Remote (telephone) interpreting in healthcare settings

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1 Introduction

Remote interpreting can take different shapes and forms. Ruiz Mezcua (2018: 10) defines remote interpreting as the interpreting that ‘happens when the interpreter is not in the same room with the rest of the participants. This means that the interpreter needs a piece of equipment or tool to be connected to the speakers.’ Braun and Taylor (2011: 352) note that ‘[r]emote interpreting by telephone is nowadays often called telephone interpreting or over-the-phone interpreting’. Remote interpreting implies that the primary participants in a conversation who are together at one site connect with an interpreter in another location through a video or audio link, and the interpreting services are provided simultaneously, consecutively and/or bilaterally in dialogue mode.

When the main participants are not at the same site and connect to one another through a three-way telephone or video call, the method of interpreting is called, following Braun and Taylor (2011: 352), ‘teleconference interpreting’. Although the authors prefer ‘telephone-based interpreting’ as an umbrella term for these two modalities, they also acknowledge that ‘telephone interpreting’ is used widely as a shortcut. Following Ruiz Mezcua (2018: 10), in a three-way telephone call ‘interpretation […] takes place in consecutive mode or dialogue mode, which means that the interpreter waits until the speaker finishes their statement before rendering the interpretation into the target language’.

In medical settings, both remote telephone interpreting (when service provider and patient are physically together and connect via telephone with an interpreter) and interpreter-mediated phone calls (three-way phone call) occur. The first modality is used, for instance, during onsite doctor-patient consultations or when allophone patients (those who do not speak the language of the host country) need to communicate onsite with healthcare staff, whereas the second one is needed, for example, when patients call a medical emergency number or when they are contacted by clinics to schedule medical appointments.

The first known reference to telephone interpreting in academic literature is that by Paneth, who characterised this modality as a ‘very neat and obvious use of interpreters’
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(Paneth 2000: 39) and foretold its future development. The first service for telephone interpreting was set up in Australia already in 1947 by TIS National (Translating and Interpreting Service). At the time, telephone interpreting services were offered thanks to joint efforts by Red Cross and the Commonwealth; they came to be offered nationally and for free under the auspices of the Australian Government from 1973 onwards (Cabrera Méndez 2016). Around 40 years later, telephone interpreting reached the United States, where Jeff Munks (a policeman) and Michael McFerrin (a former marine) joined forces to set up the company Language Line (Kelly 2008b). Ten years later, telephone interpreting arrived in Japan and the United Kingdom (Phelan 2001). Nowadays, as Ruiz Mezcua (2018: 11) mentions, ‘[t]elephone interpretation is becoming increasingly common […], as it provides a professional interpreting service almost instantaneously, saving time and money, and with successful outcomes’.

Within the wider field of public service interpreting, telephone interpreting is particularly popular in healthcare settings (Braun 2015: 353). The reasons for this are varied and usually revolve around interpreters’ availability (Phillips 2013; Gracia-García 2002; Mintz 1998; Fors 1999; Hewitt 1995, Jones and Gill 1998; Wadensjö 1999) and cost-effectiveness of the interpreting provided (Ko 2006; Phelan 2001; Rosenberg 2004).

In healthcare settings, the number of language combinations in demand is high; it is also often difficult to predict which language is going to be needed and when. Although many medical consultations are scheduled beforehand, patients’ registers do not include information on the languages they speak and, consequently, whether they will need an interpreter to be able to communicate. Furthermore, many interactions in the healthcare settings are unplanned, not only in emergency situations, but also in face-to-face encounters with administrative services (for example, when patients try to arrange an appointment) or in telephone calls when patients phone a doctor’s surgery or hotline, or receive calls about their appointments or test results.

Telephone interpreting services can be provided by governmental organisations, private agencies and non-profit organisations (Ruiz Mezcua 2018). In public healthcare settings, private institutions (hospitals and healthcare services) launch calls for tenders, and telephone interpreting agencies bid to provide services. Private hospitals and clinics can either contact interpreters directly or through agencies which offer telephone interpreting. Recently, mobile applications made telephone interpreting even more popular, as patients themselves or anyone else acting on their behalf can now contact an interpreter directly without having to rely on healthcare institutions or private practices, which also implies that the payment of interpreting services is assumed by patients themselves (Jaime Pérez 2015).

