FACULTY OF ARTS AND PHILOSOPHY

The use of ad hoc interpreters in the medical context

A CASE STUDY OF A TURKISH-DUTCH MEDIATED CONSULTATION

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Verklaring ivm auteursrecht

Preambule

De afgelopen jaren waren voor menig student, leerkracht en over het algemeen voor iedereen een hele uitdaging. Het coronavirus trof niet enkel de fysieke gezondheid van de mensen, voor velen was het ook mentaal een erg zware klap. Door de combinatie van verschillende opleidingen zoals het postgraduaat conferentietolken en daarnaast een educatieve master, werd het schrijfproces van deze masterproef een zware opgave voor mij. Gelukkig kreeg ik de juiste ondersteuning om dit proces tot een goed einde te brengen en werd het onderzoek op geen enkel moment echt in het gedrang gebracht.

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Abstract

In this dissertation, a multilingual mediated medical consultation between a Dutch-speaking general practitioner and a Turkish-Dutch speaking lay interpreter was analysed. This interdisciplinary study aims to provide a framework for both medical professionals and ad hoc interpreters containing guidelines to better mediate multilingual consultations. In order to highlight the main issues and to be able to provide possible solutions, a case study was conducted in a Ghent medical centre which features two separate consults for the same Turkish-speaking family. The patients' niece takes on the role of lay interpreter and the same male general practitioner is present during the two consults. In the analysis of this study, four strategies were defined from the doctor's perspective and three approaches were described for the lay interpreter. On the basis of these elements, a general evaluation of the consult was made. It can be concluded that a language barrier was present at times, but this did not negatively affect the fluency of the consultation overall. These strategies and approaches, however, formed the basis of the framework provided in the conclusion of this dissertation and can therefore be of great value to future ad hoc interpreter mediated medical consultations.

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Introduction

The recent Covid-19 pandemic has once again shown how important universal access to medical care is. All it takes is a single case of an infected person not being aware of what is going on to infect the entire world. It is by not being able to reach and inform all members of society about the severity of its nature that it manages to strengthen its grip and maintain its relevancy. Especially as this is a pandemic that can be curbed through the informed use of preventive measures such as the correct use of facial masks and the social distancing principle.

Anyone can see how communication is of vital importance not only in the treatment of illnesses, but also in the prevention thereof. Furthermore, a language barrier can impede the daily functioning of a foreign language speaker in our country in other ways such as in social services, in work-related communication and even in the housing market (Roels, 2015). In an ever increasingly globalized world, that sort of communication often needs to happen in multiple languages, whether it be through means of leaflets and brochures translated in a number of languages, or through the usage of interpreters in medical situations as is the subject of study in this dissertation. Professional interpreters are not always available, thus other solutions might be found. These include using a bridge language such as English or French or using gestures when no help through a third party can be achieved.

In this dissertation, a clear distinction will be made between professional and non-professional interpreters who mediate conversations in the medical context. More specifically, the use of an ad hoc interpreter, that is to say, a non-professional language mediator, will be investigated and compared to the deontological codes usually upheld by professional interpreters. These non-professional interpreters are often members of the same language community, family members or friends for example.

The use of non-professional interpreters is quite widespread. This is logical when looking at the current demographic figures in Flanders. At the beginning of 2021, almost 634,000 people of foreign nationality (accounting for 9.5% of the total population) were living in the Flemish region according to official statistics published by the Flemish Government (https://www.statistiekvlaanderen.be/en/population-by-nationality-0). Out of those 634,000 people, just under 144.000 have the Dutch nationality. That means that 475.000 people, or 7.5% of the entire Flemish population, are not native Dutch speakers. Considering nearly 1 out of 13 people does not have the Belgian Nationality, it is fair to assume that a lot of these people are not fluent

in the Dutch language. According to Flemish government statistics, the most spoken languages apart from Dutch in the Flemish region are Romanian, Polish, Moroccan and Bulgarian. It should therefore surprise no one that interpreters are frequently used in a number of services in Flanders. Examples include but are not limited to, court interpreters, medical interpreters and student guidance centre interpreters.

This study will examine the following topics:

- What impact does the use of an ad hoc interpreter have on the outcome of a medical intervention between patients and a doctor? Is there a clear language barrier which perturbs the conversation and/or has a negative impact on the care given?
- How can we improve these ad hoc mediated medical conversations from both the perspective of the medical professional as well as the ad hoc interpreter?

Through means of a case study, we have attempted to tackle these questions. The dissertation is based upon two consultations filmed in a medical centre in Ghent. A Turkish speaking girl takes up the role of non-professional interpreter during two separate conversations with the same medical professional. The patients are underage relatives that are accompanied by their grandmother who speaks Turkish as well. These conversations were transcribed and the unabridged versions can be found in the appendix at the end of this dissertation. These two transcriptions were then further analysed on a macro- and micro-level, analysing the fluency of the conversation and the possible influence of a language barrier.

In order to provide these macro- and micro-level analyses, a literature study is provided in chapter 1. An array of topics was discussed, such as the language barrier, the definition and role of an ad hoc interpreter, the Calgary-Cambridge model and the deontological code followed by professional interpreters. In the chapters that follow, the methodology will be defined and the macro structure of the consultations will be shown (chapters 2 and 3.1). In chapter 3.2, the thorough micro-analysis will be discussed, supplying several examples taken from the transcripts of the consultations. Finally, these findings will be presented and summarised in the last two chapters (discussion and conclusion). This for the purpose of answering the research questions stated above. Furthermore, we will try to formulate best practices for the medical professional as well as the ad hoc interpreter.

Chapter 1: Literature study

1.1 Language barrier and language acquisition

This study will discuss the use of ad hoc interpreters in a medical context. Although some research has been carried out, many aspects of this phenomenon still require further investigation (Bührig and Meyer, as published in House and Rehbein, 2004). However, this can prove to be quite difficult, as the data on ad hoc interpreter mediated medical conversations is very limited. As Bührig and Meyer (2004) state in their research, the academic interest is certainly there, but the capacity to collect and analyse the above mentioned data is very restricted, certainly in medical institutions. Furthermore, it is quite difficult to conduct research while only using anecdotal evidence or interviews, which makes a quantitative approach nearly impossible to achieve. On the one hand, we have ad hoc interpreter and interpreter research, which has produced some insights in the use of ad hoc interpreters and professional interpreters, their training (or lack thereof) and their techniques. On the other hand, a myriad of studies have already been conducted on socio-political matters regarding immigration, culture and medicine. Combining these two areas, however, has proven to be quite the challenge for researchers, resulting in very particular research which cannot be easily extrapolated to other areas. In conclusion, data on ad hoc interpreter intervention in the medical context is scarce.

This scarcity might also be explained by the fact that doctors as well as interpreters are often bound to professional secrecy. Moreover, there is a myriad of possible language combinations that can be investigated, which also makes it difficult to extrapolate the findings between different studies. This dissertation focuses on one particular language combination: Turkish and Dutch. As a result, the analysis will differ from other studies which focus on other language pairs.

A 'language barrier' in language acquisition can appear when two languages are linguistically very far apart, which is the case for Turkish and Dutch. They belong to different language families, with Dutch being a part of Indo-European language family and more specifically, the Germanic branch and Turkish belonging to the Altaic language group and more concretely, the Turkic language. English on the other hand, can be found in the same language family as Dutch. Therefore, the research carried out by Haznedar (2001) for the University of Durham can be seen as relevant to our case. Haznedar conducted a study with a four-year-old Turkish child that

was taught English over the course of 18 months. She found that a very young child will apply the knowledge gathered from learning its first language (L1). She also concluded that a child learning a second language (L2) will not be significantly affected by their first language. In doing so, she refers to the Universal grammar mechanism described in Dulay, Burt & Krashen (1982). This is relevant for our study, as we can assume Turkish adults will in fact be significantly affected by their L1 (Turkish) when attempting to learn a new L2 (Dutch) from a completely different language family, whereas this is not the case for children.

It is often the case for immigrant families that the younger family members learn the language of the host country much faster compared to the older generations (Haznedar, 2001). Sometimes the older generation does not learn the language of the host country at all, as it is often easier for children to learn a new language and the older family member can rely on them for the most part. As Galatro (2018) states in his article for TESSA International School, children have certain advantages when learning languages compared to adults. For example, immersive experiences in multilingual environments have shown to be very beneficial for language acquisition in young children. They also do not have other engagements and responsibilities, freeing up much more time for learning. In Belgium, the OKAN initiative (Onthaalklassen voor anderstalige nieuwkomers, i.e. welcoming classes for non-Dutch speaking newcomers) is very widespread (Delarue, 2017). This initiative contributes to the language acquisition of young children. Moreover, schools in general are a great learning environment, where extra support is given to non-Dutch speaking pupils, whereas the professional field does not always focus on language training (especially for blue-collar workers). The OKAN initiative does not only focus on language acquisition, it also puts much effort toward social integration of the foreign pupils. Even though there are still many challenges ahead, this integrating system can help foreign children adapt to their new environment and provide them with a basis of knowledge, which can help them throughout their further career in education and later on in life (Angelelli, 2017). It can also give them a sense of pride, because they are able to help out their family when necessary with a skill the monolingual adults in their family have not (yet) acquired. On the other hand, children might also see this as a burden put on them, as they will feel obliged to help out their family. This can have an influence on the parent-child relationship (Cohen et al. 1999 as cited in Angelelli, 2017).

It can also be argued that, overall, children have fewer inhibitions. They are allowed and even expected to make mistakes and do not care much for sounding foolish while experimenting with

language. Adults often encounter these language barriers, for example in the form of societal ridicule for language incompetence. Malone (2019) writes about a study using MRI imaging and animation technology to view which parts of the brain are used when learning a second language, both in adults and in children. The study found that children use the "deep motor area", which is responsible for processes that do not require active thinking, for which muscle memory kicks in. Children, compared to adults, therefore will start to create muscle memory while learning a second language, leading to intuitive usage long-term. Adults process language much more actively, requiring more conscious thought when using the foreign language later on.

In Meyer (2012) the notion of the language barrier is explained in the medical context of patients with a migration background. Meyer indicates that migrants achieve different levels of proficiency in the language of their host country. Some will therefore encounter a larger linguistic barrier than others. However, most of them will at some point require health care, even the ones less proficient in the language of the host country, which is often also the language of the health care officials they will have to communicate with. Furthermore, Meyer's research has shown that these language barriers have an enormous influence on medical consultations, resulting in a greater likelihood of wrong diagnoses and a major adverse effect on the general health of the patient. Meyer also suggests that migrant patients struggle to communicate in hospitals even when they are proficient enough in the language of the host country for day-to-day activities. This suggests a certain level of language proficiency is necessary to accurately interpret in medical contexts (also stated in Napier, 2017). Consequently, this is an important aspect of interpreter training.

1.2 The ad hoc interpreter

Before we can define what an ad hoc interpreter is exactly, some light must be shed on the two separate components of the term. 'Ad hoc' is derived from Latin and literally means 'to this'. It refers to a solution for a specific problem, in this case the absence of a professional interpreter. Merriam-Webster defines ad hoc as "formed or used for specific or immediate problems or needs" (Merriam-Webster's Collegiate Dictionary, 1999). The second component of this term consists of the word 'interpreter'. Lv and Liang (2018) describe interpreting as a combination of listening to an ongoing stream of a source language and orally rendering the same message

in a target language. This can either be done at the same time (simultaneous interpreting) or with the help of notes (consecutive interpreting). Interpreting in the social context (medical, judicial, etc.) can be performed as a combination of these two types of interpreting, mostly in a triadic conversation setting, which is the case for this study. Interpreting is widely considered as very demanding, involving a lot of cognitive pressure and requiring a high level of training in order to execute each task correctly.

An ad hoc interpreter in the medical context is described in Bührig and Meyer (as published in House and Rehbein, 2004) as a bilingual third party in the conversation between a health official and a patient when these first two parties do not have a language in common. These can be but are not limited to: bilingual staff members in a hospital or a doctor's office, or a relative or close friend of the patient. Larrison, Velez-Ortiz, Hernandez et al. (2010) describe an ad hoc interpreter as a person who can offer a solution for the lack of professional interpreters available in the medical field. Moreover, they can provide patients, as well as medical institutions with an easily accessible means to facilitate communication. Larrison, Velez-Ortiz, Hernandez et al. (2010) add that it has been scientifically proven that the use of ad hoc interpreters will result in lower levels of satisfaction and in a higher number of communicative errors compared to the use of a professional interpreter. Nevertheless, these non-professionals should be encouraged to pursue a career in the interpreting profession. They already possess the ability to speak several languages (some fluently) and they often show the desire to interpret for the purposes of helping other people. A more precise field of study is called CLB, child language brokering (usually for monolingual adults, in this case for adults and other young members of the family). This dissertation will also try to formulate a general approach for these people, to help them find the tools to improve their part in the mediation of medical conversations. This might also be applicable for other fields and its purpose is to encourage them to pursue interpreting as well.

As we discussed previously in chapter 1.1, the health care sector is an important subject that needs to be taken into account when organising training for interpreters. People of all ages usually require health care at some point during their lives and communication can therein be of crucial importance. The correct diagnosis and treatment of problems can, without exaggeration, mean the difference between life and death. In Flores et al. (2012), a study was conducted on 57 separate medical interventions studied over the course of 30 months with or without the use of professional interpreters or ad hoc interpreters. Flores et al. concluded that language barriers can cause a suboptimal health status, as the patients do not take part in

preventative services such as mammograms and pap smears. Furthermore, chances are that they will leave the hospital before having fully recovered and may then fall ill again more easily in the future. In Cox & Maryns (2021) it was also suggested that there is a co-construction of knowledge between the medical staff and the patient/interpreter, which depends on multilingual communication. This can constitute a risk of diagnostic insecurity. Furthermore, Sarver and Baker (2000) noted that doctors might refrain from organising follow-up appointments because of the communication problems during a first consultation.

As stated, good medical treatment and a correct diagnosis become all the more difficult to achieve when there is a language barrier between health official and patient. Flores (2005) claims that patients with limited language proficiency in the host country's language (in the case of Flores' study this is English) receive lower quality care when treated with the help of untrained ad hoc interpreters. On the contrary, trained professional interpreters and bilingual health care providers have a positive effect on patient satisfaction, quality of care and outcomes. He consequently concludes that the best results are achieved when patients have access to trained professional interpreters or bilingual health care officials. Karliner, Jacobs, Chen et al. (2007) wrote a systematic review of the literature about the effect of professional interpreters on clinical care. They examined the following four criteria: communication, utilization, clinical outcomes and satisfaction. What became apparent is that in all four criteria the use of professional interpreters was associated with improved clinical care compared to the use of ad hoc interpreters.

In health care, ad hoc interpreters may encounter problems that professional interpreters do not. In this paragraph, an overview will be given of some of the most important problems which occur frequently when ad hoc interpreters are consulted. This overview is based on the article published in the Day Translations Blog (2019). First of all, ad hoc interpreters do not have proper understanding of medical terms and conditions. Although studies suggest that only 5-10% of medical conversations or texts contain this specialised terminology, this 5-10% might be crucial for the diagnostic outcome of the consult (Pöllabauer, 2017). While they might convey the notion of fluency in the foreign language in day-to-day activities, they often lack the incredibly specific terminology used in medical contexts, whereas trained professionals often have received specific training for these contexts and have generally gathered experience in the field over the course of their career. Second of all, the ad hoc interpreter can have a tough time remaining impartial. We see a similar phenomenon in medical ethics, where physicians

are generally advised not to treat themselves or members of their immediate families (AMA Journal of Ethics, 2012). The reasons are obvious: it is difficult to remain impartial when a relative's or your own well-being is at stake. A third problem that ad hoc interpreters encounter is the fact that they are often familiar faces to the patients. Most of the time, ad hoc interpreters are family members or friends of the family. As stated before, the younger generation is often the one learning the new language, meaning that the ad hoc interpreter is often younger than the patient. This plays a role in the delicate subjects that may arise during conversations with health officials. In certain cultures, the age difference is of great importance, as a younger person might feel it is improper to discuss personal issues of someone that is older than them. This can lead to complications, misdiagnoses and improper treatment and use of medication, putting lives at risk. A fourth and final problem is the pressure put on the ad hoc interpreter. They are engaged as an interpreter, despite perhaps not being fluent in the foreign language. However, in doing so, they became responsible for the patient's medical care, which can be a heavy burden to bear.

In spite of all of these problems, we must underline the fact that these ad hoc interpreters are often one of the only acceptable solutions for an otherwise unsolvable problem, especially when there is no language that the conversational partners have in common (as is the case in this study). Once again we see several problems arise. Professional interpreters are often too costly for newly arrived immigrant families and the government-issued budgets are growing ever tighter (De Wilde & Maryns, 2021). Moreover, immigrant families might simply not know how to engage a professional interpreter, due to not speaking the language of the host country. Furthermore, the family might not want to involve an external party in the conversation when the topic is a sensitive or culturally conflicted subject (Baraldi & Gavioli, 2017). Finally, there might not be any professional interpreters available for the language combination that they require, in the case of languages that are rarely spoken in the host country, such as Tigrinya or specific Arabic dialects (Nu.nl, 2015). De Wilde & Maryns (2021) also state that there is often a mismatch between the supply and demand for certain language combinations and a high workload for some interpreters, which also leads to scarcity. Roels (2015) states in her research that even though professional interpreters might be readily available in certain contexts (hospitals, government organisations), non-native Dutch speakers who have already acquired some knowledge of Dutch might prefer not to ask for the assistance of a professional interpreter. Some people tend to overestimate their proficiency in Dutch, resulting in a non-mediated conversation which might not run smoothly. There is also no regulation on a federal level in

Belgium, but rather at the level of the regions, in this case Flanders. There is a certification examination in place nowadays, however, there is still a substantial lack of standard procedure or guidelines for the use of either professional interpreters or any other form of language support in most organisations (Roels, 2015).

Other possible solutions are also not always feasible to organise, either for the patient or medical professional. A few examples are formulated in Cox & Maryns (2021): medical translation software (mostly only present in hospitals, but not in private doctor's cabinets) or language mediation through use of someone of the staff. The latter is of course also a form of ad hoc interpreting as these people are not professional interpreters, but in contrast to the lay interpreter in this study, they do not have a personal relationship with the patient and can therefore be seen as a more neutral party in the triadic conversation. Lastly, the use of widespread translation tools such as Google Translate or DeepL is also suggested. In De Wilde & Maryns (2021), other options such as pre-translated documents, pictographic material and video messages are brought up. These are not only multilingual, but also multimodal solutions for the communicative problem. We will look into these possibilities at the end of this study, when proposing a framework for the medical professional and lay interpreter.

1.3 Calgary-Cambridge model

We have already discussed the definition of an ad hoc interpreter in the previous part of this literature study, now it is time to have a look at the other side of the triadic conversation, i.e. the medical professional's side. This party can be but is not limited to: trained nurses, physical or occupational therapists, social workers, psychologists but also doctors in hospitals or, as in the case study for this dissertation, a general practitioner. It has been established that the ad hoc interpreter did not receive proper training to be able to mediate the conversation. This is mostly not the case for medical professionals, as they will have received a full training before being able to become a GP and also have received the necessary training concerning communication (Roscher, 2020). However, it must be stressed that the share of interpreter-mediated conversations a GP will encounter throughout their training is limited, as such encounters are equally scarce in real life. Therefore, it is still the aim of this study to provide a framework for the medical professional as well, in order to support them in interpreter-mediated conversations with an ad hoc interpreter.

On the basis of a wider-known medical model, we will attempt to formulate extra guidelines for the medical professional. This model is called the Calgary-Cambridge model and it was published in 1996 by Kurtz and Silverman. This guide provides a communication model for the health professional that can be used during consultations. This is of course of the utmost importance in the daily tasks of a general practitioner, as the better the initial consultation goes, the better the partnership between the GP and the patient and the better the treatment will be (Munson & Willcox, 2007).

In their research, Munson and Willcox studied different key factors that have an impact on how successful the outcome of a consultation is. First of all, they identified the three core tasks that the GP must execute as a means to improve the health outcome of the patient. These core tasks are:

- Identifying the problem ailing the patient
- Investigating which physical problems bother the patient the most
- Making a holistic assessment by looking into both the physical as well as the emotional and social impact of the patient's problem on the patient themselves, but also on their relatives and close friends or partner

After executing these core tasks, Munson and Willcox believe that there are three main principles to be respected by the GP during a consultation:

- The patient's beliefs about their own health and problems
- Involving the patient in the decision-making process
- Empowering patients can have a very beneficial outcome for the patient as well as for the GP

Munson and Willcox stress that using a model can be very useful, as this profiles the patient as a person rather than as a subject of examination. The personal approach can also help patients understand the process better and to make a judgement themselves about their own medical situation. Therefore, they will also be more likely to accept and to follow the proposed treatment set up by the doctor at the end of the consultation.

Kurtz and Silverman (1996) developed this model with one general purpose for the GP: building a relationship with the patient. They set out a model in five separate phases, which will be used as a structure for the macro-analysis of this study and will be discussed in this theoretical

overview. We have specifically opted for this model, as it provides a very clear and very easily accessible structure which can be applied to almost all medical consultations. It gives a clear indication to the doctor on how to continue and, in general, patients know to expect this overarching structure, which makes the consultation more structured and easier to follow for them. Furthermore, the focus lies on building the relationship with the patients. To achieve this, the GP will use appropriate non-verbal gestures (this is especially interesting in this study), but he or she will also address the patient more directly in order to involve them more in the process. These two markers have also been put in the schematic overview shown below.

