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Role and Ethics in Healthcare Interpreting in Turkey*

Türkiye'de Hastane Çevirmenliğinde Rol ve Etik

Research/Araştırma

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ABSTRACT

The objective of this study, which was designed as part of a larger study, is to analyze the healthcare interpreter's behaviour at micro-level in relation to ethics at macro-level, constituting an example of fieldwork in interpreting studies. Thus, the study consists of two levels of analysis, aiming at providing an overview of the field based on real-life data. In accordance with the fieldwork strategy, which adopts an approach that consists of watching, asking, and recording, the focus is on naturally occurring data, consisting of interviews with fourteen healthcare interpreters, participant observation at healthcare settings, and the micro-analysis of three interpreted doctor – patient interviews out of twenty-seven interpreted doctor – patient interviews. Interpreter behaviour is analyzed in relation to a discussion on (lack of) codes of ethics and conduct and national standards in healthcare settings in Turkey. This study reveals the lack of an explicit job description and a lack of codes of ethics/ conduct in Turkey. This causes challenges in practice for healthcare providers and interpreters as well as patients and implies a risk for quality of service. Since two interpreters interviewed were also those whose recordings were cited, the findings also point to a possible gap between what the interpreters say they do and what they actually do during interpretation at hospitals. One of the objectives of the present study is to put forward this gap.

Keywords: Healthcare interpreting, role of interpreters, ethics, case study

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ÖZET

Daha kapsamlı bir çalışmanın bir bölümü olan bu çalışmanın amacı, sözlü çeviride bir saha çalışması örneği oluşturan hastane çevirmenlerinin mikro düzeydeki davranışlarını makro düzeyde etikle bağdaştırarak incelemektir. Bu çalışma, sözlü çeviri çalışmaları kapsamında hastane ortamında ve sağlık bağlamında bir saha çalışması olarak planlanmıştır. Bu amaçla, sağlık çevirmenliği yapılan durumlardan ve gerçek hastane ortamlarından toplanan verilere dayanarak alanla ilgili bir bakış açısı ortaya koyan bu çalışma iki düzeyde analizden oluşmaktadır. Sözlü çeviride saha çalışması yöntemi, izleme, soru sorma, ve kaydetmekten oluşur. Buna uygun olarak saha çalışması yöntemi kullanılarak ve doğal verilere dayanarak bu çalışmada veri toplama yöntemleri, on dört hastane çevirmeniyle röportaj, katılımcı gözlem (çevirmen, doktor, hasta ve hastane yöneticileri) ile yirmi yedi kayıttan alınmış olan doktor- hasta görüşmelerinin ses kayıtlarından üç tanesinin detaylı incelemesinden oluşmaktadır. Çevirmenin davranışları, Türkiye'de hastane çevirmenliğine ilişkin etik kurallar ve ulusal standartların eksikliğiyle ilişkili olarak tartışılacaktır. Bu çalışma, Türkiye'de sağlık çevirmenliğine dair etik kuralların ve belirli bir meslek tanımının eksikliğini ortaya çıkarmaktadır. Bu durum, hastane çalışanları, çevirmenler ve hastalar için zorluklara sebep olmaktadır ve verilen hizmetin kalitesini riske atmaktadır. Görüşme yapılan iki çevirmenin ses kayıtları incelenen çevirmenler olduğu dikkate alınarak, bulgular ayrıca çevirmenlerin uyguladıklarını söyledikleri ile çeviri esnasında uyguladıkları arasında farklılıklar olabileceğine işaret etmektedir. Bu çalışmadaki amaçlardan biri de bu farklılıkların ortaya konulmasıdır.

Anahtar Sözcükler: Sağlık çevirmenliği, çevirmenin rolü, etik, vaka çalışması

1. Introduction

Countries have become multicultural and multilingual because of the existence of indigeneous groups as well as migration including migration due to war, conflict, oppression, leading to a growing need for interpreters in social settings such as health, court, police stations, etc. and also the development of community interpreting as a profession around the world. Over the years, considerable steps have been taken in the professionalization of community interpreting (Mikkelson 2012; Pöchhacker 1999). As a result, countries have started establishing codes of ethics and conduct as well as standards (Bancroft, 2005).

