

Getting their wires crossed? Interpreters and clinicians' expectations of the role of professional interpreters in the Australian health context

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ABSTRACT

The positive impact the provision of professional language services has in the health context is well documented: the greater the engagement of qualified interpreters and culturally competent health professionals, the better the health outcomes of patients with limited English proficiency. However, while most professional interpreters in Australia generally adhere to the *Australian Institute of Interpreters and Translators (2012a) Code of Ethics and Code of Conduct*, a significant number appear to ignore or reject important precepts of the Code in their practice, especially if these interpreters are casual (non-in-house) agency interpreters. Similarly, while most health professionals display an understanding of the role professional interpreters have in the health context, a number of them fail to grasp the importance of key elements of the Code of Ethics, including appropriate briefing, what should be interpreted and how, and the appropriate role boundaries of the interpreter. These findings are based on the analysis of two interpreter and two clinician surveys, both conducted in Australia.

KEYWORDS: code of ethics; culturally competent clinical care; language services; professional healthcare interpreters/ing; role of the interpreter

Introduction

Australia has traditionally been a destination country for migrants and refugees and was the first country in the world to establish a National Accreditation Authority for Translators and Interpreters (NAATI) (Hale et al. 2012). Over the past decades, NAATI has played an instrumental role supporting the Code of Ethics developed by the Australian Institute of Interpreters and Translators (AUSIT) in conjunction with staff at Monash University (AUSIT 2012a). NAATI works closely with AUSIT and has recently recommended that interpreters wishing to work in medical and legal settings need to undergo additional training before taking specialist certification tests based on recommendations made in the report by Hale et al. (2012). Previous studies (e.g. Hale 2011) have shown the importance of professionals understanding the role of public service interpreters they work with (see Hale 2011 and Ozolins 2010 for a full discussion on public service interpreting). Other studies have suggested that the role of interpreters in public service settings is misunderstood. Some health interpreter service managers (e.g. de Jong, pers. comm., 2018) confirm that doctors' misunderstanding the role of health interpreters can have an unfavourable impact on interpreter-mediated interactions between health professionals and patients.

This paper reports on the outcome of two separate sets of surveys conducted among healthcare interpreters and health professionals (HPs) respectively. The first one was conducted in-house at an urban hospital, the second was conducted online, responses were received from around Australia. The surveys were conducted to compare health interpreter and HP expectations of the healthcare interpreter role. The primary aim of the survey was to ascertain to what extent health interpreters and HPs shared the same understanding of the health interpreter role. Healthcare interpreters are health professionals also, but for clarity in this paper the term health professional (HP) refers to a wide range of clinicians including doctors, nurses and allied health staff.

We investigate commonalities and divergences in health interpreter role expectations between HPs and interpreters at an urban hospital and more generally around Australia. Further, we identify topics which should be included in interpreter education and professional development sessions in the healthcare setting. We compare the findings of the hospital-based survey with those of an online survey that was circulated around Australia, where both surveys comprised the exact same questions. The hospital included in the study provides regular professional

development sessions around the role of health interpreters. The authors, therefore, expect the hospital-based staff completing the survey to show a better overall understanding of the health interpreter role than HPs who have not been exposed to such professional development sessions.

The study touches on public service interpreter role (Hale 2011), health interpreter role (Crezee 2013), interpreter-mediated healthcare interactions (Tebble 2012, 2014), and on the AUSIT (2012a) Code of Ethics which applies to the interpreters surveyed for this study.

1. Literature Review

The main themes and debates involved in health interpreter role expectations revolve around the interpreter Code of Ethics and how this plays out in interpreter-mediated health professional-patient interactions. The AUSIT (2012a) Code of Ethics (see Appendix for main principles) provides a set of principles and guidelines as to how these should or could be applied, based on precepts that focus on competence and clarity of role boundaries. In reality, however, interpreters working in the health setting may come across a range of ethical dilemmas, some of which revolve around conflicting expectations of their role. Tang (2017) interviewed elderly Chinese migrants in New Zealand and identified that some expected the interpreter to explain their results to them. Anecdotal evidence from practising health interpreters suggests relatives commonly ask them to not interpret certain diagnoses to their family members. Such requests basically ask interpreters to stop being impartial and accurate. Ozolins (2016) held that impartiality “needs to be considered as a constitutive rule for any kind of interpreting — and is expected by purchasers and other parties” (281). He added that “[f]iltering, aligning or replacing can in no way be reconciled with impartiality, and destroy this basis for interpreting” (Ozolins 2016: 282).

Tebble (2012, 2014) undertook an analysis of the various stages of the interpreter-mediated medical interactions in Australia. She identified that the stage where introductions occur is important, as this is where the interpreter has the opportunity to explain his or her role to the other parties (patient, medical professional(s), relatives). Goodman-Delahunty and Howes (2019: 100) report that “[a]dvance briefing of interpreters to better prepare them for the interview” was “generally seen as beneficial” in high stakes police settings. In their study “[b]riefing would normally cover subject matter and interpreting expectations and procedures”

(Goodman-Delahunty and Howes 2019: 108). Crezee's (2003) health interpreter interviewees reported that they hardly ever received a briefing except in the mental health setting. The study at hand did not ask about introductions per se, but did ask about briefings (cf. Crezee 2003) – which is a slightly different concept.

Crezee (2013) emphasized the importance of interpreters having a basic understanding of anatomy, physiology and pathology in order to accurately interpret health professional-patient interactions. Hale et al. (2012) agree that interpreters working in medical settings need specialized knowledge. Crezee (2013) and Crezee et al. (2019) also argued that interpreters need to be aware of and reflect on intercultural differences, but did not specifically mention the importance of striving for pragmatic equivalence (cf. Hale 2014). Pragmatic equivalence refers to rendering the meaning of a written, signed or spoken text in such a way that the original author's or speaker's intended meaning or pragmatic intent is maintained. In her discussion of pragmatic equivalence, Hale (2014: 323) distinguishes between 'pragmalinguistic failure' and sociopragmatic failure. She argues that pragmalinguistic failure 'relates to misunderstandings as caused by the diverse ways different languages express pragmatic intention linguistically'. She contrasts this with 'sociopragmatic failure' which she describes as relating "to misunderstandings caused by the different types of behaviour that are considered appropriate in certain settings by different languages and cultures" (Hale (2014: 323).

The term "pragmatic equivalence" as such does not appear in the Code. The only indication that it might be a consideration is the appearance of the word 'intent' in the context of accuracy. The AUSIT Code (2012: 5) says: "Interpreters and translators use their best professional judgement in remaining faithful at all times to the meaning of texts and messages." The explanation that follows holds that "[a]ccuracy for the purpose of this Code means optimal and complete message transfer into the target language preserving the content and intent of the source message or text without omission or distortion" (AUSIT 2012: 5) . Intent is again mentioned on page 10 of the (2012) AUSIT Code where it says, "Accurate is defined for this purpose as optimal and complete, without distortion or omission and preserving the content and intent of the source message or text. Interpreters and translators are able to provide an accurate and complete rendition of the source message using the skills and understanding they have acquired through their training and education."

