Analysing the healthcare interpreter's role in the "in-between": An exploratory study of patient-interpreter spoken interactions in a hospital setting

Cristina Álvaro Aranda

Abstract:
Research has greatly focused on the healthcare interpreters' role in the course of medical consultations, leaving other roles they play in different activities that are also part of their work context somewhat unattended. Drawing on the notion of "in-between spaces" (Shaffer, 2020), this paper explores the roles played by interpreters in moments when they are not interpreting and must choose whether to remain (in)visible. Participant observation, fieldnotes and interviews allow establishing different areas of in-between—waiting times, accompaniment stages, interrupted consultations, and consultations occurring in two physical spaces—where participants deploy different degrees of visibility translating into interpreter-patient rapport-building that may have a positive impact on subsequent interpreted medical consultations.
Keywords: healthcare interpreting, role, in-between, (in)visibility.

1. Introduction

Increasing migration movements have transformed the landscape of healthcare provision into multilingual and multicultural spaces where healthcare interpreters are increasingly required to enable communication in language-discordant encounters. The role that interpreters must play in this process has been a major focus of interest for researchers over the years (Liu & Zhang 2019). Different voices give way to different conceptualisations, from more static visions of interpreters as neutral, non-involved linguistic machines to active participants deploying agency and exercising power, with more recent calls highlighting role fluidity to meet social and interactional needs or institutional constraints (Angelelli 2004, 2019; Major & Napier 2019).

The underlying issue of interpreters' (in)visibility is often at the core of this debate. Despite solid evidence supporting interpreters' visible participation in different ways—as moral mediators (Seale *et al.* 2013), patient empowerers (Hsieh, 2013), co-interviewers (Suurmond *et al.* 2016), advocates (Zendelel *et al.* 2018), etc.—they often "espouse invisibility" (Marin, 2020). Guiding documents sustain the idea of interpreters as conduits rendering messages in the most uninvolved way possible (Li *et al.* 2017). Furthermore, the discourse embodied in codes of ethics, and thus prevailing in training and professional circles, is firmly rooted on the idea of healthcare interpreters as neutral non-people (Martínez-Gómez 2015). In this direction, objectivity, neutrality and distance are common words to depict the role of *professional* interpreters, which further supports their image as communication tools or conduits, in detriment of alternative discourses highlighting their visibility (Shaffer 2020).

The construct of role in healthcare interpreting has been largely studied in the course of medical consultations in varied settings, such as audiology (Penn *et al.* 2010) or oncology (Butow *et al.* 2011). However, job specifications and employment contexts may require healthcare interpreters to perform tasks beyond facilitating communication in medical interviews, which may include accompanying (Bischoff *et al.* 2012) or guiding patients

(Angelelli 2019). Thus, healthcare interpreters are left alone with just one of the participants of triadic exchanges. These moments reveal additional areas of special complexity for the interpreters' role that have been recently defined as "in-between spaces" (Shaffer 2020), understood as times and sites when healthcare interpreters are not actively interpreting, but are presented with the choice whether to remain invisible or not.

In-between areas, however, have not been fully analysed. Drawing on Shaffer (2020), this paper aims to study the roles performed by a sample of five healthcare interpreters in moments of in-between that occurred at a public hospital in Madrid, Spain. Data presented in this paper is part of a larger study and was collected by a series of qualitative techniques, i.e. participant observation, fieldnotes and interviews. By analysing visibility manifestations in the in-between, I set out to explore the functions and implications these entail for healthcare interpreting as a professional activity.

2. The notion of role in healthcare interpreting

A role is conceived as a coherent cluster of behaviours shared between a group of individuals fulfilling the same position in society and as a pattern of behaviour expected by other societal segments (Havighurst & Neugarten 1962). Roles, as Herrmann *et al.* (2004) note, have four characteristics: 1) position in a social group, which entails a series of 2) functions and tasks, usually made explicit in the form of documented rights, expectations and obligations (e.g. job descriptions). Additionally, roles include 3) non-explicit behaviour expectations, covering informal notions and agreements, and 4) social interaction, which is a direct result of a "negotiation between role actor[s] and those with whom [they] interact" in the social system. In summary, roles are externally imposed onto the individual by societal norms, shaped in interaction with others and influenced by the structural system in which they take place (Benamar *et al.* 2017).

Social impositions or expectations, interactional influences and structural constraints are useful elements to understand the complexity embedded in the role(s) of healthcare interpreters. Firstly, the set of problems that interpreters need to solve has not yet been specified; it could be said that the main problem is unsuccessful communication between two individuals that speak different languages, but there is no consensus regarding how healthcare should approach this problem and the role(s) they must assume in the process (Lázaro Gutiérrez 2014). This interprofessional lack of definition is reflected in tensions between what normative conduit-based models prescribe healthcare interpreters to do in professional codes of ethics and their actual behaviour in interactional practice (Martínez Gómez 2015; Major & Napier 2019). Additionally, there is a lack of familiarity among patients and other collectives with the interpreters' role. They may have expectations about interpreters' responsibilities and tasks that may not correlate with what they can or cannot do in practice (Angelelli 2019). This is particularly relevant when interpreters are employed by an organisation, as they may be required to perform duties other than facilitating communication, such as scheduling appointments (Souza 2020). The coexistence (and sometimes collision) of all these factors tug interpreters in different directions, who are left conflicted about how to balance these forces in the search of their role.