Despite the wide range of studies on community interpreting --including healthcare interpreting --around the world, research focusing on community interpreting[1] and healthcare interpreting is scarce in Turkey. Thus, the present study aims at contributing to filling this gap, providing an in-depth analysis of the interpreter's role in Turkish healthcare settings.

In Turkey, even though small number of state hospitals are supposed to have an international patient unit where either interpreters are hired full-time or brought in through service procurement, most of the state hospitals do not employ interpreters or offer regular interpreting services; rather they solve the language problems with foreign patients and refugees through immediate solutions. As it is not possible to find

[1] Balcı Tison 2015; Diriker & Tahir-Gürçağlar 2004; Doğan & Kahraman 2011; Kahraman 2003, 2010.

a contact person or have access to interpreting services – if any – in state hospitals, the setting was specified as private hospitals where interpreting is offered. We were able to get official permission and have access to 5 hospitals. At this point, it is important to note that the situations observed are not within the scope of *health tourism*, instead *tourist health*. The difference is that, while *health tourism* refers to travelling to another country for health reasons such as plastic surgery, hair transplantation, etc., *tourist health* refers to medical treatments provided to patients travelling to another country for a vacation, in the cases of emergency during their stay in Turkey.

With this aim in mind, the current study sets out to address the following, overarching research question:

1. How does the role of the healthcare interpreter in Turkey manifest itself at both micro and macro levels?

Answers to this question are pursued through the following questions:

2. To what extent does a lack of code of ethics and conduct for healthcare interpreters in Turkey affect the role of interpreters in healthcare settings?
3. How is interpreters' lack of training traced in their daily practice?

With a view to answering the research questions, the collected data will be analyzed at two levels: during interpretation at the interaction level (micro) and beyond interpretation in terms of role and ethics (macro). Thus, the interpreter's decisions and strategies – behavior – during interpretation will be linked to broader issues of role and ethics beyond interpretation.

2. Approaches to Community Interpreting and Healthcare Interpreting around the World and in Turkey

Whether interpreters should just translate or should assume additional roles and responsibilities has been one of the major controversial issues in community interpreting. Even though in earlier studies the interpreter was viewed as "invisible", a "language modem" or non-thinking linguistic "transferring machine", there are various sociological and sociolinguistic approaches that underline the interpreter's active role and involvement in the encounters as "culture brokers", "advocators" or "conciliators". When the studies around the world (e.g. Aguilar-Solano, 2015; Angelelli 2004, 2006; Bolden, 2000; Leanza, 2007; Niska, 2002; Slapp, 2004, etc.) are taken into account, it becomes clear that the interpreter's "conduit", "invisible", "translating machine" role does not match the real role in practice. A variety of studies suggest that interpreters play an "active participant" role in healthcare settings. Also, the perspective of studies on interpreting is focused more on sociological and sociolinguistic approaches dealing with the interpreter's role in relation to broader issues of context and ethics. Recent studies on healthcare interpreting also include Hlavac, Beagley and Zucchi (2018), Krystallidou and Pype (2018), Krystallidou et al. (2017), etc.

The earliest academic study on healthcare interpreting in Turkey was carried out by Ross and Dereboy in 2009 within the scope of an EU-Grundtvig project called Training Intercultural and Bilingual Competencies in Health and Social Care (TRICC). In this study, Ross and Dereboy focus on ad hoc interpreting services in public health institutions in eastern and south-eastern Anatolia as well as in Istanbul. It was observed that language is an important barrier in communication between doctor-patient encounters (TRICC, 2011).

With regard to training of healthcare interpreters, Güven (2014) addresses the need for trained medical interpreters at public health institutions in Turkey. Thus, Güven (2014) argues that distance learning (DL) would be an effective tool for medical interpreter training in Turkey. In this regard, Güven (2014) proposes possible certificate programs for the abovementioned distance learning program. Apart from Güven (2014), there is an MA thesis (Öztürk, 2015) and a book published in (Turan, 2016). In her MA thesis, Öztürk aims at giving an overview about healthcare interpreting services, mainly healthcare interpreting services provided for medical tourism. Turan (2016), on the other hand, aims at analyzing the profession of interpreting in healthcare settings from academic, judicial, social and administrative perspectives, and makes suggestions about the interpreting services in Turkey. More recently, Şener (2017) published an MA thesis and Duman (2018) completed her PhD on healthcare interpreting.

