Interpreting in a bilingual healthcare facility: 
An ethnographic and corpus-based analysis

Verfasserin 
Roberta Favaron

angestrebter akademischer Grad 
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To my mother
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Abbreviations and acronyms

ABG  arterial blood gases
AC   antecubital
A-fib atrial fibrillation
AITI Associazione Italiana Traduttori e Interpreti (Italian Translators and Interpreters Association)
BID  twice a day (from Latin bis in die)
BM   bowel movement
CABG coronary artery bypass graft
CAD  coronary artery disease
CI   community interpreting
CL   Critical Link
CV   cardiovascular
CVP  central venous pressure
D5W  5% dextrose in water
DC   discontinue
DI   dialogic discourse-based interaction
EJ   external jugular
EKG  electrocardiogram
GI   gastrointestinal
GU   genitourinary
HBV  hepatitis B virus
HCV  hepatitis C virus
I and O intake and output
IATIS International Association for Translation and Intercultural Studies
ICU  intensive care unit
IJ   internal jugular
IMIA International Medical Interpreters Association
INR  international normalized ratio
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
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<tr>
<td>ISMETT</td>
<td><em>Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione</em>&lt;br&gt;(Mediterranean Institute for Transplantation and Advanced Specialized Therapies)</td>
</tr>
<tr>
<td>IV</td>
<td>intravenous</td>
</tr>
<tr>
<td>JP</td>
<td>Jackson-Pratt (drain)</td>
</tr>
<tr>
<td>LAD</td>
<td>left anterior descending</td>
</tr>
<tr>
<td>LS</td>
<td>Language Services</td>
</tr>
<tr>
<td>NPO</td>
<td>nothing by mouth (from Latin <em>nihil per os</em>)</td>
</tr>
<tr>
<td>OR</td>
<td>operating room</td>
</tr>
<tr>
<td>PA</td>
<td>pulmonary artery</td>
</tr>
<tr>
<td>PICC</td>
<td>peripherally inserted central catheter</td>
</tr>
<tr>
<td>PO</td>
<td>by mouth (from Latin <em>per os</em>)</td>
</tr>
<tr>
<td>PRN</td>
<td>as per need (from Latin <em>pro re nata</em>)</td>
</tr>
<tr>
<td>PT</td>
<td>physical therapy</td>
</tr>
<tr>
<td>Q</td>
<td>every (from Latin <em>quoque</em>)</td>
</tr>
<tr>
<td>QOD</td>
<td>every other day</td>
</tr>
<tr>
<td>RA</td>
<td>right atrium</td>
</tr>
<tr>
<td>RCA</td>
<td>right coronary artery</td>
</tr>
<tr>
<td>SCD</td>
<td>sequential compression device</td>
</tr>
<tr>
<td>SDU</td>
<td>step-down unit</td>
</tr>
<tr>
<td>T&amp;I</td>
<td>translation and interpreting</td>
</tr>
<tr>
<td>TEDS</td>
<td>thrombo-embolic deterrent stockings</td>
</tr>
<tr>
<td>TEE</td>
<td>transesophageal echocardiogram</td>
</tr>
<tr>
<td>TID</td>
<td>three times a day (from Latin <em>ter in die</em>)</td>
</tr>
<tr>
<td>TILS</td>
<td>Translation, Interpreting and Languages for Special Purposes</td>
</tr>
<tr>
<td>TIPS</td>
<td>transjugular intrahepatic portosystemic shunt</td>
</tr>
<tr>
<td>UPMC</td>
<td>University of Pittsburgh Medical Center</td>
</tr>
<tr>
<td>VBG</td>
<td>venous blood gases</td>
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0. Introduction

So who can I call my mentor? Who inspired me to be a nurse? Who continues to inspire me? [...] Was it the nurse of my childhood, the one with the white shoes and stockings? My heroic and energetic sister? My legendary mother, the one who taught me first about providing care? Gail, who took such a risk to bring me into the emergency room? The other ER nurses? [...] The psych nurse peer group I’ve met with monthly for 25 years? My colleagues at the hospital? The staff nurses on my unit? The nurse writers I’ve met and write with? Yes, I think so. They all inspire me, and we all inspire each other.

Joan Stack Kovach, “My Many Mentors” (2009: 29)

The short story from which this passage has been taken can be found in A Call to Nursing: Nurses’ Stories about Challenge and Commitment (Sergi and Gorman 2009), a collection of prose and poetry written by nursing practitioners who strike a balance between the major difficulties and the immense rewards of their careers. In “My Many Mentors” the author describes the insightful experiences that have nurtured her choice of becoming a nurse: she explains that behind each of the epiphanies that have marked her personal and professional path there has always been a fellow practitioner as a source of inspiration.

Such an excerpt is rarely to be found in the novel fields of medical humanities and narrative medicine, which typically focus on interactions between healthcare professionals and patients rather than among members of the clinical team. Hence scant attention has been given to the fact that a quality healthcare system is also a function of accurate communication and productive relationships among medical co-workers.

Similarly, researchers on interpreting in healthcare facilities are almost exclusively committed to the study of asymmetric interpreter-mediated encounters, often bringing to the fore issues such as power and status differentials between practitioners and migrant patients. On the other hand, intercultural face-to-face communication among peers in the medical area has been largely neglected by the scholarly community.

Running counter to this trend, the present study is concerned with interpreting in a bilingual hospital in Southern Italy, ISMETT, whose US and Italian employees interact not only with patients, but also with each other supported by a team of English-Italian in-house interpreters. The most frequent ISMETT users of the interpreting service are
nursing staff members of all ranks: in fact, the quotation above has also been chosen because the main protagonists of this study are interpreters and nurses.

The unique opportunity to explore this atypical setting opened up for me when I formed part of the ISMETT Language Services Department, first as graduate intern, from August to September 2003, and subsequently as full-time interpreter and translator, from September 2004 through August 2008. Since the beginning of my hands-on experience, the heterogeneous nature of interpreting practice at ISMETT has emerged as a peculiar feature. The interpreting service is provided in a variety of contexts, ranging from intra-social to international settings, in clinical as well as administrative areas, for the benefit of a wide array of clients and different constellations of interacting parties. For instance, during an ordinary working day, it is not unusual for an ISMETT interpreter to be involved in a nurse-patient interaction, a clinical case discussion among physicians, a top management meeting, or a medical lecture. The ensuing inability to classify these activities under a single, well-defined interpreting type, although they occur in a hospital environment, sparked my interest and curiosity.

Profiting from my privileged status of insider, I decided to develop a case-study project narrowing the analysis down to interpreting in the medical sector. The study aims at describing the product and performance of ISMETT interpreters as they are engaged in different communicative settings. More precisely, as the same interpreters are required to don different hats, how do they adjust to changing circumstances? How does the variability in interpreting domains and dimensions inform the relationship between source texts and their target-language renditions? What kinds of shifts can be identified in the role they play during mediated encounters and in their management of the interactive discourse, especially in terms of footing and turn-taking? Do such changes influence the selection of the working mode? What triggers one choice over another? Finally, is there a common ground, given the specificity of the institutional context and the status of in-house interpreters? In order to address these issues, the analysis will move from the exploration of the hospital context to that of the interpreters’ “habitus”, which will then be set against the actual “practice” in the “field” of medicine (Bourdieu 1977, 1990; see also Torikai 2009). By combining an inductive ethnographic approach with a discourse-analytical one and adopting fieldwork as the
main research strategy, the study can be placed within the DI research paradigm of interpreting studies (Pöchhacker 2004, 2007).

This thesis consists of six chapters. Chapter One briefly illustrates the development of healthcare interpreting and presents the debate on its status in relation to community interpreting. A selected overview of healthcare interpreting research is also provided: emphasis is placed on the key issues concerning the linguistic production of healthcare interpreters and their communicative performance in this role. Chapter Two introduces the context of the study by offering an institution-specific model of interpreting (Pöchhacker 2004: 85-88; cf. Marzocchi 1998): the creation and growth of ISMETT, as well as of its Language Services Department, are described with a focus on the domains and dimensions of interpreting practice within the hospital. A closer look at three typical interpreting scenarios in medical interactions, namely nursing assessments, nursing reports, and training sessions, sets the stage for the empirical study, whose methodology for data collection and analysis is presented in Chapter Three. Chapter Four examines the outcomes of one-to-one semi-structured interviews (cf. Robson 1993) conducted with the members of the Language Services to outline the generation of the Department’s normative behaviour as well as the resulting acquisition of a specific habitus, by prompting comments, in particular, on language, technical, emotional, interpersonal, and cultural issues across settings. In order to compare the dispositions thus identified with the interpreting activity proper, Chapter Five presents a discourse-based analysis of a corpus of recorded and transcribed interpreter-mediated medical interactions at ISMETT, featuring one nursing assessment, thirteen nursing reports, and two training sessions. Finally, the conclusions in Chapter Six discuss the theoretical and practical implications of the study.
1. Healthcare interpreting: Review of the research literature

1.1 Healthcare interpreting within interpreting studies

Healthcare interpreting, medical interpreting, or hospital interpreting (cf. Pöchhacker 2004: 15) are different headings yet all referring to the same typical scenario: the use of interpreters in the clinical field to help foreign patients – immigrants, guest workers, refugees, tourists, or members of indigenous populations – communicate with healthcare practitioners, such as physicians, nurses, physical therapists, or speech pathologists, to name but a few (Tebble 1999: 179-180). Although face-to-face interpreting in medicine may also be required under other circumstances and with other participants, these have hardly been explored in the literature to date.

The practice of healthcare interpreting (HCI) – to use the most common rubric (cf. Pöchhacker and Shlesinger 2007) – has gained increasing visibility and significance in recent times. Following the massive migration waves in most western countries over the last few decades, the first attempts at bridging communication gaps in public-sector institutions have been made precisely in the field of healthcare, through the provision of organized interpreting services; similarly, this area has witnessed the establishment of pioneering professional bodies for interpreters in the community outside the legal sphere. Hence HCI has also gradually attracted the interest of researchers: both descriptive accounts and more systematic empirical studies have been carried out since the 1970s from the vantage point of diverse disciplines, ranging from medical studies to social sciences or linguistics, long before interpreting scholars turned their attention to this sector (Pöchhacker and Shlesinger 2007: 1-2).

A landmark event in the development of HCI was the first international congress on community-based interpreting (CI) organized at Geneva Park near Toronto, Canada, in 1995 by “The Critical Link”, a network of specialists in the field summoned in 1992 by Brian Harris of the University of Ottawa and subsequently turned into a non-profit organization committed to the advancement of CI (Critical Link 2010). Significantly, the title of the congress – “Interpreting in Legal, Health and Social Service Settings” – made explicit reference to ‘health’ as one of the key areas of practice acknowledged by the heterogeneous Critical Link community. More specifically, one of the conference
organizers, Roda Roberts, further supported this inclusion in her opening keynote speech: quoting Collard-Abbas (1989: 81), she defined CI as the “type of ad hoc interpreting done to assist those immigrants who are not native speakers of the language to gain full and equal access to statutory services (legal, health, education, local government, social services)” (Roberts 1997: 8; emphasis added).

Nevertheless, the status of HCI as a fully-fledged field and, particularly, in relation to CI has long been debated. One of the first attempts at structuring this area of interpreting was made by Roberts in the above-mentioned contribution. The author provided a wide-ranging overview of CI – at that time still an ill-defined notion – by elucidating its most controversial issues, such as the terminological uncertainty, given the widespread use of synonyms like “cultural interpreting” or “dialogue interpreting”, and the multifarious philosophical approaches. With reference to CI’s scope and varieties, Roberts (1997: 9) reported a commonly accepted hierarchical classification (see Figure 1.1). In this model, CI is seen as a generic category that encompasses at least three varieties explicitly identified by their respective settings: “public service interpreting”, “medical interpreting”, and “legal interpreting”. Roberts herself, however, underlined the lack of consensus about this categorization, which left room for perplexity on the overlap between CI and court interpreting through legal interpreting, as well as on the boundary between these last two types. Moreover, she argued (1997: 9-10) that, as legal interpreting was turning into a distinct field, the same was likely to occur for medical interpreting, given the increasing number of specific assignments, full-time positions, and training programmes. Therefore, once the diagram no longer included legal and medical interpreting, CI would end up coinciding with interpreting in public (social) services alone, thus becoming a label bereft of its original meaning. Was

![Figure 1.1 Roberts’ varieties of CI (from Roberts 1997: 9)](image-url)
therefore Adolfo Gentile (1993) right when he challenged the separation between interpreting types based on the setting? Though acknowledging that different environments may require different technical adjustments, Gentile stressed that the interpreter’s function did not change across settings, given that the same professional skills and high standards of performance should invariably be maintained (Roberts 1997: 24).

An alternative conceptual model was developed by Garber (2000) and presented at the Second Critical Link Conference¹ (Figure 1.2). Its peculiarities are twofold: first of all, it includes not only interpreting varieties representative of CI, i.e. “court”, “police”, and “medical”, but also “conference” interpreting. Secondly, interpreting types are represented by overlapping circles, rather than being hierarchically separated. Indeed, Garber moved from the assumption that all types of interpreting, despite their unique and distinctive features, shared the same ethical common ground, namely “the fundamental commitment to accuracy or fidelity” (2000: 15), graphically symbolized by the areas of overlap. However, despite its innovative approach, Garber’s model did not

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¹ Following the successful outcome of the First Critical Link Conference (cf. Carr et al. 1997), Diana Abraham of the Ministry of Citizenship of Ontario, in collaboration with Brian Harris and Roda Roberts, strived to institutionalize it as a conference series. While the second and third gatherings were again held in Canada, more precisely in Vancouver in 1998 (cf. Roberts et al. 2000) and Montreal in 2001 (cf. Brunette et al. 2003), a remarkable step forward was taken in 2004, when the conference reached Stockholm in Europe (cf. Wadensjö et al. 2007). A further move towards internationalization was made by organizing Critical Link 5 in the southern hemisphere – in Parramatta, Sydney, Australia, in 2007 (cf. Hale et al. 2009). The Critical Link 6 will take place in Birmingham in July 2010.
take into account any other parameters that could meaningfully link HCI to the other domains.

A more comprehensive framework was provided by Pöchhacker (2004, 2007). To start with, he argued that the conceptual distinctions in interpreting have changed throughout history as a consequence of the developments in the profession. For a long time “interpreting was simply interpreting”, without any need for subcategorizations; yet in the twentieth century the emergence and steady dominance of both consecutive interpreting with note-taking and simultaneous interpreting from the booth gave rise to the well-known mode-based distinction. A rethink was only required towards the end of the century, when the new community-based contexts took centre stage: thus “the social sphere of interaction” – i.e. the “institutional setting” – in which interpreting occurred became the distinguishing feature between “healthcare interpreting, legal interpreting, media interpreting”, etc. (2007: 12), as suggested also by Roberts and Garber. However, the view of interpreting put forward by Pöchhacker at a more general level does not consist of separate entities, but is rather seen as a conceptual continuum with a dual subdivision, as illustrated in Figure 1.3 below: the first between “inter-national” settings on the left-hand side and “intra-social” or “community-based” settings on the right-hand side; the second, with reference to the “situational constellation of interaction” (2004: 16), between multilateral conferencing and face-to-face dialogue, respectively indicated by the two ellipses. Their partial overlap specifies the possibility of shared features, for instance in conference-like events in the community or during diplomatic negotiations that require dialogue interpreting (2007: 12).

![Figure 1.3](image)

Pöchhacker’s conceptual spectrum of interpreting (from Pöchhacker 2007: 12)
In order to offer a yet more detailed categorization of interpreting types, Pöchhacker (2004: 23ff) identifies additional criteria, thus creating a set of eight relevant dimensions (see Figure 1.4): 1) “medium” (human or machine); 2) “setting”, as elucidated above; 3) working “mode”, i.e. consecutive (both classic consecutive and short consecutive without notes) or simultaneous (ranging from interpreting in a booth to whispering and sight interpreting, that is the rendition of a written text ‘at sight’); 4) “language” modality (signed or spoken, the latter extending from conference languages to migrant vernaculars); 5) “discourse” (speeches, debates, or face-to-face talk); 6) “participants” (given that the interpreter’s clients can be either equals or, as indicated at the opposite end of the spectrum, individual human beings dealing with professionals and institutional representatives); 7) professional status of “interpreters” (with a varying level of training or ‘natural’ interpreters, i.e. completely untrained bilinguals); and, finally, 8) “problems”. Unlike the preceding dimensions, the last one is not intended as a continuum, but rather as an exemplification of concerns in interpreting research. Being arranged both horizontally and vertically, Pöchhacker’s diagram gains a double significance: while the horizontal categories illustrate the multifaceted character of interpreting, the chief subdomains of interpreting practice and research can be identified along the vertical axis (for instance, the main features of conference interpreting on the left-hand side, as opposed to CI aspects at the other end).

While warning against the interpretation of the chart as a map of features that can coalesce, Pöchhacker (2004: 25) also adds that the interaction of the first seven dimensions offers an overview of the leading issues in the diverse interpreting domains. Bearing these suggestions in mind, an attempt can be made at describing the typical conception of HCI: in general terms, HCI can be defined as a type of (human) interpreting, both spoken and signed, that occurs in an intra-social setting, more specifically in healthcare, where a (usually) semi-professional or (sometimes) natural interpreter uses the (short) consecutive mode to interpret face-to-face talk between an individual speaking a migrant language and an institutional representative. Undoubtedly, this broad definition confirms that HCI shares numerous features with similar CI types in other intra-social contexts. Nonetheless, it can be said that the ‘healthcare’ setting does not make the difference per se, but gains significance insofar as it entails an array of additional, specific issues that cannot be found in any other CI
Figure 1.4  Domains and dimensions in interpreting theory (from Pöchhacker 2004: 24)
environment with the same intensity (e.g. emotional problems, relation with the concepts of death and illness, notion of empathy, etc.). Such issues should thus be placed as a subgroup along the eighth dimension in the diagram – the one indicating ‘problems’ – though not as a continuum affecting all interpreting types, but rather as setting-specific concerns.

In the light of this discussion on the status of HCI, it is now possible to engage with a review of the relevant research literature. Given that the analysis performed in the following chapters is issue-based, the same approach will be adopted here, thus offering a selection of key topics in medical interpreting research brought to the fore at the international level, particularly in western countries.

1.2 Issues in healthcare interpreters’ product and performance

The most recent and comprehensive review of HCI research was undertaken by Pöchhacker (2006), who approached his object of study from three different angles: the disciplinary perspectives adopted, the methods applied, and the themes explored. With reference to the latter, he identified five chief thematic orientations, encompassed under the mnemonic rubrics of “product”, “performance”, “practices”, “provision”, and “policy” (2006: 143-151). Whereas the first two categories include investigations whose main focus is the interpreted session as such, the last three take stock of research studies that explain if and how the interpretation is ensured: for instance, accounts of the communicative ‘practices’ adopted by healthcare facilities to bridge linguistic and cultural gaps, with the emphasis on the interpreting arrangements taken; analyses of service ‘provision’, which relate such interpreting arrangements to the medical care offered, e.g. in terms of patient outcomes and satisfaction, or costs; finally, at a broader level, research studies on diversity management ‘policy’, conducted from a legal, managerial, or organizational standpoint.

The focus of interest in the empirical part of the present study will be the development of interpreted encounters, rather than the organization of interpreting services and the impact thereof. Hence the current review will only take account of overriding concerns regarding healthcare interpreters’ linguistic output, or ‘product’, and their communicative ‘performance’ in this function – two concepts that are closely
interrelated (cf. Pöchhacker 2004: 137ff). More specifically, while exploring mediated communication from a translational as well as interactional viewpoint, the following recurrent themes will be considered: source-target correspondence (cf. Pöchhacker 2004: 141ff); the heated debate on the interpreter’s role; and the joint management of the interactive discourse, i.e. the effects of the peculiar constellation of interaction on the conversational dynamics, especially in terms of footing and turn-taking.

1.2.1 Source-target correspondence
At the dawn of the HCI profession, the most prominent feature was certainly its scant acknowledgement, not only in the interpreting community, but also within clinical facilities. It could be said that, for many years, the ‘means at hand’ would be used on an ad hoc basis to meet an increasingly pressing need – i.e. allowing for mutual understanding between healthcare practitioners and patients. This could imply resorting to hospital personnel, such as bilingual nurses or orderlies, but also to patients’ relatives, including children. The underlying assumption was that a knowledge of both languages would suffice to bridge the communication gap: while accurate interpreting was recognized early on as an inherent requirement in legal and judicial settings (cf. Hale 2004: 16ff with reference to the Australian context), the crucial importance of correct information transmission in medical consultations has long been underestimated by service providers.

Running counter to this neglect at the organizational level, researchers from diverse disciplines have soon considered the ‘deviations’ of interpreted texts from their source texts in HCI. Early investigations into the same issue in conference interpreting had led to a range of taxonomies, with departures handled as errors and chiefly classified under omissions, additions and (various types of) substitutions (e.g. Barik [1971]/1994):² hence similar parameters have been applied to the linguistic output of healthcare interpreters. In this section an attempt will be made to illustrate this line of research and its major developments.

The first relevant studies, carried out by linguists and medical specialists, focused in particular on the clinical significance of errors, and their leitmotif was the common presence of hazardous deviations. One of the earliest examples was Lang’s (1975)

² For an overview of the main classifications put forward in the literature, see Pöchhacker (2004: 142-143).
pioneering linguistic analysis of the performance of medical orderlies acting as (untrained) interpreters between the native language Enga and the creole Tok Pisin in two Papua New Guinean hospitals. Using as a reference point the standards provided by European interpreting schools, the researcher examined tape-recorded and transcribed doctor-patient interactions: he thus found that the high incidence of additions, omissions, and mistranslations – especially into the physician’s language – were also ascribable to the conflicting duties between the role of orderly and that of interpreter.

Another qualitative investigation was conducted in the outpatient clinic of a Nigerian hospital by Launer (1978) in his dual capacity as language expert and clinician. Looking for deviations from a word-for-word translation, he analysed the transcribed recordings of consultations interpreted by seven medical orderlies, with the involvement of thirty local patients speaking Hausa and four English-speaking doctors. Deviations during history taking were then classified as “legitimate”, e.g. appropriate clarifications and paraphrases of the original utterances; “illegitimate” (mistranslations or omissions); or “due to the interpreter acting as independent questioner” with patients (1978: 934). Notably, the similarity between his own findings and those obtained by Lang was read by Launer as a proof that, regardless of geographical factors, the nature of history taking and the demands of interpreting were the same across cultures (1978: 935).

A linguistic study was carried out by Prince (1986) in the field of gynaecology in California. She examined the distribution and accuracy of question-answer exchanges in twelve audio-taped medical interviews between Spanish-speaking patients and English-speaking physicians. The latter were rated on a scale ranging from low to high in Spanish proficiency. Five monolingual interviews conducted in Spanish with no interpreter were set against the other seven mediated by ad hoc interpreters (either clinic personnel or patients’ accompanying persons). Overall, the use of the non-professional

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3 It should be noted that Launer commented on the interpreting activity as a whole. Undoubtedly, he was somewhat biased towards clinicians, who – in his opinion – should be in charge of the interaction, whereas interpreters were viewed as mere tools. Nevertheless, his guidelines for an adequate interpreting service were strikingly modern: “[…] I would recommend that interpreters should have no conflicting duties during consultations, such as checking documents. They should have formal training in language and the rudiments of interpretation. Doctors should be taught how to use them. The service should be checked continuously with the help of native-speaking doctors, language tests, and recorded tapes. I would also suggest some rules for any doctor who has to use an interpreter. Greet the patient to establish direct contact. […] Give only short sentences for translation, and get the interpreter to explain that the patient must do the same. […] Finally, use the interpreter to tell the patient everything you would tell him if he could speak your language.” (Launer 1978: 935; emphasis added).
Healthcare interpreting was found to increase miscommunication. More specifically, questioning patterns leading to incorrect answers in mediated interactions were attributed to five interpreter behaviours: answering instead of translating questions, translating information incompletely, translating incorrectly, mishearing, and displaying a limited linguistic competence (the last two occurrences were observed also among the physicians).

Within health sciences, significant contributions were made in mental health, such as Price’s (1975) quantitative study of nine psychiatric interviews in a Fijian hospital. These involved three doctor-interpreter pairs and several patients speaking Hindustani – a language used by most Fijians of Pakistani and Indian descent. As for the interpreters, two were hospital orderlies with some interpreting practice but no formal training, while the third was an educated but inexperienced psychiatric patient in remission. At least 100 tape-recorded questions and answers for each doctor-Interpreter pair were examined to evaluate language proficiency and identify interpreting errors, the latter being defined as alterations in meaning. What emerged was that most mistakes were made in the translation of patients’ utterances by the two orderlies, often as a result of their poor English proficiency. In particular, errors that could jeopardize the correct diagnosis included not only omissions of apparently meaningless material, but also additions easily mistaken for true competence. However, despite the quantification of error types, unclear reference was made to their assessment methodology (Pöchhacker 2006: 144).

Also Marcos (1979) looked at interpreter-related distortions in the psychopathological assessment of non-English-speaking patients, though from a qualitative rather than quantitative perspective. The first part of his study, conducted at two New York City hospitals, hinged upon discussions with English-speaking psychiatrists and (untrained but experienced) healthcare interpreters, in order to compare their major concerns. He then analysed the transcribed and translated recordings of eight psychiatric evaluations concerning patients speaking Spanish, Cantonese, and the Chinese dialect Toisanese. The interviews were mediated by ad hoc interpreters, namely a bilingual psychiatric nurse (in four cases), a nurse’s aide with no psychiatric knowledge (in two), and two patients’ relatives. Distortions consisted primarily of omissions, condensations, substitutions, additions, and content normalizations, i.e. attempts to make sense of patients’ utterances instead of providing
exact translations. According to the researcher, most errors were due to the interpreters’ lack of language proficiency, translation skills, and psychiatric expertise; as for patients’ relatives, some alterations were also associated with their personal views, as in their tendency to either minimize or emphasize psychopathological attitudes. Marcos concluded that pre- and post-session briefings between clinicians and interpreters could help reduce deviations and the related misdiagnoses. This notion that misinterpretation by untrained interpreters can lead to misevaluation of patients’ mental status – especially in terms of attenuation or exaggeration – was also supported by Vasquez and Javier (1991) through two case examples. Notably, in their classification of error types, the researchers included the category of “role exchange” for those cases in which interpreters took over the interaction and replaced the interviewers’ questions with their own.

Going back to error quantification, faults analogous to those found in Price (1975) are present in the frequently-cited study by Ebden et al. (1988). Four interviews between English-speaking doctors and patients speaking Gujarati – an Indian language – were videotaped in the outpatient department of an English hospital, with patients’ relatives as interpreters. According to the authors, interviews were conducted as if they were first visits, which might imply that they were run as simulations (Pöchhacker 2006: 144). Attention was focused on three main features: the translation of physicians’ questions, the management of medical terminology, and the influence of cultural aspects. To start with, complex questions – requiring more cognitive processing – and serial questions – likely to test the interpreter’s memory – were found to be regularly mistranslated or omitted, with the relevant percentages provided for each interpreter. Yet no explicit reference was made to the method of verbal data analysis (e.g. who carried out the assessment, how an incorrect rendition was distinguished from an appropriate paraphrase, etc.). Similar remarks can be made about the quantification of mistranslations and omissions of medical terms. Finally, physicians’ references to cultural taboos were either eliminated in the Gujarati rendition or handled ambiguously. Leaving aside the methodological issues, Ebden et al. significantly concluded that linguistic and cultural problems went unnoticed by physicians, thus potentially compromising the accuracy of initial diagnoses.
More recently, Flores et al. (2003) examined thirteen tape-recorded Spanish-English encounters in the paediatric outpatient clinic of a Massachusetts hospital, as part of a larger research project. Staff interpreters with limited training were used in six encounters, while the others were mediated by three ad hoc interpreters (three by a nurse, three by a social worker, and one by a sibling aged eleven). The goal was to establish the incidence of interpreters’ mistakes, classify them, and evaluate their potential clinical effects. Unlike Price (1975) and Ebden et al. (1988), the methodology applied for recording, transcription, transcript translation, review, and error assessment was described in detail. Partially drawing on the categories devised by Barik (1969) and Hornberger et al. (1996), errors were classified as omissions, additions, substitutions, editorializations (i.e. provision of personal views in the translation), and false fluencies (i.e. use of incorrect or non-existing expressions). The quantification showed an overall high frequency of mistakes both for hospital and ad hoc interpreters – particularly of omissions, which accounted for more than half of all errors. Although hospital interpreters committed fewer errors of potential clinical consequence, their error total was higher than that of ad hoc interpreters. Also false fluencies were common in staff interpreters’ renditions, and mainly involved medical terminology. Therefore, the findings called for the need not only to avoid using improvised interpreters, but also to adequately train those employed by healthcare facilities. The same corpus was examined by Laws et al. (2004) with the goal of creating a quality assessment method for medical interpreting. In this case, the transcripts were divided into conversation segments, each consisting of continuous monolingual turns by the same primary speaker and the subsequent purported translation into the other language. Segments were then coded to indicate their translation accuracy, partly following the above-mentioned classification by Vasquez and Javier (1991). In 66.1% of segments, the translation featured considerable errors or omissions, or was not present at all, although needed. Moreover, 29.8% of segments saw interpreters engaged in autonomous and potentially deleterious speech acts unrelated to interpretation, defined as instances of “role exchange” (cf. Vasquez and Javier 1991).

It should be noted that few studies on healthcare interpreters’ output have taken into specific account the management of medical terminology. Aside from the limited interest by Ebden et al. (1988; see above), the linguistic investigation carried out by
Meyer (2001) within a wider research project in German hospitals is worthy of note. He considered the transcribed recording of three authentic interactions between German-speaking clinicians and Portuguese migrants, mediated by a patient’s relative and two different nurses. Lexical substitutions were a noticeable occurrence: for instance, the use of everyday language instead of professional terms, or vice versa, and recourse to additions as autonomous professional explanations by the clinical personnel acting as interpreters. Interestingly, the pragmatics analysis revealed that such easily predictable deviations were not merely informed by the interpreters’ knowledge – or lack of it – of the correct terminology. Rather, Meyer ascribed them to the peculiar speech situation, the pre-existing relationship between interpreter and primary participants (in terms of closeness versus distance), and the organization of the source discourse.

More recently, Dubslaff and Martinsen (2007) highlighted the problems caused by the poor medical knowledge of non-professional interpreters involved in Danish-Arabic role-plays, and stressed the need for enhanced training in specialized terminology (see also §1.2.3).

Also from the vantage point of interpreting studies, the first explorations into source-target correspondence approached departures as errors. In sign language interpreting, Cokely (1982) conducted an experimental study on two separate interviews between a hearing nurse and a deaf patient, both mediated by professional ASL (American Sign Language)-English interpreters. According to the author, communication problems between healthcare practitioners and patients happened to be amplified in interpreted sessions, due to four main categories of interpreting-related faults: perception errors (i.e. misunderstandings), memory errors (especially unintentional omissions), semantic errors (incorrect use of lexis or syntax), and performance errors (for instance in the production of an utterance).

Other scholars have focused on the communicative effect produced by deviations, especially when unqualified interpreters are used. Pöchhacker and Kadrić (1999) examined the voice therapy session of a Bosnian child and the subsequent briefing with his parents, taking place at a Vienna hospital. The encounters, both videotaped and transcribed, were managed by two German-speaking speech therapists through the mediation of a Serbian-speaking cleaner. Despite the apparent successful outcome of the sessions, the case study analysis revealed that the interpreter frequently adopted a covert
“co-therapeutic attitude” (1999: 175) through significant shifts in the form and substance of the exchanges. The indirect effect was that the two therapists – though unaware of it – failed to maintain control over the session. Along similar lines, Jan Cambridge (1999) explored seven simulated English-Spanish medical consultations mediated by two untrained interpreters. She showed that these tended to occupy inappropriate interlocutor roles, which led them to omit information, add content (including opinions and advice), and alter meanings. The ensuing miscommunication affected not only the physicians’ ability to establish rapport with their patients, but, more importantly, the transmission of diagnostically relevant data.

The increased employment of professional healthcare interpreters in the last few years has paved the way to new research trends, first developed – once again – in conference interpreting. Attention has been shifted towards a reading of interpreters’ departures not necessarily as errors, but rather as deliberate ‘strategies’ for dealing with varying pragmatic factors, such as the situation and the recipients of the interpretation (cf. Kopczynski 1994; Viezzi 1996). Though undoubtedly significant in conference interpreting, these contextual elements are all the more crucial in face-to-face encounters. As suggested by Hsieh (2003: 19) from the perspective of communication studies:

Interpreters may consciously deviate from the original utterances in an attempt to produce effective, efficient, compressed, informative, supportive, or authoritative messages, whatever best fits their communicative goals at the moment.

One of the first authors who applied this concept to HCI was Wadensjö (1992, [1993]/2002, 1998) in her analysis of a large Swedish-Russian corpus of tape recorded interpreted events, thirteen of which taking place in medical settings and all mediated by state-certified interpreters. According to the researcher, every rendition, defined as “a stretch of text corresponding to an utterance voiced by an interpreter, [...] relates in some way to an immediately preceding original” (1998: 106). Based on the nature of

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4 In conference interpreting, a number of authors have stressed not only the frequency, but also the advisability of interpreters’ specific deviations. For instance, Palazzi Gubertini (1998) pointed out that, on occasion, additions may be required for clarity purposes. Along the same lines, Falbo (1999) distinguished between “loss” and “omission”, considering the latter a conscious interpreting choice. In the field of sign language interpreting, a noteworthy contribution to this topic was Jemina Napier’s (2002, 2004) classification of omissions in relation to interpreters’ linguistic coping strategies.
these correlations, Wadensjö devised a taxonomy of renditions, in order to detect their potential functions at the interactional level. She drew a main distinction between renditions that are “close” to their originals, in terms of propositional content and style, and those that are “divergent”. The latter were then grouped into seven categories: “expanded renditions”, if the information contained is verbalized more explicitly than in the preceding originals; “reduced”, in the opposite case; “substituted”, when an expanded rendition and a reduced one are combined; “summarized”, matching two or more preceding originals; “two-part or multi-part”, should two or more renditions correspond to one original; “non-renditions”, i.e. interpreter’s autonomous interventions; finally, “zero renditions”, if primary speakers’ utterances are not translated (Wadensjö 1998: 107-108; for a more exhaustive review of Wadensjö’s theoretical framework, see §1.2.2 and 1.2.3).

Out of the categories put forward by Wadensjö, five – namely close, expanded, reduced, zero, and non-renditions – were borrowed and further subdivided by Rosenberg (2001) in his quantitative study conducted in a Texan primary-care clinic. The transcribed corpus consisted of eleven paediatric interviews whose participants were Spanish-speaking young patients and their relatives, English-speaking medical staff, and the author himself as both researcher and interpreter. The findings revealed that, although 40.8% of the 1,334 interpreter utterances were close renditions, zero renditions and non-renditions were frequent occurrences too (26.9% and 19.5% respectively). Despite Rosenberg’s initial bafflement at these results (2001: 105), closer scrutiny proved that discrepancies between source texts and target texts did not necessarily indicate unskilled or unscrupulous behaviour on the part of the interpreter. Rather, they were indispensable tools – under specific circumstances – to ensure the successful outcome of the medical encounter as a whole, given the complex nature of mediated events.

From a qualitative perspective, divergent renditions – more specifically additions – were among the discourse features explored also by Merlini and Favaron (2007: 122-129) in the recording of three professionally interpreted sessions involving Italian-speaking patients and English-speaking speech pathologists in Melbourne healthcare facilities. Additions were classified as phatic (with back-channelling and reassuring

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5 Rosenberg did not take into account Wadensjö’s summarized, substituted, and two-part/multi-part renditions as he found them less suitable for a quantitative analysis (2001: 101).
functions), emphatic (repetitions), explanatory, and other, i.e. Wadensjö’s non-renditions, which were further subdivided into seven groups (see also §1.2.3).

Undoubtedly, the first studies on medical interpreters’ product have gradually achieved a remarkable goal: they have contributed towards stepping up awareness about the potentially dangerous use of ad hoc interpreters, whether family members or unqualified bilinguals. At the same time, they have triggered further research projects, aimed at fostering the systematic provision of healthcare interpreting services, as well as ensuring interpreters’ thorough training. A detailed account of these issues is beyond the scope of this review, as already underscored. Nevertheless, it is worth stressing that these outcomes and the subsequent increasing professionalization of healthcare interpreters have directed attention to previously overlooked features, namely the communicative and discursive functions of interpreters’ departures. This shift from the textual product to the context of mediated interactions – or, rather, to the discourse level – will be the subject matter of the following section.

1.2.2 Role definition
The attempt to outline the role of medical interpreters was the focus of one of the first contributions in the field, namely the 1966 study carried out by Bloom et al., which was published in Mental Hygiene. Discussing the results of a social-work project on the use of interpreters during psychiatric interviews, the authors identified three paradigmatic interpreting roles: interpreters may become the interviewers, function as their tools, or collaborate with the professionals. Though formulated in the area of health sciences rather than interpreting studies, these three alternatives can be said to encapsulate the main outcomes of subsequent discussions about the function of healthcare interpreters (Pöchhacker and Shlesinger 2007: 2) – not to mention their direct influence on

6 Aside from errors’ quantification and classification, the use of patients’ relatives as interpreters has usually been denounced in the literature also on ethical grounds: for instance, Carr (1997) mentioned the paradox “of an abusive husband interpreting for the victim of his abuse, or an anxious ten-year-old obliged to interpret to his mother the rationale and procedure for a frightening test the child must undergo” (1997: 271-272). Far more deleterious repercussions were reported by Jacobs et al. (1995) in their case study of post-traumatic stress reaction in a ten-year-old Muslim Asian girl who had interpreted for her parents during the hospital admission of her dying baby brother. Unexpectedly, this negative view of children interpreting was challenged by the opposite outcomes of a recent survey among young mediators (Green et al. 2005), while other research studies showed that patients felt highly satisfied and comfortable when family members or friends were used as interpreters (e.g. Kuo and Fagan 1999; Edwards et al. 2005).
analogous accounts by clinical experts (e.g. Westermeyer 1990; Drennan and Swartz 1999).

Indeed, whether interpreters ‘just’ translate or should assume additional responsibilities has always been a moot point. As elucidated in the previous section, for many years an absolute lack of rules had prevailed in the field, with the interpreting task typically accomplished by proxy mediators: hence extreme positions were taken by the first scholars, in order to buck this widespread trend. More specifically, attempts were made to specify the do’s and don’ts of healthcare interpreting – and thus foster its professionalization – by applying the principles of the more established conference interpreting domain. Hence expressions such as the interpreter’s “invisibility” and the “conduit” (cf. Reddy 1979) or “pane of glass” metaphors were coined, to assert that the gold standard for medical interpreters was to make “the situation with an interpreter, as far as possible, similar to a situation without an interpreter” (Gentile 1991: 30).

At the opposite end of the spectrum, research routes with sociological and sociolinguistic approaches stressed the need for the interpreter’s direct involvement in the interaction. This thematic orientation was strongly supported by medical anthropologists studying indigenous populations, such as Joseph Kaufert and fellow scholars at the University of Manitoba (Winnipeg, Canada). Challenging the notion of invisibility, they argued that the interpreter’s role cannot but include cultural brokerage and community advocacy, especially when the ethnomedical model (based on patients’ cultural beliefs about illness) clashes with the biomedical model (i.e. the healthcare professionals’ notion of disease). For instance, Kaufert and Koolage (1984) used participant-observation data, as well as audio-taped interviews with medical interpreters speaking Cree and Saulteaux (two native North American languages) and their clients, to describe interpreters’ divided loyalties. Conflicts arose in particular when mutual needs and expectations were ignored: for instance, if clinicians disregarded cultural customs, or patients did not comply with the recommended treatment. More specifically, the authors identified four main roles performed by interpreters: “direct linguistic translators” (or “conduits”), converting terminology from the source language into the target language; “culture-broker informants”, explaining cultural matters regarding native patients to clinicians; “culture broker-biomedical interpreters”, explaining medical terms and procedures to patients; finally, “patient advocates”, siding
with patients and their cultural values. Along the same lines, Kaufert and Putsch (1997) reported case examples about informed consent and end-of-life issues in interpreter-mediated hospital encounters that involved English-speaking physicians, patients from ethnic communities, and their relatives. They showed how the model of the neutral, objective interpreter – called for by most medical interpreting codes of conduct – was often not complied with in actual practice: interpreters were not only witnesses to, but also participants in a health delivery process informed by class divisions, different family practices, and contrasting beliefs. Yet the two authors maintained the need for further thorough studies before the interpreter’s role as intermediary could be acknowledged and legitimized, in order to avoid the premature and risky development of groundless specifications.

An answer in this regard came from a new research route that foregrounded dialogic discourse-based interaction – hence the name “DI paradigm” (Pöchhacker 2004: 79) – in interpreter-mediated encounters, giving preference to qualitative studies and employing a variety of sociolinguistic tools, such as discourse-analytical or conversation-analytical ones (Pöchhacker 2006: 146). Within the developing field of interpreting studies, a major contribution towards the establishment of this research pattern was made by Cecilia Wadensjö’s groundbreaking works (1992, 1998). Drawing inspiration from the theories on dialogism of discourse scholar Per Linell (e.g. 1997) and Russian semiologist Mikhail M. Bakthin (e.g. 1981), complemented by concepts from interactional sociolinguistics (e.g. Goffman 1981), Wadensjö put forward a revised view of the interpreter as active participant in the mediated interaction. Based on her Swedish-Russian corpus, she carried out a detailed analysis of discourse, describing the interpreted encounter as a “communicative pas de trois” (1998: 12). From this perspective, she argued that the interpreter’s task consisted of two related activities: not only “translating”, i.e. relaying the utterances of the primary speakers, but also “coordinating” the flow of talk – for instance through non-renditions. Consequently, this would result in a joint construction of meaning performed by both interlocutors and interpreter, as well as in a shared responsibility for the conversation’s development. In Wadensjö’s own words:

In an interpreter-mediated conversation, the progression and substance of talk, the distribution of responsibility for this among co-interlocutors, and what, as a result of
interaction, becomes mutual and shared understanding – all will to some extent depend on the interpreter’s words and deeds. (1998: 195)

A further discourse-based empirical study was conducted by Melanie Metzger (1999) not only to address, but also to “deconstruct” the issue of neutrality, specifically in sign language interpreting. For this purpose, she compared the video recording of a medical encounter role-play during an interpreter training class with that of an authentic paediatric consultation mediated by a professional interpreter. Metzger’s point of departure was the assumption that “interpreters, by their very presence, influence the interaction” (1999: 23), as opposed – once again – to what is contended by the supporters of interpreters’ non-participation. Her analysis focused on the expectations – labelled as “frames” and “schema” (cf. Goffman 1974, 1981; Tannen 1979) – that interactants bring with them and use as tools to comprehend the ongoing interpreted event. She thus showed that most communication problems originated from the primary participants’ misunderstanding about the role of the interpreter. At the same time, the study confirmed Wadensjö’s conclusions (1992, 1998) that interpreters did have the power to affect discourse, through their double role as participants in and coordinators of the interaction. Moreover, the additional finding that some interpreting strategies might lead to a less marked impact pointed towards a new research perspective on the “paradox of neutrality” (Metzger 1999: 204): should interpreters strive to obtain “full participation rights” during interpreted encounters, or, otherwise, should they limit their influence as much as possible and whenever feasible? In other words, how should their intrinsic power be used?

Angelelli (2004a) carried out an ethnographic study in a large Californian hospital that employed a team of Spanish-English medical interpreters who had all been trained on the job. Looking at the social aspects of the profession through a combined set of “lenses” provided by social psychology, sociological theory, and linguistic anthropology (2004a: 26ff), the author collected a remarkably large and diverse corpus of data over a two-year period: the audio-recordings of 392 interpreter-mediated encounters between healthcare practitioners and patients (381 over the speakerphone and the others in face-to-face interviews) were complemented by field notes, interviews with the interpreters and their Service Manager, survey data, as well as by what Angelelli called “artifacts” from the site (2004a: 59), i.e. information material on the
hospital interpreting services, or even the handwritten messages the interpreters sent to each other. Discourse data were coded and analysed based on a set of categories to describe the level of interpreters’ visibility – defined as a continuum ranging from high visibility (e.g. production of autonomous utterances) to low visibility (such as the control over the flow of information) – and in relation to the generated outcome. Angelelli’s findings (2004a: 129ff) confirmed that interpreters – who ultimately described themselves using suggestive metaphors such as “detectives”, “multi-purpose bridges”, or “miners” – were visible co-participants in the mediated interaction, exercising their agency when triggered “by the interplay of social factors”.

Notably, interpreters’ deeds are not prompted by social aspects alone: a key role can also be played by external dictates, established for instance by the healthcare institutions. A similar occurrence was explored from a sociolinguistic perspective by Davidson (1998) and Bolden (2000). Davidson’s ethnographic PhD study was based on the comparison of monolingual and interpreter-mediated interviews – ten English-English and ten Spanish-English – audio-recorded in the outpatient department of a Californian hospital, as well as on post-interview questionnaires to interpreters, physicians and patients. By focusing on turn-taking patterns (see §1.2.3), he showed that the in-house interpreters involved (hospital employees and therefore labelled as ‘professionals’ although untrained) were often found to edit and omit patients’ contributions, or even ask their own follow-up questions. In doing so, interpreters were largely influenced by yet another paradox, i.e. the “paradox of the competing demands” (1998: 236) they had to satisfy: on the one hand be accurate, on the other act as institutional helpers (Pöchhacker 2004: 152), being fast, efficient, and keeping the patient on track, owing to clinicians’ limited time. Comparable conclusions were drawn by Bolden (2000) in her analysis of two audio-recorded interviews between English-speaking physicians and Russian-speaking patients, mediated by an in-house interpreter. Bolden showed that interpreters, far from being mere voice boxes, adapted their roles to the ongoing activity based on their understanding of the communicative goal to be achieved. With specific reference to history-taking, in the two interviews the interpreter involved was seen to behave as a “pre-diagnostic agent” (Pöchhacker 2004: 152), i.e. mainly oriented towards gaining medically relevant information from patients and leaving out their subjective accounts in the translation for the physicians, in order to
expedite the consultations. However, the author argued that this preferential use of the “voice of medicine” to the detriment of the “voice of the lifeworld” (cf. Mishler 1984) might affect the quality of the medical care received, not only in terms of humanity, but also because essential information could inadvertently be omitted due to interpreters’ lack of medical expertise.

It should be mentioned that, next to discourse-based investigation, survey research has also been used as a methodological approach to the role issue in the last few years. Quantitative analyses were carried out through questionnaires aimed at eliciting interpreters’ self-perceptions, as in Pöchhacker (2000) or Angelelli (2004b), while studies of a qualitative nature were mainly based on interviews, either to interpreters (cf. Dysart-Gale 2005; Hsieh 2006), to their clients (cf. Leanza 2007), or to both (cf. Allaoui 2005).

This succinct overview has shown the significant progress made since the earliest contributions in the field: despite the initial hostility, there is now almost unanimous agreement that interpreters are not invisible conduits, but active participants in the interaction, with a substantial power to influence its progression through their words and acts. What remains to be explored is how interpreters perform this role, or, in other words, how they select the suitable level of participation on a case-by-case basis.

1.2.3 Management of the interactive discourse

Valuable insights into the dynamics of interpreter-mediated communication in healthcare have been provided within the DI paradigm of interpreting studies. Also in this regard, Cecilia Wadensjö’s input has been crucial. Her analysis was largely based upon the notion of “participation framework”, first developed by the Canadian sociologist Erving Goffman (1981) to indicate that all individuals have a specific status or level of involvement in communicative interaction.\footnote{More precisely, Goffman explained that “when a word is spoken, all those who happen to be in perceptual range of the event will have some sort of participation status relative to it” (1981: 3).} With reference to hearers, Goffman had drawn a distinction between “unratified recipients” (“overhearers” and “eavesdroppers”) and “ratified recipients” (“addressed”, “unaddressed”, and “bystanders”). As for the speakers’ stance, or “production format”, he had identified three main categories to specify an increasing ownership of the words uttered: the “animator” is the “talking machine” who produces the speech sounds; the “author”
formulates the utterance; finally, the “principal” bears responsibility for the viewpoint or position expressed – though a single speaker may well embody all three roles at the same time (1981: 124ff). Moving from the assumption that interpreting is just another ‘form of talk’ – to draw on the title of Goffman’s opus – Wadensjö (1992, 1998) applied this model to interpreters, in their simultaneous capacity as hearers and speakers in face-to-face encounters. For these purposes, she matched Goffman’s production format with a corresponding classification of recipientship, namely the “reception format”, which consisted of three modes: “reporter” (expected to repeat the words heard without assuming any responsibility for them); “recapitulator” (listening in order to give an account, through an authorized voice, of what was said); and “responder” (listening with the purpose of speaking as a primary participant; 1998: 91-92). Significantly, Wadensjö emphasized that the interpreter’s listening activity is not passive: moving from the role of listener to that of speaker, the subsequent linguistic production is informed by the previous reception, based on the correlations in Table 1.1. It should be understood that interlocutors’ participation status in interaction is subject to constant negotiation and redefinition: hence Wadensjö also adopted Goffman’s notion of footing, that is to say “a person’s alignment (as speaker and hearer) to a particular utterance” (Wadensjö 1998: 87), which allowed for an utterance-to-utterance analysis of interpreters’ changes in terms of production and reception.

Ever since Wadensjö’s innovative work, healthcare interpreters’ footing has become a priority object of analysis in the field. Some researchers have elaborated on

<table>
<thead>
<tr>
<th>Reception format</th>
<th>Production format</th>
<th>Animator</th>
<th>Author</th>
<th>Principal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reporter</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recapitulator</td>
<td>✓</td>
<td></td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Responder</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

Table 1.1 Interpreter’s participation framework (cf. Wadensjö 1998: 92-93)

8 In Goffman’s (1981: 128) words: “A change in footing implies a change in the alignment we take up to ourselves and the others present as expressed in the way we manage the production or reception of an utterance. […] Participants over the course of their speaking constantly change their footing, these changes being a persistent feature of natural talk.”

9 For the sake of simplicity, the mode of ‘reporter’ has been matched with the production format of ‘animator’ alone, although Wadensjö specified that interpreters necessarily produce linguistically different versions of the original utterances (1998: 93), thus constantly acting also as ‘authors’.
her model, such as Merlino and Favaron (2007) in the aforementioned study on interpreter-mediated speech pathology sessions. Viewing the “voice of interpreting” as oscillating between the professional’s “voice of medicine” and the patient’s “voice of the lifeworld” (cf. Mishler 1984), the authors focused on a selection of linguistic features, including footing. More precisely, they developed a pattern based on the primary participants’ mutual alignment, their alignment to the interpreter, and the interpreter’s attitude as subsequent speaker. The seven resulting categories of interpreter’s footing are exemplified in Table 1.2, in which the utterances of an English-speaking clinician as primary interlocutor are translated into Italian. To start with, when the speaker addresses the other participant, the interpreter can choose among three options: the “reporter” (use of the first person); the “pseudo-co-principal” (use of the first person plural, to signal commonality of purposes); and the “narrator” (use of the third person). If, on the other hand, the primary speaker addresses the interpreter, explicitly asking to translate for the other party, the interpreter’s choice is between the two categories of “direct” and “indirect recapitulator”, i.e. between, once again, the first person and the third person. Finally, while the footing of “responder” sees the

<table>
<thead>
<tr>
<th>Primary Speaker</th>
<th>Interpreter</th>
<th>FOOTING</th>
</tr>
</thead>
</table>
| Now I’ll ask you some questions | Ora ti farò delle domande  
*Now I will ask you some questions* | REPORTER |
| | Ora ti faremo delle domande  
*Now we will ask you some questions* | PSEUDO-CO-PRINCIPAL |
| | (Dice che) ora ti farà delle domande  
*(She says) she will ask you some questions* | NARRATOR |
| (Tell her)  
I’ll ask her some questions now | Ora ti farò delle domande  
*Now I will ask you some questions* | DIRECT RECAPITULATOR |
| | (Dice che) ora ti farà delle domande  
*(She says) she will ask you some questions* | INDIRECT RECAPITULATOR |
| Will you go with the patient? | Yes, I will | RESPONDER |
| Initiator | Will you move over there, please? | PRINCIPAL |

Table 1.2 Categories of footing (cf. Merlino and Favaron 2007: 117)
interpreter relating as interlocutor to a primary speaker’s utterance, the category of “principal” indicates the interpreter as autonomous producer. The analysis of the three recordings showed that the interpreters’ marked involvement in the interactions contributed to reinforce the voice of the lifeworld: under specific circumstances, this was also achieved through the adoption of the footings of principal, responder and, occasionally, pseudo-co-principal.

The same volume in which this paper was published – entirely devoted to discourse and interaction in medical settings (Pöchhacker and Shlesinger 2007) – featured another two contributions on interpreters’ footing, with specific regard to the choice between direct or indirect speech. Dubslaff and Martinsen (2007) carried out a quantitative analysis of pronoun shifts in four simulated medical interviews, based on the same script and mediated by untrained Arabic interpreters who worked for a Danish agency. The rationale behind their study was the traditional equation of the use of the first person with qualified interpreting, as opposed to the frequent employment of the third person by non-professionals. The four interpreters adopted different styles of address: two preferred the direct one, while the others used the indirect style more frequently. Some general remarks could nevertheless be made: firstly, all interpreters tended to personalize the indefinite pronoun ‘one’ when translating into the patient’s language, probably to express solidarity or identify with the client; secondly, the other pronoun shifts were found either to convey distance, or to act as compensating strategies, especially when the interpreters’ lack of medical knowledge brought about interactional problems; as a result, indirect speech was often found to ensure seamless communication and resolve ambiguities. The other research study was conducted by Hanneke Bot (2007), a psychotherapist specialized in treating asylum seekers and refugees, thus working with interpreters on a regular basis. To examine reported speech, she videotaped two consecutive psychotherapy sessions of three different groups, each consisting of a Dutch therapist, a patient speaking Dari and Persian, and an interpreter recruited by a government-funded interpreting agency on completion of a specific exam. In Bot’s analysis, the three interpreters displayed diverse strategies for indicating detachment from their translations, which mainly hinged upon turn length or structure, complexity, and assumptions about the recipient’s understanding. More specifically, she
could identify four types of changes in the perspective of person, summarized in Table 1.3: what is particularly noteworthy about her taxonomy is the category of “direct representation”, in which the interpreter maintains the primary speaker’s first person pronoun, yet prefaces the rendition with a reporting verb (e.g. “he says”). Bot concluded that interpreters’ perspective shifts should not be viewed as shortcomings, but rather as natural occurrences stemming from the very nature of dialogue interpreting as three-party talk.10

Moving to a higher discourse level, healthcare interpreters’ active involvement in the encounter has also been explored with reference to the distribution of talking turns between the participants. While Merlini and Favaron (2007) compared smooth transitions from one turn to another, pauses (i.e. inter-turn discontinuities), and overlaps (cf. Sacks et al. 1974; Roy 1996), Englund Dimitrova (1997) gave prominence to the management of communicative feedback. She examined the transcripts of two videotaped encounters between Spanish-speaking patients and Swedish-speaking physicians, mediated by a trained and experienced healthcare interpreter. With reference to back-channelling, feedback was essentially provided between the interpreter and the respective parties, and it was largely of a nonverbal nature. Yet the function of “deputy listener” performed by the interpreter required caution: Englund Dimitrova suggests that it should be limited to signalling understanding, without conveying any communicative agreement. The analysis also highlighted the pivotal yet delicate role of the interpreter in structuring the flow of discourse, given her responsibility for allocating – within ethical constraints – not only her own, but also the interlocutors’ speaking space.

10 A more extensive investigation into the communication processes in interpreter-mediated psychotherapeutic dialogue can be found in Bot (2005).
Also Davidson (1998, 2002) examined turns-at-talk in interpreted medical interviews. He moved from the assumption that accurate interpreting is necessarily a function of proper understanding: therefore, he designed a “collaborative model” of all possible turn types which included also “stretches of same-language discourse” (2002: 1285), i.e. those turns in which interpreters may question previous statements before providing the target-language rendition – for instance, in the event of misunderstanding or mishearing. According to the author, these turns, though frequently overlooked in the literature, would play a key role in the construction of linguistic common ground and in meaning negotiation between interpreter and interprète. In addition, Davidson’s study shed light on the patterns of information transmission from one party to the other: while translating for physicians in a straightforward and reverent manner, the interpreters were also seen working extensively with the patients to shape their statements into more focussed contributions to the discourse (see also §1.2.2).
2. Interpreting at ISMETT

This study investigates interpreting activities in an unusual scenario, namely a bilingual specialty hospital in Southern Italy that employs a team of English-Italian in-house interpreters. The establishment and development of this facility will be briefly outlined here, with specific reference to its peculiar linguistic status and the ensuing creation of a Language Services Department. Finally, a closer look at interpreting domains and dimensions will set the stage for the subsequent analysis.

Drawing on Pöchhacker’s (2004: 84ff) multi-level model of interpreting according to seven different conceptual focal points (i.e. anthropological, socio-professional, institutional, interactional, textual, cognitive, and neural), the following account can be viewed as an attempt to model interpreting at the level of the institutional setting in which it occurs. Interpreting researchers have rarely been concerned with institutional models, as preference has been given, in particular, to representations foregrounding the interactional and cognitive dimensions. An exception to this trend is Agger-Gupta’s (2001) study in the field of HCI, which identified various models to describe the provision of interpreting services in fourteen healthcare institutions across Canada and the US, from early stages to fully-fledged status. With reference to international organizations, Marzocchi (1998) turned his attention to the European Parliament; he described how interpreters engage in a wide range of settings, from meetings of political groups and permanent committees to plenary assemblies, “with contrasting statutory goals and patterns of communication, in terms of the degree of planning, openness of confrontation and formality of address” (1998: 71). Marzocchi argued that these institutional setups necessarily shape interpreting performance, suggesting that an institution-specific approach could effectively be adopted in more extended analyses of the European Union as well as of other settings. He placed emphasis, among other things, on the different “constraints” that institutional features pose on interpreting: similarly, the identification of a number of constraints placed on the interpreters involved in the present study plays a key role in modelling interpreting at ISMETT.
2.1 The institutional context

ISMETT or *Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione*, i.e. Mediterranean Institute for Transplantation and Advanced Specialized Therapies, is a transplant centre located in Palermo, the capital city of Sicily, Italy. A historical account is useful for understanding its clinical significance, as well as the relevance to a study on interpreting. Before ISMETT was created in 1997, no transplantation programmes existed in Italy south of Rome: therefore, the numerous Sicilian patients in need of a transplant – especially for liver failure – were usually referred to centres in continental Italy or abroad. As mentioned in a recent media report, “the local joke that the best transplant service in Sicily was Italy’s national airline was too close to the truth to be funny” (Fraser 2008: 41). Moreover, what became known as the ‘journeys of hope’ occurred at considerable expense to the Region of Sicily, which was the chief provider of health care. This dramatic situation aroused the interest of UPMC (University of Pittsburgh Medical Center), a large non-profit health system based in western Pennsylvania, USA, and one of the most renowned academic medical centres worldwide. At that time, UPMC’s administration was exploring the possibility of an overseas venture with the purpose of exporting the successful experience of its Thomas Starzl Transplantation Institute, named after its founder, i.e. the surgeon who had performed the first liver transplant in the world.\(^{11}\) UPMC’s proposition that public money could be saved if Sicily had its own transplantation programme was eventually embraced by the Italian representatives: ISMETT was thus established as a public-private partnership between UPMC and the Region of Sicily through two of its public healthcare facilities (the Cervello and Civico Hospitals in Palermo).\(^{12}\) As for the respective responsibilities, the original agreements assigned the Region of Sicily the financing role, whereas UPMC was put in charge of ISMETT’s clinical and

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\(^{11}\) An additional reason behind the intention of UPMC officials was that in 1995 the United Network for Organ Sharing (UNOS), the body in charge of coordinating the US organ transplantation system, had limited cadaveric donor transplants on foreign patients to 5% of all procedures performed in American centres, given that a high number of US citizens (approximately 50,000) were on the waiting lists (Woods 2005; Petechuk 2006: 95).

\(^{12}\) More precisely, ISMETT was one of the first ‘Management Experimentation’ projects sponsored by the Italian Ministry of Health: by virtue of a 1992 law (Art. 9 bis of Legislative Decree No. 502/92), Italian hospitals were encouraged to implement new methods of healthcare management, also through partnerships between the State and private entities. If successful, these experiments would eventually be institutionalized into the National Health System (ISMETT 2002: 12).
Interpreting at ISMETT

administrative management.\textsuperscript{13} this also entailed transferring its healthcare delivery model and scientific know-how, as well as providing staff training (ISMETT 2000; ISMETT 2002; UPMC Anesthesiology 2002; UPMC 2008). From a restricted group of enthusiastic experts, ISMETT has gradually turned into a state-of-the-art hospital and a primary source of employment in the area, especially for young people: in 2007, more than half of its 654 staff members were younger than 35 (UPMC 2008: 9; 42).

The Institute’s development consisted of two main stages: while the clinical activity was launched in 1999 in the temporary premises made available by Civico Hospital, the permanent location was only inaugurated in early 2004. The new venue is a five-floor building, featuring seventy beds (divided between inpatient, intensive care, step-down, and post-anaesthesia care unit), four operating rooms, the outpatient clinic, a medical simulation centre, as well as endoscopy, dialysis, radiology, laboratory, pathology, and telemedicine services, to mention but a few (UPMC 2008; ISMETT 2010).

ISMETT provides assistance to both adult and paediatric patients\textsuperscript{14} affected with (usually) severe diseases that have brought about end-stage failure of vital organs (UPMC 2008: 21). Nowadays, clinical activities range from liver, kidney, heart, lung, and pancreas transplantation to highly specialized procedures, but the long-term goal is becoming a multi-organ transplant centre that could be a guiding light not only in Italy, but also for other Mediterranean and Middle-Eastern countries. Indeed, since 2004 foreign patients principally coming from Mediterranean rim countries have been treated at ISMETT within the scope of its International Patient Services Programme: a specific hospital unit manages the whole therapeutic path, from the first inquiry until the return home, ensuring – among other things – a 24/7 interpreting service in the patient’s native language and the translation of all relevant documentation (UPMC 2008: 74-75).\textsuperscript{15}

In addition, ISMETT is strongly committed to the development of new strategies to fill the huge gap between the chronic paucity of organs and the high number of patients on the waiting lists. While living donor liver transplantation has been an answer

\textsuperscript{13} In order to manage ISMETT, UPMC created a specific division, UPMC Italy, whose administrative premises are also located in Palermo (ISMETT 2010).

\textsuperscript{14} It should be underlined that patients who are referred to ISMETT are treated within Italy’s National Health System.

\textsuperscript{15} Throughout the years, freelance interpreters have been provided, for instance, for Albanian, Arabic, Chinese, French, Greek, and Spanish.
to this concern (next to the more common living donor kidney transplants), the latest challenge consists in advancing the frontiers of clinical and biomedical research. In particular, pioneering studies in the field of regenerative medicine and cell therapy are currently conducted in the laboratories of the ISMETT cell factory, inaugurated in 2007 with the purpose of processing human cells to repair damaged organs (Di Bartolo 2008; UPMC 2008: 60-62; Terapie Cellulari 2010). Close ties also exist between the Institute and Ri.MED, a Foundation resulting from a more recent partnership between Italian bodies and UPMC to undertake biotech and biomedical research projects.\textsuperscript{16}

Generally speaking, a transplantation centre is rather different from any other hospital. Patients are extremely sick, and often in acute emotional distress; given their critical conditions, physicians and all clinical staff are constantly under pressure; moreover, as soon as an organ becomes available – an event which is clearly unpredictable – and the transplant call tree is triggered, an immense machinery is swiftly set in motion to coordinate the entire process, from the alert and organ harvesting phases, to the surgical procedure proper. In this framework, a crucial role is played by the multidisciplinary team, which includes not only healthcare practitioners, but also staff members from diverse areas, such as laboratory technicians, administrative personnel, or those ensuring transport for the donor team: each component is essential to the entire mechanism.

When it comes to ISMETT, all these features combine with its peculiar nature at the crossroads between the American and Sicilian cultures to create a unique environment. The partnership with UPMC has undoubtedly affected the provision of care and the management philosophy, but it has also shaped everyday interactions among ISMETT staff members, as well as between ISMETT and third parties. With reference to communication, one of the most conspicuous aspects is that two languages, namely English and Italian, are concurrently used in the same working environment.

\textsuperscript{16} The Ri.MED (Ricerca Mediterranea, i.e. Mediterranean Research) Foundation was established in 2006 by the Presidency of the Italian Council of Ministers, fully funded by the Italian Government. In addition to UPMC, the other member partners are the Region of Sicily, the Italian National Research Council (Consiglio Nazionale delle Ricerche – CNR), and the University of Pittsburgh. The first goal of Ri.MED is the creation of a Biomedical Research and Biotechnology Center (BRBC), to be built near Palermo and deemed to attract numerous Italian as well as foreign scientists (Ri.MED 2010).
2.2 An unusual language contact situation

The linguistic status of ISMETT largely depends on the role of the American and Italian partners. On the one hand, the commitment of UPMC to training and expertise transfer has entailed a considerable presence of US representatives and personnel since the preliminary negotiations. As a consequence, right from the start English has virtually been the hospital’s official language both in verbal exchanges and in numerous written documents, such as medical records. On the other hand, Italian has also been adopted in everyday communication, given the Region of Sicily’s equally crucial function and ISMETT’s location, with a majority of Italian patients. Moreover, the impact of Italian has steadily grown in conjunction with the increasing number of Italian-speaking employees: although English proficiency has always been specified in all job descriptions, newly-hired staff inevitably display varying levels of competence in the foreign language.

Overcoming linguistic and cultural barriers between the two sides of the partnership soon emerged as a priority in this unusual language contact setting. The initial recourse to freelance translators and interpreters proved unsustainable in the long run, due to the heavy workloads and the excessive costs. The additional requirements of continuity and standardization led the management to opt for the employment of in-house professionals: hence, in 2000, a Language Services (LS) Department was set up (Mucè and Schillaci 2007).

It should be understood that language needs have changed over time: for instance, while in the first years of activity the number of Americans exceeded that of Italians, English is now the mother tongue of a minority within the hospital. Yet this ‘minority’ includes key ISMETT staff, such as the Chief Nursing Officer or – until late 2009 – the Director of Nursing, in charge of nursing education; furthermore, there are regular contacts with UPMC top management, ranging from conference calls to medical symposia; English is still the language of medical charts and physicians’ rounds; and, most importantly, all clinical and administrative documents, whose bulk and typologies have increased greatly, must circulate in bilingual format.

Significantly, just as the innovative professional profile of “unit interpreter” was introduced at ISMETT based on the hospital’s initial requirements (ISMETT 2002: 32;
UPMC 2008: 22), the strength of the LS has been the ability to adjust to the company’s evolution (Mucè and Schillaci 2007). The main stages of this process will now be examined in detail.

2.3 The Language Services Department’s evolution: A mirror of the times

In an extensive presentation given by two members of the LS at the Critical Link 5 Conference in Sydney (Mucè and Schillaci 2007), three main stages were identified in the history of the Department: the “creation”, the “consolidation”, and the “evolution” proper. The authors show how the LS increased the number of components, modified the set-up of tasks, developed further technical and interpersonal skills, and acquired new working tools to meet the shifts in corporate needs, expectations, and users. Interestingly, each phase did not replace the preceding one, but rather enriched it, as a result of the additional duties and areas of competence. Table 2.1 sums up the key features characterizing each phase, whereas Table 2.2 presents demographic data on the interpreters employed at ISMETT since 1999. For the sake of simplicity, interpreters have been given fictitious names beginning with consecutive letters of the alphabet. The guidelines provided by the LS Department to its customers are included in Appendix One (see also Putignano 2002; Díez 2003; Tomassini 2005).

During the first phase of development, from 2000 to mid-2003, the creation of the Department coincided with the establishment of the hospital itself. In that period, the LS included the (then) Department Head and a senior interpreter, both with extensive experience in the field, as well as five junior interpreters, with diversified personal and educational backgrounds: two were Italian native speakers with university education in Translation and Interpreting respectively, while three were bilinguals with degrees in Architecture, Marketing and Communication, and Modern Languages. Indeed, no specific expertise had been required during the selection process, while preference had been given to interpersonal skills – such as flexibility and problem-solving – and proficiency in both languages. At this stage, processes and methods had to be designed from scratch, alongside the gradual development of internal glossaries covering all disciplines involved in the implementation of a transplant centre. Written translations

17 Although the LS Department was established in 2000, some of its prospective members started to work in 1999 either as freelancers or under fixed-term contracts. For further information, see §4.2.
<table>
<thead>
<tr>
<th>Phase 1: Creation</th>
<th>Phase 2: Consolidation</th>
<th>Phase 3: Evolution</th>
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<tbody>
<tr>
<td><strong>Time</strong></td>
<td></td>
<td>From mid-2003 to mid-2006</td>
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<tr>
<td>From 2000 to mid-2003</td>
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<td>From mid-2006</td>
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<tr>
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<tr>
<td>1 Department Head</td>
<td>1 Department Head</td>
<td>1 Coordinator</td>
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<tr>
<td>5 junior interpreters</td>
<td>1 Coordinator</td>
<td>5 interpreters*</td>
</tr>
<tr>
<td>1 senior interpreter</td>
<td>7 interpreters</td>
<td>1 English language instructor**</td>
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<tr>
<td></td>
<td></td>
<td>1 International Patient Services Coordinator***</td>
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<tr>
<td><strong>Requirements</strong></td>
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<td>Education and/or experience in T&amp;I</td>
<td>Degree in T&amp;I</td>
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<td>Interpreting</td>
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<td>Support services</td>
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<td>Italian tutorials (organization &amp; teaching)</td>
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<td>Italian tutorials (organization &amp; teaching)</td>
<td>English tutorials (organization &amp; teaching)</td>
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<td>English proficiency test</td>
<td>English proficiency test</td>
<td>English proficiency test</td>
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<td>HCI seminar (organization &amp; teaching)</td>
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<td>HCI seminar (organization &amp; teaching)</td>
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<td>Italian/US clinical and administrative staff</td>
<td>Italian/US clinical and administrative staff</td>
<td>Italian/US clinical and administrative staff</td>
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<td>Italian patients</td>
<td>Italian/international patients</td>
<td>Italian/US clinical and administrative staff</td>
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<td>ISMETT BoD</td>
<td>French-speaking patients</td>
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<tr>
<td>Italian/US third parties</td>
<td>ISMETT BoD</td>
<td>ISMETT BoD</td>
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<td></td>
<td>RI.MED BoD</td>
<td>RI.MED BoD</td>
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<tr>
<td></td>
<td>Italian/US third parties</td>
<td>Italian/US third parties</td>
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<td><strong>Tools</strong></td>
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<td>CAT tool (SDLX)</td>
<td>CAT tool (SDLX)</td>
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<td><strong>Research</strong></td>
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<td>Alcalá Conference (April 2005)</td>
<td>CLS Conference (April 2007)</td>
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<tr>
<td>IATIS Conference (July 2006)</td>
<td>IMIA Conference (October 2007)</td>
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<td>TILS Conference (February 2008)</td>
<td>TILS Conference (February 2008)</td>
<td></td>
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<tr>
<td><strong>Continuing Education</strong></td>
<td>Dialogue interpreting</td>
<td>Simultaneous interpreting</td>
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<td></td>
<td>Consecutive interpreting</td>
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</tbody>
</table>

*4 as of September 2008  **As of February 2008  ***As of February 2008, subsequently employed by the International Patient Services Department on a permanent basis

Table 2.1   Evolution of the LS Department (cf. Mucè and Schillaci 2007)
were already a major component of the Department’s duties, given the above-mentioned corporate requirement to produce documents in bilingual format. Text types ranged from e-mails to journalistic, administrative, legal, and medical-scientific texts. As for interpreting, while needs in the managerial areas were mainly met by the Department Head, the other staff members ensured 24/7 coverage of the hospital premises over morning, afternoon, and night shifts. Interpreting skills were mainly acquired thanks to shadowing, i.e. following and observing more experienced colleagues in action, and on-the-job training sessions in which guidelines were provided by the senior interpreter and the Department Head. Yet learning also occurred through “trial and error” in the field (Mucè and Schillaci 2007; cf. Toury 1995: 256), i.e. in the units and conference rooms: here the complexity of the topics was counteracted by the ‘safe environments’ – usually restricted settings, with most interactants being colleagues willing to help and collaborate.

The phase of “consolidation” (from mid-2003 to mid-2006) corresponded not only to the complete standardization of processes and workflows, but also to an increase in interpreters’ “job consciousness” and “self-awareness” (Mucè and Schillaci 2007). The transfer to the new facility led to an upsurge in hospital activities and, consequently, in translation and interpreting needs, to the extent that another three interpreters – graduated in Translation or Interpreting – were employed. The establishment of further connections between the hospital and third parties, such as Palermo’s University and Municipality, created new users for the LS. Moreover, interpreters were now involved in executive meetings, institutional events, medical conferences requiring simultaneous interpreting, as well as in the provision of on-site support to Italian clinical staff sent to Pittsburgh for educational purposes. Instructions on the use of translation and interpreting services began to be offered on a regular basis to newly-hired staff through specific workshops, which comprised simulations of interpreter-mediated encounters. Following the acknowledgement of the Department’s status within the company, significant steps were also taken in the field of training and research, such as continuing education sessions in dialogue interpreting, with the support of an external trainer; internship programmes for undergraduate and graduate students in translation and interpreting; and the participation in international conferences both as audience (in
<table>
<thead>
<tr>
<th>Interpreters</th>
<th>Mother tongue</th>
<th>University education</th>
<th>Job-related experience</th>
<th>Employment period at ISMETT LS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aldo</strong> (LS Department Head until mid-2006)</td>
<td>Italian</td>
<td>Hispanic Languages and Literatures</td>
<td>UPMC Staff Associate</td>
<td>1999-2006</td>
</tr>
<tr>
<td><strong>Barbara</strong> (senior interpreter)</td>
<td>Italian</td>
<td>Interpreting</td>
<td>Freelance interpreter and translator</td>
<td>2000-2004</td>
</tr>
<tr>
<td><strong>Christian</strong> (LS Coordinator as of mid-2005)</td>
<td>Italian/English</td>
<td>Architecture</td>
<td>Freelance architect</td>
<td>1999-</td>
</tr>
<tr>
<td><strong>Dario</strong> (International Patient Services Coordinator as of Feb 2008)</td>
<td>Italian</td>
<td>Interpreting</td>
<td>Freelance interpreter and translator</td>
<td>1999-2008</td>
</tr>
<tr>
<td><strong>Eric</strong> (English Language Instructor as of Feb 2008)</td>
<td>English/Italian</td>
<td>Modern Languages and Literatures</td>
<td>Consultant at Italian-Canadian association</td>
<td>1999-</td>
</tr>
<tr>
<td><strong>Francesca</strong></td>
<td>Italian</td>
<td>Translation</td>
<td>Tourist entertainer</td>
<td>1999-</td>
</tr>
<tr>
<td><strong>Georgia</strong></td>
<td>English/Italian</td>
<td>Marketing and Communication</td>
<td>Assistant buyer</td>
<td>2000-</td>
</tr>
<tr>
<td><strong>Henry</strong></td>
<td>English/Italian</td>
<td>Interpreting</td>
<td>Freelance interpreter and translator</td>
<td>2004-</td>
</tr>
<tr>
<td><strong>Italo</strong></td>
<td>Italian</td>
<td>Interpreting</td>
<td>Airline customer care consultant for UK/IE</td>
<td>2004-</td>
</tr>
<tr>
<td><strong>Julia</strong></td>
<td>Italian</td>
<td>Translation</td>
<td>Italian teacher</td>
<td>2004-2008</td>
</tr>
</tbody>
</table>

Table 2.2 Demographic data on ISMETT interpreters. During employment, ages ranged from the late twenties to thirties.
Interpreting at ISMETT

Alcalá de Henares, Madrid, in 2005)\(^{28}\) and as speakers (for instance, at the IATIS Conference in 2006).\(^{29}\)

In the “evolution” proper (from mid-2006) the outcomes achieved have been improved and perfected (Mucè and Schillaci 2007), while many adjustments have been made under the leadership of a new Coordinator – a staff member who had been working at ISMETT since 1999. On the one hand, night and Sunday shifts came to be cancelled due to the steady decrease in US clinical staff;\(^{30}\) on the other hand, additional needs have been met in three new areas, namely biomedical research, international patients, and language teaching. Firstly, the establishment of the Ri.MED Foundation (see §2.1) has led to a proliferation of translation and interpreting duties in this field. Secondly, the LS and the International Patient Services Department have developed active collaboration: one of the LS staff members was assigned to this unit as of February 2008, first temporarily and then on a permanent basis; another two – upon completion of a refresher course – have added French to their working languages, while in-house Arabic courses have been jointly organized, given the increased number of Arabic-speaking patients. Thirdly, the LS have been put in charge of ensuring that US and Italian personnel achieve appropriate levels of proficiency in the foreign language through teaching and assessment.\(^{31}\)

With reference to interpreting research and training, the activities launched in the previous phase have further been promoted through the above-mentioned participation in the Critical Link 5 and other international conferences, in-service sessions on simultaneous and consecutive interpreting, and, most importantly, the organization of a healthcare interpreting workshop for outsiders. This event, supported by the Sicilian division of AITI (Associazione Italiana Traduttori e Interpreti, i.e. the Italian

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\(^{28}\) The Sixth International Conference on Translation and Second International Conference on Public Service Translation and Interpreting, entitled “Translation as Mediation or how to Bridge the Linguistic and Cultural Gaps”, was organized on April 28-29, 2005, by the FITISPos Group (Grupo de Formación e Investigación en Traducción e Interpretación en los Servicios Públicos) of the University of Alcalá.