Now, an overview will be given of the five stages that doctors need to go through during a consultation. This overview is based on the findings of Roscher (2020), Munson and Willcox (2007) and Kurtz and Silverman (1996). The first stage is called "initiating the session" and sets the tone for the entire consultation that will follow. It is therefore very important to make a good impression on the patient from the start (Cooper et al, 2006). Kurtz and Silverman identify non-verbal behaviour as a very important factor in these first few instances. Munson and Willcox (2007) provide a few examples: good eye contact, being polite to your patients, dressing smartly and allowing the patient to speak freely and also encouraging this with your facial expression and gestures. It is important to come off as sympathetic and empathic, and to create a safe space for the patient. This will reduce the patient's anxiety and will make them more prone to opening up about their problems. In a later stage, patients will also be more open to the proposed treatment and more willing to follow the proposed next steps. This first stage has been divided into three steps by Kurtz and Silverman.

First, the encounter needs to be prepared by the medical professional. A few steps can be taken by GPs. They can plan their schedule ahead of time and always foresee a bit of time between two consultations. This can help alleviate stress of the doctor as well, as they will be more prepared to dive into another problem. This also gives them the time to tie up the last few loose ends for the previous patient's treatment. In general, and now especially due to the Covid pandemic, GPs need to rearrange their work space after one consultation has ended. This can also help them reset their mind before the next patient comes in. Moreover, it is always good to have the necessary documents and tools prepared. Examples are evaluation forms, doctor's notes, medical equipment etc. Finally, the doctor can look into the patient's medical history prior to the consultation, which might be very relevant throughout the course of the conversation.

Second, the medical professional needs to establish an initial rapport with the patient and other people present in the consultation. We have already underlined how important it is to have a good relationship with the patient earlier on. To achieve this, the first step for the doctor can be to introduce themselves and to give an explanation about their role as a medical professional. It can be argued that this step is especially important when working with foreign patients, as this might help them understand how a doctor's visit here is usually organised. Furthermore, it can be stated as well that this can have a big impact when children or young adults are involved. This can help relieve anxiety from these two groups of patients. In order to maintain this relationship throughout the consultation, the doctor should use the patient's first name often. This keeps them engaged in the conversation.

Finally, it is important for the medical professional to keep an open body positioning towards the patient. This can be achieved by orienting your body towards the patient, by sitting on the same eye-level and by using some gestures such as handshakes or other forms of welcoming. Looking too much at a computer screen must be avoided. However, it is also important to still keep some amount of distance as to not overwhelm the patient. This can be achieved through means of a desk or table, which is common in most doctor's offices.

A next step in the process is called 'gathering information' (Kurtz and Silverman, 1996). Once a relationship is established with the patient, the doctor can begin to identify why the patient requested a consultation. It is vital to start the clinical questioning with what Roscher (2020) calls an "open-ended general enquiry". This is an open question, which does not relate to any visible physical ailments or assumptions made by the doctor. For example, it is preferred to ask "Could you tell me why you're here?" or "Can you tell me what is wrong?" instead of "I see you have a wound/scar/problem with X, let me help you". When the patient starts to formulate an answer, it is vital that the medical professional let them speak. Overall, patients tend not to speak longer than one minute (Munson and Willcox, 2007), so it is key to letting them tell their story in order to maintain the fragile relationship of trust. Facilitation strategies such as non-verbal signs (nodding) or cues such as saying "uh-huh" or "tell me more" can be useful and will also be discussed in the analysis of this study. In this specific study, we could argue that it is important to push the interpreter to let the patient speak freely. Munson and Willcox also emphasize the role of the doctor as an attentive listener. They suggest letting the patient speak in their own words and to have the doctor indicate to the patient whether something is clear or not. As there is an intermediate person in this case study, we would suggest that this

confirmation should be executed more explicitly, that is to say through means of a verbal check with the interpreter ("Can you check whether this is correct" / "Can the patient repeat this but in other words?" / "Is it correct to assume that X, can you check this with the patient please"). Especially in the case of ad hoc interpreters, information can be lost between turns, so it is vital to always check.

Munson and Willcox suggest a simple mnemonic structure to set out the preliminary questions which is called ICE: ideas, concerns and expectations. What does the patient think is happening? What is the biggest concern the patient has now? What are the expectations of the patient going into the consultation?

It is important to stick to these principles, as patients often do not have the capacity to fully and correctly describe what is wrong with them. Especially in this type of mediated conversation, a lot of information can get lost in translation (see 1.1 on the language barrier). Patients often describe symptoms at random and do not provide a chronological order in their story. It is therefore good for doctors to help them structure their stories by using small summarizing turns and extra questions. Upon returning to the ICE questions, the doctor may discover additional factors or symptoms the patients did not think were important or did not wish to share in the first place, while they could be very important for a correct treatment at the end of the consultation.

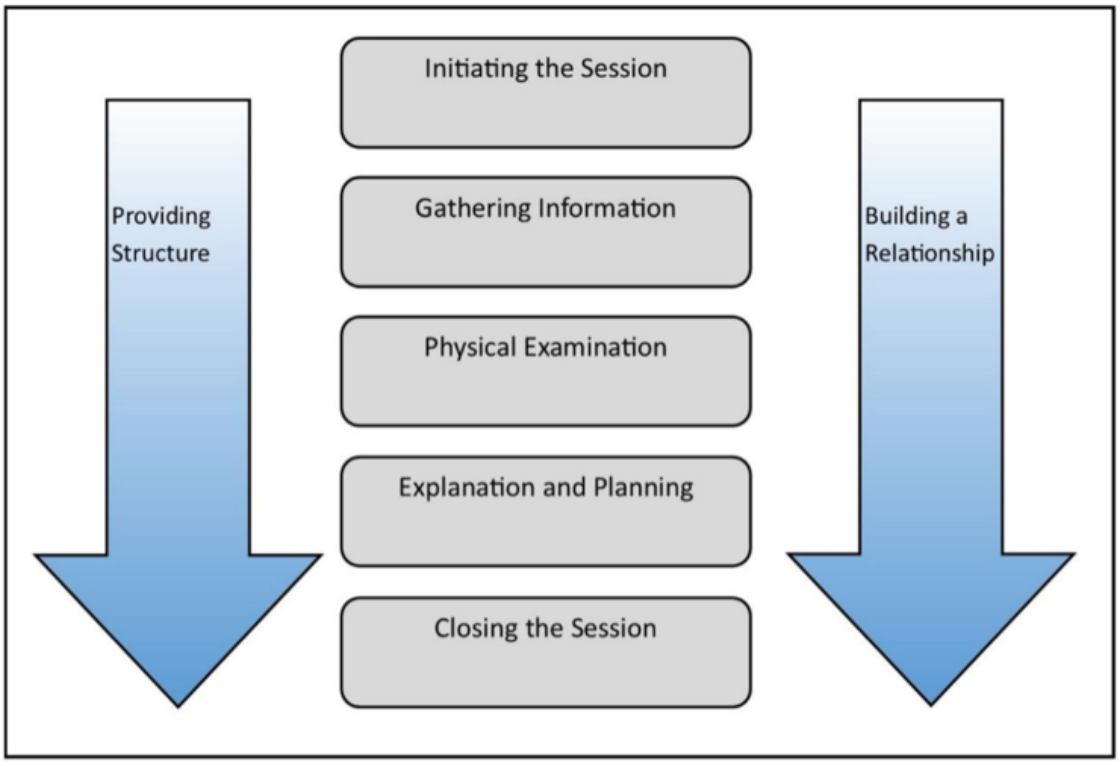
After establishing the problem, the doctor will usually proceed to a physical examination. This is the third main step in the Calgary-Cambridge model and was commented by Mashem (2016). A good and thorough physical examination is not only great for a proper diagnosis and treatment, it is also paramount for maintaining the balance in relationship between doctor and patient. Asif and Hassan (2017) state that leaving out this part of the consultation could give a blow to the patient's trust in the doctor and therefore it might also influence their willingness to cooperate later on in the treatment. During the examination, the doctor can use verbal and non-verbal strategies. Non-verbal strategy consists of touch mostly, which reinforces again the patient's feeling of being truly helped by the doctor. Verbal tools can consist of signposting, summarizing and giving feedback (as described in Mashem, 2016). Signposting involves the doctor describing the next steps to the patient, always keeping him or her in the loop about what is going to happen next. Summarizing also helps keeping this structure intact for the patient and finally, giving feedback each step of the way is also a good tool for alleviating stress in patients. Mashem also recommends using a positive affirmation ("good job" / "well done") instead of

the negating mode ("no not like that") when examining patients to boost their confidence. Additionally, when discussing the outcome of the problem, it is always good to focus on the positive findings instead of the troubles.

In this last part, we will discuss the fourth and fifth step in the Calgary-Cambridge model together: 'Explanation and planning' and 'Closing the session' as was described in detail by Hunter (2021). With the tools mentioned above (signposting, feedback, summarizing), the medical professional will give a brief overview of the session. Before going over to the treatment, Hunter advises ensuring that the patient understood everything, which in this case is something that must be achieved via the interpreter. In this instance as well, the doctor should address the patient to ensure shared decision making. It is also advised to check whether there are any final questions and whether everything is clear. Hunter describes this with three terms: comfort, confirmation and confidence. The patient will be more comfortable after shared decision making, the doctor needs to confirm each step again with them and that will give them confidence in following the next steps proposed by the doctor.

Two elements are important in these last steps: forward planning and safety netting. Forward planning means discussing the next steps with the patient. Whether a follow-up consultation is needed or whether they should visit another specialist/doctor. This can also go hand in hand with a clinical proposal (prescribed medicine, physical treatment etc.). Hunter also speaks of safety netting. This is a description of hypothetical outcomes for the patient. For example, the doctor might say: "When X occurs, you should immediately do X". This can help the patient to self-manage and to recognise any symptoms related to their illness or to the side effects of their treatment. After a final check, the doctor will close the session.

In this chapter, we briefly discussed the relevancy of the Calgary-Cambridge model in medical consultations that are mediated by ad hoc interpreters. This model will serve as a basis for the upcoming analysis of the case study. The overarching steps (five phases) will be used as a macro structure and in the micro-analysis, we will come back to several mediating strategies that we encounter from the doctor's perspective.



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1.4 Deontology of the interpreter

In 1.1 we briefly touched upon the ethics regarding a doctor treating patients who are close to them. Interpreters, much like doctors, have an ethics system, a deontology that prescribes how an interpreter should act in certain situations. Professional interpreters are extensively taught this system during training. They are handed a system of ground rules to help them decide how to act depending on, for example, the circumstances in which they are working and who the participants of the conversation are. It goes without saying that this is information given to professional interpreters during their training that ad hoc interpreters lack. Loach (2019) says in Ethics, Medicine and Public Health, an online journal published by Elsevier, that professional medical interpreter training has evolved over the years. In the past, it focused on the interpreter playing the role of a "conduit" who enabled communication across language barriers for health care official and patient as much as possible. The ethics standards required interpreters only to translate without adding, changing or removing anything that was being said. This conduit model was, however, found to be too restrictive as those same standards evolved over the years.

Interpreters are the participants in the conversation with the most complete awareness of what is happening on each party's side. Therefore they often need to communicate about information that is not being spoken about by either party. For example: an interpreter might intervene at certain points in the conversation to ask questions about what exactly was meant, or to mediate any miscommunications. Loach calls this new role interpreters fulfil the role of "culture broker" or even "advocate". In the analysis we will see several instances in which the ad hoc interpreter fails to meet certain criteria established in the deontological code. It is fair to assume that a professional interpreter would have met these criteria.

We will later on refer to two concepts introduced by Wadensjö (1998) that are infractions of the ethics standard: 'zero-renditions' and 'non-renditions'. A zero-rendition occurs when an original statement uttered by a speaker is left untranslated. A non-rendition is when the rendition by the interpreter does not correspond with the original that was uttered by the speaker for whom the interpreter is translating during the non-rendition. These two phenomena will be discussed in the micro-analysis and will be described as 'translation deviations' as these deviate from the original speech.

Furthermore, it could be assumed that professional interpreters are not only trained to act as a mediator, they are primarily trained in multiple languages in order to provide accurate translations from the source language into the target language and vice versa. This is also mentioned in the interpreter's oath and in the positioning the interpreter usually presents at the beginning of the conversation. The interpreter swears to fulfil their duties accurately, honestly, and in good conscience. They present themselves as a neutral third party who is bound by professional secrecy and who will not actively take part in the conversation. Professional interpreters focus on the rendering of the message as it was uttered by the conversational partner, without leaving out, adding or changing anything (Atlas, 2022). They therefore need good knowledge of both target and source language to be able to perform their tasks accurately. This element, the fluency in both languages, is not always present when using ad hoc interpreters. A professional interpreter would not accept an assignment if they do not fully master a language, whereas this is mostly the case for ad hoc interpreters. That causes some disruptions in the principles laid out by the professional interpreter in his or her positioning: accurately translating, i.e. not adding anything, leaving anything out or changing anything. We often see these phenomena in ad hoc interpreters. Some parts of the conversation are left out as a result of a lack of knowledge in one of the languages. This can be due to insufficient

grammatical knowledge, but could also be a vocabulary problem, especially so in the medical context. This might also push ad hoc interpreters to change parts in the translation to make the rendering easier for them. They will generalize some phrasings or will use an alternate way of saying something instead of translating the actual words spoken by the patient or doctor. Lastly, they will add onto what the doctor said or what the patient said to make everything clearer for either party. For the patient, they might know that they need to specify something because they know this person very well. For the doctor, this can occur due to them bringing parts of their own knowledge into the conversation. This can be, for example, something that they had noticed themselves about the patient's ailment or some further explanation on what the patient provides as information. Sometimes, entire turns can occur without them being translated. This is what Watermeyer (2011) calls a side conversation and it is generally not accepted in professionally mediated conversations from a deontological point of view. When these side conversations occur, interpreters should be as transparent about them as possible, explaining to the third party what was said in general and why the side conversation took place. We can assume that this is not always the case in ad hoc interpreted conversations.

In this literature study, we looked into different aspects of the interpreter-mediated conversation in the medical context. First of all, language barriers were discussed (see 1.1). Then, a description of who an ad hoc interpreter is, was provided (see 1.2). Next, the Calgary-Cambridge model was explained (see 1.3). This will form the basis of the macro-analysis presented in chapter 3.1. Finally, the deontological practices followed by professional interpreters were outlined. Furthermore, some hypotheses were put forward about how the ad hoc interpreter might handle certain situations that might be difficult to handle from a deontological point of view (see 1.4).

In the next chapter, a methodology will be presented. This will be followed by the analysis, which was split up into a macro- and micro-analysis. These will be structured following the main phases described in part 1.3 of this study, the Calgary-Cambridge model. Furthermore, some aspects described in 1.3 and 1.4 will be used to look into the ad hoc interpreter's approach. The analysis will be presented in chapter 3 and a few tips for the medical professional as well as the ad hoc interpreter will be formulated on the basis of the main findings of the analysis.

Chapter 2: Methodology

In the previous chapters, a theoretical literary framework of several studies has been established. On the basis of the concepts discussed, the current research will explore the use of an ad hoc interpreter in a medical setting. In the first few chapters of this dissertation, the general assumption was that there is no clear, defined strategy that can be used by either the ad hoc interpreter or the medical professional in medical examinations with an ad hoc interpreter. This dissertation, along with others that are part of the interdisciplinary project, aims to look into possible strategies and solutions that can be used by both parties in a mediated conversation. The analysis that will be presented in chapter 3, consists of a macro- and micro-level part, both of which will be structured through means of the Calgary-Cambridge model. The results of this analysis will be shown in chapter 4 of this study. The main research questions that will be answered are:

- What impact does the use of an ad hoc interpreter have on the outcome of a medical intervention between patients and a doctor? Is there a clear language barrier visible which perturbs the conversation and/or has a negative impact on the care given?
- How can we improve these ad hoc mediated medical conversations from both the perspective of the medical professional as well as the ad hoc interpreter?

This dissertation will look at a case study of two medical consultations recorded in a community health centre in Ghent (gezondheidscentrum De Sleep) with a male general practitioner, a male and a female patient of Turkish origins and the niece of both patients functioning as an ad hoc interpreter. Furthermore, the grandmother of both patients and of the interpreter is present as a chaperon and a spectator. The two consultations were filmed with consent of all parties involved and will be analysed in this dissertation. The analysis will be focused on the role the interpreter and the doctor play in the communication, mainly in their choices and the effects of those choices on the result of the consultation. This dissertation is part of an interdisciplinary study in cooperation with the Department of Family Medicine and Primary Health Care within Ghent University, which attempts to help create an outline of measures that can be taken by GPs to help them approach a consultation with an ad hoc interpreter.

The present study will discuss two separate conversations with the same patients and the same general practitioner. These conversations were filmed by the doctor and were later transcribed. The transcriptions can be found at the end of this study in the appendix. The transcripts contain

the spoken words from five participants. These are the doctor (indicated as D), the ad hoc interpreter (indicated as T) and the three other Turkish-speaking family members, who have been indicated as patients (P1 being the niece, P2 the grandmother and P3 the nephew). The conversations are split up into different turns, each turn having been indicated by a number. Each turn represents a separate phrase or idea uttered by one of the participants. Pauses were indicated as well as overlaps in the speech. The Turkish parts of the conversation were translated by a department teacher and were indicated in green and yellow in the texts provided in the appendix. These transcriptions will be the main object of study. However, it must be indicated that these are not always complete. Often it is very difficult to understand what the participants are saying as the sound quality is not ideal. The doctor and patients also move around, which perturbs the sound quality and when the physical examination takes place, the patients and doctor move to another part of the room, where the microphone cannot always pick up what they were saying.

In the macro-analysis, we will describe the course of the conversation through means of the Calgary-Cambridge model and its five steps outlined in part 1.3 of this study. In the micro-analysis, two main parts will be distinguished: the role of the ad hoc interpreter and the role of the medical professional in the mediated conversation. For the interpreter's part, we will look at three main categories: translation deviations, that is to say the zero- and non-renditions defined by Wadensjö (1998), the side conversation and other deviations from the deontological code as described in part 1.4 and the fluency the interpreter has in the target and source language. For the doctor's perspective, we looked into these aspects: accommodation strategies (containing summarizing, repeating, checking with the interpreter and other parties and giving feedback), meta-communication, the perception of the role of the ad hoc interpreter and facilitation strategies (including non-verbal signs, open-ended questions, small talk and the use of humour). For each of these categories, examples from the transcripts will be provided and analysed.

In the last chapters of this dissertation, the whole of the analysis will be summarised in the conclusion (see chapter 5). The two main research questions will be at the centre of this summary. We will also aim to provide some general guidelines for the ad hoc interpreter as well as the doctor, as is also the purpose of the overarching project this study is a part of.

Chapter 3: Analysis

3.1 Macro-analysis

In what follows, we will take a closer look at two consults between a general practitioner (GP) and a family of Turkish people living in Belgium. The consults were filmed by the GP, with the express consent of the Turkish family, in WGC De Sleep, a community health centre located near Dampoort in Ghent, Belgium. Ghent, like most large cities, is an increasingly diverse city. There are several neighbourhoods housing large communities with migrant roots, such as Dampoort with its large Turkish and Bulgarian communities.

The family consists of a grandmother who is accompanying three of her grandchildren; a little boy, a little girl and a teenage girl. The teenage girl will be functioning as a lay interpreter in the conversation. She speaks both Turkish and Dutch. She is a native speaker of Turkish, whereas she presumably learned Dutch from going to school in Belgium for a number of years. Occasionally, she struggles expressing herself in Dutch, often because she lacks the specific medical vocabulary necessary to successfully interpret a medical consultation or for a lack of formal training in basic grammar. This will later on be analysed in the micro-analysis of this study. The grandmother does not give any indication of understanding Dutch during either of the consults, whereas the little children at times seem to understand what the doctor is saying in Dutch. However, neither of them express themselves in Dutch at any point during the consults.

As previously stated, the teenage girl functions as the interpreter. Because of the relatively large number of people present in the consultation (doctor, grandmother, two siblings and herself) she does not continually address everyone. In reality, most of the time she does relay the information coming from all family members to the doctor, whereas the information given by the doctor is generally only relayed to the grandmother, as she is the adult party accompanying the children. The family often talks among itself in Turkish without relaying all of the information to the doctor, especially when the doctor leaves the room.

In this macro-analysis, an overview of both the transcripts will be given in detail. The five big phases as defined by Kurtz and Silverman (1996) will be used as the basic structure of this analysis and will be supplemented with detailed information from the two separate consultations. These are: initiating the session, gathering information, physical examination,

explanation and planning, and closing the session. The two consecutive consultations will be divided into the five phases separately to see whether the doctor follows the main structure twice or not.

For the first transcript, 181 turns were identified. We will divide these turns into five groups as per the Calgary-Cambridge model:

- Initiating the session: turns 1-24
- Gathering information: turns 24-106
- Physical examination: turns 106-159
- Explanation and planning: turns 159-170
- Closing the session: turns 170-181

Turns 1-24 encompass the 'initiating the session' phase. The doctor welcomes the family into his cabinet and asks how he can be of service (1). The niece (and lay interpreter) immediately takes up a speaking role and explains that one of the female patients (indicated as 'she') is suffering from pain in her foot (2). The doctor repeats this to confirm (3) and the interpreter reacts that there is also a pain noticeable in the legs (4). All of this started yesterday (7). The doctor returns to the initial welcoming and asks about the relationship the interpreter has with the three other people present (8). The interpreter explains that the first patient is her niece and that the elderly woman is her grandmother. She also indicates that the boy present is the brother of the first patient (9-15). During the first part of this phase, the interpreter and doctor have a separate conversation. Only in turn 10 does the interpreter provide some information to the grandmother. The doctor then continues to humorously approach the situation by stating that there are many people present, almost a whole family (16). The doctor attempts to establish a relationship by asking for the name of the interpreter (18). He continues by explaining her role as a mediator in the conversation and compares this to a game of Ping-Pong (20-24). We see in this phase that the doctor tries very hard to establish a relationship with the interpreter, but he is not very involved with the patients themselves yet. He does adopt a very personal approach, which can be very beneficial to the outcome of the consult (Munson and Willcox, 2007). We can establish that the doctor has done his very best to make a good first impression. The video footage also confirms this, as it can be clearly seen that he uses many gestures and facial expressions.