Thus, it is not surprising that the notions of institutional, interpersonal and social restrictions (Angelelli 2004), issues of power (Mason & Ren 2012) and interactional objectives (Zorzi 2012) have heavily influenced research on role. Under this prism,

healthcare interpreters play different roles depending on the context, its needs and restrictions, adopting several identities in the same communicative event that are negotiated and (co)-constructed in interaction (Zorzi 2012; Martínez Gómez 2015; Angelelli 2019). Research thus reveals interpreters moving along a scale of invisibility and visibility, acting as linguistic converters in their default role and surpassing it to clarify cultural differences (Rosenbaum *et al.* 2020), keep the medical interview on track (Davidson 2000), initiate information seeking (Suurmond *et al.* 2016), empower patients (Hsieh 2013) or provide emotional support (Lara-Otero *et al.* 2019). And, despite the evidence, stepping away from the conduit role entails going against industry expectations and standard practices (Shaffer 2020). To address this tension, interpreters find an invisible space where to become visible in the in-between (*ibid.* 191).

3. Defining in-between spaces

Following Shaffer (2020), I will use the expression in-between spaces to allude to sites and times when healthcare interpreters are not involved in interpreting and must face the choice to remain (in)visible. For this author, moments of in-between occur before healthcare providers arrive or when they step away, and may take place in three different physical places, i.e. the examination room, the waiting room and the in-patient hospital room. When unaccompanied by a member of staff, healthcare interpreters of the study are expected to follow the "leave the room practice", that is, leave the presence of the patient, as dictated by the hospital policy or the interpreting agency. However, in-between spaces present a major source of tension where healthcare interpreters must choose whether to stay or leave; whether to become visible or not. They must juggle imposed expectations and additional elements, such as the patient's vulnerability and derived feelings of compassion. In these complex moments, the notion of healthcare interpreters as conduits clashes with that of community partners.

4. Methodology

Based on a dataset collected at a public hospital in Madrid (Spain) over a period of five months in 2017, this exploratory study sets out to analyse how a sample of five participants conduct themselves in in-between spaces. Data presented in this paper is part of a wider dataset that the author collected for developing her doctoral dissertation (Álvaro Aranda 2020)[1]. For the purposes of this paper, we will focus on a subset of spoken interactions that occurred between patients and healthcare interpreters. Collection of data was performed using participant observation. No audio or video recording could be obtained due to several factors (i.e. background noise, sensitive nature of the setting, other patients' privacy when they were sitting in the same room). These elements impeded full registration of conversations and their

1 This research presents an ethnographic case study exploring differences in the performance of healthcare interpreters depending on their levels of specialised training and professional experience. After presenting the study to staff at positions of responsibility at the interpreters' organisation and signing a confidentiality form, permission was granted to perform participant observation twice a week. All participants—patients, interpreters, providers—granted oral consent prior data collection in individual sessions.

subsequent transcription, but illustrative excerpts were documented through fieldnotes. Additionally, interpreters were interviewed at different moments to gain some insight into their perceptions. Interviews were recorded and subsequently transcribed for analysis.

5. Participants

5.1. Interpreters

Five interpreters took part in the study. To preserve their identity, fictitious names were assigned to participants (see Table 1). One of the interpreters held a degree in Translation and Interpreting and also received on-the-job training in interpreting and intercultural mediation in healthcare settings for a month. This interpreter had worked at the hospital where data collection took place for four years. Remaining participants were students enrolled in the MA in Intercultural Communication, Interpreting and Translation in Public Services[2] offered at the University of Alcalá (Spain) who were doing their internships for approximately a month. As part of the programme, students are required to complete a specific module in healthcare translation and interpreting. Among other contents, students are introduced to different techniques (consecutive and simultaneous interpreting, sight translation, note taking, etc.), codes of ethics and specialised terminology. The interns had no previous formal professional experience in healthcare interpreting. Concerning their undergraduate background, they pursued studies in Modern Languages, Interpreting and/or Translation. The job description for participating interns specified that students were expected to interpret in medical consultations and, occasionally, healthcare promotion workshops, as well as carrying out punctual translations of informative materials (e.g. brochures).

	Status	Age	Gender	Professional experience	Nationality	Mother tongue	Working languages
Lucía	Staff interpreter	28	F	4 years	Spanish	Spanish	Spanish<>French, English, Arabic
Sandra	Intern	23	F	N/A	Spanish	Spanish	Spanish<>French
María	Intern	22	F	N/A	Spanish	Spanish	Spanish<>French
Viviana	Intern	23	F	N/A	Spanish	Spanish	Spanish<>French
Javier	Intern	22	M	N/A	Spanish	Spanish	Spanish<>French

Table 1 *Main characteristics of interpreters*

5.2. Patients

Except for very few isolated cases, interpreters interacted with male patients. Most of them fell within an age range of fifteen to thirty years old and came from Sub-Saharan African countries, such as Cameroon, Nigeria or Guinea. The patients' mother tongues were very varied, ranging from Wolof to Bambara, Susu, Koniake, Pulaar or Malenke. French was used as a lingua franca in all interactions with healthcare interpreters presented in this paper.