The issues discussed above are evident in the findings of the research reported in this paper, in that there does appear to be confusion around the role of interpreters among healthcare interpreters and clinicians. Such misunderstandings may be successfully addressed in a pre-briefing (Goodman-Delahunty and Howes 2019) especially if the Code of Ethics is invoked and if interpreter role expectations are discussed. The survey tools used in this research project explored the main themes and debates touched on in the above literature review section.

2. Methodology

The study used a paper-based survey at one health setting and an online version of the same survey which was circulated throughout Australia. The online survey received 233 responses from accredited interpreters. The total number of active accredited or certified interpreters working in Australia across all languages is believed to be in the vicinity of 5,000 (Correspondence with Ari Pappas, OnCall Interpreters and Translator Executive Director of Marketing, pers. comm., 30 July 2019).

Hale and Napier (2013) argued that when reporting on questionnaires, researchers can only report on findings “as what interpreters said they do, rather than what interpreters actually do” (53). They noted that large scale surveys use predominantly closed questions that can be analysed quantitatively, with some room for qualitative analysis (Hale and Napier 2013: 59). The current study used a survey instrument to collect data, where the hospital-based survey was ‘paper based’ and the nationwide survey was electronic and available online. The survey was based on one originally designed by staff at the International Criminal Court in the Hague - both the original survey and this one were designed to elicit responses around the code of ethics from professionals and the interpreters working with them. Written permission was received from the interpreter section at the ICC for the researchers to adapt the survey to interpreters and professionals working in the healthcare setting.

A combined quantitative and qualitative analysis was undertaken, equally applied to the in-house and the nationwide survey, where findings from the larger online study were compared to those from the smaller, paper based study.

Crezee (2003) used a survey to elicit responses from New Zealand based healthcare interpreters around ‘the cultural divide’. She found that respondents’ comments added value and

perspective to their survey responses. Crezee et al. (2013) and Lai et al. (2015) also used surveys to elicit responses pertaining to issues around interpreting in refugee settings. Wang and Grant (2015), Magill (2017) and Issa (2018) all supplemented survey data with information collected during interviews with interpreters. Wang and Grant (2015) surveyed and interviewed Auckland-based court interpreters, while Magill (2017) used a similar method to explore the perspectives of New Zealand Sign Language interpreters working in the health setting. Issa (2018) surveyed and interviewed conference and media interpreters. This added depth to their data and allowed them to drill down into issues uncovered by survey responses. Crezee et al. (2013) also carried out Focus Discussion Group (FDG) interviews.

The research design of the study reported on here was to include FDG sessions, however, the researchers were unable to carry these out for a number of logistical reasons, including the opportunity to get a number of HPs and interpreters together in the same location. The survey questions asked explored role expectations from either the perspective of the interpreter or the healthcare professionals. They were formulated in such a way that respondents were presented with brief scenarios that presented ethical dilemmas, to see how they would respond. Qualitative questions elicited a variety of responses that have been analysed and included in the findings.

Participants

In-hospital participants were recruited through a regional interpreting service. The authors emailed all the accredited/certified interpreters listed on the NAATI website inviting them to complete the survey. A total of 259 (233 + 26) accredited interpreters were recruited for the electronic and paper based surveys respectively. A total of 47 (41 + 6) health professionals responded to the electronic and paper based surveys respectively. Only those interpreters who were working in healthcare settings were eligible to contribute to the study. Eligibility for health professionals was defined as working with interpreters in health settings. Demographic information about the interpreters is presented in Table 1.

Data collection methods

Data was collected through questionnaires both paper-based and electronic. Respondents were encouraged to include comments in addition to their question responses. The surveys have been

attached here. The surveys, including both paper versions and electronic versions, comprised 22 questions each and were distributed to in-house interpreters and clinicians either via email or in a physical format. Completed surveys were returned to the interpreting service manager.

Institutional ethics approval was obtained from the lead author's university in New Zealand. University staff undertaking research need ethics approval to undertake research. In this instance, approval was required also to include interpreters and professionals working in countries other than New Zealand (cf. Crezee and Jülich 2020).

Data analysis

Qualitative survey responses were thematically analysed. Responses for in-hospital and online respondents were compared with each other and salient and/or recurrent findings highlighted. In the survey respondents were asked to signal their level of agreement across a 5-point Likert scale ranging from 'completely agree' or 'extremely important' to 'completely disagree' or 'completely unimportant.' For the purposes of this paper the data has been aggregated to present data for those who responded in the 'agree' or 'important' and 'disagree' or 'not important' categories. Somewhat agree or somewhat important has been included in the agree or important categories. Data has been rounded to whole numbers.

Researcher positioning

All researchers are involved in interpreter education or professional development and research into interpreting in specific settings. The authors include an interpreter educator who is also a health professional, a hospital language service manager and a health and social work researcher. The first and third authors are not based in Australia and it is very unlikely that they had any influence on the research. The second author was known to the interpreters in the hospital involved in the study, but not to the online respondents. We have no way of knowing how the relationship of the second author and participants has impacted on how participants in the hospital setting answered the survey.

3. Findings

Below we report on the findings of the four surveys, starting with the perspectives of interpreters who filled out the online and paper-based surveys respectively, followed by the responses of the HPs who filled out the online and paper-based surveys.

Interpreters' perspectives

Respondents' answers indicated that generally they work within the Code of Ethics, although responses did reveal some areas of concern. Interpreter respondents to the in-house survey appeared to show greater adherence to professional practice and the Code of Ethics than those who responded to the online survey. This may have been due to the fact that these were staff interpreters working in a health facility with regular monthly supervision sessions in which any ethical dilemmas were discussed. Comments provided by respondents demonstrate that more work must be undertaken to ensure that patients and HPs are aware of the role of professional interpreters, as will be discussed below. It is important that government agencies and the language services industry raise awareness about the role played by professional interpreters and translators; patients should feel reassured interpreters and translators are professionals bound by a Code of Ethics, working in a multidisciplinary team, and looking after their health.

Table 1 provides details regarding the background of respondents for both the in-house survey and the online survey.