As interpreting assignments in healthcare settings are often short (compared to e.g. conference interpreting), telephone interpreting emerges as a convenient option, as it cuts the cost of travel for interpreters, and consequently, for the clients. Waiting times are usually difficult to predict, as it is not uncommon for medical appointments to be delayed, which adds on to the costs of an interpreter onsite. Telephone interpreters, on the other hand, are not contacted until the conversation actually starts. Although these are the most commonly stated reasons for the popularity of telephone interpreting in healthcare settings, this interpreting modality has other advantages that will be commented on in the following sections.
2 Critical issues in telephone interpreting

Telephone interpreters require specific skills to perform effectively without being physically present during the interaction. They usually do not have access to contextual information, including the individuals who are present, their roles, body language, movements, as well as other relevant elements which can provide contextual information, such as clothes, furniture, instruments, signs, etc. Furthermore, difficulties may arise due to the use of a telephone, such as lack of coverage, damaged or old equipment, its incorrect use, etc. (Pertusa Elorriaga 2012). Telephone interpreting therefore has a set of characteristics and peculiarities which will be explored in this section under the following subheadings: lack of visual context, coordination of discourse, use of technology, working conditions, stress and emotional impact, training, and ethics.

2.1 Lack of visual context

One of the most critical issues concerning telephone interpreting is the lack of visual context. It has been singled out by researchers and practitioners as one of the most notable difficulties of this modality of interpreting and has been frequently targeted as a research topic and described as both an advantage and a disadvantage (Heh and Qian 1997; Phelan 2001; Gracia-García 2002).

Visual cues help onsite interpreters to gain a clearer understanding of the communicative situation and to make interpreting decisions. Telephone interpreters, however, miss out on gestures, postures and facial expressions (Gentile, Ozolins and Vasilakakos 1996; Roy 2000; Wadensjö 1998, 1999; Oviatt and Cohen 1992; Fors 1999; Kurz 1999; Mack 2001; Vidal 1998; Lee 2007) and they have to develop coping skills to address this (Lázaro Gutiérrez and Cabrera Méndez 2019). Interpreters themselves have stated that the lack of visual cues results in additional effort. For example, David Mintz, former President of NAJIT (National Association of Judicial Interpreters and Translators) sent a letter to the journal Proteus after having visited the US Court Telephone Interpreting Project together with other interpreters. Experienced interpreters reported having had to struggle with the insecurity that the lack of visual information provoked in them (Mintz 1998).

Lázaro Gutiérrez and Cabrera Méndez (2019) argue that telephone interpreters’ lack of visual context in healthcare emergency settings has a high impact on interpreters’ performance. They may, for instance, have no information on the number of people present in an emergency setting or on their particular roles (e.g. paramedic, nurse, doctor, etc.). The impossibility of proper briefing prior to an emergency aggravates the situation.

Other researchers state that lack of visual context does not necessarily impair communication (Braun 2006) or affect the interpreter’s performance, as skilled interpreters are usually able to overcome these difficulties (Ko 2006), providing sound is clear and assignments are not long (Mintz 1998). They argue that interpreters are still able to perceive paralanguage and other auditory cues, such as tone of voice, breathing patterns, inflection, pitch, or volume (Kelly 2008b; Crezee 2013; Cheng 2015). In fact, non-verbal communication cues have even been considered a distraction by some researchers (Mikkelsen 2003, Lee 2007) and some interpreters prefer interpreting remotely because they can allegedly remain more neutral (Lee 2007) and/or avoid being in close physical proximity to unpleasant and/or traumatic situations (blood, vomit, injuries, etc.). Interpreting over the phone in healthcare settings may also ensure less interference with patients’ privacy.
Nevertheless, several authors agree on the unsuitability of telephone interpreting for particular situations. For example, Wadensjö (1998) discourages this modality when many participants are involved in a communication, and Kelly (2008a: 9) specifically suggests that telephone interpreting is not a good choice for those doctor-patient interviews in which visual information is especially important, such as patient education and teaching scenarios. In the same vein, patients who have to undergo mental health evaluations or have suffered from trauma might not be in a condition to communicate over the phone (see e.g. Lázaro Gutiérrez and Cabrera Méndez 2019, describing an interpreter-mediated consultation with a drunk patient). Lázaro Gutiérrez and Cabrera Méndez (2019) describe the most common challenges a telephone interpreter faces in healthcare settings and state that they often occur at the beginning of the interaction, as that is the moment when most information is missing. In their research, they found out that the interpreter repeatedly sought to collect contextual information by leaving aside an invisible role and interacting with healthcare providers and patients by means of questions and requests for repetitions.