From turn 24 to 106, the second phase "gathering information" really sets off. It could be argued that the doctor already received some information at the beginning of the consultation, but this is very minimal information to get a general idea and can therefore be seen as preparation for the further questions that will be asked during this phase. Turn 24 is taken up in both phases, as the beginning of the doctor's sentence still refers to the explanation about the role of the interpreter, whereas the second part leads to the investigation of the problem. The doctor repeats that the patient has pain in her foot and leg and the interpreter confirms this (24-25). The doctor established the period during which the pain occurred (26). He asks a first question about medical history, which the interpreter immediately tries to convey to the patient, but the doctor still continues his sentence. As a result, the doctor's question and the interpreter's translation overlap a bit (28-31). The patient speaks for the first time and indicates that in the past, she did not have this problem (31). The interpreter indicates this, but adds that the pain is very sporadic (32). The doctor picks up on this and repeats it, while additionally asking whether the pain is also very severe (33). The audio quality was unfortunately insufficient for turn 35, which resulted in a Turkish sentence that was not translated. We can however assume that this involved further description of the pain in the knee, as the interpreter continues to talk about something resembling water (36). The doctor asks for further clarification and together the doctor and interpreter come to the finding that the knee is swollen like there is water in it (38-42). The doctor goes on and asks which activities make the pain worse (42). The interpreter confirms this with the patient as she says walking indeed makes it worse (43-46). The medical professional wants to zoom in on other activities that might cause harm (48), but the interpreter asks instead whether the patient has pain anywhere else in her body (49). The patient's answer 'no' is interpreted as an answer to the original question. In turn 53, the doctor assesses when the pain occurs, during the day or the night. After speaking with the patient, the interpreter confirms that there is no pain during the night (54-58). In turns 59-65 the doctor and interpreter establish that there were no special activities which might have caused the pain. From turn 66 onwards, the medical professional tries to find out more about the physical aspect of the pain, whether the patient is restricted in doing certain movements. The interpreter refers in turn 67 to an arm, whereas the focal point of the pain was already situated in the foot/leg. In turn 75, the doctor wants to know whether any medication had already been taken. After consulting with the patient, the answer turns out to be: 'no' (76-81). In both the first and second phase of the consultation, the doctor uses open-ended general questions (Roscher, 2020) and he regularly checks whether the information he received is correct by using summarizing turns.

The third phase "physical examination" is announced by the doctor in turn 82. But before the examination starts, the doctor comes back to the own beliefs of the patient. This is very important as was explained in part 1.3 of this study. The doctor not only wants to know the opinion of the patient, but also that of the interpreter and of the grandmother who accompanies the children. When the interpreter mentions the patient's parents and their concerns (83), the doctor wants to dive deeper into this subject (90). The interpreter proposes some options (scan, physical therapy) in turns 93-95. After asking all participants present what might have caused the pain (97-105), a story about playing with her brother comes up. In turn 106, the doctor proposes to examine the patient. During the next 40 turns, the doctor examines the patient, asking her via the interpreter to execute certain movements and whether anything hurts when he moves or touches it.

In turn 159 we see again an overlap in two phases: the physical examination is finished and the doctor immediately puts forward a hypothesis about the issue. In turns 160 and 161, he proposes a treatment. Furthermore, he discussed some practicalities with the interpreter (absence from school). The interpreter is urged by the grandmother to ask about the consultation for the male young patient (169), the doctor first wants to formally close this session before starting another one (175). He closes the session by asking if there are any more questions, but everything seems clear to all parties (175-181). This marks the end of the first consultation.

Now, the macro-structure of the second transcript will be analysed. This transcript consists of 235 turns. We will start the analysis from turn 7 onwards, as the first 6 turns still refer to the previous consultation. The doctor initiates the same way he already did in the last consultation. Here as well, we will apply the phases of the Calgary-Cambridge model. However, in this case as the first encounter already took place in the previous consultation, there is no real initiation of the session anymore. We can see a sort of interaction between the doctor and the new patient (young boy) from turns 85-119, which correlates with an initiation conversation. Therefore, this is indicated as a second phase, which we called the Interaction phase.

- Gathering information: turns 7-85
- Interaction (initiation session): turns 85-119
- Physical examination: turns 119-193
- Explanation and planning: turns 194-222

- Closing the session: turns 222-235

The conversation immediately starts with an explanation from the interpreter about the troubles ailing the young male patient. In this case, the issue is mainly nosebleeds and generally not feeling well at school. The interpreter briefly adds that the boy had surgery in the past (12). The doctor requests more information about the operation and the nosebleeds in general and their frequency (13-37). When he wonders whether there are any other problems with the patient, the interpreter answers that there are no further issues after consulting with the grandmother (38-41). In turn 44, the doctor reverts the question about further treatment to the patients again. This results in a vague reply from the patient and interpreter (45-47). The doctor returns to the topic of the operation the patient had in the past (48) and the implications this has now (50-56). The grandmother suggests a possible cause to the problem (57) and the doctor wants to know what the patient thinks of this himself (59). The doctor inquires whether this could be linked to the accident the two children had, which caused the small injury of the female patient (63). The interpreter confirms with the patient that this was not the case (64-70). The doctor initiates the physical examination (71), but the grandmother first wants to establish the other problem the male patient has encountered (72-84). Then the interaction phase starts with a question about school. This conversation goes on until turn 119 and involves the doctor trying to encourage the young patient to go to school to ensure a future career. In the second part of turn 119, the doctor initiates a physical examination of the boy. The interpreter, grandmother and doctor all try to reassure the boy that the examination will not hurt and that he should not be afraid (120-123). In turn 124, the doctor states he needs some medical equipment and he goes to fetch it from another room. This leaves the family alone in the medical cabinet, and they have a side conversation which is not transmitted to the doctor in a later stage (125-153). After this, the doctor returns and continues the examination of the patient's nose whilst reassuring him that this will not hurt (154-193). In turn 194, the medical professional explains what he saw in the patient's nose to the interpreter. He talks about the blood vessel that had caused the nosebleeds and that he has cauterised this now in order to fix it. The interpreter and grandmother then discuss this (195-197). The interpreter asks for a tissue in turn 198, the doctor obliges but wants to confirm that his explanation came through in the interpretation (199). From turns 200-217, the interpreter further explains to the grandmother what the doctor had said. In turn 218, the doctor discusses possible outcomes for the patient. This is then discussed between the interpreter and the grandmother from turns 219 to 221. The doctor starts the Closing the session phase in turn 222 by asking if there are any more questions. The initial answer is no (223-225)

and the doctor starts to thank the interpreter for her cooperation in this consultation (226). The grandmother reminds the interpreter to ask for a doctor's note (228-229), there is some confusion at first but the doctor seems to comprehend what needs to be done now (230-232). The doctor turns off the camera and says goodbye to the family (233-235). This is the end of this transcription.

This concludes the macro-analysis of the two transcripts. The general course of the consultations was presented and the actions taken by all parties involved were described in detail. In what follows, we will discuss a number of striking elements in the two consultations. In contrast to the macro-analysis, the micro-analysis will take examples from the two consults interchangeably. A division will be made however, on the level of perspective. First the doctor's perspective and mediation will be examined and then the interpreter's actions will be reviewed. Each role will be assigned certain strategies that were briefly touched upon in the literature study of this dissertation and these will be discussed in detail now. To support our findings, examples will be provided along the way coming from the two transcripts.

3.2 Micro- Analysis

In this micro-analysis, we will take a look at a number of categories of striking, reoccurring elements in the consultations. These categories are part of a dual analysis in which both the doctor's actions as well as the ad hoc interpreter's actions will be studied. The factors which will be examined for the doctor's part are: accommodation strategies used by the GP, whether because he is talking to a non-native speaker, or because he is talking to a child, both of which apply to the lay interpreter. The following elements will be studied: summarizing, repeating, checking with other parties or the interpreter and giving feedback. Another category is that of the meta-communication used during the consultation. Meta-communication's definition was expanded by Gregory Bateson (1968) as: "All exchanged cues and propositions about codification and relationship between the communicators", essentially this means "communication about communication". Thirdly, the doctor's perception of an interpreter's function in the conversation will be examined. More specifically we will discuss what the medical professional expected from the interpreter and if those expectations were met. This is especially relevant from the perspective of the doctor as he will come into contact with lay interpreters quite often. Furthermore, it is precisely the improvement of the interaction between

GP and lay interpreter that is the goal set out by the overarching study this dissertation is a part of. Lastly, we will also discuss some non-verbal and verbal facilitation strategies as were brought up in the Calgary-Cambridge model (as discussed in chapter 1.3) and in the study executed by King & Hoppe (2013). These include non-verbal encouraging signs (such as nodding and humming), the use of facial expressions, open-ended questions, small talk and the use of humour.

Three main aspects from the perspective of the ad hoc interpreter will be looked at. A first one is the translation deviations as they are described in Wadensjö (1998): zero-renditions and non-renditions, which are segments of the conversation that were not interpreted, and a translation that does not correspond with the original, respectively. Second, all non-triadic renderings will be looked into. These are the so-called 'side conversations', when there is a multiple turn long segment between two parties, either between doctor-interpreter or between interpreter-patient. Third and last, the fluency of the lay interpreter will be analysed on the basis of the jargon used to see which quality of service they provide.

In order to show these elements, excerpts from the transcriptions will be provided below and explained in the context of either the doctor's mediation strategies or the interpreter's.

3.2.1 Micro-analysis from the perspective of the medical professional

In the first main part of this micro-analysis we will zoom in on the doctor's perspective. As was stated above, he received extensive medical training and presumably also training in professional communication with patients (Roscher, 2020). A possible consequence may be that the doctor uses more strategies and guides the conversation more than the interpreter does. As an adult, it could also be argued that he will predominantly take the floor during the conversation (as is also the case in Cox & Maryns, 2021). There is a presumed hierarchy in this conversation due to the lay interpreter's young age. Still, an interpreter-mediated conversation is not standard for medical professionals and they might also struggle to find the best way to communicate with people who do not fluently speak Dutch. In the next four sections, several coping mechanisms will be discussed and evaluated.

3.2.1.1 Accommodation strategies

For the purpose of this study, a differentiation was made between accommodation strategies (which will be discussed in this paragraph) and facilitation strategies (which will be presented

at the end of this part of the micro-analysis). Accommodation strategies in this case-study will be seen as elements which are put forward by the doctor to clear the way for the ad hoc interpreter. These are mainly verbal signs of medical importance the doctor uses to help render the conversation more fluently. This helps the ad hoc interpreter to translate the conversation as the conversation itself is put more clearly or plainly for them to render. Especially in cases like these, with a non-native minor with little to no experience in the role of interpreter who has to intervene in a technical medical consult, these strategies are of the utmost importance.

In the next couple of paragraphs, we will dive into the transcriptions. In order to illustrate the different strategies, a number of extracts will be copied in this analysis. The unabridged version of the transcripts can be found at the end of this study in the Appendix.

Summarizing

A first accommodation strategy entails all turns in which the doctor summarizes what was said during a number of turns in the consultation in order to bring a clear message to the patient through means of interpreting, but also a short summary of what was said only by the doctor in one or more turns. That is to say, the doctor can for example explain a treatment in detail and end by summarizing a limited number of straightforward tasks in one or two sentences. In the first consultation, the doctor proposes a treatment in turn 160. He proposes a pain-relieving gel that he will prescribe to the patient and explains how many times and when this gel should be used. At the beginning of the next turn (after a brief pause from the doctor), he proposes to 'just use the gel'.

160) D: wa dak nu voorstel is het volgende kga dan eigenlijk pijnstilling gel voorschrijven [ja] dan mag ze da opdoen als ze pijn heeft mag ze da beetje rapper euh opdoen dan mag ze da zelfs vier vijf keer per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie dus [ja] ik ga een voorschrift maken voor die echografie he dan moet je nie nog ne keer komen ge zijt hier nu toch eh ma je moet die echografie niet nu al direct gaan doen ma als da binnen een week eh volgende week woensdag nog altijd nie :XXX dan maak je een afspraak voor die echo (.) dus nu nog niet maar binnen een alst binnen een week nog klachten doet dat dan [okee] ja voorlopig eigenlijk

((T hoest))

161) D: Gebruik maar gewoon die gel [ja]

In turn 24, at the beginning of the consultation, the doctor also summarizes again what was stated in the above turns by the interpreter. The interpreter mentions that the patient is struggling with pain in her feet and legs since the day before (turns 2, 4 and 6). In between turn 6 and 24, the doctor deviates briefly from the anamnesis to interject a sort of introduction (which will be discussed later in detail in this analysis). In turn 24 he returns to the anamnesis by using the marker "dus" (so).

2) T: (eigenlijk voor haar) [ja] ze heb zo voetpijn en da zo kweenie zeb last van een zo van gister al ze (huilt van verdriet) [ja] :xxx

4) T: en benen ook

6) T: Ja allebei haar benen

24) D: en jij bent de bal he [((lacht))] okee we gaan het spel zo goe mogelijk proberen spelen [okee] **dus** voetpijn en beenpijn

This strategy is very helpful for untrained interpreters as it puts simply what they have stated over the course of multiple turns and it's also handy for them to have this summary in mind when going further in the consult.

Repetition

A second accommodation strategy is repetition and it serves roughly the same purpose as the previous strategy. In several instances the doctor either literally repeats a word or sentence or slightly reformulates a word or phrase in order for the interpreter to better understand the question or remark. He does this in his own turns, when trying to clarify what he is meaning to say, but he also repeats the words of the interpreter or slightly reformulates her sentences to check whether he completely understood her message. In the first excerpt, he asks the interpreter whether the patient has ever experienced this pain in turn 28. In turn 29 then, he repeats this message by asking the opposite question: whether this was the first time the patient had ever experienced this pain or not. This is a very useful strategy, as it gives the ad hoc interpreter two opportunities to understand the question asked. If he or she does not understand the first grammatical structure used, chances are they might understand the second one. One could argue that this might also confuse interpreters as they might see these two turns as two

separate questions, but in this case the two sentences are both not very challenging and are uttered soon enough one after the other to still belong to the same idea.

28) D: okee kzou graag keer willen weten [naam] eeft zij da vroeger nog gehad die pijn [Turks #00:01:47-5# Eskiden…
Vertaling Turks: Vroeger…
29) D: of is dat de eerste keer?

In the next example, the doctor repeats the explanation of the interpreter in the next turn. In turn 32, the ad hoc interpreter describes the pain coming and going, but she has a bit of difficulty expressing this idea (it comes so suddenly and does not stop, and it comes back later). To help her out, the doctor repeats what she said in turn 33 (that the pain comes and goes).

32) T: euhm ik denk nog (niet voor nu) maar ze weet niet da hoe da ook komt zo dat da zo direct gaat da nie da stopt en da komt nog ne keer

33) D: Okee dus de pijn van [naam patiënt] die komt en die gaat (.) soms is die dus heel heftig [Turks

In turn 53, the doctor begins to ask in a general way whether the patient encounters pain at night, but repeats and clarifies in the second part of the sentence that he wants to know whether the patient encountered pain the previous night. To enhance the understanding of ‘at night’, the doctor adds the verb ‘to sleep’. This is also an example of a repetition in which the doctor adds extra info to clarify what he means for the interpreter.

53) D: Bijvoorbeeld 's nachts nu da ze sliep vannacht had ze geen pijn dan?

An interesting turn can be found at the end of the first consultation. The doctor takes a few moments to carefully explain the treatment of the first patient to the interpreter. He does this in one long turn (160), which is presumably not the best method to have the interpreter fully convey the different aspects of the treatment. This aspect will be highlighted in the discussion of this dissertation. The doctor does use markers (ja, dus, he, eh) here to check with the interpreter from time to time, but overall the turn is too long to be conveyed simply into another language without taking notes. Earlier in the consult, the interpreter asked whether the patient would be needing X-ray photos taken. The doctor now comes back to this topic, but as his reply

is a little complex, he tries his best to explain it the best way that he can. In the excerpt, we see that the doctor puts a lot of stress on 'WEEK'. After explaining the use of the pain-relieving gel, he continues to describe a scenario in which the pain would not disappear after a week. As this conditional phrase is rather complex, he emphasizes and repeats the information several times in several different ways. We see this in the following phrase: "Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie" (emphasis and repetition of WEEK + if the bump is still very bad/if it is still swollen). At the end of this turn, the doctor repeats the time period of one week and adds the phrase "volgende week woensdag" (next Wednesday), to specify the period again for the interpreter. He also describes this as "niet nu al direct" (not yet now). The sentence is also formulated in a good way, first giving a situation A and then a result B to work with. This helps the interpreter to better understand the correlation between the two situations (situation A being that the pain is still there after a week and situation B being that she should make a follow-up appointment). This concept is also described in Hunter (2021) as safety netting, a description of a hypothetical outcome.

It is clear that the doctor attaches great importance to this part of the suggested treatment. Of course, a follow-up treatment might depend on this information, so it is very important that the patient has this information in order to be treated as best as possible. Other researchers (such as Baker, 2000) have found that ad hoc interpreter mediated consults do not always lead to the necessary follow-up appointments due to shortcomings in the communication. It is positive that the doctor focuses as much on this as he did, especially as this was a part of the treatment the family had already enquired about earlier in the consultation.

160) D: wa dak nu voorstel is het volgende kga dan eigenlijk pijnstilling gel voorschrijven [ja] dan mag ze da opdoen als ze pijn heeft mag ze da beetje rapper euh opdoen dan mag ze da zelfs vier vijf keer per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie dus [ja] ik ga een voorschrift maken voor die echografie he dan moet je nie nog ne keer komen ge zijt hier nu toch eh ma je moet die echografie niet nu al direct gaan doen ma als da binnen een week eh volgende week woensdag nog altijd nie :XXX dan maak je een afspraak voor die echo (.) dus nu nog niet maar binnen een alst binnen een week nog klachten doet dat dan [okee] ja voorlopig eigenlijk

Transcription 2

In the second transcription, there is also an example of a literal repetition of the word 'bloedneus' (nosebleed). It could be presumed that the doctor repeats this word as it could be seen as a medical term which is maybe not as evident to translate.

42) D: nee das goed dus als ik het goe begrijp hij eeft al een paar jaar last van een bloedneus die bloedneus die komt lijk om de twee weken wel ne keer terug en hij zou nu wel ne keer willen weten wat da we daar kunnen aan doen

Checking with interpreter or other parties

In lay interpreter-mediated conversations, it is often very important to check with the different parties whether a concept is clear to everyone. This can be a concept explained by the doctor to be transferred to the patients via the interpreter, but also vice versa. Munson and Willcox (2007) also stress the importance of having a doctor who listens attentively and who regularly asks questions. In turns 36-42, the interpreter describes what feeling the patient experiences in her knee. As the explanation 'zo iets gelijk zo water' (such a thing like water) is not very explicit, the doctor asks the interpreter to clarify what she means to say. He then also proposed a possible explanation which is also confirmed by the interpreter. It is a very useful tool to hand to the interpreter in this case, because she can build on this main explanation and add more details to it (turn 41).

36) T: Ja (.) en bij die knie da ze zo iets gelijk zo water

37) P2: (turks) #00:02:28-4# xxxxxx

38) D: Wa bedoel je daarmee? [euh

39) D: me d- dat er water in je knie zit staat die [P2 turks knie dan DIK xxxx

40) T: Ja zo dikke en dan zo [P2 turks xxxx

41) T: en als zij da zo (raakt doe) en als zij da zo raakt da zo die zo raar doet

42) D: Okee (en) die knie is dik en vochtig okee ça va

During the consultation, the doctor often uses markers (e.g. he) to indicate that he wants to check the information with either the interpreter or the patient as can be seen in this example:

46) D: ja (dus stappen) geeft meer pijn he [naam]?

During the anamnesis, the doctor tries to find out what the patient is still able to do. As there was some confusion in the previous turns, the doctor wants to check the statement of the interpreter in turn 69 “Jawel zij kan dat wel” (Yes she can do that), by asking two questions: “Ze kan alles?” (She can do everything?) and “Der blokkeert niets?” (there is nothing that is blocked?). As it is very important to check this medical information with the patient, it is good that the doctor double-checks this with the interpreter.

69) T: Jawel zij kan dat wel

70) D: Ze kan alles?

71) T: Ja

72) D: Der blokkeert niets?

73) T: Nee

At the end of the first consult, the doctor asks whether there are any more questions. This is also a tactic described in the Calgary-Cambridge model (Hunter, 2021).

175) D: Ja okee das waar jullie hebben ook een afspraak voor [naam broer P1] ma we gaan da dan straks doen [okee] is het duidelijk voor [naam patiënt] [ja das duidelijk] okee das dan heb je nog vragen mevrouw?

Transcription 2

In the second consult, we also find an example of the use of markers:

54) D: Ja maar zijn neus zit niet meer verstopt he?

In turn 199, the doctor wants to check with the grandmother whether she understood the next few steps that have to be taken in the treatment of the male patient. It is a very good idea to also check with the other parties present and not only via the interpreter. The doctor directly addresses the grandmother in this case by looking at her and using the word ‘mevrouw’

(madam) to indicate that he is talking to her and not the lay interpreter. Especially from a medical point of view, it is important that the adult present knows what the treatment of the patient is, to be able to execute the steps as well as possible.

199) D: Jaja zeker begrijp je da mevrouw?

The second consultation also ends with the doctor checking if everything is clear. This is in line with Hunter's (2021) concept of the three C's: comfort, confirmation and confidence.

222) D: Heb je nog vragen hierover?