Table 1. Healthcare interpreter respondents to online and in-house survey respectively

	Online survey	In-house survey
Number of interpreter respondents	233	26
NAATI accredited	233	26
Working in healthcare setting	93%	100%
Work experience	Over 10 years: 60% 5-10 years: 20%	<2 years: 3 out of 26 2 to 5 years: 4 out of 26 5 to 10 years: 5 out of 26 >10 years: 10 out of 26
Healthcare settings worked in include*	wards, clinics, primary healthcare, mental health	A combination of all of these: 26 out of 26
Frequency of work in healthcare setting through an agency	Frequently: 45% Occasionally: 26%	Always

More than 100 assignments completed	80%	100%
Permanent employment as full- or part-time healthcare interpreters	9%	16 out of 26 identified as ‘in house part-time or fulltime’
Employed in health setting on casual basis	20%	10 out of 26 identified as ‘in-house casual’
Hours worked per week	< 6 hours: 47% 6-10 hours: 23% 10-15 hours: 14% >15 hours: 16%	<6 hours: 1 out of 26 6-10 hours: 3 out of 26 10-15 hours: 22 out of 26

Only 9% of online interpreter respondents were permanently employed in the healthcare setting on a part-time or full-time basis. Online survey respondents reported also working in other areas, including mental health sectors, the private health sector, the migration setting, community organisations, the disability and Centrelink,¹ as well as legal and correctional settings. The survey did not ask respondents which language pairs they worked with, but it was clear from some of the responses that both spoken and signed languages participated.

Those online respondents who answered ‘No’ to working in a health-related setting were exited from the survey. Percentages provided in the findings are calculated as a percentage of the number of respondents who answered the question. We first discuss the findings from interpreters who responded to the electronic survey that was circulated around Australia followed by the in-house interpreter respondents.

Online survey of interpreters

It is notable that 9% of interpreters responding to the online survey said that it is not important to prepare in advance. This may be true for repeat appointments where interpreters are familiar with the situation and associated terminology, but it is certainly not true for specialist consultations or assignments interpreters have not undertaken previously. Similarly, 45% of interpreter respondents agreed that it is not necessary for them to be briefed before appointment. While extensive briefing might be unrealistic in a complex working environment (Mahdavi Forthcoming), not being briefed goes against evidence-based practice (AUSIT

¹ Centrelink operates under the umbrella of the Australian Government Department of Human Services and is responsible for social security payments to Australians. See: <https://www.humanservices.gov.au/individuals/services/centrelink>

2012a: 11; Crezee 2003; Goodman-Delahunty and Howes 2019: 107; Wilson and Walsh 2019). Briefings are essential as they provide an opportunity for the clinician to state the aim of the interview and provide some background information. Briefings allow interpreters to explain their role and discuss the preferred mode of interpreting (Tebble 2014). The question about the need for a briefing appeared in the survey twice, worded slightly differently. More than a third of interpreter respondents (35%) interpreters disagreed that it is essential to have a debriefing at the end of the appointment.

The authors were concerned that 13% of interpreter respondents said that it is not important to show empathy. While interpreters do not have to show empathy, this is an issue that could benefit from wider discussion within the profession of interpreting. Bot (2005) reported that her participants sometimes switched to the use of the third person when interpreting content of an emotional or traumatic nature. On a related matter, 22% of respondents said that it is not important to warn the clinician if a question may offend patient. Several points can be made here. If the interpreter has a duty of care towards the patient, and if the patient is offended, s/he may become less cooperative (cf. Crezee and Grant 2016), and this, in turn, will have an impact on patient health outcomes. In addition, if the interpreter is to interpret the HP's illocutionary intent correctly, in order to achieve pragmatic equivalence (Hale 2014), the interpreter may either alert the professional to the potential misunderstanding or convey the statement in a pragmatically appropriate manner.

In addition, 12% of online-survey interpreter respondents said it is not important to explain non-verbal language. Non-verbal language which includes proxemics, vocalics, haptics, gaze (Lan 2019) substantially adds to overall communicative meaning (Lan 2019; Phutela 2015). This is something that needs to be discussed during professional development sessions and interpreter education programmes, where attendees can be asked how they respond if clients exhibited specific examples of culturally specific non-verbal communication, how and in what situations.

A very small percentage (2%) said they would respect the family's wishes if asked to omit or edit what the health professional said. It could be argued that these particular respondents should not work as interpreters since this goes against the precepts of accuracy and impartiality. Just over half (52%) of the online survey respondents agreed that they should explain technical

jargon to the patient. This is of concern, as this is not their role (Goodman-Delahunty and Howes 2019: 102).

Just over a third (37%) of interpreter respondents disagreed that they could help with translation (sight translate) documents during their assignment. There could be a difference here depending on whether the interpreter is in-house or freelance, and they would argue that sight-translation of up to around 300 words is a requirement. This is in line with both NAATI testing and with the *Guidelines for clinicians working with interpreters in healthcare settings* (Migrant and Refugee Women's Health Partnership 2019: 13). A similar proportion, 38% of interpreter respondents, disagreed that they should help patients fill in forms. Again, there may be a difference in terms of what freelance interpreters are expected to do, as opposed to in-house interpreters who are abiding by specific in-house guidelines. In the hospital environment [name of hospital redacted], interpreters are encouraged to help the patient fill-in forms if they have no other patients to see.

Some 16% of all respondents disagreed they should provide information of a cultural nature. Interpreter training emphasizes that providing information of a cultural nature may be beneficial and will help the clinician better understand the patient's background, such as behaviours, actions, questions and any messages to be relayed. The proviso, however, is that the information given by interpreters is subjective, and therefore the onus is on the clinician to check with the patient whether what they have learnt about their culture actually applies to them, which constitutes patient-centred care.

Almost a third (32%) of interpreter respondents disagreed that their emotional wellbeing was taken seriously by their employer. This may indicate that interpreters feel they are not perceived on par with other staff working in hospitals. This is an important point as several studies (Crezee et al. 2015; Harvey 2015; Lai et al. 2015) have reported there is a potential for the interpreter to be impacted negatively when interpreting traumatic content. In these situations, the aforementioned studies indicate that interpreters may require access to supervision or counselling. Casual interpreters, such as permanent staff members, should be eligible for Employee Assistance Programmes (EAP) which allow them to have three free counselling sessions. However, given that only 9% of the interpreters responding to the electronic version of the survey and 38% of the in-hospital interpreters were employed either part time or full

time in a permanent capacity, few are likely to be eligible for an EAP. Therefore, it is not surprising that almost one fifth (18%) of interpreter respondents disagreed with the statement that their physical safety was taken seriously by their employer.

A significant number of interpreters (77%) disagreed they should tell the HP if the patient is not telling the truth. In other words, almost a quarter (23%) of interpreter respondents agreed that they should tell HPs if they felt patients were not telling the truth. According to the AUSIT (2012a) Code of Ethics, it is not the interpreter's role to tell the clinician if the patient is telling the truth. However, when working in hospitals interpreters have a duty of care and are required to tell the HP if they think the patient may not be telling the truth and where not telling the clinician may result in a life-threatening situation². One example would be where the client assures the clinician that they are taking important medication when they have told the interpreter in the waiting room that they are not. Another scenario might be where the client discloses to the interpreter in the waiting room that he or she is feeling worthless and thinking of ending their life. In both cases, not telling the HP may impact on patient health outcomes. We discuss this further below.