2.2 Coordination of discourse

Discourse coordination is a typical concern in bilateral onsite interpreting but presents a set of particular challenges when performed over the phone. One of the main issues related to discourse management and coordination is the use of first- or third-person pronouns. Although interpreters are strongly encouraged to use the first person (Bot 2005; Kelly 2008b), it has been found out that telephone interpreters need to use the third person more often, particularly when difficulties and misunderstandings arise and interventions become necessary to provide clarification (Lee 2007; Hsieh 2006; Oviatt and Cohen 1992; Rosenberg 2004). This practice has also been reported as a means through which interpreters distance themselves from the interpreted information. For instance, Gracia-García (2002: 8) states that telephone interpreters in medical settings can more easily avoid situations in which they have to act as an advisor, such as culturally marked situations, episodes in which interpreters feel identified with or emotionally attached to patients, or cases when they are asked questions they are not prepared or qualified to answer.

Wadensjö (1999) studied coordination in telephone-interpreted conversations in depth and observed that inaccuracies arise for three main reasons: interpreters may fail to control turn-taking; they may not be able to retain long utterances in memory; or they may need to interrupt the participants to ask for clarification. Wadensjö also found out that it is more difficult to control turn-taking when the interpreter is not physically present and that this necessitates the interpreter to take a more active role; other authors such as Hsieh (2006) and Oviatt and Cohen (1992) also make the same observation. Similarly, as interpreters lack visual information, they may attribute any silence or naturally occurring pauses between turns in a conversation to a connection breakdown (Mikkelsen 2003; Oviatt and Cohen 1992).

Fernández Pérez (2015, 2017) also identified coordination of discourse amongst the specific skills telephone interpreters must possess. The interpreters’ coordination role involves managing the beginning and ending of the encounter, organising turn-taking, and interrupting the speakers at appropriate times. Lázaro Gutiérrez and Cabrera Méndez (2019) indicate that a good way to make this coordination task possible is to allow the interpreters to properly introduce themselves to all participants in the conversation. In this way, interpreters are able to explain their role and code of ethics, and suggest basic guidelines for successful communication. These guidelines may include avoiding speaking over each other, speaking directly to the interlocutor using the first person, not addressing
the interpreter directly unless it is necessary to transmit situational information, or to correct a misunderstanding. The interpreter may also wish to emphasise at the start that they will translate everything that is said and will keep the interaction confidential, and that they may have to speak on their own behalf if they feel there is a misunderstanding or a need to clarify information.

2.3 Use of Technology

The increasing prevalence of mobile phones and videoconferencing, the decreasing price of telecommunication costs, and the almost instant availability of large teams of interpreters through agencies have made telephone interpreting highly popular in recent years. These interpreters can receive calls from any part of the world, cover a wide range of languages and can commit to work over many hours a day, thus making it unnecessary to spend money on interpreters’ transportation to the location of the interaction.

Although technological improvements allow for more frequent and better communication, sound quality is still a concern. Several researchers have focused on technological needs of telephone interpreters and have emphasised the importance of the sound quality of the phone and connectivity of the line (Kelly 2008b; Lee 2007), particularly since the increased use of mobile phones. Mobile phones’ hands-free equipment is highly popular amongst clients, preferred over the passing of the handset back and forth, but have proved to cause difficulties for interpreters, as their use impacts on the sound quality and, consequently, the interpreters’ performance (Kelly 2008b; Rosenberg 2004). For instance, in the study carried out by Lázaro Gutiérrez and Cabrera Méndez (2019: 57–58), sound quality was not checked at the beginning of the interaction, and it took up to six minutes for the interpreter to be able to hear properly during a telephone call made from an emergency department. This prevented the interpreter from collecting essential details about the communicative event that would have helped her to subsequently build up the meaning in the interaction.