\(^{29}\) “Intervention in Translation, Interpreting and Intercultural Encounters” was the topic of the Second Conference of the International Association for Translation and Intercultural Studies, held at the University of the Western Cape, Cape Town, South Africa (July 12-14, 2006).

\(^{30}\) Night shifts, originally scheduled to support US personnel in the wards, had become like exhausting daytime shifts, almost entirely devoted to written translations.

\(^{31}\) English teaching is provided by a member of the LS Department in collaboration with an external consultant; they are also responsible for testing the proficiency gained by the personnel, in compliance with a recent company policy sponsored by the LS (see Appendix Two). As for the US staff, other members of the Department currently hold Italian classes on a regular basis.
Translators and Interpreters Association) and entirely taught by department members, also offered a chance to explore the potential to generate company profits; similar experiments are likely to be repeated in the near future with the provision of translation and interpreting services to third parties.

It should be understood that the achievements of the LS despite drawbacks and changed circumstances have a twofold explanation: a remarkable cohesion among department members and the compliance with the rule “do first, define after” (Mucè and Schillaci 2007). The latter is best exemplified by the official job description of ISMETT interpreters: from a succinct and generic outline drafted in 2000, the sweeping developments in the duties and responsibilities of the Department were eventually acknowledged by the company in 2007.

2.4 Domains and dimensions of interpreting at ISMETT

The atypical nature of interpreting activities at ISMETT arises from a combination of factors, partially suggested in the previous sections. An attempt will now be made to recapitulate them, using Pöchhacker’s diagram of interpreting domains and dimensions as a point of reference (2004: 24; see §1.1). As illustrated in Table 2.3, some adjustments have been made to his model in order to suit the context under study: firstly, for the sake of simplicity, only four of the eight dimensions are taken into account, namely communicative genre, participants, discourse, and mode; secondly, a new dimension has been devised and labelled as ‘constraints’; thirdly, the subdomains of interpreting practice identifiable along the vertical axis are inverted as compared to the original diagram, i.e. the features specified on the left-hand side – and thus foregrounded – add up to healthcare interpreting as it is traditionally conceived of, while those on the right-hand side relate primarily to conference interpreting.

To start with, interpreting occurs both in international and intra-social settings (Table 2.3, first row), although the latter are by far the most frequent spheres of interaction. Starting from the left, the first genre typology in the chart comprises interactions between patients or family members and clinical staff, which are typically associated with hospital interpreting. Yet at ISMETT these are but a limited part of the

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32 The labels “status differential”, “equal status”, “dialogue”, and “monologue” used in the chart were devised by Raffaela Merlini in an unpublished revision of Pöchhacker’s (2004: 24) diagram.
Table 2.3  Domains and dimensions of interpreting at ISMETT (adapted from Pöchhacker 2004: 24)
overall activities beside the broad range of encounters involving staff members: for instance, extemporaneous interactions to settle organizational or emergency issues; medical rounds; end-of-shift nursing reports; training courses, mainly held by US educators; clinical meetings, e.g. hospital committees or discussions of clinical cases; administrative meetings, including ISMETT and Ri.MED Boards of Directors; conference calls and videoconferences between Palermo and Pittsburgh; intra-social or inter-social job interviews, gatherings, and lectures held at ISMETT (where there are no booths); finally, international medical congresses taking place in fully equipped conference venues.

This variety of settings necessarily entails a wide array of participants: patients and their relatives (mostly Italians and, occasionally, English-speaking international patients); ISMETT and UPMC clinical staff (especially physicians, nurses, aides, physical therapists, respiratory therapists, and pharmacists); ISMETT and UPMC administrative staff (from unit clerks to department heads and top management); and Italian or US clinical and administrative third parties (e.g. physicians from other healthcare facilities, local authorities, pharmaceutical companies, or consultants, to name but a handful). The main distinction across settings is between interlocutors of equal or unequal status (second row). Notably, the latter applies not only to interactions between individuals speaking on their own behalf and representatives of the institution (e.g. physicians and patients), but also to specific intra-social encounters among staff members of different ranks. While at the two opposite ends of the spectrum the distinction is more clear-cut, cases of either equal or unequal status may occur in conjunction with the intermediate settings: hence the partial overlap between the two bands in the chart.

With reference to discourse (third row), dialogic interactions predominate over monologue, although long sequences of monologic discourse may alternate with dialogue under specific circumstances (e.g. presentations of clinical cases by a single physician or training courses).

Working modes (fourth row) are selected on a case-by-case basis depending on several factors, including setting and number of participants. Short consecutive\textsuperscript{33} and whispering (with or without portable transmission equipment) are by far those most

\textsuperscript{33} In general, consecutive interpreting with note-taking is not employed by ISMETT interpreters.
frequently adopted. Different modes may also alternate during the same event: for instance, when an English-speaking department head meets with a number of Italian-speaking employees, the same interpreter adopts whispering for the US interlocutor and whispering through microphone and headset receivers for the Italian participants. Simultaneous interpretation in the booth is limited to medical congresses organized in other venues, given the aforementioned lack of booths on the hospital premises.

The last row in the chart specifies seven overriding constraints placed on ISMETT interpreters in their daily activity (cf. Marzocchi 1998). Unlike the preceding dimensions, these constraints are not limited to a particular position along the spectrum, but they may be present all across it and in conjunction with different communicative genres. More precisely, while four of them are closely related to intra-social areas of interaction, or, in other words, to the microcosm of ISMETT (namely knowledge of participants, language proficiency of participants, trust, and professional distance), the others apply to any interpreted event (confidentiality, background knowledge, and contextual diversity). Regardless of this distinction, all the constraints can be said to hinge upon the status of in-house interpreters. For instance, ‘confidentiality’ is unanimously acknowledged as one of the basic requirements for the interpreting profession, yet ISMETT interpreters have developed an acute awareness of this responsibility: it is not only an ethical concern, but also a corporate need, since the Department guards company and patient information obtained from interpreted meetings and written translations, many of which are strictly off the record. At the same time, having a broad ‘background knowledge’ is often essential to the successful outcome of the interpreting sessions: reference material is not always provided beforehand, and the support of an interpreter may also be requested for unscheduled events.34 Then there is, once again, the ‘contextual diversity’ that permeates interpreting activities, as the LS members are required to wear many and various hats. Moving to the intra-social constraints, the knowledge of the topics at hand is matched by the ‘knowledge of the participants’ in the interaction, given that interpreters can easily relate to all staff members irrespective of roles and positions, so as to establish relationships on the basis of mutual ‘trust’. For instance, they are aware that their co-

34 While the lack of reference material and last-minute assignments were major issues for the LS in the first years of activity, ISMETT users have gradually become more sensitive to interpreting needs. Nevertheless, unexpected events can never be ruled out – especially in a hospital.
workers display varying levels of foreign ‘language proficiency’, which call for varying levels of intervention: situations requiring interpreting proper alternate with those in which the interpreter is simply asked to assist in case of misunderstanding. However, the opposite side of the coin is that this closeness may hamper the neutral stance of interpreters during mediated encounters: thus keeping a ‘professional distance’ is of the essence not only during interactions involving patients, but also to separate the role of colleague from that of interpreter.

By comparing the model of interpreting domains and dimensions at ISMETT with the typical conception of HCI previously described (see §1.1), the most noticeable feature is that the LS members cannot be labelled as ‘healthcare interpreters’ in the strictest sense. Being the prototype of multifunctional interpreters, they defy definition: they work in a hospital environment and the interpreting activity revolves around patient care, yet direct contact with the sick (as in HCI) is but the last link in the chain.

2.5 Typical interpreting scenarios in medical interactions

The following sections offer a more detailed description of interpreting at ISMETT. They take account of three medical scenarios – featured in Table 2.3 – in which the support of the LS Department has frequently been requested in the last few years. Though differing substantially in terms of communicative purposes, these three contexts of interaction share a common feature: their participants are mostly nurses.

It should be understood that nursing staff have always played a major role at ISMETT. Ever since the establishment of the hospital, one of the main goals has been to train highly specialized nurses who act autonomously, think critically, make decisions, and advocate for the patient (Stitt 2000: 34). This has primarily been accomplished through a corporate teaching and mentoring programme, which has entailed Italian nurses being sent to Pittsburgh and American nursing staff stationed in Palermo on rotations (Stitt 2000: 34; Dubois et al. 2006). As a result, nowadays nurses far outnumber any other professional group in the hospital, given that the complex clinical cases require a high patient/nurse ratio. Moreover, they have established a multi-layered hierarchy with various levels of responsibility and skills, in line with the model adopted
at UPMC. Therefore, it is not surprising that nurses have been among the most frequent users of the interpreting service.

2.5.1 Nursing assessments

The assessment is the core of the nursing process, that is the overall activities aimed at delivering the best care to every patient. Subjective data from the patient are combined with objective data collected from the physical exam through a systems-based approach, i.e. the evaluation of the psychosocial, neurological (including pain management), cardiovascular, pulmonary, gastrointestinal, genitourinary, and integumentary systems. Notably, the guiding principle is “charting by exception”, i.e. documenting only abnormal findings or changes in patient conditions based on the requirements of the different patient types (ISMETT Department of Nursing Education [n.d.]).

Nursing assessments at ISMETT can be placed among the interactions specified in the first column of Table 2.3. Given that this task is accomplished at the beginning of the shift, US nurses take advantage of it to introduce themselves and the interpreter to the patients, especially when these have just been admitted and could be puzzled by foreign staff. It is therefore a delicate step, since it has to be clarified that the language barrier will not hinder either communication or the provision of care.

As for the interpreting dimensions specified in the chart, two elements should be underscored. Firstly, with reference to the working mode, short consecutive is the rule when translating for the patient, while whispering is often adopted for the nurse. Secondly, despite the difference of status between the two participants as a result of the nurse’s professional role, at ISMETT nurses are the ‘outsiders’ (in contrast to the typical HCI scenario, in which the outsiders are the migrant patients), thus partially reversing the traditional asymmetry of ‘power’ specific of these settings (cf. Shackman 1984:18).

2.5.2 Nursing reports

The change-of-shift report is the transfer of information on patient’s conditions, nursing practices and relevant therapies that takes place between nurses to guarantee continuity of care across the shifts (Miller 1998; Lally 1999). Reports at ISMETT occur in three dedicated time frames during the day (7 a.m., 2 p.m., and 9 p.m.), when all nursing staff gather at the nurses’ stations and the noise level in the unit reaches its peak; incoming
and outgoing colleagues sit or stand next to each other and discuss the status of their assigned patients in sequence. Should the report involve an American and an Italian nurse, an interpreter may be requested to ensure communication. The main features of this interpreting setting are summarised in Table 2.3, third column.

Wolf (1989: 78) defines report as an “orderly progression of facts and words [imposing] order on the easily disordered events of patient units”, whose duration is a function of the acuity level of patients and of their length of stay in the hospital. The delivery follows a precise pattern and includes information on the patient (name, age, date of admission, diagnosis, medical history, allergies) and on the preceding assessment. The review of each system is commonly summarized in global judgments and communicated in the form of general statements. According to Lamond (2000), these global judgments or “concept labels” (such as ‘psychosocially okay’, ‘neurologically weak’, ‘vital signs stable’, etc.) are the product of the assimilation of a range of information: by communicating only the result of this process, the nurse giving report is saving the nurse receiving it from processing such information again, thus reducing time and cognitive load.

During the verbal report the nurse is guided by written tools: the patient’s medical records – on paper and in electronic format – and the hand-written notes taken during the previous report and updated throughout the shift. The relevance of these notes’ design and organization for a successful change-of-shift process is stressed by Miller (1998), to the extent that the use of a pre-prepared handover sheet is suggested. The report ends with the joint reading, signing off, and acknowledging of the new medical orders in the chart.

At first sight, nursing reports might seem cold and impersonal interactions, whose only function is sheer data transmission. However, a large number of research studies on this topic (cf. Lally 1999) have identified an array of other, less evident social functions, which can be summed up in the definition of shift report as a nursing “ritual”, a practice passed on within the nursing group’s cultural system and thus reflecting and transmitting nursing values, beliefs, and rules of conduct (Wolf 1988, 1989). It is a forum for socialization where nurses “learn the ropes” of their profession (Lally 1999): there is room for teaching, team-building and cohesion, since nurses warn about possible errors, acknowledge mistakes, and set the standards of nursing care (Wolf
1989). But it is even more than that: taking place away from the patient, nursing report is also a safe environment for “staff catharsis”, where frustrations, worries, complaints as well as emotions such as grief, anxiety or amusement are shared and released (Lally 1999). Effective communication during nursing reports is therefore of crucial importance for two main reasons: first, to accurately transfer information, thus ensuring patients’ safety; secondly, to strengthen and support the camaraderie among nurses.

2.5.3 Training sessions
The interpreting service at ISMETT is also provided in educational settings, i.e. during on-the-job training courses organized principally for the nursing staff (Table 2.3, fourth column). The Institute has a Nursing Education Department in charge of the orientation of newly-recruited employees as well as of the continuing education of senior nurses by means of both classroom and bedside training. As already mentioned, the US personnel have always played a major role in this area, through permanent and visiting instructors with specific areas of competence (e.g. respiratory therapy, skin care, paediatrics, etc.).

Although the interpreters have no prior expertise in the field of health care, throughout the years they have gained confidence with the general medical vocabulary used in the hospital; as for the specific terminology of the instructor’s subject, teaching material is provided beforehand by the nursing educators, so that interpreters can study and develop glossaries. Moreover, the same session is often repeated for several groups of trainees, usually over a few weeks, and the entire cycle concludes with summary lectures: hence, the problems experienced at the beginning are easily overcome with time.

It should be noted that the interpreting mode varies: when smaller groups of trainees are involved, whispered interpreting with microphone and headset receivers – usually the rule – is replaced by short consecutive. This mode is also preferred in lessons for newly-recruited staff: by listening to both the source and the target texts, novice nurses can gradually become acquainted with English, given that they are then required to use it in their daily work.

Interpreting in this context partially differs from the traditional notion of ‘educational interpreting’ or ‘classroom interpreting’: for many years, these expressions have been used exclusively to indicate sign language interpreting for deaf students at all
levels of education. As underscored by Pöchhacker (2004: 163), in countries – such as the US – whose legislation provides for the mainstreaming of deaf students, sign language interpreters are frequently employed in educational settings, and, as a result, research in this field has always been prolific. Among the manifold issues brought to the fore, special emphasis has been given to the need to ensure effective interpreting and provide deaf students with the same level of access to the curriculum available to hearing students (Harrington 2000; Schick *et al.* 2006). It is only recently that a completely new field of practice and research has emerged in education following the implementation of a pioneering classroom interpreting project in South Africa, a country well known for its eleven official languages in addition to a plethora of unofficial vernaculars. Since 2004 a simultaneous interpreting service involving Afrikaans, English, and Setswana has been provided in a number of faculties at North-West University and other educational delivery sites, thus striving to turn multilingualism into an asset rather than an obstacle to the establishment of a common communicative environment (North-West University 2010). Interestingly, interpreters are not only students with interpreting skills, but also post-graduate subject specialists and retired professors (Olivier 2008). Research studies on this unique setting have been focusing on a number of issues, such as service quality assessment and in-service training requirements (North-West University 2010; see also Verhoef and du Plessis 2008). Verhoef and Blaauw (2009), in particular, placed special emphasis on the ‘dichotomy’ of these spoken-language educational interpreters, given that they mainly adopt the simultaneous interpreting mode while fulfilling typically community-interpreting roles. As a result of changes in circumstances and participants’ needs, interpreters were found to display varying levels of involvement, shifting from the function of conduit to that of clarifier and, occasionally, culture broker. More importantly, interpreters themselves perceived their task “in terms of a social responsibility towards the end-users” (Verhoef and Blaauw 2009: 205). In this regard, food for thought was also provided by Olivier Wittezaele (2007) at the last Critical Link Conference: the interpreter’s presence and activity were seen by the researcher to redistribute the socio-linguistic power in the classroom, both at the macro-level (speakers of minority languages can access education) and at the micro-level (part of the
lecturer’s power is channelled to the interpreter and, consequently, to the interpreter’s audience).

Although undoubtedly emphasized by the peculiar South African social context, the unbalanced distribution of power and knowledge between trainer and trainees is generally acknowledged as an inherent feature in classroom communication (cf. Sinclair and Coulthard 1975; McHoul 1978; Orletti 2000: 91-110). Running counter to this trend, more symmetrical conversational exchanges are to be found when training occurs in the workplace, as at ISMETT. During the lesson, educator and nurses are not separated by a social distance for which the interpreter compensates; on the contrary, the atmosphere is more informal than at school or at university, as the sessions take place on an occasional – rather than regular – basis and all participants are colleagues, though of different ranks.
3. Methodology

The previous chapter has placed emphasis on the complexities of interpreting at ISMETT; more precisely, it has underscored how the variability in domains and dimensions is matched by an array of well-defined constraints closely related to the status of in-house interpreters.

The unique opportunity to delve into this multifaceted milieu opened up for me as a member of the LS: I attended a graduate internship programme at ISMETT from August to September 2003 (Phase One of the research project), and was subsequently employed – following a public selection procedure – as no-term, full-time interpreter and translator from September 2004 through August 2008 (Phase Two). Being an integral part of the staff over this extended period of time enabled me to conduct a case study of the ISMETT LS Department, i.e. an intensive contextualized analysis of this peculiar institutional setting, focusing on the individual case rather than on generalization (cf. Pöchhacker 2006: 153).

Summary information about the research methodology is presented in Table 3.1. The main overall interest lies in qualitative data and the purpose is to describe how interpreting dimensions and constraints interact to determine the product and performance of ISMETT interpreters. Significantly, attention is focused solely on interpreting activities in the medical area, although the service is provided in a variety of contexts, as already pointed out. Fieldwork – that is the collection of “data on people or occurrences in their real-life context” (Pöchhacker 2004: 63) – was adopted as the main research strategy, while combining an inductive ethnographic approach with a discourse-analytical one (cf. Davidson 1998; Angelelli 2004a). Thus the prevailing research paradigm is the one focusing on dialogic discourse-based interaction, or the DI paradigm of interpreting studies (Pöchhacker 2004: 79; see also §1.2.2). Preference was given to a multi-method approach to data collection, triangulating different sources and having recourse to the three different techniques subsumed by Pöchhacker (2004: 64) under the labels “watch, ask and record”: more specifically, participant observation and semi-structured interviews to the interpreters were conducted to identify their habitus (Bourdieu 1977, 1990), while documentary material was collected and analysed to compare it with the actual practice. This material includes miscellaneous documentation
on the hospital and its LS Department (e.g. information material, company policies and procedures, and LS guidelines), along with the audio-recordings of authentic interpreter-mediated encounters in the medical field. These data collection techniques were jointly used during both Phase One and Phase Two.

The following sections will thoroughly describe the methodology adopted, with a focus on the two main research approaches, namely ethnography and discourse analysis.

3.1 Ethnography

3.1.1 The double role as co-worker and researcher

By and large, conducting an ethnography of a bilingual healthcare facility means entering the study site “without a hypothesis” and “being present to observe, record, and write down what [is] seen and heard” (Angelelli 2004a: 4). In this specific case, however, the researcher is not an external observer, but an insider who directly experiences the same problems or difficulties as the other employees and can even turn into one of the informants (e.g. occasionally acting as interpreter during recorded events; cf. Rosenberg 2001). It is still debated whether healthcare interpreting researchers are able to engage in inductive studies without their personal and theoretical background informing data collection and analysis (Pöchhacker 2006: 154); hence the possibility of maintaining an objective stance should be all the more contentious in the present study, calling for a discussion about the implications of this peculiar situation.
With reference to data collection, a valuable insight is provided by Labov (1972). While discussing the methodology for gathering linguistic data, he highlighted the paradoxical need to “observe how people speak when they are not being observed” (1972: 113): in other words, the mere presence of the researcher would distort the authenticity of the phenomenon under study. Yet this “observer’s paradox” does not fully apply to the ISMETT case study, given that the status of staff member turned the researcher into a less invasive observer of the LS Department and, particularly, of interpreter-mediated interactions. To start with, the crucial “trust-building process” (Angelelli 2004a: 45) with the interpreters and the whole healthcare team developed naturally and smoothly: it easily began in Phase One favoured by the physical location, i.e. the old, temporary facility – a restricted environment with few employees – and it was further strengthened during Phase Two. Although this process occurred regardless of the research study, the establishment of friendly or even very close relationships undoubtedly fostered a cooperative attitude towards the researcher and the project. The fellow interpreters agreed to become an ‘object of study’, to the extent that, throughout the years, many of them have been encouraged in their turn to look at translation and interpreting duties from a research perspective (see §2.3); by the same token, they showed no hostility towards the observation and recording of interpreted encounters, understanding that these were not meant to assess interpreting accuracy or lack thereof (cf. Angelelli 2004a: 45). Also hospital employees readily lent their support; furthermore, they were never unsettled by the presence of a silent colleague watching them, given that they are used to the presence of two interpreters during the same event, not only when the service is provided in both language directions (e.g. during debates), but also when newly-hired staff shadow senior interpreters. In fact, preceptoring and mentoring are a common occurrence at ISMETT for many professionals – from physicians to nurses and physical therapists – who all undergo a period of ‘orientation’ in the ward before entering the shift system; therefore, even patients are accustomed to such pairings. As a result, the observed exchanges featured a high degree of spontaneity by all interaction participants.

Somewhat different considerations apply to the interviews with the LS members, given that the close bonds between interviewer and interviewees had twofold implications. On the one hand, while in some fields it is difficult to obtain cooperation
from potential respondents (Robson 1993: 230), this was not the case with the colleagues at ISMETT. The relaxed and uninhibiting atmosphere undoubtedly led the interpreters to open up about their real attitudes, unlike what they would probably have done with an outsider. On the other hand, however, it was difficult for the researcher to maintain neutrality, without being influenced by prior knowledge of the informants and the Department. For this reason, the interviews were allowed to develop – to some extent – as “informant interviews” (Powney and Watts 1987), that is, the interviewer remained in control of the key topics, yet prominence was also given to “the interviewee’s perceptions within a particular situation or context” (Robson 1993: 231).

Moving to the analysis of the data, this proved far more problematic due to the necessarily subjective perception of relevance. However, this inevitable shortcoming was somewhat mitigated by two main advantages. Firstly, the constant sharing of ideas and readings with the other department members facilitated a more unbiased scrutiny: indeed, joint discussions about daily interpreting practice are a common habit of the LS, also for the purposes of continuing education and on-the-job training. Secondly, in many instances the researcher’s personal experience at ISMETT could be used as an additional tool to make explicit what had been left unsaid by the informants, or to grasp intentions that an outsider would probably have overlooked or misunderstood.

In short, it can be said that acting in the dual capacity as researcher and in-house interpreter facilitated discreet observation and thorough comprehension, but required a special effort of detachment. In addition to the above-mentioned triangulation of diverse sources, this overall limit was partially overcome by choosing to carry out the analysis of the data after the researcher’s resignation from ISMETT, acknowledging that “being an ethnographer means leaving the study site and responsibly telling its story” (Angelelli 2004a: 4).

3.1.2 Interviews with the interpreters

In order to identify attitudes and beliefs of the LS members towards medical interpreting – or, in other words, their habitus – one-to-one interviews were carried out. These were informally arranged based on the working shifts of the interpreters and taking advantage of the infrequent moments of quiet. The interviews, which were digitally recorded and subsequently transcribed verbatim, lasted approximately thirty
Methodology

As for the methodology, the interview schedule was developed following Robson (1993: 227ff). His approach particularly suited the nature of the study, given that the author explicitly stated his intention to address small-scale enquiries, carried out by a single person, and possibly regarding a situation in which the researcher is already an actor (1993: 228). With reference to the degree of structure, the interviews to the interpreters can be classified as “semi-structured”, i.e. “the interviewer has clearly defined purposes, but seeks to achieve them through some flexibility in wording and in the order of presentation of questions” (Robson 1993: 227). Open-ended questions were generally preferred, since they are more flexible and can produce unexpected outcomes (Cohen and Manion 1989: 313).

The questions followed a conventional sequence consisting of five main sections (Robson 1993: 234). In the “introduction”, the goal of the interview was explained, while reassuring the respondent about the confidentiality of what was going to be recorded and transcribed. The first, general questions were asked during the “warm-up” so as to set both interviewer and interviewee at ease: they concerned the personal and educational background of the interpreter, details about previous professional assignments in the medical field, and the beginning of the working experience in the LS Department. The “main body” of the interview addressed five basic themes, with a focus on medical interpreting at ISMETT: the nature of the interpreting training, especially if occurring on the job, should the respondent have no university education in the field; the first impression of the hospital environment; challenges of interpreting at ISMETT, prompting comments on language, technical, emotional, and interpersonal issues; the influence of the variability in settings and users; finally, cultural issues with and between US and Italian staff. The “cool-off” shifted attention toward a distinct topic, taking into account the notion of ‘interpreting style’. This concept is occasionally mentioned in the literature on simultaneous interpreting, for instance by psycholinguist Frieda Goldman-Eisler ([1972]/2002: 73) and by Eva Paneth ([1957]/2002: 36), who identified varieties in the performing style of different interpreters (cf. also Yagi 2000). The interviewees were asked to explain what, in their opinion, made the style of an
interpreter and to describe their own. In the “closure” any additional remarks were explicitly requested, to avoid the “hand on the door phenomenon” suggested by Robson (1993: 235). The schedule followed during the interviewing process and the full transcribed interviews are included in Appendix Three.

3.2 Discourse-based analysis

3.2.1 The corpus of interpreter-mediated encounters

The development of a corpus of recorded and transcribed interpreter-mediated encounters occurred over two main phases, corresponding to the different status of the researcher first as intern and subsequently as employee.

It should be underscored that recording and transcription activities were a result of a joint effort of the LS: indeed, the material gathered has become property of the Department and, to date, it has partially been used for ISMETT research and training projects, some of which in collaboration with Professor Raffaela Merlini from the University of Macerata. In addition, a crucial role in the creation of the corpus was played by three other LS interns from the University of Trieste (Eleonora Iacono, Simona Orefice, and Cristina Scardulla). The data collected\(^{49}\) and the respective roles of all research partners are briefly described in Table 3.2.\(^{50}\)

During the first phase of the study, the researcher submitted a project to the Department Head – and, through him, to ISMETT representatives – asking for permission to record interpreted interactions. Unfortunately, official approval was only granted towards the end of the internship period, so that only few recordings could be made. Nevertheless, these feature the only nursing assessment of the corpus, that is, the only interaction involving a patient.

Although Phase Two spanned almost four years, a number of issues of either an ethical or a logistical nature limited the expansion of the corpus. First and foremost, it

\(^{49}\) Additional encounters were recorded, namely eight nursing reports (for a total of approximately 80 minutes), eight in-service training sessions (ca. 360 minutes), and two lectures (ca. 120 minutes); however, they were not taken into account in the present study.

\(^{50}\) More precisely, some of the recorded and transcribed interactions of the corpus were discussed in: Scardulla (2005-2006), using conversation analysis tools; Iacono (2005-2006), placing emphasis on politeness strategies; Orefice (2005-2006), from the point of view of footing; Romeres and Favaron (2006) and Di Fresco (2007a, 2007b), focusing on nursing reports; Favaron (2009), on repair activities; Merlini and Favaron (2009), on norm behaviour.
<table>
<thead>
<tr>
<th>Transcript</th>
<th>Place</th>
<th>Date</th>
<th>Time</th>
<th>Duration</th>
<th>Interpreter</th>
<th>Prevailing interpreting mode</th>
<th>Recorded by</th>
<th>Transcribed by</th>
<th>Previous research</th>
</tr>
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<td>Floor*</td>
<td>18/09/2003</td>
<td>9 a.m.</td>
<td>00:13:20</td>
<td>Barbara</td>
<td>Short consecutive</td>
<td>R</td>
<td>R, CS</td>
<td>CS, LS</td>
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<td>Floor</td>
<td>22/01/2006</td>
<td>2 p.m.</td>
<td>00:18:34</td>
<td>Dario</td>
<td>Short consecutive/whispering</td>
<td>R, EI</td>
<td>R, EI</td>
<td>EI, LS, R + RM</td>
</tr>
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<td>22/01/2006</td>
<td>2:30 p.m.</td>
<td>00:04:05</td>
<td>Dario</td>
<td>Short consecutive</td>
<td>R, EI</td>
<td>R</td>
<td>-</td>
</tr>
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<td>Floor</td>
<td>24/01/2006</td>
<td>7 a.m.</td>
<td>00:03:21</td>
<td>Georgia</td>
<td>Short consecutive</td>
<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS</td>
</tr>
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<td>Floor</td>
<td>24/01/2006</td>
<td>7 a.m.</td>
<td>00:06:38</td>
<td>Georgia</td>
<td>Short consecutive</td>
<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS</td>
</tr>
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<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS</td>
</tr>
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<td>25/01/2006</td>
<td>2 p.m.</td>
<td>00:07:26</td>
<td>Italo</td>
<td>Whispering</td>
<td>R, EI</td>
<td>R</td>
<td>-</td>
</tr>
<tr>
<td>NR.FL.07</td>
<td>Floor</td>
<td>30/01/2006</td>
<td>2 p.m.</td>
<td>00:08:32</td>
<td>Julia</td>
<td>Short consecutive</td>
<td>R, EI</td>
<td>R, EI</td>
<td>EI, LS</td>
</tr>
<tr>
<td>NR.FL.08</td>
<td>Floor</td>
<td>07/03/2006</td>
<td>2 p.m.</td>
<td>00:09:55</td>
<td>Henry</td>
<td>Short consecutive</td>
<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS, R + RM</td>
</tr>
<tr>
<td>NR.FL.09</td>
<td>Floor</td>
<td>11/03/2006</td>
<td>7 a.m.</td>
<td>00:04:57</td>
<td>Italo</td>
<td>Short consecutive</td>
<td>R, EI</td>
<td>R, EI</td>
<td>EI, LS</td>
</tr>
<tr>
<td>NR.SDU.01</td>
<td>SDU</td>
<td>21/01/2006</td>
<td>2 p.m.</td>
<td>00:08:26</td>
<td>Eric</td>
<td>Short consecutive</td>
<td>R, EI</td>
<td>R, EI</td>
<td>EI, LS</td>
</tr>
<tr>
<td>NR.SDU.02</td>
<td>SDU</td>
<td>23/01/2006</td>
<td>7 a.m.</td>
<td>00:08:43</td>
<td>Georgia</td>
<td>Short consecutive</td>
<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS, R + RM</td>
</tr>
<tr>
<td>NR.ICU.01</td>
<td>ICU</td>
<td>23/01/2006</td>
<td>2 p.m.</td>
<td>00:09:36</td>
<td>Francesca</td>
<td>Short consecutive</td>
<td>R, EI</td>
<td>R, EI</td>
<td>EI, LS</td>
</tr>
<tr>
<td>NR.ICU.02</td>
<td>ICU</td>
<td>16/03/2006</td>
<td>9 p.m.</td>
<td>00:07:55</td>
<td>Henry</td>
<td>Short consecutive</td>
<td>R, SO</td>
<td>R, SO</td>
<td>SO, LS</td>
</tr>
<tr>
<td>TS.01</td>
<td>Conference room*</td>
<td>27/08/2003</td>
<td>10 a.m.</td>
<td>01:03:55</td>
<td>Christian</td>
<td>Short consecutive</td>
<td>R</td>
<td>R</td>
<td>R</td>
</tr>
<tr>
<td>TS.02</td>
<td>Conference room</td>
<td>28/11/2007</td>
<td>1 p.m.</td>
<td>00:18:52</td>
<td>Italo</td>
<td>Whispering (microphone)</td>
<td>R</td>
<td>R</td>
<td>-</td>
</tr>
</tbody>
</table>

*Sessions taking place in the old facility

**Legend**

- CS Cristina Scardulla
- EI Eleonora Iacono
- LS ISMETT Language Services Department
- NA nursing assessment
- NR nursing report
- RM Raffaela Merlini
- SO Simona Orefice
- TS training session
- R researcher

Table 3.2 Summary information about the corpus
was decided not to record any (other) interaction involving patients and their relatives: given that the clinical cases treated at ISMETT are extremely serious, as already mentioned (see §2.1), recording might have added to the discomfort of patients or intruded upon the grief of their families. Secondly, also hospital meetings had to be ruled out: discussions involving numerous participants would have posed significant difficulties to transcribing, whereas smaller gatherings are generally devoted to extremely delicate and confidential matters. Thirdly, the high incidence of unscheduled events requiring the immediate support of an interpreter precluded the necessary organization preliminary to recording. Fourthly, the simultaneous interpreting service from the booth during medical conferences was occasionally taped for educational purposes, yet it was decided not to take this material into account so as to give preference to intra-social settings.

Eventually, out of the interpreting contexts that could nevertheless be explored thanks to the privileged status of insider, it was decided to focus primarily on two interaction types in the medical area: nursing reports and (nursing) training sessions.

The recording of nursing reports was initially arranged within the scope of the internship programme of two of the aforementioned students collecting material for their post-graduate theses under the co-supervision of the researcher. They submitted a research project to the Director of the Education Department and to the LS Department Head, who both authorized audio-recording after the anonymity of all interlocutors involved in the sessions was assured. Indeed, nurses were asked to sign a consent form (see Appendix Four) granting permission to use the recorded data only for scientific purposes, with staff members and patients as well as any other patient-related information (e.g. procedure dates, room numbers, etc.) replaced by fictitious names.

With reference to the training courses, a fortunate combination of mutual needs enabled the researcher to carry out the recordings, which were also stored by the nursing educators as future reference material. Hence, although all trainees were informed about the recording at the beginning of the session, no written authorization was necessary and arrangements were rather made with the instructors on a case-by-case basis. Nevertheless, a comprehensive research project was drafted by the Department in order to regulate and provide a framework for future research activities of the LS.
A few words should be spent on the recording process. While a cassette tape recorder was initially used, as of mid-2006 audio quality was significantly improved by recourse to one or even two digital recorders – one next to the primary participants and one for the interpreter when the working mode was whispering through microphone. However, also analogue recordings were later converted into audio files, thus enabling digital archiving of the whole corpus.

Fieldnotes indicating the most relevant nonverbal features were regarded as an important aspect of the research to increase the credibility of the data and its overall trustworthiness (Guba and Lincoln 1985), as well as to offer a “feeling of the situation” (Lally 1999).

As for the transcription methodology, the conventions applied – mostly the same as those used by Merlini and Favaron (2007) – are largely based upon the models developed by Gail Jefferson for symbols (see Atkinson and Heritage 1984: ix-xvi) and by Eggins and Slade (1997) with reference to fillers (for the full transcription key, see Appendix Five). The transcripts were revised for accuracy with the help of the other department members by regularly returning to the recordings to confirm, in particular, the correctness of the technical terminology.

3.2.2 Categories of study

As pointed out at the beginning of the chapter, the analysis of the transcribed recordings aims at describing how the specific characteristics of a given communicative situation inform the choices and adjustments that are made by the interpreter. In setting this goal, a source of inspiration was provided by Bolden (2000), when she stated:

> Interpreters’ actions manifest a choice between several alternatives available to them at any particular time within the frame of the ongoing activity. These alternatives, ranging from being a ‘translating machine’ to having an independent interactional position, embody interpreters’ moment by moment decisions about what role will be the most appropriate in a particular interactional environment. (2000: 390)

Although Bolden specifically addressed the notion of role, her view of “interpreter’s moment by moment decisions” was borrowed and transposed to the scrutiny of the ISMETT corpus, by applying the model summarized in Table 3.3.
<table>
<thead>
<tr>
<th>DIMENSIONS</th>
<th>GENRE</th>
<th>n</th>
<th>r</th>
<th>t</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTICIPANTS</td>
<td>nursing assessments</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>DISCOURSE</td>
<td>nursing reports</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>MODE</td>
<td>training sessions</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>CONSTRAINTS</td>
<td>background knowledge, confidentiality, contextual diversity, knowledge of participants, language proficiency of participants, professional distance, trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PARTICIPANTS</td>
<td>status differential</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>DISCOURSE</td>
<td>equal status</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>MODE</td>
<td>dialog</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PRODUCT</td>
<td>monologue</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PERFORMANCE</td>
<td>short consecutive</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PRODUCT</td>
<td>simultaneous</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PERFORMANCE</td>
<td>sight</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PERFORMANCE</td>
<td>whispering with or w/o portable equipment</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PRODUCT</td>
<td>close renditions VS divergent renditions (additions, omissions, substitutions)</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PERFORMANCE</td>
<td>interactional management (footing, turn-taking)</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
<tr>
<td>PERFORMANCE</td>
<td>role (linguistic support, message relayer, mediator, medical co-expert)</td>
<td>n</td>
<td>r</td>
<td>t</td>
</tr>
</tbody>
</table>

Table 3.3 Categories of study
Taking as a point of departure the illustration of interpreting domains and dimensions at ISMETT presented above (see §2.4 and Table 2.3), the new diagram focuses exclusively on the (intra-social) interpreter-mediated encounters featured in the recordings. Each interaction is viewed as essentially shaped by the combination of the dimensions specified in the first three rows, namely communicative ‘genre’ (nursing assessment, nursing report, or training session), ‘participants’ (of either equal or unequal status),\(^{51}\) and ‘discourse’ (dialogic versus monologic). Whereas these three components are externally given factors, the working ‘mode’, though influenced by contextual requirements, is also intentionally selected; moreover, it may be subject to shifts during the encounter. Hence the use of short consecutive versus simultaneous interpreting, the latter including sight, whispering, or whispering with portable equipment, occupies an intermediate position in the diagram, on the border between the three dimensions and the interpreter’s autonomous decisions. These are depicted in the last two rows under the headings of ‘product’ (see §1.2.1) and ‘performance’ (see §1.2.2 and 1.2.3): as the interaction unfolds, the interpreter generates a linguistic output and a specific performance that are a result not only of situation-based macro-choices, but also of adaptations in terms of ongoing micro-choices among the multiple options available.

Based on the theoretical framework provided by the DI paradigm and illustrated in Chapter One, in the model product is viewed as a manifestation of the interpreter’s use of close versus divergent renditions. More specifically, the departures from the speakers’ original utterances are classified as additions, omissions and substitutions, following Merlini and Favaron (2007), as summarized in Table 3.4. On the other hand, performance is regarded as a function of the interpreter’s interactional management, especially in terms of footing and turn-taking. With regard to footing, the analysis will place emphasis on shifts in the use of direct or indirect speech by the interpreter. Reference will mostly be made to the categories devised by Merlini and Favaron (2007) whenever the primary speakers’ addressees are explicitly stated, though bearing in mind that their taxonomy does not cover all possible occurrences but only those found in the corpus they examined; also the change of perspective of person suggested by Bot (2007) will be considered. As for the distribution of talking turns among the participants, marked patterns in the succession of “smooth transitions”, “pauses”, and “overlaps”

\(^{51}\) For the sake of simplicity, the number of participants has not been taken into account in the diagram.
Methodology

Additions

1 Phatic (=back-channelling and reassuring tokens)
2 Emphatic (=repetitions of the same phrase or of synonyms)
3 Explanatory (=clarifying information)
4 Other
   a Asking for clarification
   b Pointing out clients’ misunderstandings
   c Alerting to possible missed inference
   d Asking clients to modify their delivery
   e Commenting on own renditions
   f Answering in the first person if directly addressed
   g Offering help and giving instructions

Substitutions

Originals left untranslated
Semantic shifts

Table 3.4 Classification of divergent renditions (cf. Merlini and Favaron 2007)

(Merlini and Favaron 2007) will be examined, also in the light of Davidson’s (1998, 2002) collaborative model. The role played by the interpreter during the interaction and its possible modifications are grouped under four labels: the ‘linguistic support’ (Merlini 2009) intervenes in monolingual exchanges between US and Italian staff only to solve specific communication gaps; the ‘message relayer’ faithfully transfers the message from source to target language while coordinating the flow of communication among participants (cf. Wadensjö 1998); the ‘mediator’ clears up misunderstandings or disagreements of a cultural or professional nature; and the ‘medical co-expert’ has or is given considerable latitude in speaking and acting as if belonging to the healthcare staff. Finally, on the right-hand side, the diagram features the already-identified constraints that are placed on the LS members at the intra-social level, regardless of the specific communicative situation. These constraints (background knowledge, confidentiality, contextual diversity, knowledge of participants, language proficiency of participants, professional distance, and trust) are therefore arranged on a continuum, as they may be present in conjunction with different dimensions and, at the same time, they have a constant effect on the decision-making process of the interpreter.
4. The interpreters’ perspective

4.1 Habitus and norms

The interviews with the LS members serve as an ideal point of departure for the scrutiny of interpreted medical interactions at ISMETT. As specified in Chapter Three, the purpose of these interviews was to identify attitudes and beliefs of the respondents towards medical interpreting, thus eliciting information on their *habitus*. Along with other key ideas – such as field or symbolic capital – developed by French sociologist Pierre Bourdieu (e.g. 1977, 1990), the notion of *habitus* has increasingly been featured in sociological approaches to translation and interpreting since the late 1990s. Bourdieu’s theoretical framework was applied, for instance, to the study of the institutional and professional status of translators, as in Simeoni (1998), while a wide-ranging account of his influence on both translation and interpreting studies was provided by a special issue of *The Translator* edited by Moira Inghilleri (2005a). Inghilleri herself further explored the interpreting *habitus* with specific reference to interpreter-mediated political asylum interviews (2003, 2005b). More recently, Kumiko Torikai (2009) adopted the concepts of *habitus*, field, and practice to examine the role of diplomatic interpreters in Japan after the Second World War.

According to Bourdieu (1977: 72), the *habitus* consists of “systems of durable, transposable dispositions” moulded by the experiences of the social actors (“structured structures”) and, at the same time, able to produce practices and representations of the world (“structuring structures”). Thus, as the term ‘disposition’ suggests, the *habitus* is, on the one hand, “the result of an organizing action”, while, on the other, it identifies “a way of being, a habitual state […], a predisposition, tendency, propensity, or inclination” (1977: 214). Such dispositions are not stringent rules governing deeds or choices, but rather loose guidelines that orient actors while remaining flexible and allowing for improvisation, in order to suit new or different contexts. Moreover, although these propensities are deeply rooted, individuals are mostly unaware of them, as the *habitus* is a form of “embodied history, internalized as a second nature and so forgotten as history”, and thus “a spontaneity without consciousness or will” (Bourdieu 1990: 56; see also Calhoun *et al.* 2007: 259-266).
A pivotal role in the process of inculcation of the *habitus* is played by ‘norms’. Defined as “the social reality of correctness notions” (Bartsch 1987: xii), norms can be viewed as shared, conventional assumptions about what is appropriate and expected in a given community (Schäffner 1999: 1). This notion was again borrowed from sociological theory and introduced in the field of translation studies by Gideon Toury (e.g. 1980) to identify “regularities in translational behaviour, resulting from internalised socio-cultural constraints” (Merlini and Favaron 2009: 190; see also Schäffner 1999; Baker 2009). Although to a more limited extent, norms have also been adopted in interpreting research (e.g. Shlesinger 1989; Harris 1990; Schjoldager [1995]/2002; Gile 1999; Garzone 2002; Marzocchi 2005).

The relevance of these notions to the present study becomes evident by viewing the ISMETT LS Department as a small-scale community in which norms are negotiated through socialization (Merlini and Favaron 2009: 190), or, more precisely, through “professional socialization”, that is “the process by which a practitioner acquires the values and the behavioural patterns necessary to operate as a fully fledged member of a particular profession” (Gentile et al. 1996: 64). Hence the interviews with the interpreters can also be seen as a device to trace the generation and transmission of norms, as well as the resulting acquisition of those “dispositions” that are “collectively orchestrated without being the product of the orchestrating action of a conductor” (Bourdieu 1977: 72). The following sections will first introduce the interviewees and then examine their responses for recurrent patterns and discrepancies.

### 4.2 Profiles of the interviewees

ISMETT interpreters, first presented in Table 2.2, have played a role in the research project to varying degrees. Seven out of the ten LS staff members working for the Department between 1999 and 2008 have been involved in the interview study, namely Christian, Dario, Eric, Francesca, Georgia, Henry, and Italo.

Christian has been Coordinator of the LS since mid-2005. Although much of his time is currently devoted to translation revision and administrative duties, the interview did not focus on his institutional role, but rather on his extensive experience in the hospital. Despite a degree in Architecture, Christian was the first interpreter to be hired
in 1999 thanks to his native-like proficiency in both Italian and English, as he grew up in Palermo, but his mother comes from England. Therefore, he was trained solely on the job, learning the ropes from the former Department Head (Aldo in Table 2.2), to whom he largely owes his professional development.

Dario is an Italian native speaker with an educational background in Translation and Interpreting at the university level, in addition to studies in economics and political sciences. He started to work at ISMETT as a freelance in July 1999, supporting Christian, and was subsequently employed on a permanent basis. Except for some previous translation assignments, this was his first experience in the medical field.

Also Eric’s initial contact with ISMETT goes back to 1999, as he collaborated with the LS for a short period of time while he was still pursuing his university studies in Modern Languages and Literatures. Following his hiring in 2000, he learnt to become an interpreter on the job, taking advantage, in particular, of his proficiency in both working languages, as he was born in Canada and lived there until he was thirteen, when his family returned to Italy.

Francesca, whose mother tongue is Italian, studied Translation. Her interpreting training occurred at ISMETT, where she was hired at the end of 1999 after working five years in the field of tourism.

Georgia thinks of herself as an English native speaker, although she is aware of her equally high level of proficiency in Italian. She spent her first ten years in the United States and then, after eight years in Italy, she returned to New York to earn her bachelor’s degree in Marketing and Communication. Having returned to Italy in 1996, she was employed at ISMETT in 2000, despite her lack of experience in translation and interpreting. She learnt in the field, especially thanks to the help and support of the then senior interpreter, Barbara, who taught her everything she knows.

As for Henry, his personal and educational background sums up a number of features that can be found individually in the other LS members: he is an Italian-English bilingual, as he was born in the US and lived there thirteen years before returning to Italy with his family; he has a university education in Conference Interpreting; and, after six years as a freelance translator and interpreter, he was employed at ISMETT in 2004, thus entering the Department when tasks and activities were already in the phase of “consolidation” (Mucè and Schillaci 2007; see §2.3). As a result, he more easily adapted
The interpreters’ perspective
to the new job and environment in comparison with the other colleagues, despite his more recent hiring date.

Italo, finally, was also first employed in September 2004. He is an Italian native speaker with a degree in Translation and Interpreting, gained at the same School for Translators and Interpreters in Palermo attended by Dario and Francesca, and with some previous experience in the private sector.

4.3 Key issues from the interviews

Before examining the main outcomes of the seven interviews, some preliminary considerations are required. The views presented are inevitably shaped not only by the Weltanschauung and personality of each respondent, but also by two additional factors, already evident from the brief profiles presented in the previous section: firstly, the differences in the educational and professional backgrounds, and secondly, the employment dates of the department members. With regard to the latter, in particular, the colleagues who have been at ISMETT since its creation provided more wide-ranging perspectives as compared to Henry and Italo, hired in 2004. This was easily predictable, given that the hospital itself and, consequently, the LS underwent radical changes between 2000 and 2004 (see §2.1 and 2.3).

However, despite these distinctions, the analysis of the interviews brought out specific leitmotifs in the interpreters’ perceptions of medical interpreting at ISMETT. Undoubtedly, some of these concerned topics explicitly addressed by the interviewer, but other, less predictable issues were raised by the respondents themselves, thanks to the deliberate flexibility of the semi-structured interviews (see §3.1.2).

4.3.1 Learning

Although none of the interviewees had formerly worked in a healthcare facility, dealing with medical interpreting was not traumatic at all for Dario and Henry, by virtue of their university education in interpreting and their experience in the private sector. Dario had no major difficulties from a technical or linguistic point of view; along the same lines,
Henry thinks that “the challenge actually was over after the first year or so” (I-6, 49), given that working at ISMETT is not as stressful as freelancing, but chiefly entails the acquisition of a specific jargon, as in any other field.

Conversely, mastering medical terminology and interpreting skills was not a straightforward process for the colleagues trained on the job (Christian, Eric, Francesca, and Georgia), or with little experience in the private sector (Italo). Georgia foregrounded the issue of terminology as her greatest obstacle since the very beginning, describing her initial impression of the hospital environment as “terrible” (I-5, 73). She recalled an amusing anecdote about one of her first interpreting assignments during a meeting between the former US Chief of Anaesthesiology at ISMETT and an Italian physician from another hospital, under the supervision of the LS Department Head. The anaesthesiologist listed a number of complex procedures that a patient had undergone:

I-5 (78-84)
And so he started listing one thing after the other, and it was all medical, highly technical stuff. And I am just listening, and I am hoping that everything derives from Latin. And then it was my turn to speak […], so I said – in Italian of course: “The patient underwent… all of the above procedures that the doctor has just specified.” And it was funny because everybody started laughing, and the former Chief looked at me and said: “I don’t think I was that brief!”.

Georgia believes that this was an excellent method for giving her a flavour of the job ahead, which would have required ongoing study, research, and updating: “It was just making mistakes and learning from them” (I-5, 96-97). Italo stressed that a key role was played by the direct experience in the units; according to Christian, the lack not only of a medical background but also of the habit of developing glossaries entailed a considerable effort, which was nonetheless repaid over time.

With reference to the technical aspects of interpreting, some of the staff members trained at ISMETT are still not completely confident about their interpreting performances. For instance, Christian now faces any interpreting assignment, including simultaneous interpretation in the booth, which he initially feared most; yet, throughout the interview, he projected significant feelings of inadequacy for his lack of theoretical background or field experience outside the hospital, for instance when he stated: “I had

55 For easier reference, the abbreviations I-1, I-2, I-3, I-4, I-5, I-6, and I-7 identify the transcribed interview from which a given excerpt has been taken; line numbers in the transcript are also specified in brackets (see Appendix Three for the full transcripts).
to learn to be an interpreter, which I still have not learnt, but I am doing my best” (I-1, 22-23), or “I sometimes just have the feeling that I have reached a certain goal, but not going through the easiest way to get there” (I-1, 108-110). The strategy he devised consists in watching more experienced professionals and trying to act as they do, in a lifelong learning process. Also for Eric simultaneous interpreting was one of the major challenges he had to face: he believes that he would have been much better off with an academic background in the field, yet he recognizes that performances can be improved by practice and perseverance. Francesca thinks that training is a never-ending process (“I never feel perfect”, I-4, 42): this awareness makes her feel worried or anxious at times, although much also depends upon the subject matter of the interpreted event and her capacity to follow the logical development of the speakers’ words. By contrast, Georgia and Italo seem to have overcome most difficulties, with few exceptions: videoconferences are still Georgia’s worst nightmare, as the lack of synchronization between video and audio signals prevents her from lip-reading; in Italo’s opinion, medical conferences are the most challenging assignments, not only because of their highly technical level, but also because they are attended by experts from all over the world with whom there is not the acquaintance and easy familiarity typical of interactions involving ISMETT users.

Nevertheless, the LS members are aware of the progress made throughout the years in comparison with the sessional interpreters working for ISMETT’s International Patient Services Department. Through direct observation of their mediated interactions, Christian identified basic, astounding mistakes attributable to a lack not only of training, but also of common sense, such as answering the physician’s questions instead of translating them, or not leaving the patient’s room when required. Also Dario commented on the activity of the freelancers: following his assignment to the International Patient Services Department (see §2.3), not only does he coordinate the activity of this external staff, but he is also a user of their services whenever he needs to communicate with foreign patients who speak no English. Dario explained that, despite his repeated reprimands, these interpreters often engaged in side conversations with single participants without translating to the others. Incidentally, Dario specified that an in-service training session on the basic interpreting rules was likely to be organized before long.
4.3.2 Job organization

As seen above, during the first years of the LS some of its members were learning a new profession through on-the-job training and field experience. At the same time, however, the Department was engaged in teaching the co-workers how the interpreting service should be used: on the one hand, the hospital personnel needed to become accustomed to it, overcoming the initial discomfort and scepticism; on the other, they were to understand the role and professional requirements of interpreters. Achieving both goals was not easy and straightforward, as emphasized by Dario, who explained that, at the beginning, “it was total chaos” and “work organization” was the most challenging issue (I-2, 79-80). Dario added that, for this reason, a Service Level Agreement was still under discussion – at the time of the interview – to establish the standards of use of interpreting and translation services.\(^{56}\)

Despite the improvements made over the years, also Henry, recalling his first months at ISMETT, identified as a testing situation the periodic medical lectures whose organizers would typically ask for an interpreter at the last moment, expecting the LS members to promptly deal with any assignment without prior preparation or knowledge of the topic:

I-6 (96-107)

They had the terribly bad habit of wanting an interpreter at the lectures, so they would just call upstairs: “We need an interpreter”. So take the headphones, take the microphones, go downstairs, without having any material, and just having to translate straightaway with the room full of physicians who anyway do understand some English. It is more like the pressure, the scrutiny of those listening to you. I mean, if you work in the field, you understand how difficult it is: they call you in, you do not have any prior knowledge, you have not had any chance to study, to do any research, or whatever, but then whoever is listening to you expects that you come up with a perfectly suitable and appropriate translation, which is not always the case. […] There was a lot of pressure on those occasions.

Henry explained that these events are now scheduled in advance with far greater frequency, while reference material is often provided beforehand; nevertheless, unpredictability still remains a key feature of the job, which calls for a significant degree of flexibility (see §4.3.4 below).

\(^{56}\) The final Service Level Agreement of the Language Services was approved and published in the company Intranet in October 2009.
Incidentally, it should be noted that Dario and Henry are the only interviewees who commented on shift work. According to Dario, the hectic night shifts of the first years, with a considerable number of Americans in the units, made the job exhausting in the long run, although the situation was partially enhanced by the employment of new staff members. Henry pointed out that the pressure did not ease off when nights were devoted to written translations, adding that shifts in general inevitably affected his regular life.

4.3.3 Teamwork
The idea of ‘team’ was a recurrent topic in the interviews, suggested by the interpreters from different perspectives.

To start with, the ‘team’ par excellence is the LS. Italo, for one, believes that successful teamwork is a major asset for the Department: when he was hired, the support of his senior colleagues was essential not only to become familiar with the place, the people, and the tricks of the trade, but also with the “peculiar language that is spoken at ISMETT”, i.e. “a mixture of Italian and English”, as “sometimes, even when the staff is speaking in Italian, they use English terms” (I-7, 58-60). For Italo the internal cohesion among staff members translates into what could be defined as the ‘corporate identity’ of the LS within the hospital, given that interpreters are generally perceived by their co-workers not as individuals but rather as a Department.

‘Team’ also stands for the healthcare team, a group that actually includes the LS. In Italo’s words: “Even though we do not have a medical background, we are not nurses, we are not physicians, we are very well integrated in the clinical setting, and we are seen as a part of the clinical staff in that sense” (I-7, 159-162). Both Italo and Georgia think that this ‘sense of belonging’ goes hand in hand with the notion of ‘trust’. Over the years, Georgia has understood that gaining the trust of the colleagues was the most helpful key to successful interpreting, probably because when you work in a hospital “there is also a human level involved [...] in every exchange” (I-5, 115; 117-118). In her opinion, the customers need to look at the interpreters and feel comfortable and reassured by their reliability, which should entail not only properly conveying messages, but also being loyal and ensuring confidentiality. Georgia explained that the establishment of this mutual trust was not a seamless process: for example,
terminological inaccuracy in interpreting was initially read by the healthcare staff as a lack of professionalism. But a major change has occurred with time: “the scepticism becomes trust [...] you do not know when exactly it happens, but it happens” (I-5, 126-127), and trust yields collaboration, so that, at present, physicians are the first to prompt a word that does not come to the interpreter. Interestingly, even interacting with the newly-hired staff is a constantly appealing endeavour for Georgia, “a shorter way to build up the trust and the bond” (I-5, 240) developed at the beginning, yet taking advantage now of the consolidated position of the LS Department within the hospital.

The active collaboration between interpreters and hospital personnel was suggested also by other interviewees. According to Francesca, guidance and support are commonly offered by the clinical staff, who facilitate both learning of new terms and understanding of topics. As for Eric, although he regards paraphrasing as a useful strategy, he is aware that language issues can often be resolved by asking the healthcare staff for advice:

**I-3 (71-76)**
Sometimes you can use strategies to get around [the technical terminology], by explaining things instead of having to pinpoint each medical term. But that is not always possible. So sometimes you have to intervene and interrupt perhaps a conversation, or to ask exactly the meaning of a term in order to continue, when you get stuck and you know that you cannot just get around by explaining it, because maybe you do not know what they are really talking about.

Along similar lines, Christian offered valuable insights into the status of in-house interpreters who are on familiar terms with all hospital staff, as compared to freelance professionals. For example, with regard to his likes and dislikes in terms of working modes, Christian prefers short consecutive rather than consecutive interpreting with note-taking, as he can easily invite speakers to pause every couple of sentences to allow for the translation. But he also underscored other, noteworthy advantages:

**I-1 (154-160)**
[...] we can ask a physician to stop or repeat. Or, not having understood something, it is easy, it is easier for us, because we have the liberty, and the luxury, and the confidence to stop somebody when we do not understand. And also we have managed to establish the consolidated practice by which we are able to ask anybody who wants an interpreter for a lecture to give us handouts or presentations beforehand, so we can study terminology from the slides and text. It was not easy to make these people understand the importance of doing so, eventually we did.
4.3.4 Versatility

The interviewees were explicitly asked to state their opinions about a noticeable peculiarity of medical interpreting at ISMETT, namely the diversity of communicative genres. Yet again, the prior experience gained by Henry and Dario facilitated their adaptation to the new environment. Whereas most colleagues described this multifaceted job as exciting but demanding, Henry explained that the variety of working contexts already belonged to his everyday routine in the private field, as he had never specialized in a specific sector: therefore, once at ISMETT, “having to hop from a meeting between physicians, a nurse speaking to a patient, or going to Board of Directors meeting” (I-6, 115-116) was quite easy. Only when questioned more explicitly did he state that, to be a good interpreter at ISMETT, versatility, flexibility, proactiveness, and openness were essential. Also Dario stressed that variety was not a problematic aspect; undoubtedly, it entailed having recourse to different strategies depending on the number of participants, the type of interaction, or the more or less stressful conditions, especially during emergencies. Nonetheless, the wide-ranging character of the job could also become an asset to the interpreters, as it enabled them to gain a broader view of the hospital activities:

I-2 (87-93)

[...] the variety probably allowed us to become more familiar with all the aspects of the medical care that was being provided at ISMETT. So, if you were aware of some aspects, you could use those aspects even in different situations. For instance, if you knew the psychological background of a patient from a previous event, and then you had to deal between a surgeon and the same patient, maybe you could use the psychological background that you had acquired on that patient.

Conversely, the other LS members regard the multiplicity of assignments as a challenging issue, to the degree that they brought up this topic also in relation to other questions. For instance, while describing the most significant features of medical interpreting, Francesca cited examples from diverse communicative genres, ranging from interactions between healthcare practitioners and patients to meetings among staff members:

I-4 (60-65; emphasis added)

Maybe contact with the patients, of course, so when you have to face sickness or suffering of other people; unexpected events, when you feel unprepared, so you need to study as quickly
as possible the subjects you are going to translate; meetings, when people speak all at the same time, so you need to manage the situation, you need to take control of the situation […]; and then maybe variety, as you never know what you are going to do before doing it.

Significantly, Francesca in her account foregrounded not only variety, but also unpredictability. A similar thought was expressed by Georgia: “You do not know what is going to hit you and when it is going to hit you” (I-5, 152-153). Therefore, among the distinguishing characteristics of ISMETT interpreters she suggested flexibility, i.e. being mentally prepared for everything and anything on a constant basis, and stress management, which is necessarily related to this call for immediate responsiveness.

Flexibility has become a keyword for the LS, as underlined also by Eric and Christian: despite the lack of fixed rules, interpreters are expected to make the most suitable choices for any given context, for instance in terms of strategies, techniques, or even positioning. According to Eric, the ability to adapt to each setting and use the resources available – such as clarifications by the participants in face-to-face interaction versus help by the fellow interpreter in the booth – is a determining factor for the outcomes of the encounters. Christian added that sometimes it may also be “a question of understanding when to intervene” (I-1, 140), as during job interviews: although they should occur in English, the candidates are often extremely nervous, or not proficient enough, to the extent that the interpreter has to perform the delicate task of assessing whether a translation is required or not.

It should be understood that the status of in-house interpreters greatly helps to deal with this wide array of situations and interlocutors. Georgia supports the notion of “custom-made service” (I-5, 169): being familiar with almost everybody in the hospital makes her aware of each user’s goals and attitudes, so that she is able to provide them with the interpreting product and performance they require. Yet she calls, once again, for mutual consideration: “It is just a constant give-and-take: I give my customers everything I can give, as long as they respect the boundaries of my job […] and the way I arrange my work” (I-5, 184-186).

4.3.5 Interpreting style
Confronted with the concept of interpreting style for the first time, the interviewees had some initial doubts as to its definition and provided their answers after a momentary
hesitation. First of all, Italo seemed to match the notion of interpreting style with the expression ‘having style’, which carries a positive connotation: he believes that an interpreter with a nice style is very clear and easy to follow, as well as comfortable with the setting and the situation, notwithstanding difficulties. Also Christian defined style as a distinctive feature of a good interpreter, i.e. of an interpreter who makes the “correct choice” (I-1, 200); in particular, he placed emphasis on the “choice of the words”, the ability of “adjusting” (I-1, 188-189) the register to the speakers and the situation (e.g. a doctor-patient interview versus a meeting between physicians), and on “the choice of positioning” between the two parties (I-1, 199).

The idea of adjustment was brought up by other respondents as well, who – more or less consciously – suggested a link between the concept of style and the variety of settings and participants in mediated encounters. Dario initially described interpreting style through litotes, that is, by identifying the ‘negation’ of style with the performance of ISMETT freelance interpreters (see §4.3.1), thus using the term as a synonym for professionalism. Upon reflection, he added that style also meant “trying to keep the same register as the speaker” (I-2, 159), although in the subsequent explanation he made reference to mood or intentionality rather than register: “if the speaker is calm, the interpreter should be calm, if the speaker is speaking in a loud voice, then the interpreter should probably speak in a loud voice” (I-2, 159-161). Dario’s view is shared by Georgia, who thinks that the interpreting product should reflect tone of voice, volume, and body language of the speaker: the transfer of these features would thus make the style of an interpreter. The downside is that she has to come to terms with her “bubbly personality” (I-5, 360) and with the risk of overdoing it, given that she does not like “monotone interpreters” (I-5, 359). Nevertheless, her bottom line is: “when I look at the customers, the audience, it is nice, because everybody is smiling and everybody is relaxed, so I do not know if you can define that style” (I-5, 366-368). Delving more deeply into this issue, Georgia added that style was also a function of the communicative context, once again related to her already expressed views of flexibility and tailor-made service, i.e. giving clients what they need and how they need it (see §4.3.4). Hence, in formal situations, such as top management discussions or meetings with outsiders, the LS members are expected to be extremely professional, go by the book, be “as precise and sharp as a knife” (I-5, 404-405). But when it comes to more
familiar scenarios such as gatherings among nurses, in which they know everybody on a personal basis, interpreters have more leeway: thus making humorous comments into the microphone, joking with the co-workers, or being asked to express an opinion become likely and accepted occurrences, given that the participants themselves “involve the interpreter as an active part of the interaction” (I-5, 376-377). More importantly, whenever the service is provided in this fashion, the users unambiguously show their appreciation.

On the contrary, Francesca and Eric view the style of each interpreter as somewhat unrelated to the interpreting situation. Francesca started from the premise that, although some colleagues are more experienced or trained than others, the goal of the LS is to ensure that all staff members are able to face any interpreting assignment and provide faithful renditions of the source texts. Yet she thinks that, in doing so, everybody adopts a different, peculiar style, which mainly hinges upon their character. According to Eric, the distinctive style of an interpreter results from the unique mix of strategies and techniques – whether waiting, chunking, or summarizing – that come most naturally to him or her.

For Henry interpreting style, which is “what someone can actually see, perceive, when [they] are working with an interpreter” (I-6, 186-187), may largely differ from one professional to the other, and still be perfectly acceptable, in theory; in actual fact, however, he thinks that the expectations of the listeners play a key role in establishing what is best. Henry mentioned tone of voice and speech rate as the main distinguishing features of a specific style: he argued that some interpreters get more carried away when they are translating, which results in a more vigorous, forceful, or lively rendition, while others are calmer in their enunciation and adopt an even tone. These differences may also depend on more technical aspects, such as the time delay, so that interpreters with a longer décalage sound more relaxed, as opposed to those who prefer sticking closer to the speaker.

Defining their own interpreting styles was even more challenging for the respondents, with Eric and Christian providing the most indefinite descriptions. The style of Eric is not the product of an academic pathway, but was rather developed by experience, and, as a result, he regards it as “probably naïve” and “out of the ordinary”, “certainly full of imperfections” (I-3, 150-151). When encouraged to further elaborate
on this, Eric added: “I make do with my own resources. For example, I tend to summarize, and I have strategies to try to bridge difficulties when I encounter them.” (I-3, 146-148). As for Christian, his style consists of two components, the first of a procedural nature – “getting help from most of the resources available, be they physicians or slides” (I-1, 207-208) – and the second referring to the interpreting product – “choosing words” and “trying to leave very few gaps” in his renditions (I-1, 207). The relation to the target text lies also at the heart of Henry’s style, described as “rather aggressive” (I-6, 196) by using a vivid image: “I am like a bulldog. […] I bite the text and I stick to it. [...] It is like throwing a bone to a bulldog, and it starts chewing and playing with it, and it does not give up.” (I-6, 192; 194; 209-210).

By contrast, the other four interviewees did not foreground technical aspects, but the attitude they adopt during mediated encounters. A remarkable correspondence can be found between the descriptions provided by Italo and Dario. The latter said: “I never try to be myself when I translate. I am just trying to disappear as much as possible” (I-2, 155-156), while Italo portrayed his own style as “non-invasive”:

I-7 (147-152)
I would rather say that I am a non-invasive interpreter, because I try to be, of course, effective and efficient with interpreting, because, first of all, my main concern [...] is conveying the message. But I try to be, as I said, non-invasive, because I am there because I am doing my job, [...] but I try to be very soft-spoken, like pretending I am not there, even though I am actually there, because I am allowing communication.

For the same reason, Italo specified that whispered interpreting was his preferred working mode, especially during meetings: as he can only be heard by the person he is interpreting for, he feels more at ease and thinks it is “more transparent, less invasive” (I-7, 112-113). On the other hand, Francesca and Georgia are inclined to expose, rather than conceal, their personalities while interpreting. Although initially doubtful about her style, upon reflection Francesca concluded that she tried “to be sympathetic” (I-4, 116), whereas Georgia’s interpreting style hinges upon the attempt to “have fun if possible” (I-5, 401): she explained that this could be read as a cathartic release, a method to defuse tension and stress, which counterbalanced the heavier and stricter aspects of the interpreting job (“Today we are serious, today we can joke around a little bit”, I-5, 414-415).
4.3.6 Empathy
The years spent at ISMETT have gradually enhanced the ability of the LS members to control their emotions, although to varying degrees. Initially, the contact with the sick – especially children – and their relatives was hard to handle for Christian, while Italo was “scared” (I-7, 29) by medical interpreting scenarios, as they required not only language skills and specialized knowledge, but also an adequate training “from an emotional point of view” (I-7, 81). Francesca explained that in most cases, despite her initial concerns, she was unexpectedly able to detach herself from the poignant stories of the patients, with the exception of a few heartbreaking cases. At the opposite end of the spectrum, the first contact with the sick had no major implications for Dario and Henry; incidentally, Henry stressed that the years of work in the units have generated his utmost respect for those patients who face illness with dignity and appreciate the efforts of the staff taking care of them. Also for Eric the possibility of interacting with the patients and providing his own support was not traumatic at all, but pleasing and gratifying.

When explicitly questioned about her management of emotional aspects, Georgia offered a rather striking account. She stressed that, in general terms, she can be very empathic and transmit, for instance, the same involvement and compassion as shown by the clinical staff talking to the family members of a dying child. However, no matter how shattering a situation can be, this would not hinder her interpreting task: “I am not going to break down and cry. I can go home and break down and cry, not here” (I-5, 331-332), because “somebody has got to do the job [...] somebody has got to be strong” (I-5, 333; 337). She thus associated the identity of the interpreter with that of the healthcare practitioner, of the “authority figure [...] who is supposed to hold the reins” of the situation (I-5, 341).

4.3.7 Cultural mediation
Although conflicts between the US and Italian staff have always existed, their nature has changed over the years. At the beginning, job-related tasks and methods were a major source of friction: Italians – or, better yet, Sicilians, whose culture “is not similar to any other in the world” (I-4, 83), according to Francesca – were not keen to accept the ‘imposition’ of the American healthcare model, especially on more experienced
nurses. In Henry’s opinion, there is an unconscious competition between the US and Italian staff: while the former can rely on their better technology and organization, Italians usually have a more complete and comprehensive training and are better at improvising. Henry believes that, at times, the two approaches are equally needed, so that “the real problem is managing the advantages and disadvantages of both, trying to strike the right balance” (I-6, 161-162).

The clash of the first years has gradually been smoothed out; however, a certain degree of scepticism and bias that is still present against the US colleagues has shifted the divergence from a professional to a more wide-ranging cultural level. As specified by Georgia, also the perception of the Americans is inevitably affected by some unpleasant conditions they encounter: these are not strictly related to hospital matters, but rather concern daily life in Palermo (e.g. inefficient means of transport, widespread lack of civic culture), or communication patterns, such as the Italian habit of speaking in a loud voice, or the frequency of overlapping talk. Interestingly, Italo is the only interpreter who thinks that, overall, the relationships between the US and Italian staff are good, and that Americans are welcomed co-workers.

Moving to the role played by the LS Department, there is unanimous agreement among the interpreters that they have fostered the integration of the US personnel on several fronts, by bridging language barriers, explaining the cultural reasons behind attitudes and stances, but also, occasionally, by toning down the exchanges to ensure communication, as underlined by Francesca. In particular, the bilingual staff can perform this mediating function quite easily: Christian and Henry feel completely at ease with co-workers of different nationalities; Eric can deeply understand the work ethic and the mentality of US employees; as for Georgia, the disagreements between Italians and Americans somehow make her laugh, as she perfectly understands what is underlying the two contrasting mentalities. Nevertheless, she is aware that, in her capacity as language mediator, she cannot let the situation run out of control, so that, under specific circumstances, she can easily intervene.

The LS Department has established good relationships with both cultural groups, although on different grounds. Georgia thinks that the strong bonds with the Italian co-workers have been formed over time, as these are the regular users of the interpreting service; conversely, the US staff members rotate, so that the contacts with them
inevitably last for short periods of time, yet they are more intense. More specifically, Henry could identify diverse approaches of the US and Italian personnel to the LS. During their stay, the Americans are heavily dependent not only on translation and interpreting services, but also on the logistical support occasionally provided by the Department. Henry pointed out that there have been occasions in which this assistance even went beyond the interpreters’ duties, for instance when

I-6 (138-143)

[...] they had towed away the Chief Nursing Officer’s car: she called us and we managed to find where the car was and to tell her “Go there”, not to worry, and whatever, and that if she needed anything, she could always call us. So, it is something that goes beyond [...] And we have always been very open, and willing to provide this sort of support.

As a result, the Americans are usually warmer and more appreciative. As for the Italian staff members, Henry thinks that in some cases there is a problem that does not occur only at ISMETT, but is rather typical throughout Italy: people want to be respected for their own professionalism and expertise, yet they do not show that same respect to other professionals. Hence he sometimes feels that interpreters are like “the children of a lesser God” (I-6, 150), from the Italian perspective.

4.3.8 Conclusions

The analysis of the interviews has shed light on the *habitus* of each interpreter and, more importantly, on what could be labelled the ‘corporate *habitus*’ of the LS Department in the ‘field’ of medicine. Moreover, it has further illustrated the medical interpreting dimensions and constraints that had already been foregrounded in Chapter Two (see §2.3 and 2.4; Table 2.3). More precisely, it can be said that the prevailing concerns, thoughts, and topics centre around two macro-areas: the position of the LS as internal Department and the multifaceted nature of the interpreting activities at ISMETT.

First of all, the respondents highlighted the marked difference between interpreted interactions among co-workers and those including also outsiders. Next to the variation in the level of formality, it can be said that the familiarity with the participants informs the development and nature of the encounters. Once the organizational difficulties had been overcome, the joint accomplishment of routine activities gradually led to the
establishment of close bonds between the LS and their ISMETT users, to the extent that interpreters are now perceived as part of the clinical staff. This friendliness translates, first of all, into mutual collaboration: the interpreters ensure proactiveness and reliability, which at times transcend the mere interpreting duties, especially with the US staff, while the healthcare team serves as ‘linguistic resource’, for instance by explaining obscure concepts and terms. More significantly, in intra-social settings the users do not regard the interpreters as ‘transparent’ or ‘invisible’ conduits, but rather as active participants in the interactions (cf. §1.2.2), who can be involved in jokes, or, under specific circumstances, even asked for an opinion. Notably, the ability to build relationships of mutual trust with the other departments and services was also a prerequisite for the successful cultural mediation in the clashes between US and Italian professional approaches.

Secondly, the diversity of communicative genres enabled interpreters to gain a broader view of the hospital activities, yet it entailed a significant unpredictability. In Georgia’s words, not knowing “what is going to hit you and when” (I-5, 152-153) is undoubtedly thrilling, but also very stressful and demanding. Flexibility and versatility become essential, as there are no fixed rules; it is a matter of continuous adjustments and constant selection of the most suitable interpreting strategies (e.g. working mode, positioning, mediating modality, etc.) based on the resources provided by the situation at hand. Also the notion of interpreting style fits into this framework. Style is necessarily influenced by personality: for example, Dario tends to disappear while interpreting, and Italo thinks of himself as a non-invasive interpreter; in contrast, Henry bites the text like a bulldog; Francesca tries to be sympathetic, whereas Georgia would rather have fun during the interpreting assignment. But personality has to face up to circumstances and users’ requirements: hence style can also change and turn into the “correct choice” (I-1, 200) that reflects the intentions of the primary speakers. Indeed, the ultimate goal of the LS is to offer a “tailor-made service” (I-5, 384), providing each customer with “what they need and how they need it” (I-5, 388). In other words, as argued by Chesterman (1993), the “professional norms” regulating the activity of the LS members, i.e. “the norms constituted by competent professional behaviour” (1993: 8), tend to take into account the “expectancy norms”, that is the expectations and the needs of the clients (see also Chesterman 1999: 91; Pöchhacker 2004: 132).
Variety and LS members’ sense of belonging can be seen as two sides of the same coin: interpreters have a privileged position in the organization, which gives them a leeway that would hardly be granted to freelancers, yet this status constantly exposes them to testing situations. The following chapter will take into account the recordings of authentic interpreter-mediated medical interactions in order to describe the effects of this twofold condition on the product and performance of ISMETT interpreters.
5. Transcript analysis

5.1 Tailor-made services: The chameleon interpreter

5.1.1 Adjusting to the communicative context
The exploration of the transcribed recordings of interpreter-mediated encounters will begin with a comparison of prototypical excerpts belonging to the three communicative genres featured in the corpus, namely nursing assessments, nursing reports, and training sessions.\(^{30}\)

The first interaction to be taken into account is the only patient assessment recorded. It involves a man in his fifties (P) just hospitalized at ISMETT’s regular admission unit with suspected lung cancer and assigned to a US nurse of the same age (N) who has been staying at ISMETT for a few weeks. The nurse has some knowledge of Italian, also thanks to her fluency in Spanish, yet she needs the support of interpreter Barbara (I) to communicate with the patient.\(^{31}\) Barbara introduces herself to the man as soon as she enters the room:

**Excerpt 1**  (NA.FL, 1; 4)\(^{32}\)

1 I 

\( ((\text{to the patient}) \) buongiorno \)

\textit{good morning}

[\ldots]

4 I

\( \text{io sono l’interprete} \)

\textit{I am the interpreter}

Following the identification of the rationale behind the admission, the nurse starts the assessment. At first, she listens to the patient’s chest (Excerpt 2, lines 53-58), back (59-62), and abdomen (71-74), and asks general questions concerning his smoking habits (63-71) and the presence of any gastrointestinal (79-81) or urinary (82-84) problems:

\(^{30}\) Table 3.2 provides concise data about the corpus, whereas the three medical interpreting scenarios are described in detail in §2.5.

