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SPECIAL ISSUE: TECHNOLOGY IN INTERPRETER EDUCATION AND PRACTICE

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INTRODUCTION

Technology in Interpreter Education and Practice: Introduction

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Interpreting on the phone: interpreter's participation in healthcare and medical emergency service calls

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Abstract & Keywords

English:

The rise of remote interpreting (RI) - by telephone, videoconference or through internet platforms - is a natural consequence of both technological advances and various socio-economic trends characterising the second half of the 20th century: migration flows and freedom of movement have made societies increasingly multilingual, multicultural and multi-ethnic; businesses have become global; public institutions are increasingly under pressure to contain the costs of providing services; and last but not least the Covid-19 pandemic. This paper deals with the participation of the interpreter in healthcare and medical emergency service call. Drawing on a set of recordings of interpreter-mediated telephone healthcare interactions, changes in the structure of participation in the different phases of the calls compared to monolingual ones are discussed on the basis of examples.

Keywords: remote interpreting, telephone interpreting, healthcare service calls, medical emergency calls, conversation analysis

0. Introduction

The rise of remote interpreting (RI) - by telephone, videoconference or through internet platforms[1] - is a natural consequence of both technological advances and various socio-economic trends characterising the second half of the 20th century: migration flows and freedom of movement have made societies increasingly multilingual, multicultural and multi-ethnic; businesses have become global; public institutions are increasingly under pressure to contain the costs of providing services; and most recently the COVID-19 pandemic.

In Australia, since January 2018, remote interpreting – in which two parties are face-to-face but the interpreter is elsewhere over the phone - has been included as one of eight tasks in the test to become a NAATI (the National Accreditation Authority for Translators and Interpreters) Certified Interpreter (Wang 2018a). As regards telephone interpreting (TI), it first took hold in Oceania and America, and only later spread to Europe, where it is now expanding rapidly. In a recent survey conducted in Italy, Spain and the United Kingdom (Veasyt 2018), 199 users of interpreting services in the public and private sectors were asked how often they use TI services compared to face-to-face and videoconference. 15.5 per cent of respondents said they use it always or often, 29.6 per cent said they use it occasionally and 31 per cent said they have never used it but are open to trying. It is therefore a service that not only already has a market share in the three countries of the survey, but also some growth potential, as almost a third of the responders have not yet tried it out and have not expressed any aversion to it.

The objective of this paper is to see how the "presence" of the interpreter in healthcare and medical emergency service calls changes the structure of participation. To this end, some seminal studies conducted by conversation analysts on monolingual service calls that highlight the constituent sequences of talk will be briefly presented, followed by a summary of the main pros and cons of TI identified in the literature. Finally, drawing on a set of recordings of telephone-mediated healthcare interactions, patterns of participation in the different phases of service calls involving telephone interpreters are discussed on the basis of examples.

1. Monolingual healthcare and emergency service calls

A service call can be defined as an interaction in which a user/client calls a service or institution to submit a request and the receiver decides whether and how to meet the caller's request. Service calls can cover a wide range of areas and have been studied by many researchers who generally agree on the structure of this particular type of interaction (Schegloff 1979 and 2002; ten Have 2002; Varcasia 2013).

Of particular relevance to the present study is Zorzi and Monzoni's (2003) analysis of a corpus of service calls in the health sector recorded between 2000 and 2003. Their study was conducted on recordings of calls to the Emergency Service of the Local Health Authority of Forlì, which can be accessed by dialling 118. Two types of interactions were studied: a) service calls from hospitals for the transport of patients and/or medical equipment and b) emergency calls made by ordinary citizens or health workers and law enforcement agencies (family doctors, police, fire brigade, nurses in nursing homes, etc.). The typical overall organization of calls to 118 identified by Zorzi and Monzoni reflects that identified by previous studies on service calls to the emergency number 911 in the United States (in particular Zimmerman 1984; Whalen and Zimmerman 1987 and 1990; Whalen, Zimmerman and Whalen 1988; Zimmerman 1992; Wakin and Zimmerman 1999) and consists of six phases:

1. Pre-opening: the telephone rings and the operator/service dispatcher opens a communication channel;
2. Opening/identification/recognition: the operator/service dispatcher of the institution or service receiving the call answers and self-identifies, the caller recognises the institution or service s/he has called;
3. Caller's request for a service;

4. Interview by the service or institution operator/service dispatcher asking a series of questions to assess whether and how to respond to the caller's request;
5. Answer to the caller's request;
6. Closing: usually expressions of thanks and greetings.

The duration of each phase is variable, but in monolingual calls they tend to follow this order and are conducted by the operator/service dispatcher. Before turning to an analysis of how the presence of an interpreter affects the organization of this type of service call, in the following paragraph the main pros and cons of TI will be briefly presented.