The main telephone interpreting agencies usually offer their clients telephone devices with dual handsets (landline) or headsets (mobile phone). However, healthcare providers have reported the unavailability of these devices (usually located in particular rooms or units) when they needed them and have expressed a clear preference for their own mobile phones. In three-way conversations, when patients are also in remote locations, it is impossible to control the quality of their devices or connectivity; therefore, it is not uncommon that connections break down or the sound quality is too poor for effective communication.

The appearance of smartphones allowed for further developments in telephone interpreting practice and accessibility. For example, in 2005, a Spanish company, Migralingua, developed an application called Voze, which popularised the use of telephone interpreting in Spain, as it was made available to any user with an Android-operating mobile phone. Before Voze, telephone interpreting services did not reach all users in Spain, since it was usually the public institutions that decided whether or not to offer this service, depending on their financial budgets and levels of awareness of the patients’ needs. This application has also become a platform for data collection that allowed for the evaluation of issues such as frequency of use, areas where the service was most requested, languages required and average length of calls. It also allowed random recordings of interpreting sessions for subsequent assessment of their quality (Jaime Pérez 2015). The user of this application may access telephone interpreting services anywhere in the world through
virtual geographic numbering and they can do so through an app for Android phones, the system’s website, or prepaid cards for use with any kind of mobile phone or landline. Apart from telephone interpreting, the application includes additional services, such as general, sworn, and express translations of short texts and pictures (of, for instance, handwritten texts or diagrams and images that contain text).

2.4 Working conditions

Professional interpreters and associations have often discussed telephone interpreters’ working conditions, as performance over phone implies a new understanding of interpreting assignments. One of the most discussed issues is the lack of briefing, particularly in emergency situations. The immediacy of telephone interpreting is both a great advantage and a great challenge for interpreters, as they often have to deal with unpredictable content (Lee 2007). Kelly (2008b) suggests that terminology frequently used in emergency situations should be provided for interpreters in advance. Some telephone interpreting agencies currently try and put together protocols and glossaries for their workers, however these efforts are not yet sufficient or widespread. Lázaro Gutiérrez and Cabrera Méndez (2019) suggest that service providers offer interpreters basic information about the setting, such as how many people are present and who is going to speak in which language, in order to avoid misunderstandings and render the conversation more fluent. Background information about the patient is also desirable.

It has also been mentioned that telephone interpreters are not able to specialise as much as onsite interpreters (Heh and Qian 1997; Gracia-García 2002) because they are subject to the contracts signed by the agencies they work for. This means that agencies may offer interpreting for regional healthcare services on the one hand, and for an insurance company on the other, hiring the same interpreters for both contracts.

One of the main advantages of telephone interpreting is its near constant availability. Agencies provide interpreting services round the clock in a wide range of languages. This can be achieved either through hiring interpreters from different time zones or by using local interpreters who prefer the flexibility of interpreting outside typical working hours (Kelly 2008b). Some agencies have developed online systems that allow interpreters to avoid being called outside their chosen working hours.

Interpreters are usually not paid for ‘being on-call’, although some agencies do make additional payments on a monthly basis for overnight and weekend shifts. The majority of telephone interpreters receive payment according to the number of minutes they are on the phone; some agencies may have a minimum amount of minutes paid to the interpreters for each call. As the interpreters can choose their working locations, they can combine their work as telephone interpreters with other occupations, such as freelance translation.

2.5 Stress and emotional impact

Most telephone interpreters work part-time and as freelancers (Crezee, Jülich and Hayward 2013; Iglesias Fernández and Ouellet 2018). It has been reported that the unpredictability and irregularity of their assignments, together with lower pay rates compared to other forms of interpreting, may cause stress and impact on work-life balance.