\(^{31}\) For further information about the interactions under study and their participants, see Appendix Six, in which the full transcripts are accompanied by summary tables.

\(^{32}\) The abbreviations in brackets identify the transcribed recording from which a given excerpt has been taken. Line numbers in the transcript are also specified; these additionally appear beside each line for easier reference to the comments in the analysis. Idiomatic translations into English are provided in a different typeface below the Italian utterances, and do not count as lines in the transcript. Features of interest are shown in bold. For the full transcription key, see Appendix Five.
Transcript analysis

Excerpt 2  (NA.FL, 53-84)

53  N  I would like to listen if I may
54  I  può:: auscultarla↑
      may she listen to you
55  P  *sì*
      yes
56  N  okay >if you would ask him< to take a deep breath
57  I  faccia un respiro profondo
      take a deep breath
58  ((pause)) ((the nurse listens to the patient’s chest)) ((background voices))
59  N  oka::y (. ) I would like to listen back here if I may ( . ) ((making the
60  patient bend slightly forward)) another deep breath
61  I  profondo↑
      deep
62  ((pause)) ((the nurse listens to the patient’s back)) ((background voices))
63  N  °okay ° is he a cigarette smoker↑
64  I  lei fuma↑
      do you smoke
65  P  poco
      a bit
66  I  >a bit<=
67  N  =un poco↑ (. ) how many cigarettes a day
68  I  quante sigarette al giorno
59  P  umm:: dieci
      ten
60  I  ten↑
61  N  >ten okay< (. ) may I listen to his belly↑
62  I  puó ascoltarle la pa::ncia↑
      may she listen to your belly
63  P  ((amused)) sì sì ((soft chuckle))
      yes yes
64  ((pause)) ((the nurse listens to the patient’s abdomen))
65  P  non sono incinto (. ) sicuro
      I’m not pregnant for sure
66  N  °perfetto °
      perfect
67  I  ((smiling)) he’s not pregnant (. ) that’s for sure
68  P  ((wholehearted laugh))
69  N  ((smiling)) does he have regular bowel movements↑
70  I  va di corpo regolarmente↑=
      do you move your bowels regularly
71  P  =sì sì
      yes yes
72  N  and does he have any difficulty (. ) urinating
73  I  ha difficoltà a urinare↑
      do you have difficulties urinating
74  P  no no
      no no
For the most part of the encounter, a dialogic discourse occurs between two primary speakers of a different status who meet for the first time; given the nature of the interaction, the topic development is mainly controlled by the nurse, with a prevalence of the question-answer pattern. Although the patient occasionally brings up new subjects, for instance when he jokes about his large belly (line 75: “non sono incinto/I’m not pregnant”), the nurse gently keeps him on track (79). As for the interpreter, despite her lack of background knowledge about the clinical conditions of the patient, she is familiar with the nurse and knows how a nursing assessment is usually carried out. Moreover, Barbara is aware that the American nurse can understand some Italian, as this is also evident from the transcript: at the beginning of line 67, while talking about the patient’s smoking habits, the nurse uses the Italian phrase “un poco”, thus echoing the answer provided by the patient (65: “poco”), rather than Barbara’s translation into English (66: “a bit”; see also §5.1.2 and 5.1.4).

This combination of factors shapes the choices of the interpreter, first of all at a macro-level: the prevailing mode is short consecutive, with overlaps reduced to a minimum. Indeed, turn-taking is rather straightforward, with a marked prevalence of smooth transitions throughout the whole session. As for the selection of footing, Barbara’s use of the third person matches the stance of the nurse on several occasions: for example, “may I listen to his belly” is translated as “può ascoltarle la pancia/may she listen to your belly” (lines 71 and 72). The reported speech is also used in the translation of the above-mentioned comment made by the patient (75 and 77: “he’s not pregnant”). Yet, whenever possible, Barbara does not express the addressee of the message, so that a question such as “is he a cigarette smoker” becomes “lei fuma/do you smoke” (63 and 64). Renditions are generally close to the originals, with the exception of rare omissions of information that can nevertheless be inferred from the context: in Excerpt 2, the request of the nurse in line 59 (“I would like to listen back here if I may”) is not translated into Italian, given that the nurse has already made the patient bend forward.

Notably, the resulting role of message relayer played by Barbara goes unchanged throughout the encounter, also when she happens to be personally addressed by one of the primary speakers. For instance, on one occasion, the nurse briefly leaves the room,

33 During the assessment, an Italian nurse briefly enters the room to discuss patient-related information with the US colleague.
and the patient, who remains alone with the interpreter, asks her for information about his ‘missing pillow’, as the following exchange shows:

Excerpt 3  (NA.FL, 140-143)

140  P  ((to the interpreter)) il cuscino ancora non lo porta↑

141  I  ah il cuscino↑ aspetta il cuscino↑ ora glielo dico (.) ora glielo dico

142  (short pause) ((the nurse returns to the room, but she stops on the threshold)

143  reading the patient’s medical record))

147  I  [...] ^he’s still waiting for his pillow^
Excerpt 4  (NR.ICU.02, 1-17)

1 ((background voices))
2 N °let’s start with her° ((pointing at the patient’s room))
3 I cominciamo da:: [lei ((pointing at the patient’s room))]
4 INF >la signora< {Pontardi}
5 °okay°
6 ((pause)) ((the Italian nurse starts writing down her notes))
7 N uh twenty years old
8 I vent’anni twenty years
9 N allergic to: (.) pollen and dust
10 I allergica alla polvere e al polline allergic to dust and to pollen
11 N >O positive<
12 I O positivo O positive
13 N uh has malig – malignant cancer
14 ((the LS mobile starts ringing))
15 I ha un tumore maligno (.) ((answering the mobile)) scusa::te she has a malignant cancer excuse me
16 ((the interpreter talks on the phone with another US nurse requiring the interpreting service and then hangs up)) ((background voices))

After the interruption, the report is resumed. Before moving to the review of the systems, the US nurse explains that the cancer site is the adrenal gland and adds that the tumour is also spreading to the left kidney and the liver (Excerpt 5, lines 26-35), so that the patient was submitted to nephrectomy (37-38):

Excerpt 5  (NR.ICU.02, 26-40)

26 N metastas(e)s in=
27 I =c’è una metastasi there is a metastasis
28 N the:: uh left kidney↑
29 I al:: rene sinistro to the left kidney
30 N and liver
31 I sorry↑
32 N and also to the liver
33 I e anche al fegato and also to the liver
34 N °it’s spreading°
35 I si sta diffondendo it’s spreading
36 INF okay
37 N so they resected the left kidney
I le hanno fatto una resezione del: e::hm rene sinistro
they did her a resection of the left kidney

N >okay< and she was brought here due giorni fa
>ed è stata portata qui< and she was brought here two days ago

Excerpts 4 and 5 show the cooperative attitude of the outgoing nurse towards Henry, as she utters short sentences to allow for the short consecutive interpretation. Smooth transitions thus prevail, whereas the rare overlaps are negligible (lines 3-4, 33-34, and 39-40). As for the Italian colleague, in these passages she essentially listens to the report without intervening, except for the feedback token “okay” in line 36 – a bivalent expression, i.e. identical and serving the same function both in English and in Italian (cf. Davidson 2002: 1289). One instance of Davidson’s (1998, 2002) collaborative model of turn-taking can be found in line 31 (“sorry”), when the interpreter, due to mishearing, double-checks the previous piece of information provided by the American nurse before translating. In the excerpts, as well as throughout the whole interaction, Henry mainly produces close renditions and plays the role of message relayer.

However, the interpreting choices identified in this standard nursing report cannot be applied to all exchanges of the same genre, given that, under specific circumstances, monologue is replaced by dialogic sequences. This is best exemplified by one of the reports mediated by Dario in the regular admission unit, which at ISMETT is known as the ‘Floor’. In the initial part of the interaction (Excerpt 6 below) a misunderstanding occurs about the names of the patients to be discussed between the outgoing US nurse, who wants to start with Mr “Patenno” (line 1), and her incoming Italian colleague, who would rather receive information about Mr “Porrato” (23). The reason behind the confusion is that the two co-workers have different patient assignments, but reaching this conclusion is no easy task. At first, the US nurse, looking puzzled, wants the interpreter to repeat the name of the patient just mentioned by the colleague (24: “who she wanna start with”); Dario replies, thus acting as responder, and adds “it should be one of yours” (25). Prompted by this remark, the nurse checks her notes, yet she repeatedly asks why Mr Patenno cannot be the first to be discussed (27-28). It is only when the co-worker clarifies that the man is not one of her patients (line 30 and translated in line 31) that the US nurse concedes that they have different assignments. However, her reiterations of the same concept (32-33, 35, and 38) are initially left
untranslated, as Dario gives prominence to the new piece of information simultaneously provided by the other interlocutor (34 and 36-37: the nurse who will take care of the patient Patenno might be “Irene”). Subsequently, the interpreter condenses the comments of the American nurse by using the reporting mode (39: “quelli non ce li ha lei/she doesn’t have those”) and compensates the previous omissions by syntactically expanding her words and nonverbal behaviour of lines 40-41 (“that one nah nah” is translated as “questo non ce l’ha/this she doesn’t have him”, line 42). The identification of the other different assignment (the Italian nurse needs to receive report from her colleague “Ivo” on the patient “Porta”, lines 44 and 46) leads to the closing acknowledgments of both participants (lines 50 and 53 for the US nurse, line 52 for the Italian nurse):

Excerpt 6  (NR.FL.01, 1)

1 N  okay (. ) we’ll start with {Patenno}

(23-53)

23 INF  {Porrato}  
24 N  ((puzzled)) who she wanna start (with)↑=
25 I  °mister° *{Porrato}* (. ) >it should be one of yours<
26 ((pause)) ((the US nurse checks her notes))
27 N  you wan – you don’t want to start with (. ) {Patenno} eh↑ (. )
28 I  do you want to start with {Patenno}↑
29 I  vuoi cominciare con *{Patten}° do you want to start with Paten
30 INF  ma non è mio {Patenno} ((chuckle))
31 I  that’s not °her patient°
32 N  °oh that’s not yours° oh okay all right (. ) okay
33 INF  >then you have the other four<
34 INF  deve darglielo:: forse a {Irene}=
35 N  °you don’t have all my people then°
36 I  maybe {Irene:} is the nurse °who needs to get
37 the other report°
38 N  °you don’t have all my people then (. ) I don’t have them=
39 I  |no allora forse sono diversi perché quelli non ce li ha lei
40 N  °that one° ((pointing at one patient’s medical record and shaking her head))
41 I  nah nah
42 I  °questo non ce l’ha↑
43 N  °nah°
The most conspicuous feature of this rapid exchange is the lack of an orderly distribution of talking turns. The frequent overlaps, which are also attributable to the equal status of the two primary speakers, lead to considerable confusion and hinder a smooth development of the interaction. Moreover, although the US nurse mainly addresses the Italian colleague (except for the question in line 24), the other tends to talk to the interpreter rather than through him; Dario himself uses the indirect speech in this part of the interaction. Along the same lines, by omitting repetitive comments or providing explanatory additions, he attempts to pinpoint the underlying issue in order to solve the deadlock, thus foregrounding his mediating function.

When the actual report finally begins, it develops similarly to the one illustrated above in Excerpts 4 and 5. There is a predominance of monologic discourse, chiefly interpreted in the short consecutive mode, although Dario occasionally shifts to whispered interpreting, as in Excerpt 7, line 74:

Excerpt 7  (NR.FL.01, 71-82)

71 N  okay regular diet (.) according to that ((pointing at the Kardex))\textsuperscript{34} he is
72  allergic
73  to an antibiotic but they don’t know – they don’t know what kind
74 I  secondo questo è allergico a un antibiotico però non *sa*
    according to this he is allergic to an antibiotic but she doesn’t know
75  quale antibiotico

\textsuperscript{34} Kardex is a trade name for a flip-over card that contains a condensed version of the patient’s medical record. In addition to patient data and indication of the current diagnosis, it provides the healthcare staff with the most important information concerning the daily care (e.g. diagnostic tests and treatments, diet, level of ambulation, bathing schedule, etc.). The Kardex is usually written in pencil, so that it can easily be updated, should the needs or conditions of the patient change (cf. Carter 2007: 79).
Dario’s choices in terms of footing are also worthy of note. Soon after the initial misunderstanding, he continues using the third person (as in Excerpt 7, line 74: “non sa/she doesn’t know”), then he gradually changes to the footing of reporter, in conjunction with his shift from the role of mediator to that of message relayer. Instances of first-person interpreting can be found in Excerpt 8, lines 211-213 (“I gave him the IV potassium” is translated as “gliel’ho dato endovenamente/I gave it to him intravenously”) and Excerpt 9 (“ho preso i parametri/I took the vitals”, line 537):

Excerpt 8  (NR.FL.01, 208-213)

208 N his potassium was *low* (.) this morning  
209 I stamattina il potassio era: (.) basso  
this morning the potassium was low  
210 INF °mhm°  
211 N and (.) this afternoon I gave him the – (.) I V (.) potassium poco fa  
212 I °gliel’ho dato endovenamente°  
he gave it to him intravenously  
213

Excerpt 9  (NR.FL.01, 536-537)

536 N [...] I did his vitals  
537 I °ho preso i parametri°  
he took the vitals  
537

Although as a general rule nursing reports are two-party or, when interpreter-mediated, three-party encounters, the situational constellation of interaction may occasionally include additional participants. This is what happens, for instance, in one of the exchanges mediated by Italo (NR.FL.06) between one English-speaking and two Italian-speaking participants. The US nurse involved, a woman in her forties recently
arrived at ISMETT, is engaged in the initial period of shadowing and orientation, in order to familiarize herself with the model of care delivered at the hospital; her temporary supervisor, called ‘preceptor’, is an Italian nurse with a basic competence in English (INF2). At the beginning of their afternoon shift, in which they will jointly take care of the same patients, the two colleagues need to receive report from another Italian nurse (INF1), who requests the assistance of the interpreter. As a result, during the interaction two parallel conversations develop, as Excerpt 10 illustrates: the column on the left shows the progression of the ordinary nursing report between the two Italian nurses, whereas the column on the right shows the interpreter whispering the contents into English to the US co-worker. In order to set the atmosphere, it should be stressed that the exchange takes place on a particularly hectic day for the unit with all participants standing at a crowded nurses’ station, unfortunately to the detriment of the audio quality in some passages (see lines 27-28, left column). The outgoing nurse explains that the assigned patient, who was submitted to a liver transplant, is extremely agitated and keeps shouting or ringing the call bell:

Excerpt 10 (NR.FL.06, 1-29)

1  INF1  allora°
2  INF2  {Perotti}↑ {Perotti}↑  I  {Perotti}
3  INF1  allora il signor {Perotti}  so mister Perotti
4  INF1  praticamente il {ventitré}  basically on the twenty-third
5  INF1  {dodici} ha fatto un  twelve he had a
6  INF1  trapianto di::: (.) transplant of
7  INF1  ((looking at her notes))
8  INF1  fegato da vivent –  living donor liver
9  INF1  (dad:::) cadavere cadaveric
10  INF1  then liver  liver
11  INF1  allora lui praticamente so he basically
12
13
14  INF1  allora lui praticamente so he basically
15
16
*donor* liver transplant↑
15 psicologicamente
   psychologically
   16 è *mo::lto* nervoso
      he's very nervous
           I    psychosocial
           he’s *very* nervous
   17 INF2 ah pure idda m’ha
       also this to me
  18 INF1 e:::...
       and
   19 INF1 suona sempre
       he always rings
       I and he’s
   20 INF2 ((ironically)) a:::h
       very demanding and he
   21 INF1 gli ho spiegato
       I explained to him
   22 INF1 le prossime volte di
       next times to
   23 INF1 suonare
       ring
   24 INF1 ( )
       bell
   25-INF1 il campanello e di non gridare
       the bell and not to shout
   26-INF1 perché mi chiamava (un sacco
       because he called me (lots
   27-INF1 di volte) ( )
       of times)
   28-INF1 ( )
       shout
   29-INF1 ( )
       for help

With reference to the working mode, recourse to whispered interpreting is the most suitable option for the most part of the interaction, given the long stretches of same-language discourse and the need to expedite the exchange. Along similar lines, the translation is provided in a condensed form, by avoiding the rendition of data which are tentatively formulated, but rather waiting for the relevant repair by the primary speakers. For instance, when INF1 indicates the typology of procedure the patient underwent, at first she identifies it as a “living donor” liver transplant (lines 7-9, left column), but then corrects herself, given that it actually was a “cadaveric” liver transplant (11); Italo only translates the amended piece of information (12-13, right column). On the same grounds, he omits the words of complaint uttered by the nurse preceptor in line 18 (left column): although in Sicilian dialect and partially inaudible, they convey her annoyance at having to deal with a difficult patient. The attitude of the nurse can nonetheless be inferred with no need for the translation, as further confirmed

---

35 Sicilian dialect for the Italian *questa*, meaning ‘this’. 
by her ironic exclamation in line 21. As for footing, in Excerpt 10 Italo is seen to act as narrator, so that it is constantly clear who performed a certain task or expressed a specific thought (e.g. “gli ho spiegato/I explained to him” in line 22, left column, is translated as “she was trying to explain”, line 26, right column).

However, possible changes in the interactional requirements may lead Italo to modify his delivery accordingly. For example, the US nurse, though chiefly an observer, occasionally becomes an active participant in the conversation, should she address the Italian nurses or be addressed by them. An occurrence of the former case is offered in Excerpt 11: when the outgoing nurse argues that the patient is not oriented – i.e. that he is not aware of the existing situation – especially with reference to time, the US nurse points out that his neurological status was different the day before, when she had the same patient assigned (line 60):

**Excerpt 11 (NR.FL.06, 60-79)**

60 N he was oriented yesterday
61 INF₁ ehm
62 I comunque dice era orientato ieri si orientava anyway she says he was oriented yesterday he oriented
63 INF₁ (to the US nurse) no
64 N not today
65 I non oggi not today
66 INF₁ questa notte completamente at all last night you see (not) last night at all alla collega the colleague
67 I
68 INF₁ l’ha fatta impazzire i pazienti si sono tutti lamentati= the patients all complained nurse –
69 I
70 INF₁ =perché non ha because riposato nessuno nobody rested nurses and patients were complaining about him
71 I
72 N really↑
73 INF₁ yes....
74 INF₂ that they were not able to rest
75 I
76 INF₂ ((willing to continue )) *pa:in*
77 INF₁ dolore no pain no
78 con me non l’ha avuto with me he didn’t have it I pain no pain
79 with her
A number of shifts in the interpreting product and performance can be identified. First of all, although the interjection in line 61 signals that INF1 is about to continue with her report, Italo steps into the flow of talk as soon as the US nurse intervenes, thus momentarily moving to the short consecutive mode (line 62: “comunque dice era orientato ieri/anyway she says he was oriented yesterday”). Interestingly, as underlined by Bot (2007: 86), the use of the reporting verb (“dice/she says”) acts as a turn-entry device to indicate the interpreter’s need for turn transfer and his simultaneous intention to avoid information loss caused by overlapping talk. Moreover, in this section of the exchange no additions or omissions can be identified, as Italo’s renditions are essentially close to the originals. The sum of all these adjustments paves the way for a brief direct exchange between the outgoing Italian nurse and her American colleague: when the latter exclaims “really” (line 73), INF1 replies in English (74: “yes”). At this point, INF2 asks about the pain condition of the patient, thus introducing a new topic (76): although she does it in English, her tone of voice denotes the intention to resume the orderly progression of patient data rather than prolong the four-party interaction (see also §5.1.2 about the use of English medical terminology by the Italian healthcare staff). Hence the previous communication pattern is restored as of line 77.

The last interaction type in the corpus includes two training sessions. The first to be recorded, labelled as TS.01, is part of the specialized orientation to critical care provided by an American instructor (N) to three young nurses (INF1, INF2, and INF3) just hired to work in the hospital’s intensive care unit (ICU). More specifically, the lesson concerns an invasive method used to assess and diagnose cardiopulmonary function in ICU patients. While the first part of the session is mainly theoretical, the second is of a more practical nature and deals primarily with the interpretation of the values measured through specific catheters. At the time of the recording, the interpreter involved, Christian, was still refining his interpreting technique, especially in the simultaneous mode (see §4.3.1); therefore, as he confirmed in a post-assignment interview, during the lesson he opted for the short consecutive mode, as he felt more confident about it.

Excerpts 12 and 13 illustrate two different interaction patterns: the first is an instance of monologic discourse, i.e. of the speech produced by the instructor during most of the lesson, whereas the second passage is of a dialogic nature. Both excerpts
show that the session unfolds seamlessly. The trainer’s elocution is noteworthy: the frequent intraturn pauses (as in Excerpt 12, lines 65-67; 72-74) and the lengthened vowel or consonant sounds (as in Excerpt 13, line 257: “for a lo:::ng time”) result in a very low speech rate. She also regularly emphasises significant expressions, a typical feature of instructors’ speech that here is often emulated by Christian (e.g. in Excerpt 12 the English “anticipate”, line 66, and the Italian “anticipare”, 69; the English “task-oriented”, line 73, and the Italian “esecutore/performer”, 77). Moreover, the US nurse is used to working with interpreters, so she generally pauses spontaneously to allow for the interpretation, as Excerpt 12 shows:

**Excerpt 12 (TS.01, 65-78)**

65 N and our (.) approach at giving (.) nurses (.) all of this information is it
66 so: they can *anticipate* and critically *think* (.) what will the orders
67 be what is the physician going to::: (.) uh write u:h
68 I >tutto questo viene fatto< anche per – per sviluppare nel –
69 nell’infermiere la capacità in un certo senso di *anticipare* quelli che
70 saranno gli ordini scritti o verbali del – del medico quindi:: diventerà
71 anche una forma mentis capace di anticipare quello che succederà
also a mental attitude able to anticipate what is going to happen
72 N °okay↑ (.) °all right and° (.) u::h it just helps the – >the nurses have a
73 very – < become not just *ta:::sk* (.) *oriented* (.) uh in the I C U >but
74 understand< (.) why they are doing what they are doing why the
75 physician is doing what he or she is – °is doing°
76 I quindi l’importanza per l’infermiere in terapia intensiva non soltanto di
77 essere u:n – semplicemente un *esecutore* (.) degli ordini ma anche di
78 capire (.) perché stai facendo una cosa o i motivi che ci sono °dietro°

Moving to the dialogic sequence in Excerpt 13, the familiarity with the interpreting service emerges also in terms of conversational alignment: trainer and trainees address each other directly (see line 246, “you can tell me”), and the same stance is maintained by the interpreter’s marked preference for the direct speech, as in line 251 (“ditemelo/you can tell me this”). Excerpt 13 consists of a typical “question with known answer” that follows the three-turn sequence of initiation-reply-evaluation, or IRE (Macbeth 2004: 703-704). The instructor wants the students to explain the risks
of leaving air in the small balloon at one extremity of the catheter they are examining, when this is inserted in the pulmonary artery of a patient (lines 246-247); interestingly, she specifies that the nurses can answer in Italian (246: “you can tell me in Italian”, translated as “anche in italiano ditemelo che io lo capisco/you can tell me this even in Italian as I can understand it”, line 251). Indeed, the educator has a good passive knowledge of Italian, after three years spent in Palermo, but she is not confident enough to actively use it for the lesson:

Excerpt 13 (TS.01, 246-257)

246  N  and you can tell me in Italian what’s the *danger* of leaving the air in
247  this↑(.  why (. [ why is this that ]
248  I  qual è – qual è il pericolo se lascio what is... what is the danger if I leave
249  I  l’aria qua dentro= the air
250  N  ed è chiuso and it’s locked
251  I  anche in italiano ditemelo you can tell me this even in Italian
252  INF3  =sì ((cough)) perché se
253  INF3  si apre la valvola di sicurezza e il paziente schiaccia il:: (. la siringa↑= the locking device opens up and the patient squeezes the
254  I  =mhm=
255  INF3  =spostandosi (. può (. fare:: while moving it can allow
256  INF2  >entrare l’aria dentro< the air to get in
257  N ° yeah° and it could be there for a lo:::ng (. ) time […]

The educator is able to provide the trainees with direct feedback (line 257), although their turns (lines 252-253, 255, and 256) are left untranslated. In another context, these would be read as instances of omission, apparently in contrast with the role of message relayer that Christian has so far played in the interaction; in this case, however, they result from a deliberate choice, given the explicit request made by the US nurse. But how would Christian have behaved in the absence of specific indications in this regard? In a bilingual setting, the diverse linguistic requirements of the primary speakers are of crucial importance in shaping the decisions and adjustments of the interpreter, as will be examined in more detail in the next three sections.
5.1.2 Adjusting to the linguistic requirements

As a result of the atypical situation of language contact at ISMETT, during interactions between co-workers passages in Italian and in English frequently alternate with each other: this phenomenon is known as codeswitching, namely the use of two languages “within the same speech situation and often within the same sentence” (Angermeyer 2005: 1). More specifically, the medical jargon used in the hospital – often consisting of numerous abbreviations and acronyms – is essentially based on English terminology, which is generally understandable to both US and Italian personnel regardless of their language proficiency. This trend has developed throughout the years to the extent that many Italian signifiers have now been replaced by their English equivalents even among Italian staff, who perceive them not as foreign words, but rather as belonging to a new, common language which might be called ‘Ismettese’.

Hence the LS members are frequently faced with a “partially transparent bilingual constellation” (Meyer 2002: 167), especially during change-of-shift reporting. Excerpt 14 offers a characteristic example of medical terminology management in the translation of a report from English into Italian. During the exchange, the outgoing American nurse provides information on the dietary requirements of a patient, who was started on a regular diet after an initial period of “NPO” (line 136). The acronym, which comes from the Latin *nihil per os*, i.e. nothing by mouth, indicates the withholding of oral food and fluids that is commonly ordered in the pre- and post-operative periods. Despite its etymology, the acronym does not belong to standard medical terminology in Italian, yet interpreter Henry keeps it also in his rendition (line 137), pronouncing it as Italian nurses at ISMETT usually do. Moreover, the Italian incoming nurse herself asks for more details about the new order by using the English adjective “regular” (141) instead of the Italian *regolare*. Notably, Henry adjusts to this choice when he reports the answer of the American nurse (145):

**Excerpt 14 (NR.FL.08, 136-145)**

<table>
<thead>
<tr>
<th>Line</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>136</td>
<td>okay↑(.) he’s no <em>more</em> on N P O</td>
</tr>
<tr>
<td>137</td>
<td>non è più in N P O</td>
</tr>
<tr>
<td>138</td>
<td>I don’t know why they haven’t (   )</td>
</tr>
<tr>
<td>139</td>
<td>non sa perché è ancora ”è segnato qui” it’s written here</td>
</tr>
<tr>
<td>140</td>
<td>from yesterday</td>
</tr>
</tbody>
</table>

...
Paradoxically, the ISMETT staff are now so accustomed to the English terms that at times the equivalent expressions in Italian are not recognized, as shown in Excerpt 15 below. During the interaction (NR.FL.01) mediated by Dario and already examined above (see Excerpts 6, 7, and 8), the US nurse giving report warns her Italian co-worker about the presence of external pacemaker “wires” on the patient (line 414). Yet Dario’s rendition (“cavi”, line 415) is apparently unclear to the Italian-speaking party, who asks for repetition (417: “che cos’ha/what does she have”). The inquiry is not reported straightaway, given that the interpreter (line 418) is still translating the latest turn of the US nurse (416); nevertheless, the American co-worker is able to reply directly, with no need for the translation (419: “wires are still there”). Her intervention and, more specifically, the reiteration of the English term clear up the misunderstanding, to the extent that the Italian nurse further repeats it in English, although with a non-standard pronunciation (420: “w[air]es”), to ask for feedback:

Excerpt 15 (NR.FL.01, 414-421)

414 N she still has the wires up here ((pointing at the chest))
415 I ((whispering)) ha ancora i: (.) cavi (.) qui su (.)
416 N she still has the wires under the two by twos
417 INF che cos’ha↑= what does she have
418 I sotto i due per due under the two by twos
419 N wires↑ wires are still there
420 INF w[air]es↑ ((the interpreter nods)) va bene (.) ((writing down her notes))
421 okay

In terms of interpreting product, the options available in the Italian renditions are either to use the standard translation or to preserve the English terminology, although the latter occurrence is perhaps the most common at ISMETT. On the other hand, when the report is provided in Italian to an American staff member, the interpreter has a wider range of choices. In this regard, significant sequences can be identified during the report
of an Italian nurse at the end of his exhausting night shift in the step-down – or semi-intensive care – unit (SDU). Excerpt 16 refers to the cardiovascular assessment of the patient:

Excerpt 16 (NR.SDU.02, 44-47)

44 INF cardiovascular↑ ehm la signora è: in:
45 I =è in normal s[i]nus rh[i][t]m
46 INF she's
47 I she is in normal sinus rhythm

The remarkable linguistic construction used by the Italian nurse belongs to a subcategory of codeswitching, namely to code-mixing: elements of both languages are combined into the same utterance. More precisely, following Angermeyer (2005: 272), the choices in lines 44 and 46 – despite the mispronunciation – can be defined as “insertions”, since single phrases in English are included into Italian structures. The interpreter involved, Georgia, decides to ‘echo’ what has just been said, i.e. to repeat the utterance in English (as in line 45, in which the acronym “CV” stands for ‘cardiovascular’, and in line 47); although the lexical items remain unchanged, the rendition mainly aims at supplying the syntax of the target language. Conversely, in the subsequent passage (Excerpt 17) Georgia avoids to replicate the information already given in English (the position of the intravenous access, “left antecubital”, line 48). She just translates the gauge of the access (48: “numero venti”; 49: “number twenty”), with a low tone of voice:

Excerpt 17 (NR.SDU.02, 48-49)

48 INF c’ha un left antecubital(.) numero venti(.) come accesso
49 I ((whispering)) °number twenty°

The variety of codeswitching types offered by this interaction includes also instances of “self-translation” (Angermeyer 2005: 298), i.e. the nurse’s repetition of the same propositional content both in English and in Italian. In Excerpt 18 (line 76) the first statement (“voids”) and the self-translation (“urina”) occur in immediate succession:
Excerpt 18 (NR.SDU.02, 76-78)

76 INF genitourinario::↑ (. ) **voids urina::**: 
   she voids

77 I =((whispering)) "she voids spontaneously" =

78 INF ="tranquillamente" [ ]

Interestingly, the following turn by Georgia (77: “she voids spontaneously”) sums up three functions: it is an echo of the English verb, a translation of the Italian equivalent, and an anticipation of the rest of the utterance voiced by the Italian nurse in line 78 (“tranquillamente/easily”). Indeed, ‘the patient voids spontaneously/il paziente urina spontaneamente’ is a typical “concept label” used during nursing reports (Lamond 2000; see §2.5.2), so that Georgia knows that the sentence of the Italian nurse is likely to conclude with the adverb *spontaneamente* or a synonym, as in this case.

When code-mixing involves a longer segment of speech, the translation becomes unnecessary, as in the example below:

Excerpt 19 (NR.FL.07, 28-38)

28 INF =non è andata ancora di corpo=
   she didn’t move her bowels

29 I =no B Ms=

30 INF =ha fatto aria comunque
   she passed flatus anyway

31 I *but* flatus

32 INF **ha un:** right lower quadrant J P ( . ) to bulb suction ( . ) serosanguineous
   she has a

33 °(with me)° one hundred °with me° ( . ) e:::hm D C teds ( . ) **avev** – edema
   she had... edema

34 agli arti superiori infatti::
   to the upper extremities indeed

   [è difficile prendere:: accessi venosi
   it’s hard to find IV accesses
   upper – to – to the arms – ]

35 I edema

36 to the arms=

37 N **((writing down her notes))** edema

38 I =so it’s:: (. ) *hard* to find an I V access=

In lines 32-33 the outgoing Italian nurse begins the sentence with an Italian verb (“ha un/she has a”), but then she shifts to English in order to describe the type of drainage of the patient (called Jackson-Pratt or “JP”), its location (“right lower quadrant”), how it works (“to bulb suction”), what it produced (“serosanguineous” drainage), and in what amount (“one hundred”). She also adds that the thrombo-embolic deterrent stockings,
commonly known under the acronym TEDS, have to be discontinued (“DC teds”), and finally goes back to the Italian language. Interpreter Julia first interrupts her translation (after line 31), since it would sound superfluous, and then resumes it at the end of the sequence in English (line 35).

Although the linguistic production of the primary speakers is largely the outcome of unconscious shifts, nurses occasionally display a certain degree of awareness of their foreign language use. This happens, for instance, in the four-party interaction (NR.FL.06) described in the previous section (see Excerpts 10 and 11). The nurse preceptor who is taking report (INF2) prompts the Italian outgoing colleague (INF1) to provide patient information in English by asking her close-ended questions in the same language (Excerpt 20 below, lines 296-312, left column). Then she ironically addresses the interpreter to point out that she is temporarily relieving him of the interpreting duty (line 313: “ti diciamo risparmio un po’ di lavoro/let’s say I save you some work”). Italo expresses his appreciation (315: “grazie/thank you”, followed by a chuckle) by using the footing of responder:

Excerpt 20 (NR.FL.06, 296-320)

296 INF2 °(mhm)° < (. ) quindi
so

297 integumentary abdominal

298 infusion

299 INF1 yes open to air

300 INF2 open to air

301

302

303 INF1 dry intact

304 INF2 dry (ed) intact (and)

305 INF1 °yes°

306

307 INF2 ismett one and=

308 INF1 domani tomorrow

309 INF2 FK for tomorrow↑ ((INF1

310 nods))

311 ((pause)) ((INF2 goes on writing her

312 notes))

313 INF2 ((to the interpreter)) >t – t – < ti::: diciamo risparmio un po’ di lavoro

let’s say I save you some work
314  let’s say
315  grazie ((chuckle))
316  INF₁ ( ) ((chuckle))
317  INF₂ chest [iks]-ray done all done↑
318  ((INF₁ nods)) done done
319  done done=
320  INF₁ sì:ce:rto
       yes sure

Although the interpreter does not translate the comment of INF₂ (lines 313-314) into English, the excerpt is followed by a hilarious exchange in which the American nurse is not excluded from the interaction, but rather jokes with the other participants. Subsequently, the report is resumed in Italian, following the pattern already seen in Excerpt 11. What ought to be highlighted here is the interpreting behaviour of Italo in conjunction with the use of English by the two Italian nurses. In lines 301-302 and 306 (right column) he echoes data already given by INF₁ and INF₂, so that he compensates for any unclear enunciation. Yet he does not feel the same need when it comes to the indication of the laboratory tests scheduled for the following morning (“ismett one and FK”, lines 307 and 309), or of the chest X-ray that has already been performed (317, left column), so that he momentarily steps aside from the interaction. The same choice is made by Julia in lines 33-34 of Excerpt 18 above, or by Christian (Excerpt 13, lines 252-256). In other words, under specific circumstances a temporary shift can be identified from the interpreter’s task of message relayer to that of linguistic support.

5.1.3 ‘Back-up’ interpreting

In order to further explore the role played by ISMETT interpreters when only selected turns of the primary parties need to be translated, two representative reports will be considered (NR.SDU.01 and NR.FL.02). The first, mediated by Eric, is given by a US nurse at the end of her morning shift to an Italian co-worker with a satisfactory English proficiency. After providing the general information on the patient, including diagnosis and medical history, the American nurse moves on to the review of the systems. First of all, she gives an account of the psychosocial and neurological conditions:
Excerpt 21 (NR.SDU.01, 13-22)

13 N [...] uh psychosocially she’s (. ) anxious: she’s okay
14 INF (. ) unless: someone’s (. ) *bothering* her
15 INF mhm<
16 N like her family but oth – but otherwise she’s quiet (. ) she was sitting
17 at the side of bed today
18 INF mhm
19 N a::nd (. ) no pain (. ) she can move around (. ) fine
20 INF okay (. ) he hav::e (. ) need (. ) P R N no[tling]=
21 N =no:
22 INF okay

The report develops smoothly: the Italian nurse acknowledges her understanding of the information received through the agreement tokens “mhm” (lines 15 and 18) and “okay” (lines 20 and 22); she also autonomously asks for information about pain treatment (line 20: the acronym PRN, which stands for the Latin pro re nata, i.e. “as per need”, is commonly used at ISMETT to indicate drugs which are not routinely given to patients, but only if required, such as analgesics). Although the sentence is not grammatically correct, the nurse gets her message across. But where is the interpreter?

The interaction then unfolds with a more detailed description of the patient’s conditions:

Excerpt 22 (NR.SDU.01, 23-38)

23 N uh (. ) she does sometimes have this headache ((touching her forehead
24 with the right hand))=
25 INF =>mhm<
26 N and her eyes hurt (. ) which her (. ) mum said it’s chronic (. ) she’s had it
27 for years ‘cause she’s blind (. ) from one eye she’s blind ((the Italian
28 nurse looks at the interpreter)) and then (. ) causes her to have a
29 headache and [(troubles)=
30 I è cieca
she’s blind
31 N =(reading)
32 I è cieca in un occhio e questo le causa mal di
she’s blind in one eye and this causes her a
33 INF [te:sta
headache
34 questo↑ this
35 I si e anche dolore agli occhi (. ) °proprio°
yes and also pain to her eyes exactly
36 N so I mentioned it to the doctors (. ) °but° (. ) no order for pain med when
37 I asked
38 INF °okay°
Eric, who so far has not been involved in the interaction, is silently called to intervene by the Italian nurse looking at him (lines 27-28): whereas the feedback tokens had previously signalled that the translation was unnecessary, the nonverbal cue now functions as a request for help. Indeed Eric translates (lines 30 and 32), responds to the additional question (33-34) of the Italian nurse and finally concludes his intervention by summing up other information (the patients’ eyes hurt, line 35) that the Italian nurse might have missed. The interaction then moves back to English and the new piece of information requires no translation (36-38). The passage continues with the review of the cardiovascular and pulmonary systems:

Excerpt 23 (NR.SDU.01, 39-52)

<table>
<thead>
<tr>
<th>Line</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>39</td>
<td>N</td>
<td>uh (.) normal sinus rhythm=</td>
</tr>
<tr>
<td>40</td>
<td>INF</td>
<td>=&gt;mhm&lt;</td>
</tr>
<tr>
<td>41</td>
<td>N</td>
<td>she has a left (.) ((pointing at the left arm)) A C twenty gauge (.) with D</td>
</tr>
<tr>
<td>42</td>
<td>five and W (.) at a: (.) fifteen M Ls (.) &gt;no blood return&lt;</td>
<td></td>
</tr>
<tr>
<td>43</td>
<td>INF</td>
<td>((to the interpreter)) fifteen↑</td>
</tr>
<tr>
<td>44</td>
<td>I</td>
<td>quindici</td>
</tr>
<tr>
<td>45</td>
<td>N</td>
<td>u:h (.) no edema</td>
</tr>
<tr>
<td>46</td>
<td>I</td>
<td>((to the US nurse)) °you said <em>fifteen</em> right↑°</td>
</tr>
<tr>
<td>47</td>
<td>N</td>
<td>°yeah° (.) u::::h↑ respirator she’s trach-mask twenty-eight percent and</td>
</tr>
<tr>
<td>48</td>
<td>five liters of (.) oxygen</td>
<td></td>
</tr>
<tr>
<td>49</td>
<td>INF</td>
<td>((to the interpreter)) [a]l↑</td>
</tr>
<tr>
<td>50</td>
<td>I</td>
<td>ventotto per cento</td>
</tr>
<tr>
<td>51</td>
<td>INF</td>
<td>mhm</td>
</tr>
<tr>
<td>52</td>
<td>I</td>
<td>e l – e cinque litri di ossigeno</td>
</tr>
<tr>
<td></td>
<td>and... and five litres of oxygen</td>
<td></td>
</tr>
</tbody>
</table>

Again, Eric is asked to repeat or confirm what has been stated by the American colleague, but on this occasion in a more explicit and targeted manner (lines 43 and 49).

The difficulties with less technical terminology identified in this report find confirmation in the second exchange under study (NR.FL.02), which involves a step-down unit nurse coming from the US and an Italian one who works in the regular admission unit; it does not occur at the change of shift, but during the afternoon, when a transplant patient needs to be transferred from the SDU to the Floor. Also in this case, the interaction is chiefly in English, given that the Italian nurse has some knowledge of the foreign language; nevertheless, the two women request the support of interpreter Dario to prevent communication gaps. As in Excerpt 23 above, the comprehension of
numbers may be problematic: in the following example (Excerpt 24), the Floor nurse easily understands most information concerning pain and vital signs (lines 14-18), except for the indication of the patient’s heart rate (line 18), perhaps owing to the quicker speaking pace of the colleague and the unusual wording (“like in the seventies and eighties”). The Italian nurse thus calls Dario’s attention to this passage (19: “non ho capito qua la frequenza/I didn’t understand here the rate”), so that he supplies the relevant translation (lines 20-21 and 23):

Excerpt 24 (NR.FL.02, 14-26)

14 N u:h complains of no pain↑(.)(background voices)) she – (.)(has been
15 INF "okay"=
16 N =u:h off the monitor (.)(down in step-down (.)(doctor said that was fine↑
17 INF >heart rate's like in the seventies and eighties<
18 N one thirties (.)(u::h >heart rate's like in the seventies and eighties<
19 INF ((to the interpreter)) "no non ho capito (qua)° la frequenza sui la frequenza° no I didn’t understand (here) the rate
20 I °
21 settanta=
22 INF =oh=
23 I =ottanta√
24 INF okay=
25 N =u::h (.)(she has a number twenty in her left hand
26 INF mhm

The same pattern can be found with reference to narrative passages similar to the one in Excerpt 22. For instance, when the US nurse explains that the patient has no restriction of sugar intake, Dario is asked to intervene (Excerpt 25, line 39: “che ha detto/what did she say”). Interestingly, in his translation (lines 42 and 44) he does not reiterate that the woman is on a regular diabetic diet (line 36), as he is aware that the lack of understanding is limited to the comment on the “sugars” (36-37):

Excerpt 25 (NR.FL.02, 36-44)

36 N she (.)(is on a regular (.)(diet (.)(diabetic but she’s allowed to have (.)
37 INF her sugars if she wants them (.)(doctor said
38 ((the Italian nurse looks at the interpreter with a puzzled expression))
39 INF ((to the interpreter)) >°(che ha detto)°< (what did she say)
It should be noted that the function of linguistic support usually corresponds to a less active involvement of the interpreter in the encounter and in the service provision (cf. Merlini 2009). However, the peculiar language situation at ISMETT and the corporate goal of fostering staff proficiency in both Italian and English often turn this ancillary task into a most welcome asset to the interaction. In addition, this fluctuation between involvement and non-involvement, between stepping aside as an observer and moving back into the turn-taking sequence when required, is more demanding than it might appear. ‘Understanding whether the person has understood’ entails a constant monitoring of the interaction in all its components, both verbal and nonverbal, in order to assess how and when to translate: a ‘back-up interpreter’ must select the right timing and attitude, to make sure that the intervention is not perceived as interference.

This is best exemplified by an excerpt from one of the training sessions in the corpus (TS.02). The main speaker is an American visiting instructor who discusses the role of nurses and other healthcare providers in the event of a patient crisis. The session is attended by ISMETT nursing educators, clinical coordinators, physical therapy and respiratory therapy coordinators, as well as by exchange nursing students from the US. The interpreters, Italo (I₁) and Georgia (I₂), are sitting on one side of the conference room, with a microphone each: headsets have been distributed to the Italian staff who need the translation and to all US attendees, so that Italo can interpret in whispering mode from English into Italian and Georgia from Italian into English, should the Italian participants intervene. 36 Given that all comments are eventually made by those participants who are fluent in English, the role of Georgia is chiefly confined to helping Italo as if they were in the booth. And yet she is physically present in the room. The passage to be examined concerns the final debate and, more precisely, the involvement

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36 As a general rule, for less formal events there is only one interpreter who alternates between one microphone and the other, each for a language direction. However, on this occasion Georgia and Italo kindly offered to provide the interpreting service as a team.
of two Italian nurses (INF$_1$ and INF$_2$). For the sake of clarity, the mutual positions of the relevant parties – without taking into account the other audience members – is illustrated in Figure 5.1. In Excerpt 26 the column on the left shows the turns in English of the primary speakers, whilst Italo’s rendition appears on the right. One of the two Italian nurses (INF$_1$) would like to know who set the criteria that must be met for a code to be called in the UPMC hospital of the instructor (lines 435-437). A ‘code’ is an emergency situation, such as a cardiac arrest or respiratory failure, requiring a specific medical team to immediately reach the pertinent location and provide support, for instance to resuscitate the patient. The nurse, who talks in English, has some trouble formulating the question; at first, the other Italian colleague (INF$_2$) comes to the rescue (left column, lines 438 and 440), but then INF$_1$ tries to complete the sentence autonomously (441-443):

**Excerpt 26 (TS.02, 435-448)**

<table>
<thead>
<tr>
<th>435</th>
<th>INF$_1$</th>
<th>who decide about the:: (.)</th>
<th>INF$_1$</th>
<th>chi decide (.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>436</td>
<td>u::h (.) calling criteria there is</td>
<td>INF$_2$</td>
<td>a C P R committee† who:::</td>
<td>INF$_2$</td>
</tr>
<tr>
<td>437</td>
<td>who:::</td>
<td>INF$_1$</td>
<td>criteri:: da:: (.)</td>
<td></td>
</tr>
<tr>
<td>438</td>
<td>which are the=</td>
<td>INF$_1$</td>
<td>which are=</td>
<td></td>
</tr>
<tr>
<td>439</td>
<td>INF$_1$</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
As the US nurse hesitates about answering (444 and 448), Georgia decides to intervene ‘off mic’ and clarify the message by rephrasing the inquiry (Excerpt 27, left column, lines 449-450):

Excerpt 27 (TS.02, 449-460)

Undoubtedly, the communicative goal is achieved: the US nurse understands the question and replies accordingly. What cannot be ascertained is whether Georgia’s adjustment has been perceived by the Italian interlocutor as an indirect threat to her self-image, given that, when she acknowledges the correction, she also apologizes (line 453: “sorry”). Most likely, the nurse appreciated it as form of collaboration, by virtue of the mutual trust relationships built throughout the years between the LS Department and the ISMETT users; in fact, after this exchange INF₁ asks further questions in English. Nevertheless, Excerpt 27 sheds light on the tact and diplomacy required for back-up interpreting.
5.1.4 Language teaching

Being cast in the role of linguistic support may also entail that the LS members occasionally act in their capacity as language experts rather than interpreters. Language teaching and back-up interpreting can actually be viewed as two sides of the same coin, as evident in Excerpt 28 below. The passage is taken from one of the two nursing reports examined in the previous section (NR.SDU.01; see Excerpts 21, 22 and 23). The US nurse needs to know whether the colleague is able to increase the free water that is co-administered with the enteral feeding of the patient (lines 144-145 and 147-148). Also on this occasion, the Italian nurse would like to reply directly, but she is unsure about the English word for the Italian verb provare, to try. Therefore, she asks the interpreter, Eric, for corroboration (line 149):

Excerpt 28 (NR.SDU.01, 144-163)

144 N [...] you can increase the free water on that
145 (. ) feeding pump can you↑
146 INF mhm
147 N will you show me↑ can you increase (. ) the water on the feeding tube
148 ( ↑ ) –
149 INF we can – (. ) ((to the interpreter)) provare è try vero↑

150 I provare e *tentare* (. ) >lei – lei vuol sapere<
    try and attempt she... she wants to know
    possiamo provare we can try

151 INF

152 I =si se si può provare
    yes if it is possible to try

153 INF “possiamo provare” we can try

154 I vorrebbe vedere come si fa sostanzialmente
    she would like to see how to do it basically

155 N can you↑

156 INF possiamo provare ((chuckle))
    we can try

157 I we can try

158 N “okay” (. ) ‘cause I didn’t know how to do it so it’s still at twenty-five (. )

159 INF M Ls

160 INF ((to the interpreter)) come↑
    what

161 I dice io non sapevo come fare allora è sempre a venticinque M L
    she says I didn’t know how to do it so it’s still at twenty-five mls

162 N that’s it

163 INF “okay”
What is particularly noteworthy about this excerpt is the apparent inability of the interpreter and the Italian-speaking party to establish who is going to respond in English. Following the inquiry of the Italian nurse, Eric provides nuances of meaning (to try can be translated as “provare” and “tentare”, line 150). Subsequently, as he does in Excerpt 22, he feels the need to reinforce the contents of the latest turns uttered by the American nurse through explanatory additions (lines 150, 152, and 154) and using the footing of narrator (150: “lei vuol sapere/she wants to know”). Although the nurse should now have all the information necessary to reply autonomously, she rather repeats the sentence in Italian three times (151, 153, and 156: “possiamo provare/we can try”); eventually, Eric translates it (line 157). At the root of the misunderstanding there might be conflicting expectations of the task to be performed by Eric in this specific situation: should he relay the message on behalf of the Italian nurse, or should he just support her in phrasing the question in English? On the other hand, this dilemma does not apply to the following turn of the American co-worker (lines 158-159), as the Italian nurse explicitly asks for the translation (160: “come/what”). Interestingly, in his rendition Eric uses the strategy of direct representation (Bot 2007), i.e. the direct rendition of the previous turn is preceded by a reporting verb (line 161: “dice io non sapevo come fare/she says I didn’t know how to do it”). Given the aforementioned role confusion, this choice may be read as an attempt to temporarily re-establish Eric’s translating function, which is incidentally kept from this moment until the end of the report.

In other cases, the border between the diverse duties of the interpreter is more clear-cut. In Excerpt 29, taken from the second interaction analysed in §5.1.3 above, the American nurse explains that the patient has the so-called “clamshell incision” (line 30), which is the standard approach used in bilateral lung transplants. Dario is explicitly asked (32-33) to give the correct spelling of the word “clam” (34):

**Excerpt 29 (NR.FL.02, 30-35)**

```
30 N [...] she has a **clamshell** (.) **incision** °( )° and that looks fine
31 INF (.) °(opening)° no drainage
32 INF ((to the interpreter)) ehm **me lo puoi dire com’è lo spelling di clam**
33 e::hm [incisione]
34 I °C L A M** ((background voices))
35 INF °C L A M° ((writing down her notes)) clam (. )° [injúilzjion] (. )° okay
```
A significant occurrence of language teaching can also be found during the nursing assessment mediated by Barbara. As already pointed out (see §5.1.1), the US healthcare practitioner involved in the interaction speaks some Italian. While checking the sublingual temperature of the patient, the nurse hears the phrase “sotto la lingua/under the tongue”, used by Barbara in her rendition for the patient (Excerpt 30, line 192), and tries to echo it, although incorrectly (195: “sopra lingua/upon tongue”). The interpreter reacts immediately by correcting her (196: “sotto/under”) and repeatedly stressing that “sotto” means “under” (198 and 200) rather than “low” (199), although she concedes that the expression “sotto voce” can be translated as “low voice” (201):

Excerpt 30 (NA.FL, 190-201)

190  […] ((the nurse takes the thermometer))
191  N  >°(   ) this°< under – under his tongue
192  I  >sotto la lingua< “lo metta°=
              under the tongue  put it
193  N  =yeah
194  ((the patient opens his mouth and the nurse sticks the thermometer tip into it))
195  N  “sopra lingua”
              upon tongue
196  I  *sotto*
              under
197  N  *sotto* li:ngua (.) °sì° (.) ((to the interpreter))  sotto=
              under
198  I  °under°
199  N  =is low yeah sotto=
              under
200  I  °under°
201  N  =sotto voce is low voice↑ ((the interpreter nods)) sì
              low voice
              yes

It should be underlined that Eric and Dario, in Excerpt 28 and 29 respectively, are addressed by a primary speaker and therefore adopt the footing of “responder”, whereas in the last example Barbara acts on her own initiative, thus behaving as “principal” (Merlini and Favaron 2007). What is shared by all three cases is that, whenever the interpreter engages in a metalinguistic dialogue with one of the participants, the other interlocutor is inevitably excluded from complete understanding.
5.2 A multifaceted teamwork

5.2.1 Meaning negotiation
As pointed out by Graham Turner at the Critical Link 4 Conference, over the last few years interpreting practitioners and researchers have been underscoring the notion that “making meaning is a co-operative venture” (2007: 183). For this reason, Turner stressed, interpreters “would benefit from working with clients who are active collaborators in the face-to-face interpreting process” (2007: 188). At ISMETT, these remarks find confirmation in the fact that the cooperation between LS members and healthcare personnel plays a decisive role in disambiguating messages and enabling communication: for instance, recourse to the ‘human factor’ by asking back is a common strategy to resolve medical terminology issues (see §4.3.3). This is not an unusual occurrence in mediated interactions: in fact, it is acknowledged as an operational need of the interpreter, who is allowed to intervene and “ask for clarification if the concept voiced by one interlocutor has not been clearly heard or thoroughly understood” (Zimman 1994: 219). Yet, in order to achieve “a shared image or notion of the world” (Turner 2007: 183), it may occasionally happen that ISMETT interpreters themselves assist the primary interlocutors in producing meaningful original utterances.

In an ‘unmarked’ sequence (Excerpt 31) taken from the four-party nursing report (NR.FL.06), a doubt about the content of the interaction is raised by one of the primary speakers, namely by the US nurse, rather than by the interpreter. With reference to the genitourinary assessment of the patient, the outgoing nurse (INF₁) explains that she carried out the so-called “bladder training” (mispronounced in lines 203-204, left column, and adjusted by Italo in lines 205-206, right column; cf. Excerpt 20). The American colleague is not familiar with this concept, and asks for explanation (217, on the right: “what is that”, further reinforced in line 219); however, it is not clear whether she is addressing the interpreter or the Italian nurses, given the twofold development of the entire interaction described in detail above (see §5.1.1 and 5.1.2). Italo opts for interrupting the report by translating this technical inquiry into Italian (lines 218 and 222, in which the use of the reporting verb “dice/she says” serves as a turn-entry device; cf. Excerpt 11):
The nurse preceptor (INF2) provides an exhaustive answer, which is only partially reported here (Excerpt 32, lines 225-242). In brief, the bladder training refers to the need to re-educate the bladder to contract and dilate soon after the removal of the urinary catheter (or “Foley” catheter, line 226). What needs to be highlighted is that the communication gap is bridged as a result of a joint effort of the four participants, and that, more specifically, direct contact is, once again, established between primary parties. Indeed, this section of the exchange closes with the mutual acknowledgment of the two incoming nurses (lines 263 and 266):
Excerpt 32 (NR.FL.06, 225-242)

225  INF2  ((to the US nurse)) e:::hm praticamente quando un paziente tiene per  
basically when the patient has for
226  INF2  molto tempo il Foley 

227  INF1  la vescica – 

228  I  when the 

229  INF2  patient has the Foley for l –  

230  INF2  =*has* the Foley =

231  INF2  l’urina –  

232  I  =for a long time

233  INF2  l’urina esce sempre  

the urine pours out constantly

234  I  so he just urid – voids  

235  INF2  =for a long time

so la vescica 

236  I  =(has) always °(   )°

237  INF1  non ha più  

has no longer

la vescica non si  

238  INF2  allena più nella=  

the bladder is no  

longer trained in the

239  I  and so the:

240  INF2  dilatazione  

dilation

241  I  bladder is no longer trained in contracting and –

((the US nurse nods))

(263; 266)

263  INF2  ((to the US nurse)) okay↑

[...]

266  N  ((to INF2)) °thank you°

In the following excerpt (33) a content-related query is raised both by one of the primary interlocutors and by the interpreter. During a nursing report taking place in the ICU and mediated by Francesca, the outgoing American nurse explains that her assigned patient underwent an interventional radiology procedure because of a liver disorder, but at first she is not able to specify the name of the disease. She therefore checks the electronic medical record, and finds out that the woman was affected by “Budd-Chiari” (line 45). Francesca asks the nurse to repeat the name of the disorder (47: “what does she have”) and then attempts to report it, yet with an uncertain tone of voice (49). Given that doubts are expressed also by the Italian nurse (50: “cos’è/what is
it”), the American co-worker explains that the illness is related to portal hypertension (52). Although the incoming healthcare practitioner makes comments (54 and 56: he will look for further information in the documentation) and suggests hypotheses (58: perhaps the patient was affected by a “K”, i.e. by a cancer), these turns are left untranslated, and only the final outcome of his reflections is conveyed into English (“ho capito/I’ve understood”, line 62). Moreover, in the rendition (65: “he knows what it is”), both the footing of narrator and the word choice – the verb ‘to understand’ is substituted for ‘to know’ – create a distance between the interpreter and the Italian-speaking party: Francesca foregrounds her mediating role, thus implicitly stressing that it is the nurse who should take responsibility for grasping the concept. Similarly to the occurrences discussed above (Excerpts 31 and 32), it can be said that the ultimate goal of the report, i.e. the information transfer, is eventually achieved:

Excerpt 33 (NR.ICU.01, 45-66)

45 N so ((reading from the electronic medical record)) she had Budd Chiari
46 I what does she have↑
47 N Budd (. *) Chia::ri:*
48 I ((doubtful)) il B[a]dd Chiari↑
49 INF "cos’è"↑
50 INF "what is it"
51 I "what is it" "with the"
52 INF " >with the<" "uh (.) portal hypertensio::n::"
53 INF "iper – ipertensione portale"↑
54 INF "most likely she had..."
55 INF " >with the<"
56 INF " vabbè ora la ="
57 INF "i look for the (piece of information) probably there was"
58 INF "either a [K – Ca]"
59 INF "ah ∧B[a][t]∧ Chiari"
60 INF "Budd Chiari:°"
61 ((pause)) ((background voices))
62 INF "sì sì sì< (. ) >°ho capito°<
63 INF "yes yes yes I’ve understood"
64 INF "yes"
65 I he knows what it is
Providential assistance in enabling communication is occasionally offered not only by the healthcare team, but also by written tools such as medical records and Kardex sheets. Excerpt 34 below illustrates one such example. The interpreter is Italo; the Italian nurse who is giving report specifies that a patient, in addition to other medications, has a skin patch called “duragesic”, and points at its name written on the Kardex (line 26). As already shown while discussing the diverse requirements of ISMETT users, medical terms that are potentially problematic for interpreters may be transparent across languages when it comes to the healthcare personnel, so that often there is no need for translation or repetition by the interpreter (see §5.1.2 and 5.1.3). Hence Italo first verifies whether the name of the patch – that he has probably missed – is clear to the US nurse (27); given that the woman sounds confused (28), he uses the deictic pronoun “this”, while pointing at the item on the Kardex (29) and replacing the term with the phrase “the one she is showing to you” (31). Once again, the message is conveyed (line 30):

Excerpt 34 (NR.FL.09, 23-31)

23 INF in più ha il cero::tto:: il du:=
       plus he has the patch the du...
24 I =plus he also has
25 (pause) ((the Italian nurse looks at the Kardex))
26 INF (pointing at the item on the Kardex)) il duragesic
       the duragesic
27 ((the interpreter looks at the US nurse to see whether she understands))
28 N “has what”↑” ((looking at the Kardex))
29 I (pointing at the item on the Kardex)) this=
30 N =ah >duragesic<
31 I the one s – she is showing to you↑

As mentioned above, in the negotiation of meanings cooperation is two-sided, i.e. the primary parties put their medical expertise at the interpreters’ disposal as much as interpreters can at times be asked to provide support beyond interpreting proper. The corpus features two noteworthy occurrences that are both associated, yet again, with the use of written material. In Excerpt 35, an American nurse has troubles reading one number from the patient chart; however, instead of asking the Italian colleague for advice, she rather addresses (675) the interpreter, Dario, who makes his own assumption
(677: “it’s a ten maybe”). The nurse is thus able to comprehend the whole order (678-679):

**Excerpt 35 (NR.FL.01, 675-679)**

675 N ((to the interpreter)) >what is it< ((pointing at an item on the medical record))
676  I ((whispering)) °ah it’s a ten maybe°
677 N ((reading from the medical record)) °( ) ten D C captopril start enapril
678  D C coumadin° (. ) °chest X-ray tomorrow mobilize° […]

In the second case (Excerpt 36), it is the interpreter (Henry) who spontaneously decides to back up the outgoing US nurse who cannot understand a medical record instruction (365: “what’s that”, “I can’t even read it”; 367-369), albeit written in English. Henry intervenes, reads the final part of the order (370 and 372: the patient is to undergo an angio CT scan “as for agreement with doctor Darbedo”), and then translates the content into Italian (375 and 378):

**Excerpt 36 (NR.FL.08, 363-378)**

363 N ((reading from the medical record)) *angio C T scan* (. ) for a:
364  I una tac: a CT scan
365 N ((doubtful)) >°what’s that°< (. ) I can’t even read it↑
366  I ((getting closer to the US nurse)) non riesce a leggere she cannot read
367 N ((trying to read from the medical record)) agree:: with doctor (. )
368  something for an agree:: (. ) something with doctor (. ) ((misreading the name)) {Darti} (. ) I agree↑
369  I ((reading from the medical record)) as for agreement ← with doctor= with doctor
370 N *
371 INF >cioè deve fare< that is he has to do una:: a
372  I ={Darbedo}*
373 N ={Darbedo}*
374 INF >cioè deve fare< that is he has to do una:: a
375  I come da accordi con as for agreement with il dotto:rz::= doctor
376 N angio C T (scan) tomorrow
377 INF scan °okay°
378  I ={Darbedo}*

A new interpreting function can thus be identified, namely that of medical co-expert, although with two variants. Whereas in Excerpt 35 it is one of the primary speakers who
casts Dario in this role, as confirmed by the interpreter’s footing of “responder”, in Excerpt 36 Henry assumes the same position of his own accord, acting as “principal” (Merlini and Favaron 2007). In either case, it can be said that the attitude of all participants is evidence for the spirit of comradeship among ISMETT co-workers.

The familiarity of the LS members with the communicative genre at hand may occasionally lead them to perform as medical co-experts in order to anticipate needs or difficulties. In this sense, a paradigmatic example is offered by interpreter Georgia in Excerpt 37, taken from the SDU nursing report (NR.SDU.02) already presented (see Excerpts 16-18). The outgoing Italian nurse involved in the interaction specifies that the blood sugar levels of the first assigned patient must be checked although she is not diabetic (lines 123-124 and 126). He is ready to move on to the second report (129), when Georgia interrupts him to ask whether the woman takes any insulin (line 130: “insulina ne prende/insulin does she take it”), through an autonomous intervention as principal. Prompted by the inquiry, the nurse checks the Kardex and verifies that the patient actually has an insulin scale, i.e. she must be given a specific insulin dose on the basis of blood sugar results (133-134). Georgia first translates this piece of information to the incoming US nurse (135) and subsequently reiterates the same pattern to obtain additional information on the type of insulin scale (137: “che scala è/what scale is it”). What is more, she looks at the Kardex herself and reads that it is a “medium” scale (137), as confirmed by the Italian nurse (139):

**Excerpt 37 (NR.SDU.02, 123-139)**

123 INF [...] la signora non è
   the lady is not
124 diabetica però ha i controlli
   diabetic but she has the checks
della::
   of the
125 I
   she’s not a diabetic
126 INF della glicemia
   patient=
   of the blood sugar
127 I =but we have to check her blood sugar levels
128 ((pause)) ((the Italian nurse looks at the medical record))
129 INF okay (. ) passiamo adesso↑ (. ) ((looking at his notes)) a {Pampinato}
   let’s move now
   to Pampinato
130 I insulina ne prende↑
   insulin does she take it
131 INF >come↑<
   pardon
The atypical behaviour exhibited by Georgia seems in line with her idea of ‘tailor-made services’ that ISMETT interpreters should offer to their users (see §4.3.4 and 4.3.5). In a post-assignment interview, Georgia explained that, after many years of experience in the units, she was able to predict what data nurses needed, and she felt that it was her duty to make sure that they were all accurately transmitted. Notably, with reference to the second report given during this interaction, the Italian nurse spontaneously includes information on the insulin scale of the patient (lines 219 and 221):

Excerpt 38 (NR.SDU.02, 213-222)

... he is diabetic the mister a diabetic patient

Yet the cooperation among staff members, in order to establish effective communication, is all the more evident in a peculiar aspect of the conversational dynamics, emerging from a closer analysis of the corpus: the presence of repair activities.
5.2.2 Repair activities

Repair in conversation is the fixing of a piece of talk, either in the course of its production or in subsequent turns, and it is normally – but not exclusively – carried out by replacing the trouble-source material (called “reparandum”, following Shriberg 1994) with the correct one (Macbeth 2004: 706). Moreover, repairs can occur not only to correct errors, but also for purposes of intentional or linguistic appropriateness (cf. Levelt 1983). Although the illustration of this immense field of research goes well beyond the scope of the present discussion, a few basic concepts will be drawn from repair theory, more specifically from the seminal work by Schegloff, Jefferson and Sacks (1977), and applied to the ISMETT corpus (see also Favaron 2009).

In a conversation between a “self” and an “other”, the person who initiates repair – i.e. who recognizes the reparandum as such – is not necessarily the speaker, nor is it the same person who accomplishes it (Schegloff et al. 1977: 364). In other words, repair may be initiated by the speaker (self) or by the interlocutor (other), and performed by self or other as well. This yields a four-cell grid of possibilities, based on self-or-other initiation and self-or-other repair (Macbeth 2004: 706). The four options are illustrated in Table 5.1 below. Self-initiation self-repair is exemplified on the top left: the speaker initiates repair and accomplishes it. On the top right, repair is initiated by the speaker, but accomplished by the interlocutor, whose suggestion is then ratified. Moving to the bottom, on the left repair is initiated by the ‘other’ interlocutor, who sounds doubtful and thus implicitly prompts the accomplishment of repair by the ‘self’. Finally, on the bottom right, repair is initiated and accomplished by the interlocutor.

In the field of interpreting, the concept of repair is found in Bot (2005), with reference to the resolution of communication problems in interpreter-mediated mental health sessions. In this context, repair strategies are generically indicated as those applied by the interpreter to re-integrate previously lost information, either in later turns during the same encounter or in subsequent therapy sessions. More specifically, repair activities are detected by Birgit Apfelbaum (2007) during the training of technical translation students as dialogue interpreters. In their simulated interactions, the researcher underscores that setting-specific tasks, such as the negotiation of technical terms, are often achieved through self- and other-repair, to the extent that repair activities are recommended as a standard instructional resource in interpreter training.
Significantly, most instances of repair in the ISMETT corpus are to be found in the training session on critical care nursing (TS.01; see §5.1.1, Excerpts 12-13), which bears marked similarities to the framework of Apfelbaum’s research study. As explained above, this lesson is an instance of on-the-job training also for the interpreter, Christian; in other words, during the session both trainees and interpreter are engaged in the acquisition of knowledge and skills in their respective fields. Hence the same categories used by Apfelbaum, i.e. those devised by Schegloff et al. (1977), have been applied to the instances of interpreter’s repair in the session under study. Predictably, self-correction, signalled by hesitations or false starts, is by far the most frequent occurrence, being a typical feature of the interpreter’s impromptu speech (e.g. Enkvist 1982), as in Excerpt 12, lines 68-70. However, attention will be focused here on instances of self-initiated other-repair, i.e. on those repairs initiated by the interpreter and accomplished by one of the primary speakers.

First of all, repair activities frequently occur in connection with “word and terminology search” (Apfelbaum 2007: 57), in particular at the beginning of the lesson. Drawing inspiration from Gail Jefferson’s (1987) distinction between “exposed”, i.e. explicit, or “embedded”, i.e. implicit, repair, the same categories are applied here to self-initiation, as shown in Table 5.2.

The following example (Excerpt 39) refers to an ‘exposed’ self-initiation. The educator is providing a succinct overview of the lesson’s contents, and mentions three technical concepts she is going to illustrate (lines 50-51: “systemic vascular resistances”, “cardiac output”, and “cardiac index”). When translating, Christian clearly points out that he cannot recall one of them and asks for the instructor’s support (55-56:

Table 5.1 Classification of repairs (from Favaron 2009: 445)

<table>
<thead>
<tr>
<th></th>
<th>Self-repair</th>
<th>Other-repair</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-initiation</strong></td>
<td>S Mark Smith has – sorry. John Smith has just arrived.</td>
<td>S John... what’s his surname... O Smith? S Yeah, Smith. He’s just arrived.</td>
</tr>
<tr>
<td><strong>Other-initiation</strong></td>
<td>S Mark Smith has just arrived. O Mark Smith? S No, sorry. John Smith.</td>
<td>S Mark Smi – O It’s John Smith. S Right, John Smith has just arrived.</td>
</tr>
</tbody>
</table>
Table 5.2 Exposed and embedded self-initiation and other-repair (from Favaron 2009: 446)

“what was the other thing”), which is immediately provided (57). Undoubtedly, this is a common and accepted interpreting practice (cf. Excerpt 5, line 31):

Excerpt 39 (TS.01, 47-58)

47 N and then hemodynamics three which is *supposed* to be today this is
48 the third day u::h goes into more (.) u::h (.) *parameters* looking at
49 mo::re u::h (.) >we say< in addition to the >pulmonary artery< pressure
50 numbers we look at (.) u:::h (.) system**ic vascular resistances** we look
51 at cardiac output cardiac index
52 I quindi guardiamo il – l’output cardiaco – questo è quello che si –
53 so we look at the... the cardiac output... this is what will...
54 55 I =quindi l’output cardiaco i vari indici e::: ((to the educator)) °what was
56 the other thing°
57 N cardiac index cardiac output system**ic vascular resistance=
58 I =la re – resistenza vascolare sistemica “eccetera”=

In contrast, ‘embedded’ self-initiation is a much more remarkable case, especially when the ‘others’ who accomplish the repair are the newly-hired nurses, ready to assist, in particular, if the interpreter is in trouble with the technical terminology. Notably, the three nurses are already graduated, and the orientation course is primarily aimed at reviewing subjects studied at university. Therefore, they are familiar with the contents and are able, for instance, to complete the sentences left ‘unfinished’ by Christian, as shown in the following excerpt:
The instructor explains a specific procedure, called “wedge” procedure, performed by inserting a catheter in the pulmonary artery (lines 89-91). Interestingly, the interpreter first states his intention to use the English word “wedge” also in the translation into Italian (93: “da ora in poi dirò wegde/from now on I’ll say wedge”), a common choice at ISMETT, where the medical jargon of the Italian staff features plenty of English terms. For the sake of clarity, however, he decides to specify the Italian equivalent (93: “è praticamente/it’s basically”): his final ellipsis, signalled by the lengthened vowel sound, is a cue for one of the trainees (INF1) to intervene and supply the correct term (94: “incuneamento”), immediately ratified by Christian (95).

On some occasions, the nurses provide their help when the interpreter’s word search is related to slips of the tongue or issues of linguistic appropriateness. For instance, in the hands-on part of the lesson, the instructor is holding a sample catheter and showing how to deflate the small balloon placed at one end, to prevent its rupture (Excerpt 41, lines 274, 276, and 278). While explaining this in Italian, the word “funzionamento/functioning” does not come to Christian. Also in this case, the embedded self-initiation of repair is signalled by the lengthened vowel sound and the hesitation (284: “diciamo ehm la – la:::/let’s say the... the...”). INF3 comes to the rescue (285):

Excerpt 41 (TS.01, 274-286)

274 N =>okay< the reason why you don’t *actively* (. ) pull back
275 INF2 mhm=
276 N =to *de*flate the balloon the company says that creates *wear* and tear
277 I mhm=
278 N =*on* the balloon and it might cause it to rupture
I lo fai sgonfiare = senza tu tirare via l’aria=

But a striking instance of repair concerns the trainer, i.e. one of the primary speakers, rather than the interpreter. In Excerpt 42, the educator is talking about values taken directly from the electronic medical record (at that time called “Emtek”, line 660), which is ‘interfaced’ with the monitor connected to the patient. Given her momentary doubt about the right technical word, the instructor asks the interpreter for advice, with an exposed self-initiation of repair (662: “what’s the word inter – ”). The interpreter accomplishes the repair by providing the sought-for word (663), subsequently ratified by the educator (664). Though a natural and common occurrence in everyday conversation, this pattern is undoubtedly atypical between primary speaker and interpreter:

**Excerpt 42 (TS.01, 660-664)**

660 N […] or you:: Emtek and it
661 takes it from the (.) the screen it’s – if they are (.) u::h (.) ((to the
662 interpreter)) °what’s the word inter – °
663 I interfaced °thank you°
664 N
under the category of “not-yet-competent in some domain”, as stated by Schegloff et al. (1977: 381), who interestingly add that, in this context:

[...] other-correction is [...] a device for dealing with those who are still learning or being taught to operate with a system which requires, for its routine operation, that they be adequate self-monitors and self-correctors as a condition of competence. It is, in that sense, only a transitional usage, whose superseding by self-correction is continuously awaited.

5.2.3 Team-building

The idea of ‘team’ can be regarded as an underlying leitmotif of interpreter-mediated encounters in intra-social ISMETT settings. As shown so far, a successful co-production of the interaction presupposes effective collaboration among participants; at the same time, however, these events are also incidental opportunities for strengthening the cohesion within the group, for instance by sharing laughs and little jokes. In this regard, a preliminary consideration is required. It has been illustrated above that exchanges with an extensive use of medical terminology may require that interpreters momentarily ‘disappear’ from the verbal interaction (see §5.1.3); on the other hand, the translation is provided by default in conjunction with more light-hearted remarks, given that the language used in these cases – not technical at all, but containing slang expressions, metaphors, or puns – might jeopardize comprehension.

In the training session on critical care nursing (TS.01) some occurrences can be identified in which the interpreter, Christian, retains the witty mood and informal register of the nursing educator in his Italian rendition. In Excerpt 43, the English-speaking party explains that, in the event of complications during the wedge procedure (see Excerpt 40 above), some air may be pushed into the intravenous catheter. She comments on such an event as follows:

Excerpt 43 (TS.01, 379-389)

379 N =as – nurses we tend to see *air* in I V tubings and we get nervous like
380 ((mocking a worried voice)) ah there’s an air bubble=
381 I =mhm=
382 N =((mocking a worried voice)) it’s going to kill the patient
383 I mhm ((soft chuckle)) a noi succede per esempio di vedere delle – delle bolle d’aria nelle – nei tubi delle – delle medicazioni endovenose
384 air bubbles in the... in the tubes of the... of the intravenous meds
Christian’s interpretation (lines 385-386: “c’è una bolla d’aria/there’s an air bubble”) reflects the phrasing and, more importantly, the ironically worried tone of voice of the educator (380); despite the partial omission of the instructor’s turn (382: “it’s going to kill the patient”), the desired effect is produced on the trainees, who give a soft chuckle (387-389). In line with his macro-choice throughout the encounter (see Excerpt 13), Christian adopts the direct speech: the original in line 379 (“as nurses we tend to see”) is translated as “a noi succede per esempio di vedere/to us it happens for instance to see” (383). At a later stage during the lesson, the US nurse wants to make it clear that a knot may accidentally form in the catheter during repositioning manoeuvres at the level of the heart. She compares the catheter to a fishing rod (Excerpt 44, lines 1049-1051), and warns against the risk of damaging the tricuspid valve in the procedure (1056 and 1059-1061). As hilarity sets in, Christian becomes so engrossed in the exchange that he translates the last sentence of the educator (1060-1061: the catheter “should come out empty”) by adopting the verb *scippare*, literally ‘to bag-snatch’, with the denotation it has in Sicilian dialect, i.e. ‘to grab’ (1062: “evitare di scippare pure la valvola tricuspide/try not to grab also the tricuspid valve”). This odd word choice can be said to indirectly reinforce the bond between trainer and trainees, given that the latter all come from Sicily:

**Excerpt 44 (TS.01, 1049-1066)**

1049  N  >you – you’re not – it’s not like you’re going fishing< ((mimicking a fisherman with a fishing rod)) >and like you’re like<
1050  INF2  ((empathetically)) o:h my Go::d a *bi:g* one ((chuckle))
1051  INF2  ((wholehearted laugh))
1052  INF2  è come quando vai a pesca no↑
1053  I  it’s like when you go fishing isn’t it
1054  N  vai a pescare= you go fishing ⑨( ) that ⑨
1055  I  =e ti abbocca l’amo e ti::ra=
and it bites the fishhook and it pulls
More frequent team-building efforts are featured in the reports. Notably, change-of-shift reporting is one of the “rituals” of the nursing profession (Wolf 1998), given that, next to its primary function of data transmission, it performs specific social tasks (see §2.5.2). For instance, the report’s scenario can become a sanctuary for “staff catharsis” (Lally 1999), in which irony and humour help exorcise the most unpleasant duties. The interaction mediated by Francesca (NR.ICU.01) is a typical example of this, as the primary speakers engage in a number of witticisms, such as the one in Excerpt 45. In this case, the joke between the two colleagues is triggered by the double meaning of the verb ‘to order’. Although here it clearly refers to a medical prescription (line 199), the Italian co-worker plays on the second meaning of ‘asking for food at the restaurant’ (205 and 207):

Excerpt 45 (NR.ICU.01, 199-209)

199 N °what else° other than – then they ordered en – lactulose enemas
200 ((looking at the medical record)) °>(I don’t know how much)<°
201 I

202 ordinato:: un:: cлистere di lattulosio=
ordered a lactulose enema
203 INF =((disgusted)) oh::: oh:::=
204 N =ah=
205 INF =((ironically)) °buо:no° co:me↑
°good how
with Parmesan
col Parmigiano↑=
206 N too much lactulose
207 INF =((ironically)) >sсaglie di Parmigiano↓<
Parmesan flakes
208 I can we put some Parmesan cheese on top↑
209 N ((chuckle)) ((ironically)) stop i::t ((chuckle)) […]
In her rendition (208: “can we put some Parmesan cheese on top”), Francesca maintains the metaphor and further expands it, by making more explicit the culture-bound image of a (pasta) dish seasoned with some Parmesan cheese.

