

Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers¹

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This paper is an attempt at defining more clearly the various roles of community interpreters and the processes implicitly connected with each of them. While the role of the interpreter is a subject that has been widely discussed in the social science literature, it is less present in the biomedical one, which tends to emphasize the importance of interpreting in overcoming language barriers, rather than as a means of building bridges between patients and physicians. Hence, studies looking at interpreted medical interactions suggest that the presence of an interpreter is more beneficial to the healthcare providers than to the patient. This statement is illustrated by the results of a recent study in a pediatric outpatient clinic in Switzerland. It is suggested that, in the consultations, interpreters act mainly as linguistic agents and health system agents and rarely as community agents. This is consistent with the pediatricians' view of the interpreter as mainly a translating machine. A new typology of the varying roles of the interpreter is proposed, outlining the relation to cultural differences maintained therein. Some recommendations for the training of interpreters and healthcare providers are suggested.

Keywords: pediatrics, cultural difference, interpreters' roles, mediation, assimilation, integration, education

Professionally interpreted consultations: A must for culturally sensitive health care

Language barriers in health care have been explored in many studies reported in the biomedical literature. There is strong evidence that the whole healthcare process is at risk when these barriers are not overcome. For example, language

differences between patient and clinician are associated with inappropriate diagnostic investigations (Hampers et al. 1999), lower adherence to treatment (David & Rhee 1998; Karter et al. 2000; Manson 1988), lower rates of follow-up (appointments proposed and kept), poor referrals, incomplete investigations (Sarver & Baker 2000) and lower rates of preventive interventions by physicians (Hu & Covell 1986; Solis et al. 1990; Woloshin et al. 1997). These difficult consultations place patients at risk for misdiagnosis, which can lead to inappropriate or inadequate treatment (Vasquez & Javier 1991) or to unnecessary hospital admissions (Hampers & McNulty 2002). Both patients (Carrasquillo et al. 1999; Morales et al. 1999) and healthcare providers (Leanza 2005; Raval & Smith 2003) may have a low rate of satisfaction in these situations.

One approach to addressing these barriers is to work with an interpreter. Studies suggest that interpreters employed in medical settings tend to be ad hoc or proxy interpreters, that is, untrained people drawn from the patient's family or the (non-medical) staff of the institution where the consultation takes place. While this strategy addresses the issue of language, it raises other important problems. There remain risks of misdiagnosis of patients (Vasquez & Javier 1991), and consultations are less likely to help the patient express difficult feelings or events (Eytan et al. 2002); confidentiality is not assured, and there is evidence that untrained interpreters feel significant stress and discomfort (Sasso 2000). When children interpret for their parents, not only are the dynamics of the family challenged (Ngo-Metzger et al. 2003), but the children themselves may be at severe risk for psychological sequels (Jacobs et al. 1995)².

It is evident that better medical care is obtained with the use of trained community³ interpreters. If the goal is the best care possible, it is an ethical imperative to hire such professionals in medical settings (Blake 2003). But interpreting in medical settings is not only about "best practices"; it also involves larger social issues (i.e., the integration of minority or allophone groups into the society). Contrary to the frequently voiced concern that the use of interpreters will hamper the social and cultural integration of new immigrants, the provision of interpreting services involves acknowledging differences and diversity in what is usually a very normative institutional context. Integration, as opposed to assimilation, is a mutual adaptation process and also a joint process of meaning construction (Perregaux et al. 2001). It begins in the social institutions (schools, justice, welfare and health care), where interpreters may be crucial. Indeed, interpreters in these settings have many roles beyond being "translation machines"; they can facilitate intercultural communication,

construct bridges between different symbolic universes and facilitate the process of migrant integration.

The biomedical literature rarely addresses these larger issues. For example Flores et al. (2002) underline the benefit of having a professional interpreter for pediatric care as this can permit the physician to obtain information about folk explanations and treatments. This information may help prevent harmful, even fatal, folk treatments. However, these authors make no mention of the role of the interpreter as a cultural mediator or an advocate for patients, improving their level of understanding of medical care and their feeling of being respectfully received and treated. In contrast to the narrow focus in the medical literature, work on interpreters' roles in social sciences ranges more widely (e.g. Cohen-Emerique 2003; Drennan & Swartz 1999; Jalbert 1998; Roberts 1997; Weiss & Stuker 1998) but remains mainly theoretical, with few empirical studies.

The first aim of this paper is to present some recent (mainly francophone) research done on "interpreted interaction" in medical settings, with an emphasis on interpreters' roles. This brief review will be followed by a presentation of some results from a study conducted at a pediatric outpatient clinic in Switzerland. The purpose of the study, anchored in a cross-cultural psychology framework and rooted in a complementarist epistemology (Devereux 1970), is to explore the kinds of relationship that healthcare professionals, in this case pediatricians, maintain with respect to cultural difference, and how the presence of interpreters affects this relationship. The theoretical framework (called the professional activities niche) not only emphasizes the individual experience, but also addresses the need to explore (1) the context where the professional activities take place (here a pediatric hospital and Swiss society); (2) the actual practice going on (here interpreted preventive pediatric consultations) and (3) the ethnotheories (or representations) of the healthcare professionals, i.e. the norms for being a good physician and for child rearing. In the study, interpreters' roles, viewed from the perspectives of the interpreters themselves, physicians, and the researcher, are considered as indicators of the processes going on in the construction of the relationship to the Other. The second aim of this paper is therefore to present the results with a focus on interpreters' roles. In other words, the broad question which will be addressed is: Do interpreters help building bridges between two symbolic worlds? The conclusion proposes a new typology for interpreters' roles that addresses the complex (and sometimes ambivalent) polyvalence of their work.