Crezee et al. (2015) argue that there are many factors that can cause stress for healthcare interpreters. Lower working rates, instability and unpredictability have already been
mentioned as examples, but other personal factors, such as life experiences, their level of resilience and their psychological skills naturally also play a part (Crezee et al. 2015; Cheng 2015). Besides these factors, some authors mention that remote interpreters suffer more stress than onsite interpreters. For instance, Andres and Falk (2009: 21–22) point, on the one hand, to the lack of non-verbal information, which could lead to confusion and misunderstandings, causing stress, particularly in healthcare settings where human lives are at stake. On the other hand, they mention that telephone interpreters may also have to deal with many different topics over a short period of time, which can lead to stress and a higher risk of quality loss. However, some authors, like Gracia-García (2002) point out that interpreters’ remoteness can allow them some detachment from the patients’ suffering and a relatively lower level of emotional involvement.

Generally speaking, public service interpreters and, in particular, healthcare interpreters, tend to empathise with their clients. It is hard for them to control their feelings when they hear traumatic experiences and have to recount them using the first person (Costa, Lázaro Gutiérrez and Rausch 2020; Hale 2007; Wadensjö 1999; Wilson 2010). Some situations, like end-of-life care, can be more emotionally-loaded (Schenker et al. 2012). Telephone interpreters find debriefing even more difficult, as most of the time they are not contacted prior to an assignment and miss the opportunity to obtain information and get ready, if needed, for an emotionally challenging situation (Wilson 2010), and sometimes they move too quickly to their following phone call, even before being able to recover from the emotional impact of a previous traumatic assignment (Kelly 2008b).

2.6 Training

Training provided to telephone interpreters is relatively scarce, even though it is crucial for high-quality telephone interpreting (Kelly 2008b). In Spain, for instance, the results of the investigations conducted by Luque (2008), Murgu and Jiménez (2011), Prieto (2008) and Martínez-Gómez (2008) point to a general lack of knowledge on telephone interpreting and, consequently, a lack of educational resources for both community interpreters and public service providers that use telephone interpreting systems. Kelly (2008b) mentions the need for specific protocols and training for telephone interpreting and contributes with a comprehensive guide for telephone interpreters which includes guidelines for working as a telephone interpreter, a full chapter on ethics, and scenarios for practice (2008b), as well as an abridged version specifically aimed at telephone interpreters working in healthcare settings (2008a). Verrept (2011), in his study of remote interpreters in four Belgian hospitals, signals that interpreters need supplementary training to make adequate use of equipment. Ozolins (2011) suggests that further research is needed in this field so that technological issues can be resolved and the performance of interpreters improved. Although Hlavac (2013) does not endow technology with a prominent position in the interlingual transfer, he acknowledges that telephone and video-link interpreting should be included in both training and testing interpreting programmes. Fernández Pérez (2012), another scholar insisting on the need for training specifically for telephone interpreters, first identifies the characteristics of this type of interpreting (lack of visual information, increased access to interpreters in a short period of time by a larger number of users from different backgrounds, use of technical equipment) and later establishes a classification of particular skills telephone interpreters need to acquire according to their two main roles: the discourse coordination role, as discussed above, and the translation role (e.g. adapting note taking to the use of telephone). Command of prosodic elements and direct/
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indirect speech are two further skills which relate to both roles. Fernández Pérez also designed a set of training activities based on role-play (2015).

Although when compared to onsite interpreting, remote and telephone interpreting involve some new skills that must be acquired, training in telephone interpreting at university level remains scarce for many reasons. First of all, the field of practice is relatively new. Second, in order to achieve optimum learning, a certain amount of technology is needed for its practice, which means that the little training that is offered at university level remains theoretical. Finally, it is a highly specialised field that does not fit easily into undergraduate programmes, and graduate programmes usually already have full course loads. University training usually consists of intensive workshops and seminars that take place over the course of a day or two and are not normally mandatory for undergraduate or graduate students. It is not rare for telephone interpreting agencies to be called upon to offer this kind of training to postgraduate programmes or in the form of professional development courses.

Therefore, the bulk of training available is provided by agencies that offer telephone interpreting services. Besides entry training for new workers (both members of staff and freelancers), telephone interpreting agencies have significant quality control and continuous professional development programmes. Training usually includes the use of specific protocols, basic information about the field in which work will be conducted (for instance, healthcare interpreting), and ethical issues. They also incorporate new content into their training programmes as needed for latest technological advances or new clients. Ongoing training is also usually provided as part of quality assurance programmes, and it is informed by the changing needs and emerging challenges.