When compared to studies conducted on the role of interpreters in healthcare settings around the world, it is clear that there is little academic research on healthcare interpreting in Turkey and only a small percentage of these few studies have been conducted as case studies based on real-life data.

3. The Issue of Ethics, National Standards and Role in Healthcare Settings

As the profession of healthcare interpreting has evolved and matured around the world, the importance of constituting shared knowledge as to what is appropriate and what is ethical practice in the field has become imperative (NCIHC, 2005). In addition, as Bancroft (2015, p. 227-228) expresses, a code of ethics and standards helps interpreters make critical decisions such as whether to summarize or not. Without such published ethics and standards, community interpreters often have to make decisions “on the fly” guided by their intuition and training (p. 227-228). However, it should also be noted that not all interpreters working in community settings have training in professional interpreting. To this end, associations in a variety of countries have developed a set of principles or a code of ethics and conduct as well as standards of practice.

There are various examples of codes of ethics and standards published by various associations[2] and followed by community interpreters worldwide.

A review of codes of ethics and standards of those associations (primarily healthcare interpreting associations) also shows that the common ethical principles could be listed as follows:

- Accuracy
- Confidentiality
- Impartiality
- Respect
- Professionalism
- Professional Development

As for Turkey, there is no association that directly guides and defines the role of community interpreters including healthcare interpreters except an association established for conference interpreters named TKTD (The Conference Interpreters' Association of Turkey). Some of the ethical principles published by TKTD are the same as the principles above. For example, TKTD asserts that the interpreter accepts the assignments in fields of expertise due to the principle of professionalism. Moreover, the principle of confidentiality is emphasized in TKTD's codes of ethics. However, lack of an official job description, codes of ethics and conduct, and national standards for healthcare interpreters in Turkey might pose a risk for the quality of service as well as patients' health conditions.

4. Methodology

Ethnography, which is one of the most prevalent methods used in Interpreting Studies, is described by Hale and Napier (2013, p. 84) as "the study of a social group or individual or individuals representative of that group, based on direct recording of the behavior and "voices" of the participants by the researcher over a period of time". Spradley, on the other hand, describes ethnography as "the work of describing a culture" (Spradley, 1979, p. 3). In line with the description above, this study can be regarded as an ethnographic study since it focuses on the actual behaviors and voices of the participants i.e. interpreters. It is also a case study adopting fieldwork strategy as it focuses on a specific case and analyzes the *field* in which the case is embedded. In

[2]The California Healthcare Interpreting Association (CHIA) (United States)
The National Council of Interpreting in Healthcare (NCIHC) (United States)
The International Medical Interpreters Association (IMIA) (United States)
New South Wales Healthcare Interpreting Services (NSW HCIS) (Australia)
The Irish Translators' and Interpreters Association (ITIA) (Ireland)
The National Register of Public Service Interpreters (NRPSI) (United Kingdom)
Healthcare Interpretation Network (HIN) (Canada)

order to analyze the case under this study, a variety of methods has been employed through triangulation of data including *interviews* with healthcare interpreters; *participant observation*; and *audio-recordings* of interpreted doctor- patient interviews. As Pöchhacker (2004, p. 64) indicates, the basic data collection methods could be summarized as "*watch"*, "*ask*" and "*record*" in research on interpreting. According to Pöchhacker, multiple sources of data, i.e., "*triangulation*" - collecting data from more than one source- are particularly valuable in qualitative research in Interpreting Studies (Pöchhacker, 2004, p. 64). Triangulation of data was conducted through the comparison and contrast of the above-mentioned data in this specific setting in order to seek similarities and differences, if any, between what interpreters claim to do and what they actually do in practice. The analysis is expected to contribute significantly to forming the 'big picture' in this setting, and relating the findings to the broader issues of ethics and role.