2 http://www3.uah.es/master-tisp-uah/presentacion/

6. Context of the study: a normal day at the hospital

The hospital is divided into separate buildings which further split into different departments and wards. Interpreters have their own physical office in one of the buildings, strategically located in an area that receives a large number of non-Spanish speaking patients on a daily basis. When one of these patients arrives, either alone or accompanied by an NGO volunteer, they hand in an appointment slip to the secretary at the reception and wait in a sitting area in the corridor. If the patient has an appointment in the area next to the interpreters' office, one of the doctors approaches this space to ask for assistance. However, some of the patients' appointments require visiting another building. Sometimes they need to hand in urine/stool samples, have a blood test, x-ray or ultrasound exam, or receive medical attention in a specific ward elsewhere. On these occasions, the secretary heads to the office and informs the interpreters about the case. One of the interpreters—sometimes two, if the staff interpreter opts to assess interns' performance or requests them to watch hers—subsequently leaves the office and meets the patient in the waiting area. After greeting each other, the interpreter accompanies the patient to their appointment, hands in slips if necessary, waits with them and usually walks them to the exit. Interpreters are required to fill in a form describing the main features of each particular case (name of the patient, age, country of origin, etc.), which also contains a section where the patient is asked to rate the service provided.

7. Finding the in-between

Participant observation in this study reveals different moments leading to the in-between that serve to complement Shaffer (2020). These occur 1) when providers leave the room in the middle of the consultation whilst the interpreter and the patient wait for their return. On the other hand, when appointments take place in the medical area next to the interpreters' office, medical providers develop the interview, physical examination and prescription of treatment in a consultation room, but they must go to the secretary's office to collect materials or print out documents. Some other times a consultation room does not have an examination table and a shift of space is required to perform a physical examination. On these occasions, there exists 2) an intermediate pause where patients are asked to either accompany the provider to this space, sit in the waiting area or stay in the corridor, which presents interpreters with the choice of distancing themselves or staying with the patient. Additionally, interpreters may choose to become visible when they 3) accompany patients to different areas of the hospital, implying moving down corridors, taking the lift or the stairs and even stepping out into the street if an appointment is scheduled in a different building of the hospital. Finally, 4) waiting times can also create an area of in-between. These moments occur in waiting rooms or when interpreter and patient need to queue, for example, to hand in samples.

8. Analysis

This section examines illustrative excerpts obtained by means of fieldnotes and interviews. Interactions occurred in Spanish and/or French, but for reasons of space and clarity they have been translated into English in this paper. I include references to the original language

between parentheses, whereas brackets are reserved to indicate actions, body language, pauses or silences. Finally, the label (Interpretation to 'language') represents rendering of messages by an interpreter of the sample.

8.1. When the interpreter accompanies the patient

One of the most recurrent moments in-between takes place when interpreters step out of the office to meet patients in the waiting room to subsequently accompany them. After initial greetings and introductions that precede moving to another building, participants usually participate in small talk (e.g. weather talk) and/or provide information regarding the reason for the patient's hospital visit or the location of a specific area in the institution. This is best illustrated through examples:

(1) (French) 1 María: You are gonna get the Mantoux test today. Do you know what that is?

[The patient shakes his head]

2 María: No? Well, it's a test to see if you have been around people with TB. You cannot scratch the area in 72 hours or you will get a positive test result. It'll leave you with a little scar, but don't worry about it, it will disappear with time.

In case 1, the secretary informs the interpreters that a patient is waiting at the sitting area for someone to accompany him to get a Mantoux test. María steps out of the office to meet him and introduces herself before indicating him to follow her. Far from staying silent before they reach the nursing area, María becomes visible by asking the patient if he is familiar with the test, to subsequently describe it and provide some general instructions.

Thus, María considers this moment as an opportunity to educate the patient and alleviate potential concerns due to a lack of specialised knowledge. This kind of behaviour is particularly recurrent in all interpreters. None of them appear troubled to use these moments alone with patients to temporarily adopt the healthcare provider's role and offer information belonging to the medical field. It should be noted, however, that in some other examples patients ask participants specific questions regarding medical concepts in the in-between, which interpreters refuse to answer by establishing professional limits and reminding patients that "they are not doctors."

Additionally, interpreters may step into the field of visibility to pursue a different goal during accompaniments. On these occasions, they resort to jokes and humour or light, informal conversation in an attempt to connect with the patient and earn their trust.

(2) (French) 1 María: Was Cristina nice to you? I'm going to tell our bosses otherwise!

[The patient remains silent for a few moments and then laughs]

2 Patient: No, no, she was kind to us.

3 María: Good.

Case 2 is a prime example to illustrate how healthcare interpreters of this study become visible to patients to make them feel at ease before they receive medical attention. In this scenario, the patient is a sixteen year old Ivorian male that has attended the hospital on a

previous date. The author of this paper accompanied him to get a blood test done, which is known by María. The patient stays silent until the interpreter initiates small talk and resorts to a humorous tone which is successfully reciprocated by the patient. María presents herself as a professional by alluding to an existing hierarchy at the institution ('I'm going to tell our bosses'), but also tries to build rapport, almost as a partner. In other cases, patients are the participants who seek constructing a connection with interpreters. These initiatives are habitual when patients have worked with interpreters before and recognise them. Previous experiences seem to originate a shared ground leading to a somewhat cordial relationship. Some patients, for example, inquire about the interpreters' well-being or ask interns about the end date of their time at the hospital.