In addition to the necessary general training in telephone interpreting, interpreters need training in the specific field they are working in – in this case, healthcare. To this end, interpreters need to gain knowledge of healthcare topics, awareness of typical procedures and communicative situations, linguistic and cultural knowledge, an understanding of terminology, as well as stress management skills for tense situations. In this field, it is also very important to know that a specific protocol is designed and established for each client institution (for example, some protocols for emergency hotlines require interpreters to ask themselves about personal data and location in order to gain time), and telephone interpreters must have a solid knowledge of these protocols and be aware of the motivation behind certain procedures and questions.

2.7 Ethics

Telephone interpreting can contribute to maintaining confidentiality and privacy (Hewitt 1995; Kelly 2008b; Wadensjö 1999; Rosenberg 2004; Phillips 2013; Ko 2006; Mikkelsen 2003). During onsite interpreted medical consultations, it is common that interpreters have to remain behind a curtain or turn around when patients are asked to get undressed, whereas over the phone, the interpreters cannot see the patients. Telephone interpreting also cuts down on cases where onsite interpreters are asked to stay with the patients in waiting rooms until the actual consultation starts; this reduces instances of personal conversation with patients (see Lázaro Gutiérrez 2018 for examples in which patients disclose information to interpreters when members of medical staff are absent).

A recurrent topic within interpreting ethics is role boundaries. In the healthcare domain, interpreters are considered part of the healthcare team that assist the patients, as dictated by medical protocols, and usually have some general knowledge of the medical
field. In Gracia-García’s words, ‘[…] guidelines on interpreter professionalism and ethics affirm […] interpreters are professional mediators and, therefore, both parties [medical staff, on the one hand, and interpreters on the other] should be present to discuss anything that is relevant to the medical case’ (Gracia-García 2002: 202). However, it must be remembered that interpreters are not medical staff and may lack information about particular protocols and procedures. The best practice would be to inform interpreters of the reasoning behind the questions and procedures so that they can better adapt their interpreted discourse to the situation (Lázaro Gutiérrez and Cabrera Méndez 2019). When the healthcare professionals ask interpreters for advice, for example on cultural matters, all parties should be conscious of the limitations of the interpreter’s knowledge and only base their exchanges on the information that is mastered by the interpreter.

3 Research on telephone interpreting

Six decades after the first mention of telephone interpreting by Paneth in 1957 (2002), research about this interpreting modality is still scarce (Ruiz Mezcua 2018). However, the increasing use of telephone interpreting in more diverse settings has stimulated the curiosity of researchers around the world, who have begun to study this modality either for academic purposes or in order to develop policy recommendations and training materials.

Among the first studies carried out on telephone interpreting, Oviatt and Cohen (1992) compared telephone conversations with and without an interpreter, and Wadensjö (1999) compared an onsite interpreter-mediated conversation with a telephone-interpreted one. A few years later, telephone interpreter-mediated conversations became a subject of enquiry on their own, distinct from onsite interpreting, and studies using large amounts of data were produced, such as that by Rosenberg (2002), who analysed 1876 telephone interpreter-mediated conversations in healthcare settings.

Although research about telephone interpreting that focuses on healthcare settings is limited, in recent years, several projects have focused on telephone and remote interpreting. For instance, the Department of Justice of the European Commission, within the framework of the Criminal Justice programme, funded the Avidicus project (www.videoconference-interpreting.net/index.html) from 2008 to 2016. It was coordinated by the University of Surrey and its main objectives were to identify situations where remote interpreting and videoconference interpreting are most useful within the legal field, to compare remote interpreting and face-to-face interpreting, and to elaborate on training courses for interpreting students, interpreters and legal professionals.

The group FITISPos-UAH, based in Madrid (Spain) and active since 1998, is also carrying out research in the field of telephone interpreting. Among the main outcomes of their latest research activities are the creation and improvement of performance protocols, description of typical interactions between patients and healthcare professionals, identification of the most frequently used vocabulary and sentence patterns, selection of real examples for training, translation of terms, and some guidelines for stress management and coordination of interaction. These projects also contributed to the improvement of mutual understanding between university researchers and agencies, and the adoption of a more informed approach to the elaboration and use of protocols, as transgressions have been analysed in a more systematic and scientific way.