4.1 Data Collection Methods

In order to collect data at doctor-patient encounters within private hospitals, we obtained administrative approval from hospital executives, which was sufficient for participant observation.

Throughout the summer of 2016, interviews were carried out with fourteen healthcare interpreters working at private hospitals in Istanbul, Izmir and Aydın. Interviews were semi-structured with open-ended questions in order to enable interpreters to explain their experience, ideas and issues freely during the interview process. Interview questions were categorized as "General Qualifications of Interpreters", "Interpreter's Role", "Terminology" and "Ethics". A profile of interpreters is given in the following table:

Table 1: *Demographic information regarding the interpreters*

INTERPRETERS			
SEX	TRAINING IN INTERPRETING	LANGUAGES	WORKING EXPERIENCE IN HEALTHCARE
13 Male 1 Female	9 Untrained Interpreters. 5 Trained Interpreters.	German, English, Arabic, Kurdish, Spanish, Italian, French	Range from three months to ten years

While selecting the interpreters to conduct an interview, speakers of different languages and interpreters with Turkish as a native language were included in the study in order to have a broader overview of the field. Thus, not only interpreters with English as B language, but also those with Spanish, Italian, Arabic, German, and French as B language have been included. As interpreters assert, there is no examination for assessing medical knowledge or interpreting skills during the recruitment phase at private hospitals. As can be seen in the table, only five out of fourteen interpreters

have training in translation and interpreting. The remaining nine interpreters have training neither in the medical field nor in translation and interpreting. The hospital executives seem to attach importance solely to language skills, as a language qualification is required from interpreter candidates, rather than experience in interpreting or medical field.

Participant observation is also a common method in ethnographic research in which the researcher observes the behavior(s) of a certain group or individual and takes notes (Hale, 2007, p. 231). Silverman (2001, p. 14) indicates that the aim of observation is to gather information from firsthand sources about social processes in a "naturally occurring "context like any observational study. Therefore, the aim of using the method of participant observation in this study was to observe the whole interpretation process of interpreters in their natural working environment. A total of four interpreters were observed in five different private hospitals in Turkey (Due to the need for transfer of the patient to a larger hospital, one interpreter worked at two hospitals). Thus, it was possible to participate in the interpreter-mediated encounters and to observe what they do, and to compare the data obtained with what they say they do. In addition, notes were also taken in order to keep track of the behavior of the participants and nonverbal communication as well as reactions of participants during the observation. Especially what the interpreters do besides interpreting was noted.

The last data collection method is obtaining the audio-recordings of interpreter-mediated encounters between healthcare providers and patients. Consent was obtained from hospital executives, patients and interpreters. Upon obtaining consent, a total of twenty-seven audio-recording by four interpreters working in the abovementioned private hospitals in Istanbul, Izmir and Aydın were gathered. The language combinations in the encounters between healthcare providers and patients were English-Turkish and German-Turkish. The English and German encounters were audio-recorded. Parts of the German-Turkish encounters were translated into English by Olcay Şener.

As a consequence, data obtained from participant observations and interviews will be backed by a detailed analysis of these recordings, providing an overall perspective of the field, which puts forth a rich description of the role and the profession in Turkey.

5. Analysis of Interviews with Healthcare Interpreters

In this part of the study, the data obtained by the interviews held with a total number of fourteen interpreters will be analyzed in relation to role and ethics.

5.1 Role and Ethics

Unlike countries such as Australia, Sweden, Canada or the U.S.A, where community interpreting has become institutionalized as a profession (Pöllabauer, 2012, p. 289), one cannot talk about such an institutionalization in this field of healthcare

interpreting in Turkey. Accordingly, there are no codes of ethics and conduct or standards that define the role of healthcare interpreters in Turkey. According to Güven (2014), 15% of the adult population is estimated to have a native language other than Turkish. Indicating that the citizens who are illiterate also need interpreters, Güven (2014) assumes that 10% of the illiterate adult population (approximately 265, 464 people) visits a hospital administered by the Ministry of Health 3.5 times a year. She further asserts it can be estimated that some intervention by a medical interpreter is needed 929,124 times a year in Turkey (p. 289). Despite the fact that healthcare interpreting is commonly used in Turkey, very little is currently known regarding the interpreter's role between healthcare providers and patients.