Participant observation in this study reveals that accompanying patients is a frequent and productive moment of in-between that interpreters may use to educate patients or connect with them. In the first case, it seems that they align themselves with the institution and somehow present themselves as part of the staff, as they provide medical information concerning different elements. In the eyes of some interpreters, connecting with patients in these spaces necessarily implies moving beyond being an *interpreter*, incorporating additional social roles and responsibilities that they attribute to other professional figures.

> (Spanish): Javier: I think that interpreting is a part of mediation. Basically. That is what I learned here. Because after when I, when you accompany patients, you are not interpreting there, but you are… That little walk from one building to another (…) When they talk that they complain [He corrects himself] that we always complain about the weather, or stuff like that. That is not interpreting anymore, that is… Chit-chat, talking.

Javier describes accompanying patients as a stage when he sheds himself of his default conduit role. He steps outside an imposed identity and enters a territory of visibility clashing with traditional views of interpreters as depicted in codes of ethics or good practice guidelines. As chit-chat transcends what Javier considers to be the interpreter's role, he mentions the figure of the intercultural mediator, implying that he assumes other roles that he attributes to professionals who, in his opinion, are allowed more visibility in their work. However, informal chat with patients sometimes comes with a risk. Viviana describes the following situation:

> (Spanish) Viviana: (…) And when we were going to leave he told me… On Saturday… Were you waiting on someone? Were you going to pick someone up? I said yes, I was going to see my friends. And then he said, you looked wonderful on Saturday. When I saw you, you looked wonderful. And I said wonderful, what? I did not know what to say, I did not understand, I did not know if I had understood correctly. And he said yes, you looked wonderful. (…) Then he said what time do you finish work and when do you start? (…) And I said, well, I say thanks, see you next time (…) And then I realised that he really wanted to know if I was going to meet someone, someone *else*. My schedule, it was for… And then I realised that, yeah… (…) And no, you have to stop that.

Viviana describes a personal experience involving a patient with whom she has previously interacted on several occasions. After accompanying him to the area where he had a Traumatology consultation and later on scheduling a subsequent appointment, Viviana

walks the patient to the exit. Instead of saying goodbye to close the interaction, the patient brings up a fortuitous encounter that occurred a few days earlier outside the medical facility and inquires the interpreter about it. This time, however, the patient does not seek to build rapport with Viviana by means of informal talk, but rather makes flirtatious comments that bring discomfort to the interpreter. Once she becomes aware of the patient's intentions, she adopts an uninvolved position and prompts the end of the interaction. Thus, by presenting themselves as visible in moments in-between, interpreters may face situations when patients expect them to exceed professional boundaries. These cases could be labelled as situations that interpreters participating in Shaffer (2020: 197) define as a 'can of worms', when patients consider interpreters to be more companions than professionals.

8.2. When the interpreter waits with the patient

When interpreter and patient arrive to a specific area of the hospital, they often wait for some time before entering the consultation room. These moments of in-between may unfold quite differently. If patients behave in a way that has made the interpreter feel uncomfortable during the accompaniment stage, participants in the sample willingly sit somewhere else. On the other hand, and as noted by Shaffer (2020: 196), the interpreter also follows the patient's level of interest and acts accordingly. Interpreters sometimes sit next to the patient in the waiting room and discuss trivial matters, which allows passing time and strengthening a potential connection between both individuals. This is a situation that usually occurs when patient and interpreter know each other. For example, one of the patients shares with Sandra some details about his life in his country of origin whilst they wait for the patient's name to be called. What is particularly interesting about these situations is that they may have an influence in the subsequent consultation.

(3) (Smiling tone)

(Spanish) 1 Doctor: Have you had protected sexual relations with all those hundreds of girls?

2 (Interpretation to French)

[The patient laughs]

(French) 3 Patient: Yes, except the mother of my son.

4 (Interpretation to Spanish)

(Spanish) 5 Doctor: How old is your son?

6 (Interpretation to French)

(French) 7 Patient: A year and eight months. These questions are really hard.

[The patient has tears in his eyes]

8 (Interpretation to Spanish)

(Spanish) 9 Doctor: Why?

10 (Interpretation to French)

(French) 11 Patient: They make me remember things I do not like.

[The patient turns to the interpreter]

(French) 12 Patient: When you asked me if I was really young when I left my country is because of all of that. It is difficult to have a child in my country, be Muslim and not be married. One day the mother of my child gets married and leaves the child with my

parents. I do not like to talk about that.

13 (Interpretation to Spanish)

(Spanish) Sandra: He is telling me, because we have been talking before.

14 Doctor: I can imagine that it is hard, [name of patient]. We are going to think that this is for your son's health. We are going to take care of your health.

15 (Interpretation to French)

In this STD consultation the patient is asked about previous sexual partners and contraceptive use to determine the risk of sexually transmitted infections. He is uncomfortable and tries to avoid answering, sometimes laughing nervously. The doctor succeeds to obtain some information by resorting to a humorous tone, but the interview takes a different direction once the patient expresses how he feels. When prompted to elaborate by the doctor, he turns to Sandra and brings up the conversation they held in the waiting room. The previous connection they formed in the in-between translates into a certain degree of willingness to share delicate information with the interpreter that is later on rendered to the doctor.