Giving feedback

Throughout the conversation, the doctor often thanks the interpreter and affirms that she is doing well. This kind of positive feedback is very useful, as it empowers the interpreter to continue performing her tasks. This was brought up in Munson & Wilcox (2007) as a great push for the patient's confidence and empowerment, but it could also be transferred to the interpreter and her self-confidence in performing this highly complicated and difficult task. Mashem (2016) also proposed using positive affirmations instead of a negating mode to boost confidence. We see this in the following examples:

66) D: :xxx danku (.) wa dak ook nog zou willen weten eeft ze soms het gevoel dat er iets blokkeert bij

74) D: Dankuwel :xxx

81) D: ((mompelend)) Das goed

The doctor thanks the interpreter multiple times and in this last example (turn 105), he is very happy because part of the root cause of the patient's medical problem is discovered through means of the interpreter checking again with the patient.

105) D: Ah kzie ze heeft gisteren toch een accident gehad [ja] ah voilà (.) ben heel blij da je da vertelt [naam tolk]

Transcription 2

We see the same continuation in the second consult as well.

209) D: heel goed gedaan

226) D: Okee dan dank ik u voor de medewerking en de goeie vertaling

In this last instance, the doctor thanks the interpreter for the good translation.

3.2.1.2 Meta communication

In this subpart of the micro-analysis, the use of meta-communication by the medical professional will be reviewed. This was earlier on in this dissertation defined as "communication about communication". We see many examples occur throughout the two transcriptions. The doctor often begins his turns with describing that he will ask the interpreter a question 'wa dak nog zou willen weten' (What I would also like to know). For interpreters, and especially ad hoc interpreters, this might be advantageous, as it announces that there will be a question for the patient and that the interpreter will need to listen carefully in order to translate accurately.

Mashem (2016) describes the phenomenon 'Signposting', which implies informing the patient about what you are about to say or do to help them feel less anxious and give them a sense of control. This signal from the doctor might make ad hoc interpreters feel more at ease, because the information is provided gradually and not all at once. This specific phrasing is repeated throughout the consultation:

59) D: Okee wa dak nog zou willen weten is euh het volgende eeft zij de voorbije dagen iets speciaals gedaan waardoor da zij nu zoveel pijn zou kunnen krijgen? Heeft zij veel gelopen heeft ze gesport heeft ze heeft ze een ongeval gehad is er iets gebeurd?

66) D: :xxx danku (.) wa dak ook nog zou willen weten eeft ze soms het gevoel dat er iets blokkeert bij haar? Da ze bijvoorbeeld haar knie wil strekken ma dat da nie lukt? of da ze haar voet wil plooien en dat dat blokkeert?

82) D: Het verhaal begint mij wat duidelijk te worden he kga straks nog ne keer kijken naar [naam patiënt] (.) maar kzou graag nog eerst ne keer willen weten wat da jullie zelf denken dat er aan de hand is (.) en ik stel de vraag aan jou maar ook aan [naam patiënt] ook aan oma wat denken jullie zelf dat er aan de hand is?

In turn 160, the doctor also announces that he will come up with a treatment. As this is of high importance for both the young patient, the grandmother and the interpreter to know, it is advised to use this kind of signal for the interpreter.

160) D: wa dak nu voorstel is het volgende kga dan eigenlijk pijnstilling gel voorschrijven [ja] dan mag ze da opdoen als ze pijn heeft mag ze da beetje rapper euh opdoen dan mag ze da zelfs vier vijf keer per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie dus [ja] ik ga een voorschrift maken voor die echografie he dan moet je nie nog ne keer komen ge zijt hier nu toch eh ma je moet die echografie niet nu al direct gaan doen ma als da binnen een week eh volgende week woensdag nog altijd nie :XXX dan maak je een afspraak voor die echo (.) dus nu nog niet maar binnen een alst binnen een week nog klachten doet dat dan [okee] ja voorlopig eigenlijk

Transcription 2

During the second consultation, the doctor uses signposting to announce a medical examination. Signposting in this case is more aimed at the young male patient, as the examination of the nose might cause a minor inconvenience to him. This is done by the doctor in order to reassure the patient, because from the previous conversation it became clear that the patient was anxious about the problem in his nose. This can be related to the surgery the patient underwent a couple of years ago, which he might be reminded of when having to visit a doctor again now.

160) D: een plekje op me heel wa bl-bloed [mm] he nu wa da ik gewoon ga doen [mm] is me een spatel daar keer tegengaan da doe geen pijn

3.2.1.3 Perception of the role of the interpreter

In a few striking instances, the doctor describes to the interpreter what he expects of her during the consultation. This can help the interpreter to better respond to the needs of the doctor, which ultimately also results in a better diagnosis and treatment.

However, some precautions have to be taken in practising this strategy, as the doctor is also not a professional linguist or interpreter. He might offer some advice that is not always attainable or good for the purpose of the translation. An example we see in turn 20 of the first transcript:

20) D: [naam] ah kzou u willen vragen [naam] om als je da vertaalt om lijk zo letterlijk mogelijk te te vertalen he

The doctor asks the interpreter to translate 'as literally as possible'. Of course this statement was uttered with the best intentions, but it goes against the general practices of professional interpreters who mostly want to transfer the message rather than functioning as a 'conduit' between two languages (see research papers such as Wadensjö, 1998).

It is a good idea to let the medical professional explain the different roles in the conversation at the beginning of the consult. This is something that can be implemented during the doctor's training on how to work with ad hoc interpreters. We see an example of this in turns 22-24. The doctor compares the interpretation with a game of table tennis, where the ad hoc interpreter plays the role of the Ping-Pong ball. This is a well-intentioned way to explain the dynamics that will take place during the conversation and it also lightens the mood at the very beginning of the consult. Especially in this case when working with a young lay interpreter, this is a great start, when it comes to establishing personal rapport with the interpreter. However, like in turn 20, this does go against the general practices of professional interpreters, as the Ping-Pong ball does not have free will and functions more as a 'conduit' passed around from player to player (Loach, 2019, and Wadensjö, 1998).

22) D: ist goed? euhm ook als zij iets n- naar jou vertelt geef maar gewoon door naar mij [mhm] ja eigenlijk is het een beetje een pingpongspel

23) T: ja ((lachend))

24) D: en jij bent de bal he [((lacht))] okee we gaan het spel zo goe mogelijk proberen spelen [okee] dus voetpijn en beenpijn

The doctor tries his hardest throughout the conversation to get information from all parties present. However, as only the lay interpreter can understand him, it is often more difficult to really reach the non-Dutch speaking patients. He tries to use the name of the patient to speak to her directly, but this confuses the interpreter who clarifies in turn 98 that the patient is not capable of speaking fluent Dutch. The doctor then reminds the interpreter that she could help

by asking the patient what she thinks about the issue. This example shows that the interpreter did not completely understand what the doctor was trying to do. The doctor should perhaps specify that he also needs the view of the patient on the problem to be able to gain a complete idea about the patient's condition.

97) D: Das goed (.) ça va (.) [naam patiënt] wat denk jij eigenlijk dat er aan de hand is? Weet jij?

98) T: Zij kan nog niet goed Nederlands

99) D: Nee? Ma jij kan het haar wel vragen he

Transcription 2

We see in the second consultation that the interpreter often wants to respond to the doctor's questions herself, whereas the doctor would like to know what the patients' view is on what happened. Therefore it is a good idea to clarify to the interpreter that you really want to know what the patient thinks, as the doctor does in turn 65:

65) D: Ga je het hem toch nog ne keer vragen

When the doctor notices that some turns remain untranslated, he encourages the interpreter to still translate (part of) his turns. An example can be found in turns 108 and 113. In these turns, the doctor is not explaining or asking anything of a medical nature, which might explain why the interpreter does not attach much importance to these turns and consequently does not translate them. As these turns do have a purpose (calming down the patient), it is advisable to urge the interpreter to still convey the message.

108) D: Ej schitterend mijn zoontje wilt ook politieagent worden [jaaa] je mag hem dat vertellen

113) D: Ja maar als je dan hier politieagent wil worden dan moet je goed kunnen schrijven (.) ja en ook goe kunnen rekenen om dan goe je boetes uit te schrijven he [naam P3] [turks: xxx] dus tis wel belangrijk da je naar school gaat om een paar dingen toch te leren he [turks: xxx] kan je da vertellen?

3.2.1.4 Facilitation strategies

In this last subsection of the study of the medical professional's point of view, facilitation strategies will be discussed. A large group of tactics are mentioned in Cox & Maryns (2021)

and King & Hoppe (2013) as all sorts of non-verbal means, to which we have added open-ended questions, small talk and the use of humour. The differentiation between accommodation strategies and facilitation strategies lies in the fact that accommodation assumes that the medical professional interferes himself in the conversation to smoothen the course of the conversation and to maintain the structure of the consult for medical purposes, whereas facilitation implies stimulating the ad hoc interpreter to cooperate and to be more open, making them feel at ease. Facilitation strategies imply a more personal approach, whereas accommodation entails a smooth course of the medical consult, focusing on the anamnesis and diagnosis. Therefore, it could be said that facilitation entails less linguistic input of medical importance from the doctor than accommodation strategies, hence the difference made in this case study.

In the transcriptions, most of the first category of facilitation strategies, the non-verbal encouraging signs, cannot really be seen. We do see some sentences in which words are capitalised, meaning that the doctor put stress on that word (spoken louder than normal, paused after saying the word etc.). For example in turn 160 and 149:

160)

per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog

149)

Azcık çeksene ayağını sen de. Vertaling Turks: Trek je voet dan toch eens een beetje.] plooi ma plooi ma jouw knie ja doet da pijn? [turks T: Acıyır mı? Vertaling Turks: Doet het pijn?] ik ga ne keer jouw knie nu strekken [naam patiënt] duw ma tegen mijn hand (.) gewoon STREKKEN zo

In the videos of the consultations, the doctor can be seen using all sorts of non-verbal encouraging signs such as nodding, gestures, eye contact, facial expressions and paralanguage (voice pitch, volume and also rhythm, intonation and stress as in the example above). These signs were put forward in both King & Hoppe (2013) and Cox & Maryns (2021). Especially during the medical examination phase, the doctor uses different kinds of intonation and gestures to indicate to the patients that he expects them to do something. They might not understand the actual words that he uses, but through means of the gestures and facial expressions, they might guess what they need to do. Some of the words the doctor uses are what we can call ‘universal sounds’. These are not really words in the sense that they have a specific meaning, but they embody a sound that can more easily be linked to a general feeling. For example, in turn 122 the doctor says ‘oeioeioei’. This ‘word’ in itself does not have a specific definition, but it has

the connotation of ‘there is a problem’, which even non-Dutch speaking people might recognise due to the sound and the facial expression which accompanies it. Other examples are indicated in yellow below (hoppa, voilà, ok).

122) D: Tis goed, kun je ne keer ergens hieruit stappen we moen haar lijk efkes helpen [turks] hoppa oeioeioei ge zit hier helemaal vast [mm] voilà andere kant ook (we gaan ne keer mooi naar die linker knie) voilà [turks] en als ge wilt kom ne keer hier staan benen mooi samen ok benen goe samen (.)

The same phenomenon can be noticed in the second transcription:

Transcription 2

124) D: Eh seg jij doet da keigoe (.) seg seg seg (.) ik ga hier efkes me iets groters kijken iets da sterker is [ja]

Asking for permission

It has been established that a relationship of trust needs to exist between doctor and patients in order to come to the best possible outcome. For the purpose of a good diagnosis, a physical examination is often needed. This is also an important step in building the relationship, as was established by Asif and Hassan (2017). They state that leaving out the physical examination could give a blow to the patient’s trust in the doctor and therefore it might also influence their willingness to cooperate later on in the treatment. In this, touch is a very important element. This is a very strong non-verbal indicator as well, which can provide a safe space for the patients. However, as there is also a culture difference in this case, the doctor must be very wary to respect cultural sensitivities. In this case especially so, when dealing with children, it is prudent to always ask for permission. We see this in turns 106, 71 and 189. He first announces that he will look at the patient and then confirms by asking if that is OK.

106) D: goed we gaan toch ne keer kijken om te zien of er niets gevaarlijks [ja] euh kapotgegaan is he (.) ist goed?

Transcription 2

71) D: Nee [turks] toch niet nee [turks P1: Ben o xxx geceleğin xxx] voilà goed ik zou dan gewoon [sshh] ne keer willen kijken : eigenlijk naar die neus ist goed

189) D: Mag ik nog ne keer kijken naar jouw neus nu?

Open-ended questions and small talk

Roscher (2020) described open-ended questions or 'open-ended general enquiry' as a question which does not relate to any visible physical ailments or assumptions made by the medical professional. It is very important to keep an open mind during the consultation and to give the patient enough input in the process. It is best to begin the anamnesis by asking these questions instead of zooming in on the problem if it is already introduced by the interpreter or if it becomes clear from the patient's physical appearance. The doctor makes enormous efforts to keep the patients involved throughout the whole consultation. Not only the interpreter, but also the young patients and the grandmother. We see this in turn 82:

82) D: Het verhaal begint mij wat duidelijk te worden he kga straks nog ne keer kijken naar [naam patiënt] (.) maar kzou graag nog eerst ne keer willen weten wat da jullie zelf denken dat er aan de hand is (.) en ik stel de vraag aan jou maar ook aan [naam patiënt] ook aan oma wat denken jullie zelf dat er aan de hand is?

In the next segment, the doctor even wants to know what the parents of the patient think about the problem, even if they are not present during the consultation.

90) D: wat ik nu zou willen willen weten is euh ja (.) ebn die ouders (.) verteld op een of andere manier oe da we die best zouden kunnen helpen (.) wa da we het best zouden kunnen doen voor [naam patiënt] [ja] hebben zij een idee [nee] of oma heeft zij een idee?

97) D: Das goed (.) ça va (.) [naam patiënt] wat denk jij eigenlijk dat er aan de hand is? Weet jij?

To make the patients feel at ease, small talk can be used in the beginning or during the consult. The doctor comes back to this introduction after he already began with the anamnesis in the first few turns. He wants to understand the relationship between the parties present, which is very important in this case as well, when a young lay interpreter is present to know the family dynamics before beginning the consult.

8) D: is goed mag ik ne keer vragen wat is jouw relatie ben jij grote zus of?

9) T: Nee das mijn nichtje

10) D: Nichtje das goed [T turks: Soruyo, senin neyin diyo.
Vertaling: Hij vraagt, wie is ze van jou, zegt hij.

11) D: En uw?

12) T: Oma

13) D: Oma okee en daar de broer?

14) T: de broer van [naam patiënt] xxx

15) D: Ja okee

85) D: en hoe gaat het op school [naam P3]?

86) T: (turks): Neden okulu sevimiisin?
VERTALING: Waarom hou je niet van school?

101) D: Ja en [naam P3] wa wil jij worden later?

108) D: Ej schitterend mijn zoontje wilt ook politieagent worden [jaaa] je mag hem dat vertellen

In this second example, the doctor wants to calm down the nervous patient by trying to ask him about school. The interpreter brought up that the boy did not like school very much and the doctor wants to elaborate on the subject. He uses it as a way to divert attention away from the upcoming physical examination of the boy's nose. The interpreter does not really understand why the doctor is asking about school and chooses to not always convey his remarks, but the doctor insists in turn 108 to bring the message to the young male patient.

Use of humour

A last facilitation strategy is the use of humour. The doctor has tried to diffuse the tension on several occasions through means of small jokes. This is also a contributing factor to a good patient-doctor relationship. Still, the interpreter does not always convey this message to the patients, which is why some of the jokes go to waste. A few examples are listed below:

16) D: Tis een hele familie die hier is he

This is a joke referring to the number of people present after the doctor asked about the family relationships.

22) D: ist goed? euhm ook als zij iets n- naar jou vertelt geef maar gewoon door naar mij [mhm] ja eigenlijk is het een beetje een pingpongspel

23) T: ja ((lachend))

24) D: en jij bent de bal he [((lacht))] okee we gaan het spel zo goe mogelijk proberen spelen [okee] dus voetpijn en beenpijn

In this case, the doctor uses humour to describe how he sees the role of the interpreter (see 3.2.1.3)

105) D: Ah kzie ze heeft gisteren toch een accident gehad [ja] ah voilà (.) ben heel blij da je da vertelt [naam tolk] [naam patiënt] jij bent [naam tolk] en zij is [naam patiënt] ((lachend)) [haha ja] ja [naam patiënt] :XXX (.)

In turn 105, the doctor confounds the name of the interpreter with the name of the young female patient. This is accompanied with the necessary laughter afterwards as he indicates that the names resemble each other a lot.

159) D: Je mag ze weer aankleden (.) anders ist een beetje belachelijk om zo naar buiten te gaan he

The doctor makes a joke just after the physical examination, a critical point in the consultation. After the patient undressed herself to let the doctor take a look at her knee, the doctor jokingly

tells the interpreter that she can put everything back on, as walking around outside without clothes would look a bit silly.

Transcription 2

In the second consult, the doctor directs his joke more towards the interpreter than to all patients. As the young male patient encountered a minor feeling of pain during the physical examination, the doctor jokingly suggests he might not be willing to come back if the problem should arise again. But in the end he clearly states that the patient should come back if he were to encounter any more trouble with his nose.

218) D: Euhm goed [turks] normaal gezien nu gaat da nie meer elke twee weken gebeuren [turks] ja moest da wel nog blijven gebeuren ja dan mag je altijd ne keer terugkomen (lachend) als als die da nog durft maar nee hij mag altijd nog ne keer terugkomen maar ik denk eh nu dat da ga weg zijn ja

3.2.2 Micro-analysis from the perspective of the ad hoc interpreter

In this part of the micro-analysis, the actions of the lay interpreter will be studied. Of course it can be argued that the doctor should intervene more during the consult due to his knowledge of a (deontological) code, which is arguably larger than the knowledge of the lay interpreter. As is stated in De Wilde & Maryns (2021), this is a very complex multilingual and multimodal context, therefore one of the two parties is at a slight disadvantage because they do not possess the same knowledge and resources as the other. As a result, more 'strategies' were defined in the first part of this micro-analysis, whereas more 'approaches' will be examined in this part. Here, the interpreter's approach with respect to the deontological code of the interpreter will be discussed. Lay interpreters cannot and should not be evaluated on the basis of 'mistakes' but rather should be guided from less effective interpretation choices to more regulated ones on the basis of the deontological code. Of course, lay interpreters can sometimes already apply these choices (or rather strategies) unknowingly. These should be encouraged throughout the consult and also reinforced later on in their potential interpreting career. The less effective interpretation choices on the other hand, should gradually be removed from their mediated conversations. However, it is very interesting for the ad hoc interpreter as well as the medical professional to know where the difficulties lie. These can always be a good lesson for other starting (ad hoc) interpreters as well as become a guide on what not to do. Therefore examples will be provided

throughout this analysis and a general guideline will be presented in the discussion of this dissertation.

An argument which can be brought up is that some of the deontological practices that professional interpreters follow are not really essential in ad hoc interpreted conversations. Some practices, such as neutrality and professional secrecy are not always feasible as an ad hoc interpreter, as these people are often related to the people they translate for. Other ground rules, such as translating without adding, changing or leaving out anything can be more useful to take up in a guideline for non-professional interpreters. Furthermore, it can of course be useful to teach them to interpret in the first person singular, but we would propose seeing this as a secondary ground rule, as this is maybe not always achievable over the course of one or a few interpreting sessions. Of course professional interpreters can be counted on to provide this extra value. This is also stated in Roels (2015), a study in which end users and clients indicated that they preferred working with community interpreters instead of ad hoc interpreters for those exact reasons. Professional interpreters ensure neutrality, objectivity and confidentiality and more language proficiency than lay interpreters. In Roels' study it became apparent that ad hoc interpreted conversations often create misunderstandings between the speaking parties and that there are multiple misinterpretations and omissions occurring. In chapter 4, we will provide a framework of primary and secondary guidelines for the interpreter to take into account while interpreting. In the next three parts of the study, three approaches of the ad hoc interpreter will be examined in detail and excerpts coming from the transcripts will serve as examples of these approaches.

3.2.2.1 Translation deviations (Wadensjö, 1998): zero-rendition and non-rendition

In this first subchapter, some zero- and non-renditions of the interpreter will be looked into. Wadensjö (1998) defined these concepts as follows: a zero-rendition occurs when an original statement uttered by a speaker is left untranslated. A non-rendition is when the rendition by the interpreter does not correspond with the original that was uttered by the speaker for whom the interpreter is translating during the non-rendition. A few examples will now be discussed in detail.

Zero-renditions Transcript 1

In the first consultation, some questions asked by the doctor go by untranslated. Instead the interpreter often answers on behalf of the patient as she knows the specific situation they are in.

This is a problem that often occurs with non-professional interpreters as they do not always follow the deontological code of being a neutral, objective party (Roels, 2015). In the first example (turns 59-60), the doctor suggests a few possibilities of activities during which the patient might have gotten injured. These are not all translated by the interpreter, instead she asks the patient whether she lifted something heavy. In that sense, this turn could also be seen as a non-rendition. It should be noted that enumerations often cause trouble for interpreters to fluently translate. A useful tip in this case might be to note down some key words or from the doctor's perspective to keep the examples very short or to divide the different activities into different turns for the interpreter to ask the patient.

59) D: Okee wa dak nog zou willen weten is euh het volgende eeft zij de voorbije dagen iets speciaals gedaan waardoor da zij nu zoveel pijn zou kunnen krijgen? Heeft zij veel gelopen heeft ze gesport heeft ze heeft ze een ongeval gehad is er iets gebeurd?

60) T: (turks) Bi şey yaptın mı? Bi sey ağır kaldırdın mı? Ya da xxx
Vertaling Turks: Heb je iets gedaan? Heb je iets zwaars getild? Of xxx

Zero-rendition: enkel het tillen komt hierin voor, niet de andere activiteiten

Another example can be found in turns 82-84. The doctor indicates that he wants to hear the opinion of the interpreter, of the patient and of the patients' grandmother. This is a bit confusing for the interpreter, who promptly replies to the question herself. This might be resolved if the doctor asks the interpreter to redirect the question once to the patient, once to the grandmother and once to the interpreter herself. A general guideline here could be to keep the bits of information short and simple.