Aiming at unraveling the role of healthcare interpreters in Turkey, one of the questions posed to the interpreters regarding their role was whether they had other responsibilities and tasks apart from interpreting in the hospital. All of the interpreters explained that they were also busy performing other tasks apart from interpreting, including accompanying the patients in the hospital and conducting their hospital procedures etc. In addition to this, one interpreter gives a striking example regarding their role within the hospital[3]:

> Our job includes helping the patient wear their overshoes, pushing their chairs, settling them in the chairs and picking them up, taking their arms, holding their bags, putting on their trousers, cleaning up their ultrasound gel in the navel... All kinds of responsibilities... Also accompanying them to the toilets... You are the only person dealing with the patient as if you were a hospital attendant or a nurse. You are the patient's mouth; thus, it is not like you have a choice to say "Stay here" or "Go to that department". It is like dealing with your own procedures (Interpreter I)

Interpreter I mentioned the details of the work they have within the hospital, including physical assistance to the patients. In that case, Interpreter I implies that their role in such situations is similar to that of a hospital attendant or a nurse rather than an interpreter. A similar perspective was explicitly stated by Interpreter N, even taking their role one step further. Interpreter N stated that they also provide medical assistance for the patients in addition to physical assistance:

> [...] Standing by the patient, helping them in their hospital procedures [...] There are even times when we perform gastric lavage. We even sometimes enter into the surgery room with foreign patients. This is of course caused by the need for an interpretation service, however, it is sometimes necessary to accompany the patient to the X-ray department due to the lack of staff at that time. Since the patient is foreign, we help them settle in the chair and take them out of the department. We

[3] The interviews were conducted in the interpreters' native language, i.e. Turkish. However, due to space restrictions the original version was not included in this paper. Interview questions are included in the Appendix.

> encounter such situations; therefore, we have to help them in these situations. (Interpreter N)

As understood from the comment of Interpreter N, they even provide medical services for patients, such as performing "gastric lavage", which might have negative implications for the patient's health. Even though Interpreter N commented that he had studied in the medical department at the university, specifically regarding health management skills, structures of health facilities and financial issues in health facilities, providing medical assistance such as "gastric lavage" is far beyond the interpreter's training and capacity. Likewise, Interpreter I has a university degree in translation and interpreting. However, any medical or physical assistance provided might do harm to the patients, since the interpreters have not acquired medical training in order to be able to provide this kind of assistance.

Almost all interpreters deal with a number of tasks apart from interpreting and are under a lot of pressure. Interpreter J also underlines the lack of clarity of the job title in his remarks, as they are recruited not as an interpreter, rather as an "International Patient Authority" or "Guide". In the same vein, Interpreter K also supports Interpreter J's argument by stating that they make up their title as "Foreign Public Relations Department" in their hospital. Even this title and the lack of codes of ethics and conduct in Turkey reveal that the interpreter's role deserves further exploration and discussion. All the responsibilities imposed on the interpreters, physical and particularly medical assistance to the patients also result in violating the principle of *professionalism*, since the interpreters who provide such kind of assistance have not acquired medical training in this field.

One of the points tackled by the interpreters that we would like to touch upon is the financial perspective of the sector. Interpreter K explicitly highlights the financial perspective of the sector by indicating that they have to make the hospital earn money, even though they deal with the health sector. At this point, Interpreter L gives an interesting example. He asserts that he also has the task of persuading the patient to undergo further examinations. This is because if the patient stays for a longer time period in the hospital, this would be rewarding for the hospital in financial terms. Therefore, the executives of the hospital expect the interpreter to persuade the patient to stay at the hospital, even though the health condition of the patient does not require a longer stay.