It was disappointing to find that 34% disagreed interpreters could/should take notes during an assignment. These respondents have a very narrow view of the interpreter's role. This was a surprising finding since interpreters are taught to take notes in order to be able to interpret all content accurately.

Some 14% of interpreters who responded to the online survey said they agreed they can explain medical procedures to patients while healthcare professionals are occupied with other duties, for instance surgical procedures, proposed treatment options, diagnostic studies, etc. However, it is the HP's role to explain medical procedures, including proposed treatment options and diagnostic studies (Crezee 2013). It is possible that patients expect that interpreters will provide explanations (Tang 2017). Surprisingly, 37% of interpreter respondents agreed they should be ready to calm the patient down if needed. Although interpreters may have a better understanding of the patient's culture, and therefore may even be better positioned to calm the

² This would only apply if the client tells the interpreter (in a scenario Ozolins, in a 2019 webinar on ethics referred to as 'the terror in the waiting room') prior to the appointment that he/she is not taking important medication with potentially life-threatening consequences.

patient down, it is not their role according to the AUSIT Code of Ethics (2012a). It is the role of the HP, while the interpreter interprets in a pragmatically equivalent manner. However, this may again depend on the guidelines of the service which interpreters are asked to abide by.

Just under a third of respondents (33%) disagreed they should make a phone call on behalf of the healthcare professional. This question may not have been worded very clearly and should be amended in future similar surveys. Interpreters in Australia are asked to contact patients by telephone to remind them of appointments. Sometimes interpreting services ask interpreters to ring patients to check if they were able to obtain their medication after discharge from hospital (de Jong, pers. comm., 2018). In other words, responses to this question may depend on the guidelines for practice that exist in particular hospital interpreting services.

In-house interpreters

With regard to the role of the interpreters, in-house respondents appeared to understand the AUSIT (2012) Code of Ethics and Code of Conduct. In terms of relationships with service users, almost all respondents gave answers in line with the AUSIT (2012a) Code of Ethics and Code of Conduct, however some respondents seemed to be confused about their role. Their responses raised issues regarding non-verbal communication, briefing prior to and debriefing after sessions, sight-translation of documentation, and alerting clinicians when patients are apparently dishonest.

Four of 26 interpreters (15%) disagreed that they should explain non-verbal language such as facial expressions, gaze (Lan 2019), when in fact non-verbal communication is an important component of the overall 'message' conveyed (Phutela 2015). Nine out of 26 interpreters (35%) agreed that it is not necessary to have a briefing with the healthcare professional before an appointment which is somewhat disappointing since briefing sessions are considered essential (Tebble 2012). Two out of 26 (8%) interpreters agreed they should limit their interpretation to the main points only. This goes against the AUSIT (2012) Code of Ethics precept of accuracy. It is not up to the interpreter to decide what the main points are. Four respondents (15%) indicated that they did not feel debriefings with clinicians are needed after an appointment. Debriefing sessions are important opportunities for HPs to ascertain that they have not missed anything, including culture-specific information, and to ascertain that the interpreter is okay and has not been negatively impacted by the interpreted interaction.

Eleven (42%) respondents disagreed that they should (sight)translate documents as part of an assignment. However, the question may have been misinterpreted, by using the term ‘translate’ instead of ‘sight-translate’. Nine (35%) respondents disagreed that they should help healthcare consumers fill-in forms. In fact, at the hospital included in the study, in-house interpreters are expected to help patients fill in forms if they do not have other clients to interpret for. Seventeen (65%) respondents disagreed they should tell the HP if someone is not telling the truth. In the hospital environment in-house interpreters are considered part of the healthcare team and as such have a duty of care to tell HPs if they believe patients are not telling the truth. The difference here is that the in-house Code of Conduct at the hospital overrides the AUSIT (2012a) Code of Ethics and Code of Conduct³. If an interpreter is in doubt about a patient telling the truth, they should ask the clinician to step out of the room and express their concerns. In this case, there is no breach of the AUSIT Code of Ethics (2012) because there is no longer a 3-way conversation context, but rather a 2-way conversation where the Code does not apply, and the interpreter must perform their duty of care. Ultimately if the patient lies and this poses a risk to their health, an in-house staff member has the duty of care to alert the HP. Of course, the patient may indeed be telling the truth, but the onus is on the HP to ascertain facts by extending their conversation with the patient.

Health professionals’ misunderstanding of the health interpreter role

Several interpreters commented on HPs’ misunderstanding and thereby sometimes compromising the healthcare interpreter role. Health interpreters are bound by the AUSIT (2012) Code of Ethics and may feel conflicted if HPs expect them to exceed the role boundaries prescribed by the code (e.g. Mahdavi Forthcoming). The most salient themes that emerged related to HPs not wanting interpreters to take notes, expecting interpreters to complete paperwork with patients, or not interacting with patients. The following two comments relate to notetaking.

I was told by an oncology nurse that she found my notetaking distracting. The nurse made the comment in front of the patient. I explained to her the importance of my notetaking very briefly. When I finished the assignment, I contacted the language service manager and requested that professionals should be trained on how to work with interpreters.

³ And indeed, this is accepted by AUSIT itself.

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I got my notebook and pen out to take notes for my interpreting, and the doctor insisted that I was not to take any notes. I explained that it was simply a tool of the trade. The doctor insisted that I was not to take any notes as this distracted him.

Interpreter respondents also relayed a number of instances of HPs not interacting with the patients but expecting interpreters to take on part of their tasks, as reflected in the comments below.

Specialist doctor is rushing through appointments and doesn't give me enough time to interpret or [they] talk to the family member in English because it's quicker and I have to remind them that I need to interpret what they are saying to the client.

Health professional expecting me to sit with the patient while they attend to other tasks or expect me to go through paperwork/questionnaires with patient by myself (which I always refuse to do).

Another area of misunderstanding the health interpreter's role involves HPs treating interpreters as healthcare assistants, rather than as impartial interpreting practitioners. It is not clear from the statement below why this happens, or whether HPs feel the interpreters must be able to assist on the basis of their intercultural awareness or familiarity with a given patient population. The final statement below seems to reflect the interpreter feeling it is risky that the clinician is handing over responsibility for understanding all of the client's health issues to the interpreter – when that is in fact their role.

Something that happens to me very regularly is the healthcare professional trying to have a one-on-one conversation with me about the client's health needs during the assignment or asking what I think they should do and not talking directly to the client.

Many times, mainly when the Healthcare Professionals try to talk to me or hand me the prescription, appointment slip or docs rather than to the healthcare consumer. When I explain the correct procedure, sometimes offence and ill feeling is shown.

When the health professional asks me to explain the procedure to the client without his involvement because I have interpreted the concept so many times.