A significant passage is also offered by the nurse preceptor in NR.FL.06 (Excerpt 46). At the beginning of the four-party report, the outgoing nurse (INF₁) gives details on the problematic neurological status of the assigned patient. The incoming Italian colleague (INF₂) first manifests her annoyance through ironic exclamations and comments (see Excerpt 10), then decides to share her feelings with the American co-worker. Initially, she addresses interpreter Italo to find out the name of the nurse just arrived from the United States (lines 47-49, left column: “come si chiama lei/what is her name”). As soon as she hears Italo’s translation (50, right column), the nurse preceptor decides to reiterate the question in English herself (51: “your name sorry”). Although she immediately goes back to the Italian language, in her subsequent turns she keeps addressing the US interlocutor, joking about the fact that during their afternoon shift they will have to resort to ‘force’ in order to soothe patients. Although Italo omits the first part of the sentence (53: “ora ci armiamo così/now we arm ourselves like this”), the proxemics of the preceptor seems meaningful enough, as she claps her hands and rubs them together (53-54):

**Excerpt 46  (NR.FL.06, 47-59)**

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Translation</th>
</tr>
</thead>
</table>
| 47   | INF₂    | ((to the interpreter)) come si chiama lei (what is her name) [...]
| 48   | INF₂    | ((pointing at the US nurse)) come si chiama lei (what is her name) [...]
| 49   | INF₂    | (nurse)) come si chiama lei (what is her name) [...]
| 50   | INF₂    | I what’s your name (your name sorry)
| 51   | INF₂    | ((to the US nurse)) your name sorry (your name sorry)
| 52   | N       | Helen
| 53   | INF₂    | Helen (. ) [ellen] ora ci armiamo così (now we arm ourselves like this)
| 54   | INF₁    | facciamo (ah) mi raccomando dobbiamo calmare tutti (we do we must calm everybody down)
| 55   | I       | so we’re going to work and ((chuckle)) and calm every –
| 56   | INF₁    | allora (so)
| 57   | INF₁    | ((chuckle))
It is no accident that the first words of the US nurse during the interaction (see Excerpt 11 above) are uttered immediately after this exchange: the amusing comments of the preceptor, as well as her caring attitude, build up team spirit among the staff and enable the foreign colleague to overcome the initial embarrassment. A noteworthy feature of Italo’s rendition is the footing of reporter (line 56), in contrast to the prevailing use of the indirect style throughout the encounter (see right columns in Excerpt 10, line 26; Excerpt 11, line 79; Excerpt 31, lines 215-216). He actually shifts from the footing of narrator to that of reporter whenever the primary speakers express themselves in the first person plural, or even in conjunction with impersonal forms. In Excerpt 47 below, “non si riesce a capire/it is not possible to understand” (line 98, left column) becomes “we cannot understand” (100, right column):

**Excerpt 47 (NR.FL.06, 97-102)**

| 97 | INF₁ | anche | also |
| 98 | non si riesce a capire se | it is not possible to understand if |
| 99 | ha veramente dolore | he has really |
| 100 | forte o se è pigro | strong pain or if he is lazy |
| 101 |
| 102 | […] |

Similar observations can be made with reference to Francesca in Excerpt 45 above (line 208: “can we put”). Also Georgia, in another report (Excerpt 48), translates the statement of the outgoing Italian nurse “il gruppo sanguigno è noto/the blood type is known” (line 11) as “we know the blood type” (12):

**Excerpt 48 (NR.FL.05, 11-12)**

| 11 | INF | il gruppo sanguigno è noto | the blood type is known |
| 12 | I | we know the blood type | [...] |
In another context and with a different constellation of interacting parties, this use of the first person plural might be viewed as a device to create verbal alliances: for instance, Pöllabauer (2004) found that interpreters in asylum hearings adopt it to position themselves next to the members of the institutions interviewing the asylum seekers (cf. also Pöllabauer 2007). Conversely, when it comes to ISMETT interpreters, the most likely explanation for these choices seems to be that no effort of detachment is required when the interlocutors – whether Americans or Italians – speak for the group rather than for themselves, as a result of the interpreters’ sense of belonging to the healthcare team (see §4.3.3).

Also from the point of view of the clinical staff, the translating function may at times be secondary to the visible presence of the LS members as colleagues who can be involved in the interaction, as shown in the following passages. The US nurse giving report at the end of her morning shift complains about her busy day, in which she has had no time to update the electronic medical chart of her patients (Excerpt 49, line 236: “I haven’t even written meds all day”); hence she ironically warns the colleague (238: “you’re gonna be busy”), who replies in tune (242: “che simpatica/how nice”). All passages are carefully translated by interpreter Henry, who manages to convey the amusing atmosphere (lines 240 and 244):

Excerpt 49  (NR.FL.08, 236-244)

236 N I haven’t even written *meds* all day (.) I think – =  
237 I =cioè non ha manco avuto modo di:: segnare i m:: le medicazio:ni  
that is to say she didn’t even have the time to write down the m... the meds  
238 N ((ironically)) you’re gonna be *busy*  
239 ((chuckle))  
240 I [((ironically)) avrai un pomeriggio:: pieno  
you’ll have a busy afternoon  
241 N okay *so*  
242 INF ((ironically)) che simpatica ((wholehearted laugh)) how nice  
243 ((wholehearted laugh))=  
244 I ((chuckle)) ((ironically)) you’re so nice ((wholehearted laugh))

What is more, in the subsequent passage (Excerpt 50) the US nurse continues venting, yet with greater emphasis (247 and 249-250) and ‘physically’ involving Henry, as she starts banging her head against his shoulder:
Excerpt 50 (NR.FL.08, 245-251)

245 INF = [(laugh)]
246 N I was busy fourteen hours yesterday
247 I *ieri* ha avuto d – è stata qui per quattordici ore yesterday she had... she was here fourteen hours
248 N and came back into the same mess ((banging her head against the interpreter’s shoulder))
249 I ed è tornata qui e ha trovato lo stesso casino and she came back and found the same mess

At the conclusion of another report (Excerpt 51), while the outgoing Italian nurse is trying to explain that the assigned patient is extremely emaciated, the physical presence of interpreter Julia ends up providing material for one more joke. The Italian nurse first repeats nine times the adjective “magra/skinny” (line 202) – undertranslated by Julia in line 203 (“she’s very very skinny”), although giving prominence to the adverb; the nurse then indicates that the patient is as thin as half of her own leg (208). The incoming US colleague ironically points at the interpreter and asks whether the patient is “so skinny” (211), thus drawing laughter from all participants. The relevant translation into Italian is unnecessary, as the outgoing nurse replies directly through the codemixed utterance “lei (i.e. she) is good” (212) to underscore that Julia’s thinness is not pathological. The latter finally intervenes as principal, given that her turn (214: the patient is “more more skinny”) does not correspond to any preceding original:

Excerpt 51 (NR.FL.07, 202-215)

202 INF è ma:::gra >magra magra magra magra she’s skinny skinny skinny skinny
203 I magra magra magra °magra°< skinny skinny skinny skinny
204 N skinny↑
205 I yeah
206 N o::h
207 ((pause))
208 INF ((ironically)) >^metà:::^< ((indicating half of her leg))=
209 N =oh↑
210 I half
211 N well ((laugh)) so skinny↑ ((pointing at the interpreter))
212 INF ^no:::^ no lei:: ((chuckle)) is good she
213 N ((laugh)) ((laugh))
214 I ((chuckle)) more more skinny
215 N ((chuckle)) okay=
The LS members can occasionally take off their interpreting hats and become a source of amusement to the other co-workers through their own words and deeds, as Dario does in Excerpt 52. When the report begins (line 1; see also Excerpt 6), the two nurses are sitting next to each other, while the interpreter is standing; since also Dario would like to sit down, he interrupts the exchange to grab a chair. In doing so, he jokes with the US nurse, acting as principal (as of line 2):

Excerpt 52 (NR.FL.01, 1-9)

1 N okay (.) we’ll start [with {Paterno}]
2 I ((ironically)) wait wait I want to feel
3 comfortable (.) ((looking around in search of a chair)) "ah" ((grabbing a chair and sitting down)) four patients↑ [it’s lo:::ng]
4 ((emphatically)) five
5 N
6 five
7 I =((ironically)) five↑ see >I need to get<=
8 INF [...]  
9 I =a lo:::ng chair=

5.2.4 The interpreter’s divided loyalties
It should be understood that the camaraderie among staff members manifests itself in various ways: beyond the quipping, it may entail showing empathy and solidarity, or providing help and support. But is it always possible to identify just ‘one’ team, regardless of cultural differences and personal preferences? More specifically, when it comes to the LS members, can they keep a professional distance also in intra-social settings, given that the border between the role of colleague and that of interpreter is at times so ill-defined? This final section will consider the “paradox of the competing demands” (Davidson 1998: 236) that ISMETT interpreters have to satisfy when they mediate between US and Italian parties.

The first example (Excerpt 53) concerns a case of miscommunication during a nursing report taking place early in the morning and mediated by interpreter Italo. The outgoing Italian nurse explains that a component of the patient’s thoracic drainage (“chest tube”, line 68) fell down overnight (70). Despite Italo’s correct rendition (71), the US co-worker understands that it was the patient who had a fall, and asks for clarification (91):
Excerpt 53 (NR.FL.09, 68-71)

68 INF il *chest tube* stanotte non ha dato nulla= the *chest tube* last night did not give anything
69 I =chest tube (.) no drainage (.) last night
70 INF *però* è caduto but it fell
71 I but it fell

(91-96)

91 N the patient fell (though)↑ "in my"=
92 I ^=no no no^ the=
93 N =oh:: the tube ┌ fell out
94 I stiamo parlando ┘ del:: ┬ tube └ drainage
95 INF ┬ tube<
96 I "the tube" [...]

Given that the interpreter replies directly (92) without either translating the query of the US nurse into Italian or supplying the piece of information in later turns (e.g. in line 94), the Italian party is excluded from complete understanding. Therefore, as shown in the subsequent passage (Excerpt 54), she assumes the US nurse is objecting that the fall of the drainage does not concern her own duties, and she shares this idea with Italo (98: “che c’entra lei dice/what does she have to do with it she says”). It is clear that the comment is meant for Italo alone; in fact, he does not translate it into English, but rather tries to explain the reason behind the reaction of the American colleague (99: “aveva capito che il paziente/she understood that the patient...”). Yet he is unable to finish the sentence owing to the interruption of the US nurse in line 100:

Excerpt 54 (NR.FL.09, 97-103)

97 INF [...] ((chuckle)) ((ironically)) ((to the interpreter))
98 "che c’entra lei dice (in poche parole)" what does she have to do with if she says (basically)
99 I "aveva capito che il paziente che il paziente:: she understood that the patient..."
100 N so:: it didn’t fall completely out (.)
101 "it -- "
102 I ma *non* completamente but not completely
103 INF ^no::^
The turns of the American nurse and of Italo in Excerpt 53 (lines 91-92) can be read as an instance of Davidson’s (1998, 2002) collaborative model of turn-taking, i.e. an attempt to establish common ground between interpreter and interpretee. On the other hand, Italo’s omission of the remark made by the Italian nurse in the last excerpt (line 98) aims at defusing a potential source of friction and foregrounds his mediating function.

A different type of omission is made by Julia in another report at the end of the morning shift. When the outgoing Italian nurse points out that no physician has assessed the patient yet (Excerpt 55, lines 176-177: “non ci sono stati ordini perché lei non l’ha vista nessuno/there have been no orders because nobody has seen her”), the incoming US colleague blames “the slow cardiologists”, as “it always ends up this way” (lines 180-181). Her statement is immediately followed by a similar yet softer comment by the Italian counterpart: “i toracici non hanno fatto nessun giro ancora/the thoracic physicians haven’t done any round yet” (182). Julia decides to translate the turn of the Italian-speaking party only (“there was no thoracic round”, line 183), while omitting the previous one:

**Excerpt 55 (NR.FL.07, 176-184)**

```
176 INF e::hm (.) basta (.) >non ci sono stati ordini perché lei non l’ha vista
    that’s it there have been no orders because nobody has seen her
177 nessuno< ¬°ancora non l’ha vista nessuno°¬
    yet nobody has seen her
178 I  there were no orders be::cause the physicians
179 haven’t seen her yet
180 N  >°right°< ((background voice)) (.) that’s the slow cardiologists >°(it
181 always ends up this way)°<
182 INF i toracici non hanno fatto nessun giro ((background voices)) ancora=
    the thoracic physicians haven’t done any round
183 I  =there was no thoracic u::::h *round*= 
184 N  =okay (.) °okay° [...]
```

Unlike Italo in the previous example (Excerpt 54), Julia was not the addressee of the remark, nor did it concern the other nurse; yet the “slow cardiologists” belong to the Italian establishment within the hospital. The assumption that the words of the US nurse could sound hostile towards the Italian colleague may have led the interpreter to leave them out.
The most noticeable role of mediator is played by interpreter Dario in the only nursing report of the corpus (NR.FL.01) that features a serious disagreement between the two primary parties. In this situation, the same American nurse involved in Excerpt 55 above has not carried out some of her assignments, given that, incidentally, the physicians wrote down the relevant orders only towards the end of her shift. Therefore, the incoming Italian colleague feels annoyed, since she will have to do extra work. For instance, in Excerpt 56, she reads from the medical record the last of several unaccomplished duties (“check body weight”, line 488) and does not hide her incredulity. In this part of the session, Dario faithfully renders the turns of both primary parties using the direct speech (490: “should I also do this”; 493: “posso rimanere un po’ di più e lo faccio io/I can stay a bit longer and I will do it”; see also Excerpts 8 and 9):

Excerpt 56 (NR.FL.01, 488-493)

Throughout the report, the list becomes longer and longer, especially because quite a few patients have an order for the urinary (or Foley) catheter to be discontinued. In Excerpt 57 below, the American nurse keeps blaming the medical staff (lines 717 and 719; 723 and 725-726) and volunteers to stay after the end of her shift to carry out the outstanding tasks (e.g. 704: “now I’m staying and I’m doing this”; 714: “I’ll do it”). On the other hand, the Italian nurse, despite her irritation (710), does not openly accept the offer of the colleague (708 and 713: “per me è lo stesso/to me it’s the same”). The latter turns, however, are not translated by Dario: indeed, the deadlock is only solved thanks to the mediation of the interpreter, who omits these sentences to emphasize the solution put forward by the American nurse. More importantly, Dario shifts from the first to the third person to render both the words of the US nurse (e.g. lines 705: “li toglie lei questi Foley/she removes herself these Foley”; 716: “lo può fare anche lei/she can do it
herself”) and those of the Italian colleague (727: “she believes you”), in an attempt to reconcile the two parties:

**Excerpt 57 (NR.FL.01, 704-729)**

704 N =now I’m [staying and I’m doing this 
705 I vabbè lei vuole – li toglie lei] questi [Foley↑ ok
yay she wants... she removes herself these
706 N don’t – (.) don’t
707 INF even ( ) [per me] è lo stesso= to me it’s the same
708 INF =I’ve got it
709 N =I it’s not just discontinuing the Foley °there is also an E K G
710 INF ((annoyed)) però c’è l’è – l’[e] K.G da fa::re °insomma°
but there’s the e... the EKG to do well
711 I °which needs to be done°
712 INF per me è lo stesso però to me it’s the same anyway
713 INF =I’ll do it I’ll do it
714 N °lo può fare anche lei° she can do it herself
715 INF °( )°
716 I °( )°
717 N =I ((annoyed)) the doctor’d better °*write* all the time he °*rounds*=
718 INF okay okay
719 N =next time because this is not °the time that he rounded<
720 I la prossima volt – cioè il 
ext time... actually the
721 INF medico dovrebbe scrivere l’orario in cui – perché questo °non è*
physician should write the time in which... because this is not
722 INF l’orario in cui le ha scritte le cose eh†=
the time in which he wrote these things
723 N =but that’s=
724 INF =ma le credo [dille che le credo
tell her I believe her ”
725 N between me and him” that’s
726 I ((whispering)) °she believes you°
727 INF dille che le credo
728 I °( )°
729 I glielo dirò: (.) io stessa a questo medico […]
I will talk personally to this physician

It should be noted that the third person is often used by interpreters to distance themselves from the words uttered by primary interlocutors (e.g. Excerpt 33, line 65). In this specific situation of conflict, however, Dario’s shift in footing strengthens his efforts at pacifying the two nurses: while making him appear as a more detached
participant, the indirect style also enables him to foreground his presence as a third party that both colleagues know and can trust. Conversely, as soon as the argument is settled and rapport re-established, Dario can shift back to first-person interpreting (Excerpt 57, line 729: “glielo dirò io stessa a questo medico/I will talk personally to this physician”; see also Merlini and Favaron 2009).

5.3 Summary

Taking as a point of departure the interviews with the interpreters, which identified the main features of medical interpreting at ISMETT with its multifaceted nature as well as with the position of the LS as internal Department, the analysis of interpreting product and performance as emerging from the transcribed recordings produced a number of findings.

With reference to the variety of settings and users, the most noticeable outcome was the need for the LS members to constantly act as ‘chameleons’ not only across genres but also within the same exchange. The specific combination of dimensions and overall constraints of any encounter, whether a nursing assessment, an end-of-shift report, or a training session, necessarily informed the choices made by interpreters at a macro-level at the outset of the sessions. On the whole, they opted for the role of message relayer and produced close renditions; short consecutive was the dominant working mode, although whispering was also adopted under specific circumstances, e.g. in conjunction with monologic discourse in nursing reports or training sessions; during the latter, a high number of participants or a larger venue could also allow for the use of microphone and headset receivers; as for footing, the selection of direct or indirect speech largely depended on the personal preferences of the interpreters. However, as the interactions unfolded, the conversational dynamics and requirements of the participants were often subject to changes, hence leading also the interpreters to continuous adjustments: for instance, variations in the interactional stance of the participants and thus in the discourse required shifts in the working mode and footing; similarly, the lack of orderly turns-at-talk called for interpreters to act as mediators, which entailed also the use of divergent renditions or a more marked adoption of the indirect speech.
It also emerged that, in this specific bilingual setting, a crucial role was played by one of the overarching constraints, namely the diverse linguistic requirements of the co-workers involved in the interactions. Given the frequency of codeswitching phenomena, the use of bivalent expressions, and the fact that medical jargon at ISMETT is largely based upon the English language, the LS members often dealt with a “partially transparent bilingual constellation” (Meyer 2002: 167). This necessarily moulded the interpreting product: first of all, interpreters needed to adapt to the word choices of the primary parties, for instance by keeping English medical terms across languages instead of translating them; secondly, information and data that had already been provided in the language of the other interlocutors were often echoed by the interpreters, especially to compensate for any unclear enunciation; thirdly, omissions were recorded whenever the translation was deemed unnecessary owing to the proficiency of the speakers. Consequently, also the interpreting performance had to adjust accordingly, as (more or less) temporary shifts from the role of message relayer to that of linguistic support could be identified. These fluctuations between stepping aside as observers and moving back into the turn-taking sequence entailed a constant monitoring of verbal and nonverbal cues: interpreters had not only to assess if and when the translations of “chosen parts” of the discourse (Meyer 2001: 101) were required, but also to select the right timing, using tact and diplomacy to ensure that their intervention was not perceived as interference. Notably, in conjunction with the back-up interpreting function, short consecutive mode and third-person interpreting were most frequently selected to clarify who had performed a certain task or expressed a specific thought, given that many turns were left untranslated. Occasionally, the LS members acted also in their capacity as language experts and engaged in metalinguistic dialogues with the primary interlocutors. These additions to the source texts were often a result of explicit requests by the other participants, who cast the interpreters in this role and led them to use the footing of “responder”; only seldom did the LS members autonomously decide to step in by adopting the footing of “principal” (Merlini and Favaron 2007) with the purpose of supplying linguistic explanations.

When considering the effects of the status of in-house Department on the interpreting activity, teamwork proved to be an underlying leitmotif in intra-social settings. To start with, the close, two-sided cooperation between interpreters and
healthcare personnel was found to play a crucial role in the negotiating of meanings. On the one hand, the primary parties put their medical expertise at the disposal of interpreters whenever these needed to resolve medical terminology issues; although this is not an unusual occurrence in mediated interactions, an uninhibited use of the asking-back strategy by ISMETT interpreters was observed in the corpus. More importantly, the clients proved to be active collaborators in the interpreting process – as longed for by Turner (2007) – and helped bridge communication gaps also in the absence of explicit requests by interpreters, especially through repair activities. Drawing inspiration from repair theory (Schegloff et al. 1977; Jefferson 1987) and from its application to interpreting training (Apfelbaum 2007), occurrences of embedded self-initiation and other-repair, i.e. of those repairs implicitly initiated by interpreters and accomplished by primary speakers, were mostly found during the critical care nursing session that was an instance of on-the-job training, in the respective fields, not only for the newly-hired nurses but also for the interpreter involved. In this context, repair frequently occurred in connection with “word and terminology search” (Apfelbaum 2007: 57), but also in case of slips of the tongue or issues of linguistic appropriateness. On the other hand, the analysis of the transcribed recordings showed that interpreters themselves were at times cast in the role of medical co-experts and compelled to adopt the footing of “responder” (Merlini and Favaron 2007), in order to assist the primary interlocutors in producing meaningful original utterances. Moreover, the knowledge of the participants and the familiarity with the communicative genres at hand occasionally led the LS members to perform as medical co-experts of their own accord to anticipate needs or difficulties, by using the footing of “principal” (Merlini and Favaron 2007).

In a chicken and egg situation, the camaraderie among ISMETT co-workers appeared to be both the reason for and the outcome of this successful co-production of interactions, given that mediated encounters were also occasions to build up team spirit by sharing laughs and small jokes; particularly during change-of-shift reports, irony and humour often helped exorcise the most unpleasant duties of the nursing profession. The language used in these cases was not technical at all, but rather featured slang expressions, metaphors, or puns; hence interpreters generally opted to act as faithful message relayers, transferring also tone of voice and register of the primary speakers. In addition, the LS members occasionally took off their interpreting hats to become a
source of amusement to the other co-workers through their own quips, although never to
the detriment of a professional behaviour and rendition.

The interpreters’ sense of belonging to the healthcare team was also evident in
their frequent shifts from the indirect to the direct speech whenever users expressed
themselves in the first person plural, or even in conjunction with impersonal forms. The
medical staff, in their turn, were often found to consider the translating function of the
LS members as less important than their visible presence as colleagues that could be –
also ‘physically’ – involved in the exchanges. However, it was also observed that
interpreters had to foreground their mediating role in the event of disagreements
between US and Italian speakers: in particular, sporadic omissions of potentially
threatening remarks and momentary shifts from first-person to third-person interpreting
were recorded, in order to reconcile the conflicting parties.
6. Discussion and conclusions

This thesis is essentially a case study of a team of English-Italian in-house interpreters based on an ethnographic and discourse-based analysis of their interpreting activities in the medical area. Despite the descriptive character of the investigation, some concluding remarks can be made on its theoretical as well as practical implications, in the belief that “the evolution of a profession implies systematic reflection and academic pursuit” (Pöchhacker 2007: 11).

Following a line of research that is often neglected by scholars (cf. Marzocchi 1998), valuable insights were initially gained by modelling interpreting at the level of the healthcare institution (Pöchhacker 2004: 85-88), that is, by portraying the interpreting settings, the prevailing patterns of interaction, the status of interpreters within the organization, as well as their relationships with the other staff members. An integral part of this description is the concise diagram of interpreting (Table 2.3) based upon Pöchhacker’s conceptual model (2004: 24ff; see also Figure 1.4). The diagram accounts for the multifaceted character of interpreting practice at ISMETT through a range of interacting dimensions, while offering a glimpse of the manifold subdomains in which the LS members operate. In particular, the ISMETT model sums up the wide variety of intra-social and international communicative genres in which the service is provided, along with the multiplicity of users in clinical and administrative areas, the presence of both monologic discourse and dialogic interactions, and the ensuing recourse to different working modes. It also takes account of a number of constraints placed on ISMETT interpreters in their daily activity, which mostly hinge upon the position as in-house staff and the peculiar language contact situation in the facility. This environment-specific approach has helped illustrate that, although the study is placed within the framework of HCI research literature, the interpreting service at ISMETT is not restricted to face-to-face interactions between patients and clinical staff: while the LS members work in a hospital setting and any interpreting task is ultimately performed ‘for’ the patient, only to a limited extent does their job take place ‘with’ the patient.

Against this background, the direct observation of participants, the interviews with the interpreters, and the corpus of authentic interactions in the empirical part of the study have served to further explore interpreting at multiple levels: more specifically,
from the negotiation of norms, to the ensuing acquisition of a specific ‘corporate
habitus’ and its subsequent translation into the daily practice. On the one hand, the
analysis of the interviews has shed light on the conscious behavioural regularities in the
interpreting activities. Despite the differences in the educational and professional
backgrounds of the respondents, the leitmotivs in their answers further exemplify the
dimensions and constraints that are foregrounded in the earlier part of the study. Issues
mainly centre around two closely related macro-areas, namely the privileged position of
the LS as internal Department and the multifaceted nature of interpreting in the hospital.
On the other hand, in the light of this twofold condition, the dispositions to act of the LS
members, that is, their (somewhat unconscious) “lex insita” (Bourdieu 1990: 59), were
taken into account in the transcript analysis.

The triangulation of data from the different sources has shown that the habitus of
the LS members is substantially consistent with the norms they have developed
throughout the years, despite the lack of an internal Code of Ethics to abide by (cf.
Angelelli 2006). This correspondence can easily be explained by considering that the
norms regulating interpreting behaviour at ISMETT are mostly the result of on-the-job
training and professional socialization processes within the hospital. In particular, out of
the dispositions to action of which interpreters are mostly aware, providing each
customer with a tailor-made interpreting service frequently emerged as a priority. While
it is true that, by definition, “professional norms” are largely influenced by “expectancy
norms” (Chesterman 1993), the latter were found to play an all the more crucial role in
the case of the ISMETT LS Department. Being in-house, interpreters have established
relationships of mutual trust and collaboration with the Italian- and English-speaking
staff; they have developed the flexibility and versatility necessary to deal with the
diverse settings; and, most importantly, not only do they know the specific needs of
primary speakers, but customers themselves expect that interpreters constantly meet
such variable requirements. For instance, under specific circumstances, the role of
linguistic support and the additional function of language instructor are openly required,
given the corporate goal of fostering staff proficiency in both Italian and English. At the
opposite end of the spectrum, on other occasions primary interlocutors call for
interpreters to act as “visible co-participant[s] with agency in the interaction” (Angelelli
2004a: 132), especially in intra-social settings. The LS members have gained a latitude
that would hardly be granted to freelancers, as they are often perceived by their co-workers as members of the healthcare team; hence their professional profile can at times be defined as ‘hybrid’, given that it overlaps with that of the clinical personnel. Similarly, the habitus of ISMETT interpreters is to be viewed as ‘hybrid’ as well: it is not representative of interpreting or HCI as such, but its shifting contours are rather a function of the peculiar ISMETT microcosm in which it was developed.

Conversely, more general comments can be made on the theoretical approach to the transcript analysis. The diagram (Table 3.3) that was devised for this purpose correlated interpreting product and performance with the dimensions and the continuum of constraints that shape each interaction of the corpus. This flexible conceptual model, although limited to just three communicative genres in the medical field, could easily accommodate the whole range of intra-social and international communicative genres in which the LS members operate. In fact, though designed as a theoretical device, it may also be regarded as a basic mental map through which interpreters examine the communicative context at hand and make macro-choices at the beginning of the encounters as well as micro-adjustments during the exchanges, selecting from the range of alternatives available “within the frame of the ongoing activity” (Bolden 2000: 390). Hence the diagram could also be adapted for other institutional contexts and used as a didactic tool to step up interpreters’ awareness of the combined effects of dimensions and constraints on their “contextualized decision-making” (Pöchhacker 2004: 187); this further supports the notion of interpreting as a continuum rather than as a set of separate entities. By applying this model to the ISMETT corpus, a correlation could be identified between the relevant shifts in product and performance: the choice of the role to be assumed at the outset of the encounter and its possible changes, based on the appraisal of varying dimensions and constraints, appeared as the key aspect with which the other features (working mode, use of close or divergent renditions, footing, and turn-taking management) aligned accordingly.

Finally, by foregrounding peer-to-peer interactions, this study showed that interpreters play a crucial role in the medical field not only when they mediate between healthcare practitioners and their patients, but also among clinical staff members. As hinted at in the Introduction to this dissertation, only through effective communication
can medical co-workers “inspire each other” (Stack Kovach 2009: 29) and work as a cohesive team for the benefit of the ultimate goal of all their efforts: the patient.
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References


Appendix One: ISMETT Language Services Tips

One of ISMETT’s distinctive features is that it is a bilingual facility. The Language Services Department was created in 1999 to facilitate and enhance the quality of communication across language (and occasionally cultural) barriers. Please take some time to read through these “tips” we have put together for you to make the best use of the service we provide.

Communicating with Patients and Family

1. If you need an interpreter let us know in advance the event for which you require support
   Tell the interpreter what you need to communicate to the patient/family member before the event. This helps us to prepare for the event and allows a more effective service.

2. Communicate time/place of event
   This allows the interpreter to arrive on site with accurate timing.

3. Always introduce the interpreter to patients and family
   Introducing the interpreter allows patients and families to immediately identify the people around them. This makes them feel more at ease. While you are talking to the patient/family member, the interpreter will position him/herself in the best place to allow the patient/family member to focus the attention on you throughout the conversation. It is also important you address the person directly (see next paragraph).

4. Address the patient directly in first person: privilege the patient for your attention
   If you are in a room with the interpreter, address patients directly in your own language as if they understood you fully. Remember the patient is the person you are communicating with, so keep your eyes and attention focused on him/her – not on the interpreter – despite the language barrier. The interpreter will generally translate using the first person. Occasionally, some explaining is appropriate and the interpreter will resort to the 3rd person (e.g. “s/he is saying that ….”).

Communicating with Staff

ISMETT is a bilingual facility where English and Italian are the means of communication. The facility offers several opportunities in day-to-day tasks to practice both languages, such as reporting between English and Italian speaking staff. Language Services do not intend to eliminate such opportunities; on the contrary, we intend to favor the learning process by quietly attending, when requested, an exchange of communication, and intervening only when necessary. Thus, the interpreters’ activity means to stimulate bilingual proficiency and encourage staff efforts to communicate in both languages.

An example:

Giving report on shift change between English and Italian speaking staff is a great opportunity to practice basic and technical proficiency in another language. The interpreter may support the event by being present to assure an effective exchange while granting and encouraging your efforts to communicate in the foreign language. We are sensitive to all circumstances, levels of proficiency and staff’s language requirements. So do not hesitate to request our support!

A suggestion:

*Be patient, articulate your words clearly with those who are striving to improve their proficiency in your language: value their efforts – they will value yours!*

Meetings/In-Services

1. **Request in advance, communicate topics, forward us any available material**
   It is highly appreciated when you can inform the interpreter in advance about the meeting for which you require support. This is particularly important if you are the person holding the meeting or presenting the in-service. Communicate time/place, topics, presenting language and – if possible – the number of participants. In order to make the service more effective, forward any related material (presentation, handouts, etc.) to Language Services along with your request.

2. **Seat and positioning**
   Please follow the interpreter’s indications on placing and seating. The position of participants is crucial for a good outcome of the meeting (it helps to hear the speaker, prevents distraction to others etc…). It also avoids the interpreter having difficulty hearing the speaker, heavy over-voicing and other distracting situations.

3. **Delivery of speech**
   Please make an effort to speak loudly, clearly, and at a moderate pace. At times, the interpreter may ask you to slow down or to speak up or might ask people to speak one at a time. Please understand this is by no means a form of disrespect towards you or the people who are attending the meeting. On the contrary, it allows us to perform a better service and facilitate improved communication.

4. **Interpreter’s suggestions**
   You may at any time consult with an interpreter on how interpreting during an event should take place (headphones vs. over-voicing, etc.). We strongly recommend you follow these suggestions for a more effective service.

Written Translations

One of the many tasks of ISMETT’s Language Services is to offer translation of internal documents. Contact the interpreter on duty if you need a translation of documents such as letters, e-mails, notes, etc. In such cases, it is usually more practical and timesaving to request a “sight translation”, where we verbally translate the document alongside you. Sight translations also have the advantage of interacting with the interpreter who may help clarify any doubts instantly.

Please address all translation requests to ISMETT Language Services (languageservices@ismett.edu) indicating author/source and intended use of the document, and deadline for its translation. Before you forward your request, however, please make sure you check with your unit or department coordinator that the document has not already been translated.

Language Classes
We offer English and Italian courses for ISMETT and UPMC Italy staff.

How to Contact the Interpreter
An interpreter can be reached at 091 2192 664 (if you are calling from outside ISMETT), at 664 (if you are inside ISMETT), or at 335 7000 381 (our 24-hour on-call service). If for any reason we are unable to answer your call, an answering service will automatically be activated. Please leave your name and message so that we can call you back.

*(Reviewed: March 2009)*
Appendix Two: ISMETT policy on English proficiency standards for the clinical and administrative staff

Policy & Procedures Manual

For

Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione

POLICY: ISMETT ED-01
INDEX TITLE: Education
SUBJECT: English proficiency standards for the clinical and administrative staff
DATE: November 29, 2008

I. POLICY

It is the policy of the Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione (ISMETT) to promote a bilingual environment involving all levels of staff, so as to guarantee clear and effective communication in the interest and safety of patients, and improve the staff’s language proficiency. The ISMETT Language Services department offers English courses and commits to ensure the clinical and administrative staff possesses standard levels of spoken and written English.

II. GOAL

The goal of this policy is to promote opportunities to improve the English proficiency and language skills of the ISMETT staff. Such skills include the ability to communicate effectively in English in a verbal and written form.

III. SCOPE OF APPLICATION

This policy applies to the clinical and administrative personnel of ISMETT and UPMC Italy, with the exception of the medical staff.

IV. PROCEDURE

1. Language skills at ISMETT are subject to evaluation in the following cases:
   a. Selection/orientation of new staff
   b. Internal selections to higher positions
   c. Selections for exchange programs with UPMC (traveling to Pittsburgh)

   Skills are assessed through a mandatory English Proficiency Test.

2. The newly-hired staff that has not taken the test at the time of selection will take the test during their orientation period and, in any case, within the first 2 weeks from the start date of their contract, according to different levels based on professional categories (see Table 1).

3. ISMETT Language Services will differentiate course levels on the basis of test scores, in order to promote the successful outcome of the language proficiency test as
needed, and the achievement of predetermined language proficiency standards at corporate, departmental and individual levels.

4. Employees who do not pass the English Proficiency Test (see policy item IV.1) may be required to attend the English courses offered by the Language Services department.

- In this case, courses are free of charge and held during working hours, in the form of paid leave.
- English courses are articulated in 4 levels (basic, intermediate, upper intermediate, advanced), which represent the proficiency standards for different professional categories. Courses are held on clinical and administrative premises, as scheduled and organized by the Language Services.
- Students will be requested to take a language proficiency test during and at the end of the course. Students must achieve a predetermined minimum score to pass the test.
- Test scores will be notified to the employees’ respective supervisors.
- Students who fail to pass the final test at the end of course will be offered the possibility to attend other English courses held by the Language Services, but outside working hours.

5. Employees who successfully pass the test may improve their language skills using specific educational materials selected by Language Services and available on the corporate FAD (remote learning) platform.

6. Through the performance evaluation process, department heads/supervisors promote the improvement of their co-workers’ language skills and, in general, support as much as possible their attendance to classes. During the completion of the performance management review form, department heads/supervisors assign a score to language skills considering the commitment showed by the employee to improve his/her skills. The score will be also based on the feedback given by the Language Services.

7. Training and education activities are scheduled and managed by ISMETT Language Services. Regular classes, hands-on training, one-to-one tutoring, technical English in-services, conversational classes, and English movies are some of the educational methods utilized. The available English classes are advertised to All ISMETT users by means of e-mail.

SIGNED: Gabriele Cappelletti
Director General
ORIGINAL: February 2008
PREVIOUS: February 2008; November 2008
SPONSOR: Giulia Padovano
Recruitment & Retention Manager
Table 1

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Appendix Three: Interviews with ISMETT interpreters

Interview schedule

Introduction
Thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer.

‘Warm-up’
1 First of all, what can you tell me about your personal and educational background?
2 When did you start working at ISMETT?
3 Have you had any previous similar professional experience?
   If yes, take details of
   a what
   b where
   c how long for
   If no, advance to 4

Main body of interview
4 [Depending on the answer to 1, i.e. if no interpreting education] How did you learn to become an interpreter?
   If trained on the job, ask to describe it
5 What can you tell me about your [specify ‘first’ if no to 3] impression of medical interpreting?
6 In your opinion, what are the most challenging features of medical interpreting at ISMETT?
   If necessary, prompt with examples, e.g.
   a language issues
   b technical issues
   c emotional issues
   d interpersonal issues
7 Does the variety of settings and participants have an effect on the interpreting activity?
   If yes, ask in what way
8 What can you tell me about cultural issues at ISMETT?
   a relations between US and Italian staff
   b relations between the LS Department and the staff

‘Cool-off’
9 To conclude, let’s talk about ‘interpreting style’. In your opinion, what makes the style of an interpreter?
10 How would you describe your interpreting style – if any?

Closure
Thank you very much for helping me and giving me your time. Can I finally ask you if you think that there are any aspects of your experience at ISMETT that have not been covered in this interview and that you would like to point out?
Appendix Three

Transcripts of the interviews

In order to indicate turns in interviews, the researcher is designated $R$, while interpreters are indicated with the first letter of their fictitious names ($C, D, E, F, G, H,$ and $I$).

I-1 Christian

$R$ Thank you very much for taking part in this interview, which is an integral part of my PhD research project.

$C$ You are welcome.

$R$ The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous.

$C$ Okay.

$R$ It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer, okay?

$C$ Okay.

$R$ First of all, what can you tell me about your personal and educational background?

$C$ Well, strangely enough, my educational background is basically a degree in Architecture. I finished my studies in 1997 and after two years of working as a freelance architect, for a series of coincidences, I heard about ISMETT, because my sister was working here and she told me that they were looking for people bilingual and who spoke good English. As I was not making much money as an architect, I decided to give it a try and eventually I was hired as a consultant for just over a year and then my position was turned into a no-term position. And I have been here ever since, which is roughly eight years now. Which makes it kind of strange, because I have always thought of myself as something else, either a musician or then, eventually, an architect, and then turned out to be something quite different altogether. So I had to really learn this new job. I did do some translations in the past, but never so technical as the ones that we do here. I had to learn to be an interpreter, which I still have not learnt, but I am doing my best.

$R$ How come that you speak both Italian and English?

$C$ Because I was lucky enough to have an English mother and I was born in London, England, and raised by my mother who always spoke English to me and my sister, despite the fact that we were brought up here in Palermo. So I have heard English since I was a very small kid, a baby, basically, and then Italian growing up in Italy. So I quickly became bilingual, with perfectly no effort, which is something I should be doing with my kids, but I am not, because I have two very small kids and all my situation is different, because the mother is Italian and she spends most of the time with them. But it is obvious to me that I should make the effort and talk to them in English.

$R$ So you said you started working at ISMETT in 1999.

$C$ I started in 1999, yes.

$R$ Okay. And you have already told me that you had no previous similar professional experience, and that you were trained on the job. Let’s focus on this on-the-job training. So, how was it carried out?

$C$ Well, I was lucky enough to be one of the first people to actually be part of the team which is the Language Services. Initially there was just myself and my then boss. I was lucky enough because he was a very talented person in his field. He basically taught me everything, because I remember it was just himself, he was alone and I came here, then a couple of other people came after me, but afterwards just maybe another person. So I learned everything from him, which is something I have never
told him, but I should be grateful, because I have never done interpreting in my life, let alone going into an interpreting booth, or doing simultaneous interpretation, which is something I feared very much. I never thought I could do it. But watching him and trying a little at a time basically made me gradually more and more confident. Again, I am still not a hundred percent confident, but I do things now which I never thought I would do, like the things we do here. So it is thanks to him that I learnt everything within the scope of this job.

R And what can you tell me about your first impact with medical interpreting, working in a hospital?

C It was not easy, because I have never been in a hospital, luckily not as a patient, let alone as an interpreter. So being the hospital that ISMETT is, which involves obviously very sick patients… It is worse now than it was before, because we have kids now, which makes it even more difficult dealing with paediatric patients, but nevertheless it was hard at the beginning to step into a room with an American nurse or in the outpatient clinic with an American physician talking to patients or family members and explaining all sorts of terrible things that were going on – it was occasionally good news, obviously. There were several difficult moments, so it is not easy at all. I remember going in the OR sometimes, at the very beginning, helping American surgeons on the field, on the job. It was not easy, but it was challenging because it was so new. Plus this was such a different hospital, such a different atmosphere from all the hospitals we are used to in Palermo, all falling to pieces and run-down, and people wandering around everywhere. Here it is really a different place and it is very well organized, with qualified staff and rules for everything, which makes it quite a departure from the Sicilian way of life. It makes it quite pleasant to work here. So my first impression was to be in a special place, a different place, and a new place, so this helped, and I suppose it encouraged also curiosity on my side. And, obviously, I liked it, because I would not have stayed here for so long if I did not like it. I do not buy the debate about no jobs in Sicily and people sticking to jobs even if they do not like them. I never could do that. So I recognize that it is difficult, that it is not like in other places, where you just shift from one job to another, but I would not stay here if I did not like it – if I had not liked it so much.

R You have already talked about the challenging features of medical interpreting at ISMETT, but can you mention other challenging aspects? For instance, what about the terminology?

C Yes, I was referring basically to the interpreting side, but obviously part of our job here involves translating.

R Well, talking about medical interpreting.

C In interpreting? Well, it goes the same actually, because another major issue was learning medical terminology. It is not general medicine, but it is quite specific, considering this is a transplant centre, so it is very specific surgical, clinical, and medical terminology, which I had to learn in Italian first, because I had no idea what exactly ejection fraction, or T-tube, or a catheter were in Italian, let alone in English. So it was not easy at all. Obviously, I was not a physician, but I have never been a professional interpreter or translator, so I was not accustomed to medical terminology, and it was hard. But again, it helped to have somebody like my former boss: it helped me, because he taught me the importance of putting together glossaries, which is something I did not understand in the beginning. I did not understand the actual importance of it. I was quite naïve at the beginning, but it was rather boring at the beginning to make these lists of terms, but eventually I recognized that I encountered them over and over again, so it was useful. And obviously, like every other thing, the more you do it, the less difficult it becomes. So, here, when we are translating a medical paper or physicians’ consults… We did all sort of stuff in the beginning: we translated the old electronic medical record, the old system they had here, then patient
education material, so it was not easy, I had to learn a lot, a lot in terms of terminology.

R In your opinion, what makes a good ISMETT interpreter, a good medical interpreter? What are the requirements?

C I will stick to the first definition you gave, a good ISMETT interpreter, because I am in no position of giving any definitive answers to this question, because I was not trained to become an interpreter, so I have no definitive answers on what to do to become an interpreter or a medical interpreter. I can tell you what is required to work as an interpreter here.

R Or what helps?

C What helps? That is not to say that I am doing it the right way: I sometimes just have the feeling that I have reached a certain goal, but not going through the easiest way to get there, which mainly has to do with the different academic background and no knowledge of the actual theory of this subject. What makes a good interpreter? Well, I think the only thing to do is to see how people who already work here as interpreters work, and then try to look, hear, and act as they do, and learn, learn as you go along, that is what I do.

R For instance, let’s think about the variety of settings and participants. Do you think that this has an effect on the interpreting activity? And if so, in what way?

C It is different, obviously, as in all contexts, I would say. If you are crammed into a tiny room with a nurse or a physician, and a patient, and all the family, you have to stand in a certain position and talk at certain times and not answer when you are not supposed to. It is all stuff that I see with freelance interpreters here at the moment. They are not interpreters, just people called in because of their knowledge of other languages with the International Patient Programme. And I see people coming in here because they are asked to interpret, even if people without such a background, who speak Greek, Spanish, Chinese, and other languages. And I see them making mistakes, which we should not do, like, as I said, answering when you are not supposed to, or not leaving the room when you are supposed to, or other stuff. I mean, just things that I learnt by watching people who had more experience than I had, and then just common sense, because when the physician asks, he does not ask me: if he asks the patient if he has had previous episodes of a certain disease and I know the answer, I do not answer, if the patient does not answer before. I mean, this is just common sense. So little stuff like that, if you are in a certain or in a similar scenario. If you are translating a lecture, then it is quite different: you have your set of headphones, and you are sitting in a detached position, so it is more like, I suppose, simultaneous interpreting. If you are translating, as we do, during a meeting, it is more a question of choosing the right place to sit, because you are aware of who is going to need an interpreter. Other times we translate Board of Directors’ meetings over the phone, which is not easy. Other times we are translating during interviews with new staff, which is also a delicate thing, because you are never sure the candidate… They all say they speak fluent English in their CVs: then, when they sit down, you realize that it is not so. So it is a question of understanding when to intervene, you are sitting on the other side of the desk, and these people are obviously nervous. What else? I cannot think of any other. It is a variety of scenarios, so I think it is just a question of acting as you… It depends on the situation, there is no fixed rule. And also the choice of the technique you are going to adopt is a consequence of the setting, I think.

R Do you have any preference?

C Well, despite people trying to teach me, I have never been good at the presa di note,37 I am not very… I do not feel awfully comfortable with that, so I am not very good when a person goes on and on for ten or fifteen minutes and then returns to me for a

37 The Italian for ‘note-taking’.
Appendix Three

150 translation. I tend to lose stuff, even if I have got pencil and paper, so I prefer to gently put a hand on a person’s arm or something, or making sure they understand they need to stop every couple of sentences, so that I can get the message across. Because, having said that, it is mostly the good thing about this place, working as an internal Department, we have the luxury of knowing everybody here, so we are in the position of… It is not as a freelance, we can ask a physician to stop or repeat. Or, not having understood something, it is easy, it is easier for us, because we have the liberty, and the luxury, and the confidence to stop somebody when we do not understand. And also we have managed to establish the consolidated practice by which we are able to ask anybody who wants an interpreter for a lecture to give us handouts or presentations beforehand, so we can study terminology from the slides and text. It was not easy to make these people understand the importance of doing so, eventually we did. So it gets easier, as time goes by.

R And what can you tell me about cultural issues at ISMETT?

C Well, not much in my experience, because I was born in England, but I was raised here, in Sicily, and we are in Sicily now, so I am pretty much aware of how Sicilians think, act, and speak. I was raised in a bilingual and bicultural family, so I am used to having people around of a different culture. All my mother’s side is from the UK, so I am pretty at ease with people from other nationalities, that is what I meant to say. So the cultural differences I can recognize, and I can recognize them between the Italian and the American staff, basically. What I was trying to say is that they did not affect me, but I could see that there were differences, basically between American and Italian staff here. There were elements which I could single out, different backgrounds.

R Does this create problems among staff members?

C Oh, yes, occasionally.

R Maybe at the beginning?

C I could go as far as saying that maybe cultural differences in some instances – that is my assumption, a very personal assumption – actually called for some people to actually leave this place and go work some other place. I am talking about, obviously, the non-Italian staff, so it may have caused even leaving ISMETT and going for some other place. Because at some point it can become so frustrating to some that it can become a problem. You know, in other cases it is – as I see it – it is more a question of enriching your own background, because if you work and live – as most people do here – many hours of the day with somebody that comes from the other part of the world, it is a good thing, as I see it. It is just a way of learning there is something else, it is not just where you live, there is something else going on.

R Okay, let’s move to the last part of the interview. I would like to talk about interpreting style. In your opinion, what makes the style of an interpreter?

C The style? That is an awfully difficult question. The style… I do not know. I can tell a good interpreter from a bad one, now, and the style, I should say, is in the choice of the words you use and in the ability of adjusting your register to the situation you find yourself in, to adopt certain words, certain terminology based on the context, on the people you have in front of you. That is, to make a stupid example, to use simple words if you, obviously, are in front of a family of not terribly well-educated people, I would choose some words; if I am in a consult between physicians I would use others, because I have the ability – thank God – to do so, I have a wide enough vocabulary in Italian certainly, in English mostly, to be able to adjust. In this setting, in this particular setting, I think that is probably the most difficult thing, otherwise it sounds strange to the ear if you are using too pompous words in a more down-to-earth setting. So, yes, the choice of words, and, obviously, the setting, how you place yourself between the two parties, and the way you stand, you sit, the choice of positioning, as I said, lots, lots of things, which, by now, I can tell if they are a correct choice or if the interpreter is making mistakes. But again, this is restricted to this particular
environment: I have by no means any general knowledge of interpreting as a general profession. My experience is quite limited to this, so my answers should be taken for what they are.

R I think you have already answered the next question too. How would you describe your interpreting style? So, you mentioned the ability to choose the right words…

C Choosing words, trying to leave very few gaps in what I say, getting help from most of the resources available, be they physicians or slides, if I have anything. Different techniques I have learnt over time, like during a lecture, if I do not grasp everything that the speaker said, trying to reach some of the slides, so things that everybody knows. That’s it.

R So, thank you very much for helping me and giving me your time. Can I ask you if you think that there are any aspects of your experience at ISMETT that have not been covered in this interview and that you would like to point out anyway?

C Any aspects of what I do here?

R Yes, something that was not stressed, highlighted, or something that you would like to say.

C I cannot think of anything...

R Okay, thank you.

C You are welcome.
Appendix Three

I-2 Dario

R Thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer. First of all, what can you tell me about your personal and educational background?

D Let’s start by the educational part. Basically scientific studies in High School, and then economics: I studied at the university, Faculty of Economics. And then the High Institute for Interpreters and Translators, after which Political Sciences at university. So this is the background. And then, just recently, a couple of years ago, I upgraded my educational title by attending for one year and getting the additional year for language mediator. This is the new job title. That’s it.

R When did you start working at ISMETT?

D 1999. Easy answer, because it is the same year when ISMETT started becoming operational. So the very beginning: ISMETT started in May 1999, I started in July. So just two months later. It was quite hard. I was working with two other interpreters, it was just the three of us, with plenty of Americans, crazy working times, day and night, no time to have lunch, and that went on for a year. And then new incredibly skilled staff members arrived, and everything became easier.

R Why did you apply at ISMETT?

D Actually, I did not apply. I did not mean to work at ISMETT. I was working as a freelance at that time, so my goal was to just collaborate from time to time as a freelance with translations, with interpreting, but just once in a blue moon, not on a regular basis. Then I was contacted, there was like a phone interview which I was not aware of: I was called by ISMETT and they were asking questions in English, and later I learnt that was my job interview. So they were testing my skills over the phone, without telling me. Then they offered me to go visit the premises, which I did. They offered me to start working twice a week, which I accepted, because twice a week was reasonable, since I had my personal professional activity, so I accepted for two days a week, but it was immediately clear to everybody that two days a week were not enough, so very, very soon – probably in a couple of weeks – that became a daily commitment.

R So that was your first experience in the medical field.

D Not really. Because already I was working with the National Institute of Social Security, INPS, as a translator, not as an interpreter, and I was in charge of translating also medical documents of Italian immigrants, people who had kept Italian citizenship but worked abroad. So they lived abroad and they applied for a retirement, pension, compensation, whatever, medical insurance. Italy paid, because they still had the Italian citizenship, and they sent all the medical documents to Italy, and those documents needed to be translated by me. So I did have some medical experience.

R But it was your first experience in a hospital, right?

D Yes, sure.

R And what can you tell me about your first impact with working in a hospital?

D Quite thrilling, exciting. There was activity day and night. I remember the first night shifts flew away really, really fast. I would go in at midnight – at that time the night shift would begin at midnight – and I did not even notice it was already sunrise, because the activity was crazy, so there was no time to rest, not even at night-time, so it was quite exciting. So the first times it was exciting, then it became very tiring, because, of course, you can understand, if you do not sleep… During the first times you learn, everything is new, people are new, and you do not know anything, and that is exciting. But then, after a few months, it started to become really, really exhausting.
But it was quite exciting. My first impact was very... I was really interested in this experience.

R You said that you were already a professional interpreter, right?
D Yes.
R So you were not trained on the job.
D No, no.
R Okay. And in your opinion, what are the most challenging features of medical interpreting at ISMETT?
D At ISMETT?
R Yes.
D It is hard to say now, because nine years later everything seems to be like normal now. So I should go back and think...
R I do not know: language issues, technical issues, interpersonal issues, emotional ones?
D Probably, the fact that... I mean, in any field there are language issues, in any field: if you deal with lawyers, for sure there are words that you have to study beforehand, if you deal with, I do not know, port engineering, I am sure that probably language problems are even worse, because in medical English they come from Latin, so probably it is less difficult than in other fields. Maybe the most difficult thing was to have the other staff understand what the role of an interpreter is. So, everybody else at ISMETT took for granted that since you are an interpreter, since you are ISMETT staff, you have to be ready any minute. So they would call you thirty seconds before the event and they would expect that you know how to deal with that event. Well, we know that that is not always true, I think. Very often you do not know what the situation is going to be, what the topic is going to be, so this is probably the most challenging thing. I am not talking about myself, but about the whole Department. And, in fact, a Service Level Agreement was discussed for several years because we wanted to make it clear that there should be some standards to use our services. That was probably the most difficult thing. Not language issues, just the work organization. It was total chaos at the beginning, total chaos.
R What can you tell me about the variety of settings and participants in the medical events?
D Events?
R I am talking about medical interpreting in the broadest sense, so doctor-patient interviews, nursing reports, medical meetings, or conferences. Does this variety affect the interpreting activity? And if so, in what way, in your opinion?
D I do not think that the variety affected. Actually, the variety probably allowed us to become more familiar with all the aspects of the medical care that was being provided at ISMETT. So, if you were aware of some aspects, you could use those aspects even in different situations. For instance, if you knew the psychological background of a patient from a previous event, and then you had to deal between a surgeon and the same patient, maybe you could use the psychological background that you had acquired on that patient. So... No, I do not think that was difficult.
R Do you think that you have to use different strategies according to the setting?
D Well, sure, that is for sure. As we know, it depends, first of all, on the number of participants, and the situations vary, so that was an issue. Stressful conditions, clearly, that was also an issue: sometimes you had to deal with urgent conditions, like patients being intubated immediately, or with the need of a defibrillator, so things in which there is even no time to think, so even without a language barrier, even between two people speaking the same language, there would be no time to speak. They just have to act and this is why there are protocols, there are policies, there are regulations already, and people practice these situations in order for them to be ready to act without speaking in those situations. So just imagine somebody who has to translate. So, yes, for sure a situation like that would oblige the interpreter to use some kind of
strategy, which I do not think can follow any rule, it is just instinct. But of course, regarding strategies, there are strategies to translate. In the medical field at ISMETT you can work in a conference, you can work in a medical meeting, in meetings between peers, between physicians, and on that occasion you would use a strategy. Then you can have an exchange between a doctor and a patient, and the strategies would be totally different. So, yes, for sure, variety did not imply, in my opinion, any difficulty, but it implied for sure different strategies.

R Okay. And what can you tell me about cultural issues at ISMETT? American and Italian staff, position and role of interpreters…

D For the new staff, for the new staff only, but then, normally, the American staff used to stay for quite a long time, so they would understand culture. Plus they would receive some information before coming over to Italy, so they kind of expected to have to deal with our cultural attitudes, so to say. It was probably more difficult for the Italian staff, because the Italian staff did not like this American influence so much, so the Italian staff tended maybe to criticize the American staff a little bit more than they should have. So that probably went beyond the cultural thing. The Italian staff used to blame everything on the American culture, whereas it was not like that, it was not due to the American culture, it was just the different professional background.

R To conclude, let’s talk about a different concept, let’s talk about interpreting style. In your opinion, what makes the style of an interpreter? I know it is an unusual concept, but if you hear this phrase, interpreting style, what does it mean to you?

D Well, I do not know if I am going to reply your question. As you know, in the most recent months I have worked in a different role and I have dealt with other interpreters, who call themselves interpreters, but technically they are not real interpreters. They are people whose mother tongue is not Italian and we use them as interpreters here at ISMETT, but they do not have any educational background as interpreters. Well, what I noticed is that they have no style! I thought about that several times. One thing that actually bothers me is that they seldom translate what the speaker is saying.

R What do you mean?

D For instance, if I am speaking to a patient, even though I look into the patient’s eyes in order to facilitate the interpreter, you know, to make it clear that I am talking to the patient, I am not talking to the interpreter, ninety percent of the times the interpreter would reply himself without translating: the interpreter would reply!

R Not the patient, but the interpreter?

D Yes. Or the interpreter would start speaking to me, and disregard the patient, or vice versa, the interpreter would start speaking with the patient for five minutes without translating to me.

R So this really happens! It is not just in books!

D It happens ninety percent of the times! And I often thought: oh, they have no style. I do not know if I am replying to your question…

R So, you mean that style is like accuracy?

D Well, in that case it is not really accuracy, probably a lack of professionalism, completely. They do not do their job! I also asked Christian to organize an in-service for these new interpreters, because they really needed it. I told them what they should do, that they should always translate, even if something might sound like a silly question, even if they know the answer, etc. Still they do not behave! So they lack style.

R That is very interesting. And how would you describe your interpreting style, then?

D Well, based on what I have just said in this respect, I probably sometimes tend to translate too much, meaning that I never try to be myself when I translate. I am just trying to disappear as much as possible. But, with regard to other aspects of style, I need to know what you mean by style.
R I do not know yet, so that is why I am asking!
D Okay, we can also define style as trying to keep the same register as the speaker, so if
the speaker is calm, the interpreter should be calm, if the speaker is speaking in a loud
voice, then the interpreter should probably speak in a loud voice, with respect, and so
on! Also, not just relaying the message, but also the way all the message is reported is
really important, and the way should reflect the speaker’s way, so that is also part of
style, I guess.
R Thank you very much. That was it. Would you like to add anything else?
D No, not really.
I-3 Eric

R So, first of all, thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. Anyway, if you don’t mind, it will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer.

E Okay.

R So, to start with, how did you begin your experience at ISMETT?

E What do you mean?

R When, how, why did you apply…

E Actually, at first it was just an opportunity to make some extra money. I was a university student at the time and I found out that they were looking for interpreters on a fixed-term contract.

R When was that?

E I believe it was in 1999. So I worked for ISMETT as an interpreter for approximately two weeks, perhaps a month, not more than that. And then I left the post because I wanted to pursue my studies and I was invited a year later to participate in the selections for the opening of the Language Services, here at ISMETT. So I applied as an interpreter and I was hired in July 2000 on a permanent contract.

R Okay. And you said you were a university student at that time. In what field?

E I am a graduate in Modern Languages and Literature, so I was completing my degree in this field.

R Okay. Have you had any previous similar professional experience?

E Not really. I worked for a cultural association before working for ISMETT when I was a student, and I acted as an interpreter at dinners and on other occasions, but it was not really a professional task, so this was my first real professional experience.

R Especially in the medical field?

E Especially in the medical field, yes.

R Okay. So, how did you learn to become an interpreter?

E I learnt on the job, as I went along. As you know, we did go through a period of orientation at the beginning, but we actually did learn as we went along, we adapted to the circumstances and we made do with our own knowledge of the language. That is what I did, because I certainly did not have any previous professional experience as an interpreter.

R And as for the proficiency in English and Italian, do you regard yourself as a bilingual? Or can you tell me something about your background from a language point of view?

E Certainly. Well, I was born in Canada and I lived there for thirteen years; I studied at a language High School, and I pursued languages at university, as I said earlier. So I consider myself basically an English native speaker, although I have been living in Italy for over twenty-four years. So, I guess, overall, I consider myself bilingual, Italian-English bilingual.

R Okay. And this helped here at ISMETT…

E Yes, it certainly helped. Actually, it was probably my only real asset as an interpreter.

I had cross-cultural experiences in general, so I did have other assets that have nothing to do with languages per se, but my biggest asset was my bilingualism and that is what really allowed me to get the job, I think. Of course, I had also other experiences: I have published a book and some articles both in English and Italian, I think that interested the recruiters at the time, but my knowledge of both English and Italian certainly made the difference.
R Okay. Going back to the activity at ISMETT, what can you tell me about your first impact with medical interpreting?

E Interpreting or translating?

R I would like to focus just on interpreting, even if I know that we deal with a lot of translation activities too.

E That is a good question. I do not recall it being a traumatic impact, for example, no trauma at all. I think I adapted to the role pretty naturally. Of course, I did not have a wide knowledge of medical terminology in English or Italian, so I had to acquire that as I went along. But I do not remember particular difficulties related to that. The most difficult events were certainly highly technical meetings, for example the paediatric liver meetings and so on, where physicians would come together to discuss various cases. Those were very technical and certainly the most demanding events. But other than those, I never really experienced real difficulties, for example interacting with patients.

R You had no emotional issues or interpersonal issues…

E No, no, on the contrary, I found it quite pleasing to be able to interact with patients and contributing my own way to encouraging them. So that was very pleasant, actually, and gratifying.

R Okay. In your opinion, what are the most challenging features, again, of medical interpreting at ISMETT?

E Having to master all the technical terminology. Sometimes you can use strategies to get around them, by explaining things instead of having to pinpoint each medical term. But that is not always possible. So sometimes you have to intervene and interrupt perhaps a conversation, or to ask exactly the meaning of a term in order to continue, when you get stuck and you know that you cannot just get around by explaining it, because maybe you do not know what they are really talking about. Of course, that improves with experience, but it certainly takes time and a certain amount of study as well. I think that is the most challenging aspect.

R So you mean terminology, how to deal with the technical terminology?

E Well, in some cases it is. Again, with experience, you learn to solve these problems as you go along, you find strategies to solve them. Another challenge was mastering simultaneous interpreting in the booth, because, again, I had no experience with that. But, you know, with practice and perseverance, you improve as you go along. Of course it would have been much simpler, I think, if I had some kind of academic background, which I lacked completely. I think I would have been much better off if I had that academic background.

R Okay. Then, as for the variety of settings and participants, you know, in the different situations in which we have to interpret, do you think that this variety has an effect on the interpreting activity? And if so, in what way? I mean, you mentioned some strategies, right? Are these strategies always the same, whether you are in a meeting with physicians or in a patient room, or during nursing reports?

E Well, they are often similar. Of course, it depends on the circumstance, it depends on the resources you have at the moment. For example, in the interpreting booth, your fellow interpreter can give you a hand, you know, with a lot of things. At a meeting, you can always ask questions to the speaker; same thing when a physician is interacting with a patient, for example. So, basically, you make do with the resources you have at the moment, in order to solve a problem, a language problem, to bridge the barrier. So, the setting does matter because you have different resources. The resources vary according to the setting, so being able to adapt to the setting and use the available resources to your advantage makes the difference, and it improves your performance.

R Anything else that you would like to mention? Anything else you can think of?
E Nothing in particular comes to my mind at the moment. I probably take for granted a lot of things that do not come to mind at the moment.

R Let’s talk a little bit about the cultural issues. So, for instance, the relations of the Language Services Department with the US and the Italian staff. How are such relations in your opinion?

E Between the Language Services and the US staff?

R And the Italian staff.

E Well, I think there are good relations between our Department and the staff in general, both US and Italian. I do not think there have been any difficulties or any specific cultural issues between our Department and the local and foreign staff. I think that we find ourselves kind of in between and we understand the difficulties and the needs of both groups. Actually we are often there to – I think – bridge the cultural barriers between US and Italian staff, so, again, I think we can be a reference point for both groups.

R Do you think that you were facilitated from this point of view, given your personal background?

E Very much so. Especially at the beginning, when the US staff was more numerous. Being Canadian, I understand pretty deeply the ethics, the work ethic, and mentality of US employees. So I often understood their difficulties and the cultural clash with the Italian environment. So I think that I lent a big hand at the beginning to help US staff understand Italian mentality and vice versa. And I think that when you come out and explain certain things, it is easier for one group to understand the other and to accept the other, and that improves relations between the two groups and also ends up improving their performance, I think.

R Okay. To conclude, let’s talk about something different: let’s talk about interpreting style. In your opinion, what makes the style of an interpreter?

E The style of an interpreter? What do you mean by style? Do you mean at a technical level?

R If you hear this phrase, interpreting style, what comes to your mind? What features?

E Well, if we speak in terms of style, the first things that come to mind are technical skills and strategies that interpreters use. In other words, one interpreter may tend to use décalage much more than another interpreter; some interpreters maybe use, for example, chunking more than others; some interpreters may summarize more than others; in other words, you know, there is a wide variety of techniques and strategies that an interpreter can use. I think that each interpreter probably uses the strategies that come most natural. And that makes the style, I think, of each interpreter, in other words the mix of strategies and techniques that one interpreter uses compared to another.

R And how would you describe your interpreting style, if any?

E That is a good question, because, as I mentioned earlier, I do not have an academic background, so I have never really had the chance of absorbing all the techniques and developing my own style, having all the academic resources available. So, my style, whatever it is, is not the product of an academic course, of an academic pathway. I kind of developed it as I went along, by experience. So I make do with my own resources. For example, I tend to summarize, and I have strategies to try to bridge difficulties when I encounter them. It is hard to say: I do not think I have ever thought about it. It will probably be unique in a way, because I do not have an academic background. So I do not know, I would not know how to define it. It is probably naïve, it is probably out of the ordinary. It is certainly full of imperfections.

R Just one thing. You mentioned again strategies: are you referring to the ones you mentioned before, like trying to explain a term that you do not know or asking, or are you referring to other strategies?
E  No, no, no. Basically, the ones I mentioned throughout the interview. Of course there are a lot of other strategies and techniques that an interpreter uses for interpreting. Of course I use some of them as well. The techniques you choose also depend on the circumstances. For example, if you are at a meeting, okay, you can take the time to interrupt perhaps a conversation, if necessary, ask for an explanation, make sure the message gets across, and then continue. You cannot do that inside the booth. So, of course, the setting also influences the decisions you make and the strategies you choose.

R  Well, thank you very much for helping me and giving me your time. Can I finally ask you if you think that there is any aspect of your experience at ISMETT that has not been covered in this interview and that you would like to point out?

E  Not particularly.

R  Okay. Thank you.

E  You are welcome.
R Thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English, but please feel free to switch to Italian at any time. First of all, what can you tell me about your personal and educational background?

F I attended the language High School (Liceo Linguistico), because I was in love with the English language when I was a child. I wanted to know everything about foreign songs! So my curiosity pushed me to learn foreign languages and I wanted to travel a lot. Then, after that, I attended a school for interpreters and translators in Palermo and then I started to work in the tourism framework, environment, in tourist resorts, which was very nice at that time. I was young, I could go around the world by myself. After about five years I sent my CV here at ISMETT and I was hired as a junior interpreter.

R When was that?

F December 1999. Since then I have started and I am still here.

R Okay, very good. Why did you apply at ISMETT?

F Because I was looking for some roots. I mean that before ISMETT I travelled and I changed job every season. So, when I was about twenty-eight, I needed a place where to live, I wanted a place where to live. I mean, I wanted that place to be my hometown, Palermo, but actually I did not have so much hope. So, when I knew about ISMETT, I thought that was the perfect place for me, because I could be independent and I was sure that my job there would be very gratifying for me, for what I needed at that time, at that moment. And that is what I found: I mean, I was happy to be hired and I could start to live a regular life as a citizen of my city.

R But it was your first professional experience in the medical field, right?

F Yes, my very first.

R And what can you tell me about your first impact with medical interpreting?

F Before coming, the person that hired me had actually asked me what kind of impact I could have in this kind of environment with sick people and a lot of suffering, and I really did not know, because, I mean, I had never had an experience like that. So I could try myself on the field, and, surprisingly, I could be able to detach, so to observe the scenarios without feeling completely involved in most of cases. I had like two or three episodes when I felt involved, when I had to give bad news, for instance, and I could see the people becoming very upset, or worried, or they started to cry sometimes. In those cases it was very difficult for me to detach, but, I mean, now so many years have passed, so maybe I am a little used to it. I know it is not nice to say that, but I try not to be involved too much.

R Okay. As for the interpreting training, you said you studied translation, is that right?

F Yes.

R So you were trained on the job?

F Yes.

R What can you tell me about it?

F It was something that I could learn day by day. I never feel perfect! Also now, I mean, sometimes I am a little worried, I feel anxious sometimes. It depends on what kind of subjects I have to face. The training was, I think, provided for what we needed. We started with some courses with a professional interpreter, maybe the first or second year we were here. Before that, I mean, we tried. We shadowed other colleagues who were here before us. We just observed and tried to catch their techniques. After that, as you know, we tried to structure some courses – simultaneous and consecutive interpretation – and I think we had nice tips that could be followed. But I think training is never enough. That is what I feel.

R In what sense?
Every time I think we need to learn. Every time we are on the field, like in the booth. It depends on the subject, I repeat, because if it is a technical translation you can learn the terms, the vocabulary; some other subjects can be more easily followed by us. It depends on how much you put yourself inside the situation, if you are able to follow logical speech, maybe. I do not know. I think I would need more, so maybe I will start to have training by myself, I do not know if I can involve some other colleagues.

In your opinion, what are the most challenging features of medical interpreting at ISMETT?

Maybe contact with the patients, of course, so when you have to face sickness or suffering of other people; unexpected events, when you feel unprepared, so you need to study as quickly as possible the subjects you are going to translate; meetings, when people speak all at the same time, so you need to manage the situation, you need to take control of the situation; long hours, maybe, when events are long; and then maybe variety, as you never know what you are going to do before doing it.

And what about terminology, language issues?

We created this glossary at the beginning, which is enriched every day, so terminology is acquired thanks to other professionals’ support, so doctors, other staff, they are very helpful, and they are very important for us to learn new terms and to understand what you are talking about.

Does the variety of settings and interlocutors have an effect on the interpreting activity?

Yes, I think so. There are some environments that are more familiar to us, so maybe you can feel more at ease when you are working, there are some others when you have to be in front of many other people, sometimes you do not know the audience, so in that case maybe it is more challenging. But I think both are very nice, I like both. They are different situations that give you a lot of thrill.

And what can you tell me about cultural issues at ISMETT?

Between the American and Italian staff, and the role of interpreters in this setting.

In this sense, I think we were very involved at the very beginning, because, as you maybe know, they were very, very different cultures. Sicilian culture is a culture apart, I mean, it is not similar to any other in the world, I think. It is very peculiar and it is not easy to explain, of course. Americans are very organized, have their standards, so Sicilians, at the beginning, were not ready to understand that. And I think the interpreters in that case had a fundamental role, because they had to mediate between the two cultures, so avoiding to say things exactly as they were said. I mean, sometimes the tones were very hot, so we needed like to hide, sometimes, something in order to let the message be transmitted to the other person, so we had a role of mediators as we explained also… Do you remember when we went to Australia? We did a deep study about this aspect, which was very interesting also for us, because maybe before that moment we could not imagine how, at the end, Sicilians could learn. I think the Americans were important for this facility because they gave us the keys, the standards to follow, they taught us every little thing, I mean, how to overcome any kind of situation thanks to their suggestions and policies, protocols, something that we really did not know at all. I do not know if it is clear.

Yes, it is, absolutely! To conclude, let’s talk about something a bit different: let’s talk about interpreting style. In your opinion, what makes the style of an interpreter?

I think a good background, cultural background, educational background, first of all, and… I do not know, what do you mean by style?

I do not know either, so I would like you to tell me! I would like to find out whether it is possible to talk about the style of an interpreter, if each interpreter has his or her own peculiar style or not, so I would like to have your opinion.
F  I think so. We have sort of guidelines we need to follow, we try to be able to do the same things. I mean, that is the goal: every single member of the Department should be able to do the same things as the others. Actually, of course, there are people who are more structured – I do not know how to say... In this particular environment I think everybody has a personal style, which is based maybe on personality, first of all. I can tell everybody has a personal way of working in the environment. The goal is to transmit the faithful message, and then everybody has his way of doing it.

R  And how would you describe your interpreting style?

F  Well, first of all there are different environments, so it depends on what I have to interpret. I do not know what my style is, I have no idea. I have started to listen to myself, to what I have translated, just recently, so I do not have a real definition of my style. Maybe I can work on it and let you know later. It is the first time I receive a question like this, so I do not know what kind of style... I try to be sympathetic...

R  Okay. Thank you very much!

F  You are welcome! It was a pleasure!

R  Thank you for helping me and giving me your time. Is there anything else that you would like to add, something that was not addressed in the interview but that is important for you?

F  I think that you gave us a very important contribution with the academic aspect, which is something I would really like to carry on with my colleagues, if we are able to do so, because you introduced us a new world. So we could take our experience outside the country, we could compare ourselves with other realities that do not exist in Italy, but we know that somewhere, in the world, there are little departments like ours, and I would like to continue to share this experience with other people that do the same job that we do here, and thank you for this very important contribution. I do not know if we have the cultural and the educational background to continue in this way, but I hope so.

R  I think you can do it! And thank you for saying this!

F  You are welcome! I really think that, I believe in this!
I-5 Georgia

R First of all, thank you very much for taking part in this interview.
G You are very welcome!
R This is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English. I know it does not apply to you, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer.
G Okay.
R So, how did you start your experience at ISMETT?
G I started in 2000 when a friend of mine told me there was a call for applications and I applied. And I went through the selection process.
R Which year did you say?
G 2000. July 2000 was my hiring date.
R And why did you apply?
G Because I did not like my previous job. I was working for a financing company and it bored me. So I tried something new, something I had never done, and everything went well.
R So it means that you had no previous similar professional experience?
G I had no experience whatsoever in the field of interpreting and translating. Oh, actually I had translated a couple of handbooks.
R So can you tell me something about your educational background?
G I have a Bachelor’s Degree in Marketing and Communication, I got my degree in the United States, and after that I worked for Salvatore Ferragamo; transferring to another company, I was an Assistant Buyer, and those where the most important experiences from an educational point of view and professional point of view. Other than that, I have an IT background as far as High School is concerned, and I have worked ever since I was 16 years old, mostly in stores, you know, working like a sales person, making money on commissions.
R But in 2000 you spoke both English and Italian...
G I have always spoken both languages. I was born in the States and English is my mother tongue, although I was initially raised in the States and, even though we were supposed to be speaking English, my parents decided to speak to my sister and I in Italian, because they figured we would have learnt English in school. So, when we went to apply for kindergarten for the first time, they actually kicked us out because we could not speak English! We understood it but we just did not speak it, because I guess when you teach a child two languages at the same time, a study proves that they start speaking later. And that was the case, actually. Yeah, my mother tongue is English, and I never stopped thinking in English. I still think in English, I dream in English.
R So you regard yourself not as a bilingual, but more as an English native speaker?
G Well, I do not know what to answer that, because in one way I am an English native speaker, on the other hand, if I am not tired, I think I am quite fluent in Italian too. If I am tired, then my brain kind of has a meltdown, and I start switching from Italian into English, back and forth constantly in the same phrase, but if I am relaxed I speak in Italian fairly eloquently, I think, better than a lot of people I know!
R And, overall, how many years did you spend in the US?
G Ten... My first ten years were in the US. Then eight years in Italy, then back in the States for six, and I have been back here since 1996. Half-way down the line.
R Okay. Let’s go back to ISMETT. So you said that, when you started working at ISMETT, it was not just your first experience with medical interpreting, but with interpreting in general.
G For interpreting, as in interpretation, right, that was my first ever experience. I had never verbally interpreted anything for anyone. I had worked on translation, such as the handbooks. I translated a couple of handbooks, and they were for a company called Amplifon, the hearing aid company. So it was fairly technical. And another handbook was also about information technology, but I cannot remember whom that one was for. And then I translated a website, it was a website about Sicily and all the touristic places one could visit, so to speak. But that was the limit, the extent of my experience, so I had never done anything else, really.