> Since their health is in question and the hospital is private, the patient is sometimes encouraged to stay in hospital because of financial reasons, even though it is not required for the patient's health. We are expected to persuade the patient in that situation. The medical doctor evaluates the results and we interpret them to the patient. However, we need to utter additional remarks. For example, the patient has an infection at the rate of 5% in the blood. However, it does not necessitate staying in hospital. Nevertheless, we have to interpret it in a way that the patient should stay in hospital. We do of course, because the medical doctor wants us to do so. Otherwise, we do not utter such remarks unless the

> doctor tells us to say them. We interpret according to the doctors' and the hospital's working procedure. However, we sometimes interpret unethical decisions as the job requires. (Interpreter L)

Another point, which could be problematic in terms of ethics, is that the interpreter acts as if he were the healthcare provider, unaware of the negative implications of the situation. For instance, Interpreter N indicates that he persuades the patients to stay at the hospital not because of financial reasons but to help the patients who refuse to stay at the hospital and have a treatment. In such a case, the interpreter acts as a medical doctor rather than an interpreter, by informing the patient about possible consequences of the treatment without consulting the doctor, which might have serious consequences for the patient's health. For example, Interpreter L also mentions that he makes additions when he needs to persuade the patient through explanations, for example "Your infection rate is too high in your blood. This might lead to gangrene in the future. Or your arm might be amputated, etc.". However, these strategies, namely additions and omissions, are problematic in terms of patients' health conditions. Moreover, these interpreters act as institutional staff and side with the hospital again. Therefore, they also violate the principle of impartiality.

Likewise, all the responsibilities and duties including giving the patients physical and particularly medical assistance lead to violation of the ethical principle of professionalism, since the interpreters have not acquired any professional training in this field. From the same perspective, informing patients without consulting doctors might also violate the principle of *professionalism*, since medical doctors and interpreters do not have medical knowledge at the same level. In other words, these interpreters' academic qualifications in terms of medical knowledge to inform and guide the patient are not sufficient. Therefore, giving medical information to the patient might risk the patient's health.

The findings obtained in the study show that only five out of fourteen interpreters have been trained in a translation and interpreting department. Also, interpreters who have no training either in a translation and interpreting department or in the medical field were recruited. This suggests that academic qualifications including medical terminology knowledge do not necessarily make the interpreters eligible for hospitals.

6. Analysis of Observation and Audio-Recordings in the Interactions

The present section focuses on the data obtained from observation and audio-recordings taken from real-life situations in healthcare settings. The three sessions, which are part of a wider corpus of twenty seven interpreted interviews, were recorded at five healthcare facilities during summer 2016. The phrases in the excerpts relevant to the discussion in that section are highlighted and discussed following the excerpt. In these excerpts; the participants, i.e. interpreters, healthcare providers as well as patients will be denoted using an abbreviated form. The letter "I" stands for an interpreter, "P" stands for the word patient, "N" stands for a nurse and, "D" stands for

the word doctor. Due to space restrictions, the original utterances (in Turkish and German) were not included in the excerpts.

6.1 Divergent Renditions

Interpreters' initiatives to add, omit, summarize certain parts of the original speech were analyzed according to Wadensjö's typology of divergent renditions (1998). Among non-rendition, zero rendition, expanded rendition, summarized rendition as well as reduced rendition, only zero and expanded renditions were observed in the interpreted interactions.

6.2 Zero Renditions

There are instances observed in which the interlocutors' utterances are left untranslated. Thus, this category consists of omissions made by the interpreters, either intentionally or unintentionally. In other words, the interpreters hide information from the patients or the doctors.

The first excerpt in this category takes place during an encounter between an ophthalmologist and a patient, who has a complaint of a stye in the eye.

Excerpt 1:

I: After the treatment...

D: Afterwards we will have to give her glasses.

I: It is possible that the optics degree might be changed.

D: It is possible.

D: Of course.

I: So, let me explain that. It happened, this one as a small cyst that really makes this side for the blurry. Okay? But after the medication and also the treatment you are going to get or take... okay? The doctor's suggestion is you have to change the left optics. Left one, okay? [*sic.*]

P: Change it?

I: It might, it might or may. Okay? But we have to wait for the medication at first. If it disappeared or ceased itself, we do not need to. But we can understand that while we just closed your right side...[*sic.*]

P: Yeah.

I: It has a little bit of a problem for now.

P: What kind of medication is it?

I: He already prescribed.