2. Interpreting on the phone: pros and cons

Telephone interpreting is one of the possible forms of RI that allows communication between participants in an interaction who do not share the same language and are not in the same place[2]. Interpreting Studies have focused on remote interpreting mainly in the last two decades. Some scholars have investigated the advantages and disadvantages of this interpreting mode from the point of view of the two main stakeholder groups: users and interpreters (Gracia-García 2002)[3]. For the institutions or service agencies using TI, the main advantages identified are the following: (almost) immediate availability of the interpreter – an aspect which is crucial in case of emergencies (Kelly 2008; Braun 2012); no travel costs (*ibidem*); greater ease in finding interpreters for languages of lesser diffusion (*ibidem*). In the healthcare sector advantages include: more privacy and less physical exposure to a stranger during medical consultations (Kelly 2008; Gracia-García 2002); the possibility for foreign users to make an appointment or receive report or lab results without having to go to the healthcare centre in order to communicate via an interpreter on site (Gracia-García 2002). For interpreters, the main advantages include the possibility of working from "peripheral" locations (Lee 2007), flexibility in working hours (*ibidem*) and the opportunity to accept more work since no time is wasted traveling or waiting (Gracia-García 2002). In the case of interviews in police or legal settings with aggressive or violent people or of road accidents, greater safety is also a plus: in both instances, the interpreters need not be physically present, thus reducing the risks for their safety (Andres and Falk 2009; Braun 2012; 2014 and 2015).

On the other side of the coin there are disadvantages that can affect all or only some of the participants in a remote interaction, and in particular on the phone. Among those identified in the literature and that can affect all participants, there is lack of "social" presence in the interactions, with the ensuing difficulty in building rapport between the interlocutors (Ellis 2004; Ozolins 2011); the lack of visual, tactile and kinetic components of communication (Poyatos 2002) and the difficulties due to the poor quality of the channel or sound (BiD 2008; Causo 2012; Wang 2018b). In a conversation over a conventional phone - without a video channel - only the linguistic and paralinguistic components are accessible (rhythm, intonation, etc.) while the kinetic components cannot be perceived (body movements, posture, gestures, gaze). According to various studies, this creates a "communicative uncertainty" that leads the interlocutors to produce rephrasing and repetitions because they are not sure they have been understood and they cannot draw on information from feedback provided by gestures or facial expressions. The absence of visual inputs makes it difficult to regulate turn taking between speakers who do not see each other and interpreters may thus need to work harder at coordinating turns at talk in order to avoid overlaps (Oviatt and Cohen 1992; Wadensjö 1999), which are another perceived challenge by interpreters (Wang 2018b). In a survey conducted in Australia by Wang (2018a) on 465 interpreters, the respondents stated that they felt obliged to coordinate interactions more explicitly when interpreting over the phone. Another serious disadvantage for interpreters is low remuneration since they are paid by the minute, whereas free-lance community interpreters who work for healthcare centres or in courts are usually paid by the hour and can charge the mileage and waiting time (Gracia-García 2002). In the survey mentioned above, 76 per cent of 465 telephone interpreters perceived poor sound quality as the main disadvantage (Wang 2018b). Other studies have shown that telephone interpreters find it difficult to make use of contextual information (Andres and Falk 2009; Braun 2015). The unpredictability of the topic at issue in telephone calls and therefore the impossibility of preparing for a particular telephone interaction is another drawback for interpreters (Gracia-García 2002; Rosenberg 2007; Lee 2007) who also reported the lack of a briefing by the client about the topic and the context of the call in the survey by Wang (2018b). A number of researchers, however, also state that with well-functioning facilities and equipment, well trained and experienced interpreters and service providers, most telephone interpreting disadvantages can be managed and overcome (Gracia-García 2002; Andres and Falk 2009; Braun 2012).

Drawing on the analysis of data recorded during simulations organised by a company that deals with RI, the following sections will highlight how the structure of participation in healthcare and medical emergency service calls changes when an interpreter enters the scene. The benchmark for this analysis of interpreter-mediated service calls is the structure identified in the literature for service calls in a single language and described in section 1.