R So how did you become an interpreter?

G Working here, in the hospital. It was an on-the-job training, so to speak. When I went through the selection process, everybody had a title in interpreting and translating. That was kind of scary, I have to admit it. But then again, if you know you want to try something different and believe in it, or believe in the hopes it may represent for you, I guess you can learn just about anything. And they were focusing on training people on the field here, and that is how I learnt. Plus there used to be a woman here working, she had fifteen years of experience and she taught me basically everything I know. Her fifteen years of experience were in the field of T&I. So that was of great support and great help to me. I did not spare myself from anything, she was very harsh as far as teaching methods and criticism, but I guess it all paid off.

R Going back to your first years at ISMETT, what can you tell me about your first impact, especially with medical interpreting?

G It was terrible. I remember my very first interpreting. It was my first week or second week here at ISMETT. There used to be a Director of this Department who no longer works for ISMETT, our previous Director. He called me saying that the former Chief of Anaesthesiology needed an interpreter to speak with a physician from the Civico Hospital. And he was updating this external physician on the conditions of a patient, and on a long list of procedures and tests the patient underwent. And so he started listing one thing after the other, and it was all medical, highly technical stuff. And I am just listening, and I am hoping that everything derives from Latin. And then it was my turn to speak, and there I was, so I said – in Italian of course: “The patient underwent… all of the above procedures that the doctor has just specified.” And it was funny because everybody started laughing, and the former Chief looked at me and said: “I don’t think I was that brief!”. And I started laughing, and I said: “I’m really sorry, but I only got the first two! There’s no way I can repeat everything!”. I’m pretty sure I always had this feeling that I was kind of set up by my former Director and the former Chief of Anaesthesiology.

R What do you mean by ‘set up’?

G ‘Set up’ like they did that on purpose, they were trying me out, just throwing me out there, otherwise there was no reason for everybody to laugh. I am assuming they would have looked at me funny or something, like: “What the hell are you doing here, wasting our time!”. I always had that feeling. But that was an excellent way to understand immediately what this was going to be about. So there was a lot of Internet research and reading; that’s what I used to do constantly, every night shift I worked I was always on the net, always reading some medical articles, always looking at hard copy articles that our former Director used to bring in, or whatever, and it was just making mistakes and learning from them, that’s all.

R Okay. So you mentioned, in particular, the issue of terminology, of medical terminology?

G Yes, that was one of the main obstacles, and not during the first year, but during the first years. I mean, it is a never-ending process anyway. I do not know every single medical term today, I know the terms that I need to work. But, even today, every time they add a new program to the list of ISMETT programs, there is always something new to go study and learn. When they started adding the cardiac program, the heart
transplant program, there was something else to learn; they added the lung transplant program... Who knew anything about the anatomy of the lung? We did not! So it is an ongoing process, really! That was the far most greatest obstacle ever.

R In addition to medical terminology, what does working in a hospital imply, in your opinion?

G I do not know... It implies anything you can think of to make sure the people trust you. In order to work in a hospital, people need to look at you and feel comfortable and reassured. They need to look at you and think of reliability: reliability not only as far as the message is concerned, and conveying their meanings, their intentions, but reliability also as in confidentiality, trustworthiness. It is a weird job: working in a hospital is really funny. I guess it is because there is also a human level involved. Even if our physicians sometimes can treat patients like numbers, we see that happening very rarely here. So there is a lot of everyone’s private person involved in every exchange. So that is the one thing that I have found most helpful in working in this hospital. You know, once you win people’s trust over, then it is downhill. That is when you see situations where: “Oh God, I don’t know a word”, and a physician will suggest the word. Whereas before, when nobody knew us, nobody knew how I worked or my degree of correctness or being loyal to whomever, if I did not know a word, they just looked at me like: “Ah! You don’t know the word!”; whereas now they would be the first ones prompting the word. And that is a major change. Those are changes I think everyone of us in here has experienced throughout the years. You know, the scepticism becomes trust. You do not know exactly, you cannot see it really happening, like you do not know when exactly it happens, but it happens. And then it is downhill. Then your life becomes really easy. Our job is way too stressful to handle, but we do it anyway, but easy from a relational point of view. You are free to set your own conditions and set your terms. You know, in order for me to do my job, I need to have these conditions in place, and everybody needs to respect my terms. Once they trust you, they are very collaborative. At least, that is my experience.

R So, if you had to describe medical interpreting at ISMETT, what comes to your mind?

G Impossible!

R If you had to describe it to an outsider...

G Medical terminology?

R No, no: what it means being a medical interpreter at ISMETT?

G Being constantly ready, being on the ball, on the ground, always. Unfortunately, being a medical interpreter is very unpredictable. Like there are certain scenarios where you kind of know what is going to happen next: especially if there are patients with similar pathologies, you know what is coming next. But then here comes the day when there is a patient with ten different complications and half of them you have never heard of, because every subject is different from the other. Or, considering the administrative part of a hospital, that is a whole other sphere, that is a whole other area where anything can really happen, especially when there are lawyers involved, or consultants involved, outsiders who do not really know what is going on at ISMETT. If I had to describe the number one aspect that is the most important to be a medical interpreter... We are speaking at ISMETT, not a medical interpreter in general?

R Yes.

G Be flexible, as flexible as possible. Be prepared for everything and anything. And if you think about it, you really cannot be prepared for everything. I am talking about being mentally ready for it, you know. You do not know what is going to hit you and when it is going to hit you. As long as you do not fear it, you know, and just realize: “This is part of the daily activities of this hospital, and I am here to help them go smoother, so do not panic!”. That is also very important: not to panic! I am a very relaxed person: I can get very stressed-out when the workload is too much, but then, when there is a crisis or difficult situations, I become automatically very relaxed,
because otherwise I cannot think. As long as you can keep your cool, I think that is like one of the most important tools for working at ISMETT. Keep your cool, be flexible, and be prepared, mentally ready to understand, because anything can happen, you just do not know what every day is going to bring you. You do not know.

R So you mentioned flexibility, and something like stress management?

G Yes, definitely stress management.

R You mentioned the different settings where interpreters work at ISMETT. So, in what way does this variety affect the interpreters? Are there specific tools that have been developed in order to deal with every different setting, for instance?

G I cannot speak on behalf of the entire Department, I can speak for myself.

R Yeah, sure: from your point of view.

G Actually, I have mentioned this in the past too. I like to call it a custom-made service. The way I make my life easier is like... I know a lot of the people in this hospital, or anyway the people that more than others would require or request the intervention of an interpreter/translator. Something that has helped me a lot throughout the years is getting to know everyone, getting to know that one customer. I kind of know what that person wants, what that person is aiming at, what final results he or she would like to see accomplished. I know their styles, I know who gets really bothered by wasting over, and who does not mind. I know who has got time to spare, so they would rather me interpret after they are done with their talking. That helps me a lot in my job: knowing what the customer, each customer wants, and giving it to them the way they would like me to repeat it. You also have to know what the customer could be at, working in this hospital. And what I am referring to is like... every request is urgent. If you get to know the people, you really know whose requests are urgent, and whose are not. Some people just have got this bad habit of: “All I need is urgent”. It is just a habit, like they think it is going to skip our minds or something, if they do not write: “It is urgent”. That also helps me with managing my time. It is just a constant give-and-take, really: I give my customers everything I can give, as long as they respect the boundaries of my job, you know, and the way I arrange my work, and the way I set the variables of my job. I never tell anybody: “There is only so much I can do”. In my opinion there is always something more you can do, but that is just the way I think, and that is not only on the job, it is even outside: outside I think the same way. So, I will give you everything I can give you, and more: just do not stress me out, do not add on to my stress. And whoever knows me, knows that is exactly the way I think, you know! So I guess that is a win-win situation for everybody. Of course a lot of people are going to play smart, and are going to try to get to you one way or the other. And I do have my five minutes, and those who know me know I have my five minutes. But then just take a deep breath and move on. That’s basically it.

R And what about interpreting modes or techniques? You know, sometimes you have to select the best interpreting mode...

G The best that works for me is whispering interpretation, with and without the aid of the headphone system. I do prefer whispering while the speaker is talking, first of all because I think it is best not to hear the interpreter, except for that background whisper. I can really manage to whisper at a very low volume in the microphone or in somebody’s ears, and I think that is just best for the fluidity of a meeting, or of an exchange, or whatever it is. Plus – I should not be saying this! – I get bored really easily. So if I had to do the voice-over thing and like you talk, and I wait, and then I speak and interpret, I would probably...

R You are talking about consecutive interpreting.

G Yes, I would probably fall asleep! I am not saying it doubles the time, but at least it becomes a time and a half, and as there is so much work to do, and so many translations to get to, I do not have that kind of time to spare. I do not. Plus it just
annoys me when I start thinking about how much time I am wasting doing the short consecutive technique, whereas I could be whispering and saving everybody’s time!

R Sometimes, for instance, the clients do not like the headphones...
G I really do not care.
R ... or just the fact of hearing the two voices at the same time. You do not care?
G I really do not care. I usually work things out, so that I can actually manage to find the way to make them comfortable. You know, if I am whispering and they get de-concentrated because they hear two voices, even if it is one person, I will get the headphone, and invite that person to wear it, so that way they will only hear me. They cannot hear the other person, because they are wearing the headset. Other people have complained that the headset is too heavy, and it weighs on their heads, and I really just ignore them. I just shrug my shoulders and say: “Eh! C’est la vie!” Again: when you get to know the people, you know, you can joke with them, and fool around – even if fooling around is a totally different territory. You can joke with them and some people are like: “Why can’t you just use the consecutive?” And I have actually been in situations where I told people: “Because I’m really busy and I have got to get out of here as soon as possible”. And they laugh, they understand perfectly. There is an implicit message, you know: “Please just a little sacrifice: how much can the thing weigh?” You see what I mean? Let’s just go out of here. Because if I speak after the speaker, we are going to be in here forever. That’s all there is to it. And I think they will be happy to leave as soon as possible too. You know, everybody is really busy, everybody has got something to get back to.

R What is the most challenging aspect of being a medical interpreter at ISMETT?
G That is a very good question... I do not know what to answer. I find that the most challenging is interacting with the newbies, with the new hires. Because they are constantly hiring people at ISMETT, and right now the most challenging thing I have experienced is starting from ground zero with the new physicians, the new nurses. It is a shorter process, it is a faster process, because we have referrals in here: the senior physicians, those with whom we have worked for years, always end up telling the new physicians, you know, that interpreters are good, that interpreters work really well, so it is a shorter way to build up the trust and the bond compared to when we started. And I also have a very hard time still with videoconferences, because unfortunately technology does not put audio and video... They are not synchronized! Technically speaking, that is my number one challenge. When they call us for videoconferences, it is just a nightmare. You try to read lips, because I am one who reads lips a lot, so when I cannot make out the word, if I did not hear it well, I am reading the lips, so that kind of helps a lot. Videoconferences are the worst nightmare from a technical point of view. From a general point of view, it is the interaction with the people I do not know yet.

R Just a couple of questions about the cultural aspects at ISMETT. In your opinion, what are the relations of the LS Department with the US and with the Italian staff?
G Again, am I supposed to be speaking for the overall Department or for myself?
R No, no. Your opinions, for yourself.
G Well, that I know of, each one of us has very good relationships with both Italian and American staff. I mean, the Italian staff sees us every day, and most of them have worked with us by their side, so there are strong bonds there. As for the American staff, we have known them for sure for periods of time, but they rely on us so much, they depend on us so much, that the bond goes strong in a short amount of time, but just there is more intensity there. So, from what I have experienced myself and from what I have seen, you know, watching my colleagues, the relationship is really good with both sides. Yet there have been problems when both sides were face to face and the interpreter in the middle, we have all been there. I actually find that quite amusing, you know, like the conflict between the US staff and the Italian staff, that is like a
refresher during the day to me, because I belong to both cultures, I have personally experienced both cultures, and habits, and ways of life, and when I see them conflicting – you know, Italian nurses versus American nurses and vice versa – I actually have a chuckle, I laugh, because I perfectly understand what is supporting the American mentality, what is in the back of their heads, and what is supporting the Italian mentality! So, you know, thank God I am not the kind of person... I am not intimidated by conflict, I am not – especially other people’s conflict. You know, I am just the kind of person who likes watching, and of course we cannot just let things get out of hand. I have found it very easy to intervene in cultural conflict, maybe because – now that I am thinking about it – maybe it is because I know both sides.

R So there are conflicts...

G Yes, there are conflicts. Well, in the beginning the conflicts were because, you know, the Italian nurses were working with the American nurses, and I think that is a shock per se. You know, like: “Who are you?”, with the interpreter or not. The first thing that comes to my mind would be: “Who are you and what are you doing here? Why don’t you go back home?” Let’s not forget that, in the beginning, when there was the whole know-how transfer goal – and which is why the American nurses were here – ISMETT did not only hire young nurses: ISMETT also hired nurses with several years of experience. So, that time was extremely conflictual, because those nurses with more years of experience did not like it at all to have American nurses – sometimes even young, much younger than them – come here and tell them how to do things, or: “This is the way things should be done because that is the American way”. So, now things are kind of smoothing out a little bit. First of all, we do not have a lot of American nurses any more. Not in the units, anyway. We have other figures that do not interact with patients. The conflict that I can feel and sense today is because there is still that degree of scepticism. I do not know if it is because people are narrow-minded. Here, unfortunately, I cannot support the Italians. When there is an American professional arriving at ISMETT, the first thing Italian nurses say – I am talking about the nurses because so far no physician has ever dared make the following comment in my face – is like: “Oh! Another one from Pittsburgh coming for vacation!”. You know, these are professionals that are coming from the States, and they are here for a purpose. They have a goal. They have to reach those goals, that is why UPMC has sent them here, and that is the conflict that I have seen most, when there is somebody new coming from the States, even before that person lands in Sicily, somebody is already saying something negative about them. And, then, of course, that is my job: once the person is here, once I get to know that person, you know, to support – not knowing that person, because I would never get to know the people in depth – but once I get to know what kind of work they do, and how they work, then I become everybody’s supporter. When Americans arrive here, it is not that better either, you know. They do not find optimal conditions, and I am talking about transportation, I am talking about civil sense, common sense: there is not a lot of that here. There is not, no matter which way you look at it, you know. When Americans have got certain ways... a lot of things there are unsaid: you wait on line, you respect traffic signs. It might sound stupid, but it is not, you know. American people speak and listen, they do not talk at the same time. And they do not yell and scream at each other when they are discussing something, whereas here it is the contrary. But now the conflicts are more on a cultural level, whereas in the beginning it was literally on a very professional level, like it is not a matter of different cultures, but we were talking about job-related tasks causing conflicts, and job-related methods causing conflicts. Whereas now, you know, it is a little bit more wide-ranging.

R Before moving to the very last part of the interview, I wanted to ask you something which is not scheduled. You hardly mentioned any emotional issues, when we were
talking about being a medical interpreter: is it because at the moment we are no longer working with patients, so that did not come to your mind?

G No, not really... The emotional aspect of my job was never a problem to me. I do not know if it is because of my background: I used to volunteer as I was a teenager. Between the age of sixteen and a half and eighteen I volunteered in a hospital. I used to work in the oncology unit, and you see a lot of elders there. Several of the patients died during my period of volunteering. I do not know, I have a very good way to cope with emotions, at least that is how I feel. I do get very empathic with people. I do get very emotional with them... I do not know how to explain this: how sad something can make me, that would not prevent me from doing my job, that would not prevent me from reaching whatever goal the physician is trying to reach, or the nurse is trying to reach. That does not hinder my job, I have to reach the final goal. I mean, it is not easy to be with the physician and the parents of a child and hearing, having to translate the physician into Italian: “Sorry, there’s nothing else we can do for your six-year-old daughter. She’s going to die within hours”. I am not saying that it is easy. I can interpret that without a problem, and I will sound heartbroken as much as the physician is, but I am not going to break down and cry. I can go home and break down and cry, not here. We already have relatives and parents and mothers and fathers crying, you know. Somebody has got to do the job. Once I clock out, then if I want to cry I will cry. If I need to talk about it with somebody, I will call my mum and have a chat with my mum, you know. I do not know, I have a very funny relationship with other people’s emotions: I do get touched and very emotional for them, but what dawns on me is that somebody has got to be strong here. I do not know how to explain it...

R It is perfectly clear.

G They are going to lose it any second, you know. We have been talking about the authority figure, of who is supposed to hold the reins of everything, you know – if we break down with them, I think it would be disastrous. Once you clock out, go home, have a glass of wine, cry if you want to cry, watch a good movie or go dancing, and you are fine. I have a very good relationship with the whole context of disease. The only thing that really makes me uncomfortable is the concept of pain, which I hate, especially in Italy, because everything is so taboo about pain, pain killers, and pain therapy. But the idea of death is something I have never feared, the idea of sudden death has never scared me. I like going to bed knowing that everything is in place and that everything is okay with everybody, that is as much as I can achieve and that is not always possible. But I do believe in faith: so I strongly believe that whatever needs to happen will happen, no matter how upset I make myself get, you know what I mean.

R So, to conclude, let’s talk about something completely – or let’s say a bit – different: interpreting style. So, in your opinion, what makes the style of an interpreter?

G Style as in what style?

R If you hear this phrase, interpreting style, what does it mean? Just your first impression, if you have ever thought about this concept...

G Well, no, not so focused on it, no. What I can say is that I do not like... I like it when an interpreter has personality... Okay, wait, that is difficult to explain, like... I hate monotone interpreters, you know, like... I do not know how to explain this... I have a very bubbly personality, okay, so first of all, if I am interpreting for somebody, I will make sure that the tone and the volume of my voice and my body language reflect that person’s body language and tone, because I just feel that that makes the message more complete. Sometimes, what I do have a hard time with is my attitude and my personality, because I can become very bubbly, and, you know, I live out of pure adrenaline and sometimes... I do not think I overdo it, but I actually fear the possibility of overdoing it. But then, when I look at the customers, the audience, it is nice, because everybody is smiling and everybody is relaxed, so I do not know if you
can define that style, or not. Maybe yes, maybe no. Here at ISMETT there is also
another thing to say: I, my colleagues, we are allowed a certain degree of freedom of
action, so to speak, you know. If there are outsiders, or depending on which physician
is involved in the interaction, of course I am going to behave in one way, be extremely
professional, go by the book, not make a single mistake, because that is the way it
should be. But it is also true... Let’s say there is a meeting among nurses, where the
whole environment is a lot more relaxed, you know everybody on a personal basis.
You know, it has happened before to make comments in the microphone, or to joke
with them, because they actually involve you, they involve the interpreter as an active
part of the interaction. Now, can you call that style? I do not know. Is that kind of my
imprinting, my signature, or my colleagues’ signature? I have no idea. I have never
given the concept of style that kind of specific thought.

R So you mentioned tone, volume of voice...
G Yes, the volume is important.
R But then you added that, in your opinion, the style of the same interpreter can change,
according to the setting?
G Yes, mine does. Well, I believe that goes back to that tailor-made service depending
on the customer. It goes back to that concept of flexibility. Probably I am being
repetitive, but that is where it all goes back to, for me. You know what I mean? It
depends on who is standing in front of me, who is requesting my services and my
intervention: I will give that person what they need and how they need it. And if I find
myself in a situation that is more relaxed and with a greater degree of flexibility, and a
situation that gives me more leeway, I will try to have fun with it, why not? You
know, it is heavy to come and work every day, we have a very stressful job, and I will
take advantage of any situation where I too can chill out and relax with the people I
am working with. Especially if they are more than happy about it and they are the first,
on their own will and initiative, to involve me in what they are doing. A lot of times
they would go: “What do you think about this?”?, “I am not part of the meeting!”;
“Yes, but what do you think about it anyway?”. That is nice, it is very nice. But then
again there are other situations where I cannot do it, and so I will have to adapt to
other aspects that are a lot more severe, they are strict, they are by the book. It depends
on who my customer is in that moment of the day. If I can have fun, I would rather
have fun.

R So that is your interpreting style: have fun if possible.
G Oh, yeah. Because it is a very tiring job, it is very stressful. So I have to make the best
out of it, every time I can, and there is going to be a hundred situations where I have to
be... top management, wear my suite, do not smile, do not laugh, go by the book, be as
precise and sharp as a knife. Fine, I will do that. That will take the life out of me, of
course, because not only are you concentrating on the messages and everything, you
actually have to concentrate on yourself, what you are portraying as the interpreter.
There are other situations where you can just blend in a lot more and a lot better, and a
lot easier, and that is when I can relax too, and laugh at other people’s jokes, and join
them while they are joking, and it kind of counterbalances the heavier, most severe
part, the stricter aspect of our job. So if that can be called the style, so be it. It helps
me go home and still feel sane! I lose my sanity, otherwise. I can never. It is just like
working in a booth, everyday, for the entire month: I would go crazy! Need some
variety there! I little bit of this, a little bit of that! Today we are serious, today we can
joke around a little bit. And since everybody seems okay with this, I am okay with
this.

R Okay, so thank you very much for helping me...
G You are very welcome!
R ... and giving me your time. Can I finally ask you if you think that there is any aspect of your experience at ISMETT that has not been covered in this interview and that you would like to point out?

G No. No, no, no, it was very exhaustive, actually. Oh, yeah. Weird questions: I was not expecting that kind of questions. That was very interesting, thank you. Anytime.
Appendix Three

I-6 Henry

R First of all, thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer, okay? The first question is: how did you start your experience at ISMETT?

H A friend of mine sent me an e-mail with this call for applications. She told me, if I was looking for a new experience and I felt like trying, to give it a shot, even though she warned me that we were working on night shifts, and that the pay was bad. But I decided to give it a try.

R When was that?

H I got the mail around May, June of 2004. Then they called me for the selection in July 2004, and my first day of work here was on the 13th of September 2004.

R Okay. So why did you apply, basically?

H A new experience.

R A new experience… And have you had any previous similar professional experience? Similar, meaning in a hospital, or in the medical field?

H I did just a couple of conferences, but that’s all, as an interpreter, though.

R So you were already an interpreter before coming to ISMETT?

H I have a proper training as conference interpreter. I was doing translations. I was working as a freelance, basically.

R After your university education?

H Mhm.

R Okay. What were the main differences between the training you had at the university and actually working in the medical field?

H Well, I do not know. I have never found the job here particularly challenging, because the skills I have developed in university and, you know, having to manage the stress in a conference and tight deadlines with translations… I mean, actually, from a certain point of view, working here, at the hospital, was actually easier… from a certain point of view.

R In what sense easier?

H I mean, more easygoing. I mean, there are busy days here, they can get hectic, but it is never like when you are working in the outside, I mean, when you are working as a freelance. Because when you are working as an interpreter, you are working in the booth and of course you have all the stress and everything that is typical of working in the booth; when you are working as a translator, you are working like ten, eleven, twelve hours a day, you have your deadlines, you have customers calling, asking “Are you available? Where is the translation?”, and this and that, and, even while you are working, you would have to take care of the accounting stuff. I mean, it is something completely different. So, I mean, it is much more stressful from a certain point of view. I mean, more regular: from a certain point of view it is more regular, in terms of the routine, but it is much more pressing. Because, of course, I mean, here you know that you do your hours, and at the end of the month you get your salary, every the first or the second of the month. When you work as a freelance, if you do not work, no money.

R So it is less pressing working here.

H That is the basic difference. I mean, once you start to master the terminology, I think that things here are not that… I mean… by now, it is four years now, and the challenge is over. The challenge actually was over after the first year or so.

R So, I think you have already answered my next question, that your first impact with medical interpreting was quite good. Is that what you are saying?
H Well, I mean, as I was saying, once you learn the jargon, it is always the same. And, of course, like in every other field, there are always new words that pop up, but then, of course, if you are a good translator, a good interpreter, you know how to do your job, you know how to find what you are looking for. That’s it.

R Okay. Any other issues that were new or which had a great impact when you started working here, like emotional, interpersonal issues?

H Oh, no, I mean, I was pretty lucky because there was already a core group of interpreters who had been working together for so many years and everything. I mean, after the initial impact, which was greater for them, I suppose, than for me… because probably, from what I have understood, when I first started working here, I was pretty overwhelming. I mean, I was pretty…

R You were overwhelming?

H For them, from a certain point of view, maybe I was too proactive, a bit too loud and everything, so people probably even misunderstood the reasons why I was that way. But otherwise, I mean, I get along perfectly with everyone, I think. The only issue was getting used to working on a shift basis. That was a bit tough, especially for someone like me who had always had a regular life. Especially the nights were a bit heavy; issues were… even the night shifts, because our former Coordinator or Chief had the strange idea that the night shift was just like any other shift, and that you were supposed to work hard all night long, which, I mean… that was basically the only major issue, at least. And then, of course, I mean, other issues were – maybe not immediately, but at least in the first year… There was this impression that the Department could have done so much more, so many new things, but that were like being, you know, sort of… not suffocated, but at least… our wings were sort of clipped.

R At the beginning, you mean?

H Yeah, by our former Chief.

R And what about the first impact with disease, with patients...

H I thought it would have been worse, but actually… I mean, I just remember one patient, once. It was not a particularly difficult case, it was nothing special. It was just on this one occasion that I was sort of captured by the beauty and dignity of a sick person. Because, I mean, when you are dealing with patients, I think that there are many different types of patients. There are actually many patients who can actually be a nag. I mean, I understand that it is a difficult moment, and whatever, and they have got all the reasons in this world to be the way they are. But there are some people who like experience disease, their illness, with greater dignity. There are others who just let themselves go and become a nuisance to those around them, to those trying to help them and… and that’s all, even to the point that sometimes I believe they lack respect to the professionals taking care of them. I mean, it is their job, there are some professional figures who are actually there to do it, but, I mean, you should always appreciate: I know it is their duty to do it, but there should always be a certain degree of appreciation, and not taking everything for granted.

R Okay. And, in your opinion, what are the most challenging features of medical interpreting at ISMETT?

H I do not know… Probably, the most challenging part was actually years ago. They had the terribly bad habit of wanting an interpreter at the lectures, so they would just call upstairs: “We need an interpreter”. So take the headphones, take the microphones, go downstairs, without having any material, and just having to translate straightaway with the room full of physicians who anyway do understand some English. It is more like the pressure, the scrutiny of those listening to you. I mean, if you work in the field, you understand how difficult it is: they call you in, you do not have any prior knowledge, you have not had any chance to study, to do any research, or whatever, but then whoever is listening to you expects that you come up with a perfectly suitable
and appropriate translation, which is not always the case. So you are there, trying to do your best, and... I mean, that was a bit... There was a lot of pressure on those occasions. But those days are now sort of gone, things are much more consolidated, the whole machinery, the whole mechanism is well-oiled, and it is running smoothly.

R Does the variety of settings and speakers affect the interpreting activity? And, if so, in what way?

H Probably I am sort of a case of my own, because, having had experience before as a freelance, and not having specialized before in a particular field, I was like used to anyway doing, you know, commercial contracts, manuals, a bit of everything, basically. So, variety was part of my everyday routine anyway, so coming here and having to hop from a meeting between physicians, a nurse speaking to a patient, or going to Board of Directors meeting, or whatever... It was not that big of a challenge, in the end.

R Do you think you have to make a selection every time, depending on the context where you are going to interpret? Are there any tools or strategies specific to every different setting? Is there anything you can think of, from this point of view?

H Well, one of the main differences is that, of course, in most of the cases, unless I am with a patient, I always do sort of *chuchotage*, basically, I do a sort of simultaneous interpreting in most of cases. I try to, at least.

R Okay. So, you limit the selection also from this point of view.

H Yes, I mean, I try to do it, at least I try to keep the speaker down to very short sentences, not having them speak too much, and then translate, that's basically it.

R That is the main thing. Okay. And what about the relations of the Language Services Department with the US and Italian staff? What is your impression?

H Well, I think that, overall, it could even be something culture-bound, or even considering the different types of experience. I have always found that the American staff has been more appreciative and warmer towards us than the Italian staff. Not that the Italian staff does appreciate us or does not, but, after all, Italians are in their own country, they are at home, and, I mean, most of the time they are speaking in Italian, so there are very few occasions when they actually have to speak in English or need an interpreter, whereas the American staff is often heavily dependent on our service, and there have been occasions when our service or the assistance we provide would even step beyond our duties. For instance, they can rely on us even for their own... for other needs. I mean, about a month ago they had towed away the Chief Nursing Officer’s car: she called us and we managed to find where the car was and to tell her “Go there”, not to worry, and whatever, and that if she needed anything, she could always call us. So, it is something that goes beyond... It is even like providing a bit of logistic support as well. And we have always been very open, and willing to provide this sort of support. Italian staff appreciates us; of course there is always a problem that is typical throughout Italy, I believe, that everyone has this sort of attitude, that: “Oh, yeah, I’m good at my own job, I’m the expert, I’m the professional”, and they want to be respected for their own professionalism and their own expertise, and whatever, but they do not give that same respect to other professionals and they do not show the same respect to other professionals, and so on. So that is something that is not only here at ISMETT, it is something much more in general, but I think sometimes you still have today that sort of feeling that we are like ‘the children of a lesser God’, from their own point of view.

R And what about the relations between the US and the Italian staff? Again, from your point of view.

H Well, I mean, it has always been good, but then there is always this sort of competition. They do not do it deliberately, but there is a sort of competition, so the Americans, of course, can rely on their better technology, better organization, and so on, they are very professional. From a certain point of view they are more professional
because they are more serious. Whereas Italians, I mean, they have got a more
complete, more comprehensive training, they are better at improvising, but, in general,
they make a lot of confusion, basically. So it is this sort of competition where you
actually need both at times. So I think the real problem is managing the advantages
and disadvantages of both, trying to strike the right balance.

R Before moving to the next question of the questionnaire, let me ask you another thing:
to be, let’s say, a good interpreter at ISMETT, what are the main features of an
interpreter?
H Versatility, of course: you have to be flexible, proactive, you have to be open… I think
those are the main features.

R To conclude, let’s talk about a particular concept: interpreting style. In your opinion,
what makes the style of an interpreter?
H Well, I can talk to you about my own style, and what I have been able to see…

R That was the next question, so no problem!

H I mean, anyone has his or her own personal style, and they are all perfectly acceptable.
If often depends: the better style does not actually depend on the interpreter, it is much
more. It depends much more on what the listener expects.

R But from which point of view? You said that every interpreter has a personal style, but
what does this style imply? How can you describe the style of an interpreter?
H There are those who get more carried away when they are translating, they are more
vigorous; there are others who are calmer in their enunciation, while they are
speaking, they have an even tone; there are others who are like more vigorous, more
forceful; there are some who listen more, who have a longer décalage, others who
prefer sticking closer to the speaker.

R So you mentioned like, let’s say, tone of voice, or elocution…
H Yeah.
R ... and you also mentioned something more technical, the décalage. So you think that
these are some of the features.
H I mean, what someone can actually see, perceive, when you are working with an
interpreter: the style basically goes down to that, I mean, whether someone has a more
monotonous tone, someone who has a more lively tone, someone who is like on top of
the speaker, someone who is like more relaxed and, you know, waits a bit more before
speaking…

R What about your interpreting style?
H I am like a bulldog.
R What does it mean?
H I bite the text and I stick to it!

R Do you mean you are aggressive or precise?
H Rather aggressive. Well, precise… I mean, precision…
R No, no, to understand what you meant.
H Accuracy is something very… I do not believe one hundred percent in accuracy.
When you are working as an interpreter I think the main issue is catching the idea and
conveying the idea. There is no way that you always have one hundred percent the
proper, perfect term in a given situation, you have to be able to get around, not finding
that right word, so, I mean, accuracy is important, the more accurate you are the
better; it often depends on how well you have done your homework before, but it can
happen that even if you do know, it might not come up, you know, it is like on the tip
of your tongue, and you just cannot wait for it to come, so you have to get around it,
you have to move on, it is something fast.

R I mentioned that just because I wanted to understand what you meant by being a
bulldog and biting the text.
H It is like throwing a bone to a bulldog, and it starts chewing and playing with it, and it
does not give up.
R  Very nice! Thank you very much for helping me and giving me your time. Can I finally ask you if you think that there is any aspect of your experience at ISMETT that has not been covered in this interview and that you would like to point out? Anything you would like to mention?

H  No, not really.

R  Okay.
R First of all, thank you very much for taking part in this interview, which is an integral part of my PhD research project. The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous. It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer. So, how did you start your experience at ISMETT?

I Okay, I started to work at ISMETT in September 2004. I actually found out about ISMETT because at that time, in that period, I was working for an airline company, at the reservations office of this airline, and a colleague of mine was actually hired by ISMETT to work as a secretary. So I went to the ISMETT website and I saw that they were looking for an interpreter. So I applied, I did the online application for that position and then I started: I did all the selection, the interviews, and in September I got the good news that I actually won the selection and was hired.

R So which year was that?

I It was in the summer 2004.

R 2004. Okay. And have you had any previous similar working experiences?

I I have a degree in interpreting and translation and yes, I did have previous experiences as a translator and interpreter: like for one year I was working for like an agency, they used to organize training courses for young students, young people, and I was teaching English, and, at the same time, I was in charge of all the translations, because these projects were to be submitted to the European Union for funding, so I was translating all the correspondence and the projects into English and from English into Italian. And, occasionally, I worked as an interpreter, in some conferences, and so I had some occasional experiences as an interpreter.

R But have you ever worked as a medical interpreter?

I No, this is the first time. At ISMETT it was the first time that I worked as a medical interpreter.

R So what can you tell me about your first impact with medical interpreting?

I At first it was very, very difficult. I was kind of scared by medical interpreting, because I do not have like a medical background, and dealing with real stuff, with patients, and doctors, and American nurses was very difficult in terms of emotions, and also in terms of the linguistic aspect. It was difficult learning the terminology, the medical terms, the medical acronyms, the medical language, so, at first, it was very difficult: it took some time before actually I got used to being a medical interpreter, and working in a hospital, with medical situations.

R And what helped you to become a medical interpreter? You said that it took some time. And in what way? Where you trained on the job?

I I went through like a short period of training. What helped me was actually studying by myself: we had glossaries, we were given a glossary of medical terms, so at that time I was actually studying. What helped me was also the on-the-job training, because after the first week we were already working in the unit, and working with the American staff in the hospital, so I was actually learning by practicing my job, by working in the units. But actually I did a lot of studying by myself. I was studying all the glossaries, and reading about all the procedures that are performed in the hospital and all the diseases that are treated in the hospital, so that helped a lot: studying, doing some personal research.

R So, this is with reference to the medical terminology. And what about the emotional aspects that you mentioned?

I I have to say that you get used after a while. At first it is very difficult because you are not prepared, you are not a doctor, so at first it is very difficult having to deal with
very sick patients. But then you kind of get used to deal with your emotions, even if it is still difficult sometimes, but with time you get used to being in a hospital.

R And what about the help or support, if any, provided by senior colleagues?

I Yes, I actually forgot to mention that, because my senior colleagues, my senior interpreters, did help a lot, especially with getting to know the place and getting to know the people, with knowing all the tricks, and because there is some special terminology that you do not find in the dictionary or in the vocabulary. There is a sort of peculiar language that is spoken at ISMETT, because sometimes there is a mixture of Italian and English, so sometimes, even when the staff is speaking in Italian, they use English terms. So it is difficult at first to get used to this kind of jargon. So the senior interpreters did help a lot with terminology, with introducing me to the people, and to the staff, and telling me about all the things that we needed to know about the hospital and the people that work in the hospital.

R Okay. So, in your opinion, what are the key features of medical interpreting at ISMETT, if there is anything else in addition to what you have just mentioned?

I The key features...

R If you had to describe what it is like being an interpreter, especially a medical interpreter at ISMETT, what comes to your mind?

I I think that being a medical interpreter at ISMETT can be a very exciting job, and one of the distinctive, key features of being a medical interpreter at ISMETT is that you work with people that you know sometimes. All the people trust what you do, and they have trust in you, so they see you as a part of the team, and you really have the opportunity to familiarize with the people you work with. They not only see you as an interpreter, but they also see you as part of the team. So, sometimes, you are actually involved in the conferences, or in the things that you are interpreting. And one of the key features is that you actually have to be anyway very well instructed, very well prepared, anyway, to do your job.

R Do you mean from a technical point of view?

I Yes, from a technical point of view, because you need to have very good language skills and also be prepared, very well trained with medical information and medical preparation, from a technical point of view. And also from an emotional point of view.

R And what about the settings in which you work at ISMETT? There is a variety of settings and participants to these encounters or meetings: so, does this have an effect on the interpreting activity or not, and in what way?

I It does, because working with patients, of course, is different than working in a meeting or in a conference where there are only physicians.

R In what terms?

I I mentioned earlier the emotional aspect. Working with patients is different because you are there in the room, and, first of all, you need to make clear who you are just to avoid any misunderstanding, and – as I said before – whenever you are working with patients, you have to consider the emotional aspect. So you have to use a more familiar language, and you try to be more familiar with the people you are working with, and whenever you are working in a conference or in a meeting with physicians or clinical coordinators, you try to be, let’s say, more professional. You are seen, you are there as an interpreter, and your first goal is actually to convey the message, so it is different.

R Okay. Out of all the aspects that you mentioned – still talking about medical interpreting – what is the most challenging for you?

I The most challenging... I would say medical conferences, because medical conferences, especially those organized by our hospital, are very technical, so you need to be very well prepared for all the conferences. I would say that medical conferences are the most challenging, because of the difficulty of the level of the interpreting, and also because the conferences are attended by a variety of people and
physicians from all over the world, especially physicians that do not know you and rely on you to understand, and also because of the technical level and difficulty of all the conferences. In all the conferences that I interpreted for, the level, the difficulty was very high, so this makes it very challenging.

R Okay. What are the interpreting modes or techniques that you use most at ISMETT (consecutive, simultaneous, whispered interpreting…)?

I I would say *chuchotage* or whispering. I think it is more comfortable for me. First of all, you are not heard by everyone: especially when you are in a room and there is a meeting, the only person that you are interpreting for can hear you and it is like more transparent, less invasive, so I feel more comfortable with whispering.

R What about the relations of the Language Services Department with the US and Italian staff, and what about the relations between the Americans and the Italians?

I Well, ISMETT is a bilingual facility, so the official language is English, and, of course, we are in Italy, so, anyway, Italian is the most frequently spoken language in the hospital. But, because of this, the entire staff relies on us to communicate throughout the hospital. The relations are very good with all the departments, because they see us as an integral part of the hospital: even though we are not clinicians, they trust us, they have no problems talking about anything in the presence of an interpreter, so there is a very good relationship with all staff in the hospital. And as for the relationships between the Italian staff and the US staff, there is a good relationship between the two parties, and I have to say we help a lot with this, because, beside the mere language barriers, we help a lot with cultural barriers, and we help the US staff, the foreign staff to integrate in these settings. And, anyway, the relationships, I would say, are good: the US staff is a very well welcomed part of this facility, of the hospital.

R Okay. So, my final question is – going back to interpreting – what is in your opinion the style of an interpreter?

I The style of an interpreter?

R Yes, how would you define the style of an interpreter? If your hear, for instance: “Oh, that interpreter has a nice interpreting style”, in your opinion, what does it mean? What are the features that are considered when you talk about the style of an interpreter?

I Well, maybe an interpreter that has a nice style is an interpreter that is very clear, that is very well understood, and is very comfortable with what the interpreter is doing, with the setting, and with the situation. So style is being familiar and, even though it may be like a difficult situation, the interpreter has a good style as being comfortable with what he or she is doing, even though you are interpreting or you are working in a difficult situation, in not preferable conditions.

R So, in any case, style implies something positive to you?

I Yeah, positive, like demonstrating there is not a problem, you are not having any difficulty translating, interpreting, demonstrating that you are comfortable with what you are doing. Yes, style is something positive.

R And how would you describe your interpreting style, if you have one?

I As I said before, I used the term non-invasive, which is also technical, a medical term. I would rather say that I am a non-invasive interpreter, because I try to be, of course, effective and efficient with interpreting, because, first of all, my main concern, my first concern is conveying the message. But I try to be, as I said, non-invasive, because I am there because I am doing my job, I do my job first, but I try to be very soft-spoken, like pretending I am not there, even though I am actually there, because I am allowing communication. So, I would say non-invasive.

R Very nice. So, thank you very much for helping me and giving me your time. So, finally, can I ask you if you think that there is any other aspect of your experience at ISMETT that has not been covered in this interview and that you would like to stress, to point out?
I Yeah, I would like to stress the fact that at ISMETT we work as a team, so we, as a
Department, we are not seen, most of the time, as individuals, but as a Department,
and we do great teamwork. Even talking widely, at ISMETT it is very nice that, even
though we do not have a medical background, we are not nurses, we are not
physicians, we are very well integrated in the clinical setting, and we are seen as a part
of the clinical staff in that sense. Even though we deal with the linguistic aspect, we
are seen as part of the clinical team, and that is very nice.

R Okay, thank you.

I You are welcome.
Appendix Four: Recording authorization form

AUTORIZZAZIONE ALLA REGISTRAZIONE

Il/La sottoscritto/a ___________________________ autorizza a registrare su audiocassette il colloquio mediato da un interprete che avrà luogo in data _______, con la garanzia che il materiale registrato verrà utilizzato esclusivamente per attività di ricerca e che sarà mantenuto il più stretto anonimato su fatti, persone e situazioni.

Firma Palermo,

AUTHORIZATION TO RECORD

The undersigned ___________________________ authorizes the taping of the interpreter-mediated interview scheduled on _______ with the guarantee that the recorded material will exclusively be used for research purposes and that all information, facts and names processed will remain strictly confidential.

Signature Palermo,
## Appendix Five: Transcription key

### Symbols

<table>
<thead>
<tr>
<th>Meaning</th>
<th>Symbols</th>
</tr>
</thead>
<tbody>
<tr>
<td>overlapping utterances</td>
<td>A</td>
</tr>
<tr>
<td>latched utterances</td>
<td>B</td>
</tr>
<tr>
<td>omitted portions</td>
<td>[...]</td>
</tr>
<tr>
<td>untimed pause within a turn</td>
<td>(.)</td>
</tr>
<tr>
<td>untimed pause between turns</td>
<td>((pause))</td>
</tr>
<tr>
<td>rising intonation</td>
<td>↑</td>
</tr>
<tr>
<td>lengthened vowel or consonant sound</td>
<td>wo:::rd</td>
</tr>
<tr>
<td>abrupt cut-off in the flow of speech</td>
<td>wo – word</td>
</tr>
<tr>
<td>emphasis</td>
<td><em>word</em></td>
</tr>
<tr>
<td>loud voice</td>
<td>*word^</td>
</tr>
<tr>
<td>low voice</td>
<td>°word°</td>
</tr>
<tr>
<td>quicker pace</td>
<td>&gt;word&lt;</td>
</tr>
<tr>
<td>transcriber’s guess</td>
<td>(word)</td>
</tr>
<tr>
<td>unrecoverable speech</td>
<td>( )</td>
</tr>
<tr>
<td>acronym pronounced as a single word</td>
<td>ismett</td>
</tr>
<tr>
<td>acronym pronounced as a sequence of letters</td>
<td>U P M C</td>
</tr>
<tr>
<td>marked non-standard pronunciation</td>
<td>w[0]rd</td>
</tr>
<tr>
<td>shift from one language to the other</td>
<td>word parole word</td>
</tr>
<tr>
<td>fictitious names and patient-related information*</td>
<td>(name)</td>
</tr>
<tr>
<td>relevant contextual information; characterizations of the talk; vocalizations that cannot be spelled recognizably</td>
<td>((description))</td>
</tr>
</tbody>
</table>

### Fillers

<table>
<thead>
<tr>
<th>English</th>
<th>Italian</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>umm</td>
<td>umm</td>
<td>doubt</td>
</tr>
<tr>
<td>ah</td>
<td>ah; eh</td>
<td>emphasis</td>
</tr>
<tr>
<td>mhm</td>
<td>mhm</td>
<td>expression or request of agreement</td>
</tr>
<tr>
<td>nah</td>
<td>nah</td>
<td>negation</td>
</tr>
<tr>
<td>eh</td>
<td>eh</td>
<td>query</td>
</tr>
<tr>
<td>uh</td>
<td>ehm</td>
<td>staller</td>
</tr>
<tr>
<td>oh</td>
<td>oh</td>
<td>surprise</td>
</tr>
</tbody>
</table>

### Abbreviations**

<table>
<thead>
<tr>
<th>Meaning</th>
<th>Abbreviations*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eleonora Iacono</td>
<td>EI</td>
</tr>
<tr>
<td>interpreter</td>
<td>I</td>
</tr>
<tr>
<td>Italian nurse</td>
<td>INF</td>
</tr>
<tr>
<td>(from the Italian infermiere, nurse)</td>
<td></td>
</tr>
<tr>
<td>US nurse</td>
<td>N</td>
</tr>
<tr>
<td>Simona Orefice (second researcher)</td>
<td>SO</td>
</tr>
</tbody>
</table>

* All names of staff members and patients as well as any other patient-related information (e.g. procedure dates, room numbers, etc.) have been replaced by fictitious names with the same number of syllables. In particular, for more straightforward reference, all names and surnames of doctors begin with the letter D; names of Italian nurses with the letter I; names of US nurses with the latter N; names and surnames of patients with the letter P.

** If, within the same transcript, there is more than one speaker in the same professional capacity (e.g. two or more Italian nurses), abbreviations are followed by consecutive numbers (e.g. INF, INF1, INF2, etc.).
Appendix Six: Transcripts

Nursing assessments

NA.FL

<table>
<thead>
<tr>
<th>Typology</th>
<th>Nursing assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor), old facility</td>
</tr>
<tr>
<td>Date</td>
<td>September 18, 2003</td>
</tr>
<tr>
<td>Time</td>
<td>9:00 a.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:13:20</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Barbara I</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Nurse, Italian (female, aged 26-30) INF</td>
</tr>
<tr>
<td></td>
<td>Nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td></td>
<td>Patient, Italian (male, aged 51-55) P</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher R</td>
</tr>
<tr>
<td>Situation</td>
<td>The patient, just admitted for a day-hospital procedure, is sitting in a chair by the window in his room.</td>
</tr>
<tr>
<td></td>
<td>The US nurse assigned to him enters the room with the interpreter and the researcher to perform the nursing assessment.</td>
</tr>
<tr>
<td></td>
<td>During the assessment, an Italian nurse briefly enters the room to discuss patient-related information with the US colleague.</td>
</tr>
<tr>
<td>Language direction</td>
<td>English &gt; Italian / Italian &gt; English</td>
</tr>
<tr>
<td>Prevailing mode</td>
<td>Short consecutive</td>
</tr>
</tbody>
</table>

I ((to the patient)) buongiorno
R ((to the patient)) "buongiorno"
((the patient smiles))
I io sono [ l'interprete ] okay are we recording↑ ((the researcher nods)) >okay< u::h () would you: ask him plc:ase (.) u:h (.) what brought him to the hospital (.) >why did he come<
I perché è venuto in ospedale °qual è il motivo per cui = °
P "devono fare° () "una puntura nel polmone°
10 I he:: (. ) is to undergo: (. ) "a puncture in his lung°
N say it one more time=
I =he is to undergo a *puncture* [ in – in his lung ] mediastinotomy (. )
N and for what reason
15 I per quale motivo↑
P temono che io abbia un tumore
I they think I’ve got a tumour
N a tumour okay "in the mediastinum° [ he’s u::h
I ] nel mediastino↑=
20 P =eh↑
I nel mediastino↑ ((the patient looks puzzled))
N sì sì sì "mhm° (. ) uh:: (. ) he – is he (. ) is he having any discomfort
Appendix Six

I ha disage: disturbi:

25 ((the patient shakes his head)) ((background voices))
N "okay" (.) any difficulties breathing
I ha difficoltà a respirare
P no no le dica che sono un trapiantato io di fegato
I he's a liver transplant "to say the truth"

30 N oh he is† how many years ago
I da quanti anni
P cinque anni
I five=
N =cinqu[ö]↑

35 P Marsiglia
I in Marsiglia "in France"
N ((enthusiastically)) oh in France↑ in Marseille okay (.) why did he go to France↑
I perché è andato in Francia

40 P perché allora qua::: s – non c’era l’ismett
I because at those times ismett=
N =ismett=
I =did not exist=
N =did not exist right right >I was gonna say when we are so good why
did he go to France< ((laugh)) okay may I look at his chest↑
I può:: dare un’occhiata al:: suo [petto↑
N =grazie
((pause)) ((the patient unbuttons the top of his pyjamas; the incision is visible
on his abdomen))

50 N ((enthusiastically)) beautiful incision
I una bellissima incisio::ne °dice°
N I would like to listen if I may
I può:: auscultarla↑

55 P *sì*
N okay >if you would ask him< to take a deep breath
I faccia un respiro profondo
((pause)) ((the nurse listens to the patient’s chest)) ((background voices))
N oka:::y (.) I would like to listen buck here if I may (.) ((making the
patient bend slightly forward)) another deep breath
I profondo↑
((pause)) ((the nurse listens to the patient’s back)) ((background voices))
N "okay" is he a cigarette smoker↑
I lei fuma↑

60 P poco
I >a bit<=
N =un poco↑ (.) how many cigarettes [a day
I [quante ] sigarette al giorno
P un::mm dieci

70 I ten↑
N >ten okay< (.) may I listen to his belly↑
I può ascoltarle la pa::ncia↑
P ((amused)) sì sì ((soft chuckle))
((pause)) ((the nurse listens to the patient’s abdomen))

75 P non sono incinto (.) sicuro
Appendix Six

((smiling)) he’s not pregnant (.) that’s for sure

((wholehearted laugh))

((smiling)) does he have regular bowel movements?

va di corpo regolarmente?

=si sì

and does he have any difficulty (.) urinating

ha difficoltà a urinare?

no no

°okay° (.) °oka:y° does he take any medicine?

prendi farmaci?

>si< il prograf (.) antirigetto

ah sì sì sì=

=e una pillula=

°prograf°

=e:

°tacrolimus°

mhm e una pillula=

°prograf°

=e:

=una pillula=

*mhm*

=e:

=una pillula=

a:nd three quarters of a pill for (.) for pressure °for arterial

=blood pressure°

=>°splendidi°< (.) °le pulsazioni°

and his belly has lots of good gurgles

e nella pancia ci sono dei bei gorgoglii

che sì – ci sono?

°be! gorgoglii°

=ha detto°

ah sì sì (.) abbastanza=

and I would like to –

=la notte

°((laugh))

adesso le misura la: saturazione d’ossigeno e il polso

°((pause)) °((the nurse measures oxygen saturation; piercing, intermittent sound of the machine))

°(ninety)° it’s (very) slow?

°((long pause)) °((the nurse measures the pulse rate)) °((background voices))

°>okay< fifty six that’s not bad° and if I ma:::y I would like to check

his blood pressure?
I cinquantasei >non è male< adesso:: vorrebbe misurare la pressione

((pause)) ((the nurse starts to prepare the blood pressure equipment))

P l’avrà alta

I it’s certainly high

P perché non ho preso la pillola

I because he didn’t take the pill

135 N oh >it’s gonna be up a little bit he thinks<

I yeah

N let me just write this down before I forget ((leaving the room)) ((voice fading out)) because you know I have no brain†

((pause)) ((interpreter and researcher remain in the room with the patient))

P ((to the interpreter)) il cuscino ancora non lo porta↑

I ah il cuscino↑>aspetta il cuscino↑<°giustamente° (. .) ora glielo dico

((short pause)) ((the nurse returns to the room, but she stops on the threshold reading the patient’s medical record))

P me l’ha detto la signorina (un minuto libero)=

P si si vede che ha–

I °he’s still° waiting for his pillow^ ha avuto ] da fare

N ((getting closer to the patient)) oh (. .) we don’t have any I have to find

150 N =to get you one because we have *none* ((laugh))

I m:hm mhm really↑↑((to the patient)) non ne hanno deve trovare un

ausilia:rio che gliene:: >procuri uno<

N I’m very sorry tell him ((laugh))

I le dispiace molto

N I looked in – tell him I went all the way >to the end of the unit< I

looked in *every* room

160 I ho cercato in tutte le sta:nze] unless I was to *steal* one there is no way I

could get one ((laugh)) >steal one from another patient<

I pote – poteva soltanto [rubarne uno a un altro pazie:nte (laugh)] and I know

165 he wouldn’t want me to do that

P no:

I °non sarebbe stato (carino) farlo°

N ((laugh))

((pause))

170 N >you know what↑<

((pause)) ((the nurse prepares the blood pressure equipment))

N has he had cardiac catheterization >or what<

I ha avuto la catete – ha fatto la cateterizzazione cardi:aca↑

((sound of the blood pressure cuff being inflated))

175 P “no°

((sound of the blood pressure cuff being inflated))

((long pause)) ((the nurse measures the patient’s blood pressure)) ((background voices))

N ((removing the blood pressure cuff)) okay his pressure is one sixty over eighty >which is not bad considering he didn’t take his medicine<
l pressione è centosessanta su ottanta (.) non è male

"okay now if I just° (. ) °may check his° (. ) temperature >did I check

your temperature just now↑<

I le ha misurato la temperatura↑=

N =no=
P =no=

N =no I didn’t °no°

((pause)) ((the nurse puts the blood pressure equipment away))

N °okay now if I just° (.) °may check his° (.) temperature ↑

I the nurse takes the thermometer)

°°sotto la lingua< °lo metta°=

N =yeah

((the nurse opens his mouth and the nurse sticks the thermometer tip into it))

N °sotto la lingua< °lo metta°=

I °sotto° (.) °sì° (.) °under°

((to the interpreter))

N =is low yeah

I °under°

N °sotto° (.) °is low° (.) °under°

((the nurse removes the thermometer))

I °sotto°

N °m::hm°=

I =the:: test

P >ma più di un (mia)< (. ) più di un mese

I one month ago (. ) >he had C T scan a scintiscan

N °m::hm°=

I °di cui può avere bisogno°

INF =((to the Italian nurse))

I ((to the US nurse))

INF E K G:: done↑

"di cui può avere bisogno°

I ((to the Italian nurse))

INF =((to the US nurse))

INF c::hm (. ) before O R
Appendix Six

214

N ((to the Italian nurse)) is he going today↑ oggi↑ ((the Italian nurse
nods)) ((high-pitched sound and background voices)) (. ((puzzled
voice)) °oh oggi°

((the Italian nurse is about to leave the room))
N ((to the interpreter)) ↵ask {Ilaria}↑ if he’s going to surgery today
((pause)) ((the Italian nurse comes back))

235 I ((to the Italian nurse)) vai da –

INF ((to the interpreter)) no: >gli ho detto che deve fare
l’elettrocardiogramma< o:ra (. °lo sto dicendo ora° (. °okay↑°
((the Italian nurse leaves the room))
N ((to the interpreter)) >°what did she say°<=
I =he – she told him that he’s supposed to do an E K G now
N ((to the interpreter)) °o:h° (. yeah but she told *me* before O R and I
wanted you to ask her if he was going to surgery today she – she didn’t
say↑ I °u::mm no no she didn’t°

240 N go ask if he’s going to surgery today
I °later°
N >°okay° uh I would like him then to u::h ((looking at the tape recorder))
>are we finished recording no we’re recording< I would like him then
to come and lie on the bed so I can do the E K G

245 I adesso se si può distendere a letto↑ cosi (. fa l’elettrocardiogramma
N ((sorrowful)) and I’m so sorry we don’t have a pillow
I e si scusa – >le dispiace molto< per il °cuscino°
N ((laugh)) ((laugh)) a::::h (. and he needs to take off hi:s uh (. actually if I could give him a
250 camic[$i:] (. °actually° if you – >if he could come over here and I could
weigh (him)<
I se viene → qua la pesa
N then I’ll get him a gown
I e poi le dà un camice

255 ((the nurse moves the scales)) ((piercing sound)) ((the interpreter leaves the room to look for the Italian nurse))
N ((moving the scales)) ah (. so: (. °too much°
((long pause)) ((sequence of piercing sounds))
((the interpreter returns to the room))

260 ((one camice [i:] (. °actually° if you – >if he could come over here and I could
weigh (him)<
I se viene → qua la pesa
N then I’ll get him a gown
I e poi le dà un camice

265 ((the nurse moves the scales)) ((piercing sound)) ((the interpreter leaves the room to look for the Italian nurse))
N ((moving the scales)) ah (. so: (. °too much°
((long pause)) ((sequence of piercing sounds))
((the interpreter returns to the room))

270 I so he needs to have an E K G now [ ( ) (instead)] (of getting directly) to
the surgery=
I = yes (. °he’s going=
N when he’s going↑

275 I =this afternoon=
N =oka::y (. °I understand°
((pause)) ((long, piercing sound)) ((the patient stands up on the scales))
N °all right° so: am I able to read this from the (back) no ((moving to the
front of the scales)) so that’s seventy:: so it’s gonna be like seventy

280 three [ point –
P settantaquattro e °cinquecento°
((the patient gets off the scales and goes back to his chair))
N seventy three point one eh↑
I settantatré e uno fa

285 N [ seventy three point one ] (. ((writing down)) °seventy three point
one kilos° okay and now we’ll get the E K G
I adesso facciamo l’elettrocardiogramma=
N =(leaving the room) I’ll get you a clean gown
I le porta un camice↑

290 ((pause)) ((interpreter and researcher remain in the room with the patient))
((background voices))
P ma non è che mi devono operare
I oggi pomeriggio↑
P ma mi devono fare solo una puntura

295 I sì ma in sala operatoria
((pause))
I magari comunque per la ( ) –
((interruption in the recording)) ((interpreter and researcher leave the room
and then come back with the US nurse))

300 P ( )
I >uh< is he supposed to take his (. ) pyjama off↑
N please
I sì
P (mi [leo]) il pigiama↑

305 N sì=
I =sì ( ) *noi ci spostiamo di là° ((interpreter and researcher are about to
move))
N and *ma::ybe* >if he could put it on< this way ((pointing at the back))
( )

310 I (going back next to the patient) mettendoselo: (.) [di spalle put it on ]
N ((showing back next to the patient)) this way↑=
I =così vede↑
N just for a moment↑ like this↑=

315 P =°okay°
I per un attimo
((long pause)) ((the patient wears the gown)) ((piercing sounds in the distance))
N °can he just lie down a little bit°
I può coricarsi↑=

320 N °andiamo a letto°
((pause)) ((the patient tries to tie the gown))
N I = I’ll tie this (pointing at the gown) after I get the EKG ((laugh))
°okay↑°
P ci pensa dopo↑=

325 I =dopo l’elettrocardiogramma lo:: rile:ga °dice° (.) lo °riallaccia°
((pause)) ((background voices and sounds))
N >okay<
Nursing reports

NR.FL.01

<table>
<thead>
<tr>
<th>Typology</th>
<th>End-of-shift nursing report (reported cases: 3 out of 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td>Date</td>
<td>January 22, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:18:34</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Dario</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Incoming nurse, Italian (female, aged 31-35) INF</td>
</tr>
<tr>
<td></td>
<td>Nurse, Italian (female, aged 26-30) INFf</td>
</tr>
<tr>
<td></td>
<td>Outgoing nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (EI)</td>
</tr>
<tr>
<td>Situation</td>
<td>The two nurses are sitting next to each other at the nurses’ station, while the interpreter, who is initially standing, sits down between them as soon as the interaction begins. During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical records and patient Kardex sheets. At some point, another Italian nurse who needs to take report from the US colleague comes and sits down near them waiting for her turn.</td>
</tr>
<tr>
<td>Language direction</td>
<td>English &gt; Italian / (Italian &gt; English)</td>
</tr>
<tr>
<td>Prevailing mode</td>
<td>Short consecutive/whispering</td>
</tr>
</tbody>
</table>

N okay (. we’ll start [with {Patreno}]
I "((ironically) wait wait)" I want to feel comfortable (. {(looking around in search of a chair)} "ah" "((grabbing a chair and sitting down))" four patients↑ ["it’s lo:::ng"]
5 N "five"
I "=((ironically)) five↑ see >I need to get≤
INF "this one" "((pointing at the list of patients))"
I "=a lo:::ng chair="
10 INF "={Ivo} one person to {Ivo}"
N who↑
INF "((pointing at the list of patients) ≈ this"°
N what=
INF "={Porta}"
15 "((pause)) "((the US nurse checks her notes))"
N "you don’t have five↑ all five↑
I "quantie hai cinque↑"
INF "yes"
N "oh okay oh I *have* five↑"
20 I "maybe she wants to start with ≈ this mister — ° "((to the Italian nurse)) °da chi vuoi comincia:re°"
Appendix Six

who\up\{Porrato\}\ ((puzzled)) who °she wanna start (with)\up°=

\textit{((pause)) ((the US nurse checks her notes))}

you wan – you don’t want to start with \{Patenno\} eh\up (.)

\begin{itemize}
\item you want to start with \{Patenno\} \up
\end{itemize}

\begin{itemize}
\item °mister° \{Porrato\} °
\end{itemize}

\begin{itemize}
\item \{Pattenno\} eh
\end{itemize}

°=
The US nurse checks her notes

\begin{itemize}
\item >then you have the other four<
\end{itemize}

\begin{itemize}
\item forse a \{Irene\}=
\end{itemize}

\begin{itemize}
\item °her patient°
\end{itemize}

\begin{itemize}
\item °not yours\up oh okay all right (.)
\end{itemize}

\begin{itemize}
\item °all my people then
\end{itemize}

\begin{itemize}
\item °maybe \{Irene\}°
\end{itemize}

\begin{itemize}
\item °she needs to get
\end{itemize}

\begin{itemize}
\item °from °
\end{itemize}

\begin{itemize}
\item °on him°=
\end{itemize}

\begin{itemize}
\item °regular diet\ ((pointing at the Kardex)) he is allergic
\end{itemize}
to an antibiotic but they don’t know – they don’t know what kind

*quale* *antibiotico*

okay

*he is* (.) neurologically intact

he gets up in the chair without assist

sta:: si mette da solo sulla se::dia (.) *senza bisogno di aiu::to*

*è indipendente*

*mhm*

((pause))

room air sats *ninety-four percent*

*non lo posso fare* ((chuckle))

è::: non ha::: (.) ehm dunque respira >autono( )mente)< la

saturazione è *novantacinque*

che cosa hai de:ttot

saturazione *novantacinque*

è in room air

respira *( )mente* sì in room air*

=okay

lungs clear

suono chiaro polmonare

slight edema in lower extremities=

=un po’ nelle gambe ha degli edemi

*mhm*

((pause))

no no edema

*non ne ha no no no=

*scratches no edema no edema*

=si gra – si gratta ma non ha edemi

okay abdominal incision with staples (.) ((announcement over the

intercom)) dry ‘n’ intact *open to air*

incisione *addominale con punti: metallici*

intatta asciutta c:: aperta (.) *senza garze*

va b:ene

has two J Ps left

*ha due J P=

*or right side*↑

on the right side

*left* or right side↑

on the right side

tutte e due *che ha detto*↑

*both* on the right side↑

both on the right side=

*tutte e due sul:: lato destro=

=A e B↑

A and B↑

*°C*

sì=

°C e D°=
Appendix Six

219

I =A e B
N the one on the left’s gone [>they took it out<
I quello che c’era a sinistra] l’hanno tolto
INF >quindi<=

130 N =and that’s actually trace
INF a sinistra [>ne aveva uno<
I e: drena qualcosa] delle tracce
N two [>two more< he had one on the left]
I  

135 N he had
I ne aveva °un – °=
N =he had *three*
I ne aveva tre [>in tutto<] (. but one
N earlier )

140 I [>però quello< a sinistra è stato tolto
INF °oh okay° [>u:no a sini::stra< e due a destra è stato tolto
INF oggi]
I did they remove it today?

145 N yes [>si<
I si
INF okay drenano molto questi
I do they drain a lot
N no (. trace

150 I no un po’ – un pochino °alcune *tracce*°
N [>we’re talking of< *big* (. ((opening her arms)) big J Ps
INF okay=
N =>and not the little ones<
INF okay

155 I [>sono:: i J P< [>grossi= *grande*
N 
I non [>sono quelli piccoli° si si °okay°=
N =okay]

160 INF °okay°
((background voice of another nurse))
N ha – has not had an X-ray yet they said to me this
I gli avevano detto stamattina che: ] doveva fare una radiografia
165 ma non l’ha fatta ancora
N [>but it’s not in ( )°
INF [>((writing down her notes)) una radiografia dove
I ((whispering)) °where° (. °what kind of X-ray↑°
N thoracic X-ray

170 I ((whispering)) °tora:cica°
INF okay
N he voids spontaneously
I urina spontanee::nte
INF okay

175 N u::h (. ) he had a fleets enema yesterday morning
I ie::ri [matti:na gli è stato fatto un=
N for a sma::ll amount of output
I =cliste::re ma: ha prodotto poco
Appendix Six

N so he

180 INF "mhm"
N = was concerned today
I quindi oggi c'era un po' di preoccupazione
N so we got the doctor to order
I him

185 I e allora –
N another fleets enema and I've just done giving it to him
I abbiamo chiesto al medico di ordinare un altro di fare un'altra: un altro clistero
INF ((writing down her notes)) l'ha fatto
I > did you do it <
N yes
I sì
INF "okay"
N I've just done doing it
190 INF con esito positivo
I sì ora ora adesso adesso ((to the US nurse)) what about the output
N INF è giovane questo:
I don't know if he is going yet he would
INF (writing down her notes)
N he
I *non so*

195 N I've just done doing it
I con esito positivo
I sì ora ora adesso adesso ((to the US nurse)) what about the output
N INF è giovane questo:
N =I don't know if he is going yet he would
INF (writing down her notes)
N he
I *non so*

200 I l'ha fatto
N "he did not" go as of yet "from the fleets"
I ancora non ha avuto effetto il clistero
INF ((the Italian nurse makes a gesture of disappointment))
N I just got them doing it
I l'ho fatto in questo istante
INF o: kay
N his potassium was low this morning
I stamattina il potassio era basso
INF "mhm"
N and this afternoon I gave him the
I gliel'ho dato endovena
N "from the doctor" which is an order
INF on that on that ((pointing at the medical record)) "okay"
N quindi ce l'ha in corso
I ed è già ordinato troverai: "negli ordini"
INF ((taking the patient's medical record)) dico allora: l'ha in corso
I so is the potassium still running
INF ((the Italian nurse starts shuffling the medical record))
N ((shuffling of pages)) no is done
I no finito
INF "done"
N ((pause)) ((the Italian nurse starts reading the orders from the medical record; the US nurse reaches her hand out to take the medical record))
INF "un attimo" aspetta
INF "questi li ha fatti" ((pointing at the written orders))
I "what about the other orders"
((the US nurse takes the medical record and starts reading the orders))

N the potassium D C the ( ) yeah=
INF =okay

235 N okay ismett tomorrow
INF mhm
N enoxaparin I *gave* at noon
I ((whispering)) °gliel’ha data [ a mezzogiorno° ] I started at noon so I

240 N wi – I still have to chart >all this<=
I =lo devo ancora:: caricare [ ma l’ho fatto ] this is an enema (.) and D
N C (.) I don’t know what this J P – well *C* [ which they did= okay
INF

245 N =>they did that<
INF okay [ °okay° ] ( °( )° okay↑
INF okay
N any questions

250 I domande↑
INF °no°

((the US nurse signs off the medical record and closes it))

255 N next
INF [ firmo pure io ((pointing at the medical record))

255 I she has to sign
INF
N ((giving the medical record to the Italian nurse)) oh

260 INF okay no seconda
N °okay° no::w –
I °ho usato° la terza persona
N {Persito}
INF ((chuckle))

265 N {Pamela}

((INF1 approaches them))

INF: ((to the Italian nurse)) ehi (. ) devo prendere l’ultima consegna
N coronary artery disease
INF [ ((to INF1)) ( ) (devi) aspettare un pochettino ] ((chuckle)) ((to the

US nurse)) {Persito}

((INF1 sits down near them))

270 N has a cabg times three
I wait wait (.) {Persito} is that right ((the US nurse nods)) yes
((background voice of INF1))

275 INF ehm
I cabg per tre
N cabg times three and mitral valve repair
I riparazione valvola mitra:lica
N and left ventricle reconstruction

280 I ricostruzione ventricolo sini:stro
INF ((writing down her notes)) °aspetta° (. ) ricostruzione::ne ventricolo
sinistro↑
((the interpreter nods)) ((another Italian nurse who is sitting at a workstation nearby asks the Italian colleague for information about a computer program; inaudible question))

285 N she’s on a regular diet
INF ((to the Italian colleague)) >io non< ci so andare in questo programma
N no known allergies
290 I dieta regolare non ha allergie
INF ventricolo siero:stro (. ) regolare
N psychologically she gets depressed
I è un po’
N =when her family is not around
300 I depresse
INF mhm
I ogni tanto piange
INF è diabetica
I =has she diabetes=
305 what they are doing=
I =per adesso stiamo facendo
N =alle sei< e alle dodici alle sei e alle dodici
N =six A M it was one fourteen
I si
INF quindi ha l’accu:check ogni sei ore
I (whispering) =so:: she has to check the: blood sugar every six hours=
N oh (. ) yeah they are doing it at six and twelve and six and twelve that’s
310 I =when her family is not around
I Alle sei< e alle dodici alle sei e alle dodici
N =six A M it was one fourteen
I =alle sei di:: stamattina era:::
INF quindi ogni dodici ore
I =centoquattordici
N =alle sei< e alle dodici alle sei e alle dodici
I =alle sei < e alle dodici alle sei e alle dodici
I =it was two eleven
N =no alle sei e alle dodici (. )
INF =alle sei e alle – ma qua
((pointing at the Kardex)) c’è scritto ogni sei ore
((the interpreter looks at the Kardex with a puzzled expression))
I ogni sei ore e alle sei e alle dodici ogni sei ore è
320 INF ((sarcastically)) alle sei alle dodici alle dicio:otto (chuckle)
I mhm
INF =e a mezzanotte
INF =mhm
INF =*così* è ogni sei ore=
N every six hours I know
INF =alle sei e alle dodici sembra *alle sei=
N =it’s stupid=
330 INF =*e*: alle dodici *punto* lo fanno
I no:: lo fa
N o:: alle sei e alle dodici alle sei e alle dodici
I =so:: every six hours< right=
N =you’re right and it’s stupid because she’s eating and it should be
I >seven eleven four nine< però perché sta:: mangiando=
INF
I =e dovrebbe – ((slightly annoyed)) ah però parlate uno alla volta okay↑
335
340
345
350
355
360
365
370
375
380
385
N ((long laugh)) °a:h° (.) two eleven at lunch time I a:: ora di pranzo era °duecento° undici°= N I covered her with eight units okay
INF
N =l’ho coperta con otto unità but she is not on any=
I =l’ho coperta con otto unità
INF
N okay↑
INF
N ((slightly annoyed)) e quale fa↑ I so what insuline is she on
N I =e dovrebbe – ((slightly annoyed)) >ah però parlate uno alla volta okay↑
335
340
345
350
355
360
365
370
375
380
385
N ((slightly annoyed)) e quale fa↑ I so what insuline is she on
N I =e dovrebbe – ((slightly annoyed)) >ah però parlate uno alla volta okay↑
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N ((slightly annoyed)) e quale fa↑ I so what insuline is she on
N I =e dovrebbe – ((slightly annoyed)) >ah però parlate uno alla volta okay↑
335
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345
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365
370
375
380
385
N ((slightly annoyed)) e quale fa↑ I so what insuline is she on
N I =e dovrebbe – ((slightly annoyed)) >ah però parlate uno alla volta okay↑
335
340
345
350
355
360
365
370
375
380
385
N = open to air (.) and bilateral lower extremities=
I = non coperta
390
N = right here (pointing at her legs) I did the dressings
I = nelle gambe
INF in entrambe*
I = ho cambiato le medicazioni
N and I did the dressings (.) a little bit ago<
395
INF poco fa
I = le ha me – because she oozes sometimes so=
N > they are covered< yes those are covered
400
INF okay
N = ha un accesso all’avambraccio destro
I ((whispering)) ha un accesso all’avambraccio destro
INF okay
N she has a Foley putting out an – uh (.) yellow urine
405
INF ehm ((reading the orders from the medical record)) qui c’è scritto D.C. Foley
N > she put out < five hundred –
I ^there is an order^ to
N = discontinue the Foley=
410
INF okay
N °oka:y u:h (.) she’s a right forearm twenty gauge
I ((whispering)) ha un accesso all’avambraccio destro
INF okay
N she has a Foley putting out an – uh (.) yellow urine
405
INF = dal Foley produce urina (.) gialla
N = okay
I ((whispering)) ha ancora i:° (.) °ca:vi° (.) =° qui su° =
INF = okay
N she still has the wires > up here < (pointing at the chest)
415
INF = ((whispering)) ha ancora i:° (.) °ca:vi° (.) =° qui su° =
I = the two by twos
N = w[air] ((the interpreter nods)) va bene (.) ((writing down her notes))
420
INF = okay
N = ((the interpreter nods)) va bene (.) ((writing down her notes))
420
INF = okay
N = diluted but I think I only give it to her I don’t think you do (.)
I > nah nah < (.) ((pointing at a medication written on the Kardex)) this:=
425
I = poio io credo che tu non glielo debba dare ma io gliel’ho dato (.)
INF = quess:to ((pointing at the medication written on the Kardex))
N °is this (her)?° ((looking at the Kardex))
INF = cos:sa
N ((looking at the Kardex)) did they get rid of it (.)°
I = yes o:::
430
I = ((whispering)) è stato cancellato
N good they got rid of the hydralazine did they say D.C. hydralazine
I = c’è un ordine di discontinuo di: °interrompere l’idralazina°
N = does it say disc – > D.C it?<
((the two nurses take the medical record))
435
I = ((whispering)) è stato cancellato
N good they got rid of the hydralazine did they say D.C. hydralazine
I = c’è un ordine di discontinuo di: °interrompere l’idralazina°
N = does it say disc – > D.C it?<
((the two nurses take the medical record))
440
INF let’s read it °together°
INF = ((ironically)) quindi (.) lo devo togliere io
I so should I remove the Foley
N yeah yes yes INF questo ((chuckle)) c ((reading)) change
N (   )
INF dressings
445 N °change dress – ° I did that I did that= questo l’ho fatto io
I =I did that INF okay (.) ((reading)) [v]arfarin
N today ° I didn’t do that right= INF °questo okay°
I °non° l’ho fatto INF °mhm° ((reading)) ismett due tomorrow morning=
N =tomorrow
INF ((reading)) ((annoyed)) [c] K.G↑
450 N I didn’t do that because – = INF °questo okay°
I °non* l’ho fatto
N =I didn’t do that yet I °non ancora°
INF ((annoyed)) dodici e venti ((pointing at the time written on the medical
record))
455 N for you know what† they’ve just made their rounds
I no hanno fatto il giro visite:: poco fa
N °he did *not* make his round at this time
460 INF °non l’ha fatto: in quest’orario scritto °qui°
I °mhm°
N ((looking at the medical record)) see† I don’t see D C ((pause)) ((the US nurse continues shuffling the medical record))
465 INF °hydralazine°
I °(   )°
470 I ((whispering)) °vedi non c’è idralazina°
INF ((reading from the medical record)) D.C.i dro:::°° I did °yes° there is
°(   )°
475 N what is that
INF ((reading)) i dro::: i lazin°
N is that hydralazine↑
((the interpreter nods))
480 N °oh okay okay good good because it comes in a phial=
INF °cos’è cosa mi vuole dire non l’ho capito
I =and you have to mix it ° with water
N °con dell’acqua=
I =e:: poi lei se lo deve bere
485 INF ha °carvedilolo
N °yeah
INF °sei punto venticinque ((reading from the medical record)) °°(   )° sei
punkt venticinque P O ° B I D ° okay ehm check body weight↑ ((no
longer reading)) no:: quindi (. ) ((amazed)) la devo pesare↑
490 I should I also do this↑
N okay unless you want me to s – I mean
I °oh vabbè posso rimanere ° un po’ di più e lo faccio io=
Appendix Six

INF =no:: °dille di non preoccuparsi°

495 I no never mind
N yeah because (.) they [they rounded they sh – he sh – =
INF he (just got them rounding) (.) [ºdove arrivo metto ( )º
I [l’hanno scritto ] poco fa:: °hanno fatto
500 il giro visite poco faº=
INF =okay [va bene
N °okay
((pause))
N °she’s up walking° (. ) the halls
505 I lei si alza cammina:: [nel corridoio
N °con:: i pare:nti°
INF okay
((short pause))
510 N a::ll right now her next
I adesso °chi facciamo°
N °let’s see° {Paride}↑
INF °(un momento)º (.) [ {Pastura}]
N °{Paride}↑ {Pastura}↑ okay on {three} (.)
515 {thirteenth}
I ((whispering)) °operato il {tredici}º
N cabg times two
I ((whispering)) °cabg per dueº
INF mhm okay
520 I ((whispering)) °per °du:: e*°
N no known allergies
I °non ha allergie^°
((background noise))
INF okay
525 N regular diet (. ) psychosocial okay
I ((whispering)) °psicosociale okayº
N generalized weakness throughout=
I °debolezza un po’ generalizza:ta ovunque°
N doctor wanted him to get up – out of bed to [i medici ↑ vo::levano
530 I che si:: [°^*alzasse*^° per mangiare il pranzo
N ]>_a little bit ago< and he said no
([making a gesture of annoyance with her hand]) I am not sitting
I ma non l’ha:: non ha voluto farlo
535 INF °va beneº
N uh (. ) (squeaking noise)) I did his vitals
I ho preso i parametri
INF mhm
N and (. ) earlier and they were good at eighty=
540 I =erano [buo::ni::º
N pulse (. ) one twenty-seven [over seventy-three e
I centoventisette su:: (. ) settantatré
N thirty-six eight ninety-nine percent sats on three liters
545 I trentasei e otto con saturazione ]
novantanove per cento con tre litri
INF a che ora li ha presi questi parametri
I what time did you take these vitals↑

N and I did it between ten and eleven

550 I tra le dieci e le undici
INF "mhm va bene°
N he is on strict I and O
I controllo di: bilancio idrico
N he did have three hundred in and three hundred out

555 I ha preso ha assunto trecento e ha: emesso trecento
INF ha il Foley↑
I ((whispering)) "does he have a Foley°
N Foley sì!

