, your asthma and allergies (.) will continue to bother you.

I3: Y: hasta que usted esté fumando, sua sus alegias y su asma te van a estar (.) ah: dejando incómodo.

S4: And, youah at risk for cancer, <emphysema>, heart problems, and other diseases.

(2)

I3: Y uste:d todavía ahm t(i)ene- (.) Doctor, can you repeat please?

S4: And you are at risk

I3: And you eh- Y e >ustedes tiene riesgo de tener cáncer<, enfasima, y otroh problema de salud.

P1: Ah, le voy a decir algo muy sinceramente. A mí me gusta >hacer lo que me da la pinche< ga:na y no me importa cuántas personas que me digen que deje de fumar >no lo hago a menos que yo quiera hacerlo<. Si no fumo m- no me siento vivo el fumar es un placer, pues, chingá:, la gente hoy en día está obsesionada [por]

I3:   [s:-]

P1: la salud.

I3: Señor Jodríguez, por favor, será que usted puede leer en corta: s frases, y más
    [dehpacio]

P1: [<u>Oh</u>   ]

I3: por favor?

P1: Por su puesto, por su puesto.

I3: Gracias.

P1: Decía que- que le voy a decir algo muy sinceramente.

I3: Ah (.) wanna tel- tell you something and sincerely.

P1: A mí me gusta hacer lo que me da la pinche gana y no me importa cuántas personas me dicen que deje de fumar.

I3: Seño Rodríguez, yo tengo que interpretar todo lo que usté dice. Usted quiere que yo diga lo que usted está diciendo <u>así</u> como está diciendo al doctor?

P1: <Uh sí>, por favor.

I3: Puede repetir entonce

P1: Sí, digo que a mí me gusta hacer lo que me da la pinche gana, y no me importa cuánta gente me dice que deje de fumar.

I3: Uh:m- I wanna do whatever I feel like to do it, and I don- I don't care whatever people tell me, I don't gonna quit smoke.

P1: Y que yo no voy a dejar de fumar a menos que quiera hacerlo.
I3: And I'm not gonna quit smok in unless I wanted to do it.
P1: Porque si no fumo, no no no me siento vivo.
I3: Because if I don't smoke, I don't feel alive.
P1: El fumar es un placer, y: hoy en día (.) la gente está obsesionada por la salud.
I3: Ah: esmoke is a pleasure an: today people are obsess with uh smoke.
P1: Y que un hombre debe poder fumar si quiere, >qué fregaos<.
I3: e:ah and a man has to: smoke if h- he wants. I don't care.
S4: < ↑Alright. Very well then, Mister Rodríguez>.
I3: ↑Okay:, está bien Señor Rodríguez.
S4: I think I understand. I still <u>wish</u> (.) you'd quit smoking=
I3: =Yo [cre-]
S4:   [<u>But</u>-]
I3: I'm sorry doctor. Yo creo que entiendo, pero yo ehpe- ehperara que usté dejara de fumar, pero
S4: But I agree that <u>no one</u> can <u>force</u> you to do something you <don't want to do>.
I3: Pero entiendo que nadie te (.) puede decir que uste haga algo que usted no quiere hacer.
P1: ↑Bueno pues, le agradezco.
I3: Okay. I thank you.