When the health professional asking me to go through a health questionnaire and asking the client to respond and sign the consent that he has understood everything. I sometimes am not confident that I know all of the issues in detail and I feel it is very risky conduct.

The statement below seems to exemplify the complexity of workplaces in that the medical professional did not want to take the time to hear the patient's comments prior to a medical procedure.

Today, for example, an anesthetist wanted me to interpret what he said to the patient but NOT what the patient said to him (I guess the reason was that he was 'in a hurry'). He explained this to me raising his voice and the patient, who was about to enter surgery seemed somewhat alarmed. I tried to keep calm and, after interpreting what the Doctor said, I decided to ignore the incident and I continued interpreting both ways. By not answering back I avoided arguing with him. In the end, he seemed sorry about his outburst and concluded amicably the interpreting session.

The following reflected the HP mistakenly thinking it was the interpreter who was aggressive towards them, rather than the latter relaying the health consumer's tone and pragmatic intent:

Yes...Deaf client was abusive and swearing. Professional thought it was ME being aggressive... I [had to] explained my role.

Interestingly, respondents reported that HPs do not appear to appreciate being reminded by interpreters about their role and role boundaries. One respondent commented that many healthcare professionals respond in an aggressive manner when interpreters resist following the interactional rules imposed by the former. It would seem that some healthcare professionals do not know how to use an interpreter and become aggressive when an interpreter resists following their 'unilateral' rules.

Another respondent described a situation where the interpreter had explained their role sensing a misunderstanding on the part of the specialist and the former had then continued the conversation in a more appropriate manner.

Another time another specialist said that the pain which patient was complaining about after the surgery that the specialist performed previously on that patient was unlikely or should not be happening as he did everything correctly. I had to point out to him that I was not there to make a judgement on his performance or do the patient's bidding, but rather to convey the patient's feelings, she was obviously suffering, to him as a specialist. The specialist realized he acted inappropriately,

and the conversation continued in a more appropriate way with the patient feeling more accepted and understood.

Another respondent reported a situation where the HP had continued the interaction without the interpreter, using ‘pen and paper’, assuming that the deaf client was literate in English.

Too many to report! But one that comes to mind from a few years ago is a diabetes clinic, where despite being told several times I had to leave right at 12 (as booked), they didn't take the patient in until 5 mins to 12. Once inside the patient had an extremely erratic and dangerous pattern of hyps, (very high insulin levels) and displayed immediately a very unclear and unsound knowledge of her condition (this was partially due to her level of language - being a deaf person, she'd had very limited access to language until she was past the crucial age of language acquisition, a common problem amongst deaf people - this had been ascertained out in the waiting room.) She was only sometimes taking her insulin rather than 4x a day, etc. I had to leave almost immediately and urged the healthcare professional to make another urgent appointment with the patient, as she needed some serious diabetic education. The nurse assured me they would continue the appointment without me. I asked her how she would do this, and she said pen and paper. I explained that the deaf patient, though they may be able to read and write very basically in written English, had very poor comprehension and was unlikely to understand the complex interaction required (such as what number to dial up on her insulin, what times to take it, how many etc.) She basically hushed me out of the room and the appointment continued without me. I reported this to the Patient Liaison officer - I have no idea if there was any outcome but it seems doubtful, I was never contacted about it again. This patient has since died from diabetic complications.

Some comments made by interpreter respondents pointed to the potentially harmful consequences of HPs not understanding the importance of patients being able to communicate in their preferred language of medical care (Crezee and Roat Forthcoming).

Health professionals' perspectives on the healthcare interpreter role

This section contains a summary of HPs' responses. The following table (Table 2) provides demographic information regarding the HPs who responded to the in-house survey and the online survey.

Table 2: Health professional respondents to online and in-house survey respectively

	Online survey	In-house survey
Number of health professional respondents	41	6
Resident in Australia	41	6
Working in healthcare setting	95%	6
Healthcare settings worked in include*	Public hospital: 80% Primary healthcare: 6% Private hospital: 3% Combination of the above: 11%	Public acute and subacute hospital setting
Employed in health setting on casual basis	20%	0
Hours worked per week	< 6 hours: 47% 6-10 hours: 23% 10-15 hours: 14% >15 hours: 16%	not known

Online survey of health professionals: role of the interpreter

HPs who responded to the online survey appeared to be relatively familiar with the healthcare interpreter role, but some misunderstandings were apparent. More than one fifth (22%) of these HPs responding to the online survey did not think it was important for interpreters to prepare in advance. This suggests that HP respondents did not fully understand what it means to be a professional interpreter, and that this role involves preparing for assignments as thoroughly as possible. Furthermore, 42% of online clinician respondents indicated it was not necessary to brief an interpreter before their assignment. Almost one in two HPs therefore dismiss one of the pillars of the profession (AUSIT 2012a: 11; Minas et al. 2001; Salaets and Balogh 2019; Wilson and Walsh 2019). These responses reflect a lack of understanding of the professional interpreter’s role.

The online survey revealed a similar lack of awareness among HP respondents of the importance of debriefing. Debriefing is essential for a number of reasons, one of which is the health professional doublechecking whether there was anything they might have missed and any crosscultural issues that might have been at play (Minas et al. 2001; Tebble 1998). This is also an opportunity for interpreters to state how they feel after a potentially traumatic assignment – an important part of their selfcare. Almost one third (29%) of health professionals responding to the online survey disagreed that it is essential to debrief an interpreter at the end of their assignment. Again, this means they do not see the importance of debriefing as an

opportunity to check on potential crosscultural issues, or to ensure that they had not missed anything.

Almost one third (27%) of health professionals responding to the online survey, expected the interpreter to limit their interpretation to the main points only. This indicates that, aside from health services where health professionals are given transcultural training, there is still work to be done in training clinicians about the interpreter role, which does not include summarising the main points.

Online survey of health professionals: Relationship with the interpreter

A misunderstanding of the interpreter's role affecting the relationship with the interpreter is evidenced by the 65% of health professionals who agreed that interpreters should explain the meaning of technical or medical jargon. It is the health professional who is in charge of the interaction and it is their role to clarify any technical jargon. The fact that 58% of clinician respondents expected the interpreter to tell them if the patient is not telling the truth raises a somewhat controversial issue in terms of the AUSIT (2012a) Code of Ethics, which prescribes that interpreters are to remain completely impartial. As we have noted earlier, in hospitals where interpreters are seen as part of the interdisciplinary team, health professionals may indeed expect this.