In the excerpt above, the doctor only remarks that it is possible to change the glasses. However, the interpreter explains the situation to the patient in a more detailed way. At the end of conversation, the patient wants to get information about the medicine that will be utilized. When the patients pose a question regarding the medication, the interpreter omits the patient's question instead of directing the question to the doctor. However, omitting this kind of information may affect the patient's treatment process negatively. Thus, the interpreter violates the principle of accuracy by not interpreting the question of the patient.

The second interview in this category takes place in German between an interpreter and the patient who is about to get an MR. Before getting into the MR, the hospital gives the patient a Turkish document to be signed, encompassing possible risks, conditions, etc. Therefore, the Turkish document should be interpreted to the German patient by the interpreter, since it includes important information regarding factors which might affect the patient's health condition. However, the interpreter follows a different way, instead of interpreting the document.

Excerpt 2:

I: [...] And sign here. Everything is in Turkish here. You can not understand anything. But unfortunately this is it.

P: But what is it?

I: Okay. You will now have a tomography.

P: What?

I: You will have a computed tomography scan...

P: X-Ray.

I: Yes, from the mouth.

I: Yes.

I: **During MR, if something goes wrong, but it cannot... something bad occurs, we make this as a precautionary measure. You will go into tomography. I have also never done this. I will do it for the first time with you. It takes 15 minutes. I cannot interpret everything.**

P: Yes yes yes yes. Let's continue.

The excerpt above demonstrates that the interpreter refrains from interpreting a very important document to the patient by first explaining that the document is in Turkish. However, after the objection of the patient, the interpreter is obliged to interpret. After interpreting a couple of sentences, he says that he cannot interpret everything and summarizes the whole document which includes pivotal information regarding the patient's health and safety. While signing the document, the patient says to herself “This is so funny. I am signing, but, I do not understand anything.” According to the patient's comment, it is clear that the patient is not satisfied with the

interpreter's attitude. Yet, the patient signed the document, even though she felt uncomfortable about the situation. For this reason, not interpreting this kind of important information to the patient may lead to misinformation for the patient and this is a controversial issue in terms of ethics. As in the examples discussed above, the interpreter also violates the principle of *accuracy* by hiding medical information from the patient.

This section also encompasses parts of a conversation between healthcare providers and interpreters regarding patients' illnesses and treatments. It is one of the recurring situations observed and a reason for complaint for some of the patients.

In the case below, Interpreter D converses with a nurse regarding the patient's serum.

Excerpt 3:

I: How long does it take, Mrs. Nurse?

N: It does not take long.

I: Too- Please open it so that we do not wait long since we have also other patients, we are too busy. We are coming from another hospital.

N: I see.

I: The patient already does not want to stay here.

N: Okay.

As seen in this excerpt, the interpreter requests that the nurse could open the serum up in order to tap and finish faster. However, it is important to note that all these conversations above take place in front of the patient. The interpreter again did not interpret the conversation they held with the nurse. However, this kind of omission might make the patient anxious about the situation since they do not understand anything going around them, which are stated by some of the patients. When the above-mentioned examples are analyzed, the interpreters refrain from interpreting even vital medical information for the patients. Thus, they violate the principle of *accuracy*.

6.3 Expanded Renditions

There are also instances in which interpreters provide more information than the speaker, thus act as a healthcare provider rather than as an interpreter, such as informing the patient's relatives regarding the patient's general health condition, or giving medical advice for the patients.

Excerpt 4:

P: It is not necessary to cut or drain?

I: Not, actually.

P: Okay, good.

I: Cut means a small operation, you do not need to do...

P: No, I do not want. No.

D: Early. Very early for operation.

I: Yeah, just wait for the therapy.

D: It is medication is very important. [*sic.*]

P: Yeah. I would rather not have a cut.

D: From the very start, if it had been, a small operation could be done.