Returning to the in-between, and as observed in accompanying stages, interpreters often appear as conversation partners in waiting times. However, they are aware that visibility demonstrations in this area of in-between contradict their prescribed role and even their training:

> (Spanish) Viviana: Well, the deontological code tells you that outside of the consultation room it is over. Well, listen, well, it is not like that, it is not real. Many times… And accompanying them and maybe talking to them… The deontological code… Many lecturers tell you: 'No, when you are in the corridor you do not need to talk to him, you move away from him, so as not to create a bond.' But that is really complicated. And I ask myself: 'Why?' Well, I am not going to create a bond with the patient because… But why not talk to him? Why not make those people who have a hard time smile? And at least make them smile, I think that is really important. So the deontological code yes, it is applied, maybe more in the consultations than outside, but there are things that, that cannot be like that one hundred percent.

It is revealed in this interview that Viviana finds it justifiable to interact with patients, even if this implies flouting her code of ethics occasionally. This testimony is in line with voices that reveal disparity between prescribed and actual behaviour of interpreters in practice. Emotions seem to come to the fore in this decision, as Viviana seeks to 'make those people who have a hard time smile.' Following Shaffer (2020: 202), the in-between is a place that can be filled by compassion, pushing aside what is expected as standard behaviour for a professional interpreter. That being said, Viviana highlights that she never intends to create a bond outside of the consultation but, rather, tries to ensure that patients' have a positive experience in the hospital. She finds a space where to pursue this goal in the in-between, which she considers a sociological place that follows a different set of rules to those governing consultations.

Waiting times can also be home to opposite scenarios. Patients may take a seat away from interpreters or busy themselves with their phones, remaining disinterested or

unresponsive in interacting with interpreters. In these cases, participants are seen respecting the patient's space. There are, however, certain occasions when interpreters breach this principle and approach patients to inquire about the nature of the appointment:

> (Spanish) Lucía: It is useful if you have the chance to do it to anticipate potential difficulties or look up some vocabulary. The patient had an ultrasound and a semen analysis done and he comes to know the results.

As described by Lucía, waiting times may be good opportunities for interpreters to obtain information that can facilitate the subsequent encounter, which is particularly interesting if they have not been briefed before.

8.3. When doctors leave the consultation room

The in-between can also occur when doctors leave the consultation room before the medical interview comes to an end. This situation is caused by different reasons. Amongst others, doctors may need to collect materials somewhere else or may wish to discuss certain topics with other colleagues. In any case, patient and interpreter are left to each other's company. Participant observation reveals both visible and invisible behaviours. Interpreters sometimes avoid eye-contact and focus on their notebooks or mobile phones. For their part, patients may also choose to remain silent. The opposite scenario is observed in other cases:

(4) [Three doctors leave the consultation room. The interpreters stay with the patient]

(French)
1 Sandra: Are you okay?
2 Patient: I have questions…
3 Sandra: But ask him.

[Pause]

4 Sandra: Where are you from?
5 Patient: Cameroon.
6 Sandra: Do you speak more languages?
7 Patient: No.
8 Sandra: Just French?
9 Moussa: [Name of the patient], do you speak Wolof?
10 Patient: No.
11 Sandra: I am doing my internship here, and she [points at the author of the paper] is doing a study.
12 Patient: I want to know more about loa loa.

[The interpreter takes out her phone, searches the word on the internet and then hands her phone to the patient]

This follow-up appointment in Tropical Medicine involves the participation of a twenty-seven year old Cameroonian patient, three doctors and two interpreters. One of the doctors is a consultant and the remaining professionals are residents. Regarding the interpreters, Sandra serves as a communication bridge whilst she is supervised by Moussa, an interpreter outside the sample used in this paper. The patient is informed about the results of some previous tests, which point out to a number of illnesses. Upon hearing the news, the

patient shows distress, curses and has teary eyes. He asks questions to seek clarification, sometimes to Sandra, and she encourages him to inquire the doctors of unknown concepts in different moments of the encounter.

At one point the medical professionals leave the room to collect materials for an additional test, thus creating a moment of in-between. Sandra seizes the opportunity to ask the patient if he is okay and, once more, urges him to pose questions to the doctor. Subsequently, Sandra initiates small talk, an attempt to distract the patient and build rapport which is supported by Moussa, but not reciprocated by the patient. He replies with one-word answers and shows no interest in small talk, redirecting the conversation towards loa loa, his main concern. Once more, the interpreter surpasses her role as a conduit and takes it upon herself to educate the patient by providing him information on her phone. Compassion seems to be the underlying reason for Sandra's decision.

Moments of in-between occurring in the middle of a consultation can also trigger conflictive situations for interpreters if patients share information when the doctor is not present. This is one of the main reasons why standard practices highly recommend interpreters to avoid staying alone with patients. Viviana and Lucía share their impressions concerning these situations:

> (Spanish) Viviana: I stayed alone with the patient, who told me that he had taken antibiotics for four days and they were doing nothing. When the doctor returned I told her directly.
> Lucía: In these cases I say to the patient: 'OK, say it all when the doctor comes back.' If patients are educated I stay when the doctor leaves and ask them things about the socio-political situation of their country. If not, if I think they are going to flirt with me, I walk out when they doctor does and I say: 'I will be right back, I am going to collect some papers.'