Further evidence of misunderstanding the interpreters' role is that 68% of the online survey clinician respondents disagreed that interpreters need to make notes during their assignments. This reinforces the earlier point that health professionals, in general, need more training on how to work with interpreters. Well over two thirds of clinician respondents (68%) agreed that the interpreter can help them calm the patient down if needed. This would seem to contradict the AUSIT (2012) Code which prescribes impartiality. However, at the hospital where the paper-based survey was conducted, in-house interpreters are part of a multidisciplinary health team looking after the patient, and in this context the interpreter can help calm the patient down. However in general, and as per the AUSIT (2012a) Code of Ethics, this is the clinician's role and if they calm the patient down, the interpreter can assist by conveying the clinician's words, including the pragmatic intent (Crezee et al. 2017; Hale 2014; Morris 1999; Teng et al. 2018) and body language, in a culturally and linguistically appropriate manner.

In-house health professionals

Only 6 health professionals responded to the survey; all were paper based and indicated they would have been more comfortable answering an online survey. All respondents worked in a health service and were relatively experienced (see Table 2). It was evident from their responses that all respondents seemed to have a good understanding of the role of professional interpreters. The following themes emerged:

The role of the interpreter

Overwhelmingly HPs emphasized the principles of the AUSIT (2012a) Code of Ethics and Code of Conduct. All six respondents said it was ‘very important’ that no bias is shown that judgement is reserved, that information be kept confidential, that neutrality is maintained, that information is not added, that the interpreter does not answer on behalf of the clinician, that the healthcare consumer’s language is not censured or softened, and that the interpreter remains emotionally detached from the situation. Emphasis was also placed on a perfect command of the English language.

All six respondents felt that it was ‘important’ or ‘very important’ for interpreters: to have a perfect command of the English language and a perfect command of the consumer’s language as well as an understanding of the health consumer’s culture. All respondents also said that it was ‘very important’ or ‘important’ for interpreters to know the processes and procedures within the healthcare setting. Lastly, all respondents felt that it was ‘important’ or ‘very important’ for interpreters to indicate when the healthcare consumer has not understood, and to remain emotionally detached from the situation.

Relationship with the interpreter

The clinician respondents expected the interpreter to adhere to the AUSIT (2012a) Code of Ethics and Code of Conduct. All six respondents agreed with the statement “I would rather rely on an interpreter who is professionally qualified, than on an unqualified ad hoc interpreter” while all six completely disagreed with the following statements:

- Anyone who speaks and understands the required languages should be able to perform interpretation duties.
- I expect the interpreter to limit the interpretation to the main points only.

- The interpreter should be able to explain healthcare procedures for me while I attend to other tasks.

Five respondents completely disagreed, while the 6th was neutral with regard to the statement: “I feel I can totally trust a qualified interpreter to keep information confidential.” No information was provided as to why the 6th respondent was neutral in this regard.

Health professionals ‘agreed’ or ‘completely agreed’ with the following statements:

- It is essential to de-brief an interpreter after an interpreted interaction.
- An interpreter can translate documents if necessary, as part of the assignment.
- The interpreter is a good source of information on the local culture and customs.
- Interpreters need to make notes during interpreted interactions.
- Interpreters need to be introduced to all participants at the start of an interpreted interaction.

In stressing how important it is for interpreters to strictly adhere to the Code of Ethics, some health professionals, especially in conversation with the authors, implied that there are still too many interpreters who do not do so, especially agency interpreters. This is interesting because such comments could only be made by health professionals who are very aware of the AUSIT (2012a) Code of Ethics, and who can tell when interpreters are not abiding by the ethical guidelines.

4. Discussion

The main implication of the findings is that agency interpreters need ongoing professional development which may involve the use of simulated real life scenarios which enable them to discuss ethical dilemmas. Further, the findings seem to suggest that there are still many divergences between the understanding of the health interpreter role by health professionals who completed the online survey as opposed to those who completed the in-house survey. The latter worked at a hospital where transcultural services provided regular transcultural training sessions and showed a solid understanding of the interpreter role. All new staff members employed by the Australian hospital where the in-house survey was conducted undergo five two-hour training sessions. During these sessions, Government and hospital policy and frameworks are discussed, as well as the AUSIT (2012a) Code of Ethics and Code of Conduct, Transcultural and Language Services (TALS) Service Staff Guidelines (Northern Health n.d.), to mention just a few. Importantly adherence to the Code of Ethics is monitored via the bi-

monthly supervision session all staff are required to attend with their supervisor. In addition, all TALS staff participate in a monthly forum where matters pertaining to ethical dilemmas are discussed at length.

It is rare that interpreters are placed in a position that they breach their Code of Ethics, this should only occur when strict adherence to the Code of Ethics compromises patient-centred care or empathy towards the patients. This can also occur when interpreters may be expected to abide by institutional guidelines for practice established by the service and/or the hospital for which they work, and these may sometimes diverge from precepts such as those set out by national bodies such as the AUSIT (2012a), as has been noted above. Where interpreters are considered to be part of the healthcare team, there may be more of an expectation for them to act in accordance with institutional norms, perhaps as institutional gatekeepers (cf. Davidson 2000) which could contradict professional ethical guidelines. Expectations by patients and their relatives could cause interpreters to question whether they should diverge from ethical guidelines such as those set by AUSIT (2012a). Bi-monthly supervision and monthly forums in which ethical dilemmas are discussed would highlight such contradictions.

The findings indicate that HPs at the hospital that provided regular training sessions were particularly well aware of the healthcare interpreter's role when compared to HPs who responded to the online survey. However, this particular sample of 6 respondents cannot be generalized to a larger population. Several factors may have played a role here: firstly, the health professionals who responded to the in-house survey were all relatively experienced in working with interpreters and the hospital's transcultural and language service had organized regular inhouse training sessions in this area. Secondly, only health professionals who were confident that they were familiar with the healthcare interpreter role may have responded to the survey. Lastly, given the sample size, responses may not reflect those of other health professionals in the hospital in question.

Health professionals who completed the online survey seemed unaware of important aspects of the interpreter role, notably, the fact that they cannot expect interpreters to take over part of their own role in interacting with the patient. Interpreters are not there to summarize main points only: that is the clinician's role. Interpreters need to be briefed, so they are aware of the purpose of the session, the background of the patient and what the clinician is trying to achieve.

Briefing also helps to determine the mode of interpretation (consecutive or simultaneous) and will allow interpreters to explain their role. Health professionals also need to be aware that note-taking allows interpreters to convey information accurately and completely.

These findings confirm comments made by Hale (2011) about the importance of professionals understanding the interpreter's role. Bringing together health professionals with healthcare interpreters for training has proven successful. Crezee (2015) reported on shared pre-professional training sessions involving speech and language therapists together with interpreting students working through simulated real life scenarios. Similarly, (Krystallidou et al. 2018) reported on the success of like programmes. The findings confirm the importance of a briefing session prior to the health professional-patient interaction where the interpreter role is discussed, and the Code of Ethics is invoked. However, in practice, health professionals may not take the time to do so especially since interpreter-mediated interactions take longer than those which do not involve an interpreter (Mahdavi Forthcoming).