82) D: Het verhaal begint mij wat duidelijk te worden he kga straks nog ne keer kijken naar [naam patiënt] (.) maar kzou graag nog eerst ne keer willen weten wat da jullie zelf denken dat er aan de hand is (.) en ik stel de vraag aan jou maar ook aan [naam patiënt] ook aan oma wat denken jullie zelf dat er aan de hand is?

83) T: Euh alleh eigenlijk ik denk zo das gewoon van te moe te zijn en euh en de school (die lopen) zo die alleh die stappen (die spelen) daarom denk ik dat (het van zo) daarmee khad da ook zo vorig jaar das van moe te zijn denk ik [ja ja haar haar euh moeder doe zo dinges alleh die is bang [ja] over haar daarom [P1 Turks xxxxx] (en dan ook) haar oma is ook bang geworden [ja] en ze [hmh] moet van oma naar de dokter gaan (das ouders) :XXX

84) D: Ja nee das goed en euh kan je dan ne keer vragen of euh kan je mij ne keer vertellen waar de ouders echt bang van zijn of weet je dat niet?

Zero-rendition: conversatie tussen dokter en tolk, dokter vraagt iets aan oma, maar dit wordt meteen beantwoordt door de tolk

Zero-renditions transcript 2

During the second consult, the interpreter also directly replies to a question the doctor asks without checking this with one of the other parties.

48) D: Ja nu mag ik ne keer vragen waarom ist ie eigenlijk in eerste instantie geopereerd (.) is da omdat ie heel veel euh verkoudheden kreeg of heel veel keelonstekingen of is het net omdat zijn neus heel veel verstopt zat? Maar

49) T: Door zijn neus verstopt

Zero-rendition: tolk antwoordt ipv dit te checken bij patiënt

Non-renditions Transcript 1

Now we will discuss the non-renditions that occurred throughout the first consultation. These arguably constitute a bigger infringement on the deontological code than zero-renditions as the interpreter conveys a different message than was intended by the patient or doctor. In the first example, the doctor wants to know whether there are any other activities other than walking that cause the patient to feel pain. The interpreter falsely translates this as 'do you feel pain anywhere else in your body?' As the conversation runs smoothly and the answer fits the question the doctor originally asks, there is no real sign of a language barrier or a mistake having occurred. This concept was described in Cox & Maryns (2021) as false fluency.

46) D: ja (dus stappen) geeft meer pijn he [naam]?

47) T: (turks) #00:03:06-6# Ama sen yürürsen çok acıyo demi?
Vertaling Turks: Maar wanneer jij loopt doet het veel pijn he?
48) D: Ja zijn er nog dingen die meer pijn geven?

49) T: (turks) Başka bir yerin acıyır mi?
Vertaling Turks: Heb je ergens anders pijn?
50) P1: (turks) Hayır.
Vertaling Turks: Neen.
51) D: Nee

Non-rendition -> ergens anders pijn ipv andere dingen die pijn doen

In turn 66, the doctor wants to know whether the patient has difficulties extending her knee. The interpreter goes on to ask the patient whether she can still do 'something' with her arm. As the patient clearly stated herself that the pain is situated in her knee and leg, she understands that this was a mistake by the interpreter and no problem arose.

66) D: :xxx danku (.) wa dak ook nog zou willen weten eeft ze soms het gevoel dat er iets blokkeert bij haar? Da ze bijvoorbeeld haar knie wil strekken ma dat da nie lukt? of da ze haar voet wil plooien en dat dat blokkeert?

67) T: (turks) Şey dii hani mesela şimdi kolunu şey etme, böyle yapmağa. Yapabilirsin mi onu ya da yapamazsın mı ?
Vertaling Turks: Hij zegt dinges alé bijvoorbeeld nu om je arm te dingesen, zo te doen. Kan jij dat doen of kan jij dat niet doen?
68) P1: (turks) Yapabilirim ama bazen xxx
Vertaling Turks: Ik kan dat doen maar soms xxx
69) T: Jawel zij kan dat wel

Non-rendition: knie wordt arm

Non-renditions Transcript 2

During the second consultation, some more troubling non-renditions arise. The interpreter makes three 'mistakes' in her translation, which might have an influence on the doctor's diagnosis. In the first case, the mistake seems minor, but could have an effect on the treatment. In turn 15, the patient's grandmother claims that the young male patient had surgery about 4 years ago, in turn 16, the interpreter states that this happened 2 years ago, but hedges this statement by adding 'ofzoiets' (something like that). This might give an indication to the doctor that the timing of the surgery was not exactly two years ago, but might have been earlier or sooner.

15) P2: (turks): Tam bilmiyom… kesin dört (?) sene falan oldu.
VERTALING: Ik weet het niet precies… het is zeker vier (?) jaar of zo geleden.
16) T: Twee jaar geleden ofzoiets [P2 (turks)xxx]

Non-rendition: vier jaar wordt twee jaar

During the phase in which the doctor wants to divert the attention from the medical issue to something else, the interpreter asks a very specific question about the boy's feelings in relation to school, whereas the doctor asked a general question about how he is feeling at school. The interpreter added a negative connotation to school and immediately assumes that the boy does not feel well there by stating 'Why don't you like school?' This will not trigger the answer from the patient that the doctor wanted, as a focus will lie on the negative aspects of school. It could be argued that, as this is not really part of the anamnesis, this is not of great medical importance to the treatment of the patient. However, any large deviations from the intended message should be avoided.

85) D: en hoe gaat het op school [naam P3]?

86) T: (turks): Neden okulu sevimiisin?
VERTALING: Waarom hou je niet van school?

Non-rendition: tolk vraagt waarom patiënt niet van school houdt terwijl dokter wil weten hoe het op school gaat

The last example is also the most striking one with the biggest implications on the perception of the doctor. The young male patient indicates that at school he was hit by someone and that that is the reason why he does not like school. As his nosebleeds might have been explained by these hits at school, it is a vital piece of information which the doctor should know. The interpreter, however, does not convey this at all and only states that the patient does not like school. As the doctor did not understand the patient's answer and fully relies on the interpretation, he does not think anything of it and continues the consultation.

87) P3: (turks): Çünkü okulda birisi bana vurdu (?).
VERTALING: Omdat op school iemand mij heeft geslagen (?).
88) T: School is nie leuk

Non-rendition: patiënt geeft aan dat iemand op school hem heeft geslagen, maar de tolk zegt gewoon dat hij zegt dat hij school niet leuk vindt

We can state that at multiple occasions throughout the consultations, the interpreter either left out parts of the conversation (both from the doctor's statements as well as the patients' statements) or changed the message altogether. This is inconsistent with the deontological code of the interpreter and should be avoided as much as possible. In De Wilde & Maryns (2021) similar behaviour was observed. There the interpreter also actively intervened in the interaction by performing zero- or non-renditions and by answering questions without consulting the primary participants. In this study, 'filtering information' is mentioned, which is also the case in this dissertation for information that is thought of as irrelevant or extra.

3.2.2.2 Side conversations

In this part of the study, side conversations will be examined (described in Watermeyer, 2011). These are non-triadic renderings by the interpreter, which include multiple turn long segments during which the third party is not involved at all. In other words, conversations either between

the interpreter and the patients without interpretation for the doctor, or conversations between the interpreter and the doctor which are not conveyed to the patients. Examples can be, as mentioned above in 3.2.2.1, the interpreter who answered the doctor's questions instead of asking the patients, or the interpreter having a conversation with the other patients, the contents of which she does not convey to the doctor.

In turn 82, the doctor specifically states that he wants to know what all the parties think is going on with the patient (thoughts from the interpreter as well as from the grandmother and from the patient herself). Nevertheless, the interpreter does not ask the grandmother or the patient anything, but begins to answer the question herself in turn 83. She does, however, indicate that the patient's parents are worried and that that was the main reason they had made this appointment. The doctor, who initially started out by wanting everyone's opinion, does not stand firm but rather wants to continue the conversation by asking about the feelings of the parents. Instead of repeating the question to have it translated for all parties (What do you think has happened/is going on?), the doctor wants to zoom in on the fears of the parents. In this case, the doctor might have been better of repeating his initial question and starting again from that point.

82) D: Het verhaal begint mij wat duidelijk te worden he kga straks nog ne keer kijken naar [naam patiënt] (.) maar kzou graag nog eerst ne keer willen weten wat da jullie zelf denken dat er aan de hand is (.) en ik stel de vraag aan jou maar ook aan [naam patiënt] ook aan oma wat denken jullie zelf dat er aan de hand is?

83) T: Euh alleh eigenlijk ik denk zo das gewoon van te moe te zijn en euh en de school (die lopen) zo die alleh die stappen (die spelen) daarom denk ik dat (het van zo) daarmee khad da ook zo vorig jaar das van moe te zijn denk ik [ja ja haar haar euh moeder doe zo dinges alleh die is bang [ja] over haar daarom [P1 Turks xxxxx] (en dan ook) haar oma is ook bang geworden [ja] en ze [hmh] moet van oma naar de dokter gaan (das ouders) :XXX

84) D: Ja nee das goed en euh kan je dan ne keer vragen of euh kan je mij ne keer vertellen waar de ouders echt bang van zijn of weet je dat niet?

Around turn 160, two separate side conversations are happening at the same time. While the doctor and the interpreter are discussing the treatment, the young female patient is talking to her grandmother. In turn 160, the proposed treatment is put forward by the doctor. As was already stated, this is a lot of information to process for the interpreter. Therefore she should have tried to interpret small parts one by one to her family. But as the doctor wanted to express the whole idea in one turn, that was nearly impossible to do.

((D spreekt onafgebroken tegen T, in de achtergrond spreken P1 en P2 Turks)) xxx

160) D: wa dak nu voorstel is het volgende kga dan eigenlijk pijnstilling gel voorschrijven [ja] dan mag ze da opdoen als ze pijn heeft mag ze da beetje rapper euh opdoen dan mag ze da zelfs vier vijf keer per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie dus [ja] ik ga een voorschrift maken voor die echografie he dan moet je nie nog ne keer komen ge zijt hier nu toch eh ma je moet die echografie niet nu al direct gaan doen ma als da binnen een week eh volgende week woensdag nog altijd nie :XXX dan maak je een afspraak voor die echo (.) dus nu nog niet maar binnen een alst binnen een week nog klachten doet dat dan [okee] ja voorlopig eigenlijk

((T hoest))

161) D: Gebruik maar gewoon die gel [ja] en wat er ook gaat helpen is eigenlijk lokaal een beetje ijs he (da doek ook) altijd bij een verstuiking [ja] een beetje ijs nooit ijs rechtstreeks op de huid maar eerst in de handdoek [ja] ça va en eigenlijk vandaag moest zij ook naar tschool gaan eeft zij eigenlijk gegaan naar tschool of niet? [mhm nee] nee

#00:14:08-6#

162) T: (nee zij is ook thuis gebleven)

163) D: Nu en wat denkt ze van morgen gaat het morgen lukken om naar tschool te gaan [naam patiënt]?

164) T: (turks) ja

165) D: Das goed

Transcription 2

Another small side conversation occurs during the second consultation. Interestingly enough, this took place again during the intermediate conversation about school. As the interpreter saw this part as something of minor importance, she does not interpret the remarks of the patient to the doctor. The explanation then being that she did not think this was of any medical importance, and was thus not necessary to convey to the doctor. In this case, we could state that this is indeed not paramount for the further treatment of the patient, but side conversations such as these should generally be avoided as much as possible.

111) P3: (turks) [ja ja ja]: Onun da mı uşağı var?
VERTALING: Heeft die ook een zoon?
TOEVOEGING: T: *Ja*.
VERTALING: Ja.
TOEVOEGING: P3 turks: O nerde?
VERTALING: Waar is die?

112) T: (turks) *School*'da.
VERTALING: Op school.
TOEVOEGING: P3 turks: Okulda.
VERTALING: Op school.

The longest side conversation takes place while the doctor is not present in the room. The conversation lasts 26 turns and the topic is mainly unrelated to the patient's ailment, as it is about how the patients are feeling.

127) P3: (turks): xxx
VERTALING: xxx
128) P2: (turks): xxx
VERTALING: xxx
129) P3: (turks): xxx
VERTALING: xxx
130) P2: (turks): xxx
VERTALING: xxx
[turks door mekaar]

131) P2: (turks): Ama ona da veesin bi şey.
VERTALING: Maar dat hij daar ook iets voor geeft.
132) T: (turks): Veecek.
VERTALING: Hij gaat dat geven?
133) P2: (turks): xxx
VERTALING: xxx
134) T: (turks): Sen var ya çok sinirlisin. Git otur (zegt dit tegen P1).
VERTALING: Weet je, je bent echt heel kwaad/ prikkelbaar. Ga zitten (zegt dit tegen P1).
135) P1: (turks): xxx
VERTALING: xxx
[door mekaar]

136) P2: (turks): Sen otur.
VERTALING: Ga zitten.
137) T: (turks): Sen de otur. Sen de çok sinirli gibisin.
VERTALING: Ga jij ook maar zitten. Het is alsof je echt heel kwaad/ prikkelbaar bent.
#00:08:08-7#

138) P2: (turks): xxx Hiçbi şey yapmıcak. xxx yapacak sana. Bakacak burnunda kan var mı diye.
VERTALING: xxx Hij gaat niets doen. Hij gaat xxx doen bij jou. Hij gaat kijken of je bloed hebt in je neus.
139) T: (turks): *Ja*.
VERTALING: Ja.
140) P3: (turks): Burdan acımiyi. Ben çıkardım kanı artık.
VERTALING: Het doet hier geen pijn. Ik heb het bloed er al uitgedaan.
141) P2: (turks): Çıkardın mı kanı artık? Eh xxx
VERTALING: Heb je het bloed er al uitgedaan? Euh xxx
142) P3: (turks): Hadi in ordan aşağa.
VERTALING: Alé, kom daar af.
143) P2: (turks): xxx Adam baksın ona xxx

VERTALING: xxx Dat de man kijkt naar hem xxx
144) T: (turks): Offf bi saattir burdayız.
VERTALING: Pfff we zijn hier al een uur.
145) P2: (turks): xxx Girdi çıktı, girdi çıktı. xxx
VERTALING: xxx Hij komt binnen, gaat naar buiten, hij komt binnen, gaat naar buiten. xxx
146) T: (turks): xxx
VERTALING: xxx
(.)

147) P2: (turks): xxx
VERTALING: xxx
148) T: (turks): xxx
VERTALING: xxx
149) P2: (turks): xxx
VERTALING: xxx
150) T: (turks): xxx
VERTALING: xxx
(4.0)

151) T: (turks): Yerinde dur artık [naam P1].
VERTALING: Blijf nu eens op je plaats [naam P].
152) P2: (turks): xxx az dur be, az dur be.
VERTALING: xxx wees nu eens rustig, wees nu eens rustig.
153) T: (turks): Sıkıldı
VERTALING: Ze verveelt zich.
[D komt terug binnen]

In conclusion, we would argue that side conversations in general are not really beneficial for the smooth course of a consultation. However, they should not be avoided at all costs as sometimes the topics discussed during side conversations are not of great relevance to the third party. A side conversation between the interpreter and the patients might even serve the purpose of calming the patient down or explaining again what has happened or will happen during the consult. A useful tip for the interpreter might be to summarize what was said during the side conversation and to notify the doctor of that. A side conversation between the interpreter and the doctor might also be useful, for example for the interpreter to clarify what she is meant to be telling the patients. By doing that, she can make sure she understood everything and clearly convey one final message to the patients, especially if the message is about the treatment of diagnosis of the patient.

3.2.2.3 Fluency of the interpreter (medical terminology)

For many ad hoc interpreters who have to step in to translate a medical consult, the terminology is often a stumbling block. As Meyer (2006) (discussed in Pöllabauer, 2017) noted, lay interpreters tend to avoid specific medical terms by using a more general term or by describing the term vaguely. This is what Meyer calls 'determinologising', i.e. paraphrasing medical jargon. Myers-Scotton (2006) (discussed in Napier, 2017) adds onto this by stating that bilinguals often use both of the languages they master in very different contexts. They might not have the same proficiency in both languages in all domains, which is often the case for ad hoc interpreters (also in this study).

In the following excerpts, we will specifically zoom in on the more medically specific terms that are brought up over the course of the consultation. Other smaller language issues will not be discussed in detail, but in general it can be stated that the interpreter is not perfectly fluent in Dutch. Small mistakes such as 'ze heb' (She have) and the extensive use of hesitation markers (euh, zo) give a clear indication of her difficulty in speaking Dutch (De Wilde & Maryns, 2021).

Now a few examples of more difficult medical terminology used by the doctor or interpreter will be presented. In turn 66, the doctor describes the feeling of having an issue in the knee. He asks whether the patient encounters any difficulties when stretching the knee or bending her knee or foot. He wants to know whether there is anything that feels like it is stuck. The doctor uses multiple ways to describe this in order for the interpreter to understand what he would like to know. This is a very good strategy to help the interpreter when a more challenging description needs to be translated. The interpreter does struggle, which we can see in turn 67. There, she states "Hij zegt dinges alé bijvoorbeeld nu om je arm te dingesen, zo te doen. Kan jij dat doen of kan jij dat niet doen?" (He says 'thingy' euh well for example to do a 'thing' with your arm. Can you do that or can you not do that?). This must be a very unclear question for the patient, as leg/foot is replaced by arm and the actions described by the doctor are replaced by 'thing' or 'to do a thing'. Non-verbal gestures might help in this instance to explain to the patient what the doctor means.

66) D: :xxx danku (.) wa dak ook nog zou willen weten eeft ze soms het gevoel dat er iets blokkeert bij haar? Da ze bijvoorbeeld haar knie wil strekken ma dat da nie lukt? of da ze haar voet wil plooien en dat dat blokkeert?

67) T: (turks) Şey dii hani mesela şimdi kolunu şey etme, böyle yapmağa. Yapabilirsin mi onu ya da yapamazsın mı ?

Vertaling Turks: Hij zegt dinges alé bijvoorbeeld nu om je arm te dingesen, zo te doen. Kan jij dat doen of kan jij dat niet doen?

Transcription 2

During the second consult, the interpreter manages to immediately inform the doctor about the patient's nosebleed. This is not a simple term, so it is great that she came up with that so fast. However, the more specific issue that the patient has (polyps and tonsils issue) is a lot harder to describe. She makes a very good effort in describing a sort of 'meat' that was found in the patient's nose for which he had a surgery to have it removed. From that description in turn 18, the doctor could understand what the issue had been in the past, so in this case the technical term was very well managed by the ad hoc interpreter.

10) T: Nu gaat het over em euh zeb zo bloedneus hij eet niets [ja] euhm ik weet het ook niet waarom maja opeens euh zo XXX naar school enzo maar bloed uit de neus enzo

18) T: Euh ze had zo vlees (gevonden) in de neus

We do see during multiple turns that the interpreter has some difficulties finding her words even in Turkish. This might be a result of the constant switch you have to make as an interpreter. This is a very demanding task which explains the difficulty she has sometimes to express the ideas in Turkish. We can see this in the following example:

195) T: (turks) [eh goed gedaan echt goed zo he]: Şey eh bilmiyom...eh açılmış onun şeysi. O da kapatmış onu başka sey etmesin, akmasın ordan kan diye.
VERTALING: Dinges euh ik weet niet… euh zijn dinges is schijnt opengegaan. Hij heeft dat schijnt dichtgedaan zodat het niet nog eens dingest, dat daar geen bloed uit komt.
TRANSLATION: Thingy euh I don't know… euh his thingy has opened up apparently. He apparently closed that again so that it would not do that thing again, that there would not be blood coming out.

De Wilde & Maryns (2021) formulated a good strategy in their study to resolve possible terminological issues in ad hoc interpreted conversations. As the interpreter might have some gaps in his or her knowledge, a cooperation between the medical professional and the interpreter should be set up to fill in the gaps. This contextual knowledge can be provided by the doctor

through means of extra meta-communicative effort. The interpreter can also ask for a clarification or a synonym if a term is not exactly clear to him or her.

In this study, the ad hoc interpreter experienced multiple difficulties with the terminology used throughout the consult, but also with her proficiency in Dutch. The switch between the languages was also difficult to process, which is why often hedging, false starts and hesitation markers were used (De Wilde & Maryns, 2021). More often than not, these difficulties did not become clear to the medical professional and the conversation went on. This again can create a false sense of fluency (Cox & Maryns, 2021), which should be avoided as much as possible.

Chapter 4: Discussion

In this chapter, the main findings of the analysis will be discussed. On the one hand, the strategies used by the doctor will be presented, and on the other hand the approaches applied by the ad hoc interpreter will be examined. At the end of this discussion, a brief framework of guidelines for the medical professional and ad hoc interpreter will be presented. These will be split up into primary and secondary guidelines, indicating the priority they have to enable a smooth rendition of an interpreter-mediated conversation.

In this study, the doctor primarily took the lead in both consults. He guided the conversation by using multiple strategies and tried to find out as much as he could with the help of the lay interpreter. He respected the principle of establishing a relationship with the patient (Kurtz and Silverman, 1996) and subsequently also made an effort to build a relationship with the lay interpreter as well. The doctor also took into account the ICE-principle laid out by Munson and Willcox (2007) and regularly checked whether the patient wanted to share their ideas on the issue, whether they had any further concerns and whether their expectations were met. He also used various non-verbal gestures such as nodding, humming, eye contact, gestures, facial expressions and intonation. In the previous chapter, examples of multiple useful accommodation strategies used by the doctor were put forward. He applied summarizing multiple times, not only summarizing his own words, but at times also summarizing the turns of the interpreter in order to check whether everything was clear or not. Furthermore, he repeated his own turns or slightly reformulated them for the interpreter to better understand the message. Other strategies, such as the use of open-ended questions, signposting, giving positive feedback and safety netting also regularly popped up throughout the consults. And last but not least, the doctor gave a clear indication of wanting to establish a good relationship with the other parties through means of small talk and humour.