Whereas Viviana informs medical staff about information shared in the in-between, Lucía instructs patients to repeat it themselves once professionals come back. Thus, Viviana collects information in the in-between that translates into visibility when the consultation restarts, as she voices it herself. For her part, Lucía becomes visible in the in-between by instructing patients, to later on remain in the background when patients themselves take the floor and explain the situation to medical staff upon their return. Lucía comments on another aspect that affects whether she stays alone with patients. Depending on the patients' educational level and presumed intentions, she may choose to stay if she can discuss light topics that allow connecting with them or, contrarily, she may opt to leave the room if patients have intentions that put her in a difficult position. This statement gives weight to the idea that social interaction affects the interpreters' choices regarding their role not only in the course of medical consultations, but also in the in-between. Lucía avoids situations that can lead to uncomfortable situations, as these come in conflict with external restrictions on her professional role.

8.4. When the consultation takes place in two different physical spaces

The last area of in-between occurs when medical consultations take place in two separate physical spaces. This may be caused by two different reasons. Doctors may initiate the medical interview in a room that does not have an examination table, which implies moving

to a different space. On the other hand, sometimes consultation rooms do not have printers or materials and doctors must go to the secretary's office to either collect these or print out documents. At any rate, there is an intermediate pause in the course of the consultation that creates the in-between. Interpreters sometimes walk next to the doctors or follow them into the secretary's office, thus separating themselves from the patient. In opposite situations, they stay with the patients and become visible to varying extents.

(5) [The doctor abandons the consultation room and walks to the secretary's office. Sandra and the patient wait in the corridor. The interpreter seizes the opportunity to fill in a form and asks the patient about his level of satisfaction with the service provided]

[Smiling tone]

(French) 1 Patient: I am ill, I cannot complete the interview.

[The interpreter laughs]

2 Patient: Where is your colleague?

3 Sandra: She finished her internship.

4 Patient: When do you finish?

5 Sandra: On [xx] of [Xxxxx]

6 Patient: But… Why am I ill? Why do I have this in my heart?

7 Sandra: Because you have a lot of love to give.

[The patient laughs]

Case 5 depicts a follow-up appointment involving a thirty-three year old Ivorian male patient with a history of high blood pressure. After an introductory round of questions, the doctor measures the patient's blood pressure and comments on his diastolic pressure. The patient laughs in despair and tells the doctor that he does not understand why he has that health problem, giving the professional a chance to assure him that they will find the cause. Afterwards, the doctor tells the patient that they need to go to the secretary's office to print out his next appointment slip. Sandra meets the patient in the corridor and uses this opportunity to fill in the form that needs to be completed for each interpreting session. As both participants know each other, the patient uses a humorous tone and inquires about Sandra's colleague, which subsequently turns into a serious conversation when the patient voices his concerns. In this case, the in-between starts as an additional phase that the interpreter uses to perform a professional task imposed by the institution—i.e. completing a form—that evolves into small talk, and ends with the interpreter resorting to humour to appease the patient. The interpreter provides emotional support in this in-between moment.

As seen in other examples, the in-between that takes place in these spaces is also used to further build rapport between patients and interpreters.

(6) (French) 1 Lucía: She will be right back. She is going to see if she can ask for that test apart from the other tests because it would not be the same, but it would not be urgent.

2 Patient: Okay.

3 Lucía: How is your baby?

4 Patient: Good, it is a little girl.

5 Lucía: Congratulations!

6 Patient: Thanks.

7 Lucía: I think that my blood group is [X] or [Y]. Some people have medals with their groups. Have you seen it? Once a patient had allergy to many things and we made him a medal with all of that and he always used to forget it at home.

[The patient turns to the secretary]

8 Patient: Lucía does not know her group either! Do you?

9 (Interpretation to Spanish)

[The secretary shakes her head and the patient laughs]

Case 6 takes place at the secretary's office after the first stages of a follow-up encounter have been completed in a different space. The doctor prints out the next appointment slips and hands them in to the patient, who asks for an ABO typing to determine his blood group. The doctor leaves the area to forward the question to a more experienced colleague, creating a special kind of in-between where the secretary is also present. Lucía does not present herself as a detached professional in the in-between, but rather a companion, and seeks to strengthen rapport with the patient by bringing up a series of neutral topics that she knows from previous interactions with the patient (i.e. family). She does not seem conflicted to abandon her conduit role and become visible in the presence of another professional. Interestingly, the patient does not only co-construct the interaction, but also seeks to involve the secretary in the small talk that occurs until the doctor returns.

9. Becoming visible: stepping into the in-between

In-between moments emerge as areas of particular interest and complexity that need to be taken into account to approach the role of (healthcare) interpreters. Analysis reveals that spaces-in-between hold great potential for interpreters to transcend imposed identities; they open up opportunities for interpreters to become *visible*, to reveal themselves as active participants, and not just someone else's voice.

Areas of in-between are less structured and seem to be suspended in the interaction, governed by a series of rules less strict than those found in the course of consultations. In intermediate spaces, interpreters seem less conflicted to step outside pre-defined boundaries, as established by codes of ethics or standard practices. They are observed providing medical information and emotional support, engaging in humour and small talk, connecting with patients or encouraging them to pose questions.