Dialog 4 - Conversation with cashier
S4: ↑Okay, before you leave today, there are just a <u>few</u> things I need to go over with you.
I3: ah: Está bien. Antes que usted se va hoy, sólo tengo algunah cosas que tengo que revisar con uste(d).
P5: Está bien.
I3: Okay.
S4: <I see here you have no in:s:urance>. Is that correct?
I3: Yo veo aquí que ustéd no tene >seguranza< médica, Esto está correcto?
P5: Así es.
I3: Yes.
S4: Alright. We do ask our patients for payment at the time of service.
I3: (.hhh) N:- Nosotros (.) pedimoh al paciente que paguen momento del servicio.
S4: That means, we'd like you to pay <u>now</u>.
I3: Esto significa que nosotroh uh gustaríamo(s) que usted pagase ahorita.
S4: The minimum charge for the hospital i:s one hundred dollars.
I3: El mí:nimo:: ah pago para el hospital es: cien dólares.
S4: In addition to this, you will receive a separate bill from the emergency room physician, as well as from other physicians, if you received other services.
I3: En adición a esto, se va a recibir un bil separado por ah: el- el mer- emer- uh la sala de emergencia. Could you repeat after the emergency room please?=
S4: =You will receive a separate bill from the emergency room physician, as well as from other physicians, <u>if</u> you received other services.
I3: Ah de- u:li- de eh del centro de emergenciah va a recibir un bil separado de:- de- de- de- physicia- de médico, y si eh recibió ah atenció:n de otros- uh:m (1) deu- de otrah partes también uste se va a (   )
P5: Yo no tengo el dinero para pagar ahora.
I3: I don't have any money to pay now.

S4: ↑Okay. Do you: think you will be able to pay:: say: <in two weeks>?

I3: Está bien. Usted piensa que: va a poder pagah:: ah: en dos semanas?

P5: Y cuánto será?

S4: Weh=

I3: =And how much that is going to be? ((*quiet giggle*))

S4: Well, the charges aren't finalized yet. M-

I3: Okay eh no está finalizado todavía.

S4: The minimum charge is one hundred dollars, <u>but</u> (.) it's possible you may be charged more depending on the services you received today.

I3: El <u>mí:nimo</u> es cien dó:lares, pero ah: no está finalizado todaví:a. Depende de los >servicios que usté: reciba< (hoy).

P5: e Híjole, eso se me hace mucho. Por qué tanto?

I3: M- Wa- (Woa) uh, this looks like a lot. Why is that so much?

S4: That is just (.) what the hospital charges. I don't know how that is determined. Ih-

I3: Esto es sólo lo que el hospital ah le va a cobrar ah I don't know- yo no sé cómo (.) ellos cobran.

S4: If you are interested, there <<u>is</u> a financial assistance form> you can fill out.

I3: Si usted está interesado, tiene un:- <una forma> de asistencia que usted puede llenar.

P5: Sí, sí. Eso me gustaría mucho.

I3: Yes, yes. I would like that very much.

P5: Ojalá que me ayuden con eso.

I3: Ahm: I hope that (.) they help me with this.

S4: Here it is. One side is in English, the other side is in Spanish. You only need to fill out (.) one side, whichever language you feel most comfortable with.

I3: Aquí está. Este eh un lado está en español, otro lado estáeh inglés, >usté sólo necesita< llenar un lado. (s)e pue llenar que usté se siente más confortable.

(3)

P5: Ah muy bien. Y luego qué hago?

I3: Okay, and then (.) wh:at >do I need to do<?

S4: You will want to fill it out, an:d return it to us as soon as possible.

I3: Usted tiene que: llenar todo el eh eh (.) ah regresar a nosotros uh (   ) posible.

S4: Our business office will make a decision based on your family's income.

I3: eh:: Nosos- Nuestras oficinas van a:cer um: (.) Can you repeat that please?

S4: Our business office (.) will make a decision (.) based on (.) your family's income.

I3: Nuestras oficinas van a:cer un:: van a determinar cuá:nto: baseado em:: en cuá- el- en el ingreso de su familia.

P5: Téngame consideración por favor.

I3: Please be considerate with me.

S4: Well, like I said, it's based on your income, and the business office will make their decision and let youk know by mail if you qualify, and, if so, at what level.

I3: I'm sorry can you repeat=

S4: =um hm=

I3: =Uh there uh: and short please.=

S4: =Sure. Well like I said, it's based on your income.

I3: Ah a well a- como- como dije eh baseado en su ingreso.

S4: And the business office will make their decision.

I3: Y: la oficina va: va a:cer su decisión.
S4: And let you know by mail if you qualify, and, if so, at what level.
I3: Y- y te va a dejah saber por correo y: si sí en qué nivel.
P5: Muy bien, gracias.
I3: Uh ah eh, that s okay, thank you.