3. Data and methodology

The telephone calls analysed in this study were collected within the framework of the Erasmus+ "Shift in Orality" project. This three-year project involved four universities and two companies and focused on communication via telephone and videoconference, both monolingual and multilingual, with the aim of developing training tools for remote interpreting[4]. One of the two companies, Dualia Teletraducciones SL (<http://www.dualia.es>), which offers telephone interpreting services in Spain and other European countries, provided recordings of simulated interpreter-mediated service calls in different areas: healthcare and medical emergency, insurance, tourism and police emergency. This study focuses on recordings of nine healthcare and medical emergency service calls where users are either English or Italian speakers who are assisted by an interpreter in order to communicate with the service operator who speaks Spanish. The set of telephone interactions analysed here include:

- six calls made by users to set or change the date of a medical examination;
- three medical emergency calls;

In all interactions the operator, the foreign language caller and the interpreter are located in three different places and use a three-way conversation system which allows each one of them to hear everything that is said by the other two interlocutors. All calls are incoming to the healthcare or emergency service and, as mentioned above, all recordings are simulations carried out by Dualia Teletraducciones SL in order to evaluate interpreters before they start working for the company. An important feature of these interactions is that interpreters do not know

neither to be part of a simulation nor to be recorded. Although the practice of not informing interpreters about this monitoring of their work may be seen as questionable in terms of corporate behaviour, it can be justified by the fact that interpreters may have to work under pressure or emotional stress (in case of emergency calls in particular) and the company wants to be sure that they can cope with such situations. From the research point of view, the data offers a window onto spontaneous production of talk by interpreters, on which some interesting reflections can be made. The interpreters in the calls are either professionals who are about to start working for the company (and therefore have experience in interpreting but not in TI) or students who are close to the completion of their interpreting education. Both groups are acquainted with Dualia protocols for interpreters, which will be briefly described in section 4. The primary speakers are instead actors and experienced interpreters who play the roles of operator and user/caller and simulate typical situations that can be found in routine and emergency healthcare calls. The audio recordings were transcribed according to the conventions adopted for the purposes of the Shift project and derived from conversation analysis (Sacks, Schegloff and Jefferson 1978)[5]. Since the recordings are simulations, it was not necessary to anonymise data because there is no risk of revealing the identity of real operators or users, while names of interpreters, when audible, were changed. The methodology chosen to study the interactions is conversation analysis, a micro-analytical approach based on a turn-by-turn analysis, applied here with the aim of understanding not so much the (co-)construction of the single turn, but the meanings and functions of specific sequences in order to highlight the structure of participation in the various phases of the calls, with a special focus on the interpreter. Before discussing the data, however, it is important to know the "rules of the game" which apply to the interpreters who work for Dualia.

4. Dualia protocols for telephone interpreting for healthcare and social services

In order to make interpreter-mediated communication more effective, Dualia has prepared protocols for interpreters who work on the phone. The protocols concern three different types of calls defined by Dualia as: routine calls, emergency calls and calls from social service centres or reception centres. Some general guidelines apply to calls of all three types. In particular, interpreters are instructed to always:

1. make sure that the language for which they are called is actually the language required for the conversation. This language check should be performed at the very beginning of the call;
2. speak loud, slowly and with an emphasis on the main information;
3. signal any audio problems (especially if they cause loss of information);
4. avoid adding information. Interpreters however can select what to translate (i.e. summarising or eliminating the user's digressions not strictly related to the object of the call);
5. be impartial and refrain from expressing an opinion;
6. maintain confidentiality in everything that is said;
7. remain kind and patient at all times;
8. refrain from interrupting the communication or expressing their judgment about the request, even when they suspect that the user is lying.

In short, the protocol requires interpreters to provide an accurate rendition of what is said, avoiding additions or editorialisations. In routine calls, i.e. requests for appointments for medical examinations or for prescriptions of drugs, there is usually a set of questions that callers are routinely asked: first and family name, health insurance card number, name of the hospital or medical centre of reference and general practitioner's name. Once it is clear that the call is a routine one, the interpreter is allowed to ask the caller to provide all these details even without the operator formulating specific questions to obtain those pieces of information.

In emergency calls, interpreters are encouraged to leave out additional information provided by the caller and to translate only what is essential to solve the emergency as quickly as possible. They can therefore avoid rendering part of the caller's message if it does not contain the information needed to achieve the goal, or they can translate or briefly report it later on, after the main topic of the conversation has been exhausted. In the case of a traffic accident, for example, where the caller may be in an emotional state, interpreters can initiate questions that have not been asked by the operator and go straight to the point with direct questions such as: "What is the name of the street?". In case of difficulty in obtaining the necessary information to respond to the emergency (because the caller is confused or nervous), the protocol suggests that interpreters autonomously ask closed questions with a yes/no answer, for example "Is anyone injured?". Once the essential information has been obtained, interpreters can return to the conventional mode of interpreting, i.e. translate each speaker's turn.