Roles enacted in the in-between do not only play a function in building interpreter-patient rapport, but evidence found in this study also suggests that they may have a positive impact in the consultation and, thus, patient-provider relationship. For example, if interpreters build trust with patients in the in-between, the latter may find it easier to discuss delicate topics when inquired by medical staff. In-between spaces thus offer interpreters an opportunity to explore and pour their power in the interaction. This can be thought of as a departing point from which to revisit the role of the interpreter, with special emphasis on its potential in spaces that move beyond consultations. Instead of forcing invisibility on healthcare interpreters, it may be interesting to study the impact of their visibility manifestations in the in-between.

It is, however, important to note that in-between spaces are not 'lawless areas.' Sometimes interpreters remain silent—and thus invisible—in the in-between. They are also seen refusing to engage in conversations that entail surpassing professional limits if, for instance, patients make flirtatious advances. For this reason, in-between spaces must be entered carefully, as they can potentially lead patients to build expectations that put interpreters in uncomfortable situations where limits need to be established.

Areas of in-between must be understood as social places of special friction where the concept of visibility acquires special relevance, usually accompanied by a severe deconstruction of more traditional views of interpreters as linguistic machines. Thus, the in-between is particularly sensitive to dissolution of borders and boundary crossing with regards to the healthcare interpreters' ascribed role.

The level of visibility that interpreters deploy in the in-between may vary, but it is particularly noticeable when interpreters accompany patients. These in-between areas, together with the ones resulting from consultations being held in two different physical spaces, represent an extension from the areas of in-between defined by Shaffer (2020). Thus, it can be said that institutional expectations and impositions, described by means of job offers and healthcare centres' policies, together with contextual and interactional factors, may affect where and how the in-between emerges as a sociological place. Further studies will help to broaden our knowledge of the in-between and potentially find new areas of interest that, in turn, will help to advance research on role.

10. Future research

This paper set out to explore the in-between as a social area of interest for approaching the role of healthcare interpreters. Participant observation in this paper supports and broadens Shaffer (2020) findings, but also opens up new questions that need to be addressed with complementary research. More precisely, interpreters of this study did not share a cultural background with the patients, hence making it worth investigating if sharing cultural roots affects interactions in the in-between. Additionally, analysis in this paper deals with a limited number of examples. Thus, conclusions need to be further validated against a wider dataset reflecting areas of in-between in different healthcare institutions, ideally in other regions of Spain and maybe countries, or even in different public service settings. These additional approaches are necessary to further understand how moments in-between may affect subsequent interactions where medical staff is present, as well as their potential benefits in language-discordant consultations.

References

ÁLVARO ARANDA, Cristina. 2020. *Formación y experiencia profesional como diferenciadores en la actuación de intérpretes sanitarios: un estudio de caso desde la sociología de las profesiones.* Unpublished doctoral Dissertation, University of Alcalá.

ANGELELLI, Claudia. 2004. *Revisiting the interpreter's role: a study of conference, court, and medical interpreters in Canada, Mexico and the United States*. Amsterdam & Philadelphia: John Benjamins Publishing Company.

ANGELELLI, Claudia. 2019. *Healthcare interpreting explained*. Oxon & New York: Routledge.

BENAMAR, Lamya, BALAGUÉ, Christine, GHASSANY, Mohamad. 2017. The identification and influence of social roles in a social media product community. *Journal of Computer-Mediated Communication* 22 (6), pp. 337-362.

BISCHOFF, Alexander, KURTH, Elisabeth, HENLEY, Alix. 2012. Staying in the middle. A qualitative study of health care interpreters' perceptions of their work. *Interpreting* 14 (1), pp. 1-22.

BUTOW, Phyllis, BELL, Melaine, GOLDSTEIN, David, SZE, Ming, ALDRIDGE, Lynley, ABDO, Sarah, MIKHAIL, Skye Dong, IEDEMA, Rick, ASHGATI, Ray, HUI, Rina, EISENBRUCH, Maurice 2011. Grappling with cultural differences; communication between oncologists and immigrant cancer patients with and without interpreters. *Patient Educ Couns* 84 (3), pp. 398-405.

DAVIDSON, Brad. 2000. The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics* 4 (3), pp. 379-405.

HAVIGHURST, Robert & NEUGARTEN, Bernice. 1962. *Society and education.* New York: Allyn & Bacon.

HERRMANN, Thomas, JAHNKE, Isa, LOSER, Kai-Uwe. 2004. The role concept as a basis for designing community systems. *Journal of Computer-Mediated Communication*, 22 (6), pp. 337-362. Available at: <https://doi.org/10.1111/jcc4.12195>

HSIEH, Elaine. 2013. Health literacy and patient empowerment: The role of medical interpreters in bilingual health care. In DUTTA, M., KREPS, G. (Eds.). *Reducing health disparities: communication intervention*. New York: Peter Lang.