However, there are also some points of improvement for the doctor. First, he should try to shorten his turns a bit, especially when he is trying to convey important information to the patient about the diagnosis or treatment. Moreover, he should have kept encouraging the interpreter to interpret everything that is being said throughout the consult and when he noticed that she did not convey everything, he should have tried to ask her to do this still. In the beginning of the consult, he was also very keen on getting everyone's opinion on the matter, but this interest also gradually fades throughout the second consultation. Finally, it is vital to

keep on checking whether the patients understood the message or whether he understood the patients' message rights, as misunderstandings can have very serious consequences for the patient's wellbeing.

Before we discuss the approaches applied by the ad hoc interpreter, we would like to stress that this is a very demanding task which is not easy to perform, especially by a person who has never received any formal training on how to carry it out. Therefore, it should be clearly indicated that the 'mistakes' presented next should not be seen as such, but rather should be seen as a learning experience for both the interpreter as well as the medical professional. The interpreter in the past was merely seen as a conduit, a translating machine who only literally conveyed one spoken message from one language to another (Loach, 2019). Now however, the task of the interpreter has evolved into an enabler of cross-language communication. In Loach (2019), this role is called a 'culture broker' or even 'advocate'.

During both conversations, the interpreter applied a number of approaches which were not 100% effective and should consequently be avoided. Examples are the translation deviations (zero- and non-renditions, described by Wadensjö, 1998), where non-renditions arguably have a bigger impact as in these cases inaccurate information is conveyed. These should, consequently, be avoided at all costs. Furthermore, it became clear throughout the conversations that the Dutch proficiency level of the interpreter was not very high. This became apparent due to the multiple language mistakes that were made and the difficulty the interpreter encountered when faced with translating more technical messages or medical terms. Side conversations also occurred a number of times and in these cases we would argue that the interpreter should always try to clarify what was said to the party that is left out. Finally, the interpreter also consistently answered questions herself instead of consulting the patients. This approach should also be avoided as much as possible.

Nevertheless, the medical professional did give a clear indication that he was very happy with the translation of the interpreter through the many thanks he expressed throughout and at the end of the consults. The interpreter did help the doctor as best as she could, by providing him with extra information or explaining an idea again when he asked for more information and also by providing some great finds (such as bloedneus, 'nosebleed') or the description of 'meat' in the nose, which immediately helped the doctor understand even though the correct medical term was not used.

In what follows, we will present a framework of guidelines that the medical professional and lay interpreter can use for a next medical consult. A division was made between primary tips (which should be respected) and secondary tips (which might be helpful, but are not required for a well-mediated conversation).

DOCTOR

Primary

- Introduce yourself and your role to the interpreter and the patients and explain what you expect of the interpreter
- Stick to the Calgary-Cambridge structure, even when multiple consultations with the same interpreter or patient follow each other
- Keep checking if patient understood, involve all parties in the conversation
- Establish a rapport with the patient(s) and the interpreter
- Keep your turns short and simple, give the interpreter small pieces of information to convey

Secondary

- You can use an aid for medical terminology (translation tool)
- Summarize (your own words and what interpreter said), repeat (or slightly reformulate for better understanding), ask questions (preferably open-ended questions), give positive feedback
- Apply safety netting, signposting and non-verbal gestures: good eye contact, humming, nodding, gestures, facial expressions etc.
- Use small talk and humour to make the interpreter/patient feel at ease

INTERPRETER

Primary

- If you do not know the medical term, try to generalize the word or to explain it in other words, if need be you could use a translation tool
- Avoid zero- and non-renditions (translation deviations) and side conversations. When these do occur, try to clarify to the other party what is happening.

- Try to convey everything without leaving anything out, changing anything or adding to what was said. Even when you think what was said was not really important
- If you are not sure, ask more information or hedge
- Use gestures if you don't know how to explain something

Secondary

- Try to be a neutral party in the conversation and try to always consult the other party when a question was asked instead of answering the question yourself
- Interpret from the first person singular

Some of the guidelines provided above can be corroborated by research. It is for example very interesting to look into the use of translation tools such as Google Translate or DeepL during interpreter-mediated medical conversations (De Wilde, Van Praet and Van Vaerenbergh, 2019, mentioned in De Wilde & Maryns, 2021). Their study confirmed that these tools make the conversation longer, but inversely, they enhance the understanding of both parties. This development did not occur in this study though, and is consequently a topic out of the scope of this research.

Another proposed tip is to have an introduction by the medical professional at the beginning of the consultation, explaining the different roles of the parties. We could even go further and look into the possibilities of a formal language policy established in a doctor's practice or in a hospital (De Wilde & Maryns, 2021). In Cox & Maryns (2021), a linguistic assessment beforehand was even proposed to be able to determine at which level the proficiency of the ad hoc interpreter is situated so as to determine whether or not a professional interpreter should be contacted. However, this will almost certainly not be feasible in most cases as the lay interpreter is already an 'ad hoc' solution to the problem.

In this chapter, we presented our main findings and discussed possible new topics to address in further research. In the next chapter, we will present our conclusion.

Chapter 5: Conclusion

The present study aimed to examine the use of a non-professional interpreter in a multilingual mediated medical consultation. A case study was conducted in a Ghent medical centre of two separate consultations for the same Turkish-speaking family with the same Dutch-speaking medical professional. The following topics were at the centre of this dissertation:

- What impact does the use of an ad hoc interpreter have on the outcome of a medical intervention between patients and a doctor? Is there a clear language barrier visible which perturbs the conversation and/or has a negative impact on the care given?
- How can we improve these ad hoc mediated medical conversations from both the perspective of the medical professional as well as the ad hoc interpreter?

By means of two transcriptions, the analysis was put forward on a macro- and micro-level, investigating multiple striking strategies and approaches used by either the lay interpreter or the doctor. On the macro-level, the consults were divided into different phases using the Calgary-Cambridge model. On a micro-level, four main strategies used by the doctor were examined and three main approaches applied by the ad hoc interpreter were presented. In the discussion, the main findings were presented and a framework with guidelines for both the lay interpreter as well as the medical professional was proposed.

Although the conversation did not always run as smoothly as it could have with the help of a professional interpreter, the doctor gave clear indications of a good evaluation of the conversation. A language barrier was present at times, when for example a more technical issue needed to be conveyed or when the doctor did not receive all the information the patients provided through the interpreter. However, this did not impede on the general fluency of the consult and on the diagnosis and treatment proposed by the doctor. The medical professional in this case, made many efforts to keep the conversation going and to empower the patient as well as the interpreter to speak up. He built a relationship with the other parties right from the start, which resulted in a conversation that was mediated as well as possible.

These findings are corroborated by other studies such as Baraldi and Gavioli (2017). In their study, ad hoc interpreters were studied in two public service institutions in Austria. The interpreters there tended to omit, simplify or paraphrase the message, which also happened a number of times in this study.

We can conclude that interpreting is a very demanding job, which goes beyond playing a mere conduit between different languages. The interplay of intercultural aspects needs to be taken into account (Baraldi and Gavioli, 2017) and the conversations need to be mediated by both the medical professional as well as the ad hoc interpreter. Ad hoc interpreters can make a huge difference in situations where professional support cannot be found (De Wilde & Maryns, 2021). Many aspects such as neutrality, accuracy and language proficiency cannot be expected from a lay interpreter at the same level as that of a professional interpreter. However, the lay interpreters do provide a solid alternative in a continuously changing world with a super-diverse public of non-Dutch speaking patients (Roels, 2015). In conclusion, ad hoc interpreters present a solution to bridge language barriers, but further help and guidelines need to be set out in order to create a framework for mediated medical conversations so as to help them do just that.

References

Anderson, S. R. (2021). *How many languages are there in the world?* | Linguistic Society of America. Linguistic Society of America. Geraadpleegd op 23 april 2022, van https://www.linguisticsociety.org/content/how-many-languages-are-there-world

Angelelli, C. V. (2017). *Bilingual youngsters' perceptions of their role as family interpreters.* Non-professional Interpreting and Translation. https://benjamins.com/catalog/btl.129.13ang

Asif T, Mohiuddin A, Hasan B, Pauly RR. *Importance of thorough physical examination: a lost art.* Cureus. 2017 May;9(5).

Atlas. (2022). *DEONTOLOGISCHE CODE SOCIAAL TOLKEN*. Atlas Antwerpen. Geraadpleegd op 24 februari 2022, van https://www.atlas-antwerpen.be/sites/default/files/uploads/deontologie_sociaal_tolken_Atlassociaaltolkenenvertalen.pdf

Baraldi, C., & Gavioli, L. (2017). *Intercultural mediation and "(non)professional" interpreting in Italian healthcare institutions.* Non-professional Interpreting and Translation. https://benjamins.com/catalog/btl.129.05bar

Bührig, K., & Meyer, B. (2004). *Ad hoc-interpreting and the achievement of communicative purposes in doctor-patient-communication.* Multilingual Communication.

Christopher R. Larrison PhD , Daniel Velez-Ortiz , Pedro M. Hernandez , Lissette M. Piedra & Andrea Goldberg (2010) *Brokering Language and Culture: Can Ad Hoc Interpreters Fill the Language Service Gap at Community Health Centers?*, Social Work in Public Health, 25:3-4, 387-407, DOI: 10.1080/19371910903241009

Cohen, S., Moran-Ellis, J. & Smaje, C. (1999*). "Children as Informal Interpreters in GP Consultations: Pragmatics and Ideology". Social Health and Illness* 21: 2. 163–186. as found in Angelelli, C. V. (2017). *Bilingual youngsters' perceptions of their role as family interpreters. Non-professional Interpreting and Translation*. https://benjamins.com/catalog/btl.129.13ang

Cooper N, Forrest K, Cramp P (2006) *Essential Guide to Generic Skills*. Blackwell Publishing Ltd

Cox, A & Maryns, K (2021): *Multilingual consultations in urgent medical care*, The Translator, DOI: 10.1080/13556509.2020.1857501

Day Translations Blog *What Is an Ad Hoc Interpreter? (*2019, 14 juni). Geraadpleegd op 28 september 2022, van https://www.daytranslations.com/blog/ad-hoc-interpreter/

De Wilde, J., Van Praet, E., & Van Vaerenbergh, Y. (2019). *Language discordance and technological facilitation in health care service encounters.* Technology Mediated Service Encounters. https://doi.org/10.1075/pbns.300

Delarue, S. (2020, 18 april). *OKANS-rapport: knelpunten, maar vooral kansen.* Steven Delarue. Geraadpleegd op 23 april 2022, van https://stevendelarue.be/2017/06/30/okans-rapport-knelpunten-maar-vooral-kansen/

Flores, G. (2005). *The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. Medical Care Research and Review*, 62(3), 255–299. https://doi.org/10.1177/1077558705275416

Flores, G., Abreu, M., Barone, C.P., Bachur, R., Lin, H. (2012*). Errors of Medical Interpretation and Their Potential Clinical Consequences: A Comparison of Professional Versus Ad Hoc Versus No Interpreters,* Annals of Emergency Medicine, Volume 60, Issue 5, 2012, Pages 545-553, ISSN 0196-0644, https://doi.org/10.1016/j.annemergmed.2012.01.025.

Galatro, T. (2022, 12 april). *Why Do Children Learn Languages Faster than Adults?* Tessa International School. Geraadpleegd op 23 mei 2022, van https://tessais.org/children-learn-languages-faster-adults/

Haznedar, Belma. (2001). *The Acquisition of the IP System in Child L2 English.* Studies in Second Language Acquisition. 23. 1 - 39. 10.1017/S0272263101001012.

Hécaen, H. (1968). J. RUESCH, & G. BATESON, *Communication : The social matrix of psychiatry*, New York, W. W. Norton, 1951, 314 p. (Index auteurs et matières). J. RUESCH, Disturbed communication : *The clinical assessment of normal and pathological communicative behavior*, New York, W. W. Norton, 1957, 337 p. (Index auteurs et matières). J. RUESCH, *Therapeutic communication*, New York, W. W. Norton, 1961, 480 p. (Index auteurs et ma tières). Social Science Information, 7(2), 166–167. https://doi.org/10.1177/053901846800700210

Hunter (2021) C*algary-Cambridge Guide to the Medical Interview - Closing the Session.* (2022, February 20). Physiopedia, . Retrieved 15:02, March 25, 2022 from https://www.physiopedia.com/index.php?title=Calgary-Cambridge_Guide_to_the_Medical_Interview_-_Closing_the_Session&oldid=294562.

J. De Wilde & Katrijn Maryns (2021): *Multilingual support in HIV/ STD counselling in Flanders,* The Translator, DOI: 10.1080/13556509.2020.1851853

Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). *Do professional interpreters improve clinical care for patients with limited English proficiency?* A systematic review of the literature. Health services research, 42(2), 727–754. https://doi.org/10.1111/j.1475-6773.2006.00629.x

King A, Hoppe RB. *"Best practice" for patient-centered communication: a narrative review*. Journal of graduate medical education. 2013 Sep;5(3):385-93.

Kurtz, S.M., Silverman, J.D.. *The Calgary-Cambridge Referenced Observation Guides: an aid to defining the curriculum and organizing the teaching in communication training programmes*. Med. Educ. 1996 30, 83–89.

L. Loach, *A time to speak and a time to keep silent: Professional ethics, conscience, and the medical interpreter*, Ethics, Medicine and Public Health, Volume 11, 2019, Pages 52-59, ISSN 2352-5525, https://doi.org/10.1016/j.jemep.2019.100420.

Lv, Q., & Liang, J. (2018b). *Is consecutive interpreting easier than simultaneous interpreting? – A corpus-based study of lexical simplification in interpretation.* Perspectives, 27(1). https://doi.org/10.1080/0907676x.2018.1498531

Malone, J. (2021, 5 november). *Young Children Vs. Adults Learning a Second Language*. The Classroom | Empowering Students in Their College Journey. Geraadpleegd op 23 december 2021, van https://www.theclassroom.com/young-adults-learning-second-language-6635123.html

Mashem (2016) *Calgary-Cambridge Guide to Communication in the Physical Examination*. (2022, February 20). Physiopedia. Retrieved 12:55, March 25, 2022 from https://www.physiopedia.com/index.php?title=Calgary-Cambridge_Guide_to_Communication_in_the_Physical_Examination&oldid=294560.

Merriam-Webster. (n.d.). *Ad hoc*. In *Merriam-Webster.com dictionary*. Retrieved August 18, 2021, from https://www.merriam-webster.com/dictionary/ad%20hoc

Meyer, B. (2006). *Aufklärungsgespräche mit Dolmetscherbeteiligung: fachexterne Fachkommunikation im mehrsprachigen Kontext".* Fachsprache 28:1-2. 15-28. as found in Pöllabauer, S. (2017). Issues of terminology in public service interpreting. Non-professional Interpreting and Translation. https://benjamins.com/catalog/btl.129.07pol

Munson, Eileen & Willcox, Adrienne. (2007). *Applying the Calgary-Cambridge model. Practice Nursing*. 18. 464-468. 10.12968/pnur.2007.18.9.27158.

MustGo Travel Agency. (2021, 1 juli). *Language Families* | About World Languages. MustGo.Com. Geraadpleegd op 24 februari 2022, van https://www.mustgo.com/worldlanguages/language-families/

Myers-Scotton, C. (2006). *Multiple Voices: An Introduction to Bilingualism*. Malden, MA: Blackwell.

Napier, J. (2017). *Not just child's play.* Non-professional Interpreting and Translation. https://benjamins.com/catalog/btl.129.19nap

NU (2015, 11 september). *Toestroom vluchtelingen zorgt voor tekort aan tolken*. Geraadpleegd op 29 september 2021, van https://www.nu.nl/binnenland/4123675/toestroom-vluchtelingen-zorgt-tekort-tolken.html

Pöllabauer, S. (2017*). Issues of terminology in public service interpreting*. Non-professional Interpreting and Translation. https://benjamins.com/catalog/btl.129.07pol

Roels, B., M. Seghers, B. De Bisschop, P. Van Avermaet, M. Van Herreweghe, and S. Slembrouck. 2015. *"Equal Access to Community Interpreting in Flanders: A Matter of Self-reflective Decision Making?"* The International Journal for Translation & Interpreting Research 7 (3): 149–165.

Roscher (2020) *Calgary-Cambridge Guide to the Medical Interview - Initiating the Session*. (2022, February 20). Physiopedia. Retrieved 12:56, March 25, 2022 from https://www.physiopedia.com/index.php?title=Calgary-Cambridge_Guide_to_the_Medical_Interview_-_Initiating_the_Session&oldid=294563.

Sarver, J., Baker, D.W. *Effect of language barriers on follow-up appointments after an emergency department visit.* J GEN INTERN MED 15, 256–264 (2000). https://doi.org/10.1111/j.1525-1497.2000.06469.x

Statistiek Vlaanderen. (2021). *www.vlaanderen.be.* Geraadpleegd op 5 oktober 2021, van https://www.vlaanderen.be/statistiek-vlaanderen#:%7E:text=above%20EU%20average-,Nearly%201%20in%2010%20has%20foreign%20nationality,at%204.9%25%20of%20the%20population.

Virtual mentor (n.d.) *The AMA Code of Medical Ethics' opinion on physicians treating family members*. 2012 May 1;14(5):396-7. doi: 10.1001/virtualmentor.2012.14.5.coet1-1205. PMID: 23351205.

Wadensjö, C. (1998). *Interpreting as interaction*. London: Longman.

Watermeyer, J. (2011). "*She Will Hear Me": How a flexible interpreting style enables patients to manage the inclusion of interpreters in mediated pharmacy interactions*, Health communication. 26(1). p.71-81.

Appendix – Transcriptions of consultations

Consultaties met Turkse patiënten en informele tolk: WGC De Sleep

Transcriptie video 1: kneuzing voet

D = dokter

P1= patiënt 1 (klein meisje)

P2= patiënt 2 (oma)

T = informele tolk (nichtje)

#00:00:00-0#

1) D: Okee wel welkom [euh] en vertel maar ne keer [euh] wa kunnen we doen voor u?

2) T: (eigenlijk voor haar) [ja] ze heb zo voetpijn en da zo kweenie zeb last van een zo van gister al ze (huilt van verdriet) [ja] :xxx

3) D: Okee dus ze krijgt voetpijn [ja] sinds gisterenavond en ge merkt dat ze heel veel pijn heeft [ja]

4) T: en benen ook

5) D: benen ook?

6) T: Ja allebei haar benen

7) D: Voet been en :xxx sinds gisteren

(3.0)

8) D: is goed mag ik ne keer vragen wat is jouw relatie ben jij grote zus of?

9) T: Nee das mijn nichtje

10) D: Nichtje das goed [T turks: Soruyo, senin neyin diyo.

Vertaling: Hij vraagt, wie is ze van jou, zegt hij.

11) D: En uw?

12) T: Oma

13) D: Oma okee en daar de broer?

14) T: de broer van [naam patiënt] xxx

15) D: Ja okee

(2.0)

#00:01:00-8#

16) D: Tis een hele familie die hier is he

17) T: Eigenlijk euh ik moest nie mee maar niemand zal Nederlands praten [ja] daarom

18) D: dus vandaar da je mee bent [mhm] ja (.) hoe is uw naam?

19) T: [naam] Maria.

20) D: [naam] ah kzou u willen vragen [naam] om als je da vertaalt om lijk zo letterlijk mogelijk te te vertalen he

21) T: ja

22) D: ist goed? euhm ook als zij iets n- naar jou vertelt geef maar gewoon door naar mij [mhm] ja eigenlijk is het een beetje een pingpongspel

23) T: ja ((lachend))

24) D: en jij bent de bal he [((lacht))] okee we gaan het spel zo goe mogelijk proberen spelen [okee] dus voetpijn en beenpijn

25) T: ja

26) D: sinds twee dagen al ofnee sinds gisteren

27) T: sinds ja gisteren

28) D: okee kzou graag keer willen weten [naam] eeft zij da vroeger nog gehad die pijn [Turks #00:01:47-5# Eskiden…

Vertaling Turks: Vroeger…

29) D: of is dat de eerste keer?

30) T: (turks) #00:01:48-5# Eskiden ayağın acıyar mıydı böyle?

Vertaling Turks: Vroeger deed je voet ook pijn zo?

31) P1: (turks) #00:01:52-2# Eskiden... hayır acımazdı. Daha eskiden acımazdı. Ama şimdi acımağa başladı.

Vertaling Turks: Vroeger … nee, deed het geen pijn. Nog vroeger deed het geen pijn. Maar nu begint het pijn te doen.

#00:02:00-7#

32) T: euhm ik denk nog (niet voor nu) maar ze weet niet da hoe da ook komt zo dat da zo direct gaat da nie da stopt en da komt nog ne keer

33) D: Okee dus de pijn van [naam patiënt] die komt en die gaat (.) soms is die dus heel heftig [Turks #00:02:18-1# Hem geliği hem gidiği?

Vertaling Turks: En het komt én het gaat.

34) D: (en dan ist weer weg)

35) P1: (turks) [turks P2 xxxx

36) T: Ja (.) en bij die knie da ze zo iets gelijk zo water

37) P2: (turks) #00:02:28-4# xxxxxx

38) D: Wa bedoel je daarmee? [euh

39) D: me d- dat er water in je knie zit staat die [P2 turks knie dan DIK xxxx

40) T: Ja zo dikke en dan zo [P2 turks xxxx

41) T: en als zij da zo (raakt doe) en als zij da zo raakt da zo die zo raar doet

42) D: Okee (en) die knie is dik en vochtig okee ça va kzou graag nog ne keer willen weten als zij nu stapt of wandelt eeft zij dan meer last van pijn of blijft dat 't zelfde?