5. Conclusion

This paper has surveyed Australian healthcare interpreters and health professionals on their expectations of the healthcare interpreter role, by asking what they expected interpreters to do in particular situations. It has also compared the responses of healthcare interpreters and health professionals who had received ongoing training on the interpreter role at an urban hospital, with those of interpreters and professionals who responded to an Australian-wide survey. Two interpreter surveys, and two clinician surveys were analysed and compared. The first interpreter survey had 26 in-house respondents based at an urban hospital, while the second had 233 online respondents from around Australia. The first clinician survey had 6 in-house respondents based at the same hospital, while the second had 41 online responses from around Australia.

While most professional interpreters surveyed stated that they would generally adhere to the AUSIT (2012a) Code of Ethics and Code of Conduct, a significant number appeared to ignore or reject important precepts of the Code in their practice, especially where these interpreters are non-in-house agency interpreters. Similarly, while most health professional surveyed displayed an understanding of the role professional interpreters have in the health context, a number of them failed to grasp the importance of key elements of the Code of Ethics, including, but not limited to, the briefing and debriefing process, what should be interpreted and how, as

well as the role boundaries of the interpreter. The survey at hand has identified that there is a need for briefing or debriefing sessions, where interpreters may have the opportunity to clarify their role. Briefing (and debriefing) sessions should be included in interpreter-mediated clinician-patient interactions as a matter of routine. Medical school may be a good place to start such shared learning, while interpreter services in hospitals should organize professional development sessions on working with interpreters.

Interpreter education must continue to focus on the inclusion of information on interpreter role and ethics and present student interpreters with roleplay scenarios involving ethical dilemmas. The authors recommend that interpreter service providers make every effort to train clinicians as to how to work with interpreters and what the interpreter role encompasses. Scenarios whereby the health professionals have to play the role of interpreters and accurately and impartially repeat information in English have been found to be particularly effective in New Zealand (Crezee, pers. comm., 2019). Following such roleplays, professionals often admit that they had no idea how difficult it is to ‘hang on’ to information and accurately convey it.

While commending the industry on a substantial pool of interpreters who clearly understand their professional obligations - the authors invite academic institutions, certifying bodies, and other government and non-government stakeholders to demand a greater adherence to the principles of the AUSIT (2012) Code of Ethics and Code of Conduct. In other words, the authors want to see that this Code is adhered to and upheld. They strongly recommend more training for all those who interface with interpreters. At the same time, health services have to ascertain transcultural training for health professionals that address the issues raised in this study.

With regard to conveying information accurately, we note that this should involve maintaining the speaker’s or signer’s pragmatic intent. Pragmatic intent is socially constructed and both pragmalinguistic failure and sociopragmatic failure (Hale 2014) may arise in interactions between participants from different socio- and culturally linguistic backgrounds. A whole host of other factors may play a role in determining the way interpreters decode pragmatic intent, in an effort to render this accurately. This may include interpreters’ intercultural knowledge and their experience –also based on previous encounters with one or more of the interlocutors. In light of the general controversy about equivalence in Translation Studies, we would argue

that pragmatic equivalence is not a fixed theoretical concept but emerges from the interaction between participants. It would be good if the concept of pragmatic equivalence could be enshrined explicitly in the Code of Ethics. In this respect the findings of this study are very relevant to other fields of interpreting also.

Potential limitations of this research, are that because the research tool is a questionnaire, we have no way of knowing if participants have responded honestly. There is no chance to question as there might be in a face to face interview. It is likely the interpreting respondents were all quite aware of the healthcare interpreter role and of the Code of Ethics, especially given Australia's long history of interpreter accreditation and interpreter training. While the numbers of respondents to the online survey suggest that the findings could be significant, given the cohort profile, the authors, therefore, caution against generalising the findings to broader populations.

Future research should include follow-up interviews or Focus Discussion Group (FDG) to enable an in-depth and honest exploration of experiences and perspectives. This would also allow researchers to explore whether experiences reported by survey respondents are shared by FDG participants. In addition, research could focus on healthcare interpreters in other countries, adapting the survey to incorporate the ethical guidelines and guidelines for practice relevant in those geographical locations. Future studies should also ask health professional participants whether they have attended any professional development sessions on how to work with interpreters and what they learned from such training sessions. The strength of the current study consists in the fact that all interpreter respondents were professional interpreters, accredited by the same accreditation authority (NAATI) following a common Code of Ethics and Code of Conduct (AUSIT, 2012).

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References

- AUSIT (2012a) *Code of Ethics and Code of Conduct*. [online text], Australian Institute of Interpreters and Translators <<https://ausit.org/code-of-ethics/>> <http://www.ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf>, accessed October 21, 2018.
- AUSIT (2012b) *AUSIT Code of Ethics and Code of Conduct*, Australian Institute of Interpreters and Translators, <http://www.ausit.org/AUSIT/Documents/Code_Of_Ethics_Full.pdf>, accessed October 21, 2018.
- Bot, Hanneke (2005), *Dialogue Interpreting in Mental Health* (Leiden: Rodopi).
- Crezee, Ineke (2003), 'Health interpreting in New Zealand: The Cultural Divide', in Louise Brunette, et al. (eds.), *The critical link 3: Interpreters in the Community* (Amsterdam: John Benjamins), 249–59.
- Crezee, Ineke (2013), *Introduction to healthcare for interpreters and translators* (Amsterdam: John Benjamins).
- Crezee, Ineke (2015), 'Situated learning approaches to health interpreter education', *Translation and Interpreting*, 7 (3), 50-62.
- Crezee, Ineke and Grant, Lynn E. (2016), 'Thrown in the deep end: Challenges of interpreting informal paramedic language', *Translation & Interpreting*, 8, 1-12.
- Crezee, Ineke and Jülich, Shirley (2020), 'Exploring role expectations of healthcare interpreters in New Zealand', in Eva Ng and I Crezee (eds.), *Interpreting in legal and healthcare settings: Perspectives on research and training* (Amsterdam: John Benjamins), 211-41.
- Crezee, Ineke and Roat, Cynthia (Forthcoming), 'Bilingual patient navigator or healthcare interpreter: What's the difference and why does it matter?', *Cogent Medicine*.
- Crezee, Ineke, Jülich, Shirley, and Hayward, Maria (2013), 'Issues for interpreters and professionals working in refugee settings', 8.
- Crezee, Ineke, Teng, Wei, and Burn, Jo Anna (2017), 'Teething problems? Chinese student interpreters' performance when interpreting authentic (cross-) examination questions in the legal interpreting classroom', *The Interpreter and Translator Trainer*, 11 (4), 337-56.
- Crezee, Ineke, Burn, Jo Anna, and Teng, Wei (2019) 'Community translation in New Zealand', in R Tipton and L Desilla (eds.), *The Routledge handbook of translation and pragmatics* (London: Routledge).