((the Italian nurse looks at the medical record))

560 INF "mhm° "(sarcastically) c’è scritto D.C. Foley
I also *this* patient should have been discontinued
N oh like I said *I’ll do it*
I se vuoi – se vuoi rimango lo faccio io
N I’ll stay just let me do my charts↑ then I’ll go

565 INF perché sono gli ordini della mattina questi
I because like I said= these are
N =I can’t read these if –
I the orders were written early in the morning
N they are *not* written early in the morning
I ((whispering)) "no non sono stati scritti stamattina presto le::: hanno fatto poco fa il giro visite°

570 INF "oh°
N ((annoyed)) that’s crazy (.) >I was looking at *this* early in the morning< (.) like
I ((whispering)) "no non sono stati scritti stamattina presto le::: hanno fatto poco fa il giro visite°

575 INF "oh°
N ((annoyed)) that’s crazy (.) >I was looking at *this* early in the morning< (.) like
I ((whispering)) "no non sono stati scritti stamattina presto le::: hanno fatto poco fa il giro visite°

580 INF "non c’erano questi ordini
N >put them aside< I will do them=
I =comunque se vuoi=
N >before I go<
I =prima che se ne:: (.) prima di andarmene=
N don’t even look at these orders

585 INF "non ti preoccupare°
N =se vuoi li faccio io come vuole lei=
INF a questo punto
I as you wish if you want to stay
INF =deve decidere lei
N yeah I’ll do that don’t even look=
INF =come dice lei
I =vabbé lo faccio io
INF va bene

590 INF okay (. ) he’s on normal saline at thirty C Cs an hour
N all’ora
INF "mhm°
he’s edema (.). bilateral (.). lower extremities (.). bilateral (.). alle gambe

INF okay

he has decreased in the bases in his lungs with some ronchi con dei suoni diminuiti alle basi con dei ronchi

INF °mhm°

his V B G I did it (.). one o’clock

INF ¨ho preso il V B G ho fatto il V B G all’una°

INF perché è Q shift↑

three point three

ehm tre=

=°right°=

=virgola tre

three point three↑ (.). I *told* the doctor when he was walking l’ho detto al medico che stava passando poco fa e il medico mi ha detto<= and he says cover him with twenty milligrams = con venti milligramm – =

INF P O

venti millequivalenti di potassio

INF =venti millequivalenti di potassio

INF °mhm°

°mhm°

an *abdominal binder* (.). over it

INF ha una fascia:: una panciera

and the doctor says=

=una fascia addominale°

=°what is this* and then he put it back over on and he walked by (making a gesture of annoyance with her hand)

il medico lui stesso se n’è meravigliato (e poi gliel’ha rimessa) la:: l’incisione sternale è aperta↑

((whispering)) °is the incision open to air°

open to air except for a little piece like this (indicating the size with her hand)

tranne che per un= ^but^

=pezzettino piccolo così=

=again (.). this abdominal binder=

=va bene°

is crossing ((crossing her arms))=
INF = ha ancora i wires
I ((whispering)) wires still on
N but there is a little four by four it could be a wire=
655 (ma) quindi forse ce n’è uno ma due sicuramente no
INF mhm (. ) va bene
N right leg incision ((pointing at her right leg))
I ((whispering)) incisione gamba destra
INF mhm okay
N no drainage
I ((whispering)) (non) drena niente
INF questi ordini: quindi: ((looking at the medical record))
N >here< let me see
665 ((to the interpreter)) >what is it< ((pointing at an item on the medical record))
I cos’è questo
INF ( )
N what is this ((pointing at an item on the medical record))
I ((whispering)) ( )
D C coumadin (. ) chest X-ray tomorrow mobilize yeah he is not
670 gonna mobilize D C Foley
I non si muove
N ( )
I ((whispering)) ( )
D C Foley
N ( )
I what do you mean (. )
675 by that –
INF = ah ho capito
N he wouldn’t >get out of the bed<=
680 I = non si vuole alzare=
INF = mhm
N umm (. ) who else D C=
I quali erano quelli a cui togliere il Foley
690 N ( )
I ((looking at her notes))
INF =m:hm {Persito} (. ) {Pastura}=
N {{fifteen}} D C Foley
I pazienti {quindici} e {sedici}=
INF ( ) no ma non è il Foley
700 N ((worried))
I = ((aside)) (first)
INF = il problema è: tutto l’insieme ((making a circle with her hands))=
N =no I – I’m gonna finish this=
INF = non è per il Foley
N =now I’m staying and I’m doing this ques
don’t – (. ) don’t
even ( ) °( °
INF [ per me ] è lo stesso=
N =I’ve got it

710 INF ((annoyed)) però c’è l’e – l’[e] K G da fa::re °insomma°
I it’s not just discontinuing the Foley °there is also an E K G
INF °which needs to be done°
N =yes fine I’ll do it I’ll do it

715 INF °( °
I °lo può fare anche lei°
INF ((annoyed)) the doctor’d better °write* all the time he °rounds*=
N =okay okay
INF per me è lo stesso però
N =next time because this is not °the time that he rounded<
INF la prossima volt – °cioè il medico dovrebbe scrivere l’orario in cui – perché questo °non è*
I l’orario in cui le ha scritte le cose eh?°
N =but that’s=
INF =ma le credo °dille che le credo
N °between me and him °that’s
INF °between me and the doctor
I °(whispering) °she believes you°
INF dille che le credo
I glielo di:rò: (. ) °io stessa a questo medico
INF ehm volevo sapere perché ha questa °perché ha
N questa normal saline °pointing at an item on the Kardex)°
INF thirty C Cs an hour
I trenta C C
735 N =they °had° him going at thirty C Cs an hour
I °(whispering) °lo vogliono a trenta C C°
INF ah ma il motivo::
I °what is=°
INF °lo sa

740 I =the reason<
((the US nurse shakes her head))
INF °va b::ene°
N >I don’t know<
INF °okay (. ) okay (. ) °va bene°
745 N nurse didn’t tell me why it was on °thirty C Cs nah nah
I ° non mi è stato detto in consegna]
INF °perché=
I °(whispering) °doveva farlo a trenta C C°=
750 INF °okay
NR.FL.02

<table>
<thead>
<tr>
<th><strong>Typology</strong></th>
<th>Patient-transfer nursing report (reported cases: 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place</strong></td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>January 22, 2006</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>2:30 p.m.</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>00:04:05</td>
</tr>
<tr>
<td><strong>Interpreter</strong></td>
<td>Dario I</td>
</tr>
<tr>
<td><strong>Primary speakers</strong></td>
<td>Floor nurse, Italian (female, aged 31-35) INF</td>
</tr>
<tr>
<td></td>
<td>SDU nurse, US (female, aged 41-45) N</td>
</tr>
<tr>
<td><strong>Observers</strong></td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (EI)</td>
</tr>
<tr>
<td><strong>Situation</strong></td>
<td>The two nurses are standing next to each other at the nurses’ station, while the interpreter is standing between them. The report concerns a patient who is being transferred from the step-down unit to the Floor. During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They also check the medical record and patient Kardex.</td>
</tr>
<tr>
<td><strong>Language direction</strong></td>
<td>English &gt; Italian / (Italian &gt; English)</td>
</tr>
<tr>
<td><strong>Prevailing mode</strong></td>
<td>Short consecutive</td>
</tr>
</tbody>
</table>

N this patient is {Pasqualina}↑ {Porrinello}↑ (.) she’s a *bilateral* (.) lung transplant↑ (.) on the {twentieth} (.) of – (.) {December}
INF ((to the interpreter)) double
I "giusto↑°" il {venti} ↓ {dicembre} (.) ((to the US nurse)) uh *double* transplant↑
5 N mhm
I sì
INF mhm (.) ((writing down her notes)) ((background voices)) mhm
N u:h she’s A positive and she’s allergic to multiple antibiotics=
10 INF =mhm (.) ((writing down her notes)) °okay°
N neurowise she’s intact (.) she’s up (ad-lib)↑ in her room↑ to the bathroom↑ without any problem↑
INF mhm
N u:h complains of no pain↑ (.) ((background voices)) she – (.) has been
15 off the monitor (. .) down in step-down (. .) doctor said that was fine↑
INF °okay°=
N =u:h vital signs have been stable blood pressure is like in the one twenty one thirty (. .) u:h >heart rate’s like in the seventies and eighties<
INF ((to the interpreter)) °no non ho capito (qua)° la [frequenza
20 I la frequenza ]_{sui
settanta}=
INF =oh=
I =ottanta
INF =okay=
25 N =u:h (. .) she has a number twenty in her left hand
INF mhm
N and right now she has an antibiotic still infusing (. .) through it °u:h° (. .)
she’s on room air
she’s clear (.) she has a clamshell (.) incision °(   )° and that looks fine
( .) no °(opening)° no drainage
((to the interpreter)) ehm me lo puoi dire com’è lo spelling di clam
I =°C L A (   )° ok
((background voices))
C L A M
((writing down her notes)) clam °(   )° (.) okay
she ( .) is on a regular ( .) diet ( .) diabetic but she’s allowed to have ( .)
her sugars if she wants them ( .) doctor said
((the Italian nurse looks at the interpreter with a puzzled expression))
((to the interpreter)) >°(che ha detto)†°<
che può::
((background voices))
and she is up and about (   )
((moving slightly away while the report continues))
I =°Centotrentaquattro e centonovantatré° (   )°
((the US nurse moves her notes and accidentally covers the tape recorder; ( .)
inaudible exchange for 10 seconds))
((pause)) ((background voices))
((the US nurse opens the medical record))
((reading from the medical record in a low voice))
°(   )°
N =°I don’t know what it is°<=
((reading in a low voice)) °(   )°
I =°a::nd this was done this was a sputum ( .) °umm°
((the mobile starts ringing))
that’s for that
I =°her ( .) antibiotic that she has now she (   )°
((answering the mobile)) hello†
I =°a little early ‘cause she doesn’t like to be woken at ten ( .) to get an
antibiotic ( .) so the doctor said –
((the Italian nurse gestures for the US colleague to pause and wait for the interpreter)) ((the interpreter hangs up and returns to the two nurses))

N she’s on – (.) ((chuckle))
INF ((to the interpreter)) °( ) non avevo capito quello ( °
85 N she’s on an antibiotic one of – one of her antibiotics
I [°ha un antibiotico°] che prende ogni otto ore
INF mhm
N but (.) she doe – it – it was due (it) like at ten o’clock at night
90 I doveva prenderlo alle °dieci di se::ra ° complained of being awoken
N for it
I °(last night° you mean↑
N yeah (.) every night [°si tutte le sere alle dieci:: di sera] però ehm
INF °è saltata°
I so [°she didn’t=]
N =so she –
I =have it
100 N no (.) no no so: the doctor said we’ll give it to her earlier then=
I =quindi=
N =so it’s – [°it’s in there for]
I il medico >(ha detto di)< darglielo prima
N six in the morning
105 I quindi adesso è °sei° di mattina
N two in the afternoon
I °due° di pomeriggio
N and °eight° at night
I e °otto° (.) °di sera°
110 N instead
I invece che alle dieci [°di sera° °d’accordo°
INF va bene °d’accordo°
I così può dormire tranquillamente
INF °(ironically)) insomma alle due di mattina=
115 N okay so it’s sort of eight eight six
INF =non °può dormire ((soft laugh))
I actually if she has the – [°if she has to wake up at two]
N no no (.) no that would be two in the afternoon
I °due del pomeriggio°
120 INF =((ironically)) °eh°=
INF =alle due del °pomeriggio°=
N =yeah so it would be=
INF =oh=
125 N =eight and then °six° in the morning=
INF =e =
N °’cause she is=
I =quindi °due poi sei di –
INF °e alle due °le è stata fatta=
130 I =sc – (.) sc – (.) quindi sei del matti:no poi ((to the US nurse)) did you give the one at two
INF mhm
N yeah °( °
alle due è stato fatto

mhm okay
Appendix Six

<table>
<thead>
<tr>
<th>Typology</th>
<th>End-of-shift nursing report (reported cases: 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td>Date</td>
<td>January 24, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>7:00 a.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:03:21</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Georgia I</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Outgoing nurse, Italian (female, aged 31-35) INF</td>
</tr>
<tr>
<td></td>
<td>Incoming nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (SO)</td>
</tr>
<tr>
<td>Situation</td>
<td>The two nurses are sitting next to each other at the nurses’ station, while the interpreter is sitting between them. During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical record and patient Kardex.</td>
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<tr>
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</tbody>
</table>

((background voices))

INF °allora {Pizzuto}↑°
I okay the patient is {Pizzuto}↑
INF e::hm ha riposa::to tutta la no::tte↑
5 I rested all night↑

((short pause))

INF le dico soltanto le novità
I >she’s only gonna tell you< about the new stuff
INF >ha riposato tutta la notte<
10 I >right< the patient rested >(all) night< –
INF [h(o) fatto: il – come↑]
I [uomo o donna↑]
INF no è uomo
15 I >uomo okay< he rested all night
N mhm
INF ehm l’H , ‘n’. H che aveva ogni otto ore=
I =he had an H and H scheduled that every eight hours=
INF =corrispondeva:: all’incirca alle tre di notte
20 I it was >approximately [ she sh( ) it at around< *three* A M ]
INF quindi non gliel’ho fa::tto [ perché alle ci:::nque ho fatto l’ismett uno
I she didn’t do it at that time uh [ because it was scheduled= 25 I quindi quando::
INF quindi:: quando arriva l’ismett uno e::hm deve guardare l’emoglobina e
l’ematocrito=
I =okay so when ismett one results come back look at the H and H
haemoglobin and hematocrit
30 INF ((chuckle)) ehm ha urinato pochino (.) [ trecento
I [ he voided ] *very* little=
INF = concentrate
I cento↑
INF trecento=
35 I = three hundred (. ) * concentrated *
INF Jackson-Pratt e::hm cinquanta
I Jackson-Pratt drained fifty↑
INF l’N,G tube cinquecento↑
I the N G tube five hundred
INF non si è ancora canalizzato comunque è normale perché
I [ he hasn’t had any ] bowel movement ye – *yet* but it’s normal –
perché:↑
INF è presti::no
I [ he hasn’t had any ] bowel movement ye – *yet* but it’s normal –
INF è prestino [ e – ieri è andato in sala
I [ he hasn’t had any ] bowel movement ye – *yet* but it’s normal –
45 I [ app]arently the procedure was done< yesterday
INF [ ha bevuto un po’ ] di::: acqua
I he drank a >little bit of water<
INF e::hm ha sempre il normosol a ottanta [ he has normosol ] at eighty M
L per hour
INF la drip è finita
I the drip is done
INF quindi ho tolto tutto
55 I so she removed everything
INF perché: e::hm c’era: l’ordine: di toglierla:: e ::hm quando finiv(o)
I the order – there was an order to remove everything to D C everything
once the drip was over
INF quindi se dovesse avere dolore
INF ha soltanto:: l’antiemetico P R N
I >he only has °the antihaemetic drug< (. ) P R N°
INF ho messo tutto:: ha una gomma↑ chiedi se ha una gomma
I do you have – do you have something (to er –) >she can erase that
word↑<
50 I mhmm
INF [ e::hm deve chiedere al medico perché P R N per il dolore non ha
I niente=]
60 INF ha soltanto:: l’antiemetico P R N
I >he only has °the antihaemetic drug< (. ) P R N°
INF ho messo tutto:: ha una gomma↑ chiedi se ha una gomma
I do you have – do you have something (to er –) >she can erase that
word↑<
70 ((the US nurse looks for her rubber))
INF ehm in Emtek è tutto:: (. ) m::esso in D,Č
I she D Ced everything in Emtek
INF °cancelliamo qua° (. ) ((taking the rubber that the US nurse is handing
to her)) [thanks
75 ((pause)) ((the Italian nurse erases some data from the Kardex))
INF ha sempre:: le teds e l’S C D che:
I [ he’s still wearing teds and S C Ds ] maybe today they’ll
decide to remove them
INF e niente per il resto:: (. ) è andato tutto bene
I everything else was fine
((pause)) ((the Italian nurse hands the rubber back to the US nurse))
((background voices))
N ((roughly)) >(now who else)↑< (. ) ↑°(is that it)↑°<
85 INF ha – d – dubbi↑
I eh↑(.) come (.){Irma}↑
INF ha dubbi↑
I do you have any doubts or problems with this pa – patient↑
N ((roughly)) no who (.). who’s next↑
90 I no chi è il prossimo↑
INF ((looking at her notes)) u::mm (.). ^dei miei:^ nessu:no
I of mine none
N >okay<
INF grazie
95 I mhm prego
NR.FL.04

**Typology**
End-of-shift nursing report (reported cases: 3)

**Place**
ISMETT regular admission unit (Floor)

**Date**
January 24, 2006

**Time**
07:06:38

**Duration**
00:06:38

**Interpreter**
Georgia I

**Primary speakers**
Outgoing nurse, Italian (female, aged 31-35) INF
Incoming nurse, US (female, aged 51-55) N

**Observers**
Researcher
Second researcher (SO)

**Situation**
- The two nurses are sitting next to each other at the nurses’ station in front of a monitor viewing the patients’ electronic medical records, while the interpreter is sitting between them.
- During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets.

**Language direction**
Italian > English / (English > Italian)

**Prevailing mode**
Short consecutive

INF {Pollina} ieri::: (. ) me lo ha dato le i [ in consegna↑ did you give me ] the patient
I *(Pollina)* yesterday during report↑=
((the US nurse nods))

5 INF =si=
N =“yes”=
INF =quindi le dirò solo le novità
I so >she’s only giv – giving you the new stuff< (. ) °the new information°=

10 INF =allora ha dormito tutta la notte↑=
I =the patient slept all night – ((to the Italian nurse)) scusami uomo o donna↑ {Pollina} {Pasquale} hai detto↑ ((the Italian nurse nods))
°okay° ((to the US nurse)) he slept all night
INF e::hm intorno alle tre >però< s’è voluto alz:ar e perché:: ed è stato
15 un’oretta in::: sedia
I around three he wanted to get up he was in the chair for an hour (. )
*approximately* an hour
INF la colostomia:::a non ha fatto nulla
I ((to the Italian nurse)) >colostomia↑< ((the Italian nurse nods)) noth –
20 nothing from the colostomy
INF il pigtail ha drenato::: (. ) un po’ e ho svuotato il sacchetto↑
I the pigtail >drained a little bit< she emptied out the bag
INF è un ple – è un::: (. ) un pigtail pleurico
I he’s got a pleural pigtail that’s a pl – uh uh pl – u::h (. ) ((to the Italian nurse)) per un versamento *pleurico↑* ((the Italian nurse nods)) >he’s got a pleural effusion that’s why he’s got a pigtail in<
N °okay°
INF e::hm (. ) ha urinato::: dal Fo::ley
I [ the patient ] voided↑ (. ) from the Foley catheter
30 ((pause)) ((background voices))
INF °novità nessuna°
I nothing else new:: ((chuckle)) °( )°
N no↑(.) he’s still depressed I’m sure
I >sono sicura che sia ancora depresso↑< il paziente↑
35 INF sì: sì: uguale a ieri [ >non< c’è nessuna novità]
I just as yesterday nothing new::
((pause))
INF poi abbia:mo (.} {Porta} {Patrizio}↑
I is {Porta} {Patrizio} your patient↑
40 N {Porta:} {((looking at her notes))} yes
((pause)) {((background voices))}
INF >me l’ha dato pure lei< penso
I you gave him – her report on this patient >as well< right=
N ♩mhm
45 =
INF >novità<
I ♩sì ♩
INF allora andrà in sala operatoria come primo caso=
I =he’s the first O R case this morning
50 INF per:: un:: ehm:: (.) per togliere il pacemaker attua:le
e riposizionarne=
INF they’ re gonna remove –
INF =un altro
I they’ re gonna remove the current pacemaker and place another one a
new one
INF sarà un intervento a cuore aperto
I >°it’s gonna be an open heart surgery°<
INF ho fatto lo shaving total body
I >°she did the total body shaving°<
60 INF e:::: la doccia per le sue:: difficoltà motorie non l’ha fatta
I he couldn’t shower because of his: (.) difficu – >his difficulties in
moving<
N ♩( ) ♩ l’ho lavato a letto
INF ♩però: l’ho lavato a letto
65 I she did wash him °at the bedside°
INF N P [s] da mezzanott::e↑
I N P O as of midnight↑
N ♩mhm°=
INF =ha un normosol a *c:ento↑*
70 I normosol running at one hundred
INF stamattina:: ha:: tolto:: casualmen::te l’accesso periferico
I che vuol dire casualmente↑
INF >nel senso che< se l’è tirato
I oh by – uh it was an accident he removed >he accidentally< removed
75 his peripheral I V access=
INF ehm l’ho r –
= ((chuckle))
INF l’ho rimesso↑
80 I she placed a new one ((chuckle))
N ((ironically)) {I’ll bet he} >didn’t *get*< a new one ah↑ ((chuckle))
INF *right* antecubital venti
I right antecubital >number twenty<
INF però non è *ben* posizionato

85 N =mhmm=
I =it’s not well placed *though* INF l’ho lasciato perché comunque in sala ne prenderanno di altri
I [ she left it because either way they are gonna get other I V accesses ]
90 in the *O R* perhaps even a central line so it isn’t that important INF un V B G l’ho fatto stamattina alle sei:
I [ e:: va:be:ne (*looking at her notes*) ] °no scusami°
I =at six A M she did a V B G and >everything was fi – < INF °era [ lui ]° parliamo=
95 I fi:::ne no wait INF =di {Porta}↑ si=
I =are we talking about {Porta}↑ INF sì si {Porta} °scusami°=
N yes °( °)
100 INF °{Porta} {Porta}°
INF e andava be::ne °questo [ l’ho fatto ° was fine (*losing her balance and nearly falling from the chair*) ] °ouch°=
N =((to the interpreter)) °(yeah)°=
105 INF °( °)
I =e:: ho messo peso e altezza che mancavano↑
N =((as she sits back in the chair)) I – I (. ) include= INF =((to the interpreter)) °this chair is not good°=
I =weight and height be – cause they were missing that information N °( °)
110 INF °°( °)
I >continua ad avere< la nasocannula a due litri INF e::hm stop ha il ca::mice ed è pronto per scendere
I he’s – wearing his gown >and< he’s ready to go down INF °okay° <(. ) pre-op (. ) list (. ) done (. ) pre-op
115 I la lista preoperatoria delle – [ delle::= INF =degli ordini [ preoperatori ((to the US nurse)) (it’s) done ]
I =di lui non c’è::: [ antibiotic ]
INF °on call°
120 N °okay°
I =he doesn’t have ( (. ))°
I he doesn’t ha::ve [ an on call antibiotic they did not
prescribe [ an – an on call – = INF °right (teeth)°
N °ha:: [ protesi dentarie ( (. ))°]
I no ( (. )°)
125 INF =ma già gliel’ho detto di togliere tutto INF >deve< mettere solo=
I no >I already told him to remove everything< INF °okay°
N °okay okay°
INF =il cappellino:: [ e i calzari se vuole
I needs to wear his – ( . ) he – the: covers↑ for his feet and the ( (. )°
INF mhm↑
130 N °(yawning)°
INF e poi ci sono due sacche di sangue in sala operatoria=
I =there are >two units< of blood in the O R
INF ^circa i consen::si^ ha firmato solo quello all’intervento chirurgico↑
I > as far as consents are concerned< he only s:igned the one for the O R procedure
140 N °okay°
INF gli altri due sono da firma::re però li ho messi nel frontespizio della cartella
I there are another two consents↑ (. ) to be s:igned↑ (. ) he still has to sign th – ((to the Italian nurse)) dove li hai messi scusa↑
145 INF nel frontespizio della cartella
I she put them in the front part – front cover of the:: of his medical record
N okay
((pause)) ((the two nurses look at the informed contents))
I ((ironically)) > there’s two to go<
150 ((pause))
N °okay°
((pause)) ((the US nurse goes on writing her notes))
N °okay° (. ) next↑ (. ) (. )↑
INF {Pozzo} {Pierina}↑
155 I °{Pozzo} °( . ) °{Pierina}°
((the Italian nurse opens the medical record)) ((shuffling of pages))
INF la signora va in sala °domani°*[ °non oggi“] she’s going to the O R tomorrow not today=
160 N =I didn’t think she e quindi rima:ne [ °non pensavo °] che
I
INF °{avrei}° per cui rimane in [ °dieta regola:" ] on a regular diet
I
INF °{infatti}° per cui rimane in [ °dieta regola:" ] on a regular diet
I
INF non ho fatto lo °{shaving}* si farà sta:: [ °s:era o doma::ni ] she didn’t do ° the shaving
I
°{okay}° (. )° ha dormito tutta la nott:e↑
170 I slept all night
INF la pressio::ne ieri se:ra era centotrenta I the blood pressure was one thirty:: la:st night=
INF °{she}° ha dato i – ieri (. ) lei↑ [ °perché non mi ricordo °] did you give her this patient
I
175 yesterday↑ she can’t remember
N [ °(nodding)° yeah yeah yeah yeah ] conosce per questo °( °)=
INF ah okay quindi la::
I
N °yeah°
180 INF invece stamattina era centocinquantasei su sett anta=
I ⇒ the pressure this morning was one fifty-six over seventy<
N °that’s good°
I va b:ce:ne↑ ((smiling))
INF °si si si °
185 N °(chuckle)°
I yeah↑
INF ho fatto il prelievo↑
I (she) drew the blood↑
INF deve fare lei un °{K.G}↑
I she – she’s due – you have to g – give her an EKG:

N >okay she’s having a card – < she’s not having a cardiac cath – >okay<

N no tomorrow

INF ha fatto un cardiac cath=

INF =*ie::ri*

I oh o::kay↑ I’m sorry (then) l::=

I =l’errore è mio pensavo lo av – l’ave – lo dovesse ancora fare

INF °okay↑° e poi deve fare l’[ultrasound::d dei vasi del collo

I she’s also here for an ultrasound of her neck vessels

INF non ha lamentato dolo::re↑ ha dormito

I she has not complained ↓ about pain↑ she slept↑ everything was fine

INF quest’enema ieri sera non l’ho fatto↑ naturalmente↑

I of course she didn’t give her – give her an enema °last night° ((louder background voices)) (.>)she wasn’t going to the O R this morning<

N right

INF okay↑ (.>) domande dubbi

N no

N no:::
NR.FL.05

<table>
<thead>
<tr>
<th>Typology</th>
<th>End-of-shift nursing report (reported cases: 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td>Date</td>
<td>January 24, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>7:00 a.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:05:00</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Georgia I</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Outgoing nurse, Italian (male, aged 31-35) INF</td>
</tr>
<tr>
<td></td>
<td>Nurse, Italian (female, aged 31-35) INF₁</td>
</tr>
<tr>
<td></td>
<td>Incoming nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
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<td>Second researcher (SO)</td>
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<td>Situation</td>
<td>The two nurses are sitting next to each other at the nurses’ station; the interpreter is sitting next to the US nurse.</td>
</tr>
<tr>
<td></td>
<td>During the interaction the Italian nurse reads from his notes and the US colleague jots down the information. They often check the medical record and patient Kardex.</td>
</tr>
<tr>
<td></td>
<td>At the end of the interaction, another Italian nurse asks for his colleague’s help with other working matters.</td>
</tr>
<tr>
<td>Language direction</td>
<td>Italian &gt; English / (English &gt; Italian)</td>
</tr>
<tr>
<td>Prevailing mode</td>
<td>Short consecutive</td>
</tr>
</tbody>
</table>

```
((background voices))
I okay(.) {Pizzuto}
INF allora {Pizzello}=
I *=Pizzello)*
5 INF stanza (seicento::ventidue)
I room *(six two two)*
INF paziente trapiantata di fegato
I had a liver transplant↑
INF è tornata per *febbre*
10 I she came back for fever
INF il gruppo sanguigno è noto↑ [la paziente è allergica – ] the patient is
I allergic
INF a un bel po’ di farmaci [tramado::lo
15 I to several drugs
N ((looking at the Kardex)) no what’s this↑
INF ciprofloxacin=
I =which one↑=
INF =magnesio
20 I >aspetta un attimo< ((pointing at an item on the Kardex)) cos’è questo↑
INF mezzo di contrasto
I ((looking at the Kardex)) that’s a contrast medium
N ((pointing at another item on the Kardex)) this is a contrast
I ((pointing at an item on the Kardex)) no sopra questo meroo:::
25 penem
INF >meropenem< l’antibiotico
I uh it’s an antibiotic
N me – *mero:pe::nem*
```
I mhm
30 N okay when did they have the transplant↑
I quando ha fatto il trapianto↑=
INF =ma:: un po’ di tempo fa↑
I some time ago
INF non è:: la >paziente< è stata *dimessa* e poi è >rientrata per la febbre<
35 I sh::e was discharged and then [ readmitted for fe::ver ]
INF [ non è:: non è questo = il ricovero del trapianto è un ricovero precedente=]
I =yeah the transplant was a previous admission [ this is a new=]
INF °(e allora)°
40 I =admission
INF il gruppo sanguigno è noto↑ le allergie [ le conosciamo↑ ]
I type we know [ what she’s allergic to ]
INF [ psicosociale (. ) [ tutto sommato va bene ]]
45 I overall she’s fine
INF neurologicamente [ è un po’denbile ma va bene (d):i:: è:: autosufficiente ]
I neurologically she’s a little bit weak but that’s – it’s fine she’s self-
sufficient
INF e::hm cardiovascolare i vitals = bene↑ C:: ] V the vital signs are
45 INF [ fine↑ ] un left [y]rist numero venti↑=
50 I =she’s got a left wrist number twenty
INF ed è in regular diet=*
I =she’s on a regular diet
INF urina spontaneamente=*
I =she voids spontaneously↑
60 INF anche se le urine sono: [ molto:: concentrate dark amber ]
I even if her urine is very °concentrated°
INF *concentrated* colour dark amber
INF ehm la ferita::ta↑ (. ) ha una ferita:: (. ) >la – < la vecchia ferita
I sua che ormai è asciutta –
65 INF =ehm (. ) bruttii::na
I it’s ugly
INF poi quando lei la vedrà ehm [ (. )]l’addome che=
I you’ll see this
INF =si è:: questa ferita si è:: chiusa forse per seconda intenzione °perché:: è bruttina°
I it’s – on the way the – the lesion closes ugly ((phone ringing)) he s – he said something – ((to the Italian nurse)) seconda *intenzione↑*
INF mhm
70 INF =si è:: questa ferita si è:: chiusa forse per seconda intenzione *perché:: è bruttina°
I it’s – on the way the – the lesion closes ugly ((phone ringing)) he s – he said something – ((to the Italian nurse)) seconda *intenzione↑*
INF mhm
75 INF signifia che non si è chiusa con la sutura (. ) dopo i sette dieci giorni classici
it didn’t heal after the seven ten classic days apparently (.) you
know with the stitches it’s just the way it normally heals that didn’t
happen ((the US nurse nods))

va bene – niente io non: praticamente non ho altro da aggiungere le ho
fatto l’ismett

nothing else to add°

=(e l’F K levels – =

I =so he – (.) >he did ismett one this morning and F K level↑<

N okay normal saline yesterday bolus↑

INF >(< un bolo si ha fatto=

I ieri ha fatto un bolo di >soluzione salina↑<

INF =un bolo si per la::

I yes:

INF per la pressione

I for the pressure

and now everything is f –

and also for

as for the temperature

I =was thirty eight point something

INF quindi gli hanno fatto il [paracetamolo↑

I paracetamol↑

INF e:: il bolo di salina↑=

N =°okay°=

INF =and the saline bolus

N [ and the vanco level ] ieri sera↑ –

I e il livello di vancomicina↑

INF il livello di vancomicina↑ è stato fatto stamattina e

°aspettiamo i risultati°

I it was done this morning

N this morning [ okay

INF aspettiamo i risultati

we’re waiting for the results

N ((looking at the Kardex)) okay (.) so do I have to wait before I hang up

the vanco↑

I quin – quindi devo aspettare prima di ri – rimettere la vancomicina↑

INF no la vancomicina non l’abbiamo – abbiamo fatto l’*F K* il::

we didn’t do the vancomycin – we did the F K=

INF (la) vancomicina si può fare

I =okay we can do the *vancomycin*

INF ((pointing at an item on the Kardex)) quest’

ordine di quand’è

I (reading from the Kardex)) before dose on ] the twenty-third

I wait when was this order written↑=

N ==(reading from the Kardex)) before the dose on the twenty-third=

I =è scritto prima della dose il ventitré

INF [ fatto fatto fatto

I [ done

INF la – ] la vancomicina le – la – il livello di vancomicina andava fatto
pri:ma di somministrare la vancomicina was to be done before administering the—

135 N °yeah (that’s true) (   ) °
I = vancomycin
INF = già è stato è stato fatto okay
N
140 I it was done
INF done done done done
N ah okay
INF tutto fatto
N okay

145 I everything was done
N I thought *maybe* I had to do it again ‘cause (here) ((pointing at the Kardex)) it’s written twice=
I =mhm pensava che dovesse essere fatto un’altra volta >perché l’ha visto scritto due volte< no no no no< ehm=

150 INF =no no
INF °non c’è °bisogno° ((sneeze)) ah=
I =no need=

155 N =excuse me (.) all right
I bless you
INF e basta
I that’s all=
INF =basta=

160 N =okay
INF la paziente è tranquilla
I = it’s a tranquil patient
N °(reading from the Kardex) °please do not°
INF °(molto carina)°

165 I =eh↑ what↑
N °((reading from the Kardex)) administer
INF ((in the distance)) {Ivo::}↑
INF ((to INF)) si::↑
N °((reading from the Kardex)) till we get the (. ) results

170 I =non ammi –
N (   )
I c’è scritto non somministrare prima di ricev – di::: ottenere i risultati↑
INF aspetta aspetta dammi che lo cancelliamo questo↑
I =hold on a second° let me cancel that=

175 INF =lo cancello perché fa solo confusione °((to INF)) °hai una
gomma°=
I =it’s just creating confusion it shouldn’t even be there
((the Italian nurse stands up looking for a rubber and starts talking to INF; inaudible exchange))

180 N so we shouldn’t be giving it (. ) right
I I don’t know::
N every other day it says ((yawning))
I what was that the vancomycin↑
N F K
Appendix Six

185 I F K↑
((pause))
I >do you want me to ask↑<
N no I’ll get to the bottom of it somehow ((yawning))
I you’re all right↑
190 N >yeah<
((background voices of the two Italian nurses))
INF ((in the distance)) sì lo so lo so ma oggi che cos’è↑ oggi è martedì↑
((returning to his chair)) e ne abbia – ((background voice of INF1
talking to him)) ((annoyed)) vabbè ma scriviamolo qua:: oggi ne
195 abbiamo ventiquattro↑
I si
INF ((in the distance)) sì::
INF ventiquattro: allora facciamo così () ((writing down on the Kardex))
ventidu::e:: () venticinque lo deve fare () il ventise::tte >eccetera
200 eccetera<=
I =quindi lo fa ogni altro [giorno↑] D *Q O D*
INF [quindi]>un giorno sì (e uno no)<
I [yes] it’s every=
205 N <right°
I =other day=
N =right=
INF =il venticinque *sì* il ventisette *sì*
I she’s due on the twenty-fifth=
210 INF =°okay↑°=
I =on the twenty- [seventh] *no*=*
INF [oggi] today=
I =°okay↑°
215 N =°no ( )°
INF okay↑
N okay
I mhm
220 N that’s fine↑
I bene I guess we did get to the bottom of it
NR.FL.06

<table>
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<tr>
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<th>End-of-shift nursing report (reported cases: 1)</th>
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</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td>Date</td>
<td>January 25, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:07:26</td>
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<tr>
<td>Interpreter</td>
<td>Italo</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Outgoing nurse, Italian (female, aged 26-30) INF1</td>
</tr>
<tr>
<td></td>
<td>Incoming nurse, Italian (female, aged 31-35) INF2</td>
</tr>
<tr>
<td></td>
<td>Incoming nurse, US (female, aged 46-50) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (EI)</td>
</tr>
<tr>
<td>Situation</td>
<td>The US nurse has recently arrived at ISMETT and is now engaged in her period of shadowing and orientation. Her preceptor is the other incoming Italian nurse.</td>
</tr>
<tr>
<td></td>
<td>The three nurses are standing next to each other at the nurses’ station, while the interpreter is standing between the two Italian nurses and the US colleague.</td>
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<td>During the interaction the outgoing Italian nurse reads from her notes and the other two colleagues jot down the information. They often check the medical record and patient Kardex.</td>
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<td>Prevailing mode</td>
<td>Whispering</td>
</tr>
</tbody>
</table>

```
1 INF₁ ["allora"] (Perotti)↑
INF₂ {Perotti}↑

5 INF₁ allora il signor {Perotti}
praticamente il {ventitré}
{dodici} ha fatto un
trapianto di: (.)
((looking at her notes))
{fegato} da vivent –

10 INF₁ ^da::(^ )^ (.) cadavere

15 INF₁ allora lui praticamente
psicologicamente
è *mo::lto* nervoso

20 INF₂ ah pure idda m‘ha [º( )º]
INF₁ e::::

25 INF₂ ((ironically)) a:::h
INF₁ gli ho spiegato
le prossime volte di
suonare
INF₁ il campanello e di non gridare
```
Appendix Six

249

perché: mi chiamava (un sacco di volte) ( )

( )
she was trying to explain tell him to not scream to not shout for help

30 INF2 oggi gri – faccio io quattro gridi

INF1 [ ( )

però:::

è un po’ disorientato

35 nel tempo
e lo è stato=

INF2 =mhmm

INF1 e::hm

una notte e questa mattina però adesso

li c’è la moglie

40 I on his three dimensions

( )

INF 1 but=

( )

N =he is or he’s not

la moglie

I

comunque è molto collaborante

45 INF2 ((to the interpreter)) come si chiama lei↑

((pointing at the US nurse)) come si chiama lei↑

50 INF2 ((to the US nurse)) your name sorry↑

N Helen

INF2 Helen (. ) [e]len ora ci armiamo così ((clapping her hands and then rubbing them together))

55 [ facciamo (ah) mi raccomando dobbiamo calmare tutti

I so we’re going to work and ((chuckle)) and calm every –

INF1 allora

N ((chuckle))

I everybody down

60 N he was oriented ehm

INF1 I comunque dice era orientato ieri si orientava

INF1 ((to the US nurse)) no:

N not today

65 I [ non oggi ] completamente [ (not) ] last night [ at all alla collega ]

INF1 l’ha fatta impazzire i pazienti si sono tutti lamentati=

INF1 =perché non ha riposato nessuno

I nurses and patients were complaining about him

N really↑

INF1 [yes ]

that they were not able ((willing to continue )) *pa::;in*

INF2 dolor no con me non l’ha avuto

INF1 pain no pain
with her

I neuro

I he’s not oriented

I and he’s – has been walking with the physical therapists

I but he’s very weak

I he’s weak and

I is he lazy†

I yes a little bit

I we cannot understand if it’s the pain or if he’s lazy just lazy

I room air

I he’s in room air

I cardiovascular

I vital signs are fine

I right forearm (.) twenty gauge

I he has

I he’s doing these immo – immuno-globulins

I five thousand units

I because he’s received a liver from a B positive patient and
he’s H B positive
so he’s doing the immunoglobulins

and
they are running right now

every day at twelve (.) midday
allergic to contrast dye
and aspirin

G I

he’s on a soft diet

he has a J P
right lower quadrant draining traces J P B J –
and also has a J P
pure
pure

bowl movements
are present
active
Appendix Six

185  fanno:: cortisone
     (   ) e quindi
e:::

190  INF1  però
     ha fatto aria ha sempre lo
     stimolo di
     andare in bagno vuole andare
     in bagno però è aria quindi
     ha canalizzato (un po’ d’) aria

195  INF1  aveva il Foley l’abbiamo –
     l’ho tolto

200  INF2  ha urinato↑
     INF1  no dopo che
     ho tolto il Foley no

205  INF1  però ho fatto il bl[a][d]
     training

210  INF1  anche se ((chuckle))
     scientificamente forse
dicono che non è provato ma

215  INF1  e io l’ho fatto
     aveva lo stimolo

220  I  cos’è↑ (.).
     N  bladder training °what is bladder training°

225  INF1  =what↑
     I  la ginnastica  vesicale dice che cos’è=
     INF1  =what↑ ginnastica ve –
     I  =che:::

230  INF2  ((to the US nurse)) e:::hm praticamente quando un paziente tiene per
     molto tempo il Foley
     INF1  [ la vesica –
     I  when the  ] patient has the Foley for l –
     INF2  [ keep=]

235  INF2  =*has*
     I  the Foley=
     INF2  l’urina –
     I  =for a long time
     INF2  l’urina esce sempre
     I  so he just urid – voids
     INF2  =spontaneously=

240  INF2  (quindi la vesica
     I  =(has) always °(   )°
     INF1  non ha più
Appendix Six

INF2 la vescica non si allena più nella e nel restringimento
INF2 ok okay e quindi ehm si *chiude* il – il sacchetto
del catetere per far riempire la vescica

INF2 and so we clamp the bag so that the:: bladder
INF2 non appena il paziente=
INF2 =ha lo stimolo
INF2 so as soon as he has the
INF2 =stimulus if he has to pee
INF2 stacchiamo e si apre e si sgonfia

INF2 we unclamp it and (. ) and (. ) it deflates
INF2 altro è previsto quando i pazienti
tengono più di una settimana il:: catetere vescicale
INF2 usually we do this when they have the Foley for more than a

INF1 lui l’ha messo il ( ) °(he had it) three daysº
INF2 ((to the US nurse)) okay↑ l’ha avuto per tre giorni

INF1 praticamente
INF1 questo paziente dopo aver f – è tre giorni che ha fatto il
trapianto e già tu lo vedi::

INF2 probabilmente è l’F K
INF1 infatti
INF2 il paziente è nervoso perché (. ) può essere una
delle probabilità può essere
INF1 anche dovuta all’F K=

INF1 =al =
INF2 =al:: prograf
INF2 l’antirigetto
INF1 si (è vero)
INF2 è il farmaco:: il farmaco antirigetto
INF1 ³tra l’altro è un sintomo

INF1 he::: this is his third
INF2 uh post-op day and he’s doing well
INF2 perché
INF2 ( ) ((soft chuckle))
INF1 ( ) ((soft chuckle))
INF1 but he’s nervous
INF1 because
INF1 maybe he’s also nervous because of the prograf
INF2 the F K the:: uh
INF2 anti::
INF2 rejection:: drug
INF1 so he’s nervous

INF1 °tra l’altro è un sintomo because of this drug
della tossicità da farmaco ( ) anti – anti-rejection
INF2 vabbè questa è una cosa in più va’ (.) poi vabbè
INF1 lo studio allora
INF2 >°(mhm)< (.) quindi
INF1 integumentary abdominal
INF2 l'altro questo fa::°
INF1 yes open to air
INF2 open to air

I abdominal incision open to °(air)°
INF1 dry intact
INF2 dry (ed) intact
305 °yes°
INF2 ismett one and=
INF1 domani
INF2 =F K (for tomorrow) ((INF1 nods))

I *dry* and intact
INF1 (to the interpreter) ((INF2 goes on writing her notes))
INF2 ((to the interpreter)) >t – t – < ti::: diciamo risparmio un po’ di lavoro
315 I [grazie ((chuckle))
INF1 ( . ) ((chuckle))
INF2 chest [iks]-ray done all done† ((INF1 nods)) done done
320 I sì:: ce:rt°
INF2 done (> .) ((erasing items from the Kardex)) cancelliamo tutti
INF1 sì:: brava= mhm mhm mhm
325 INF2 =precisa °brava° I all done ((chuckle))
INF1 [ . ]
INF2 [ ( ) ((chuckle))]
I [ ( ) ((chuckle))]
INF2 yes yes yes
I cancella dice ((soft chuckle))
INF2 ((to the US nurse)) non mi interessa neanche sapere cos’ha fatto
I she doesn’t even want [to (know) what he has done] ( . )
INF2 perché:: ci confondiamo di più
INF1 we don’t want to get more confused
INF2 si guarda in cartella [che=
335 I [ so]
INF2 =c’è scritto
I we just need to look in the chart
((short pause))
INF2 okay↑
340 N okay (.)) (writing down her notes) ((background voices)) o:::kay
INF1 ha il tramadol:: (. ) °( )°=
INF2 =P R N e cos’è questo↑ I tramadol P R N
allora lui ieri pomeriggio ha avuto una reazione allergica agli occhi pensavamo che era il:*deursil*

ma::: stamattina l’ha preso e con me non l’ha avuto quindi hanno prescritto queste goccine per gli occhi perché lui non l’ha mai fatto

(forse) è allergico ai guanti non abbiamo ancora capito

non riusciamo a capire che cosa c’ha °( )°

io ho avuto la reazione quando io gli ho dato deursil e poi gli ho messo in corso la – il °( )°

dice che l’ha avuto anche la mattina ma in consegne non me l’ha detto nessuno (. ) e:::

( )

la fisiologica è venuta {Irma} {Isabella} (e gli abbiamo messo) questo – questo collirio però stamattina io gliel’ho dato

a mezzogiorno però alle otto l’ho sospeso il deursil a mezzogiorno gliel’ho dato e non ha avuto nessuna reazione allergica e neanche quando ha fatto gli antibiotici

he had yesterday an allergic reaction (. ) in his eyes

we thought it was this he:: took the same drug and he didn’t have any reaction

so he has been using this he’s using this for this allergic reaction

maybe it’s the gloves

but we do not understand what (. ) “it’s causing the: reaction”

the reaction was after she gave deursil (. ) and – “the other drug”

I wasn’t told about that in the (. ) but –

so they’ve been using that

drug a medication

this –

the drug was then suspended and after he hasn’t
<table>
<thead>
<tr>
<th>INF₁</th>
<th>quindi io presumo che siano i guanti che noi usiamo al lattice</th>
</tr>
</thead>
<tbody>
<tr>
<td>INF₁</td>
<td>ho usato gli altri (. quelli là:: di vinile e ha avuto meno lacrimazione</td>
</tr>
<tr>
<td>INF₁</td>
<td>quindi credo che siano i guanti</td>
</tr>
<tr>
<td>INF₁</td>
<td>non tanto allergico – =</td>
</tr>
<tr>
<td>INF₁</td>
<td>=ma i medici lo sanno questo</td>
</tr>
<tr>
<td>INF₁</td>
<td>sì non hanno prescritto niente</td>
</tr>
<tr>
<td>INF₂</td>
<td>okay ((an Italian nurse passes by and greets INF₂))</td>
</tr>
<tr>
<td>INF₂</td>
<td>((to the Italian colleague)) ciao</td>
</tr>
<tr>
<td>INF₂</td>
<td>(. okay</td>
</tr>
<tr>
<td>INF₂</td>
<td>((the three nurses look at the orders in the medical record))</td>
</tr>
<tr>
<td></td>
<td>had any allergic reaction</td>
</tr>
<tr>
<td></td>
<td>so they think she thinks it’s the gloves the latex gloves</td>
</tr>
<tr>
<td>INF₁</td>
<td>( ) – she suggested not using those gloves</td>
</tr>
<tr>
<td>INF₁</td>
<td>and the reaction was:: (. a little bit less</td>
</tr>
<tr>
<td>INF₁</td>
<td>do doctors know↑ yes:::</td>
</tr>
<tr>
<td>INF₁</td>
<td>but they haven’t prescribed ordered not – anything</td>
</tr>
</tbody>
</table>
NR.FL.07

<table>
<thead>
<tr>
<th>Typology</th>
<th>End-of-shift nursing report (reported cases: 2 out of 3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td>Date</td>
<td>January 30, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:08:32</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Julia</td>
</tr>
<tr>
<td>Primary speakers</td>
<td>Outgoing nurse, Italian (female, aged 31-35) INF</td>
</tr>
<tr>
<td></td>
<td>Incoming nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Second researcher (EI)</td>
</tr>
</tbody>
</table>
| Situation | • The US nurse is sitting at the nurses’ station in front of a monitor viewing the patients’ electronic medical records, while the Italian nurse and the interpreter are standing next to her, with the interpreter between them.  
  • During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets.  
  • When the interpreter arrives, the report on the first patient is almost over. Therefore, the transcribed recording only concerns the other two patients. |
| Language direction | Italian > English / (English > Italian) |
| Prevailing mode | Short consecutive |

((background voices))

INF poi {Pellizzari} (. ) resezione gastric – gastrica per ca – per un::
carcinoma e::hm gastrico
I gastric resection for gastric carcinoma
5 INF però lei non lo sa che aveva un carcinoma
I the patient doesn’t know that she had a cancer
INF °sapeva che aveva un’ulcera°
I she knew:: that she had an ulcer
INF lei è in N P [g] (. ) solo: un poco d’acqua per prendere i farmaci
I just some water u::h with medications
10 INF ha questa right intrajugular due lumi
I ((louder background voices)) °( . )°
INF appena finisce il (. ) potassio e il fosforo che stanno andando
I uh potassium and phosphorus↑ uh are running at the moment
15 INF appena finiscono si deve togliere
I when they finish it has to be pulled out
INF poi ha un:: (. ) left (. ) antecubital number ehm (. ) twenty dove sta
andando normosol↑
I normosol is running
20 INF a cento C C orari
I one hundred C C an hour
N in the art (. ) >hep-lock<
I “in the (left) A C yeah”
INF le ho tolto il Foley ora
25 I Foley just now discontinued=
INF =quindi deve vedere se urina da sola= 
I =you have to *check* whether she is voiding (.) by herself=
INF =non è andata ancora di corpo=
I =no B Ms=
30 INF =ha fatto aria comunque
I *but* flatus
INF ha un: right lower quadrant J P (.) to bulb suction (.) serosanguineous
°(with me)° one hundred "with me" (.) e::hm D C teds (.) avev – edema
agli arti superiori infatti:: è difficile prendere:: accessi venosi
35 I upper – to – to the arms –
N ((writing down her notes)) edema
I =so it's:: (.) *hard* to find an I V access=
N =mhmm
40 INF anche lei è diabetica e ha l'accu-check=
I (she's) diabetic
INF =ogni sei ore
N ((writing down her notes)) diabetic
I accu-check Q six hours=
45 INF =si (.) alle:: dodici non ha avuto bisogno perché era centotrentanove
I \[ she::: \] didn’t need anything at noon >blood sugar was< one hundred and thirty-nine
INF gli tocca ora a: diciotto a lei
50 I so no::w (.) it will be at six P M
INF e:: seguire la scala
I and you’ve to (.) follow the scale
INF potassio e esafosfina *messi** tutti e due quindi appena finisce può
togliere tutte cose
55 INF =si nel senso che – \[ si è l’ultima sacca del potassio \]
I \[ the potassium and esafosfina are running \] the last
bag is running right now and you can \[ “discontinue them” \]
INF e sono stati
I scaricati e
60 tutto
N \[ no V B G \] already been charted (.) e::hm=
INF =dom – =
I =niente V B G↑
65 INF no no
N °okay°
INF lei domani deve fare un: gastrograph[en] del:: (.)
I \[ dell’apparato gastrico \] \[ (reading from the Kardex) \] gastro –
70 INF \[ ga::strograph[en] \] \[ per vedere – si \] se – per vedere \[ se può mangiare=\]
I \[ tomorrow \] tomorrow
INF =poi domani
N tomorrow
75 I tomorrow
INF yes
I to see whether she will be able to *eat* tomorrow
N >okay<
INF okay↑ e: basta le faccio vedere:: gli ordini
that’s it° I’ll show you the orders°
((the Italian nurse opens the medical record)) ((shuffling of pages))

I >that’s it< °I’ll show you the orders°
((the Italian nurse opens the medical record)) ((shuffling of pages))

INF ((reading from the medical record)) R X gastrograph[ina] (. ) domani (. )
in A M (. ) ehm:: (. ) per:: gastrodigiuno e:: hm anastomosi D C teds D C
central line D C Foley ismett due esa fosfina quarantasette millimoli and

potassium quaranta milliequivalenti (. ) done=

N °done°

INF okay↑=
N °okay°=
INF °okay°

90 N °all right° next↑
I °il prossimo°

((pause))
INF e chi ha ora↑
((pause)) ((the Italian nurse looks at her notes))

INF ((reading from the medical record))

R X gastrograph[ina] domani (. )
in A M (. ) ehm:: (. ) per:: gastrodigiuno e:: hm anastomosi D C teds D C
central line D C Foley ismett due esa fosfina quarantasette millimoli and

potassium quaranta milliequivalenti (. ) done=

N °done°

INF okay↑=
N °okay°=
INF °okay°

90 N °all right° next↑
I °il prossimo°

((pause))
INF e chi ha ora↑
((pause)) ((the Italian nurse looks at her notes))

INF ((reading from the medical record))

R X gastrograph[ina] domani (. )
in A M (. ) ehm:: (. ) per:: gastrodigiuno e:: hm anastomosi D C teds D C
central line D C Foley ismett due esa fosfina quarantasette millimoli and

potassium quaranta milliequivalenti (. ) done=

N °done°

INF okay↑=
N °okay°=
INF °okay°

90 N °all right° next↑
I °il prossimo°

((pause))
INF e chi ha ora↑
((pause)) ((the Italian nurse looks at her notes))

INF ((reading from the medical record))

R X gastrograph[ina] domani (. )
in A M (. ) ehm:: (. ) per:: gastrodigiuno e:: hm anastomosi D C teds D C
central line D C Foley ismett due esa fosfina quarantasette millimoli and

potassium quaranta milliequivalenti (. ) done=

N °done°

INF okay↑=
N °okay°=
INF °okay°

90 N °all right° next↑
I °il prossimo°
\[
\begin{align*}
\text{I} & \quad >\text{quindi} < \text{a lei tocca alle diciotto} \quad \text{and at ten P M} > \text{so the next one}< \\
\text{INF} & \quad \text{è e::hm allergica a questi antibiotici} ((\text{pointing at the items on the Kardex}) \text{) meropenem amoxicillina} ^5( \text{ )} \text{floxacina} ^{( \text{ )}} \text{nonostante sia allergica al} \text{ *meropenem} ^\uparrow \text{ ( ) siccome lo} * \text{deve} * \text{fare indispensabilmente infatti gliel'ho attaccato ora=} \\
\text{I} & \quad \Rightarrow \text{okay} < \text{she’s allergic also to this antibiotic} ((\text{pointing at the item on the Kardex}) \text{) right} ^\uparrow \text{ *but* she absolutely *needs* it} \\
\text{INF} & \quad \text{meropenem} \\
\text{I} & \quad ((\text{reading from the Kardex}) \text{) me:: ro::pe::nem} \\
\text{N} & \quad \text{so:: what are we doing=} \\
\text{I} & \quad =\text{so=} \\
\text{N} & \quad =\text{( ) her some pre-meds} ^\uparrow \text{ or –} \\
\text{I} & \quad \text{quindi cosa bisogna fare=} \\
\text{INF} & \quad =\text{miente gliel’ho messo io alle quattordici} \\
\text{I} & \quad =\text{I’ve just hung it no::w} \\
\text{INF} & \quad =\text{lento<=} \\
\text{I} & \quad =\text{at uh two P M but it has to be} * \text{really really really} * \text{ slow} ((\text{pause})) ((\text{the US nurse goes on writing her notes}) \\
\text{N} & \quad \Rightarrow \text{okay} ^\uparrow \\
\text{((short pause))} \\
\text{INF} & \quad \text{ha:: un’incisione qua} ((\text{pointing at the exact position on her chest}) \text{) sottomammaria} ^\uparrow \text{ } \\
\text{I} & \quad \text{u::h underbreast} \quad \text{incision} ^\uparrow \text{ } \\
\text{INF} & \quad ((\text{smiling}) ((\text{whispering}) \text{) } \text{“thoracic incision”=} \\
\text{INF} & \quad =\text{open to a[l]r dry e intact} (.) \text{ ha un sacco di farmaci strani} (.) \text{ che però trova tutti nel senso} \quad \text{che sono divisi} - \\
\text{I} & \quad >\text{you’ll find} < (.) \text{ them all} \quad \text{in the –} \\
\text{INF} & \quad >\text{il bin} >\text{ fuori} \text{ dal frigo} \quad \text{sono divisi tra} \text{ il frigo – nel bin nel frigo e} \\
\text{I} & \quad >\text{some are –} \text{ some of them are in the} *\text{bin} * \text{in the: refrigerator and others are in the bin} *\text{outside*} \text{ the refrigerator=} \\
\text{N} & \quad =\text{in hers in her own okay} \\
\text{I} & \quad =\text{nel *suo* bin=} \\
\text{INF} & \quad >\text{si si si} < \text{ li trova tutti sono un po’} \quad \text{strani ma li=} \\
\text{INF} & \quad =\text{trova tutti=} \\
\text{I} & \quad =\text{them all} \\
\text{INF} & \quad \Rightarrow \text{okay} ^\uparrow \\
\text{INF} & \quad =\text{e::hm basta} (.) >\text{non ci sono stati ordini perché lei non l’ha vista nessuno} < ^\text{ancora non l’ha vista nessuno} ^\text{be::cause the physicians haven’t seen her yet} \\
\text{I} & \quad =\text{there were no orders} \\
\text{N} & \quad >\text{right} ^\uparrow ((\text{background voice}) (.) \text{ that’s the slow cardiologists} >^\text{(it always ends up this way)} ^\text{)} < \\
\text{INF} & \quad \text{i toracici non hanno fatto nessun giro} ((\text{background voices}) \text{ancora=} \\
\text{I} & \quad =\text{there was no thoracic} \text{ u::h *round=} \\
\text{INF} & \quad \Rightarrow \text{okay} (.) ^\text{okay} ^\uparrow (.) \text{ so she is on F K too} \\
\text{I} & \quad =\text{sta facendo anche} \text{ l’F K} \
\end{align*}
\]
INF no ehm cioè l’ha fatto stamattina [si fa l’F K she did it this] morning
I
N >okay<=
INF =però siccome nessuno li ha controllati dei – dei medici
190 I yeah no physician [°right°] the levels
N I the levels=
INF =quindi non han scritto ordini per domani=
I =so no orders have been written for tomorrow
195 N >°okay°<
INF non so quando lo faranno st[u] giro (. ) di pomeriggio=
I =I don’t know when (. ) they are going to round maybe=
N =>okay<=
I ==in the afternoon
200 INF mhm (. ) e basta↑
N that’s okay
INF è ma::gra >magra magra magra magra [magra magra magra °magra°<
I she’s *very very* skinny
N skinny↑
205 I yeah
N o::h
((pause))
INF ((ironically)) >°metà::° ((indicating half of her leg))=
N =oh↑
210 I half
N well ((laugh)) so skinny↑ ((pointing at the interpreter))
INF ^no:: no [lei:: ((chuckle)) is ^good ((laugh))
N ((laugh))
I ((chuckle)) more more skinny
215 N ((chuckle)) okay=
INF =i medici guarda *ora* sono °saliti°
I =I medici scusa↑
INF sono ora nella stanza ((pointing at the patient’s room))=
N =>(so)<
220 I physicians = are=
N I =>right now< °in (her) room°=
N =yeah [okay ]
INF okay basta
225 N ^now^ INF ((ironically)) a::h ba::sta↑
N ((pointing at her notes)) these (. ) {six fifteen} [allora
INF {six thirty}=
N =no↑ ( . ) neither one↑=
230 INF =no no ( . ) (you)
N okay [°ah okay°] (. ) dei due↑
INF questo ((pointing at the patient name in the US nurse’s notes)) c’è:
I perché [aspetta::=
235 I this::
INF =i: vestiti (. ) però già c’è la lettera di [dimissioni pronta
I oh there is –] (. ) the –
discharge letter is ready↑ he’s just waiting for his clothes
°oh okay {six thirty}↑°

I >I didn’t< (. ) pull out the I V access=

INF =perché ho detto non vorrei che si sentisse ma:le prima che se ne vada=

I =because I was: afraid he could feel:

↓ sick before leaving

whenever he is: > *ready* to go< justahas pulled it out

INF he had a cabg times three

N °okay° all right

“I think so

N °okay° all right

INF va bene↑=

N =okay (. ) all right
NR.FL.08

<table>
<thead>
<tr>
<th><strong>Typology</strong></th>
<th>End-of-shift nursing report (reported cases: 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Place</strong></td>
<td>ISMETT regular admission unit (Floor)</td>
</tr>
<tr>
<td><strong>Date</strong></td>
<td>March 7, 2006</td>
</tr>
<tr>
<td><strong>Time</strong></td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td><strong>Duration</strong></td>
<td>00:09:55</td>
</tr>
<tr>
<td><strong>Interpreter</strong></td>
<td>Henry</td>
</tr>
<tr>
<td><strong>Primary speakers</strong></td>
<td>Incoming nurse, Italian (female, aged 21-25) INF</td>
</tr>
<tr>
<td></td>
<td>Nurse, Italian (female, aged 21-25) INF1</td>
</tr>
<tr>
<td></td>
<td>Outgoing nurse, US (female, aged 51-55) N</td>
</tr>
<tr>
<td><strong>Observers</strong></td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (SO)</td>
</tr>
<tr>
<td><strong>Situation</strong></td>
<td>The two nurses are sitting next to each other at the nurses’ station in front of a monitor viewing the patients’ electronic medical records, while the interpreter is sitting between them. During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical records and patient Kardex sheets. At some point, another Italian nurse approaches them and addresses the Italian colleague.</td>
</tr>
<tr>
<td><strong>Language direction</strong></td>
<td>English &gt; Italian / (Italian &gt; English)</td>
</tr>
<tr>
<td><strong>Prevailing mode</strong></td>
<td>Short consecutive</td>
</tr>
</tbody>
</table>

((background voices))

N [...] (this) afternoon↑
I è venu – è arrivato questo pomeriggio=
N =okay↑ (. ) doctors wrote *orders*↑
5 I =i medici hanno scritto gli=
N ↗a little bit ago↑^
I =ordini
INF mhm=
N "okay" ↘
10 I giusto: un:: (. ) p – =
N =>he was in<=
I =poco fa=
N =*outpatient* (. ) before here
15 I era già in ambulatorio prima di venire su
N had type ‘n’ screen done and labs done
I gli hanno fatto il type ‘n’ screen e tutti gli esami:: (. ) tutti i prelievi
N he came up here
and they *ca::led* for him and said (. ) need to go to *cardiac cath*
20 I è arrivato su: (. ) l’hanno chiamato su >per dire che doveva andare giù a fare<
la: >cate(te)rizzazione<
INF mhm
N so *of course* I told him (. ) get undressed↑
I quindi gli ha detto spogliati
25 N >I threw in< an eighteen here ((pointing at the exact spot on the arm))
I ha messo dentro un:: diciotto
N (and) took him down°stairs°
I e l’ha portato giù
N I show::ed () the people *downstairs†* (. ) the orders
30 I ha fatto vedere gli ordini a quelli giù:
N I said for after *midnight†*
I >e ha detto per – <=
N °cardiac cath°=
I =>la cateterizzazione< per dopo mezzanotte
N °cause they said no shave†* I said *no*=
I =>perché< non è stato:: non l’hanno raso
N >they just had orders written†< ((sarcastic chuckle))
I hanno appena scritto gli ordini; ↑°appena adesso quindi::<°
N they said fine °the cath is (°)
35 N I said detto va bene °allora lo faremo (°)
N they’re *crazy*
I son – sono pazzi
N ((laugh))
INF allergy ne ha↑
40 I any allergies↑
N [°we didn’t even – ] we didn’t – *here* ((pointing at the Kardex)) I got (. ) no
known allergies
I niente allergie
INF vabbe
50 N I got to write *everything* he’s in with L A D
I è qui per – lo con ale – al – L A D ((to the US nurse)) and that is to say↑
N L A D and R C A
I e R C A
N coronary artery disease
55 ((the Italian nurse nods))
I una:: °( °)
N °coronary artery disease°] C A D (. ) okay ↑ N P O: and he *left*
I °yeah° okay è in N P [.] ↑=
N he’s down
60 I =e poi è giù – °ed è giù a=
N °he’s down there
I =fare i::l °cateterismo
INF cioè è venuto solo per il cateterismo giusto↑
I he’s just here for that basically for the:=
65 N =I guess=
I =cardiac cath=
N °yea::h*
INF okay (. ) [Piana] [Pasquale]
I [Piana]↑
70 N °but it – ° but it was supposed to be written for tomorrow so::
there is orders
I ma difatti doveva essere domani° quindi ci sono tutti gli ordini difatti
N °okay °there’s orders on that° (. ) >I think it’s a work-up< my personally
75 (. ) for transplant
INF >okay<
okay↑ (.) all right

((the Italian nurse checks the patient’s electronic medical record; sound of the enter key))

INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<

100 I poi↑
INF {Pavano} {Patrizio}
I {Pavano}
N o:::kay {Pavano} (. ) mister {Pavano} {Patrizio} ^*watch*^ there’s due:: (.)
{Pavano} on the >floor now<

120 N so they did a *thoracotomy*
I hanno fatto una:: toracotomia
N "I don’t know" ^when^
I non sa [ quando ] (.) (looking at her notes) I didn’t write it down↑

125 I non l’ha:: segnato comunque
INF (pointing at the Kardex) ah >right there< >right there<=
I =li (pointing at the Kardex))
N on on the *eight*
I (pointing at the item on the Kardex)) ^*qui*^ (.) i:::

130 INF {trentuno}=
N =yes=

INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<

80 INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<

110 INF noi abbiamo {Patrizio:::}[/]ce n’è uno anche uno qua
N =okay↑
INF okay=
N =>there’s one right up here (pointing at the patient’s room)

85 I ((looking at her notes)) °{Piana(si)}° ^no:::
I no
N ((looking at her notes)) >what< I don’t know (. ) no:: (. ) no

90 INF letto uno è vuoto↑
N =this – this guy was *in that bed* [ this is like=
INF ah se n’è anda::to
N =(sound indicating departure))
I °(he’s gone)°=
95 INF °(va bene)°
I =okay
INF ((deleting the name from her notes)) °( )°
N okay who else >that’s it↑<
INF okay

115 I è qui per insufficienza cardiaca
N he was a work-up for cardiac transplant
I era qui per il work-up per:: il trapianto per:: di cuore
N found he had a mass on the right
I hanno trovato un:: una *massa* (.) sul lato destro

125 I non l’ha:: segnato comunque
INF (pointing at the Kardex) ah >right there< >right there<=
I =li (pointing at the Kardex))
N on on the *eight*
I (pointing at the item on the Kardex)) ^*qui*^ (.) i:::

130 INF {trentuno}=
N =yes=

INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<

80 INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<

105 I ci sono d:: due {Pavano} qui
N okay↑
INF okay=
N =>there’s one right up here (pointing at the patient’s room)

110 INF noi abbiamo {Patrizio:::}[/]ce n’è uno anche uno qua
N =okay↑<=
I =she has {Patrizio}
N °okay° *in* with heart failure↑

120 N so they did a *thoracotomy*
I hanno fatto una:: toracotomia
N "I don’t know" when^
I non sa [ quando ] (.) (looking at her notes) I didn’t write it down↑

125 I non l’ha:: segnato comunque
INF (pointing at the Kardex) ah >right there< >right there<=
I =li (pointing at the Kardex))
N on on the *eight*
I (pointing at the item on the Kardex)) ^*qui*^ (.) i:::

130 INF {trentuno}=
N =yes=

INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<
INF = {gennaio}=
I = the {thirty-}=
N = okay

135 I = {first} °of {January}°
N = okay↑ (.) he’s no *more* on N P O
I = non è più in N P [9]
N = I don’t know why they haven’t ( )
I = non sa perché è ancora °è segnato qui°

140 N = from yesterday
INF = reg[ular]↑
N = he wen – (.) he went down
I = regular diet↑
N = yes yes

145 I = regular
N = he went down yesterday
I = è andato giù ieri
N = for *cardiac cath*
I = per fare il >cateterismo<

150 INF = l’ha fatto↑ °(il cateterismo)↑°
I = ha fatto il cateterismo
N = >they went through< his right groin
I = sono entrati:: dentro l’inguine destro
N = okay needless to say he’s alert and oriented
155 I = quindi è all’e:rtà e::
N = orientato [good] spirits
I = di b::uon umore
N = *walked* (.) >in the room<
I = cam::mina nell: nella stanza

160 INF = mhmm<
N = : a:: a chest tube
I = ha un chest tube
N = to twenty C M water seal
I = quan – a:: venti (. ) water seal

165 N = I did the dressing (.) this morning
I = ha cambiato la medicazione [stamattina] destra↑
INF = mhm”↑
I = right right↑
N = *yeah* (.) put a new whole chest tube (.) *container*=
170 I = ha messo
N = yesterday
I = ha messo un: nuovo contenitore per il chest tube ieri
INF = mhmm
N = has *staples* above (.) chest tube

175 I = c’ha gli staples *sopra:* il chest tube
N = open to air
I = sono open to air
INF = nell’incisione↑ °( )°=
I = this is

180 INF = °staples*=
I = on the incision for the incision::
N = the staples↑ (.) above
Appendix Six

185 INF “ah proprio sul chest tube”
N =okay↑(.) ((background voices)) it’s only like this much ↑((showing the size with her hand))
INF I è un tratto più o meno: grande: >saranno una decina< di centimetri
190 N okay(.) u:h(.) ((whispering aside)) °ah what else did I want to say°
INF e drena↑ I is it draining anything↑
N °yes yes° °somehow::↑° he went down to chest X-ray today
I è andato giù a fare l:la:: radiografia (. ) al torace=
195 N =and I *noticed* that (. ) all the *chambers*
I e ha visto che (. ) tutte le::=
N =have stuff in it so I had to mark ninety [for the one↑] le camere
 INF avevano:: qualcosa:: più di novanta=
200 N a hundred and ten for the other and sixty for the other
I =cento*dieci* e sessanta
N so he actually had that
I quindi difatti
N °((aside)) ((looking at her notes)) °ninety:: (.) zero:: (.) nine ten six° ((to the Italian nurse)) °two* (. ) *sixty*
I ha fatto ha drenato °due e sessanta° and I put *lines*
I e quindi ha metto
INF °in tutta la matti::na
210 N over the whole morn – during the whole morning↑
I =ciento dierci* e sessanta
N so he actually had that
I quindi difatti
N °(aside) °ninety:: (.) zero:: (.) nine ten six° °(to the Italian nurse) °two* (. ) *sixty*
I ha fatto ha drenato °due e sessanta° and I put *lines*
I e quindi ha metto
INF °in tutta la matti::na
215 N =ha segnato *do::ve* i vari: °livelli
I mes – =
INF °there
220 INF mhm
I magari sarà cadu:to e quandi=
INF =mhm
I il drenaggio si è distribuito nei °(pointing at the electronic medical record) °c’è° e quindi ha metto
INF ed è in °grado di quantificare:: (.) °qui
225 N °((pointing at the electronic medical record)) °c’è° didn’t write anything in°
I here yet don’t – I’m – I’m not even near done=
INF lei non: ha messo:: niente in Emtek °ancora°
N =ready to go °home ((sarcastic chuckle))
230 I °perché non – non ne ha fat – °deve ancora far:ttà la:: (.)
N °(‘sta cosa)° to write
I do ancora aggiornare Emtek=
INF =mhm=
235 I =fra tutte le cose
N I haven’t even written *meds* all day (.I think – =
I (ironically) you’re gonna be *busy* ((chuckle))
N okay *so* ((ironically)) avrai un pomeriggio:: pieno
INF ((ironically)) che simpatica ((wholehearted laugh))
I ((wholehearted laugh))= (((laugh)))
N I was busy fourteen hours yesterday
I *ieri* ha avuto d – è stata qui per quattordici ore
N and came back into the same mess ((banging her head against the
interpreter’s shoulder)) ((laugh))=
I ed è tornata qui e ha trovato lo stesso casino
N >(and where was I at now see)< umm
INF ((background voices))
I the:: the drains
N *edema* (.) bilaterally↑
I c’ha edema bilate –
N ↑*left*↑
I nei:: due lati=
N a little bit more swollen than right
I la sinistra un po’ più gon: fia rispetto alla destra
N now ( ) a couple of days ago
I qualche giorno fa::
N *crepitus* in the arm
I ehm
N has *decreased* ehm ha le:: ehm cre:piti nel:: nel braccio::
N since °chest tube was placed*
I da quando gli avevano messo il chest tube ma
N °in the arm° *it has °decreased*
I =e::hm=
N *swelling* has decreased
I anche il gonfiore:: si è °ridotto°=
N =had crepitus here ((pointing at her side)) too
I anche qui::
N but it’s °gone° I haven’t=
280 I ma è scomparso
N noticed any more ( ) °(that)° non ne ha visto più
I cioè °over the last two days °it’s disappeared” (. ) °okay°=
N =negli ultimi due giorni
N uh (. ) voids spontaneously
I urina spontaneamente::
N now (. ) his blood pressure
Appendix Six

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I la pressione è bassa sempre bassa
N eighty something over eighty-six=
I =for me this morning °you can look° okay↑
I su ottantasei puoi vede::re
290 N *still* we need to=
I comunque
N =give his captopril
I >bisogna dargli captopril<
N because if he goes high
300 I perché se dovesse salire
N >his heart will stop<
I >il cuore si blocca<
N that is why (. .) they need (. .) him to keep getting
°the captopril°
305 I ecco perché deve continuare a prendersi – °a prendere
il captopril°
N a::nd what °we did was (. .) ((gesticulating)) switch *captopril* and
*furosemi::de* every couple of hours=
I =quindi ogni paio di ore=
310 N not together
I =si::: (.) si fa:: il captopril poi il furosemi::de=
INF =sì °(lo so)°
I =ma non insieme
N if his blood pressure for you all nights is low low under eighty you have to
call – =
315 I =se la pressione dovesse scendere *so::tto* ottanta
N you have to call the doctor ^*però*^
I devi chiamare il me::dico ^*però*^
N ((gesticulating)) ^*you might^ (. .) >turn around< *wait* >a little time< a little
320 bit of *ti::me* it goes up
I =può succedere che °aspetti un po’ e sale solo
INF okay
((INF1 approaches them))
N >okay↑< he will get (. .) new orders on °him↑° saranno nuovi
325 I =ordini
N °he will get° warfarin tonight
INF ((to the Italian nurse)) >si< (ho fatto) alcuni R N G che
mancavano°
330 I dovrà fare la:: [v]arfarin °stanotte°
INF ((to INF1)) si ho °visto
((the Italian nurse opens the medical record)) ((shuffling of pages))
INF ((to the Italian nurse)) ho inserito gli R N G °che mancavano°
335 N he got it °la:st° night
I l’ha fatto ieri no – no::tte ((shuffling of pages)) °pure°
N ((shuffling of pages)) °for me° (. .) I gave him – =
INF =((reading from the medical record)) chest [iks]:ray tomorrow↑
Appendix Six

340  N chest X-ray tomorrow↑
     I sl.(.) ((reading from the medical record)) I N R
     I and lyte tomorrow morning
     I I N R=
     INF I N R::
     I = e elettroliti domani mattina
     N and give the warfarin (.) five milligrams
     I dare [v]arfari:na↑ (.) cinque miligrammi↑
     N they want *decrease* his *furo:semide*
     I e >vogliono – < (.) svezzar – lo cinquanta la matti::na↑=
     INF
     I = ridurre la: il fuorosemi::de
     N °yes° (.) see↑ fifty in the morning
     I cinquanta di matti:na
     N >right< a:nd (.) twenty-*fi:ve* (.) and twenty-fi ve e venticinque
     I °yes that’s it° (.)
     INF =°yes yes° (.) oka::
     N °okay° (.)
     (V) E S tomorrow: (.) morning
     I poi c’è questo ((pointing at the item on the medical record)) domani mattina
     N ((reading from the medical record)) °a::ngio C T scan* (.) for a:
     INF una tac: °(doubtful) >what’s< that°< (.) I can’t even read it↑
     I ((getting closer to the US nurse)) non riesce a leggere
     N ((trying to read from the medical record)) agree:: with doctor (.)
     I something for an agree:: (. ) something with doctor (. ) (misreading the
     N name)) °Darti{ } (. ) I agree↑
     INF >cioè deve fare< una::
     I come da angio C T (scan) tomorrow°
     INF °okay°
     I °(yes that’s it)°
     INF °okay° (.) °(pointing at the exact spot)) °sometimes° when they go in
     N through here they don’t have to °but I don’t know°=
     INF
     I perché a volte quando entrano per di qua non serve
     N =we’ll have to find out
     INF
     I comunque
Appendix Six

N  ((ironically)) a:h a::h I’m here again tomorrow↑
   ((shaking her head)) ah no a::h no a::h God=
I  ((ironically)) lei sarà qui domani ((chuckle)) di nuovo domani
N  =not me tomorrow (.) it’ll be my last day I’m gonna bring – =
395  I  =domani è l’ultimo giorno
N  I’ll bring a bottle of wine tomorrow
I  porta una [ bottiglia di vino ((laugh)) ]
INF  questo potassio [ delle tredici l’ha dato↑
I  did you do the potassium at (.) [ one o’clock ]
400  N  but I have to –
INF  se lo firmerà l’ha fatto deve deve fare tutto
INF  okay
N  ((emphatically)) ( ) I haven’t got( ) to do anything
405  I  non ha avuto modo di fare:=
INF  =okay
N  okay
Appendix Six

NR.FL.09

Typology | End-of-shift nursing report (reported cases: 1)  
---|---
Place | ISMETT regular admission unit (Floor)  
Date | March 11, 2006  
Time | 7:04 a.m.  
Duration | 00:04:57  
Interpreter | Italo  
Primary speakers: Outgoing nurse, Italian (female, aged 26-30) INF  
Incoming nurse, US (female, aged 46-50) N  
Observers | Researcher  
Second researcher (EI)  
Situation | The two nurses are standing next to each other at the nurses’ station; the interpreter is standing between them. During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical record and patient Kardex.  
Language direction | Italian > English / (English > Italian)  
Prevailing mode | Short consecutive

((background voices))
N no way to get organized (in there) ((chuckle))
I >(difficile)< organizza::rsi ((embarrassed chuckle))
INF ehm lei ha tol – *lui* (.) ha tolto u:::n (.) ehm dei::: linfonodi
I so
5 I so he had=
INF (>right chest tube<
I =lymph nodes removed ((the LS mobile starts ringing; the Italian nurse mimics dancing )) scusate un attimo† ((Italo talks on the mobile and then hangs up)) °scusa sorry°
INF e:::hm (.) non ha avuto dol – ((louder background voices)) cioè ha av – ha dol – ha un po’ di dolore perché lui ha un right::: – just a little bit - of pain
I because he ha::s a::
INF >right chest tube<
15 I a right chest tube
INF to gravity
I °to gravity°
INF ehm però ha il tramadol in terapia
I and he also has *tramadol* (.) I on his therapy infatti l’ho fatto ] alle undici si è
addormentato non ha avuto problemi=
I =he had it at eleven (.) P M and he *slept* °and everything was fine°
INF in più ha il cero::tto:: il du:=
I =plus he also has
20 INF ((pause)) ((the Italian nurse looks at the Kardex))
INF ((pointing at the item on the Kardex)) il duragesic
((the interpreter looks at the US nurse to see whether she understands))
N °has what†° ((looking at the Kardex))
I ((pointing at the item on the Kardex)) this=
N =ah
>(duragesic)<
the one s –
she is showing to you↑
INF
((cough))
I
((chuckle))
INF
neur=
35
((to the interpreter)) that's ((pointing at the paperwork)) not very good
for the tape
((chuckle))
((chuckle))
INF
neurologico::: va be:::ne
I
neuro she is oka::y
40
INF
psicosociale v – va beniss:imo=
I
psycho
INF
orienta::to=
I
=socially very well (.) he is oriented
INF
ehm segni vita:li::
>vanno be:ne
vital signs:: are okay↑
I
INF
non ha edema
I
no edema↑
INF
ha u::n right hand numero venti↑
I
right hand number twenty
50
INF
^è::^ >ancorato con una serie di cerotti< perché (.) e –
*esce* praticamente
I
it’s secured with
N
mhm
I
some (. ) plasters
some=
>ho messo – <
INF
=bands (. ) “because it’s not very well placed (by) the::°
N
((nodding)) mhm
INF
polmonare e::hm=
I
pulmonary
INF
=s::tarebbe in room air
I
he is in room air
INF
=novantadue novantatré
I
saturation is ninety-two ninety-
three but he had a
nasal cannula for the night
N
*mhm okay okay° ((looking at the medical record)) °here is an
order°
INF
*chest tube* stanotte non ha dato nulla=
I
=chest tube (.) no drainage (.) last night
70
INF
*però* è caduto
I
but it fell
INF
e quindi praticamente=
I
=((whispering)) °it was misplaced°
INF
e::hm ci sono le quattro colonne che sono *riempite* una per uno
I
there are the four lines that a::re *filled* (.) the four lines – ((to the
Italian nurse)) le quattro colonne hai detto↑
INF
si=
I
=the four columns (.) that are (.) f – full
INF
perché si è riversato il liquido quindi sono un po’ °un po’ un po°=
80
N
=the doctor knows↑
I
e il dottore lo sa↑
INF no vabbè non c’è bisogno perché le ho segnate=
I it’s not necessary
INF =tutte quante c’è una linea nera però:
I but ^she:^ mar – she labelled it with a (.) u::h
*black* sign (.) °with a black marker↑°
INF >tutto quello che sale nella seconda colonna< è suo
I whatever it’s in – in the second column (.) ((the US nurse looks puzzled)) is yours (.)
N °does it make sense↑°
I 
N the patient fell (though)↑ °in my°=
I =°no no° the=
N =°no::h the tube fell out
I stiamo parlando del:: >tube<
INF °the tube °sorry<°
INF sì sì (^chuckle) ((ironically)) ((to the interpreter))
I °che c’entra lei dice (in poche parole)°
I °aveva capito che il paziente::°
N °it – °
I ma *non* completamente
INF *no:::^
I questo – il:: il drena:: cioè parli del tubo che::=
105 INF =il – *no* è caduto il – il:: water seal
I the water seal
INF sì è riversato quindi=
N °all right°=
INF °the liquid of the colonne=
110 I =it actually – (.) properly *spelt*
N °( )° (^chuckle)
I ((laugh))
INF ((chuckle)) e::hm è in regular diet=
I =he is on a regular diet
115 N >wait< I wanna go back to the chest tube=
I =aspetta un attimo:: vuole ritornare sul: >chest=
INF >tube<
INF >okay< (. ) so just the (.) the=
I quind –
N=*suction* the:: water seal=
I quind i soltanto::
N =part fell over↑↑ is that what you mean↑°
125 I la *parte* del water seal
INF sì sì solo la parte del water seal
N °all right°=
I =okay so (. ) only this chest tube in is fine
INF se vuole adesso lo andiamo a vedere
I sì
INF comunque il chest tube va:: bene
I sì sì sì=
N =sì sì ((chuckle))
I if you want she can show it [to you no that’s ] okay=
N =ah va bene=
140 INF =okay va bene
((pause)) ((the US nurse goes on writing her notes))
N okay [ ((laugh)) >I feel better< ] >è in regular diet<
I regular diet
INF ha il Foley
I Foley (.) [ ha urinato ] *mille* comunque=
I =and he voided (.) one thousand (.) °ten° (.) ten hundred
N he – he does have a Foley↑
150 INF °a posto°
I that’s it for him
INF domande↑
N >does he get out the bed<
160 INF °c’è stato salito ieri alle dieci dallo step-down°
I =actually (.) he came here at ten (.) P M from the step-down=
INF =m’hanno detto che (.) neurologicamene (.) °and she was told° she
INF cioè ha dormito a lui [ (con me) (.) and he slept ] basically (.) he slept °all night°
((pause)) ((the US nurse goes on writing her notes)) ((background voices))
N thank you=
INF =>okay<=
I =grazie
Appendix Six

NR.SDU.01

<table>
<thead>
<tr>
<th>Typology</th>
<th>End-of-shift nursing report (reported cases: 1 out of 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMETT step-down unit (SDU)</td>
</tr>
<tr>
<td>Date</td>
<td>January 21, 2006</td>
</tr>
<tr>
<td>Time</td>
<td>2:00 p.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:08:26</td>
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<tr>
<td>Interpreter</td>
<td>Eric  I</td>
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<tr>
<td>Primary speakers</td>
<td>Incoming nurse, Italian (female, aged 26-30) INF</td>
</tr>
<tr>
<td></td>
<td>Outgoing nurse, US (female, aged 21-25) N</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
</tr>
<tr>
<td></td>
<td>Second researcher (EI)</td>
</tr>
</tbody>
</table>

Situation

- The two nurses are sitting next to each other at the nurses’ station, while the interpreter is standing between them.
- During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the patient’s medical record.
- In the background there is the piercing sound of the monitors.