43) T: (turks) #00:02:57-7# Yürüdüğün an yine acıyır mı?

Vertaling Turks: Het moment dat je loopt doet het dan opnieuw pijn?

44) P1: (turks) xxxx

45) T: Ja

46) D: ja (dus stappen) geeft meer pijn he [naam]?

47) T: (turks) #00:03:06-6# Ama sen yürürsen çok acıyo demi?

Vertaling Turks: Maar wanneer jij loopt doet het veel pijn he?

48) D: Ja zijn er nog dingen die meer pijn geven?

49) T: (turks) Başka bir yerin acıyır mi?

Vertaling Turks: Heb je ergens anders pijn?

50) P1: (turks) Hayır.

Vertaling Turks: Neen.

51) D: Nee

52) T: (turks) Anne sen xxxxxxx

Vertaling Turks: Mama jij xxx

53) D: Bijvoorbeeld 's nachts nu da ze sliep vannacht had ze geen pijn dan?

54) T: (turks) Bu gece acıyır değil mi?

Vertaling Turks: ’s Nachts doet dat pijn he?

55) P1: (turks) Hayır.

Vertaling Turks: Neen.

56) T: Nee

57) P2: (turks) Gece de acıyır nasıl ağrıyır.

Vertaling Turks: ’s Nachts doet het ook pijn en wat voor een pijn.

58) P1: (turks) Uyurkene acımıyır.

Vertaling Turks: Terwijl ik slaap doet het geen pijn.

59) D: Okee wa dak nog zou willen weten is euh het volgende eeft zij de voorbije dagen iets speciaals gedaan waardoor da zij nu zoveel pijn zou kunnen krijgen? Heeft zij veel gelopen heeft ze gesport heeft ze heeft ze een ongeval gehad is er iets gebeurd?

60) T: (turks) Bi şey yaptın mı? Bi sey ağır kaldırdın mı? Ya da xxx

Vertaling Turks: Heb je iets gedaan? Heb je iets zwaars getild? Of xxx

61) P1: (turks) Hayır.

Vertaling Turks: Neen.

62) T: Nee ik heb niets gedaan [Nee geen :xxx?

63) T: (turks) Spor bi şey yaptınız mı okulda? Hani xxx acısın.

Vertaling Turks: Hebben jullie iets van sport gedaan op school? Alé xxx dat het pijn doet.

#00:04:00-2#

64) P1: (turks) Hayır sadece xxx gibi bi şeyler yaptık. Hani ayağımla bi şeyler yapmadık.

Vertaling Turks: Neen, enkel xxx zoiets hebben we gedaan. Alé met mijn voet hebben we niets gedaan.

65) T: Nee (de voorbije dagen) niets zo speciaals gedaan nie nee

66) D: :xxx danku (.) wa dak ook nog zou willen weten eeft ze soms het gevoel dat er iets blokkeert bij haar? Da ze bijvoorbeeld haar knie wil strekken ma dat da nie lukt? of da ze haar voet wil plooien en dat dat blokkeert?

67) T: (turks) Şey dii hani mesela şimdi kolunu şey etme, böyle yapmağa. Yapabilirsin mi onu ya da yapamazsın mı ?

Vertaling Turks: Hij zegt dinges alé bijvoorbeeld nu om je arm te dingesen, zo te doen. Kan jij dat doen of kan jij dat niet doen?

68) P1: (turks) Yapabilirim ama bazen xxx

Vertaling Turks: Ik kan dat doen maar soms xxx

69) T: Jawel zij kan dat wel

70) D: Ze kan alles?

71) T: Ja

72) D: Der blokkeert niets?

73) T: Nee

74) D: Dankuwel :xxx

(4.0)

75) D: Okee eeft zij zelf al iets gebruikt om haar te helpen?

76) T: (turks) Bi şey ilaç içti mi?

Vertaling Turks: Heeft ze iets van medicatie genomen?

77) P2: (turks) Yok

Vertaling Turks: Nee.

78) T: Nee

79) D: Nee

80) T: Das van eigenlijk van gisteren he [ja nee

#00:04:54-1#

(4.0)

81) D: ((mompelend)) Das goed

82) D: Het verhaal begint mij wat duidelijk te worden he kga straks nog ne keer kijken naar [naam patiënt] (.) maar kzou graag nog eerst ne keer willen weten wat da jullie zelf denken dat er aan de hand is (.) en ik stel de vraag aan jou maar ook aan [naam patiënt] ook aan oma wat denken jullie zelf dat er aan de hand is?

83) T: Euh alleh eigenlijk ik denk zo das gewoon van te moe te zijn en euh en de school (die lopen) zo die alleh die stappen (die spelen) daarom denk ik dat (het van zo) daarmee khad da ook zo vorig jaar das van moe te zijn denk ik [ja ja haar haar euh moeder doe zo dinges alleh die is bang [ja] over haar daarom [P1 Turks xxxxx] (en dan ook) haar oma is ook bang geworden [ja] en ze [hmh] moet van oma naar de dokter gaan (das ouders) :XXX

84) D: Ja nee das goed en euh kan je dan ne keer vragen of euh kan je mij ne keer vertellen waar de ouders echt bang van zijn of weet je dat niet?

85) T: Euh (turks) Eh… anne şeye sor dii... korkiyir misiniz [naam P1] bi şey olcak? Neden korkiisiniz?

Vertaling Turks: Euh… mama vraag aan dinges zegt hij…. zijn jullie bang dat er iets gaat gebeuren met [naam P1]? Waarom zijn jullie bang?

#00:06:00-9#

86) P2: (turks) xxx

87) T: Eigenlijk euh haar moeder zegt dak niet bang is voor haar kweenie waarom ma [:XXX nie bang] gewoon :XXX een kindje ofzo

88) P2: (turks) Eh... yanlış mı ediyirim ki getiriyim buraya baksın bunun ayağına xxx?

Vertaling Turks: Euh… doe ik er verkeerd aan om [*haar*] naar hier te brengen dat hij kijkt naar haar voet xxx?

89) T: maar :XXX altijd zo

90) D: wat ik nu zou willen willen weten is euh ja (.) ebn die ouders (.) verteld op een of andere manier oe da we die best zouden kunnen helpen (.) wa da we het best zouden kunnen doen voor [naam patiënt] [ja] hebben zij een idee [nee] of oma heeft zij een idee?

91) T: (turks) Ne istiyisiniz xxx yapsınlar xxx

Vertaling Turks: Wat willen jullie xxx dat zij doen xxx

92) P2: (turks) Ne istiyim ki bi şey yapsınlar ayağına istiyim

Vertaling Turks: Wat zou ik willen dat ze iets doen aan haar voet dat wil ik.

93) T: Ah mm alleh mijn tante euhm [ja] wil zo zo'n foto gaat trekken van haar been ofzo [ja] kweet het nie

94) D: Ja een (RX) misschien [ja]

95) T: Of een normaal alleh jullie hebben hier toch kiné ofzo?

96) D: Of kinésitherapie [ja] ja

#00:07:03-4#

(2.0)

97) D: Das goed (.) ça va (.) [naam patiënt] wat denk jij eigenlijk dat er aan de hand is? Weet jij?

98) T: Zij kan nog niet goed Nederlands

99) D: Nee? Ma jij kan het haar wel vragen he

100) T: (turks) Sen ne düşüniyin hani? Nerden geldi bu acı sana? Nerden düşüniysin?

Vertaling Turks: Wat denk jij erover alé? Vanwaar komt deze pijn bij jou? Vanwaar denk je?

101) P1: (turks) Eh... ben bi kere atlamıştım eh... ondan sonra hep acımağa başladı.

Vertaling Turks: Euh… ik was eens gesprongen euh… daarna is het altijd beginnen pijn doen.

102) P2: (turks) Ooh xxx

103) P1: (turks) Ondan.

Vertaling Turks: Daardoor.

104) T: :XXX [naam broer?] ze was met toen haar broertje aant spelen en ze sprongen tegen elkaar heel en ze zegt mijn heb te hard :XXX ofzo en vandaag heb ik pijn aan mijn knie en :XXX zo da zo'n raar gevoel is enzo ze zegt da zo tegen mij

105) D: Ah kzie ze heeft gisteren toch een accident gehad [ja] ah voilà (.) ben heel blij da je da vertelt [naam tolk] [naam patiënt] jij bent [naam tolk] en zij is [naam patiënt] ((lachend)) [haha ja] ja [naam patiënt] :XXX (.)

#00:08:04-7#

106) D: goed we gaan toch ne keer kijken om te zien of er niets gevaarlijks [ja] euh kapotgegaan is he (.) ist goed?

107) T: (turks) xxx

108) D: ja kom hier maar mee

109) T: (turks) Bi bakcak sana.

Vertaling Turks: Hij gaat eens kijken naar jou.

110) D: Kzou graag hebben da je ne keer we gaan ze eventueel :XXX enkel jouw schoenen zijn zouk graag hebben da je ne keer jouw schoenen en jouw broek uitdoet

111) P2: (turks) xxx

112) T: (turks) Soyun. Ayakkablarını da soyun.

Vertaling Turks: Kleed je uit. Kleed ook je schoenen uit.

113) P2: (turks) xxx

114) D: Voilà je kan er mooi uit andere schoen ook uit doe maar [naam patiënt] [turks] andere schoen ook uit (.) voilà en we gaan ook ne keer kijken jouw broek zouk graag naar beneden doen ja oma doe ma (.) seg [naam patiënt] ist aan de beide kanten da je pijn hebt? Links en rechts?

115) T: (turks) Neren acii [naam P1]? Göster.

Vertaling Turks: Waar heb je pijn [naam P1]? Toon [*het*].

116) P2: (turks) Göster. xxx Bura acıyı bi de böyle gidiyir.

Vertaling Turks: Toon [*het*]. xxx Hier doet het pijn en het gaat ook zo.

117) D: dus meer aan deze kant [turks] daar meer pijn of hier ook pijn [turks]

118) T: (turks) Oran mi acıyı yoksa buran mı ?

Vertaling Turks: Heb je daar pijn of hier pijn?

#00:09:00-3#

119) P1: (turks) Buram acımıyı.

Vertaling Turks: Hier heb ik geen pijn.

120) T: Dees hier meer

121) P2: (turks) xxx

122) D: Tis goed, kun je ne keer ergens hieruit stappen we moen haar lijk efkes helpen [turks] hoppa oeioeioei ge zit hier helemaal vast [mm] voilà andere kant ook (we gaan ne keer mooi naar die linker knie) voilà [turks] en als ge wilt kom ne keer hier staan benen mooi samen ok benen goe samen (.) das goed en inderdaad hier staat het een beetje dik he [ja] ist dat da je kon zien [turks: T: Otursana sen bi Vertaling Turks: Ga eenz zitten jij] ist hier dat het pijn doet [naam patiënt]? (.) ja heb jij nog op andere plaatsen pijn doen je voeten pijn?

123) T: (turks) ((P1 duidt plek aan)) Başka bi yer de acıyır mı?

Vertaling Turks: Doet het ergens anders ook pijn?

124) D: Daar ook ja ja okee

125) T: (turks) Anne, sen karışma bi .

Vertaling Turks: Mama, moei jij je eens niet.

126) P2: (turks) xxx

127) D: en als ik hieraan kom doet da pijn?

128) T: (turks) Elledi mi acıyır mı?

Vertaling Turks: Als hij eraan komt doet het pijn?

129) P1: (turks) Hayır, acımıyır xxx.

Vertaling Turks: Neen, het doet geen pijn xxx.

130) T: Nee

131) D: Nee (.) als ik hierop duw doet da pijn?

132) T: (turks) Orasına değdi mi acıyır mı? ((P1 schudt nee)) [hmh] ah nee

Vertaling Turks: Als hij daaraan komt doet het pijn?

#00:10:01-0#

133) D: als ik hierop duw doet da pijn? [turks: Bu acıyır mı?] hmm nee kan je mij ne keer tonen waarda je zelf die pijn het meest voelt [naam patiënt]?

134) T: (turks) Nerde göster bi neren acıyı ?

Vertaling Turks: Waar is het toon eens waar je pijn hebt?

135) D: Vooral daar he die kant en waarom meer op je voet waar?

136) T: (turks) Ayağında nerese acıyı?

Vertaling Turks: Op je voet waar doet het pijn?

137) P1: (turks) Ayağımda burası acıyı.

Vertaling Turks: Op mijn voet doet het hier pijn.

138) D: Daar kga keer eventjes jouw kous gaan we ook uitdoen he (.) de andere kant ook (.) ça va (.) zou je ne keer efkes kunnen wandelen naar mijn tas en dan :XXX [turks]

139) T: (turks) Sen şimdi gel. Bu buraada dursun (?). Geç. Yörü şimdi.

Vertaling Turks: Kom jij nu. Dat dit hier blijft staan (?). Ga voorbij. Stap nu.

140) D: Ja goed wandel ma ne keer naar mijn tas (.) das goed kom maar ne keer terug [turks] ah heel goed

141) P2: (turks) xxx

142) D: Tis goed kom nu maar ne keer mee zet u maar ne keer hierop [turks: xxx] ça va (2.0) euhm

#00:11:00-2#

143) D: ((mompelt in zichzelf)) (4.0) als ik daarop duw doet da pijn [naam patiënt]?

144) T: (turks) Acıyır mı orası?

Vertaling Turks: Doet het pijn daar?

145) P1: (turks) Hayır.

Vertaling Turks: Neen.

146) T: Neen

147) D: Neen? Okee kan ze ne keer aar been plooien?

148) T: (turks) Eh…Şey et. Çek.

Vertaling Turks: Euh… doe eens dinges. Trek.

149) D: Ja euh doe maar hoor [turks: xxx] plooi maar je knie [turks: Böyle… Vertaling Turks: Zo…] (trek maar je voet een beetje zo) en ik ga tegendrukken (2.0) nee dus [turks: Böyle… Şey et ayağını Vertaling Turks: Zo … dinges je voet] jouw knie

plooien [naam patiënt] [turks] jouw knie plooien doe ma en ik ga tegendrukken doe ma [turks T: Azcık çeksene ayağını sen de. Vertaling Turks: Trek je voet dan toch eens een beetje.] plooi ma plooi ma jouw knie ja doet da pijn? [turks T: Acıyır mı? Vertaling Turks: Doet het pijn?] ik ga ne keer jouw knie nu strekken [naam patiënt] duw ma tegen mijn hand (.) gewoon STREKKEN zo

150) T: (turks) Böyle şey et ayağını. Kaldır ayağını. Kaldır ayağını. Kaldır ayağını.

Vertaling Turks: Dinges je voet zo. Doe je voet omhoog. Doe je voet omhoog. Doe je voet omhoog.

151) P1: (turks) xxx

152) D: Doet da pijn?

153) T: (turks) Acıyır mı?

Vertaling Turks: Doet het pijn?

#00:12:00-9#

(12.0)

T

154) D: (dus wat is er) gebeurd me jouw broer [hehe] (.) kan je mij et ne keer vertellen?

155) T: euh (zij was aan het spelen met :XXX) en haar broer springt op haar voet en :XXX

156) P2: (turks) xxx

157) D: Das goed he kom jij maar mee (lieve meid) tis goed (.) ça va

158) T: Mag ze aankleden?

159) D: Je mag ze weer aankleden (.) anders ist een beetje belachelijk om zo naar buiten te gaan he [ja] tis goe (.) nu inderdaad ik heb gezien dat er daar een beetje een bultje op zit [turks: xxx] maar ik denk dat dat eerder een kneuzing is nadat zij eigenlijk met haar broer euh een accidentje had als ik kijk naar haar :XXX [turks: xxx] [ja] da ist em nie

(2.0) #00:13:00-8#

((D spreekt onafgebroken tegen T, in de achtergrond spreken P1 en P2 Turks)) xxx

160) D: wa dak nu voorstel is het volgende kga dan eigenlijk pijnstilling gel voorschrijven [ja] dan mag ze da opdoen als ze pijn heeft mag ze da beetje rapper euh opdoen dan mag ze da zelfs vier vijf keer per dag das helemaal nie erg (.) ja? Moest binnen een WEEK moest binnen een week de bult nog altijd heel erg zijn moest er nog altijd een zwelling zijn dan kan ze nog altijd gaan voor een foto echografie dus [ja] ik ga een voorschrift maken voor die echografie he dan moet je nie nog ne keer komen ge zijt hier nu toch eh ma je moet die echografie niet nu al direct gaan doen ma als da binnen een week eh volgende week woensdag nog altijd nie :XXX dan maak je een afspraak voor die echo (.) dus nu nog niet maar binnen een alst binnen een week nog klachten doet dat dan [okee] ja voorlopig eigenlijk

((T hoest))

161) D: Gebruik maar gewoon die gel [ja] en wat er ook gaat helpen is eigenlijk lokaal een beetje ijs he (da doek ook) altijd bij een verstuiking [ja] een beetje ijs nooit ijs rechtstreeks op de huid maar eerst in de handdoek [ja] ça va en eigenlijk vandaag moest zij ook naar tschool gaan eeft zij eigenlijk gegaan naar tschool of niet? [mhm nee] nee

#00:14:08-6#

162) T: (nee zij is ook thuis gebleven)

163) D: Nu en wat denkt ze van morgen gaat het morgen lukken om naar tschool te gaan [naam patiënt]?

164) T: (turks) ja

165) D: Das goed

166) T: (turks) Yarın gidebilcen mi okula?

Vertaling Turks: Ga je morgen naar school kunnen gaan?

167) D: Kan je da nog uitleggen dus da van de gel ijs en als ze binnen een week nog altijd klachten echografie :XXX ja

168) T: (turks) Şey diyo ... anne. Şey diyo bi şey vercek ona anne. Hani acırsa, sürebiliyon. Bi de bi kâğıdı hazırlıcak bize. Biz bu kâğıtla normal...Ama şimdi yapmıcaz onu.

Vertaling Turks: Hij zegt dinges… mama. Hij zegt dinges hij gaat haar iets geven mama. Alé als het pijn doet, kan je het [*erop*] smeren. En ook nog hij gaat een papier klaarmaken voor ons. Wij normaal met dit papier… Maar we gaan dat niet nu doen.

P2: Neye?

Vertaling Turks: Waarom?

T: Öbür hafta için çünkü kâğıt acırsa onun şeyi o zaman yapacaz ama bu hafta değil.

Vertaling Turks: Is voor volgende week want het papier als ze pijn heeft dat is daarvoor, dat is wanneer we het gaan doen maar niet deze week.

169) P2: (turks). Tamam. Ama xxx mı yapacaz?

Vertaling Turks: Ok. Maar we gaan xxx doen?

170) T: (turks) euh mag ik iets vragen?

171) D: Ja

172) T: euhm zou [naam broer P1] [ja] :XXX euh haar broer ook heb afspraak

173) D: Kga keer kijken kheb hier nog een volgende afspraak [turks: xxx]

#00:15:00-7#

174) T: Euh daarom wij moesten om drie uur dertig :XXX (afwerken) voor [naam patiënt]

175) D: Ja okee das waar jullie hebben ook een afspraak voor [naam broer P1] ma we gaan da dan straks doen [okee] is het duidelijk voor [naam patiënt] [ja das duidelijk] okee das dan heb je nog vragen mevrouw?

176) T: (turks) Soruların var mı daha?

Vertaling Turks: Heb je nog vragen?

177) P2: (turks) xxx

178) T: Nee

179) D: Nee das goed ma kga dan eerst voorschriften maken en het ziektebriefje voor [naam patiënt] [ja] anders vergeet ik da

180) P2: (turks) ((kinderen spreken onderling)) xxx

181) D: Okee kga da hier efkes afzetten [ja] ça va

Transcriptie video 2

D = dokter

P1 = patiënt 1 (klein meisje)

P2 = patiënt 2 (oma)

P3 = patiënt 3 (kleine jongen)

T = ad hoc tolk

#00:00:00-0#

1) T: (turks) Bu da ... acıyırse xxx ama acımazsa xxx

VERTALING: Als dit ook… pijn doet xxx maar als het niet pijn doet xxx

2) P2: (turks) xxx

VERTALING: xxx

3) T: (turks): Şimdi sıra onda.

VERTALING: Nu is het zijn beurt.

4) D: (pardon) ?

5) T: ga jij ook ne keer [naam P3]

6) P2: (turks): xxx

VERTALING: xxx

7) D: W- We gaan ne keer [naam P3] ook ne keer bekijken he ook afspraak met [naam P3]

8) T: ja

9) D: Dus vertel maar opnieuw wat is er aan de hand

10) T: Nu gaat het over em euh zeb zo bloedneus hij eet niets [ja] euhm ik weet het ook niet waarom maja opeens euh zo XXX naar school enzo maar bloed uit de neus enzo

11) P2: (turks): Söyle ona xxx

VERTALING: Zeg hem xxx

12) T: Opeens iedereen is panikeer geworden [ja] en ze had zo operatie daarom ook misschien

13) D: Wanneer heeft ie operatie gehad?

14) T: (turks): Ne zaman xxx?

VERTALING: Wanneer xxx?

15) P2: (turks): Tam bilmiyom… kesin dört (?) sene falan oldu.

VERTALING: Ik weet het niet precies… het is zeker vier (?) jaar of zo geleden.

16) T: Twee jaar geleden ofzoiets [P2 (turks)xxx]

17) D: en een operatie van wat precies?

18) T: Euh ze had zo vlees (gevonden) in de neus

#00:00:59-9#

19) D: Okee kga keer kijken

20) P2: (turks): xxx

VERTALING: xxx

21) D: JA met de tonsillen en de poliepen

22) T: Ja

23) D: en das weggehaald geweest (2.0) maar das al twee jaar geleden eigenlijk

24) T: Ja

25) D: Okee eeft ie sinds euh tijdens het jaar eeft ie dan al een bloedneus al gehad of is da nu de eerste keer?