It should be highlighted, however, that the protocol does not solve one of the main difficulties mentioned above for the interpreter (section 2): the impossibility of preparing on the specific subject matter of the call. Although this is not the central topic of this study, it is still a point that deserves attention and reflection, and it is also one of the reasons why specific training for interpreters and healthcare professionals dealing with multilingual service calls is needed. In this respect our data analysis can be useful to further develop interpreter and healthcare staff joint training materials aimed at providing a better service to expatriates, tourists, foreign nationals and migrants who do not speak the language of the service or institution they need to interact with.

5. The interpreter in healthcare and medical emergency service calls

A three-party conversation in two different languages is obviously more complex than a two-party conversation in a single language from which it differs in several regards: in terms of language and cultural barriers to overcome, different levels of knowledge held by the three participants, the way in which the turns and content of the conversation are managed, and the way in which information is shared and conveyed to the parties involved. All these aspects must be considered if the interaction is to be successful (Wadensjö 1998; Mason 2001). The following analysis aims to see if and what differences emerge in the structure of participation in interpreter-mediated healthcare and medical emergency service calls with respect to the same type of service calls in a single language where the whole interaction is carried out by the caller/user and service operator.

5.1 Opening

Previous analyses carried out on the same data have shown how, when an interpreter takes part in the conversation, the opening phase is modified compared to a call in a single language (Paoletti 2015; Amato 2018). A first aspect that distinguishes interpreted calls from those without an interpreter, at least on the basis of our data, is that in the former case the operator too (in addition to the caller/user) acts as a user who needs an interpreting service. On his/her part, instead, the interpreter acts as a service provider who self-identifies in the opening, as shown in example 1 (in all examples A is the operator or doctor, B is the caller/service user and I is the interpreter).

Example 1

1. I: Dualia buenos días mi nombre es Pepe cómo puedo ayudarle?
Dualia good morning my name is Pepe how can I help you?
 2. A: hola buenas tardes (.) soy **Benito** de Salud Responde
[tengo]
hello good evening Benito from Salud Responde speaking [I have]
 3. I: [buenas tardes]
[good evening]
 - A: tengo:: una li- un alertante en inglés (.) le voy a pasar con él
I have:: a li- an English speaking caller (.) I'll put him on
 4. I: de acuerdo muchas gracias=
all right thank you very much=
 5. A: =o con ella perdón (.) con **ella**
= or her on sorry (.) her
 6. I: de acuerdo
all right
- (2)
7. B: hello?
hello?
 8. I: **hello** hello madam my name is Pepe I'll be the interpreter how can I help you?
 9. B: oh hello hello OK ehm I would like to eh OK I have an appointment for the gynae- gynaecologist

In the above excerpt, the healthcare operator calls the interpreting service and the interpreter self-identifies first. Another aspect worth mentioning is that the operator is not able to understand the caller to whom he has to provide a service and therefore becomes himself a user of the interpreting service (turns 4 to 6).

Another peculiar feature emerging from the data is a “double” opening phase. After the operator (or doctor) and the interpreter have mutually self-identified, usually another opening sequence follows immediately. This second sequence involves the interpreter and the service user; in it, the interpreter self-identifies with the foreign language caller. In example 1 the opening between interpreter and healthcare operator occurs in turns 1 to 3, while in turns 7 to 9 there is a second opening sequence between the interpreter and the caller. Turn 3, however, contains another action in addition to the identification of the institution: the operator agrees with the interpreter to share the call, by informing the latter that he will put the caller on and that the caller speaks English. As we will also see in other excerpts, in the interpreter-mediated calls analysed there are often turns with “procedural” content in which the operator and the interpreter agree on how to proceed before going ahead with the call. In the following turns in this excerpt (from 4 to 9) the interpreter, in addition to self-identifying with the patient, explains his role, in order to clarify his function from the very beginning and avoid confusion. It is also worth noting that the caller, instead, does not self-identify and immediately expresses the reason for the call.

Another difference in our data compared to monolingual calls is that during the opening phase the operator checks that s/he has called the interpreter for the right language. This activity is shown in example 2:

Example 2

1. I: Dualia mi nombre es xxx en qué puedo ayudarle?
Dualia my name is xxx how can I help you?
2. A: hola buenos días es la intérprete de italiano?
hello good morning are you the Italian interpreter?
3. I: sí
yes

This is clearly an activity specifically relevant for interpreter-mediated calls that has no reason to occur in monolingual calls.

In the following sections, phase 3 and phase 4 of the call will be discussed, i.e. the caller/user's request and the interview respectively. In monolingual calls these two phases usually contain the highest informational and procedural load, and it is therefore interesting to see how the interpreter fits into them.