Language direction | English > Italian / (Italian > English) |

Prevailing mode | Short consecutive |

((background voices))

INF a long shift (. ) ago
N >long time ago< (.), okay so you know her history↑
INF °(yes)°

5 N ((embarrassed)) oh I’m sort of like – ((chuckle)) not ready ((chuckle))
INF okay ((chuckle))
N anyway ((chuckle)) (. aortic valve (. repair (. and then like ((overlapping voice of another nurse)) ( )
INF mhm↑

10 N ((overlapping voice of another nurse)) ( ) after complications
INF okay
N ((overlapping voices of other nurses)) ( ) months ago (.) okay ((the Italian nurse nodes)) (. u:h psychosocially she’s (.) anxious: she’s okay (.) unless: someone’s (. ) *bothering* her
INF >mhm<
N like her family (.) but oth – but otherwise she’s quiet (. ) she was sitting
at the side of bed today
INF >mhm<
N a::nd (.) no pain (.) she can move around (.) fine

20 INF okay (. he hav::e (. need (. P.R.N no[t]ing↑=
N =no;
INF °okay°
N uh (. ) she does sometimes have this headache ((touching her forehead with the right hand))=

25 INF =>mhm<
N and her eyes hurt (. ) which her (. ) mum said it’s chronic (. ) she’s had it
for years ‘cause she’s blind (. ) from one eye she’s blind ((the Italian nurse looks at the interpreter)) and then (. ) causes her to have a
headache and = (troubles)=

30 I è cieca
= (reading)
I è cieca in un occhio e questo le causa mal di testa: il mal di testa è per questo↑
35 I sì e anche dolore agli occhi (proprio°)
N so I mentioned it to the doctors (°but° no order for pain med when I asked)
INF °okay°
N u:h (°normal sinus rhythm=)
40 INF = > mhm<
N she has a left ((pointing at the left arm) A C twenty gauge (°with D five and W °at a: °fifteen M Ls °no blood return<
INF ((to the interpreter)) fifteen↑
I quindici
45 N u:h °no edema
°you said °fifteen° right↑
N °yeah° u:::h respiratory she’s trach-mask twenty-eight percent and five liters of °oxygen
INF ((to the interpreter)) [a]:↑
50 I ventotto per cento
INF mhm
I e l – e cinque litri di ossigeno
N she:: s:::uctions for °thick° yellow (°blood-tinemed s – secretions (°very thick)° °yuck
INF °you said °fifteen° right↑
N °yeah° u:::h respiratory she’s trach-mask twenty-eight percent and five liters of °oxygen
INF ((to the interpreter)) [a]:↑
55 INF °fifteen° right↑
N °not a lot^ each time but it’s just really °thick°
((the Italian nurse looks at the interpreter))
60 °okay°
N she’s rhonchorous throughout and diminished (°she has her (°
INF speaking valve on↑
N so she’s talking (°always) ((making the blah-blah gesture with her hand)) blah blah blah ((chuckle))
65 INF °okay°
N she:: (°G I she’s on °has frebusin original through her feeding tube (°at sixty M Ls °it’s with the – it’s:::
INF °okay°
N °mhm° and °with the –° °you know the (°°wat:er and –°°
INF °okay°
she ((mobile phone ringing)) also eats a pureed diet (.) but she eats (.) "small" babyfood (.) and doesn’t eat very much

((pause)) ((background voices))

she:: (.) >had a small bowel movement< overnight (.) she has her diaper on

((whispering)) "ha il pannolone ha avuto una piccola:: (   )°

((overlapping voice of another nurse))

active bowel sounds (.) she has the Foley↑ good urine output (.) Foley uh:: clear urine (.) she has ((announcement over the intercom; the Italian nurse moves closer to the US nurse to hear better)) a ulcer on her back (. ) a decubitus ulcer (.) stage two

INF two↑

((the US nurse nods))

and she has (.) on the back of her head like an *o::ld* ulcer (.) but it’s healed "very (   )°

((pause))

she needs to have a (.) transesophageal (.) echo (.) a T E E

un ec – ((to the US nurse)) echocardiogram↑

"transesophageal" un ecocardiogramma *transesofageo*

quando lo deve fare

when is that

I asked no one knows I’m assuming probably Monday↑

I ho chiesto ma nessuno lo sa=

N =she=

I =imma:ghino ( ) lunedi=

N =she was supposed to have it yesterday [ "they never"=

=dove –

I doveva farlo ieri ma [ non l'ha fatto

I =I asked the doctor ] today and he said wh – wh – whatever

I ho chiesto al medico oggi ma non – non mi ha dato una risposta precisa

N and then (.) and also an ultrasound of the (.) where the stent is and the (ureter)

INF mhm

she also needs that (.) to check (.) the T E E is to check her pro – sthetic valve (. ) ((the Italian nurse looks at the interpreter)) and then the (. ) ultrasound is to check her stent °and the (ureter)°

INF serve per controllare lo stent↑

la tac

because she:: they want to make sure that she’s fine ‘cause she will be transferred to a different hospital (. ) °this week sometime°

INF okay

°that’s i::t°

INF °there is order↑°

yes

((the US nurse takes the medical record; the two nurses look at the orders))

((reading from the medical record)) ismett two tomorrow and I N R

((pause))

((reading from the medical record)) warfarin >one point two five milligram< P O once

INF mhm
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N ((reading from the medical record)) start (. ) acetam – (. ) (lo::ma::zol)
uh I can’t say this ((pointing at the name of a drug on the medical
record)) (acetazolamol) (. ) (acetazolamol)↑ I don’t know how to say
this< ((soft chuckle)) (. ) A C E T (. ) >turn to fifty milligrams P O< Q
140
INF eight
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
145
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
150
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
155
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
160
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
165
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
170
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
175
(.) feeding pump can you↑
INF >mhm<
N ((reading from the medical record)) start (pola) – (polas) – B (M) two
drops T I D (. ) ((overlapping voice of another nurse)) °D C normal
saline° (. ) ((no longer reading)) you can increase the free water on that
180
(.) feeding pump can you↑
INF >mhm<
NR.SDU.02

Typology  End-of-shift nursing report (reported cases: 2)
Place  ISMETT step-down unit (SDU)
Date  January 23, 2006
Time  7:00 a.m.
Duration  00:08:43
Interpreter  Georgia I
Primary speakers  Outgoing nurse, Italian (male, aged 21-25) INF
Incoming nurse, US (female, aged 41-45) N
Observers  Researcher
Second researcher (SO)

Situation  
- The US nurse is sitting at the nurses’ station, with the interpreter at her side. The Italian nurse is standing in front of them.
- During the interaction the Italian nurse reads from his notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets.

Language direction  Italian > English / (English > Italian)
Prevailing mode  Short consecutive

N  ((grabbing the tape recorder and singing)) [ ((laugh))
I  [ ((laugh))
INF  ((soft chuckle)) allora iniziamo
5 N  [ ((pointing at the tape recorder)) >is that on ] yet↑<
((the interpreter checks whether the tape recorder is on))
I  yes it is↑ [ ((wholehearted laugh))
INF  ((chuckle)) >“allora”< ehm iniziamo con *{Poletto} {*Patrizia}
10 I  °we’re starting° with {Poletto} {Patrizia}
INF  °okay°
N  {Poletto} {Patrizia} si trova alla stanza {quattrocento}
{undici}
I  [ ((whispering)) °she’s in ° room °four hundred° °(squeaking noise))
15 °{eleven}°
INF  letto {tre}
I  bed {three}
INF  non ha allergie la signora
I  ((whispering)) °she does not have allergies°
20 INF  il {quindici} {dicembre}
I  ((whispering)) °on °December °fifteenth°
INF  ha fatto il trapianto: di fegato=
I  =((whispering)) °liver transplant°
INF  da donatore vivente
25 I  ((whispering)) °it was a living related liver transplant°=
INF  °mhm° la signora era affetta da cirrosi alcolica
I  ((whispering)) °she – alcoholic – she’s affected by alcohol-related cirrhosis°
((pause))
Appendix Six

30 INF psychological [(whispering)] okay=
I =è orientata
INF [(whispering)] she is okay psychologically he thinks she is oriented
INF neurological *out of bed* infatti si è alzata pure
I she’s out of bed↑
INF è andata in bagno
I she got into the bathroom
INF [(whispering)] andata in bagno° per quanto riguarda il dolo:re↑
I as far as pain is concerned=
INF =ehm non ha avuto dolore (. ) con me
I she: has not complained of any pain with me
INF cardiovascular ehm la signora è:
I [(whispering)] C°=
INF =è in normal sinus rhythm
I she is in normal sinus rhythm
INF c’ha un left antecubital (. ) numero venti (. ) come accesso
I [(whispering)] number twenty°
50 INF c’ha il ritorno venoso†
I there’s a blood return
INF non sta facendo infusioni
I [(whispering)] no infusions running at the moment°
INF non c’ha edema
55 I [(whispering)] no edemas°
INF le pressioni sono buone
I [(whispering)] the pressur – the blood pressures are good°
INF ha una frequenza cardiaca che si mantiene tra i cinquanta=
I [(whispering)] °her heartbeat°
INF =e i sessanta [(whispering)] °is between fifty °per minute°
60 INF pulmonary [(whispering)] °pulmonary°
I è in room air=
INF =la signora (. ) la saturazione è adeguata†
I [(whispering)] °the saturation is fine°
INF gastrointestinal è in soft diet
I [(whispering)] °G I° (. ) °soft diet°
70 INF con me non ha evacuato
I [(whispering)] °no bowel movements with me°
INF i suoni sono attivi però
I attivi†
((the Italian nurse nods))
75 INF *active* bowel sounds
INF genitourinario:↑ (. ) voids urina:=
I =[(whispering)] °she voids spontaneously°=
INF =°tranquillamente° (. ) è andata in bagno l’ho accompagnata in bagno io sta – stanotte a fare:: >pipì<
80 I [(whispering)] °during the night° she – he actually helped her out of bed and brought to the bathroom she did void°
INF per quanto riguarda gastrointestinal*
as far as the GI system is concerned

there’re two J Ps in the right upper quadrant (.) Jackson-Pratt *A*

there’re two Jackson-Pratt A° ( )° right upper quadrant°

ha drenato poco ( )° it drained very° = po:co°

there’re two J Ps in the right upper quadrant ( )° Jackson-Pratt *A*

it drained very°

ha drenato poco ( )° it drained very° = po:co°

on the left ° upper ° ( )°

the latter drained more eightish°

=° little°

mentre a sinistra°

° ( )°

B Jackson-Pratt *B* ha drenato di più

the latter drained more eightish°

=° (okay)°

and then he emptied out the ° bag°

poi integumentary° l’incisione:=

° integumentary°

> abdominal incision<

“Did you tape me singing?”; inaudible question))

you *are* actually ° on this=

la signora

((to the interpreter)) eh°

((chuckle)) you are° on this

la signora = (chuckle))

((chuckle))

il suo canto di prima è sulla registrazione = (chuckle))°

non è diabetica però ha i controlli della:

she’s not a diabetic ° patient=

della glicemia

but we have to check her blood sugar levels

((the Italian nurse looks at the medical record))

okay (. )° passia:mo adesso° (. )° (looking at his notes)) a {Pampinato}

insulina ne prende°

>come°<

insulina ne prende°

° c’ha una scala se non mi sbaglio° ( looking at the Kardex))

° vediamo° < ° si < ha una scala

° the lady has a scale° of insulin
INF ha una scala
I ((looking at the Kardex)) che scala è ↑ medium <

((child crying in the distance))
INF medium (. ) le sp – le spunta in automatico appena::<

140 ((pause)) ((background voices and sounds))
N is she on tramadol::
I preponde tramadol↑
N °( )°
INF al bisogno però

145 I al bisogno↑ he says (at) P R N
((child crying in the distance))
N ((looking at the medical record)) °yeah yeah° (. ) °yeah yeah okay° (. )
((closing the medical record)) >°(ready)↑°<
I va be::ne

150 INF allo::ra ( . ) passiamo al signor {Pampinato} {Pancrazio}
I mister *{Pampinato} *=
INF =ehm hai visto gli ordini [ ( ) ] see the orders did you find any
questions↑

155 N °no no°
INF okay >allora< {Pampinato} {Pancrazio}↑ si trova alla stanza
{quattordici} [ {quattordici}]
I [ ((whispering)) °he is in room ] {four fourteen}°

160 INF letto {uno}
I bed {one}↑
INF non ha allergie
I no known allergies
INF ehm si è ricoverato:: il {dieci}
I ha fatto un trapianto di fegato

165 I [ ((whispering)) °admitted on the {tenth} ] he too had a liver transplant
INF [ ( ) ° ] H C V positivo
I H C V positive
INF ps[i]chological (. ) okay (. ) °tranquillo°

170 I ((whispering)) °he’s a tranquil patient°=
INF °nhm° neurological (. ) è out of bed cioè ieri (. ) ha detto che è stato
*fuori* dal letto però con *me:* è stato::
I he was told ° the patient was out of bed yesterday but=°
INF cioè n – nel mio tu:rno è stato a letto lui

175 I =during his shift for – for all the time he was in bed
INF >è stato a letto< ehm questa notte ha avuto dolore↑
I he complained of pain during the night [ (clears throat) ] ho fatto il
INF e gli tramadol=

180 I =gave him tramadol=
INF =tramadol cento milligrammi I V
I one hundred milligrams I V
INF [ ogni otto ore
I Q eight hours

185 INF [ ce l’ha al bisogno
I come↑
INF al bisogno [ °l’ha fatto° ogni=
I ce l’ha al bisogno↑
INF =otto ore
190 I he’s got it – it as per *need* >but he does have it scheduled every eight hours<
INF cardiovascular normal s[i]nus r[h]t[m] (.) afebrile
I afebrile
INF ha una right internal jugular tre lumi
195 I triple lumen
INF e non sta facendo infusioni
I ((whispering)) *no infusions at the moment*
INF p[l]monary due litri nasocannula↑
I ((whispering)) *two litres nasal cannula >as far as pulmonary is concerned<*
200 INF e la saturazione è:: buona
I good saturation
INF gastrointestinal è in soft G I (.) soft diet °( )↑°
205 N °okay°
INF no bowel movement (.) i suoni so – ci so:no sono [ ] [presenti ] bowel
I sounds
INF però ancora non ha: neanche:: (.) buttato aria
210 I but he did – ((to the Italian nurse)) no↑
INF no no per niente
I no flatus yet
INF °no° (.) °perfe:tt° è diabetico il *signore* I °he is* a diabetic patient
215 INF ha il controllo della glicemia↑
I blood sugar=
INF =schedulato↑
I accu-chek is scheduled
INF e anche una scala
220 I and he too has a scale
INF °d’insulina°
I ((whispering)) °an insulin scale°
INF mhm (.) dopo di che per quanto riguarda genitourinario (.) lui:: *non ha* il Foley [ e urina=
225 I °no Foley
INF =tranquillamente nel pappagallo ] (.) in the urinal
I he voids in (.)
INF °qua abbiamo finito° (allora) (.) sempre in gastrointestinal I one – one more thing (as for) the G I system
230 INF gastrointestinal (.) right upper quadrant (.) ha due Jackson-Pratt A e B s[i][e][r][os][a][nguin(o)s] [che hanno drenato s[i][e][r][o][s][a][nguin(o)s] ] °A* I °he’s got a Jackson-Pratt
and °B° and both in the right upper quadrant and both draining serosanguineous (.) ((to the Italian nurse)) tutt’e due stanno drenando
235 sierosanguinoso↑
INF si [ ] [yes ] both of them
I INF poi c’è un altro Jackson-Pra – Pratt in left upper quadrant [che è *C*] I °a third J P
240 INF [s[i][e][r][o][s][a][nguin(o)s]=
I °letter C
INF =°sempre°
I in the (.) *left* upper quadrant serosanguineous drainage as well
INF integumentary c’ha l’incisione addominal:le

245 ((pause)) ((the interpreter makes gestures to the Italian nurse indicating that he should not keep eye contact with her but rather with the US nurse))
INF ((to the interpreter)) >perché devo guardare lei†<
I perché non stai parlando=
INF =oh=
250 I =con me
INF ((looking at the US nurse)) integumentary:: there is a:: –
I "an incision" ((chuckle)) he said why do I have to look at her
INF >cause you’re not talking to me< changed (. ) okay† ((chuckle))
N >okay<
INF ((chuckle)) okay ((to the interpreter)) giusto↑
I beautiful
INF ehm e poi:: e basta e nient’altro (.) che ho cambiato °(durante la
notte)°=
I =nothing else I haven’t changed anything else that I haven’t told you
already
N °okay°
((background voices))
260 INF °ordini non ci sono ordini°
N °( )°
I ho fatto i prelie::vi
I c’è da fare i preliev – ah li hai fatti
he did the ( ) (blood) ismett one
270 INF ((chuckle)) ismett uno e l’F K
I =and F K level
INF °li ho fatti i prelievi°
I he’s already ( )
N °(looking at the medical record)) >°( ) A B G ( °<
275 I ((to the US nurse)) eh↑
N >(I saw) the A B G  Q two hours< ((chuckle)) (I was like) >(thanks
ah)<=
I =mhm mhm
N °( ) that one (I guess they just didn’t erase them)°<
280 I mhm mhm >quelle cose< (.) semplicemente non sono state cancella:te
quelle dell’A B G ogni due ore
INF °si si°
I okay yes “it is they didn’t erase it but ( ) not ( ) it every two hours° (.)
((to the Italian nurse)) in ambedue c’è ancora scritto A B G  Q due ore
285 INF °non penso°
I infatti anche lei ha detto non penso >proprio< ((chuckle))
N ((pointing at an item on the medical record)) "that was done right°
I ((pointing at the item on the medical record)) questo è stato fatto no↑
INF ((looking at the medical record)) si si ▲ sì sì sì
290 I °( )°
INF sì si ((cough))
((pausa)) ((child crying in the distance)) ((the two nurses look at the medical record))
INF ((looking at the medical record)) ah il maalox è vero ((chuckle))

295 I ^the maalox^
INF ((chuckle))
N was he complaining of like uh (.) reflux↑ or something
I e::hm il maalox perché >si lamentava di qualche cosa<
del reflusso
300 INF ] aveva un po’di::: ] sì sì po – ma poco
I yeah [ >a little bit< ]
INF *bruciore* perché aveva bruciore=
I =>heartburn< (.) va bene↑
N °(   )°
305 I questions↑
N nope
I a posto
INF a posto↑
I va bene
NR.ICU.01

**Typology**  
End-of-shift nursing report (reported cases: 1 out of 2)

**Place**  
ISMETT intensive care unit (ICU)

**Date**  
January 23, 2006

**Time**  
2:00 p.m.

**Duration**  
00:09:36

**Interpreter**  
Francesca I

**Primary speakers**  
Incoming nurse, Italian (male, aged 26-30) INF

Outgoing nurse, US (female, aged 26-30) N

**Observers**  
Researcher

Second researcher (EI)

**Situation**  
- The two nurses are sitting next to each other at the nurses’ station in front of a monitor viewing the patients’ electronic medical records, while the interpreter is sitting between them.
- During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical record of the patient, both on paper and in electronic format.
- Although report is given for two patients, the transcribed recording only concerns the second one.

**Language direction**  
English > Italian / (Italian > English)

**Prevailing mode**  
Short consecutive

---

```
N  all right (. ) now (. ) ^this^ lady (. ) *{Pritti}]*
INF  >{Pritti}<=
I  =un’altra signora↑ ((to the US nurse)) it’s another one
INF  sì due
5  I  *{Pritti}*
N  uh (. ) she:: (. ) came in:: (. ) °when did she come in° ((looking at her
INF  notes))  "I don’t know°
I  che ha fatto↑
INF  what did she have
10  N  she got the tips
I  ha fatto una tips
INF  m:hm
N  u::h (. ) and right now they’re just (. ) we are just – kind of letting her
15  I  si sta stabilizzando ha fatto la tips poi ha sanguinato:↑
INF  è li↑ ((pointing at the patient’s room)) la signora::
I  where is she
N  here at {four four two}↑
INF  yes=
20  I  ={quattrocentoquarantadue}↑
INF  °si°
N  °yeah°
((pause))
N  uh=
```
Appendix Six

25 INF =ha fatto la tips per: quale problema al fegato:: [un tumore:: why did she have ]
I this tips did she have a tumour or what
N I don’t know why she needed it=
INF =(mhmm)°
30 I non lo sa=
N =“honestly°
INF il – è in:: [onestamente° does she have hepatitis↑
I (ironically)) ^they didn’t tell me^ so [ but I would assume so ] *però*
N ((ironically)) ^they didn’t tell me^ so but I would assume so
I è po – è possibile
INF quando è stato ammessa qua in I C U↑
I when did she come in the I C U
N ((looking at the electronic medical record)) °a couple of days ago::°
40 [ ^report^ >was like – <=
I un paio di giorni fa
N =pretty vague (.) this morning
I ehm le consegne sono state un po’ vaghe stamattina
INF mhm
45 N so ((reading from the electronic medical record)) she had Budd Chiari
that’s what °it was°
I what does she have↑
N Bu:dd (. ) *Chia:::ri:*^I
I ((doubtful)) il B[a]dd Chiari↑
45 INF °cos’è↑°
I [ what is it
N >with the< uh (.) portal hypertension:n:::
I iper – ipertensione portale↑=
INF =“ah^ (.) >molto probabilmente ha avut – < può – [d:arsi che::=
50 INF =vabbè ora la – [ la cerco io la (notizia) probabilmente ci sarà stato=
N INF o un [ K^] °B[a][l]^ Chiari
50 INF °Budd Chiari::°
((pause)) ((background voices))
INF e:::h (.) >si sì < (.) >“ho capito<
N okay↑
INF °si°
65 I he knows what it is
N okay then ((laugh)) take it easy honey
I meglio
N uh (.) neuro (.) drowsy but arousable↑
I ehm neurologicamente è un po’ intontita
70 N intact↑
I però intatta
N u::h (.) follows all commands↑
I segue i comandi
N there’s nothing to °(add)° really °u::h °niente° altro più o meno::
75 N normal s – low sinu – normal sinus rhythm to sinus tach °low sinus
tach°=
I =va da: ritmo sinusale normale a leggera tachicardia
N u:h blood pressure’s been stable around one thirty↑
80 I pressione stabile circa centotrenta
N they want to keep her C V P: around: *ten*
I >vogliono tenere la C V P circa dieci (. ) circa
N ((looking at the electronic medical record)) they wrote – you can bolus her (. ) u:h (. ) it doesn’t say (. ) if – give albumin five per cent or normal saline so I guess ┌ five hundred┐
I caso ma:i le puoi fare un bolo
INF se scende al di sotto di dieci↑ al cinque per cento< ((to the US nurse)) if it goes:: what *below:* (. ) ten↑
N >they want it around< ten °so::°
I la vorrebbero mantenere a dieci
INF °mhm°
N >she’s< (. ) usually between nine and twelve °so::°
95 I generalmente tra nove e dodici dovrebbe stare
((brief interruption: another Italian nurse addresses his Italian colleague, while two anaesthesiologists ask the US nurse for information on the PO lactulose administered to the patient)) ((the two physicians leave))
N u::h
100 ((background voices))
INF ((to the Italian colleague)) °( .)°
N ((slightly annoyed)) lines
INF ((to the Italian colleague)) °( .)° °( )° ((chuckle))=
I linee
105 INF =((chuckle))
((the Italian colleague leaves))
N (she has the) right I J triple↑
I ha l:::a J destro triplo lume↑
N uh (. ) left E J number sixteen gauge↑
110 I un ^*E*^ J (. ) ((background voices)) numero sedici↑
N uh right antecubital (. ) angiocath sixteen °gauge°
I angiocatetere sedici (. ) ante – a:nte:cubitale destro↑ ((chuckle))
N ((laughing)) and right femoral art line
INF ((laughing)) ( .)
115 I and what↑ ((chuckle))
N right femoral art line
I ah e pure una::: arteria femorale destra
N okay (. ) u::h=
INF =ci sono ordini di gas: e::hm visto che magari forse ha sanguinato ]
120 I are blood gases:: orders::
N I know they were – (. ) u:h drawing blood gases like every *three* four hours
I so che hanno fatto prelievi per l’emogas ogni tre quattro ore
125 N uh (. ) I haven’t had time to do one since nine
I però dalle nove lei non ha avuto il tempo di farlo
N been to busy so: just – =
I =ha avuto troppa cose da fare
INF °mhm°=
130 N =there is no like written order though °so::°
Appendix Six

I però non c’è scritto niente
INF °okay° e:: sa se durante la procedura lei ha sang – ehm la signora ha
sanguinato↑
I did she bleed during the procedure↑ [°do you know°]<
-INF believe so::
I credo di sì
N uh her (.) *crit* is hanging around twenty-two now and °they are okay
with that°
I [the creati::ne↑ 135
N crit – uh (.) °hema – ° *hema*tocrit=
I =l’ematocrito è stato:: ((to the US nurse)) around↑
N twenty-two
I circa ventidue
N so::
140 INF °mhmm°
N they’re okay with that u::h
I quindi dovrebbe andar be::ne
N I don’t know how low her crit ever actually went
I non so quanto è sceso
145 INF °(just)°< it looks okay
I perché fin qua è tutto a posto
((pause)) ((background voices)) ((in the distance, an ICU physician is scolding
a nurse))
INF °okay°
150 N yeah (. ) uh (. ) so anyway (. ) °what else can I tell you↑°
((pause))
INF ((to the interpreter)) °no non lo so°
155 N uh (. ) ((whispering to the Italian nurse)) ( ) così tanto il dottore {Darso}↑
I =quindi l’ultimo che lei ha fatto è stato alle nove e mezza::
INF °(amused)° that’s what=
160 N nine
I si verso le nove=
INF °mhmm°
((pause)) ((background voices)) ((in the distance, the ICU physician who is
scolding a nurse keeps repeating the word ‘cannula’))
INF ((tapping her pencil on the board)) sta
165 =nasocannula due litri
N uh (. ) °two liters° nasal cannula (laugh)↑
I nasocannula due litri
N lungs are clear
170 N =( ) trying to ( (chuckle))
I polmoni chia::ri
INF that’s the only °(case)°
175 N no cough no secretion
I non ha tosse né secrezioni
INF (tapping her pencil on the board)) no cough no secretion
180 N u:h (. ) that’s it really G I she is °(amused)° ((leaning out of his chair to see the electronic medical record)) sta
facendo una D.fiv:e a:: quaranta M L ora↑
N =suoni polmonari chia:ri
I =quindi può
N tried to ( (chuckle))
I polmoni chia::ri
N u:h=
I =suoni polmonari chia:ri
INF (tapping her pencil on the board)) no cough no secretion
I non ha tosse né secrezioni
N u:h (. ) that’s it really G I she is °(amused)° ((leaning out of his chair to see the electronic medical record)) sta
facendo una D.fiv:e a:: quaranta M L ora↑
I
I u::h is she::=
N ="yes"=
I =having a D five forty M L per hour↑
N yes
I si
INF ci vedo bene allora ((pointing at the monitor))
190 I so: it means I can see that well
INF ((straightening himself on the chair and taking off his glasses)) °cosi
non:: non vedo niente cosi°=
N ="good eyes good eyes"=
I >buon – < hai una buona vista
195 INF ((soft chuckle))
N u::h=
I =occhio di lince
((the Italian nurse puts his glasses back on))
N °what else° other than – then they ordered en – lactulose enemas
200 INF =((looking at the medical record))📆>°(I don’t know how much)°<
I hanno
N =°good eyes good eyes°=
INF =((disgusted)) oh::: oh:::=
N =ah=
205 INF =((ironically)) °buon::: co:me↑[ col parmigiano]↑
N too much lactulose
INF =((ironically)) >scaglie di parmigiano?<
I can we put (...) some Parmesan cheese on top↑
N ((chuckle)) ((ironically)) stop i::t ((chuckle)) (...) u::h (...) ((ironically
210 annoyed, tapping her pencil on the board)) I just want to go *home*
Gian – °(   )° ((laugh))
INF °che ha detto°=
N =I’m so::rry
I ((to the Italian nurse)) hurry up
215 N u::h=
INF °che ha detto°=
N che se ne vuole andare a casa
INF [ okay=
I che è stanca
220 INF =si (. ) gli dici che mi saluta a {Nancy} quando::
I yeah please say hallo to {Nancy} when you hear from her
N ((doubtful)) (Nancy:::)↑
INF {Nadine} (. ) >°{Nancy}<
I ((doubtful)) {Nancy} o {Nadine}↑
225 INF ((laughing)) no::: [ io a=
N which one
INF ={Nadine} la chiamo {Nancy}
I oh [ that’s {Nadine}]
INF e si incazza >°(ogni volta)< ((chuckle))
230 I but he calls her {Nancy} (. ) and she gets upset
INF °((ironically)) ^I know why^
INF ((chuckle))
I ah lo so perché
235 INF ((wholehearted laugh))
N I know why Gi[ɔɔ ɔɔ]n (Ivo::) ((with a heavy US accent))
I ((mimicking the accent of the US nurse)) Gi[ɔɔ ɔɔ]n (Ivo::)
INF ((wholehearted laugh))
INF John Wayne John Way::ne ((laugh))

240 ((all laugh))
INF oka::y da::i basta
N >wait< ((tapping her pencil on the board)) Foley she was on a lasix drip
INF mhm
I e::hm ha preso il las:ix ha il Foley
INF twenty milligrams↑
N I don’t know it was yesterday before I was here (.) °(   )°
I lei arrivasse
INF mhm
245 I °quindi° non lo sa
N they D – D Ced that
INF >mhms<
I l’hanno ehm::: (. ) interro:tto
N so:=
250 INF ((ironically)) yes↑
N =now her – she’s also (. ) *o: li:gu:ric*
INF mhm
I e quindi è anche questa: (. ) *oligurica*
INF oh:::
255 N so:: (. ) I don’t know what they want to do with that
I non so che cosa hanno intenzione di fare con questo
INF mhm
N and they wrote to D C (. ) the (. ) peripheral line↑
I hanno anche scritto di staccare le linee periferiche
260 N and I didn’t do it
I però lei non l’ha fatto ((smiling))
INF °mhms°
N ((ironically)) so just deal with it during ( ) ((smiling))
I ((ironically)) quasi lo farai tu ((smiling))
INF non c’è problema guarda
((all laugh)) ((background noises of ICU monitors))
N uh (. ) °that’s it° – any questions
INF ((amazed)) le linee periferiche↑
I domande↑ (. ) ((to the US nurse)) peripheral lines which ones
265 INF ((the two nurses take the medical record and look at the orders))
INF o::h e::: chi è il: suo medico >{Denis}↑<
I who’s::: his doctor (. ) *her* doctor
INF {Denis}↑
I {Denis}↑
270 N he’s today
I e::h↑
N *he is* today (. ) *to::day* (. ) ^I^ – I don’t know (. ) I don’t know
{Dan} – {Damiani} (. ) is that – (. ) hepatologist right↑=
INF =no il medico che l’ha seguita qua in I C U {Denis} forse=
275 INF =uh who followed her in the I C U {Denis}↑
N today yeah ((nodding))
INF "okay va bene"
I si oggi si
INF e anche {Parlato}↑

290 I also mister {Parlato}↑
N {Darso} was here with –
INF mhm
N {Denis} was – and {Daniela}
INF "okay okay"

295 N okay
INF okay
N they were all here
I {Darso} {Denis} e {Daniela}
INF perfetto

300 ((pause)) ((the Italian nurse goes on reading the medical record))
INF ((closing the medical record)) va bene okay
N okay (.) ((relieved)) thank goodness
I grazie al cielo abbiamo finito
INF ((chuckle))
NR.ICU.02

**Typology**  End-of-shift nursing report (reported cases: 1 out of 2)

**Place**  ISMETT intensive care unit (ICU)

**Date**  March 16, 2006

**Time**  9:00 p.m.

**Duration**  00:07:55

**Interpreter**  Henry I

**Primary speakers**  
- Incoming nurse, Italian (female, aged 26-30) INF
- Outgoing nurse, US (female, aged 26-30) N

**Observers**  
- Researcher
- Second researcher (SO)

**Situation**  
- The two nurses are sitting next to each other at the nurses’ station in front of a monitor viewing the patients’ electronic medical records, while the interpreter is standing between them.
- During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the patient’s medical record, both on paper and in electronic format, as well as the Kardex.

**Language direction**  English > Italian / (Italian > English)

**Prevailing mode**  Short consecutive

```
((background voices))
N  "let’s start with her" ((pointing at the patient’s room))
I  cominciamo da:: ["lei ((pointing at the patient’s room))"] {Pontardi}

5  "okay" ((the Italian nurse starts writing down her notes))
N  uh twenty years old
I  vent’anni
N  allergic to: (.) pollen and dust

10 I  allergica alla polvere e al polline
N  >O positive<
I  O positivo
N  uh has malig – malignant cancer
((the LS mobile starts ringing))

15 I  ha un tumore maligno (.) ((answering the mobile)) scusa::te
((the interpreter talks on the phone with another US nurse requiring the interpreting service and then hangs up)) ((background voices))
N  "uh:::
INF  ((reading from the Kardex)) °adrenalectomi::a°

20 N  adrenal gland °( )°
I  ( ) la:: ghiandola::
INF  ((to the interpreter)) adrenalectomi::a=
I  =>mhm<
INF  si traduce adrenalectomia↓

25 I  I guess so (.) suppongo ((chuckle))
N  metastas(e)s in=
I  =c’è una metastasi
N  the:: uh left kidney↓
```
I: rene sinistro
30 N: and liver
I: sorry↑
N: and also to the liver
I: e anche al fegato
N: "it's spreading?"
35 I: si sta diffondendo
INF: okay
N: so they resected the left kidney
I: le hanno fatto una resezione del: e::hm rene sinistro
N: >okay< and she was brought here due giorni fa
((brief interruption; an anaesthesiologist gives the Italian nurse some instructions concerning another patient; the recording is interrupted and then resumed))
N: they resected the left kidney (so she’s) (   )
INF: =>del rene sinistro<
I: del rene sinistro
N: neurologically she’s:
I: >neurologico<
50 N: alert and oriented=
I: è all’er –
N: =times three
I: orientato (.) per tre
N: u:h (.) she has an epidural
55 I: ha un epidurale
N: with ((pointing at an item on the electronic medical record)) "I can’t say this (ever)" ((chuckle))
I: ((reading from the medical record)) con la:: bibucaina
N: and that goes at eight millilitres an hour
60 I: a otto millilitri: all’ora
N: complaining of pain
I: si lamenta:: di dolore
N: a little bit moderate pain in the: incision
I: e nell’incisione
65 N: uh cardiac (.) she *was* in normal [ sinus:
I: cardiovascolare:: ] n – era::
>normal sinus rhythm<
N: normal (.) sinus (.) tachy but after=
I: =a=
70 N: =they placed a picc line
I: >ma dopo che hanno messo la li – la picc line<
N: left arm
I: nel braccio sinistro
N: shortly after went to A fib
75 I: è andato in:: *(ha fatto in)* *fibrillazione* atriale (.) >poco dopo<
N: rate has been about one te::n↑
I: la frequenza è stata (.) centodie::ci=
N: =one ten to one thirties
I: centotrenta↑
80 INF: °okay°
u:h (.). her potassium has been low::: all day: il potassio è stato un po’ basso
tutto il giorno↑

because >I’ll get to it later< but she’s putting a lot of (.). NG drainage

that’s probably where she is losing her potassium<

ed è:: probabilmente è da lì che:::

perde=

u:h =tutto il potassio

so they gave her a lot of potassium during the day (. and the night↑

and I got a P R N order↑ (. for potassium↑

I e c’è un ordine *P R N* (. sempre per il potassio

and I gave – when I checked it it was three point zero and I gave sixty↑

I era: tre punto zero quando l’ha controllato: e gl – (gliene) ha dato

sessanta↑

and I rechecked it at eight o’clock (. and it was: three point=

l’ha controllato alle venti

=six (. I gave her twenty

era: a tre punto sei quindi le ha dato venti

and it just finished so:: if she wants (. to check sometime later

è appena finito quindi magari

più tardi: controlla

u:h she also got magnesium this:: (. during the day she got

three::: grams

ha fatto: magnesio: circa tre grammi durante il giorno=

and at like six P M  I gave her another two grams when she

was in A fib<

e verso le s::ei le ha dato altri (. ((to the US nurse)) >two grams

you said↑<=

=>*two* grams<=

=du – due grammi ed era in fibrillazione atriale

INF =è *ancora* (. in fibrillazione atriale↑

so she’s still in A fib↑

((nodding)) and I told them (. she’s still in A fib (. (. >they<

ha

informato i medici

they wanted me to do an E K G which I did and I showed the doctor

le hanno detto di fare un E K G e l’ha fatto↑ l’hanno fatto vedere al

medico↑

and she looked at it and (. walked away she didn’t say anything to do

INF ^=va bene^

u:h (.). blood pressure has been stable

la pressione è stata: stabile

she had a lot of lines that I D Ced

aveva parecchie::. (. l:inee che lei ha fatto il D C
Appendix Six

135 N radial
I aveva la linea radiale (.) D Ced
INF °okay°
N uh right I J triple D Ced
I right I J tre lumi °D.C.°
140 N two peripherals D Ced
I [due – ] [vabbè – ] adesso ((chuckle))
INF ^due accessi periferici^
INF adesso solo il left wrist °so just° [the picc line
so what does she have↑
I N just the picc=
I =ha soltanto l:::a la picc line
N after they put the picc in we removed the
I triple lumen
145 I dopo che hanno – prima – >ehm< dopo che hanno messo la picc hanno tolto la: i tre lumi
INF °va bene°=
N =blood return is good (. ) °in the picc°
150 INF il ritorno:: va bene
N X-ray was done and it’s ( )
I radiografia fa::ttto
N uh (. ) D five (. ) water at twenty C C$s↑
I D five water a venti C C
155 N electrolitic at sixty↑
I elettrolitica a: sessanta↑
N she was:: on a:: >I’m sorry for the blood pressure norepinephrine a couple of days ago (it) was stopped<
I sta facendo una – per la pressio::ne la: neuro::pinefrina qualche giorno
160 N fa ma ora –
INF °okay°
N u::h=
I =non più
N no edema
165 I [niente e: demi ] pulmonary [ehm=
I polmonare
N =uh equally clear
I sono:: chiari:↑ (. ) da entrambi i lati
170 N room air
I è su room air↑
N saturation is good
I la saturazione va bene
N >ninety-eight to a hundred<
175 N extubated yesterday
I è stata estubata ieri
N G I [u:h belly= gastrointestinale
I
180 N =is not distended
I non è disteso:::
very tender
molt te – e::hm molle

is she –

I changed the:: the – canister↑ ((to the interpreter) >is that how you
call it here↑<

((nodding)) ha – ha cambiato il: contenitore↑
twice – because
due volte

=she keep – she can drink water and she drinks

perché può bere ac – qua

continuously and it just

(.) drains ((chuckle))
e quindi continua a drenare in continuazione °pure°
so I] – it – (. ) I marked like a litre that I °took out°

ha segnato un

li::tro↑=

va bene°

it’s filling up again but °( . )° ((chuckle))
e si sta riempiendo di nuovo

°okay°

J P times two [ A and B ]

siero:so tutti e due↑

serous (. ) both

siero:so due volte↑

emptied once for a – [ during my shift °for a hundred° ] durante il suo:

ha svuotato: una volta

a hundred↑

cento

a hundred (. )=
=questo (. ) flexi-seal;↑

flexi-seal uh=

=what’s that↑

it’s a:=

=(reading from the medical record)) ((amazed)) rectal tube↑

>rectal tube< (. ) >I hate it< ((chuckle))

io odia ((chuckle))

°okay°

because it leaks continuously

perché *perde* in continuazione

it’s – I’ve probably changed it like (. ) four times °l’avrà cambiata°
quattro volte

°okay°

and I – I put more water in it↑

e ha messo più acqua

mhm

and it still is leaking so:
I ma continua a perdere comunque

240 N it’s just continuous there’s just a little bit the pad is a little bit dirty not – she’s not – =
I =la:::=
N =it’s just wet
I lei non è sporca è un po’ un po’ bagnata [ la::: because it’s – ] it’s

245 N continuous [ ((chuckle)) ]
I
N °so:: u::h° it – (.) and she’s putting out for me:: two hundred my shift
I ha fatto duecento durante il suo turno

250 N liquid brown [ (.) diarre:a:: (.) marrone liquido
I il Foley:: e::hm [ eighty ] to a hundred (. )° da ottanta ] a cento
I
N clear yellow
I giallo::=
INF =°okay°=
I chiaro

260 N ( (taking the medical record) ) the only orders was=
I =gli unici ordini
((the two nurses look at the medical record))
N potassium
INF sono quelli per il potassio

265 N P R N
I P R N
I il magnesio
N and then this ((pointing at an item on the medical record) ) was:: during
rounds
I e poi questi sono gli ordini:: durante::
N ((reading from the medical record) ) ismett one=
I =il giro
((reading from the medical record) ) uh respiratory consult (. ) (at) – (. )
((no longer reading) ) u::h they did this for the: u::h=
I =hanno fatto::=

270 N =for the J P (.) =°once= N ((reading from the medical record) ) ( ) P T consult (no longer
I per il J P °( )°
((reading from the medical record) ) ( ) D C (.) arterial line (.) ((no
I le hanno dato il magnesio tre grammi↑
longer reading) ) they gave three grams of magnesium

275 N ((reading from the medical record) ) she was out of bed
I è: è uscita dal letto
N ((reading from the medical record) ) uh respiratory consult (. ) (at) – (. )
((no longer reading) ) o::h they did this for the: u::h=
I =hanno fatto::=

280 N =for the J P (.) =°once= N ((reading from the medical record) ) ( ) D C (.) arterial line (.) ((no
I per il J P °( )°
longer reading) ) they gave three grams of magnesium
I le hanno dato il magnesio tre grammi↑

285 N and then this is chest [ (X-ray for the picc) ] [ la chest X-ray
I e poi:: e:::hm ] e poi:: e:::hm ] a cento
N D C central line
INF il:: l’E K G è qui↑

290 I and the (. ) ehm >is the E K G here<=
N =I gave it to the doctor [ she walked away with it ]
I ↘
INF l’ha dato al medico che se n’è andato

con::
INF ((ironically)) vabbè ((chuckle))=
295 I =con il tracciato
INF ((ironically)) è sparito↑
Training sessions

TS.01

<table>
<thead>
<tr>
<th>Typology</th>
<th>Nursing training session (Title: “Hemodynamic monitoring – Part II: Pulmonary Artery Pressure Monitoring”)</th>
</tr>
</thead>
<tbody>
<tr>
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((educator, nurses and interpreter are getting ready for the lesson))

N
((to INF₁)) a::h (. ) okay we (. ) left off (. ) °° (. )° (. ) >yesterday just to
catch< (. ) to catch you up
I
a questo punto

5
N
uh we: do hemodynamics uh >for critical care nurses< in *three* phases
I
noi l’emodinamica per in – fermieri di area critica di terapia intensiva la
dividiamo: sostanzialmente in tre fasi
INF₁
>mhm<=

10
N
=°in three classes° in our first – >we say< hemodynamics one the first
day
I
°quindi° (. ) in tre classi ‘ufficialmente° emodinamica *u:no*↑
N
it’s for (. ) arterial (. ) waveforms and looking at peripheral waveforms↑
and (. ) what you’re looking at on the monitor↑
15
I
è per le onde: periferiche insomma quello che ve – >guardi< – vedi sul
monitor in questi casi
Appendix Six

Then the *second* day we focus on *pulmonary* artery catheters and the readings what the C V P reading and the P A *pressure* readings are what they mean *how they tell us information about the heart* through lines

I e poi il secondo giorno invece sulle onde di tipo: °po –° polmonare periferico quindi la – la Ç.V.P che sarebbe la: (. ) ehm la pressione::: del – *((to the educator))* what’s the C V P

N u::h pulmonary artery

I si della – della – arteria centrale e:: e tutti:: i fenomeni collegati

N u::h ( .) a::nd we actually *looked* at the pulmonary artery catheters↑ (. )

I the different=

N =*pieces* that are necessary u::h ( .) *for* that catheter↑

I quindi le: le varie parti del catetere polmonare

N what the ports are used fo::r

I a cosa vengono – a cosa servono i vari ingressi del °catetere°

N =quindi le: le varie parti del catetere polmonare

I *reading* ( .) u::h during a wedge (. ) wedging °the balloon°

I quello che ancora=

N =(   )=

I =non abbiamo fatto e forse faremo oggi è:: >°(proprio il)°< wedge cioè il gonfiamento del palloncino e anche °di::° fare u na valutazione dei °risultati°

N and then hemodynamics three which is *supposed* to be today this is the third day u::h goes into more (. ) u::h ( .) *parameters* looking at mo::re u::h (. ) >we say< in addition to the >pulmonary artery< pressure

I =quindi guardiamo il – l’output cardiaco – questo è quello che si – dovremmo trattare oggi nella terza parte=

INF1 =mhm=

N and our (. ) approach at giving (. ) nurses (. ) all of this information is it so: they can *anticipate* and critically *think* (. ) what will the orders be what is the physician going to: (. ) uh write u::h

I >tutto questo viene fatto< anche per – per sviluppare nel – nell’infermiere la capacità in un certo senso di *anticipare* quelli che
saranno gli ordini scritti o verbali del – del medico quindi:: diventerà anche una forma mentis capace di anticipare quello che succederà

I 70 okay° (.) "all right and" (.) u:h it just helps the – >the nurses have a very – < become not just *ta::sk* (.) *oriented* (.) uh in the I C U >but understand< (.) why they are doing what they are doing why the

physician is doing what he or she is – "is doing°

I 75 quindi l’importanza per l’infermiere in terapia intensiva non soltanto di essere u:n – semplicemente un *esecutore* (.) degli ordini ma anche di capire (.). perché stai facendo una cosa o i motivi che ci sono °dietro°

N °okay° and I can make copies of this (pointing at the handouts) for you

I 80 e comunque ti faccio delle copie [°di questo° so that you can >this as ( )]
of reference< unfortunately it’s in English though (clears throat)

I è in inglese però ti serve sempre come [°riferimento° be better just

writing things as you (.). hear things

I oppure puoi prendere appunti °mentre parliamo°

N okay (.). where we sto::pped was (.). >we wanted take a look at< (.). u:h >a couple of things> during a *wedge* (.) let’s do the wedge first (.).

and then we come back up to:: the effects of:: *respiration*¹ (.) on:: this catheter that – that’s *in* your heart and (.). close to the lungs

I °okay° (.). tratteremo la – l’operazione del wedge da ora in poi di:wi::l wedge è praticamente::=

INF₁ =°l’incuneamento<

I 95 si °l’incuneamento°

N °okay°< so we’ll do that first it makes more sense to (.). uh °do that° (.).

((grabbing a sample catheter kit)) okay uh (.). when we do (.). when we perform a – a wedge we had said yesterday that you should come (.). across your patients *always* with this (.). catheter ah >sorry< with this

balloon and a syringe in the *locked* (.). position=

INF₂ =mhm

N and without anything °in here° (pointing at a part of the equipment)

I °allora° bisogna arrivare dal paziente senza niente qui ((pointing at the same part of the equipment)) ovviamente e poi deve avere una

100 posizione di chiusura=

N =and=

I °dev’essere chiuso°

N the syringe that comes packaged with (.). the:: Swan-Ganz catheter has a *stop* point (of) only (.). you can only pull up one and a half C Cs °uno

INF₁ °set* del – dello Swan-Ganz

N in pratica la pressione di incuneamento no – non posso mettere più di uno virgola cinque è il massimo che si può tirare  perché c’è un meccanismo di bloccaggio e questa: è la – la siringa che viene nel – nel *set* del – dello Swan-Ganz

N so I *can’t° inflate (.). any more than one and a half C Cs

INF₁ °and – ° and if I *did° (.). inflate more the balloon would rapture

I °se° dovessi metterne ancora si – scoppierebbe il °palloncino°

N so we pull up the one and a half C Cs of air↑ attach this

INF₂ °and then I unlock (.). the:: u::h locking device

N 110 uno virgola cinque è il massimo che si può tirare  perché c’è un meccanismo di bloccaggio e questa: è la – la siringa che viene nel – nel *set* del – dello Swan-Ganz

N so I *can’t° inflate (.). any more than one and a half C Cs

INF₁ °and – ° and if I *did° (.). inflate more the balloon would rapture

I °se° dovessi metterne ancora si – scoppierebbe il °palloncino°

N so we pull up the one and a half C Cs of air↑ attach this

INF₂ °and then I unlock (.). the:: u::h locking device
Appendix Six

I si sblocca:: i:l meccanismo di apertu::ra↑
N and each of my catheters °the balloon is broken so I can’t show you°=
125 I =⇒mhm<=
N =°the balloon actually inflating°
I ora il palloncino: che ho qua sfortunatamente s – si è rotto quindi non –
non ve lo posso fare vedere proprio: il meccanismo di gonfiaggio però
((clears throat))
130 N u::h
((pause)) ((the US nurse prepares the equipment for the demonstration))
N and what you do is *slo::wly* (. ) ( inflating the balloon)↑
I si gonfia il palloncino *lentamente↑*
135 N whi:::le you are watching ( . ) the monitor
I e nel frattempo si guarda il monitor mentre [lo °( . )°
N because ] what I want to see ( . ) and ( . ) I want to see this:: change from this P A ( . ) tracing ( . )
((pointing at the tracing on the transparency)) to this *wedge* >it looks like a C V P do you remember< yesterday we said this is a *left* ( . )
*heart* C V P ( . ) a wedge
I quindi devo passare da una formazione del genere ( . ) a questa ((pointing
at the tracing on the transparency)) che è una C V P che abbiamo visto
ieri
N °so° to change into this characteristic *wedge* ( . ) *tracing*
140 [a wedge=
I >si chiama<
N °waveform°
150 I un classico *traccia:to* di:: ( . ) di forma di incuneamento
N °okay° u::h when you *see* this↑ when you’re inflating the balloon ( . )
and you see this *change* on ( . ) your ( . ) patient stop that’s all you need
to do↑ that’s as far as you need to inflate
I >quindi quando state gonfiando guardate il monitor< appena – vedete
che l’onda:: cambia in questo – comincia a diventare di quella forma là
a quel punto vi ferma:te (. ) quello sapete che è:: il – (. ) il livello che
dovete raggiungere
N maybe it doesn’t take one and a half C Cs maybe it’s only one C C
I magari non c’è bisogno di mettere tutti uno virgola cinque magari solo
uno basta
160 N °okay° u::h (. ) if you were to: (. ) inflate the balloon *fully* (. ) u::h it
won’t rapture the balloon ( . ) a one and a half C Cs *will not* rapture
the balloon
I se glieli metti tutti:: (. ) uno virgola cinque di aria il pallone non scoppia
165 (. ) >il palloncino non scoppia<=
N =but if it only takes one C C to achieve a we:dge and I:. use one and a
half (. ) I can do:: (. ) something that’s called *over*wedging
I però se la pressione è adeguata e l’incuneamento io lo raggiungo con
soltanto u – u – un C C di aria (. ) *e^h mi spingo oltre (. ) arrivo a una
situazione di “ehm” overwedging cioè di sovra – ( . ) sovraincuneamento
and (. ) this catheter the balloon has a little – uh (. ) the tip of the catheter
(. ) has a little sensing (. ) has a little sensing (. ) uh (. ) *point* on it (. )
that will – ( . ) >wander here< so this is my balloon that’s inflated↑
I questo è il palloncino che si gonfia no↑ e sulla punta c’è una – una sorta
di senso:re che è alla – alla fi:ne alla punta del catetere
And it's just a very small tip if you overinflate this (.) what will happen is (.) the balloon (.) will inflate (.) but the tip of the catheter might get

INF2
=°mhm°=

180 INF1
=mhm=

N

in this direction in the *wall*

INF2
=mhm=

N

of the pulmonary artery

I

quindi se lo gonfi troppo >ehm< lui continua a gonfiarsi però può

succedere che la punta del catetere va a finire contro la *parete* (.) dell’arteria

N

it will take the shape (.) but it might distort (.) where the (.) tip of the catheter is pointing

I

>quindi< si gonfia ancora però >diciamo< la posizione della punta

could potentially be deviated

potrebbe essere deviata

N

>°okay↑°< so you just use the amount of air (.) ne– *ned* to achieve your – your waveform

I

quindi è importante inserire la quantità d’aria necessaria e non superiore a: (.) a ottenere una – una formazione – un’onda di quel tipo

195 N

°okay↑° u::h (.) you get your reading↑ (.) we’ll talk about the readings °soon° u::h we’ll talk about looking at the monitor and getting your reading and then you want to *allow* the balloon (.) to *deflate* (.)

I

>quindi< fai la lettura (.) ora vedremo come si fa e poi (.) fai sgonfiare il palloncino

200 N

uh (.) you should only (.) leave the balloon inflated for like thirty seconds

I

il palloncino va e::hm (.) rimane gonfio non oltre trenta °secondi°

N

°okay° remember when this balloon is inflated this area ((pointing at the picture on the transparency)) the *lung* is going without blood supply

205 I

ricordatevi che: quando è completamente gonfio questa *zona* del polmone in pratica non gli arriva aria

N

°okay° so you wanna do the *wedge* get the reading (.) *deflate* (.) and (.) allow for (.) for resumption of *oxygen* (.) *blood supply* to this (.) °zone°

210 I

quindi (.) metti il palloncino lo gonfi fai la lettura che devi fare e poi lo sgonfi per permettere:: il flusso di aria normale

N

°okay↑°

INF3
(sì) e::hm (.) °trenta secondi o sessanta°

INF2

[“trenta”] seconds

I

trenta=

N

°(trenta)° uh (.) when you (.) *deflate* this balloon (.) you *passively* >let it< *deflate* (.) °okay↑°< so: >the air gets pushed back< you just take your thumb off

220 I

°mhm° (.) per sgonfiarlo togli il pollice e – e si sgonfia da solo in maniera passiva non devi [*tirare*]

N

°okay↑° and then (.) >it – < the balloon will by itself – >I’m sorry< the syringe will by itself just come out (.) *close* to the one and a half C Cs=

225 I

=poi vedi che la – la siringa esce so:la se tu togli la pressione del pollice

esce=

N

°okay°

I

=da sola fino a raggiungere:: (.) uno virgola °cinque°
and if you see that there’s still a little bit more just pull it back

I see vedi

N °to one and a half°

I =ancora un po’ per arrivare a uno virgola cinque: tirà piano piano

INF3 okay

((the nurse hands the catheter to INF3 so he can demonstrate the procedure))

I °okay° (. ) lock it↑

INF3 °(performing the procedure) mhm

I °the air↑(.)(INF3 pushes the air out of the syringe)° °that’s right°=

INF3 °butti via l’aria

I °and put it back on°

INF3 °e la rimetti

((INF3 performs the procedure as requested))

I °and you can tell me in Italian what’s the *danger* of leaving the air in this↑(. ) why (. ) why is this that↑ qual è – qual è il pericolo se lascio l’aria nella dentro=

INF3 °ed è chiuso anche in italiano ditemelo che io lo capisco↑ perché se si apre la valvola di sicurezza e il paziente schiaccia il:: (. ) la siringa↑=

INF2 °(cough)°

I °°no – non succede niente°=

INF3 °okay° the reason why you don’t *actively* (. ) pull back

INF2 °(mhm)°

I °°no – non succede niente°=

INF2 °okay° the reason why you don’t *actively* (. ) pull back

INF3 °(mhm)°

I °°no – non succede niente°=

INF2 °(mhm)°

I °°on* the balloon and it might cause it to rupture

INF2 °(mhm)°

I °lo fai sgonfiare da solo=

INF3 °(mhm)°

I °°no – non succede niente°=

INF2 °(mhm)°

I °°on* the balloon and it might cause it to rupture

INF2 °(mhm)°

I °°no – non succede niente°=
Appendix Six

INF3 =mhm=
I =perché la:: la compagnia che produce questo catetere sostiene che può deteriorare a lungo: (.) "diciamo ehm la – la:::

285 INF3 "il funzionamento"=
I ="si"
N ="okay"
INF2 =ed è la pressione:: all’interno del polmone stesso che la fa ri::tornare indietro

290 I yes it’s the – the pressure *inside* the lung that actually (.)
N creates the –
I [yeah (.) and the [pressure in (the) blood yeah]
N to come out
I in the blood yeah

295 I e anche la:: il sangue
INF2 mhm
N okay (.) the frequency (.) we: (.) do this:: (.) *every four hours* (.) on the patients in the I C U
I per quanto riguarda la frequenza questa procedura la facciamo *ogni*
N quattro ore nei pazienti di terapia "intensiva"
I oppure se c’è un ordine medico (.) ancora:: più spesso (.). "de – di
N *or* (.) more frequently (.) *if* the physician has ordered
I oppure se c’è un ordine medico (.) ancora:: più spesso (.). "de – di
N *or* (.) if you think (.) that is (.) a piece of information (.) that will help
you (.) >like if< if you see something is happening with the patient and
their blood pressure’s dropping and – you want to get an extra set of vital signs (.) but it’s not four hours yet you can do that because it’s gonna be information the physician is going to *ask* you
I oppure voi stessi (.) se:: vedete che la pression e del paziente sta calando
N *or* (.) if you think (.) that is (.) a piece of information (.) that will help

305 INF3 =ce::rto=
I =quando arriva
N =okay† up::h (.) the:: (.) problem with repeating this (. ) >over and over
I and over again< every hour every thirty minutes† is this (. ) is this (. )
N u::h period of – of ischemia (.). "(   )"
I il problema di ] [ ] ripetere troppo spesso
N questa cosa è che c’è un pericolo di ischemia perché se lo ripeti ogni
320 o::ra così::: troppo spesso
N all the other vital signs are every two hours but the wedge is every four
I tutti gli altri parametri vitali vanno presi ogni due ore invece la – questo
N and ( ) the procedure we told you the maximum volume of inflating we
talked about overwedging
I allora questi li abbiamo visti la procedu::ra il volume massimo e::
diciamo il sovra incuneamento ne abbiamo parlato†
N what would happen if – you – (.) you could not wedge (.) you inflated
I the balloon (.) and it doesn’t do anything
330 INF3 cosa succede se:: (.) si gonfia il palloncino e non succede niente cioè tu
N and it stays in this (.) pulmonary artery waveform tracing
INF3 [ ] e con – ] continua a rimanere in questa forma di::
INF3 significa che non siamo nel posto giusto però siamo in ventricolo [we’re not] we’re not in the right place [we’re in the ventricle but not in the right place]
N well=
INF3 e leggiamo solo la [°( )°] it wouldn’t be [in the ventricle] because if
N it was in the ventricle
INF3 non siamo nel ventricolo
N our waveform [(pointing at a waveform on the tracing)] would be
345 this [perché ] se fossimo nel ventricolo l’onda avrebbe [°oh°]
INF3 =forma
N °okay° but all we see after trying to wedge=
INF2 =mhm=
N =is our [°pulmonary °( ) °( )°]
INF2 =what – what might be wrong
N secondo te cosa – cosa può essere successo ^se – ^
INF2 >ehm< il palloncino::: è rotto=
N =yeah maybe the balloon is raptured=
INF2 =esatto
INF2 e::hm (.) the complication e:hm if the; ( .)
N palloncino si=
360 °the balloon is raptured↓°<
INF2 =rompe:: (. ) l’aria (. ) e:hm [°is°]
N it’s air= (. ) air [°( )°]
INF2 =a complication
INF2 embolia [°gasso::sa °(embol[j])°]
N but – =
INF2 =embol[j]
N if you give one C C ( .)
INF2 >mhm<
N =and a half C Cs ( .) through here [(pointing at the syringe)] into the
INF2 =°mhm°
N patient u:::h that small amount is not going to=
INF2 create >danger to the patient<=
375 INF2 =°mhm°
INF2 è una quantità di aria ridotta [uno virgola cinque quindi comunque=]
INF2 °( ) °(esatto) (è poco)°
INF2 =non – non crea problemi al paziente=
N =as – nurses we tend to see *air* in I V tubings and we get nervous like
INF2 ((mocking a worried voice)) ah there’s an air bubble=
INF2 =mhm=
N =(mocking a worried voice) it’s going to kill the patient
INF2 mhm (°soft chuckle) a noi succede per esempio di vedere delle – delle bolle d’aria nelle – nei tubi delle – delle medicazioni endovenose
INF2 =°mhm°
N magari ci preoccupiamo ((mocking a worried voice)) c’è una bolla d’a::ria
i – i – it won’t (. ) but – (. ) and you need (. ) a very *lo::ng* (. ) piece of IV tubing amount of air to do damage but ^I’m not^ gonna be the one
who=

mhm

=dicó in realtà non c’è=

that won’t °(  )°

=problema perché ci – ci vorrebbe una *gro::ssa* bolla d’aria nell’intero:: (. ) tu:bo=

°okay°=

=però

but – you do need to worry about *air* °u::h° [°u::h° bisogna] comunque

preoccuparsi

°mhm°

these one and a half C Cs won’t be dangerous=

°mhm°

=if you say mhm I didn’t – (. ) didn’t – (. ) it did not uh (. ) wedge

comunque sappiate che questa minima quantità non è pericolosa se vi doves:te a – (. ) accorgere che non – (. ) non avete raggiunto ::: (. )

lo °scopo°

you can – (. ) try (. ) one more time

provate un’altra volta↑

don’t get every other I C U nurse to come (. ) and try:: (. ) wedging=

=non chiedete a tutti i colleghi a ognuno da:: a provare

°così °perché°

at that point ((ironically)) now you’ve *given* about ten C Cs of air [which °u::h° a quel punto gli hai dato già dieci C C di aria e allora:::

°(  )°

if it’s not wedging (. ) u ::=h (. ) notify the physician↑

se non hai l’incuneamento chiamai il medico↑

probably in rounds the physician might try to wedge

ci proverà lu::i durante il giro visite °probabilmente °

and say °u::h° well the balloon

e ti dirà *fo::rse* è: bucato il palloncino

uh we won’t use this we will have to rely on the pulmonary artery:: (. ) °what number↑°

°if the wedge doesn’t work↑°

se non funziona questo – (. ) il medico potrebbe dire ci basiamo su che cosa su quale:: su quale valo:re ditemelo voi

the pulmonary ^*systolic*↑^[*diastolic*]

°sistemica↑ o diastolica polmonare

e::hm (. ) diastolic=

°e::hm°
Appendix Six

N =((enthusiastically)) >okay good< diastolic [esa::tto ] diastolica

I remember that your P A *diastolic* is a li::ttle bit higher↑

N ricordatevi che la diastolica polmonare è *leggermente* più alta=

I =rispetto al wedge

N and you can see they’re very *close* to each other

I comunque vedete che sono this is my diastolic ((pointing at the transparency))

N this is my diastolic ((pointing at the transparency))

I vedete che sono=

INF2 °mhm°

I =comunque:: vicine

INF2 °mhm°

N °this is= my systolic° ((pointing at the transparency))

I questa ((pointing at the transparency)) è la=

INF2 °mhm°

I =sistol::lica ((pointing at the transparency)) più bassa=

N =la diastolica e questa ((pointing at the transparency)) è la:: pressione di incuneamento

N those are *very* close (where) they should be

I quindi più o meno () comba::ciano quindi () potete usare ‘quella’

N we’ll talk about this () °right here right here° ((pointing at the transparency)) this is my wedge °right there°

I quindi qua ((pointing at the transparency)) questa parte s – evidenziata comunque è la:: >è quella relativa all’incuneamento <=

N °okay↑° () when this is not functioning you should ta::pe it↑ or take this off and put a cap↑ or label it somewhere on here °and° in Emtek uh P A wedge °non° °functional*

I allora se non – non – funziona o togli la:: la siringa e ci metti un cappuccio a chiudere o comunque in qualche maniera ci metti un – un::: un’etichetta dicendo che non funziona e comunque lo inserisci in Emtek

N you can *free* text in the little *box* where you enter the vital signs for the P A wedge you can actually we () like you to do N F non °fun(°

I quindi ci sono del – delle parti in Emtek dove puoi inserire testo no↑

INF2 °mhm°

I e – ci metti N F cioè non funzionante

N if it’s *very* important and the physicians °absolutely° want to have a wedge () pressure () they would change the catheter

I se il medico vuole assolutamente una pressione di incuneamento allora:: cambierà il catetere – verrà cambiato il catetere ((the US nurse changes the transparency on the overhead projector))

N °okay↑° () now let’s talk about the effects of (. ) °intrathoracic* pressure

I >ora< () parliamo degli effetti della:: pressione in – intratoracica

N o:n () the measurements

I e che:: () effetto hanno sui – sul – sulla – sulla lettura dei valori

N °okay° () we breath one or two ways in the I C U () spontaneously↑ () or with a mechanical ventilator

I in terapia intensi::va () si respira in due modi o spontaneamente o col respiratore
"okay" when I breathe *spontaneously* when I take a breath in (. ) what that does in my pleural space is – even though my lungs are
*inflating* (. ) the *act* of taking a breath in creates *negative* (. ) pressure

I nello spazio:: *pleurale* quando ho una respirazione di tipo spontaneo
gonfiandosi i polmoni ho una pressione negativa

*I okay*  INF2 °mhm°

so that *negative* pressure being exerted on (. ) this catheter that’s *in*
my (. ) cardiothoracic u:::h (. ) u::h reflects the *change* in that
pressure *that negative pressure*

I quindi questa pressione si risente nel:: appunto nel catetere che è
comunque nella zona cardiotoracica

and what happens [ ] è quello che succede

N I take a breath in (. ) *negative pressure*

I tiro dentro l’aria↑

N =is created↑

I pressione negativa↑

N the waveform (. ) *(pointing at the transparency)* becomes negative (. )

on my =

INF2 °mhm°

N on my monitor

I e allora l’onda vedi che diventa negativa sul monitor

N *like that* *(pointing at the transparency)* > and then I< *exhale*

INF2 °mhm°

N a:::nd

I e poi (. ) espiro

N with my lungs collapsing (. ) during (. ) *exhalation*

INF2 °mhm°

N it creates a *positive* pressure

I quindi durante l’espirazione °c’è ° i: polmoni si riducono e c’è la
pressione positiva

*I okay*↑ then there is a period where (. ) I’m not breathing in↑ and I’m
not exhaling

I poi c’è un [momento in cui=

N =non c’è *né* inspirazione né espirazione non succede [ ]

N (. ) we call that period of nothing happening (. ) *end* (. ) *expiration*

I ora questo:: (. ) questa frazione diciamo quel – questo tempo (. ) in cui
non succede niente la chiamiamo: *fi:ne* dell’espirazione

and it’s during this period of ^*end*^ (. ) *expiration* that (. ) you get (. )
your pulmonary (. ) artery (. ) pressure (. ) readings

N *okay* so (. ) I take a breath in↑ spontaneously breath↑ this *(pointing at
the transparency)* comes down I exhale (. ) I take a breath in (. ) and

then I exhale (. ) so [ ]this is

N *end:* *expiration

I quindi questa è proprio *fine* (. ) espirazione questa::
Okay, questo momento

“this period” so (.) when I look at my monitor to get (.) the *value* of this (.) wedge (.) tracing

((pause)) ((the US nurse examines the transparency))

let’s just for ease of – ig – ignore that forty ((pointing at the transparency))

allora per facilitare non tenete conto di quel quaranta che c’è *sopra* ((pointing at the transparency)) *fate finta che non c’è*

((pointing at the transparency)) this is zero (.) this is five ((measuring the waveform on the transparency))

cinque dieci quindici venti=

=twenty-five (.) okay↑ so (.) ((measuring the waveform)) *zero* (.) five ten fifteen twenty-five zero five ten (.) fifteen (.) it’s between *ten* and *fifteen*

quindi diciamo che siamo tra *dieci* e quindici ((pointing at the transparency)) so: we

can say seven↑ (.) eight↑ whatever (.) *okay*↑° when you get the wedge you are *not* (.) looking at the s:ystolic and diastolic there isn’t a systole and a diastole it’s just a squiggly=

INF2

ovviamente in questa fase non c’è una diastolica o una sistolica

so you try to – (.) *average* (.) what that –

si prende un valore me:dio

measurement is (.) it’s not like on the uh (.) *P A* where you have a systolic and a diastolic

non è come nella – nell’arteria polmonare che c’è una:: e::hm

**sistolica e una=**

((pointing at the transparency)) very clear

diastolica ed è molto=

**systole**

=chiaro no↑

((pointing at the transparency)) very clear **diastole** ed è – ed è evidente

**indicating oscillation**

=questa è soltanto una:: un’oscillazione↑

so you can (take) on the monitor you have a cursor (.) a cursor line that you can move up and just kind of place right in the middle of this – ((pointing at the transparency)) **this line**

in monitor c’è un cursore

che:: che – che puoi alza:re fino a raggiungere diciamo mediamente la: (.) il valore medio e misurarlo *in questo modo*

°okay and get your °reading° ti metti più o meno in una posizione intermedia

°okay↑° (.) uh (.) because the P A wedge (.) and:: the uh P A pressures
are on a smaller scale (.).