26) T: (turks) Gene kanlanmıştı demi böyle o burnu?

VERTALING: Het was weer zo bebloed he die neus van hem?

27) P2: (turks): xxx

VERTALING: xxx

28) T: Ja ze heb da ook altijd zo bloedneus [XXX/turks]

29) T: (turks): xxx

VERTALING: xxx

30) D: Dus ie krijgt heel veel een bloedneus

31) T: ja

32) D: Ja (.) okee om de hoeveel tijd krijgt die da is da elke twee weken is da elke maand?

33) T: elke twee weken das altijd zo

(4.0)

34) T: (turks): Korkma ya… korkma. Bi şey yapmıcak.

VERTALING: Niet bang zijn toch… niet bang zijn. Hij gaat niets doen.

35) P2: (turks): Sana bi şey yapmıcak.

VERTALING: Hij gaat je niets doen.

36) D: Zeg [naam P3] is er nog iets anders?

37) T: Bi şey yapmicak. Kağıt yazıyı burda.

VERTALING: Hij gaat niets doen. Hij schrijft papieren hier.

38) D: zijn er nog andere problemen?

39) T: (turks): Başka problemi var mı?

VERTALING: Heeft hij andere problemen?

40) P2: (turks): Yok.

VERTALING: Nee.

41) T: nee niets anders

#00:01:57-5#

42) D: nee das goed dus als ik het goe begrijp hij eeft al een paar jaar last van een bloedneus die bloedneus die komt lijk om de twee weken wel ne keer terug en hij zou nu wel ne keer willen weten wat da we daar kunnen aan doen

43) T: ja

44) D: Das goe (.) okee [okee nu euh wat denken jullie zelf dat er best zou gebeuren? Heb je daar over nagedacht of kan je ne keer vragen aan oma

45) T: (turks): Şey dii yani bi şey istiysin yapalım onu dii.

VERTALING: Hij zegt dinges alé, als er iets is dat je wilt dat we doen, dan doen we dat, zegt hij.

46) P2: (turks): Eh bi şey eh... şeye xxx

VERTALING: Euh dinges euh… naar dinges xxx

47) T: Da was eigenlijk [turks] XXX het probleem iets zijn XXX sowieso ga nog ne keer moeten operatie of kweet het niet

48) D: Ja nu mag ik ne keer vragen waarom ist ie eigenlijk in eerste instantie geopereerd (.) is da omdat ie heel veel euh verkoudheden kreeg of heel veel keelonstekingen of is het net omdat zijn neus heel veel verstopt zat? Maar

49) T: Door zijn neus verstopt

50) D: Ja zijn neus was heel veel verstopt en nu hoe zit het nu met zijn neus?

#00:03:02-2#

51) T: (turks): Şimdi burnun acıyır mı?

VERTALING: Doet je neus nu pijn?

52) P2: (turks): Şimdi acımıyır.

VERTALING: Nu doet het geen pijn.

53) T: nee XXX want da komt altijd zo bloed

54) D: Ja maar zijn neus zit niet meer verstopt he?

55) T: Nee

56) D: Nee das goed

57) P2: (turks): xxx

VERTALING: xxx

58) T: euhm ze vraag zo is da eigenlijk van zo te veel te spelen alleh

59) D: Ja alleh euhm seg anders kunnen we ne keer vragen aan [naam P3] zelf waarom denkt hij zelf dat hij altijd zoveel bloedneuzen krijgt?

60) T: (turks): Şeyi sor bi sana. [naam P] ne için düşüniysin hani burnundan kan gelii.

VERTALING: Vraag dinges eens aan jou. [naam P], waarom denk je alé dat er bloed uit je neus komt.

61) P3: (turks): Çünkü be... benim burnumdan kan gelii.

VERTALING: Omdat er bloed uit mij… mijn neus komt.

62) T: ((lachend)) XXX [turks] te klein

63) D: te klein XXX seg en XXX [sshht] en bijvoorbeeld gisteren hebben zij een beetje gevochten tis niet dat hij gisteren een slag op zijn neus heeft gehad ofzo

64) T: Nee nee nee nee

65) D: Ga je het hem toch nog ne keer vragen

66) T (turks): xxx

VERTALING: xxx

67) P3: (turks): *Ja.*

VERTALING: *Ja.*

68) T: (turks): Yaa, oldu mu? Burnuna vurdun mu?

VERTALING: Ah zoo, is dat gebeurd? Heb je hem op zijn neus geslagen?

69) P1: (turks): Vurmadım ben burnuna.

VERTALING: Ik heb hem niet geslagen op zijn neus.

70) T: Ah nee

#00:04:04-7#

71) D: Nee [turks] toch niet nee [turks P1: Ben o xxx geceleğin xxx] voilà goed ik zou dan gewoon [sshh] ne keer willen kijken : eigenlijk naar die neus ist goed

VERTALING P1: Ik die xxx 's nachts xxx

72) T: Ja (turks): Sadece bakacak saa, tamam mı?

VERTALING: Hij gaat alleen maar kijken naar jou, ok?

73) D: kga gewoon ne keer kijken he [turks]

74) P2: (turks): Söyle ona hani xxx belki ondan belki bi şeyden.

VERTALING: Zeg tegen hem alé xxx misschien van dat misschien van iets anders.

75) D: Wa zegt ze?

76) T: Euhm mijn oma zei zo die wil nie naar school gaan dan huilt hij weer [turks P2: Ağlıyo xxx]

VERTALING P2: Hij huilt xxx

77) D: Ahja

78) T: XXX en wordt hij zo paars enzo

79) D: Ja [ja] oei

80) P3: (turks) [ja]: İyice ööle

VERTALING P3: Helemaal 

81) T: Ja en zo overgeven [turks]

82) D: Ja omdat ie nie graag naar school gaat

83) T: Ja

84) P2: (turks): *Jaa*. Böyle öö [uiting van braakneigingen]

VERTALING P3: Jaa. Zo 

85) D: en hoe gaat het op school [naam P3]?

86) T: (turks): Neden okulu sevimiisin?

VERTALING: Waarom hou je niet van school?

87) P3: (turks): Çünkü okulda birisi bana vurdu (?).

VERTALING: Omdat op school iemand mij heeft geslagen (?).

88) T: School is nie leuk

89) D: School is nie leuk nee nee (.) z-zijn er nog andere problemen [naam P3]?

#00:04:59-4#

90) T: (turks): Başka problemlerin var mı?

VERTALING: Heb je andere problemen?

91) D: Nee

92) T: Nee. Turks: Anne, sen sus.

VERTALING: Mama, jij moet zwijgen.

93) D: Nee okee (2.0) nu ja het probleem met naar school te gaan denk da we daarvoor beter ne keer babbelen met de mama en papa he

94) T: Pa- euh is niet meer ze zijn uit elkaar

95) D: ja maar dan toch met de mama

96) T: Mama ja hmm

97) D: Ja (2.0) okee als da blijft duren (.) seg als em ne keer naar XXX gaat het dan goed

98) T: euh ja maar euh (turks): Şey eh... okulda filan kanadı mı?

VERTALING: Dinges euh… heeft het op school of zo gebloed?

99) P2: (turks): Uhuh.

VERTALING: Neuh.

100) T: euh-euhm da ga wel beteren school

101) D: Ja en [naam P3] wa wil jij worden later?

103) T: (turks): Ne istiisin büyüdünmü olaysın?

VERTALING: Wat wil je worden als je groot bent?

104) P3: (turks): Benim adım xxx

VERTALING: Mijn naam is xxx

TOEVOEGING: T: Uhuh. Buyüdünmü ne istiisin yani sen? (GROEI JE OP, WAT WIL JE DAN?)

105) P1: (turks): Hani mesela polis mi şey ya doktor ?

VERTALING: Alé bijvoorbeeld politieagent of dinges dokter?

106) T: (turks): Ne istiisin xxx?

VERTALING: Wat wil je xxx?

TOEVOEGING P3: Istiyirim onun gibi eh… polis.

VERTALING: Ik wil worden zoals hem euh… politieagent.

107) T: Die wil politieagent

108) D: Ej schitterend mijn zoontje wilt ook politieagent worden [jaaa] je mag hem dat vertellen

109) T: (turks): Bak onun da şey eh uşağı istermiş senin gibi polis olsun.

VERTALING: Kijk zijn euh dinges zoon wil ook zoals jij een politieagent worden.

#00:06:00-7#

110) D: Ja

111) P3: (turks) [ja ja ja]: Onun da mı uşağı var?

VERTALING: Heeft die ook een zoon?

TOEVOEGING: T: *Ja*.

VERTALING: Ja.

TOEVOEGING: P3 turks: O nerde?

VERTALING: Waar is die?

112) T: (turks) *School*'da.

VERTALING: Op school.

TOEVOEGING: P3 turks: Okulda.

VERTALING: Op school.

113) D: Ja maar als je dan hier politieagent wil worden dan moet je goed kunnen schrijven (.) ja en ook goe kunnen rekenen om dan goe je boetes uit te schrijven he [naam P3] [turks: xxx] dus tis wel belangrijk da je naar school gaat om een paar dingen toch te leren he [turks: xxx] kan je da vertellen?

114) T: (turks): Şey ... şey dii sana eh... okulaa xxx gideysin dii xxx yani mesela birine ceza xxx Öğrenesin güzel yazmağa dii sana ama sen okula gitmezsen xxx.

VERTALING: Hij zegt dinges… dinges tegen jou euh… dat je xxx naar school gaat, zegt hij xxx alé bijvoorbeeld iemand een boete xxx. Dat je leert mooi te schrijven, zegt hij tegen jou maar als jij niet naar school gaat xxx

115) D: Ahja een goeie politieagent moet goed schrijven en goed en goe rekenen

116) T: (turks):*Jaa*.

VERTALING: Jaa.

117) D: Om de mensen goe te helpen he

118) P1: (turks): xxx

VERTALING: xxx

119) D: Nu als da echt blijft vraag ne keer aan haar mama om gewoon langs te komen bij mij ook [jaja] ma kga eerst ne keer kijken naar zijn neus ook kom maar mee

120) T: (turks): xxx Korkma tamam mı xxx

VERTALING: xxx Je moet geen schrik hebben, ok xxx

#00:07:03-0#

121) P2: (turks): xxx

VERTALING: xxx

122) D: Nee nie bang zijn hoor XXX niet doen die kant?

TOEVOEGING P2 Turks: Korkma, sade bakicek sana.

VERTALING: Je moet geen schrik hebben, hij gaat enkel kijken naar jou.

123) T: (turks): Ha bittiii.

VERTALING: Ah, tis gedaan.

(5.0)

124) D: Eh seg jij doet da keigoe (.) seg seg seg (.) ik ga hier efkes me iets groters kijken iets da sterker is [ja]

125) T: (turks): xxx

VERTALING: xxx

126) D: (kga wa halen en) ik kom sebiet terug je moet nie bang zijn

127) P3: (turks): xxx

VERTALING: xxx

128) P2: (turks): xxx

VERTALING: xxx

129) P3: (turks): xxx

VERTALING: xxx

130) P2: (turks): xxx

VERTALING: xxx

[turks door mekaar]

131) P2: (turks): Ama ona da veesin bi şey.

VERTALING: Maar dat hij daar ook iets voor geeft.

132) T: (turks): Veecek.

VERTALING: Hij gaat dat geven?

133) P2: (turks): xxx

VERTALING: xxx

134) T: (turks): Sen var ya çok sinirlisin. Git otur (zegt dit tegen P1).

VERTALING: Weet je, je bent echt heel kwaad/ prikkelbaar. Ga zitten (zegt dit tegen P1).

135) P1: (turks): xxx

VERTALING: xxx

[door mekaar]

136) P2: (turks): Sen otur.

VERTALING: Ga zitten.

137) T: (turks): Sen de otur. Sen de çok sinirli gibisin.

VERTALING: Ga jij ook maar zitten. Het is alsof je echt heel kwaad/ prikkelbaar bent.

#00:08:08-7#

138) P2: (turks): xxx Hiçbi şey yapmıcak. xxx yapacak sana. Bakacak burnunda kan var mı diye.

VERTALING: xxx Hij gaat niets doen. Hij gaat xxx doen bij jou. Hij gaat kijken of je bloed hebt in je neus.

139) T: (turks): *Ja*.

VERTALING: Ja.

140) P3: (turks): Burdan acımiyi. Ben çıkardım kanı artık.

VERTALING: Het doet hier geen pijn. Ik heb het bloed er al uitgedaan.

141) P2: (turks): Çıkardın mı kanı artık? Eh xxx

VERTALING: Heb je het bloed er al uitgedaan? Euh xxx

142) P3: (turks): Hadi in ordan aşağa.

VERTALING: Alé, kom daar af.

143) P2: (turks): xxx Adam baksın ona xxx

VERTALING: xxx Dat de man kijkt naar hem xxx

144) T: (turks): Offf bi saattir burdayız.

VERTALING: Pfff we zijn hier al een uur.

145) P2: (turks): xxx Girdi çıktı, girdi çıktı. xxx

VERTALING: xxx Hij komt binnen, gaat naar buiten, hij komt binnen, gaat naar buiten. xxx

146) T: (turks): xxx

VERTALING: xxx

(.)

147) P2: (turks): xxx

VERTALING: xxx

148) T: (turks): xxx

VERTALING: xxx

149) P2: (turks): xxx

VERTALING: xxx

150) T: (turks): xxx

VERTALING: xxx

(4.0)

151) T: (turks): Yerinde dur artık [naam P1].

VERTALING: Blijf nu eens op je plaats [naam P].

152) P2: (turks): xxx az dur be, az dur be.

VERTALING: xxx wees nu eens rustig, wees nu eens rustig.

153) T: (turks): Sıkıldı

VERTALING: Ze verveelt zich.

[D komt terug binnen]

#00:08:58-2#

154) XXX kijk [deur slaat] dit hier nie bang zijn [turks T: Korkmaa] je mag het ne keer efkes vasthouden [turks T: Tut bunu, tut.] zie maar (.) zie je da is een iets da we gewoon gaan gebruiken om ne keer wa meer in je neus te kijken [turks: xxx] da ga geen pijn doen

VERTALING: Wees niet bang.

VERTALING: Hou dit vast, hou vast.

VERTALING: xxx

155) T: (turks): Acımıicak.

VERTALING: Het gaat geen pijn doen.

156) D: Kijk kga gewoon ne keer zo doen voilà kijk en we gaan gewoon ne keer kijken zie (3.0) voilà

157) T: (turks): Acımıyı bak.

VERTALING: Kijk, het doet geen pijn.

158) D: [naam P3] (.) nog beetje meer lichtje schijnen ie doet da keigoe he

(18.0)

159) D: hmhm (.) er zit daar inderdaad een plekje op kga ne keer zo bekijken ook (.) tzit inderdaad zo wa

(5.0)

#00:10:01-3#

160) D: een plekje op me heel wa bl-bloed [mm] he nu wa da ik gewoon ga doen [mm] is me een spatel daar keer tegengaan da doe geen pijn

163) P3: (turks): xxx

VERTALING: xxx

164) T: (turks): Korkmaa. Ver elini bana ha.

VERTALING: Wees niet bang. Geef je hand eens aan mij.

165) D: Ge moet echt nie bang zijn

166) T: (turks): Korkma.

167) D: He da kriebelt gewoon een beetje ja we gaan gewoon ne keer kijken he

(3.0)

168) P2: (turks): Napiyi?

VERTALING: Wat doet hij?

169) T: (turks): Bakii anne, xxx bi şeysi varsa orda. Eh şeye...

VERTALING: Hij kijkt mama, xxx of hij daar iets heeft. Euh naar dinges…

170) D: voel je het een beetje

171) P3: (huilt) [sssh shhh]

172) T: (turks): xxx

VERTALING: xxx

173) D: Wa ist er vriend? [sshhh]

174) T: (turks): xxx

VERTALING: xxx

175) D: Doet een beetje pijn?

176) P3: (huilt) [shhht] (turks)

177) P2: (turks): Acıyır mi?

VERTALING: Doet het pijn?

178) P3: (turks): xxx

VERTALING: xxx

179) D: Oeioeioei sorry ik heb gewoon XXX zodat het eigenlijk gewoon een beetje jeukt okee

180) P2: (turks): xxx

VERTALING: xxx

181) D: XXX (gevoelig) misschien?

182) T: (turks): xxx mı acii?

VERTALING: Doet xxx pijn?

183) P3: (turks): Bura xxx

VERTALING: Hier xxx

184) T: (turks): xxx

VERTALING: xxx

185) D: He tis goed

186) P2: (turks): xxx Bitti xxx

VERTALING: www Het is gedaan. xxx

187) T: (turks): Bitti, bitti.

VERTALING: Het is gedaan, het is gedaan.

#00:11:00-1#

188) P2: (turks): Bitti gari.

VERTALING: Het is al gedaan.

189) D: Mag ik nog ne keer kijken naar jouw neus nu?

190) T: (turks): Bi xxx mi baksın.

VERTALING: Dat hij eens xxx kijkt.

191) D: Nee nie bang zijn (.) we gaan gewoon ne keer kijken

(2.0)

192) T: (turks): xxx

VERTALING: xxx

193) P2: (turks): xxx

VERTALING: xxx

194) D: Tis heel mooi toegegroeid he dus wa zit er eigenlijk wat dat er eigenlijk aan de hand is kgaat u efkes uitleggen doordat er een bloedvaatje een bloedvaatje [ja] heel oppervlakkig [ja] en wak daarmee heb gedaan is da bloedvaatje een stipje gegeven waardoor dat het eigenlijk dichtbrandt nu kan er daar nooit meer bloed uitkomen he want tis uit dat bloedvaatje dat normaal gezien het bloed komt snapje

195) T: (turks) [eh goed gedaan echt goed zo he]: Şey eh bilmiyom...eh açılmış onun şeysi. O da kapatmış onu başka sey etmesin, akmasın ordan kan diye.

VERTALING: Dinges euh ik weet niet… euh zijn dinges is schijnt opengegaan. Hij heeft dat schijnt dichtgedaan zodat het niet nog eens dingest, dat daar geen bloed uit komt.

196) P2: (turks): xxx

VERTALING: xxx

197) T: (turks): xxx

VERTALING: xxx

198) T: Mag ik een zakdoekje

199) D: Jaja zeker begrijp je da mevrouw?

200) T: (turks): Anlii misin?

VERTALING: Begrijp je het?

201) P2: (turks): Anla… Anladım şu an. Açık xxx

VERTALING: Ik heb het nu begr… begrepen. Het is open xxx

202) T: (turks): Açacaklarmış onun şeyini o da kapattı.

VERTALING: Ze gingen zijn dinges opendoen en hij heeft dat dichtgedaan.

203) P2: (turks): xxx kapattı.

VERTALING: Hij heeft xxx dichtgedaan.

204) D: Ja

#00:12:02-4#

205) P3: (turks): İstemeden, anne.

VERTALING: Zonder het te willen, mama.

206) P2: (turks): Haa öyle mi? xxx

VERTALING: Ah is dat zo?

207) D: kom der maar af he

208) P2: (turks): xxx

VERTALING: xxx

209) D: heel goed gedaan

210) T: (turks): Gel.

VERTALING: Kom.

211) D: ça va kom maar mee terug

212) P2: (turks): xxx

VERTALING: xxx

213) P3: (turks): xxx

VERTALING: xxx

214) P2: (turks): xxx

VERTALING: xxx

215) P3: (turks): xxx

VERTALING: xxx

216) D: Okee

217) P3: (turks): xxx burnumda.

VERTALING: xxx in mijn neus.

(2.0)

218) D: Euhm goed [turks] normaal gezien nu gaat da nie meer elke twee weken gebeuren [turks] ja moest da wel nog blijven gebeuren ja dan mag je altijd ne keer terugkomen (lachend) als als die da nog durft maar nee hij mag altijd nog ne keer terugkomen maar ik denk eh nu dat da ga weg zijn ja

219) T: (turks): Gelmicek dii böyle kan. Geri gelirse dii, gelebilirsin.

VERTALING: Zo gaat er geen bloed komen, zegt hij. Als het terugkomt, zegt hij, kan je komen.

220) P2: (turks): Bakalım. xxx

VERTALING: We zullen zien xxx

221) D: Okee ça va? [turks] okee das goe

[turks door mekaar]

222) D: Heb je nog vragen hierover?

223) T: (turks): Annee, anne, daha sorun var mı?

VERTALING: Mama, mama, heb je nog vragen?

224) P2: (turks): Uhuh. Yok.

VERTALING: Neuh. Geen.

225) T: Nee danku [ja]

226) D: Okee dan dank ik u voor de medewerking en de goeie vertaling

[turks op de achtergrond]

227) T: (lacht)

228) P2: (turks): xxx yazacak mı? xxx

VERTALING: Gaat hij xxx schrijven? xxx

#00:13:06-6#

229) T: Euh mag hij nog dokterbrief?

230) D: Voor vandaag of? [turks T: Hadi siz çıkın, ben gelcem. Hadi siz çıkın, ben gelcem. Ben de aynı xxx] XXX ma tis goe

VERTALING: Alé gaan jullie naar buiten, ik kom. Alé gaan jullie naar buiten, ik kom. Ik ook xxx dezelfde.

[turks op de achtergrond]

231) T: Moeten wij da nu doen?

232) D: ja (.) ah nee wacht nee das voor ons ja das voort onderzoek ja (2.0) ja juist we hebben da nu gedaan voor alletwee

[turks op de achtergrond T Turks: Siz şimdi çıkın.]

VERTALING: Gaan jullie nu naar buiten.

233) D: Euhm en nu nog ah kga da hier afleggen

234) P3 en P1: (turks -> ciao)

235) D: Ciao ciao

EINDE OPNAME #00:13:53-6#