Most of the available research on telephone interpreting deals with quality issues, comparing it with onsite interpreting (Martínez-Gómez 2008; Jaime Pérez 2015). For example,
Azarmina and Wallace (2005) review publications on remote interpreting in healthcare settings and conclude that ‘remote interpretation is at least as acceptable as physically present interpretation to patients, doctors and (to a lesser extent) interpreters themselves’ (2005: 44). Verrept (2011), in his study about videoconference interpreting in Belgian hospitals, states that this modality poses further difficulties (the need to check sound and image quality, the moderate use of gestures, note taking, and the coordination of turn-taking) when compared to face-to-face interpreting. Other studies carried out in this field focus on assessing the quality of the service through the collection of user feedback (Jaime Pérez 2015).

A very prominent contribution to the research into telephone interpreting is the European Research project SHIFT in Orality, an Erasmus+ 3-year project funded by the European Commission in 2015, within Key Action 2: Strategic Partnership in Higher Education and led by the University of Bologna, which aims at contributing to the provision of training solutions for remote interpreting and to bridge the gap between academia and the telephone interpreting industry (Russo et al. 2012; González Rodríguez and Spinolo 2017; Spinolo, Bertozzi and Russo 2018). One of their objectives is defining the telephone interpreter’s profile. Iglesias Fernández and Ouellet (2018) compare experienced and novice telephone interpreters to find out about the issues they encounter and how they grapple with various difficulties, in order to feed this information into pedagogical material. They have done so through an online survey addressed to Spanish and Swedish telephone interpreters, which highlighted the contrasting perceptions of difficulty and degree of experience on the phone.

4 Further directions in research

Further directions in research on telephone interpreting in healthcare settings must be based on cooperation among research bodies, healthcare authorities, and telephone interpreting providers (both agencies and interpreters). For instance, the research group FITISPos-UAH signed cooperation agreements with the most prominent agencies providing telephone interpreting services in Spain. It is thanks to these joint efforts between the academia and the industry that larger projects about telephone interpreting are becoming possible. The research group is interested in developing training materials for postgraduate and university-based continuous education programmes. The agencies, on the other hand, are keen on attracting graduates from these university programmes, as they will enter the labour market with sufficient knowledge to perform telephone interpreting. The agencies also benefit from the elaboration of training materials, because these can then be used for in-house training. The results of the research projects can also yield protocols, performance guidelines, glossaries, etc. which can ultimately improve the services these agencies provide.

There are three main lines along which the Group FITISPos-UAH is currently working; these could be considered as possible further directions in telephone interpreting research in healthcare settings. The first of them addresses telephone interpreting in medical emergencies from a pragmatic point of view. It uses (Im)Politeness Theories (Culpeper 1996) to explore, among other aspects, face threatening acts (Lázaro Gutiérrez 2017b; Lázaro Gutiérrez and Cabrera Méndez 2018). It has been discovered that telephone interpreter-mediated conversations are more prone to contain face threatening acts than standard and onsite mediated encounters because of their asynchronous and indirect nature, and face threatening acts have proved to be very challenging for interpreters to deal with.
The second area of innovation of the Group deals with the setting where the interpreted conversations take place. Instead of focusing on telephone interpreting in general, some particularisation has been introduced according to current research trends (Cox and Lázaro Gutiérrez 2016), and the setting has been restricted to specific areas, such as healthcare emergency services, where telephone interpreting is popular. For instance, Lázaro Gutiérrez and Cabrera Méndez (2019) found out that many of the conversations telephone interpreters have to mediate take place in the Accident and Emergency Departments or are related to other kinds of health emergencies (telephone calls to emergency services). These conversations follow generalisable patterns and characteristics, such as their asymmetry – understood as the different levels of knowledge about the topic, setting and situation and the unequal participation of interactants (Lázaro Gutiérrez 2012) – or their urgent nature, and could be classified as an ‘activity type’ (Levinson 1979) or even a ‘genre’ (Briggs and Bauman 1992). The classification of the conversations and their description provide useful contextual information, which compensates for the lack of visual cues. For instance, the urgent nature of these encounters greatly influences how the interaction is going to develop, as the speakers usually want to communicate essential information as quickly as possible.