5.2 The request

An aspect worth remembering is that in telephone healthcare and medical emergency calls the caller is the only one who possesses the information the operator needs to provide the service. Example 3 illustrates how the information related to the reason for the call is obtained and shows some discourse moves adopted by the interpreter in order to ensure both smooth communication and the achievement of the interactional goal.

Example 3

1. I: >hola buenas tardes me llamo xxx en qué puedo ayudarles?<
hello good evening my name is xxx how can I help you?
2. A: hola buenas tardes tengo aquí un usuario que parece que es de lengua inglesa

- (.)
3. I: sí de acuerdo
yes all right
- (3)
4. A: eh:: necesito saber qué le ha ocurrido: (.):eh:: de dónde es (.): eh: la edad y la dirección por favor
eh: I need to know what happened: to him (.): eh:: where he is from (.): eh: his age and the address please
5. I: vale de acuerdo (2) hello
OK all right (2) hello
6. B: hello
7. I: hello can you hear me sir?
8. B: yes yes I can ah >I need an ambulance<
9. I: one moment why do you need an ambulance sir? what exactly has happened?
10. B: ah I am not pretty sure ah I ate something ah my friend gave me something to eat (.): ahm I am diabetic and he said it was sugar-free (.): bu- but I am not sure about that
11. I: all right OK hold on please (.): how old are you?
12. B: I'm eighty one
- (.)
13. I: you are eight one [and]
14. B: [yeah]
- I: and what's your name?
15. B: my name is Peter
- (.)
16. I: Peter what's the full name sir?
17. B: ah it's it's Peter Rufus
18. I: **Rufus** OK hold on for a moment ah hola compañero? me dice que se [llama...
Rufus OK hold on for a moment ah hello colleague? he tells me [his name is...

In the excerpt above it is very clear how the structure of participation may change in interpreter-mediated service calls. In turn 2 the operator acknowledges that he is not able to understand the request of the patient (his user/client to whom he has to provide a service) and, as in section 5.1, he therefore becomes himself a user/client of the interpreting service. In turn 4 the operator explains to the interpreter what kind of information he needs to handle the emergency, but leaves the decision about how to obtain it to the interpreter. In this case the flow of questions does not go from the operator to the interpreter and then to the caller (as it would be legitimate to assume) but directly from the interpreter to the caller, generating a dyadic sequence the content of which will be reported to the operator later on by the interpreter (turn 18). In essence, the operator lets the interpreter momentarily conduct the interaction with the caller. In turn 8 the caller immediately announces his request for an ambulance, which is not translated by the interpreter to the operator. This is probably due to the fact that the caller has dialled a number dedicated to requesting an ambulance in case of medical emergencies. Without relaying the request to the operator first, the interpreter immediately initiates a question and answer sequence (the interview phase) aimed at collecting the information - already requested by the operator in turn 4 - which he reports to him only after the patient has provided the details about what has happened, his age and his name. This collaboration would not be possible without precise prior instructions (see section 4) and without mutual trust, which is essential in every form of teamwork and which cannot be taken for granted when two professionals find themselves working together, moreover remotely and therefore without a shared context and history. Cooperation and trust are crucial aspects which should not be underestimated and for which joint professional training would appear essential. This excerpt also contains a second autonomous initiative by the interpreter aimed at fulfilling the operators' initial request (turn 4): she asks for the caller's full name (in turn 16), showing that she is aware that this piece of information is also crucial for the provision of the emergency service.

5.3 The interview

Phase 4 in monolingual service calls usually contains a series of questions by the operator, followed by answers by the caller. In this phase the operator's primary aim is to obtain all the necessary information to decide if and how to provide the requested service. In the following example 4, after translating the reason for the call expressed by the patient in turn 14, the interpreter agrees with the operator on how to proceed and asks him to give him a "mandate" to autonomously collect the necessary data to make the appointment requested by the caller. Once again the flow of questions does not go from the operator to the patient, as it would in a monolingual call, but from the interpreter to the patient and then to the operator. In other words, in interpreter-mediated calls some dyadic sequences take place between the interpreter and the caller which temporarily "exclude" the operator and are then fully translated or concisely reported to the operator by the interpreter once the interpreter-caller exchange is over. Again this differs from calls in a single language where the operator is the only questioner during the interview phase.