- Crezee, Ineke, et al. (2015) 'Teaching interpreters about self-care', *International Journal of Interpreter Education*, 7 (1), 74-83.
- Davidson, Brad (2000), 'The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse', *Journal of Sociolinguistics*, 4 (3), 379-405.
- Goodman-Delahunty, Jane and Howes, Loene M. (2019), 'High-stakes interviews and rapport development: practitioners' perceptions of interpreter impact', *Policing and Society*, 29 (1), 100-17.
- Hale, Sandra Beatriz (2011), 'Public service interpreting', in Kirsten Malmkjær and Kevin Windle (eds.), *The Oxford handbook of translation studies* (Oxford: Oxford University Press), 343–56.
- Hale, Sandra Beatriz (2014), 'Interpreting culture: Dealing with cross-cultural issues in court interpreting', *Perspectives*, 22 (3), 321-31.
- Hale, Sandra Beatriz and Napier, Jemina (2013), *Research methods in interpreting. A practical resource* (61; London: Bloomsbury) 485.
- Hale, Sandra Beatriz, et al. (2012), 'Improvements to NAATI testing: Development of a conceptual overview for a new model for NAATI standards, testing and assessment', (NSW, Australia: The University of New South Wales).
- Harvey, Michael (2015), 'Reaping the benefits of vicarious trauma', *International Journal of Interpreter Education*, 7 (2), 5-20.
- Issa, Shareef (2018), 'Challenges facing conference and television interpreters', (Auckland University of Technology).
- Krystallidou, Demi, et al. (2018), 'Training “doctor-minded” interpreters and “interpreter-minded” doctors: The benefits of collaborative practice in interpreter training', *Interpreting*, 20 (1), 126-44.
- Lai, Miranda, Heydon, Georgina, and Mulayim, Sedat (2015), 'Vicarious trauma among interpreters', *International Journal of Interpreter Education*, 7 (1), 3-22.
- Lan, Wei (2019), 'Crossing the chasm: Embodied empathy in medical interpreter assessment', Unpublished Doctoral Thesis (Hong Kong Baptist University).
- Magill, Delys (2017), 'Healthcare interpreting from a New Zealand sign language interpreter's perspective', Thesis (Auckland University of Technology).
- Mahdavi, Mojdeh (Forthcoming), 'The role of interpreters in healthcare in Australia', Unpublished Doctoral Dissertation (Victoria University, Australia).

- Migrant and Refugee Women's Health Partnership (2019) *Guide for clinicians working with interpreters in healthcare settings* [online text], Migrant and Refugee Women's Health Partnership
<<https://culturaldiversityhealth.org.au/wp-content/uploads/2019/02/Guide-for-clinicians-working-with-interpreters-in-healthcare-settings-Jan2019.pdf>>
- Minas, Harry, Stankovska, Malina, and Ziguras, Stephen (2001), *Working with interpreters: Guidelines for mental health professionals* (Melbourne: Victorian Transcultural Psychiatry Unit).
- Morris, Ruth (1999), 'The gum syndrome: Predicaments in court interpreting', *Forensic Linguistics*, 6 (1).
- Northern Health (2020), 'Transcultural and Language Services (TALS) Service Staff Guidelines', <<https://www.nh.org.au/service/transcultural-language-services-tals/>>, accessed October 2.
- Ozolins, Uldis (2016), 'The myth of the myth of invisibility?', *Interpreting*, 18 (2), 273-84.
- Phutela, Deepika (2015), 'The importance of non-verbal communication', *IUP Journal of Soft Skills*, 9 (4), 43-49.
- Salaets, Heidi and Balogh, Katalin (2019), 'Interpreter mediated questioning of minors (ImQm): The voice of children and their rapport with interpreters', *Revista de Llengua i Dret*, 71, 27-44.
- Tang, Anni (2017), 'What are the experiences of older Mandarin-speaking migrants in Auckland when accessing health and support services in New Zealand?', (Auckland University of Technology).
- Tebble, Helen (1998), *Medical interpreting [videorecording]: Improving communication with your patients* (Geelong, Vic: Learning Resources, Deakin University).
- Tebble, Helen (2012), 'Interpreting or interfering?', in Claudio Baraldi and Laura Gavioli (eds.), *Coordinating participation in dialogue interpreting* (Amsterdam: John Benjamins), 23-44.
- Tebble, Helen (2014), 'A genre-based approach to teaching dialogue interpreting: the medical consultation', *The Interpreter and Translator Trainer*, 8 (3), 418-36.
- Teng, Wei, Burn, J. A., and Crezee, Ineke (2018), 'I'm asking you again! Chinese student interpreters' performance when interpreting declaratives with tag questions in the legal interpreting classroom', *Perspectives*, 26 (5), 745-66.

Wang, Danny Ding-Yi and Grant, Lynn (2015), 'Challenges of court interpreting: Implications for interpreter education', *International Journal of Interpreter Education*, 7 (1).

Wilson, Lauren and Walsh, Dave (2019), 'Striving for impartiality: Conflicts of role, trust and emotion in interpreter-assisted police interviews', *Pragmatics and Society*, 10 (1), 122-51.

Appendix: AUSIT 2012 Code of Ethics and Code of Conduct: Main principles

(see: AUSIT (2012a) *Code of Ethics and Code of Conduct*. [online text], Australian Institute of Interpreters and Translators <<https://ausit.org/code-of-ethics/>>)

	Key elements
Professional conduct	Interpreters taking ‘responsibility for their work and conduct’; providing ‘quality service in a respectful and culturally sensitive manner’, disclosing ‘any conflict of interest or any matter that may compromise their impartiality’ (AUSIT 2012b: 4).
Confidentiality	Not disclosing any ‘information required in the course of their work’ (AUSIT 2012b: 5).
Competence	‘In order to practise, interpreters and translators need to have particular levels of expertise for particular types of work’ (AUSIT 2012b: 5).
Impartiality	‘Interpreters remain unbiased throughout the communication exchanged between the participants in any interpreted encounter’ (AUSIT 2012b: 5).
Accuracy	‘Accuracy for the purpose of this Code means optimal and complete message transfer into the target language preserving the content and intent of the source message or text without omission or distortion’ (AUSIT 2012b: 5).
Clarity of role boundaries	‘Interpreters and translators maintain clear boundaries between their task as facilitators of communication through message transfer and any tasks that may be undertaken by other parties involved in the assignment’ (AUSIT 2012b: 5).
Maintaining professional relationships	Endeavouring to secure satisfactory working conditions, appropriate briefing, and ‘and clear conduct protocols where needed in specific institutional settings’ (AUSIT 2012b: 6).
Professional development	‘Practitioners commit themselves to lifelong learning’ (AUSIT 2012b: 6).
Professional solidarity	‘Practitioners (...) support and further the interests of the profession and their colleagues and offer each other assistance’ (AUSIT 2012b: 7).