LARA-OTERO, Karlena, WEIL, Jon, GUERRA, Claudia, CHENG Janice K.Y., Youngblom, Janey, Joseph, Galen. 2019. Genetic counselor and healthcare interpreter perspectives on the role of interpreters in cancer genetic counseling. *Health Communication* 34 (13), pp. 1608-1618. Available at: <https://doi.org/10.1080/10410236.2018.1514684>

LÁZARO GUTIÉRREZ, Raquel. 2014. Use and abuse of an interpreter. In VALERO GARCÉS, C.; VITALARU, B. & MOJICA LÓPEZ, E. (Eds.). *(Re)considerando ética e ideología en situaciones de conflicto=(Re)visiting ethics and ideology in situations of conflict*. Alcalá de Henares: Servicio de Publicaciones de la Universidad de Alcalá, pp. 214-221.

LI, Shuangyu, GERWING, Jennifer, KRYSTALLIDOU, Demi, ROWLANDS, Angela, COX, Antoon, PYPE, Peter. 2017. Interaction—a missing piece of the jigsaw in interpreter-mediated medical consultation models. *Patient Education and Counseling* 100 (9), pp. 1769-1771. Available at: <https://doi.org/10.1016/j.pec.2017.04.021>

LIU, Yubo, ZHANG, Wei. 2019. Unity in diversity: mapping healthcare interpreting studies (2007-2017). *Medical Education Online,* 24 (1), pp. 1-14. Available at: <https://dx.doi.org/10.1080%2F10872981.2019.1579559>

MAJOR, George, NAPIER, Jemina. 2019. 'I'm there sometimes as a just in case': Examining role fluidity in healthcare interpreting. In *Multicultural Health Translation, Interpreting and Communication*. Routledge, pp. 183-204. Available at: <https://doi.org/10.4324/9781351000390>

MARIN, Jasmine. 2020. A medical interpreter training program and signed language interpreters' decision latitude: Exploring the impact of specialised training. In SOUZA, I. & FRAGKOU, E. (Eds.). *Handbook of Research on Medical Interpreting*. Hershey: IGI GLOBAL, pp. 421-455.

MARTÍNEZ GÓMEZ, Aída. 2015. Invisible, visible or everywhere in between? Perceptions and actual behaviors of non-professional interpreters and interpreting users. *The Interpreters' Newsletter,* 20, pp. 175-194. [online] Available at: <https://www.openstarts.units.it/handle/10077/11859>

MASON, Ian, REN, Wen. 2012. Power in face-to-face interpreting events. In ANGELELLI, C. (Ed.), *The Sociological Turn in Translation and Interpreting Studies*. Ámsterdam & Filadelfia: John Benjamins Publishing Company, pp. 234-256.

PENN, Claire, WATERMEYER, Jennifer, KOOLE, Tom, DE PICCIOTTO, Janet, OGILVY, Dale, FISCH, Mandy. 2010. Cultural brokerage in mediated health consultations: An analysis of interactional features and participant perceptions in an audiology context. *JIRCD Journal of Interactional Research in Communication Disorders*, 1, pp. 135-156.

ROSENBAUM, Marc, DINEEN, Richard, SCHMITZ, Karen, STOLL, Jessica, HSU, Melissa, HODGES, Priscila D. 2020. Interpreters' perceptions of culture bumps in genetic counseling. *Journal of Genetic Counseling.* Available at: <https://doi.org/10.1002/jgc4.1246>

SEALE, Clive, RIVAS, Carol, AL-SARRAJ, Hela, WEBB, Sarah & KELLY, Moira. 2013. Moral mediation in interpreted health care consultations. *Social Science and Medicine*, 98, pp. 141-148.

SHAFFER, Laurie. 2020. In-between: An exploration of visibility in healthcare interpreting. In SOUZA, I., FRAGKOU, E. (Eds.). *Handbook of Research on Medical Interpreting*. Hershey: IGI GLOBAL, pp. 188-208.

SOUZA, Izabel. 2020. The medical interpreter mediation role: Through the lens of therapeutic communication. In SOUZA, I., FRAGKOU, E. (Eds.), *Handbook of Research on Medical Interpreting*. Hershey: IGI GLOBAL, pp. 99-135.

SUURMOND, Jasmine, WOUDSTRA, Anke, ESSINK-BOT, Marie-Louise. 2016. The interpreter as co-interviewer: the role of the interpreter during interviews in cross-language health research. *Journal of Health Services Research & Policy* 21 (3), pp. 172-177.

ZENDEDEL, Rena, SCHOUTEN, Barbara, VAN WEERT, Julia, VAN DEN PUTTE, Bas. 2018. Informal interpreting in general practice: the migrant patient's voice. *Ethnicity and Health* 23 (2), pp. 158-173. Available at: <https://doi.org/10.1080/13557858.2016.1246939>

ZORZI, Daniela. 2012. Mediating assessments in healthcare settings. In BARALDI, C., GAVIOLI, L. (Eds.). *Coordinating Participation in Dialogue Interpreting*. Ámsterdam & Filadelfia: John Benjamins Publishing Company, pp. 229-250.

Dr. Cristina Álvaro Aranda
FITISPos-UAH Research Group
University of Alcalá
Calle de la Trinidad, 1, 28801, Alcalá de Henares, Madrid, Spain
cristina.alvaroa@gmail.com

In SKASE Journal of Translation and Interpretation [online]. 2020, vol. 13, no. 2 [cit. 2020- 07-11]. Available online at http://www.skase.sk/Volumes/JTI19/pdf_doc/02.pdf. ISSN 1336- 7811.