I
e anche la – (. ) pressione arte – arteriosa comunque sono su una – una scala molto ridotta

600 N

INF2

"limitato"

N

very limited°

I

il margine di aria è estremamente limitato

N

so (. ) if *I* say that my wedge is ten↑

I

e tu dici che è quindici

N

>well< ten is normal (. ) but fifteen would kind of be elevated °in some cases°

610 I

[I dieci è normale quindici già comincia a essere alta in certi casi

N

if I say the *systolic* pressure’s twenty-five (. ) and you say it’s thirty (. ) we’ve now gone from normal to: (. ) high (. ) in some cases°

I

la sistolica se – "pe:" andiamo da venticinque a trenta già siamo in valori: a:=

INF2

=mhm°=

I

=in alcuni casi siamo (a) valori estremamente alti

N

so we just – (. ) you need to be very careful u::h (. ) a:nd (. ) dedicate a sense of *accuracy* (. ) in doing your readings

I

quindi quando fai la lettura:. (. ) va fatta con attenzione

N

which is why (. ) we – (. ) you need (. ) to read (. ) pulmonary artery pressure numbers (. ) from (. ) the screen (. ) and *not* from the digital printout °(that’s happening)°

625 I

per questo motivo la pressione:=

>the digital numbers°<

I
=a::: arteriosa polmonare va misurata *sullo* schermo e non:: nel – sulla – sulla striscia che viene stampata

N

because what is happening with this (. ) that monitor doesn’t know *end-expiration* (. ) >°okay†°< it doesn’t know that’s the phase of end-expiration and °that’s° the number I should put out here

I

il monitor=

N

=it just *averages^ everything that sees coming across it

I

il monitor fa una sorta di media di tutti i valori che riceve non è:: non è che capisce che siamo nella fase di fine inspirazione:: *espirazione* ed è quella parte che mi interessa

N

°okay†° so it will see *this*° ((pointing at the transparency))

I

non lo riconosce ≥°(quindi)i°<=

N

=it will see this it will see this (. ) and (. ) when it gets here it’s gonna give you:: this reading which is what (. ) what if – (. ) what if you make the mistake (. ) u::h (. ) oh "let’s go back to this" (. ) the monitor (. ) will print out all of these – u:h numbers around the movement

I

allora facciamo un passo indietro diciamo che il monitor ti stampa tutti – (. ) tutte queste quantità no↑ in questa per esempio in questa striscia

645 N

and you decide to get your numbers from (. ) the monitor

I
e tu decidi di:: ricavare i valori direttamente dal monitor
Appendix Six

and let’s say that that the – the time that *you* decide to take the number off the (.) digital numbers being printed is right here when when the monitor reads *this* which is what zero five (.)

two
diciamo che tu vuoi leggere dal=
three
diciamo che tu vuoi leggere dal=

indicando lei (.) ze:ro:: zero uno you say (non so)°
mhm three

mhm you write down lo scrivi pero non è quello che ti serve and it

takes it from the (.) the screen it’s – if they are (.) u::h (.) ((to the interpreter)) °what’s the word inter –°

inf: mhm

inf: you: Emtek interfaced °thank you°

oppure lo prendi da Emtek che è interfacciato con:=

inf: mhm=

inf: col monitor

inf: it’s not right

inf: sbagliato

(let’s do) this ^three::↑^ ((mocking an upset tone)) a::::::::h (. ) give them *vo::lume* you know

perché magari ti dà la lettura tre no↑↑ e allora non è quella giusta è un risultato bassiss::imo allora ti dice:: it’s –=

il medico ti dice dagli ancora del volume e invece non è quello inter –

between seven and ten and: sevenish it could be tenish maybe

invece è::

or maybe< ((squeaking noise)) between ten and fifteen

è tra dieci e quindici quindi

dodici tredici ((measuring the waveform on the transparency)) zero five – ten °fifteen° I’m sorry >I made a mistake °( )°< zero five ten °fifteen°< between ten and fifteen

invece in realtà=

°( )°

=quel:lo che ti interessa è tra dieci e quindici do:: dici ((to the US nurse)) I know

((to the interpreter)) °( )° (to the trainees) °okay↑ °>°all right↑°<

mhm

that’s a *big* difference saying thirteen

mhm °( )°

°( )°

it’s what it is versus *three* >which=

I capite bene che è una bella differenza no↑ da: tredici:
quattordici: a scendere a tre

 nombres (. ) the physicians are going to give *wrong* (. ) therapy

((squeaking noise))

I >°(quindi)°< se voi immettete in Emtek valori sbagliati il medico darà
una terapia sbagliata perché si baserà su quei valori che avete inserito

N °okay↑°

INF₂ mhmm

N it’s the same thing for C V P reading↑

I la stessa:: cosa è quando leggi una C V P=

INF₁ =°okay↑° all right let’s take a look at what happens when you have
(.) the opposite (. ) when you have (. ) *mechanical ventilation*

N °okay↑° with *mechanical* ventilation (. ) that’s a *positive* pressure

I questa è una pressione positiva di tipo positivo

N a:nd () mechanical ventilation will:: *push* (. ) pressures *into* your
lungs (. ), creating (. ) a positive pressure

I quindi praticamente è:: l’aria che entra nei polm:ni↑ gonfiandoli↑ e
creando una:: (. ) una↑ ((looking puzzled))

INF₂ °pressione°

INF₃ °( )°

I una °pressione^ >non mi veniva pressione< (. ) >pressione positiva<

N so the °opposite° happens now

I praticamente è il processo inverso l’o – l’o – l’opposto

N so let’s just reverse our thoughts let’s – erase these black lines °( )°=

I =quindi=

INF₂ °okay↑° ((pointing at the transparency))

I cancellate mentalmente queste:: queste ((pointing at the transparency))

due

N °okay↑° so=

I =linee nere↑

INF₁ we wedged the patient

I facciamo il wedge del paziente↑

N a:nd () we see () this ((pointing at the transparency))

I fate finta che queste ((pointing at lines on the transparency)) non ci
sono↑ e questo è quello che vediamo

INF₂ ventilator cycles on (. ) this is my wedge↑ (. ) the ventilator cycles on↑ (. )

I it pushes °up* the waveform

N ventilator cycles °off* (. ).

I quindi i::l respiratore comincia:: continua a funzionare con un altro

ciclo e – e spinge in alto la pressione °come valore^

I il respiratore si ferma↑ nel ciclo:: (. ) opposto↑ e:: siamo in quella

INF₁ posizione

INF₂ the ventilator will cycle on again↑

I poi si ri – riaiatta↑

INF₁ and then off

INF₁ e poi si rispegne

INF₁ now °in* (. ) °this* scenario (. ) what °is* your (. ) wedge (. ) reading
I ora in uno scenario ((squeaking noise)) del genere [qual è la le –
end-expiration].

N you can’t (.) get your reading when the ventilator is cycling on

I non puoi: leggere la:: la pressione di incuneamento quando i: i: il
respiratore è in – in ciclo attivo

N so your wedge reading (.) in this scenario (.) is gonna be >down here<

((pointing at the transparency)) this is a different patient °okay°

I °quindi è – ° (.) è un paziente diverso quindi tutta la – la situazione è
diversa

INF1 °mhm°

I ti basi su quel – su quel valore

760 N if I see this with a mechanically ventilated patient (.) my true wedge is
down here ((pointing at the transparency))

I quindi in un paziente su respiratore la:: il valore di wedge che mi serve
in realtà è questo qua in basso

N °okay° *and* if you make the mistake of reading (.) during *this* phase

(.) uh during the phase when the mechanical ventilator’s cycling on
you’re going to say ((mocking a puzzled tone of voice)) °oh the wedge is
thirteen ((going back to a normal voice)) when the wedge is three°

I quindi qua è – faresti lo stess – l’errore opposto cioè se leggessi in
quella – in quella zona leggeresti che c’è una pressione di
incuneamento: di tredici mentre invece è tre

770 N the patient needs treatments here (.) but it’s not – >he’s not gonna be
getting it< because your – (.) the picture you’re painting for the
physician is: (.) that the wedge is okay

I quindi il paziente *ha* bisogno di un trattamento specifico ma tu gli dai
un valore:: annoti un valore di tredici quindi: la terapia non scatta†

N °okay° this patient’s *hypovolemic* if you read – if they’re g( ( )
a wedge of three (.) what other *signs* and symptoms would the patient
have (.) of *hypovolemia*

I i:: (.) in caso di ipo:::

780 (INF1) °( °)

I sì voleria qual è – che altri:: *sintomi* avrebbe il paziente secondo voi
se siamo in questa situazione

INF3 ipovolemia†=

INF2 °m::hm°

785 I °sì

INF3 c’è un ridotto afflusso::

INF2 °( °)

INF3 °di sangue ( °)

INF2 °forse:: la pressione è ancora ] più bassa°

790 I a low [ low pressure ] lower

INF2 >sure< blood pressure [would be= ((clears throat))

I =low

N =low

795 I °sì

INF3 >giustame – < giustamente anche::

N how fast °>the heart rate< fa::st=

INF3 la pulsazione arteriosa

N =tachycardia
I tachicardia::a frequenze cardiache elevate

N °okay↑° so you would see the(se) signs of hypovolemia

I vedresti proprio i segni di una ipovolemia

N °all right° so uh (. ) that might make you think mhm can the wedge be thirteen if my patient *looks* and *acts* like a hypovolemic

I quindi ti dovrebbero venire i dubbi no° com’è che ho un valore:: (. )

N °tredici° se il paziente mi dà sintomi °di ipovolemia° (. ) vi dovrebbe mettere un po’ in guardia °questa cosa°

I questo (. ) is so: important with getting *accurate* readings

N importante se vuoi avere delle letturre::=

I =mhm=

N it applies for we:dge↑ it applies for CV P↑ it applies for your pulmonary artery systolic and diastolic pressures

I quindi questo vale sia per le pressioni diastoliche che:: [...]

((brief interruption in the recording in order to turn the tape; INF2 asks about the effects of breathing problems on the measurements))

N [...] if they are breathing really (heavily) (. ) I have an example of that

I cioè tu dici se respira in maniera °affannosa↑° (. )

I mhm=°( ) superficial breathing °(questo è)°

N in that situation (. ) u::h (. ) when they are really working at breathing↑ (. ) working hard

I in una situazione simile quando il paziente:: si vede che

fatica a respirare

N it’s very difficult to get your – it will be *very* difficult to get a – (. ) the period of °time ((snapping her fingers))=

I =for their °wedge °yes °mhm=

N =it’s very short

I è difficile trovare °il – °il punto quello che dicev(a) di °fine=°mhm

I =espirazione=

N =>it’s gonna be<=

I =perché è molto breve

INF2

N =infatti

I (it’ll be) (one) artefact with this (. ) ^in that^ situation what becomes more *important* is *not*: (. ) what their PA numbers are (. ) but what

is their blood gas (. ) showing=

INF2 =mhm=
and then they would need to be ventilated

$\text{INF}_2$

$\text{u::h} = \text{mhm}^\circ$

and once they are ventilated and their breathing is – (.) *regularized*

$\text{I}$

in quei casi è più:

$\text{INF}_2$

$\circ( )^\circ$

°mhm°

vedere l’emogas no† e poi vedere: muoversi di

conseguenza: e di cercare di *ristabilire* col – col:: respiratore la

situazione e poi in un secondo tempo=

$\text{INF}_2$

$mhm=$

$\text{I}$

andare a vedere i valori=

$\text{INF}_2$

certo

$\text{N}$

$mhm^\uparrow >\text{so}<=$

$\text{INF}_2$

=okay

but – °it – ° that is – is – is good thinking (.) if they’re breathing fast (.)
you are not gonna get *accurate* (.) $\text{uh}$ (.) it’ll be very difficult to get

uh your $\text{PA}$

$\text{uh}$

$\text{INF}_2$

numbers

$\text{INF}_2$

$mhm=$

$\text{N}$

°and* the wedge

$\text{I}$

°hai – hai ragione tu se (hai) un paziente che respira così

affannosamente diventa difficile vedere i valori esatti di – di pressione

$\text{INF}_2$

°okay° let’s take a look at (.) the °last* page ((grabbing the handouts

and moving to the last page)) and then we are going to go into some of

the: examples I want you to (.) feel comfortable with uh more waveform

(.) readings of waveforms (.) °okay†° (.) this last information was just

$\text{uh}$ (.) we’ll talk about complications we’ll talk about ^*re*positioning^

(.) the $\text{PA}$ catheter

$\text{I}$

allora parliamo di (.) del:: *ri*posizionamento del catetere nell’arteria

pulmonare

$\text{N}$

°when does this catheter have to be repositioned° because it’s not *in*

°the right place

$\text{I}$

allora quand’è che il catetere va *ri*posiziona:to perché non si trova

nella posizione corretta

$\text{N}$

it needs to be advanced (.) if it comes back into: the ventricle the right

ventricle

$\text{INF}_2$

°okay†° what about when (.) it needs to be pulled back or withdrawn

$\text{I}$

quand’è che dev’essere tolto ehm oppure arretrato

$\text{N}$

°okay° (.) perhaps it goes into the wedge position it goes too far and the
catheter >the tip of the catheter< (.) ^without* being (.) infl – without
being wedged the tip of the catheter has migrated *too* far and has
gone *into* a wedge position

I potrebbe essere che anche senza gonfiare il palloncino il catetere è
avanzato troppo e la punta è andata in un – in un – in una zo:na (. ) zona
d’incuneamento

N the waveform that I will see will be a wedge waveform

I vedrei una forma di questo tipo (. ) di tipo: d’incuneamento

N if you come into your patient’ s room and see this ((pointing at a
waveform on the upper part of the transparency)) on the monitor and
*you know* that you should be seeing *this* ((circling another
waveform on the transparency))

N se entri nella stanza e sul monitor del paziente c’è – quella forma in alto
((pointing at the transparency)) mentre invece dovresti vedere quella↑
(.) quella che ha: “circolato”

N do some troubleshooting check to see if *maybe* the balloon *is*
inflated

I cosa fai (. ) controlli (. ) magari il palloncino non si è – non è gonfia:to

N °okay° I will see this↑ (. ) I will – (. ) just see if I can *de*flate the
balloon if by chance somebody left it wedged

I oppure vedi se: qualcuno l’ha lasciato gonfio allora cerca di sgonfiarlo

N °okay↑ u: h (. ) and then I will notify the physician↑

I avvertire il medico [ o ( )]

N =punto

N when either of these (. ) situations occur (. ) and you’re calling the
physician °to come down° (. ) you can try (and) position the patient *on*
their side a:nd possibly should (fit (. ) out of the dangerous (. )
placement being in the ventricle °or being too far°

I allora e::hm (. ) quando succede una di queste cose tu chiami il medico e
nel frattempo che aspetti che arriva potresti cominciare a posizionare il
paziente di lato (. ) per: fare un *tentati:vo* di – “di – di” >insomma< di

N =here’ s a rule of thumb (. ) if you recognize that it’s in the right ventricle

I >allora< questa è una regola: (. ) importante da ricordare

N ((holding the sample catheter)) because these catheters tend to *have*
(. ) a *natural* curvature (to) them

I allora dato che questi cateteri come vedete hanno una sorta di:: (. )

N [ because it goes into ] the right ventricle (. ) and then (. ) goes into the:
(. ) pulmonary artery

I perché cosa fa entra [ quasi naturalmente=

N =nel ventricolo destro e poi nella:: (. ) arteria polmonare

N if it slips back into the right ventricle

I =se=

INF: =>°mhm°<=

I =torna indietro nel ventricolo

N if you turn the patient on their (. ) *right* (. ) *si::de*

I e tu i – il paziente lo gr:ri no↑ sul lato destro [ sul fianco=

N =destro

N just allow it to:: (. ) advance
I: potrebbe:: (.) in the position
N: =mettere in modo tale che: (.) il catetere avanza naturalmente=
INF2: =mhm=

960 I: =nella °posizione°
N: °if that doesn’t work you can try the other side° but °I* would try the right side
I: se non funziona puoi provare l’altro lato °io° personalmente proverei a posizionare il paziente prima sul lato destro

965 N: °okay↑° let’s say it advanced too far it’s in a °wedge° position
I: oppure (.) è avanzato troppo >quindi< è andato troppo avanti
N: °okay↑° (.) guess what side (.) >you should try to turn them on< here you’re trying to pull it back
I: quindi se è andato troppo avanti da che lato lo giri il paziente

970 INF3 °destro°
INF1 °sinistro°
INF2 [sinistro] (wedge)=
INF2: =sinistro=

975 N: =it might just be enough=
INF2: =mhm=
N: =to pull it out of that position
I: *potrebbe* essere abbastanza questo movimento per far uscire fuori:: (.) >cioè< a fare *arretrare* la punta

980 N: that’s – very – (.) typical of how these catheters (.) are placed they usually go °this° fashion (.) into the right
I: >questo< è:: è:: classico anche dato dalla forma del catetere nell’inserimento se ne va quasi naturalmente da quel °lato°
N: usually it does °not° get fed into the right ventricle and then (.) go to the left °that° way it’s usually always (.) è difficile che entra (da)l ventricolo destro e poi si gira a::: verso sinistra

((long pause)) ((the US nurse changes the transparency on the overhead projector)) ((shuffling of transparencies))

990 N: u:::hm
((pause))
N: °okay< (.) the other time that it can be °withdrawn* or °pulled back* is when it’s being pulled °back* °into* the C V P position (.) so we don’t need to use this anymore (.) as a pulmonary artery catheter I can now (.) we’re just gonna pull it back (.) into C V P position
995 I: allora diciamo che non mi serve più in quella posizione e lo devo *ritirare* devo tirare indietro in una:: posizione per:: misurare la pressione (.) venosa centrale:le questo è un altro caso per cui lo devo tirare °un pochettino indietro°

1000 N: when you do that (.) in o – in Pittsburgh (.) the:: nurses some of the nurses are trained to pull this back into (.) u:::h the C V P position
I: allora a Pittsburgh ad alcuni infermieri vien – viene fatta una formazione specifica dove:: °ehm* si insegna a: (.) tirare indietro (. ) il catetere in questa posizione

1005 N: °so< it’s basically that you are pulling this catheter without the b – with the balloon °de*flated
I: ovviamente il palloncino è sgonfio
INF2: mhm
you’re pulling it back *past* the pulmonic valve

and hoping that you are not *damaging* (. ) those valves (. ) in pulling back

con l’accurtezza *e la speranza* (. ) che non stai danneggiando le valvole 

while you’re pulling it back (. ) you’re like < (mimicking the attempt to pull back the catheter, which produces a piercing sound) nah nah

it usually happens because when it gets into here and with the – with the

succeed no† arrivati in quest’area qua con le *contrazioni* del ventricolo= 

=certo 

=quindi mvovendosi= 

=potrebbero formarsi dei nodi ‣ (. ) you end up (. ) with (. ) a situation like – like *this* ‣ (. ) come out with us (. ) this ((pointing at the tip of the catheter)) should come out *empty*
Appendix Six

I evitare di scippare pure la: la valvola °(tricuspide)°
N °right so°
INF1

N °if that °happens^ (. ) u::h (. ) physicians::

N sometimes if the knot isn’t so tight it’s kind of like a loose thing like that and (. ) °they jus – °they just have to try to work it

I in °this°
INF2

N °right so°

N °if that °happens^ (. ) u::h (. ) physicians::

N °that and (. ) °they jus – °they just have to try to work it

I in °this°
INF3

N °right so°

N °if that °happens^ (. ) u::h (. ) physicians::

N sometimes if the knot isn’t so tight it’s kind of like a loose thing like that and (. ) °they jus – °they just have to try to work it

I in °this°
INF3

N °right so°

N °if that °happens^ (. ) u::h (. ) physicians::

N °that and (. ) °they jus – °they just have to try to work it

I in °this°
INF3

N °right so°

N °if that °happens^ (. ) u::h (. ) physicians::

N °that and (. ) °they jus – °they just have to try to work it

I in °this°
INF3

N °right so°

N °if that °happens^ (. ) u::h (. ) physicians::

N °that and (. ) °they jus – °they just have to try to work it

I in °this°

I evitare di scippare pure la: la valvola °(tricuspide)°
N °right so°
INF1

I evitare di scippare pure la: la valvola °(tricuspide)°
N °right so°
INF1

I evitare di scippare pure la: la valvola °(tricuspide)°
N °right so°
INF1

I evitare di scippare pure la: la valvola °(tricuspide)°
N °right so°
INF1
°okay° uh (. ) usually what’s going to happen though i: s (. ) this needs to be left in (. ) on – and they’re going to put a "guide" wire↑ and (. ) uh over the guide wire a triple lumen

generalmente: quando è ancora in posizione mettono una sorta di::

°( ) catheter°

di:: °di° (. ) di guida (. ) °no↑°=

INF2 =mhm

se – inseriscono una guida:: e poi danno:: ((to the US nurse)) what do they give °to the::°

they put a – a guide wire=

INF2 =mhm=

through here and then (. ) put a:: this ((pointing at the sample catheter)) comes out and then a triple lumen a new catheter triple lumen

ah allora la guida poi escono questa ((pointing at the sample catheter)) e inseriscono un triplo lume

(okay) they – they change °over° (. ) uh cambiano in sostanza °i cateteri°

u:h (. ) when this ((pointing at the sample catheter)) is pulled back °into° C V P position (. ) how do I know (. ) which °ports° (. ) I can use now

allora quando – (. ) lo tirate indietro in questa posizione che chiamiamo C V P come faccio a sapere °i ports° cioè (. ) gli:: (. ) gli ingressi che posso utilizzare

it’s no longer a true Swan-Ganz catheter °it’s (a) C V P°

in realtà non – non:: (. ) non è più un catetere Swan-Ganz no↑ è un: normale catetere:: C V P=

INF2 =venoso centrale

°okay right let’s go back to° (. ) this is why you need to remember (there’s lines) the markings on here↑

questo è importante ((squeaking noise)) ricordare no↑ come vengono:: segnati::

INF2 =mhm

((holding the sample catheter)) so here we go this is my introducer this is still in place °with this°

allora questo° diciamo che ancora è:: piazzato è ancora posizionato

inside this is (on) this is °inside° the –

quanto è dentro

°all’introduttore°

°inside this introducer° (. ) °(it goes through here)°

°and I (. ) so with this in place (. ) °( ) usually we’ve got about like that much °so maybe°

°allora°

 INF2 =maybe °this°

diciamo che questo è posizionato sono in questa posizione=

=all right° so (. ) >guess what I can see< in the plastic

INF3 delle tacche=

INF2 =mhm
N °(true)°
I mhm
N "okay↑° what ports (.) exit (.) "right here" ((pointing at the ports of the sample catheter))

1170 I quali sono le::= INF3 =C.V.P=
I =gli – gli ingressi che escono da qua
N C V P↑
INF2 mhm

1175 I °C.V.P°
N that’s not good any more (.) ((disconnecting a component of the sample catheter and making a squeaking noise)) we can [ disconnect that ]
I questo lo
possiamo::= INF3 =C.V.P=
N =put a cap on here
I ci mettiamo un tappo e lo interrompiamo=
N what else
I =e poi↑
INF2 e::hm=

1185 INF3 =togliamo questo bianco
I the white one=
N the right A – yeah the R A "okay" (.) °so we can"=
INF2 atrio destro
I

1190 [ disconnect ]
N the flush INF3
INF2 mhm
N I can’t use these any more ((pointing at components of the sample catheter))
I questi non li dobbiamo usare [ più=
INF3 =quindi li [ discontinuiamo ]( ) [ ( )=
N
1200 INF2
N =(caps) (.) okay↑
INF2 they use the p[a]d ehm (.) insomma [ il lume=
N >"say it in Italian"<
INF2 =il lume per la pressione pol – polmonare penso giusto↑
1205 INF2
N okay yes (.) [ the – the
INF2 per la pressione ] polmonare=
N =P A D=
INF2 =ah P.A.D=
N =the pulmonary artery the P A *distal*
1210 I *distale*
INF2 ah è distale
INF3 distale
INF2 ((to INF3)) te lo ricordi (ieri)
INF3 ((to INF2)) >"si"<
1215 N okay (.) what has that become now what – the tip of this is my=
INF2 mhm
N C V P (.) °okay↑° [ ((to INF2)) perché questo ] non l’ha usato↑
Appendix Six

in your P \[ \text{A} \] (to INF3) perché ci vuole l’ultimo

"l’ultimo"

distal

mh

is now (. ) my C V \[ P \]

okay

mh

so this has (. ) the single stopcock from being a P A catheter we change and put a double stopcock (changing the stopcock of the sample catheter)

allora questo lo cambiamo e mettiamo un rubinetto a due

mh

we can use (it) now for ( . ) for anything°

questo si può usare per tutto a questo punto

mh

what about this (. ) right ventricular

invece questo\[ ((pointing at the sample catheter))\]

=infusion port

questo ingresso ventricolare destro\[ cosa: cosa succede\]

e::hm is:: c::hm

an introducer

è dentro no\[ ( . )\] l’ introduttore\[ for infusion\] we can=

yeah so=

=we can use for in – °for anything°

if I don’t see – if I only see *three* here\[ (pointing at the sample catheter)\]

se vedo solo tre *tacche* qui\[ (pointing at the sample catheter)\]

(in) which markings will I find the exit port ( . ) on here

come faccio a capire quali – how many\[ rings\]

come faccio a capire quali:: quali ingressi devo utilise\[ remember\]

ancora

how many ventricles do you have

di quanti ventricoli::

right ventricle

°

remember the way \[ I told you=\]

infusion

yesterday ( . )

vi ricordate ieri=

h( . ) – <=

=che vi avev(o)\[ detto – *where* (. )\] on this catheter (. ) does the right

ventricle (. ) port (. ) exit

mh

allora il i:: (. ) l’ingresso:: ventricolare *destro* (. ) dov’è che esce (. )

nel \[ o:h \] \[ u::mm (. )\] °era il più alto
Appendix Six

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INF3 [ha detto – °] era il più alto (mi sa)° (allora) è:: (. the [second il] secondo=)

INF2 ((to INF2) °c – )

1275 INF2 the second

N yeah it’s easy >do you remember< I have *two:* ventricles↑

I ricordate *due* ventricoli

INF2 [(  ) sì (  )]

INF2 (  )=

1280 INF3 =the second

N so it’s at a *two* ring mark

I e quindi=

N =>so<=

I =è al: segnale numero due

INF2 mhm

N it means that somewhere

I se non vedo due tacche

N it’s right there=

INF3 =>ecco<

INF2 ah mhm

I [(  ) qua (  )]

INF2 mhm

N so that means (. it’s still inside

INF2 mhm

I questo significa [ che è ancora= o(capisco)°

INF3 =dentro

N so you can use that

I e quindi=

1295 INF2 mhm=

I =si può utilizzare

N okay↑

((pause))

N =>so< I can use *this* ((pointing at one of the ports on the sample catheter)) for infusions↑

INF3 e quello=

INF2 =mhm=

I =ancora questo ((pointing at the PAD port))

INF3 =questo P.A

INF2 =mhm=

N no more cardiac output(s)

INF2 °(  ) certo°

I non ho più ] l’output cardiaco

INF2 mhm

1305 INF3 okay↑

((shuffling of pages))

N now (. what makes us very angry is: (. ^change-of-shift^ report (.)

INF3 okay=

INF2 =mhm

N now (. what makes us very angry is: (. ^change-of-shift^ report (.)

INF2 =mhm

N now (. what makes us very angry is: (. ^change-of-shift^ report (.)

INF2 =mhm

N now (. what makes us very angry is: (. ^change-of-shift^ report (.)

INF2 =mhm

N now (. what makes us very angry is: (. ^change-of-shift^ report (.)

INF2 =mhm
Appendix Six

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N cos’è che ci fa arrabbiare (.) quando ci sono::
I at change
N of shift what makes us angry at physicians (.) you come in
I quando c’è cambio:: cambio turno
N a::nd you look at your patient you got report pulmonary artery pressures
I have been twenty five over fifteen
N N at change
I hai dato le consiglie la pressione (del sangue)
N è intorno a venticinque
I nell’arteria polmonare
N you come in do your
I assessment on your patient
N 1325

I I come a fare la valutazione del tuo paziente ((squeaking noise))
N >then look at the monitor< (you) see *this* ((pointing at a waveform on the transparency)) and not *this* ((pointing at another waveform))
I e vedi *questo* non *quello* (.)
N sul monitor°
I °where – where – °where is my P
N A (.) where is my P A tracing
I e ti chiedi dov’è il mio tracciato:: (.) arterioso polmonare
N you automatically think somebody left it wedged or whatever you troubleshoot
I pensi automaticamente che qualcuno l’ha lasciato in posizione di
N incuneamento e quindi: (.) cominci a:: pensare a quale possa essere il problema
N we::ll physicians were talking about maybe discontinuing this in a day or two=
INF2
I =mhm
N 1330

I il medico o i medici hanno l’intenzione comunque di interrompere questa:: questa cosa:: tra uno o due giorni
N >più o meno< (.)
I =you
N =mhm::=
I =the tubing now is a lot longer
N plus *inside* this plastic it’s now filling with fluid
INF2
I =mhm::=
N 1340

I poi guardi –
N and you notice=
I il catetere
N =on your patient’s bed=
INF2
I =mhm=
N 1345

INF2
I =mhm=
N =lo vedi no†=
INF2
I =che:: il tubo=
INF2
I =è più lungo=
INF3
I °lungo°=
N 1350

INF3
I =è molto più lungo sul letto del paziente
N plus *inside* this plastic it’s now filling with fluid
INF2
I =mhm::=
N 1355

INF2
I =mhm::=
N =on your patient’s bed=
INF2
I =mhm=
N 1360

INF2
I =mhm=
N 1365

INF3
N =on your patient’s bed=
INF2
I =mhm=
N =lo vedi no†=
INF2
I =mhm=
N 1370

INF2
I =che:: il tubo=
INF2
I =è più lungo=
INF3
I °lungo°=
N 1375

INF3
N inoltre nella plastica vedi che si riempie di fluido
 INF
because your seven o’clock your six A M antibiotic that was infusing .) through here ((pointing at one of the ports on the sample catheter)) is now collecting “in here” ((pointing at the sample sheath)) [ “okay” ]

I =del mattino sta cominciando a::

INF3  
I =andare nel

INF3  
I =andare in quest – =

=what happened was the physician came in
I cos’è successo il medico è arrivato  
N decided to:: discontinue this pull it back into

C V P

I ha deciso di discontinuare questa cosa l’ha tirato=

without telling anyone

I =indietro in posizione C V P=

N =senza dire niente a nessuno ha fatto questo e se n’è andato

tranquillo  
I =or

more importantly what happens is

INF2  
(  )

the blood pressure drops and you come in the room during report and you see the blood pressure’s dropped

I oppure può succedere che tu entri pe – quando ti dai il cambio col collega ti dai le consegne e vedi che la pressione

N they are getting è scesa di molto

I =and dobutamine through this port

INF3  
I =doxapamina dopamina attraverso questo::

N the the

I =port

INF3  
I pulled it back to C V P position not even asking do you have anything infusing through this port↑

il medico ciononostante l’ha tirato indietro in posizione C V P

INF3  
I =qualcosa in

N =in here now not in the patient

I e vedi che questi:: elementi sono:: dopamina e dobutamina

INF3  
I =in questa

N =si e non vengono più infusi nel paziente

they are no – no longer infused

INF3  
I =they have every right to go that physician say ((mocking an angry tone of voice)) don’t ever pull why don’t you ask first

I a quel punto voi avete tutte le:: ((soft chuckle)) carte in

regola per andare dal medico=

INF3  
I =dirgli ((with a disappointed tone of voice)) senti ma perché l’hai fatto

INF3  
I =la prossima volta chiedimi

INF3  
I =prima

and dobutamine is meant to be *in* the patient↑ (.) not the sheath
II digli tranquillamente guardi (.) la dobu – (.) dobutamina e la dopamina
I devono stare *dentro* il paziente non nella guaina di plastica

\[ ((chuckle)) \]

\( \text{ INF2 } \)

\( \text{ N } \)

\( \text{ okay so uh physicians do do that *they just ( ) and then leave*} \)
\( \text{ I } \)

\( \text{ succede no† che i medici arrivano tirano (indietro di là) e se ne vanno} \)
\( \text{ N } \)

\( \text{ >all righ<} \)
\( \text{ ((pause)) ((the US nurse turns the pages of the handouts))} \)

\( \text{ INF2 } \)

\( \text{ N } \)

\( \text{ all right and then (shuffling of pages) this ( ) with the removal of the} \)
\( \text{ P A catheter we’ve already talked about} \)
\( \text{ I } \)

\( \text{ di quest’ultimo punto ne abbiamo parlato no† della: la *rimozione* del} \)
\( \text{ catetere} \)
\( \text{ N } \)

\( \text{ complications are fairly u::h (.) self-explanatory we talked about this} \)
\( \text{ throughout u::h the last few days} \)
\( \text{ I } \)

\( \text{ allora le complicazioni non vado in dettaglio perché già ne abbiamo} \)
\( \text{ parlato no† *negli ultimi giorni*} \)
\( \text{ N } \)

\( \text{ you can get a pulmonary artery rapture†} \)
\( \text{ I } \)

\( \text{ una rottura (.) dell’arteria polmonare} \)
\( \text{ N } \)

\[ \text{ pulmonary infarction\[ valve damage\[ un infarto\[ polmonare} \]
\( \text{ I } \)

\( \text{ polmonare} \)
\( \text{ N } \)

\( \text{ uh \[ dys – \ condoms alla valvola} \)
\( \text{ I } \)

\( \text{ dysrhythmias (.) ventricular tachicardia on insertion} \)
\( \text{ I } \)

\( \text{ tachicardia ventricolare o delle disritmie nella fase di inserimento del} \)
\( \text{ catetere} \)
\( \text{ N } \)

\( \text{ if the catheter comes back into the right ventricle=} \)
\( \text{ I } \)

\( \text{ =o se il catetere torna indietro nel: ventricolo destro} \)
\( \text{ N } \)

\( \text{ the catheter can u::h (.) irritate this ventricular septum (.) ventricular} \)
\( \text{ septal (squeaking noise)) irritation can occur} \)
\( \text{ I } \)

\( \text{ oppure ci può essere che il catetere provoca una *irritazione*=} \)
\( \text{ INF2 } \)

\( \text{ N } \)

\( \text{ =°( )° and that }\)
\( \text{ N } \)

\( \text{ can cause bundle branch blocks} \)
\( \text{ INF2 } \)

\( \text{ N } \)

\( \text{ e questo può creare un – un blocco} \)
\( \text{ INF2 } \)

\( \text{ blocco di branca} \)
\( \text{ N } \)

\( \text{ *cause your septum is what houses the bundle branch system} \)
\( \text{ I } \)

\( \text{ sapete che il setto è quello che include il=} \)
\( \text{ INF2 } \)

\( \text{ N } \)

\( \text{ =mhm=} \)
\( \text{ INF2 } \)

\( \text{ I } \)

\( \text{ =il sistema::} \)
\( \text{ N } \)

\( \text{ the balloon is raptured and you try no response you can get an air} \)
\( \text{ embolism} \)
\( \text{ I } \)

\( \text{ oppure si può *rompere* il pallon – e il pallon – il palloncino e poi puoi} \)
\( \text{ anche avere anche un embolo} \)
\( \text{ I } \)

\( \text{ 1470 N } \)

\( \text{ all=} \)
\( \text{ I } \)

\( \text{ =se ci provi tante volte} \)
\( \text{ N } \)

\( \text{ all invasive monitoring has an infection risk} \)
\( \text{ I } \)

\( \text{ ci sono dei rischi di infezione} \)
\( \text{ N } \)

\( \text{ on insertion hematoma pneumothorax} \)
\( \text{ 1475 I } \)

\( \text{ o pneumotorace o l’ematoma nella fase d’inserimento} \)
\( \text{ N } \)

\( \text{ prolonged pulmonary artery wedge can cause the infarction} \)
\( \text{ I } \)

\( \text{ questo wedge no: polmonare prolungato può creare un infarto} \)
\( \text{ N } \)

\( \text{ INF2 } \)

\( \text{ microshock=} \)
\( \text{ I } \)

\( \text{ =°( )°=} \)
=we’re gonna talk about that next week whenever the – whenever we do uh ((clears throat)) E K G uh class

I questi dei microshock parleremo (.) nelle – =

N =nelle prossime=

I =lezioni=

N =a saline filled *line* (.) (questa) è una linea:: do – dove viene

I inserita: soluzione salina

N and if you have electrical energy *leaking*=

INF2

N =somewhere near the patient

N these connections aren’t tight (. ) the saline can pick electricity and=

I =>ci può essere – <

N =*conduct* the electricity and °( )°

I un fenomeno di conduzione di energia elettrica attraverso la soluzione salina qualora:: le – le chiusure non sono fissate=

N =(what)=

N =adeguatamente=

N =electricity is invisibile (. ) how do I know (. ) that it’s *around* my patient

I naturalmente l’energia elettrica è qualcosa di invisibile quindi non – non posso essere sicuro che non ci siano dispersioni nelle – nelle vicinanze del – mio paziente

N what picks up surface electrical energy what monitoring (. ) picks up surface energy °( )°

INF2

N =electricity

I qual è il tipo di monitoraggio che::: riesce a rilevare la presenza dell’ energia 

INF2

INF3 ekg

N okay so your E C G picks up (. ) cardiac (. ) electrical activity *inside* (. ) but it will also

INF2 mhm

N display energy on the *outside*

I esatto quindi l’elettrocardiogramma oltre a r::e – gi – strare l’attività cardiaca interna

INF2

N =*and what we see* registra anche eventuali °(esatto)°

INF2

I =di co – di energia elettrica *esterna*

N what you see on your E K G is a *very characteristic* u::h (. ) this ((pointing at the transparency)) is my normal E K G
I allora diciamo=

okay↑

I =che questo è un elettrocardiogramma di tipo normale

1535 N this baseline is straight (. ) straight (. ) thin↑

okay↑

I =linea base diciamo° sottile questa

I

1540 N =current leaking around my patient maybe the: (. ) the – wires are ( ) on my E K G or maybe there’s a lot of electrical equipment

I se c’è una perdita di corrente nelle vicinanze magari di qualche altro::

ehm strumento elettronico (. ) nelle vicinanze

N

what I see here ((pointing at the transparency))

1545 N is ( . ) alternating current you know electricity is alternating current↑

I vedi la corrente alternata

N and you see this ((pointing at the transparency)) little (. ) very very (. )

1550 N form (. ) line where – where your isoelectric line is

I >in corrispondenza della linea isoelettrica vedi una cosa del genere< (. )

I lu::ngo e abbastanza costante

N and you see your isoelectric line (. ) looks (. ) like this if I had a m(a)cro

– if I had a magnifying glass

1555 I quindi diciamo *ingrandito* (. ) so – come sotto una lente di

ingrandimento questo è quello che vedrei

N okay↑° and this is because it isn’t >up down up down up down up down< it’s alternating current which is – electricity is

I questo perché non è come su e giù su e giù è una cosa continua perché è

una – fenomeno di *corrente alternata*

N if I take electrodes l – if I take E K G u:h leads (. ) and hang them near

like where – if I were to have a – the defibrillator up here

I diciamo che c’ho un defibrillatore

N and I have –

1565 e ci avvicino gli elettrodi del:: dell’elettrocardiogramma

I lo vedi che questo non è – non è infilato perfettamente

N right here=

INF2=mhm=

1570 N =I can tell you that there is electricity

I quindi stai sicuro che c’è una perdita di

N
corrente if I brought a monitor up

here and hung the electrodes near here

I stai sicuro che se avvicino gli elettrodi all’elettrocardiogramma

I’ll see this

1575 N

I vedrei una cosa del genere

N okay we’ll try to demonstrate that to you uh during the class the E K G

class (. ) we can show it on the defibrillator downstairs

I e questo possiamo fare una anche una dimostrazione di questo elettro

1580 cardiogramma↑

N when you see this on your patient (. ) on your monitor just try to

check all the electrical equipment around you make sure things are

plugged in

INF2=mhm
everything is ©°( °°) se doveste vedere una cosa del genere fate
attenzione che tutti:: tutte le cose siano in – infiletate bene nella presa tutti gli °elementi elettronici°=
N =°all right° we talked about this ((clears throat)) the first day what
1590 happens when your waveform becomes more *dampened* (. ) and more *
‘flat*
I questo l’abbiamo visto il primo giorno cosa succede se:: (. ) l’onda ha
una forma più *piatta*=
N we wanna make sure you did the troubleshooting as we said the first
day check your connections check air check line
I è importante fare queste – queste varie – questi vari:: (. ) *pa::ssi* no↑
per cercare di capire qual è il problema
N okay uh make sure that your pressure bags a – have not become empty
(in) the pressures
1600 I per esempio [ controllare==
N ↑ °( °°)
I =che le le sacche del per la pressione siano piene
[ che non siano vuote ] ( )
N you can try to rezero (   )
1605 I si può resettare tutto
N check the patient position
I controllare la posizione del paziente
N we talked yesterday about [ false readings
I queste cose le abbiamo ] viste ieri e anche
delle letture::
N >all right< let’s take=
I non corrette
N =a break and we’re gonna practice uh looking at some of those strips
that you have
1615 I allora ora facciamo una – una pausa di un – ((looking at the US nurse))
of fifteen minutes
I di quindici minuti e poi vediamo di di fare un po’ di lettura di queste
str – [ (to the trainees) is that okay↑
1620 ((the trainees nod))
N okay thanks
Appendix Six

TS.02

<table>
<thead>
<tr>
<th>Typology</th>
<th>Training Session (Title: “What can I as a nurse do in the first five minutes?”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>ISMett Conference Room</td>
</tr>
<tr>
<td>Date</td>
<td>November 28, 2007</td>
</tr>
<tr>
<td>Time</td>
<td>1:00 p.m.</td>
</tr>
<tr>
<td>Duration</td>
<td>00:18:52</td>
</tr>
<tr>
<td>Interpreter</td>
<td>Italo I, Georgia I</td>
</tr>
<tr>
<td>Primary speaker</td>
<td>Nursing educator, US (female, aged 41-45)</td>
</tr>
<tr>
<td>Speaking audience</td>
<td>Nurse, Italian (female, aged 41-45) INF1 INF2</td>
</tr>
<tr>
<td>Observers</td>
<td>Researcher</td>
</tr>
<tr>
<td>Situation</td>
<td>The training session is part of the exchange program between ISMett and UPMC nursing staff: the main speaker is a US visiting nursing educator, who shows and discusses a PowerPoint presentation on the role of nurses and other healthcare providers in the event of a patient crisis. The session is attended by ISMett nursing educators, clinical coordinators, physical therapy and respiratory therapy coordinators, as well as by exchange nursing students from UPMC. The US speaker is standing in front of the audience. The interpreters Italo and Georgia are sitting on one side of the conference room, with a microphone each. Headsets have been given to the Italian staff who need the translation into English and to all US attendees, so that Italo can interpret from English into Italian and Georgia from Italian into English, should the Italian participants intervene with questions and comments.</td>
</tr>
<tr>
<td>Language direction</td>
<td>English &gt; Italian / (Italian &gt; English)</td>
</tr>
<tr>
<td>Prevailing mode</td>
<td>Whispering with portable equipment</td>
</tr>
</tbody>
</table>

1 okay > today we’re gonna talk about <
(. ) what can I do: a – uh (.) as a nurse
in the first five minutes (.)
some of our obj – objectives uh (.) are
to explore (. ) *key* opportunities to
enhance patient outcomes from a
危机事件 (. ) identify interventions
(.) which medical surgical nurses (. ) or
any healthcare provider can institute
before arrival of the crisis responders (. )
and discuss opportunities where crises
can be:: averted (. )
so what constitutes a crisis (. )
if you look at hemodynamic instability
15 (. ) we’re looking at uh (. )
arrhythmia:=: s ↑
some vital sign change:: s ↑

11 >”allora“< oggi parleremo↑ (. ) di cosa:
( . ) posso fare in quanto infermiere nei
primi cinque minuti (. ) di una crisi (. )
gli obiettivi so: no (. ) quello di
esplorare (. ) le opportunità *chiave*
per migliorare l’esito di una *crisi* (. )
identificare gli interventi (. ) che
l’infermiere (. ) o >qualsiasi operatore
sanitario< può – (. ) fa:: re o istituire
>prima dell’arrivo della crisi < e discus
– tere (. ) dell’opportunità (. ) per
*prevenire* una crisi (. ) allora che cosa
(. ) >costituisce una crisi< può essere
la:: instabilità emodinamica
( . )
aritm:: e (. ) cambiamenti dei segni
haemorrhage:↑ glucose abnormalities:↑ (.) and maybe (.)
20 perhaps just giving too many narcotics (.) uh neurological changes
they have any seizures or possibly a new onset of a stroke (.) respiratory
alterations respiratory distress
25 decreased pulse ox uh (.) brad – bradypnea (.) and then staff concern
we pretty much know our patients when they come in and we *know*
when we can say something is just
30 *not right* I just don’t feel comfortable and then *family*
concern they also know when they’re – well ( ) not the way it really should be
( ) so we have different crises at
35 UPMC and I know you guys have (.) a lot of these as well (.) but condition A
obviously is the full cardiac arrest (.) condition C is anything else uh (.)
where you need help (.) condition H is
the family or patient *can* initiate
for any uncertain plan or to elevate for assistance and if you just want
someone to listen to you (.) we:: uh have had a number of condition Hs
where I Vs couldn’t be placed and parents just (.) for our kids ( .) get the help they needed condition O is
*obstetric* crisis condition M is mental health (.) and then condition S
uh (.) we use it for security if we have a – ( .) patient who is out of control or
a family member ( .) and uh ( .) the other thing we started doing ( .)
especially with paediatrics and I know
you guys have a number of ( .)
*paediatric patients* is condition pink
and that is uh if you find a kid missing or you just don’t know where
they are sometimes kids tend to ( .) go
out find their own when uh ( .) (they aren’t with) their parents and don’t tell
anyone where they are going so ( .)
we’ve instituted that but all of these crises are a way to get the help you
need as best as they – uh as the: ( .)
*crisis* team can get there ( .) some of the criteria ( .) for initiating a condition
C ( .) and I have cards that have this information on it as well I’ll give to
you guys uh ( .) but you can see the vitali ( .)
nor – ( .) e::hm ( .) livelli irregolari di
 gluosio ( .) or ma – ( .) care – magari::
cecessive quantità di narcotici
 cambiamenti neurologici
(.)
epilessi::a o magari l:::itus ( .) poi
(. ) difficoltà respirator::rie un::;
diminuzione della: ossigenazione poi
la:: – ( .) magari la: ( .) preoccupazione
dello staff ( .) ora n – magari ( .) il
personale >l’infermiere< si:: ha la
sensazione che qualcosa *non va*;
>con il paziente< opp:::re ( .) >anche
la stessa famiglia si può accorgere *che
qualcosa non va< qualcosa non è
normale( .)

ci sono diversi tipi di – *crisi* di
crises at UPMC so come
all’ismett la condition °A° ehm è per
arresto cardiaco la condition °C° ( .) un
altro tipo di crisi dove comunque è
necessario:: l’aiuto la condition H ( .) s –
sono appunto la: – i famiglie:ri o il
paziente che: ( .) appunto chiede:
as:ssistenza ( .) e quindi il paziente vuole
essere ascoltato magari:: è un paziente
che: aveva >dei problemi< con
l’acce::ss o ( .) >appunto< comunque chiam – a:::vano per ( .) chiedere: ( .)
aiuto la condition °O° crisi ostetrica
condition M ( .) crisi ( .) neurolo:gia
tem::iale< la condition °S° is – ci –
quando è necessario l’aiuto della
sicurezza
( .) un’altra cosa che abbiamo iniziato a
fare soprattutto con i pazienti pediatrici:
so che qui all’ISMETT avete: ( .) un
certo numero di pazienti pe:diatrici ( .)
la condition °P° ( .) ad esempio se ( .)
c’è un bambino con
( .)
una:: condition °pink* chiamata pink
ovvero rosa nel caso: appunto non si
riesce a trovare il bambino e: lui se n’è
andato da qualche altra parte
( .)
e così appunto si richiede l’intervento
veloce per rispondere
alcuni dei *crite::ri(a)* per iniziare a
chiamare una condition °C*
( .) ho queste appunto:: informazioni in
una piccola (. ) cartellina e in un
respiratory rate (.) anything less than eight (.) or greater than thirty-six (.) a new (.) onset of difficulty breathing↑ (.) a new pulse oximeter reading which is less than eighty-five percent (.) for more than five minutes (.) unless the patient suffers from chronic hypoxia (.) or a new requirement for more than fifty percent of oxygen (.) in order to keep the saturations up to u::h above eighty-five percent (.) a heart rate (.) of less than forty (.) or one forty (.) uh >greater than one forty< with new symptoms (.) and *definitely* any rate over a hundred and sixty (.) you need to call a condition (.) if the blood pressure (.) of a patient is less than eighty or greater than two hundred systolic (.) or u::h one ten diastolic with symptoms such as neurological change::s chest pain or difficulty breathing (.) and then you can see the acute neurologic changes↑ loss of consciousness↑ u::h very lethargic or difficulty waking↑ if they collapse suddenly ↑ if they have a seizure and they are *not* in a unit that uh (.) a neurological unit (.) a sudden loss of movement or weakness of the face arms and legs (.) and others uh (.) if you: (.) if it’s more than one stat page required to assemble a team you need to respond to a crisis (.) patient complaint of chest pa::in unresponsive to nitroglycerine *or* if you can’t get the doctor to call you back (.) colour changes in the patient’s extremity or if they have become pale dusky grey or blue↑ (.) unexplained agitation more than ten minutes (.) if they (.) have tried a suicide attempt↑ (.) they’ve uncontrolled bleeding especially bleeding into the airway↑ (.) narcan is used without immediate response↑ (.) or a large acute blood loss (.) and truly don’t hesitate to call a:: condition C to get help (.) we’ve called uh (.) because we have had issues in the past where the *crisis* teams did not come quick enough↑ and instead o:f getting into trouble or – (.) we:: called help – for help early and the team came in and librettino questo qua che vi ho mostrato allora una frequenza minore di °otto° (.) serie di difficoltà respiratorie:: (.) l’ossimetro – l’^ossigenazione^ (.) minore del ottantacinque – meno dell’ ottantacinque per cento (.) oppure è necessario più del cinquanta per cento di ossigeno per mantenere la:: saturazione sopra l’ottantacinque per cento la frequenza cardiaca: minore di quaranta o *cento*quaranta superiore a centoquaranta con: sintomi nuovi o comunque (.) qualsiasi frequenza superiore a centosessanta (.) se la pressione è (.) minore di ottanta o superiore a dueceto↑ sistolica↑ (.) o centodieci per la diastolica oppure cambiamenti neurolo:gici dolore toraci – co difficiltà a respirare (.) potete vedere appunto cambiamenti acuti neurologici mancan – >la:< per perdita di coscienza: paziente letargico difficoltà a respirare o se c’è un collasso improvviso (.) appunto una °crisi neurologica< (.) una: >crisi dei movimenti< o comunque debolezza del vi:so dei muscoli da::: del viso delle braccia delle gambe (.) °app – ° non risposta alla nitro –nitroglicerina o se il medico non è disponibile anche in questi casi può chiamare la: (.) condition se le: – il paziente cambia appunto ehm il colore del – del viso è un po’ più pallido o il colore è cianotico (.) oppure u::n tentativo di sricidio un sanguinamento (.) incontrollato (.) soprattutto per quanto riguarda le vie respiratorie (.) e una (.) perdita di sangue (.) abbondante (.) ci sono stati problemi in passato >quindi < (.) quando appunto il team di risposta non era (.) adeguato abbiamo appunto comunque chiam:ato la condition H e
the patient actually (.) >didn’t have to
go to the I C U< (.) so what are
priorities when dealing with a patient
crisis (.) what do we think the first
things we (.) do are (.)
((pause)) ((waiting for the answer))
the A B C’s↑ ((someone from the
audience says: “assess the patient”))
assess yeah assess the patient do the A
B C’s and uh I don’t know if you guys
have this here but I noticed when
crises are just kind of lurking (.)
people suddenly decide to take a
break or they go to lunch and I
know uh (.) a lot of people do that
because of fear (.) and their lack of
confidence in their abilities (.) >but< (.)
there are some key interventions
that we can perform to enhance crisis
response processes (.) and we need to
be proactive to prevent the crisis in the
first place so looking a few steps – (.)
being a few steps ahead of the patient
problem well truly of our uh (.) any::
(.) problem that we could – uh (.) that
we might have for a patient (.) so
what’s the most important thing to
know (.) we need to know what your
organization’s crisis response
process is (.) how do you get
assistance is there a phone number
that you ca:ll↑ is there uh (.)
equipment that you need to get↑ or
you know just how do you get that
assistance and what are staff roles and
s – responsibilities (.) perhaps – your
unit secretary makes the call↑ does the
O S S bring the crash cart in↑ is there
a n – nurse on the unit or an I C U
nurse (.) I know uh (.) on the step-
down unit I see people have different
uh *code* responsibilities so that (.) is
a very good thing to have in place and
you wanna practice the process to
improve (.) mock co – codes including
all levels of staff whether be the unit
secretary uh (.) the physical therapists
(.) respiratory (.) bring all of those
people together and the best way is to
just keep practicing and standardizing
your process↑ so that when a crisis
happens everyone’s in place and it’s
more organized (.) and I know uh (.)
with your simulation lab that’s a *great* way to practice and to really get those processes in place uh (. ) we: put together actually a crisis (. ) team training (. ) in our simulation department through U P M C a:nd different physicians nurses uh (. ) physical therapists respiratory therapists all come and go through this training and (. ) we – it’s (. ) much better to practice on a high-fidelity mannequin than (. ) to deal with it in real life and not kind of know what to do and have complete chaos so:. it’s – you know using the simulations and doing the mock codes is very important (. ) so what typically happens in a crisis< you really want >to set the scene< you wanna just take a look at the environment look at the site look at the atmosphere the situation what is truly going on ((I2 makes a gesture asking to slow down)) is it c –((to I2)) °am I going too fast↑° ((I2 nods)) °okay° ((soft chuckle)) is it chaotic or is it very organized (. ) is everyone knowledgeable of the patient (. ) do you have what you need to address the problem do you have all of that information (. ) you might even anticipate what the response team (. ) may ask for and this is where – uh >as far as information goes< S bar could be (. ) a very good ( ) to use and avoiding chaos is the goal we at Shadyside are focused on educating with a mnemonic (. ) it’s called O A B C and O stands for organized we wanna come in and get our team organized so that then (. ) once everybody is in their role they can follow the A B Cs and uh hopefully (. ) as (. ) the process improves↑ everything’ll work in a timely:: simultaneous fashion (. ) so >once you identify a crisis< you wanna call for help get that help there as fast as you can some items uh to help the situation↑ a pulse oximeter obviously maybe you need a monitor↑ a defibrillator↑ A E D↑ (. ) of some kind (. ) does the patient have I V access↑ oxygen↑ crash cart these are the (. ) voi avete un laboratorio di simulazione e questo è il: modo migliore appunto per fare “esperienza° e per fare pratica (. ) abbiamo gestito (. ) la formazione di:: alcuni team di risposta alle crisi (. ) e diversi medici infermieri tera – (. ) *pisti* della respirazione fisioterapisti sono stati coinvolti in una formazione ed è (. ) appunto la cosa migliore fare pratica con un mani – chino che invece improvvisarsi poi ehm in una vera e propria: crisi quindi la:: fare appunto: la simulazione simulare delle simulazioni è veramente importante (. ) cosa succede di solito durante una crisi bisogna comunque preparare (. ) la scena bisogna guardare l’ambiente:: guardare l’atmosfera: la situazione: che cosa sta succedendo in realtà ((pause)) se c’è troppo caos o veramente è un ambiente organizzato sono tutti infor – sono tutti informati sul paziente bisogna affrontare il problema avere tutte le informazioni potere appunto anticipare delle informazioni al team di risposta (. ) questo potrebbe essere anche una cosa molta importante evitare il caos questo è il nostro obiettivo a Shadyside noi cerchiamo di:: (. ) noi formiamo con questo atr – con – usiamo questo acronimo O A B C noi vogliamo che il team sia organizzato quando: (. ) tutti (. ) sono nel proprio ruolo possono seguire appunto l’A B C il processo con::: non appena le::: appunto il processo migliora tutto funzionerà molto “in maniera più organizzata° (. ) non appena viene identificata la crisi si chiede aiuto (. ) arrivare al luogo della crisi il più velocemente possibile allora cos’è necessario (. ) u:::n (. ) a – avere un defibrillato:re (. ) un defibrillatore automatico esterno accesso venoso (. ) il saturimetro (. )
basic things that are needed uh (.) for a crisis situation and these should all be in place by the time the crisis team will arrive or your code team and then

> the medical record you guys have an advantage (.) here↑ because you have the ability to have those in the room
> unfortunately we are so ((soft chuckle)) a step behind and trying to get all of that (.) u::h in – to Shadyside (.) and good teamwork that’s (.) obviously what is *so* important and *so* needed and I’ve seen so much of that in walking around the units here

at ismett you guys work together to get things done and to accomplish the goals and (.) it just seems that you guys are very organized and very focused on the patients (.) so things that any healthcare provider can do in the first five minutes and – by *any* healthcare provider I’m talking about O S Ss physical therapy physicians uh respiratory therapy and the nurse (.)

the first thing is to remain calm I know people tend to get all (.) *hyper* ( ((soft chuckle)) and excited during a uh (.) *code* situation (.) place the patient on a monitoring device make sure they have any A E D↑ (.) defibrillator↑ available↑ apply a pulse oximeter (.) and make sure the oxygen is in place (.) place a backboard a::nd you’re probably wondering (.) >do we have to place that< and we have been educating uh through (.). basic life support *to* use the backboard uh (.) because you never know (.) when a patient is gonna decompensate and then at that point it’s gonna be even harder to get that backboard either and as well you might have a patient who has decreased glucose but he’s still awake (.) *but* again you never know

we still encourage (.) the backboard to be placed so that in case uh – the patient will decompensate you’re available and ready (.) and you’re always gonna be thinking again a few steps *ahead* and begin C P R if indicated uh but make sure you have help first (.) if you’re the first responder or the nurse in the room (.)

tutte queste sono cos:e materiale necessarie che (.) dovrebbero essere già comunque (.) *pronte* quando arriva il team di risposta e in più la cartella clinica voi avete un vantaggio qua perché avete la possibilità di avere la: (.) cartella (.) nella stanza non è: la stessa cosa (.) presso il nostro ospedale al Shadyside (.) poi (.) è necessario appunto (.) ho visto appunto (.) qui all’ismett ehm c’è un *bel* lavoro di squadra di gruppo ehm il personale comunque lavora assieme e sembra appunto che abbia una buona organizzazione molto (.) concentrati *sull’assistenza al paziente* (.) allora (.) cose che si possono far:re >che l’operatore sanitario può fare nei primi cinque minuti< e io parlo appunto di: fisioterapisti medici ausiliari (.)

terapisti della respirazione *e* gli infermieri la prima cosa è mantenere la calma di solito appunto si è veramente: nervo:si (.) quando c’è una:: condition posizionare il paziente attaccare il paziente al monitor per – assicurarsi che vi sia il defibrillato:re poi (.) avere il saturimetro e assicurarsi che l’ossigeno sia posizionato e poi usare appunto il backboard la tav – vola da posizionare sotto il paziente in ogni caso (.)

perché comunque non – non bisogna (posizionarla) quindi non si sa mai quando il paziente sarà scompensato quindi (.) ci potrebbe essere un paziente (.) che: ha: u:n abbassamento dei livelli di glucosio *ma* comunque non si sa *mai* incoraggiamo sempre l’utilizzo appunto il posizionamento della tavola in caso appunto il paziente (.) scompensa (.) e poi bisogna pensa:re sempre ess – essere un passo avanti e poi iniziare la: rianimazione cardiopolmonare (.)
Appendix Six

and then (. ) things any nurse can do (. ) as assure (. ) a functional (. ) I V access or place one (. ) and (. ) you probably wonder (. ) do I start I V fluids↑ I have not known (. ) normal saline to kill anybody so I would say start normal saline if the patient should be in congestive heart failure↑ or acute renal failure↑ there is *always* the ability to diurese or dialyse after (. ) the situation (. ) have a crash cart at the bedside (. ) you always wanna make sure you have the equipment↑ obtain the patient chart (. ) and medication administration record↑ (. ) gather your thoughts of the important information the team will need (. ) u::h this is the down and dirty (. ) the most recent vital signs↑ any input and output and follow (. ) the – (. ) we call the ample (. ) *A* is allergies (. ) what – (. ) are their allergies and we’re not – (. ) asking about dust (. ) >we wanna know are they allergic< to I V dye↑ certain medications↑ *M* is medications whether – (. ) have been – (. ) been ordered new medications in the last (. ) you know *twelve* hours have you changed the dos:ce↑ anything out of the ordinary with meds (. ) *P* is past medical history we’re not concerned if the patient had – (. ) a colic ten years ago (. ) what we’re concerned with is (. ) did the patient have any aortic valve replacement is the patient on heparin now (. ) and do we think the patient’s G I bleeding (. ) so those are the things we want to focus on (. ) *L*↑ is last meal when did they eat last and we’re worried about uh *aspiration* (. ) as well as intubation so we’re worried about *that* *with that* and then E u:h (. ) is event what happened and how did you find the patient (. ) and then >a lot of people wonder< (. ) should family be present and uh (. ) it *truly* depends on your organization’s process or policy↑ but they’ve done research over the last ten years (. ) and have looked at different (. ) crisis situations and truly the family members (. ) just want to make sure (. ) their family members uh (. ) were (. ) >poi< (. ) cosa può fare appunto l’infermiere (. ) assicurarsi che l’accesso: endovenoso sia posizionato (. ) s – ci si chiede magari inizio i fluidi↑: non – la – una soluzione fisiologica non ha mai ucciso nessuno quindi magari iniziare appunto la: soluzione salina se – vi è una insufficienza cardiaca o renale c’è sempre – (. ) appunto la possibilità magari di dover dializzare il paziente al:: termine avere sempre il crash cart nella stanza (. ) e – (. ) sapere appunto quali farmaci sono stati somministrati (. ) appunto raccogliere tutte le informazioni che potrebbero >essere necessarie al team di risposta< segni vita:li il bilancio idrico (. ) eseguire questo: acronimo l’ample A allergie quindi sapere se ci sono allergie (. ) oppure allergie al mezzo di contra – contrasto a certi farmaci (. ) se sono stati ordinati farmaci nuovo:. i nelle ultime dodici – (. ) o:mre >se sono state cambiate< le dosi (. ) qualcosa che che (non) è comunque – (. ) fuori dall’ordinario >poi< (. ) M per la storia l’anamnesi noi s::iamo interessati a sapere se il paziente ha avuto una sostituzione della valvola aortica per esempio (. ) *se le::° (. ) quindi sono alcune cose che dobbiamo sulle quali bisogna conci – con:: e:hm >concentrarsi< poi sapere ad esempio qual è st – quand’e stato l’ultimo pranzo l’ultimo (. ) *pasto* (. ) poi la E è per evento cosa è successo e come avete – in che condizioni avete trovato il paziente (. ) allora ci si chiede se la famiglia doveva essere presente dipende comunque dalla – dalla policy dall’organizzazione del processo ma negli ultimi dieci anni si sono: state analizzate diverse crisi diverse condition di solito la famiglia vuole assicurarsi che (. )
treated with — *respect* (. ) were — had a pain — had a pain free death (. ) died with dignity (. ) and were just (. ) given every opportunity to live if they could they’re not looking to (. ) sue they’re just looking for that closure (. ) and (. ) *if* the family chooses *to* stay >you always wanna make sure that you have someone assigned< to that family member or family members (. ) and >if the family member comes in and is just out of control< then you need to (. ) >escort them out of the room< ‘cause they are adding to the confusion in the room (. ) >so can we as nurses prevent crises< (. ) evaluation of code events revealed that subtle changes happened six to eight hours prior to a crisis so early intervention obviously can: *prevent* a full blown crisis (. ) obviously if a patient is short of breath the R N titrates o::xygen↑ maybe:: the patient gets a little better↑ *then* (. ) becomes this – begins this cycle of demise and we had this huge time delay (. ) the other problem is we can contact the doctor (. ) and palliate the symptoms rather than be aggressive (. ) the one thing (. ) that (. ) all of our patients have on our side – on – on *their* side is our *astute* assessment skills (. ) *and* uh (. ) we just need to be *confident* in those assessment skills and know that we’re (. ) providing the best care for the patient (. ) (((cough))) often – uh times >it seems like forever< (. ) when you’re waiting for help I know it does for me when I’m in the situation so you always wanna stay as calm as possible keep the noise down (. ) raising voices connotes anger and fear and can often increase the chaos (((cough))) and then events are often a learning experience for many staff↑ so we don’t want to be critical of e – of each other but rather what process potentially failed (. ) we uh at U P M C (. ) in Pittsburgh do brief – *de*briefing sessions and that happens about a month after we’ve had a code situation well we’d sit around and we look at it not as a che i loro pazienti vengano trattati con:: rispetto (. ) se la – sono morti appunto in caso di morte che questa sia avvenuta con dignità e con rispetto (. ) non – sono li presenti per appunto (. ) per colp – ehm – dare delle colpe addossare delle colpe se la famiglia sceglie di essere *nella* stanza (. ) >bisogna (assicurarsi)< che ci sia sempre qualcuno dedicato ad assistere (. ) i parenti e in caso se (. ) comunque: sono troppo nervosi o comunque e::hm non è possibile controllarli o invitare a uscire dalla stanza allora possiamo prevenire una crisi↑ (. ) nella valutazione degli eventi delle condition (   ) e::hm tra l’altro che:: ci sono prima di una crisi nelle prime sei otto ore ci sono stati dei cambiamenti nelle condizioni dei (. ) pazienti magari una:: ehm difficoltà respiratorie o: mancanza di ossigeno poi comunque c’è un miglioramen:::to e poi invece questo:: il paziente comincia a deteriorare a peggiorare (. ) in questo caso appunto possiamo comunque cont – chiamare il:: (. ) dottore e e::hm trattare i sintomi invece che essere comunque aggressivi (. ) è importante comunque la valutazione bisogna (. ) essere:: sicuri della: valutazione e fornire la migliore assistenza per il paziente (. ) spesso (. ) >hai – < sembrano che pochi minuti durino un’eternità (. ) bisogna essere: rimanere più calmi possibili fare: il meno rumore possibile e:: comunque non fare troppo rumore per evitare il caos (. ) spesso si *appre:nde* molto dalle crisi (   ) di:: non bisogna criticarsi l’un l’altro *ma* capire cosa non è andato bene e discutere (   ) ciò (. ) a Pittsburgh facciamo delle *riunioni* questo di solito appunto un mese dopo una ehm condition e non questo:: >non viene criticato nessuno
blaming session (.) but we’re looking at *what failed* it’s not usually a *people* failure it’s a process failure if there wasn’t – the crash cart wasn’t supplied fully we didn’t have all the equipment we needed uh (.) maybe there was no backboard something but this is a way for us to learn and to improve our process and to make it better and uh (.) just to really focus on teamwork and if there was any (.) uh *lack* of teamwork (.) and we really want to make sure that uh >it ends up being< a good debriefing session that everyone is learning everyone feels okay coming out and we always want to know how we can do it better (.) some final thoughts (.) are to share your expertise among the team welcome suggestions and guidance (.) respect each other’s knowledge and expertise (.) recognize that you’re not alone (.) there’s a team of people that are gonna come and help (.) so:: you’re not by yourself and be confident in your skills and education you worked very hard to get to the point were you are so truly (.) *cherish* those goals that you have and the knowledge (.) now you can go and continue saving lives (.) and I have cards uh that I will give you that have uh (.) the criteria for initiating a condition C and then there’s *team rules* and goals on the other side so it talks about where – and I’m – sorry these aren’t in (.) Italian but they are in English so

**durante questi incontri< (. ) ma di solito vogliamo vedere che cosa non ha funzionato nel processo magari: il crash cart non era ben attrezzato "non c’erano tutti i materiali presenti" (. ) magari:: non c’era la tavola presente questo è un modo per noi per parlare e magari migliorare il processo concentrarsi appunto sul lavoro di squadra (. ) se c’è stata una mancanza (. ) >per quanto riguarda il lavoro< di squadra (. ) tutti apprendon – bisogna assicurarsi che tutti apprendano qualcosa durante queste riunioni e appunto è un (. ) *modo per migliorare< (. ) >ora< alcune considerazioni finali quindi *condividere* la propria esperienza con gli altri membri del team (.) e lavorare comunque in maniera collegiale e rispettosa capire che comunque non si è da soli ed essere sicuri delle proprie capacità e della:: propria formazione quindi condividere queste appunto abilità e la propria esperienza con gli altri (. )

cosi potrete continuare a salvare altre vite (.)

ho appunto qui sono:: dei bigliettini delle: (.) con i criteri appunto per iniziare una condition C e ci sono i ruoli del team (. ) mi sc – (. ) scusate che non sono in italiano (. ) però possono essere >°(tradotte)<

Ii una domanda (. )

Ii chi decide (. )

pe::r – chi decide i criteri:: da:: (.)

IIi quali sono comunque i
criteri (.)
tu parli appunto dei
Appendix Six

code=
criteri per chiama::re una
N =mhm=
condition (;)
445 INF1 =okay↑ and who decide those
criteria
*chi* decide
((the US nurse looks puzzled))
questi criteri
N °o::h° we::
I2 ((off mic to the US nurse)) who
defines them
((looking at I2)) °who defines
them° ((looking at INF2)) we::
who define – sorry (;) who
define
450 N we:: got those from our uh
we:: got those from our uh
I1 allora
N crisis team
noi li abbiamo:: (;)
N =okay=
dal nostro team di risposta
I1 allora
INF1 okay
è il team di risposta
N so it’s our crisis team that=
dal nostro team di risposta
INF1 =okay=
è il team di risposta
460 N =put those together and (;)
we have a team of physician –
la abbiamo un team
N on a team ( ) physicians
di medici un team
INF1 =okay=
comunque composto
nurses educators (.) so there’s a
di medici un team
number of people that decided
comeunque composto
465 those criteria plus it goes along
di medici educatori
with uh (;) acute life support
e poi (;) è comunque conforme
the A C L S and B L S (.)
con i corsi di A C L S
(advanced)
Appendix Seven: Abstract (English)

Research on interpreting in the medical field typically focuses on asymmetric interpreter-mediated encounters between healthcare professionals and migrant patients, while devoting little attention to intercultural face-to-face communication among peers. Yet a quality healthcare system is also a result of accurate communication and productive relationships among medical co-workers. From an atypical perspective, this study explores interpreting in a bilingual hospital in Southern Italy, ISMETT, whose US and Italian employees interact not only with patients, but also with each other, supported by a team of English-Italian in-house interpreters.

The case-study project was developed from an insider’s vantage point, first as graduate intern and subsequently as member of ISMETT Language Services (LS). Fieldwork was adopted as the main research strategy, while combining an inductive ethnographic approach with a discourse-analytical one; thus the prevailing research paradigm is the DI (dialogic discourse-based interaction) paradigm of interpreting, and the study uses multiple methods of collecting and analysing qualitative data.

Valuable insights are initially gained by modelling interpreting at the level of the healthcare institution; more specifically, a conceptual model is designed that accounts for the unpredictable nature of interpreting through a range of interacting dimensions, while offering a glimpse of the manifold subdomains in which interpreters operate. Narrowing the investigation down to the medical field, the genesis of the Department’s normative behaviour as well as the resulting acquisition of a specific ‘corporate habitus’ is outlined on the basis of one-to-one semi-structured interviews with the LS members. The interpreting dispositions thus identified are compared with the activity proper as emerging from a corpus of recorded and transcribed interpreted interactions, featuring one nursing assessment, thirteen nursing reports, and two training sessions. The transcript analysis is guided by a theoretical model that correlates the linguistic production and communicative performance of ISMETT interpreters with the dimensions and constraints that shape each interaction of the corpus.

The study shows how the specific dimensions and constraints of different communicative events are reflected not only in the situation-based macro-choices made by the LS members at the beginning of the encounters, in terms of product, interactional
management, and role, but also in the constant micro-adjustments and shifts during the exchanges. The triangulation of data from the different sources also suggests an overall consistency between the *habitus* of ISMETT interpreters and the norms they have developed throughout the years, especially as a result of on-the-job training and professional socialization processes. Yet the *habitus* of the LS cannot be considered representative of interpreting or healthcare interpreting as such, but is rather a function of the peculiar institutional context in which it was developed. In particular, the privileged status of in-house interpreters and the multifaceted character of interpreting at ISMETT are found to call for the interpreters’ flexibility and, more often than not, marked visibility, in order to provide each customer with the most suitable, ‘tailor-made’ interpreting service.

Diese Fallstudie wurde aus dem Blickwinkel einer Angehörigen der Institution verfasst, die zuerst als Praktikantin und anschließend als Mitarbeiterin des ISMETT-Sprachendienstes (LS – Language Services) tätig war. Die Studie verfolgt also methodisch den Ansatz der Feldforschung, wobei eine Kombination zwischen einer induktiv ethnografischen und einem diskursanalytischen Ansatz gewählt wurde. Die Arbeit versteht sich somit als Beitrag zum DI-Paradigma („dialogischer Diskurs und Interaktion“) der Dolmetschwissenschaft, basierend auf der Erhebung und Auswertung qualitativer Daten durch eine multimethodische Vorgehensweise.

Nützliche Einblicke werden eingangs durch das Erstellen einer Modellierung des Dolmetschens im Rahmen der Institution geschaffen. Dabei wird ein konzeptuelles Modell entworfen, das die Unvorhersehbarkeit des Dolmetschens im Einflussbereich verschiedener interagierender Bedingungsfaktoren berücksichtigt und zugleich einen Einblick in die zahlreichen Teilbereiche, in denen Dolmetscher arbeiten, ermöglicht. Im Bezug auf den medizinischen Einsatzbereich als solchen behandelt die Studie sowohl die Entwicklung der normativen Verhaltensstandards des Sprachendienstes als auch den Erwerb eines speziellen „Habitus“ seiner Mitglieder. Dafür werden halbstandardisierte Einzelinterviews mit LS-Mitgliedern ausgewertet. Die so ermittelten Handlungsdispositionen der Dolmetscher werden mit der konkreten Dolmetschpraxis verglichen, wie sie in einem Corpus von aufgezeichneten und transkribierten dolmetscher-
vermittelten Interaktionen dokumentiert ist. Das Corpus umfasst ein Aufnahmegespräch, dreizehn Krankenpflegeberichte und zwei Schulungseinheiten. Die transkriptbasierte Analyse orientiert sich an einem theoretischen Modell, das die sprachliche und kommunikative Leistung der ISMETT-Dolmetscher mit den die im Corpus erfassten Interaktionen bedingenden Einflussgrößen in Beziehung setzt.

Appendix Nine: Biographical sketch/Kurzbiographie

Roberta Favaron was born in Dolo (VE), Italy, on March 22nd, 1976. In 2002 she graduated in Translation from the School of Modern Languages for Interpreters and Translators (SSLMIT) of the University of Trieste, where she worked as lecturer in Italian to foreign students and researcher in the field of dubbing and subtitling from September 2002 to August 2004. She was employed as full-time Italian-English hospital interpreter at the Mediterranean Institute for Transplantation and Advanced Specialized Therapies (ISMETT) in Palermo from September 2004 to September 2008. She is currently collaborating with the National Institute for Health Migration and Poverty (NIHMP) in Rome as Italian-English translator. She has published in the field of dialogic interaction in medical interpreting.


E-mail: r.favaron@gmail.com