Finally, some innovation has been introduced regarding the methodology of the studies. The cooperation with telephone interpreting agencies has allowed the researchers to compile a great number of real conversations, which can be analysed in a variety of ways. Apart from the classic discourse analysis methodology, research methods from corpus-based studies have been used to allow for the extraction of recurrent terminology and discourse patterns. According to Flowerdew (1993), the main advantages for using corpora together with concordance programmes are that they give us linguistic information, and that they are a basis for creating teaching materials, including the use of real-life examples of text or discourse. Besides, sociological methods such as focus groups or Delphi questionnaires have been applied to complement quantitative and qualitative analyses (Lázaro Gutiérrez 2017a).

Other research groups are looking into similar aspects. In Australia, the University of Queensland, currently working on data extracted from surveys distributed amongst telephone interpreters, aims at completing information by introducing opinions and insights from end-users and interpreting agencies (Wang 2018). Another major concern for them is to analyse authentic telephone interpreting, focusing on performance quality and turn-taking techniques, for the purpose of contributing to the elaboration of national protocols (ibid.).

SHIFT researchers, on the other hand, after having developed training materials for remote interpreting, are now focusing on their piloting and testing. These materials include a remote interpreting handbook for trainers, trainees and professionals, a set of training materials to be used in class (role-plays and preparatory activities in English/Italian, Spanish/Italian and Spanish/English), and a glossary of remote interpreting terms in English, Spanish and Italian.

5 Conclusion

In this chapter, the main characteristics of remote (telephone) interpreting in healthcare settings have been described. Healthcare professionals and patients can connect to a remote interpreter when they need to communicate during a visit. Alternatively, healthcare telephone conversations can be interpreted in a three-way call. Telephone interpreting
Remote (telephone) interpreting presents many advantages, such as its immediacy, cost-effectiveness and availability. However, in healthcare settings, interpreters have to face some challenges, such as the lack of visual context, the use of technology, difficulties in the coordination of talk, poor working conditions, stress and emotional impact, ethical dilemmas and lack of training. Research on telephone interpreting in healthcare settings mainly deals with quality and the different roles of the interpreter, but is also evolving to address the evaluation and testing of training materials and to provide deeper analyses of performance and discourse in real-life, recorded conversations. Telephone interpreting is definitely a flourishing field both in research and practice.

Notes
1 Consent to being recorded is provided by interpreters through the contract they sign to work for the telephone interpreting company. Telephone interpreting companies and healthcare institutions sign an agreement that regulates the conditions under which the quality control and assurance process is carried out, including the way in which conversations are recorded and processed. Service providers (healthcare staff) are informed about the fact that telephone interpreted conversations might be recorded by their institutions in training courses about how to work with telephone interpreters or through guidelines and instruction packs. Finally, before the conversation with healthcare staff starts, patients are presented with a recorded message that explains that conversations might be recorded for security and quality purposes. If they proceed to use the telephone interpreting service, they consent to the recording.
2 Medical protocols state that everybody who assists a patient is part of the medical assistance team and must abide by the medical codes of beneficence and non-maleficence.

Further reading
This article discusses some of the specifics of telephone interpreting and particularly focuses on the interpreter’s coordination skills needed to manage the interaction between the participants in conversations.
This chapter offers a specific short course for telephone interpreters which includes five practical units in increasing difficulty to be used for various language combinations.
This is a short guide about telephone interpreting for medical interpreters. It is presented as a list of questions and answers and is the IMIA’s (International Medical Interpreters Association) response to its members’ doubts about telephone interpreting in healthcare settings, which had been previously submitted to the association.
This article sums up the history of telephone interpreting provision and research, and identifies future trends which revolve around technological issues, interpreting techniques, ethics and the interpreters’ role.
Raquel Lázaro Gutiérrez


This volume contains 14 chapters organised in three sections about research carried out both by telephone interpreting companies and academia, pedagogical approaches and proposals, and socio-logical and professional aspects.

Related topics

Healthcare Interpreting Ethics, Dialogue Interpreting in Mental Healthcare, Child Language Brokering in Healthcare Settings

References


Remote (telephone) interpreting


Remote (telephone) interpreting