Example 4

10. I: hello?

11. B: e:: I **need to make an appointment** please
12. I: OK ah::: (2) hola compañero?
OK ah::: hello colleague?
13. A: sí dígame=
yes tell me
14. I: =sí >el señor quiere hacer una cita< le pido: los datos:: personales no? >el número de tarjeta sanitaria< supongo?
yes >this gentleman wants to make an appointment< I ask him his personal details don't I? > his health insurance card number< I suppose?
15. A: sí [por favor]
yes [please]
16. I: [y su nombre]
[and his name]
17. A: si fuese tan amable
if you could be so kind

In our data, the request or initiative by the interpreter to proceed autonomously usually concerns “routine” questions (turns 14 and 16 in the example above) as provided for by the protocol (see section 4) and seems to be a move to expedite the call and make the service more efficient by avoiding “a waste of time” both for the operator and the caller. The interpreter’s contribution, though, besides “optimising” the service’s response to the call, can also be crucial to provide a response to the caller’s request as in example 5 below.

Example 5

24. A: mm vale (.) eh:: un momentito (4.2) vale eh: por favor eh: pregúntele eh:: dónde se encuentra
mm OK (.) eh:: one second (4.2) OK eh: please ask her where she is
25. I: eh: buen- madam? eh: where are you?
eh: we- madam? eh: where are you?
26. B: OK I’m in:: Dinama- Dinamadina?
27. I: Dinamadina?
28. B: yes
29. I: OK (1) en Dinamedina? o:: madina? (1.2) le dice algo?
OK (1) in Dinamedina? or:: madina? (1.2) does it sound familiar?
30. A: eh: no
31. I: eh: madam in what **city** are you?
32. B: in Málaga
33. I: in Málaga [OK]
34. B: [yes]
- (.)
35. I: en Málaga
- (1)
36. A: eh: pregúntele si podría ser en Benalmádena
eh: ask her if it could be Benalmádena
37. I: eh: madam might it be Benalmádena?
38. B: eh: yes I think it’s the Spanish eh: (.) °pronunciation° yes

In the example above, taken from a call where an ambulance is requested by the caller for a medical emergency, the pronunciation of the caller makes it difficult to understand the name of the place where the emergency has occurred. Since the name provided by the caller in previous turns is not recognised by the operator, the interpreter takes the initiative to ask for the name of the city (turn 31). This interpreter’s initiative allows the identification of the place by the operator who is now able to identify the location that the caller tried to communicate but mispronounced. As we saw in section 4, Dualia has a protocol for interpreters who work in emergency calls and one of the fundamental indications is to focus on one objective only: the fast transmission of the most relevant information. In example 5 the interpreter seems to be well aware of this principle and acts precisely to obtain crucial information to send an ambulance as soon as possible.

5.4 Responding to the request

In our data, the response phase is the one that seems most similar to single language calls where it is always the operator who decides if and how to provide the service. In this phase in our interpreter-mediated calls, the operator confirms that he will take care of the service requested and the interpreter performs a purely translational function, as shown in the two following examples 6 and 7.

Example 6

70. A: de acuerdo eh::: (1) pues nada (.) dígame que le enviaremos la **ambulancia**
all right eh::: (1) well nothing (.) tell her that we are going to send her an ambulance
71. I: vale eh: we’ll send the **ambulance** madam

Example 7

103. A: de acuerdo (.) muy bien (.) pues muchas gracias (2) dígame dígame a la usuaria que la

llamaremos en cuanto tengamos la cita vale?
all right (.) very well (.) thank you very much (2) tell her tell the caller we are going to call her when we have the date of the appointment OK?

104. I: eh muy bien (.) madam as soon as they have ah arranged the appointment they they call you back all right?

105. B: OK thank you very much

In both cases the operator asks the interpreter to communicate his decision to the caller and leaves no discursive space to the interpreter except for translation. It is noteworthy that in the second example (7) the interpreter asks the user to confirm not only that she has understood (at the end of turn 104), but also that she is happy with the response to her request (*all right?*) and the caller provides her confirmation in turn 105 (*OK thank you very much*). This turn makes it clear to all the parties that the purpose of the call has been achieved: the caller expresses her thanks and in this way initiates the closing phase, which we will deal with in the next section.

5.5 Closings

The closing phase in single language service calls usually contains greetings and thanks. Again the presence of the interpreter changes the structure of participation, and sometimes also the contents of this phase. First of all, there is always a "double" closing, i.e. between the interpreter and the foreign caller first and between the interpreter and the operator immediately after, as in example 8 below.

Example 8

105. B: OK thank you very much

(.)

106. I: all right thank you very much bye

107. B: bye

108. I: eh: pues eh ya se lo he dicho compañero ya está todo arreglado=
eh: well yes I told him colleague and everything is fine

109. A: =muy bien muy bien muchas gracias hasta luego
= very well many thanks bye

110. I: muchas gracias a usted hasta luego
thank you very much to you bye

Besides a double closing, the excerpt above also contains a turn (108) where the interpreter acknowledges that the goal of the call has been achieved, that the caller is happy and that it is possible to close the call.