[No interpreting]

The excerpt above takes place between a patient having a stye in her eye and the doctor. At the end of the interview, the patient asks an important question regarding her treatment process. However, the interpreter in this example clearly interferes with the patient's question. First, the interpreter answers the patient's question. Afterwards the doctor gives an answer. Although both the interpreter and the doctor give the same answer, giving an answer by the interpreter regarding the patient's treatment procedure seems quite risky, since he does not have a command of the medical knowledge. In this excerpt, it seems as if there were two doctors in the encounter, since both the interpreter and the doctor answer the patient's question. In addition to giving an answer to the patient's question, the interpreter also omits the doctor's detailed explanation regarding the patient's question at the end of the encounter.

During the observation process, it has also been observed that another interpreter informs the patient's relatives regarding the patient's current health situation. When the relatives of the patient who is in intensive care unit visit the hospital in order to get information regarding their current condition, the interpreter has received them and has given information about the patient such as “unconscious, but responds to stimulants”. In the same way, relatives of the patient who is to be operated on for kidney stones have come to the interpreter in order to ask whether their patient's operation would be that day. The interpreter has answered their questions and, moreover, directed them by giving a notice such as “The patient should go hungry tonight”. Without informing and asking the patient's doctor, the interpreter's intervention in informing the patient directly might have negative consequences for the patient's health and mislead the patient. This situation is also prohibited in the national standards and also codes of ethics and conduct of associations (e.g. the NSW, IMIA, etc.)

As a consequence, interpreters’ decisions shown above clearly indicate that they are not aware of the criticality of the service they provide, since their omissions, particularly omissions regarding the patient's treatments or health conditions, might have direct outcomes for the patient's treatment process and health.

Likewise, the interpreters acting as healthcare providers who answer or guide the patients on behalf of doctors do not have any training in medical field. Thus, the fact that the interpreters provide medical information and guidance for the patients might pose a risk to the patients' health.

7. Conclusion

In this paper, the role of interpreters has been analyzed at two levels: micro and macro levels during and beyond interpretation. Strategies and decisions of the interpreters during interpretation have been discussed from the perspective of ethics.

The role of healthcare interpreters has been analyzed under different categories by basing the data on interviews conducted with fourteen healthcare interpreters, participant observation of four interpreters' actual performances as well as three out of total of twenty-seven interpreted doctor- patient interviews at private hospitals in Turkey. The statements relevant to the issue of role, ethics and training in the interviews were analyzed. The data obtained from the participant observation and audio-recordings have been analyzed within the framework of Wadensjö's (1998) typology of divergent renditions. During the analysis, only zero and expanded renditions were observed as discussed above in detail.

Interviews with interpreters indicate that interpreters adopt additional roles and responsibilities in addition to task of interpreting that are well beyond their duty and training. However, all physical and medical assistance provided by the interpreters for the patients might pose a risk to the patients' health, since interpreters have not acquired an academic training in order to be able to provide such kind of assistance. Therefore, medical assistance by interpreters causes the violation of the principle of professionalism.

The present study revealed that some decisions of interpreters are controversial in ethical terms. One of those decisions is related to the financial interests of hospitals. In other words, the interpreters have to make decisions and adopt strategies in line with the hospital's financial interests. Thus, the aspiration of hospitals to gain money affects the decisions and roles of interpreters during the interpretation process, which causes the violation of impartiality, since the interpreters take sides with the hospitals.

According to the interpreters themselves, it became clear that interpreters are recruited under different titles such as 'corporate communication executive' or 'marketing manager'. All these titles explicitly show that a job description and official guidelines do not exist for healthcare interpreters in Turkey. Some of the interpreters claim that the interpreters are employed as an 'international patient authority' or a 'guide', or for 'Foreign Public Relations Department'. Even these titles reveal the lack of awareness regarding the profession and role of interpreters in Turkey.

Interpreters have been observed to omit certain utterances that are significant for the patients' health and also add information that they are not competent enough to have. In other words, from time to time the interpreters, either

intentionally or unintentionally, do not provide the information that they should be providing to the patients by omitting what the doctors say. On the other hand, they provide information to the patients in situations where they are not supposed to do so, violating the principles of accuracy, professionalism and impartiality. All in all, this paper, as part of a larger study, reveals the ethically problematic actions of interpreters emanating from the lack of codes of ethics and an official job description, pointing to a clear need for more research in the field of healthcare interpreting in Turkey.

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