Another activity that may occur during the closing is the offer of further help by the interpreter to the operator or the request by the operator to use the interpreter again for another subsequent call, as shown in examples 9 and 10 below.

Example 9

81. B: [thank you] very much

82. I: thank you **thank** you

83. B: bye

84. I: bye sí e:: compañero? ya: hemos terminado eso es todo? puedo ayudarle en algo más?
bye yes e:: colleague? we have finished is this all? can I help you with something else?

85. A: **nada** más (.) muchas gracias
nothing else (.) thanks a lot

86. I: a usted (.) un saludo
thank you to you (.) bye

87. A: un saludo (.) buenas tardes
bye (.) good evening

88. I: buenas tardes
good evening

Example 10

31. A: vale (2) vale eh: le podría llamar más tarde para:: [preguntarle con los resultados?]
OK (2) OK eh: may I call you again later [when I have the results]?

32. I: [sí cuando quiera] ((echo))
[yes whenever you want] ((echo))

33. A: vale fenomenal=
OK great=

34. I: =sí sí claro venga hasta ahora ((echo))
= yes yes talk to you later ((echo))

35. A: gracias hasta luego
thank you bye

36. I: hasta luego ((echo))
bye

The above analysis of the various phases of healthcare service and medical emergency calls mediated by an interpreter has shown that, on one hand, the order in which the various phases identified in the literature for single monolingual calls take place does not change, while, on the other, the structure of participation within the

different phases changes substantially. The only exception is the response phase, which contains the decision made by the operator who is the only one entitled to decision-making. This is the only phase where the interpreters confine their activity to translating only.

6. Healthcare and medical emergency incoming calls without and with an interpreter: what is different

With regard to the characteristics identified in literature (see section 1), we have seen that the overall organisation of monolingual service calls consisting of six phases is replicated symmetrically also in the data drawn from interpreter-mediated calls. What changes is the participation structure as can be seen in the actions carried out by the participants in each phase and which is summarised in table 1. The interpreting activity obviously occurs throughout the call and is inherent to an interpreter-mediated call, so it is not included in the table.

Without an interpreter	With an interpreter
<p>1) Pre-opening The telephone rings and projects an emergency/virtual request (to the operator)</p>	<p>1) Pre-opening The telephone rings and projects an emergency/virtual request (to the interpreter)</p>
<p>2) Opening/identification/recognition Institution or service identification and recognition by the caller</p>	<p>2) Double opening/identification/recognition</p> <ul style="list-style-type: none"> • <u>Opening-identification-recognition between the service/institution and the interpreter and checking the caller's and interpreter's languages</u> • <u>Opening-self-identification by the interpreter to the foreign language speaking caller</u> • <u>The service operator/doctor presents a request to the interpreter</u>
<p>3) Request Caller's presentation of request/problem to the operator</p>	<p>3) Request Caller's presentation of request/problem to the <u>interpreter</u> who then reports it to the doctor/operator</p>
<p>4) Interview Question and answer sequence conducted by the operator to obtain detailed information about the problem/request presented by the caller</p>	<p>4) Interview Question and answer sequence conducted by the operator <u>and (partially) by the interpreter</u> to obtain detailed information about the problem/request presented by the caller</p>
<p>5) Response By the operator concerning if and how the service will be provided</p>	<p>5) Response By the operator/doctor concerning if and how the service will be provided</p>
<p>6) Closing Thanking and greetings between operator/doctor and caller</p>	<p>6) Double closing Thanking and greetings <u>first between the interpreter and the caller and then between the operator/doctor and the interpreter.</u> <u>Other possible actions:</u></p> <ul style="list-style-type: none"> • <u>Request for confirmation that the service is over by the interpreter</u> • <u>Request for another interpreting service by the operator</u>

Table 1. Participation structure in a healthcare and medical emergency service call with and without an interpreter.

Table 1 shows that without an interpreter the identification of the service or institution and the recognition by the caller in phase 2 takes place directly between the operator and the user, while in the interpreter-mediated interactions during the opening the first actions are the interpreter's and operator's self-identification and the recognition of the foreign language needed (examples 1 and 2); as will be recalled, this step is required so that the operator can check that s/he has called the right interpreter. Immediately afterwards, in general, the interpreter self-identifies with the foreign caller (example 2). In this phase the operator acts as a service user and presents a request to the interpreter (examples 1 and 3). In phase 3 without an interpreter, the problem/request is presented by the caller, as occurs in calls with interpreters, but the interpreter, after having agreed with the operator or doctor on how to proceed (examples 3 and 4), is immediately put in contact with the caller to obtain information on the reason for the call. Consequently, in phase 4, which in monolingual telephone interactions contains a series of questions about the problem/reason for the call by the operator, in the interaction with the interpreter often contains some teamwork, in which the operator and interpreter work together to achieve the purpose of the call (examples 4 and 5). In particular, the interpreter is asked to take (or spontaneously takes) autonomous initiatives to speed up the course of the interview, a practice which generates dyadic sequences, even long ones, which then are reported to the operator (example 5). The response phase (5) in our data is similar to its counterpart in monolingual calls: here in both cases the operator decides if and how to provide the service (examples 6 and 7). The final phase (6) in the interpreted calls presents instead a double closing, first between interpreter and foreign caller and then between interpreter and operator (examples 8 and 9). At this stage, in addition to greetings and thanks (present in both cases), in interpreted calls there may be a request for confirmation by the interpreter that

his/her service is no longer needed or a request for further subsequent services by the operator (examples 9 and 10).

6. Conclusion

With the caveat that the number of calls examined here is quite small (the data is still subject to ongoing analysis), it is possible to preliminarily say that when the interpreter uses the freedom to take discourse initiatives granted by the protocol and when the operators are willing to teamwork with the interpreter, one can observe a shared management of information between them. The operator instructs the interpreter about what kind of information s/he needs and the interpreter takes on responsibility for communicating it in the way s/he considers most effective as an expert of the foreign language and of multilingual communication. This cooperation as the interaction unfolds seems to effectively fulfil the purposes of the telephone service call by optimising it or making it faster through a reduction in the number of turns needed to obtain the necessary information to respond to the caller's request.

Decisions made by the interpreter such as grouping the operator's questions into a single turn or proceeding autonomously with the questions the operator would presumably have asked, with or without the operator's prior agreement but on the basis of what the interpreter understands as communicatively relevant to achieving the objective of the call, seem to be effective for the progression of the interaction and do not create distortions or problems in communication if the interpreter translates what has been said to the other parties after each autonomous initiative. In this way no one is excluded from the interaction, and no information relevant to the parties is omitted.

The interview phase consists of questions and answers. The latter may present some difficulties to the interpreter when they contain proper names, in particular of drugs, people and places, which may be difficult to grasp on the phone, as shown in another study on the same data (Amato 2018). These realia may require extensive sequences of verification and confirmation. In such cases again, interpreter's initiatives can determine the speed with which information is collected and this can be crucial for an emergency call (example 5). For the interpreter to take initiatives, however, s/he must be trained; on the other hand the operator, besides being trained, must be prepared to grant the interpreter some latitude, as we have seen in some examples. In this way, the interpreter, rather than being a "necessary evil", as this professional figure is sometimes perceived, becomes a real "facilitator" of communication who can help speed up the response to emergency situations and contributes to the effective and efficient delivery of the service[6].

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Notes

[1] See Spinolo in this publication.

[2] Primary participants in the same place and the interpreter elsewhere is another possible constellation in remote interpreting.

[3] Companies which own or manage platforms and act as remote interpreting service brokers are therefore not included in this short overview of pros and cons.

[4] The project "Shift in Orality" (<http://www.shiftinorality.eu>) - funded by the European Commission in 2015 as part of the "Key Action 2: Strategic Partnership in Higher Education" - was carried out by the following partners: University of Bologna (coordinator), University of Granada, University of Surrey, University Pablo de Olavide, Dualia SL (Spanish company providing telephone interpreting services) and Veasyt Srl (Italian company providing interpreting services by videoconference).

[5] Transcription conventions are derived from conversation analysis (Sacks, Schegloff and Jefferson 1978) and also used by Varcasia (2013) in her work on monolingual service calls:

?	a rising vocal pitch or intonation
bold	emphasis
CAPITAL	loud voice, shouting
lo:ng	stretched sounds
quiet	words spoken in a low voice

>speed-up<	increased speed of delivery
<speed-down>	decreased speed of delivery
[talk]	square brackets indicate overlapping talk
=	latching, contiguous utterances or continuation of the same utterance in the next line
(.)	micro pause, up to 1 second
(2.0)	length of pause in approximate seconds
((cough))	sound or feature of talk not easily transcribable
xxx	inaudible or doubts about hearing by the transcriber
wor-	truncated word
/	truncated utterance
A	service provider
B	service user
I	interpreter

[6] In Australia NAATI (National Accreditation Authority for Translators and Interpreters) has recognised the need for an active participation and coordination role by interpreters in service calls and in the accreditation test the following skills are tested: stopping the primary speaker(s), managing turn-taking, dealing with overlapping speech, using appropriate techniques for cutting-in, reacting to the clients' side-conversations, seeking clarifications or repeats, and making self-corrections when required (Wang 2018a).

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