Communication facilitator or cultural assimilator?

Jalbert (1998) has proposed a useful typology, based primarily on the seminal work of the Winnipeg group (Kaufert 1990; Kaufert & Koolage 1984; Kaufert & Putsch 1997; Kaufert et al. 1998), to understand the varying roles of the interpreter:

1. *Translator*⁴: The interpreter minimizes her presence as much as possible. In this role she simply facilitates the communication process, not interfering with what the speakers say.
2. *Cultural Informant*: The interpreter helps the healthcare provider to better understand the patient. In this role the interpreter uses her knowledge of cultural norms and values.
3. *Culture Broker or Cultural Mediator*: The interpreter is a Cultural Informant but also a negotiator between two conflicting value systems or symbolic universes. In this role, the Culture Broker needs to enlarge, provide explanations or synthesize healthcare providers' and patients' utterances to help both parties arrive at a meaningful shared model (of care, of behavior etc.).
4. *Advocate*: In a value-conflict situation, the interpreter may choose to defend the patient against the institution.
5. *Bilingual Professional*: The interpreter becomes the healthcare professional. She leads the interview in the patient's language and then reports to the healthcare provider. She can do this because of prior training in health care or, in a more limited way, because of her knowledge of institutional practices and routines.

This typology has the advantage of not contrasting translation and mediation (or instrumental interpreting versus cultural mediation), which has often been the case in previous theorizing. French authors such as Cohen-Emerique (2003) or Delcroix (1996) tend to dichotomize interpreters' roles and by doing so, neglect the linguistic part of their work. This may obscure the potential assimilation power of their position; i.e. the possibility for the interpreter to be more a spokesperson for the institutional (dominant) discourse, a potential described by Davidson as the power "to keep the interview 'on track' and the physician on schedule" (2000:400).

In Jalbert's view, the Cultural Mediator's role appears only when there is a conflictual situation. In this case, the interpreter can contribute to conflict resolution. The typology also recognizes that the interpreter may act as a protector

of patients, i.e., as an Advocate. In most cases, filling this role requires the interpreter to be well informed about the laws, rules and procedures that govern institutional practices. The interpreter may also be a Bilingual Professional, meaning that she is in essentially the same (symbolic) position as the healthcare provider. This implies that there is an agreement between the healthcare provider and the interpreter before the consultation starts. In a way, this role is the counterpart of the Advocate one, in that the interpreter is an agent of the institution and a spokesperson for the healthcare system and its discourse. Indeed, in the role of Bilingual Professional the interpreter may act in opposition to the cultural norms and values of her own community.

In the role of Translator, the interpreter attempts to be “invisible” and avoids any level of personal involvement. One can understand that in all roles but Translator, the interpreter is not expected to completely maintain the ideal of impartiality and must proceed on the basis of identifying either with the community (as Cultural Informant, Culture Broker and Advocate) or with the institution (Bilingual Professional). This is consistent with Bot’s (2003) argument that “mythological neutrality” should be challenged based on the settings in which the interpreter works. It may be pertinent in legal settings, but not in medical or social settings, where personal involvement may be in the interest to both patient and care provider. Often, as in France (and now in Switzerland; see note 6), community interpreter codes of ethics are inspired by those of social mediators (such as family mediators or school mediators). Impartiality is thus a strong professional principle (see for example Bonafé-Schmitt et al. 1999, for social mediations in France). In community interpreting, as implied in Jalbert’s theorizing, this impartiality is not possible nor even desirable. Not only is cultural knowledge needed, but experiences of migration and with the receiving country’s institutions are necessary for professional community interpreting practice. This point challenges not only social mediation rules, but also the physician’s “affective neutrality” which, according to Parsons’ (1970) seminal work, is a key value for the medical profession.

Jalbert’s typology describes idealized views of the various roles played by interpreters in medical settings. But what actually happens in interpreted healthcare consultations? Do interpreters’ actions fall discretely into these categories? And, at the more basic level of the process of interpretation and mediation, how does the building of shared meaning take place?

Two studies reveal some of the complex roles and polyvalent actions of interpreters, who, usually hired as communication facilitators, implicitly become cultural assimilators. Traverso (2002), using qualitative linguistic analysis of

exchanges between pregnant women, interpreters and healthcare providers in a French obstetrics and gynecology clinic, found that the interaction was more regular and fluid when an interpreter was present. But this third-party presence tended to exclude the patient from the interaction. The interpreter and the physician often talked about the mother and her pregnancy without speaking to her. The interpreter acted as a Professional. Not as a Bilingual Professional, as described by Jalbert (1998), but as a Monolingual healthcare Professional discussing the “case” with a colleague, here a gynecologist.

Grin (2003), an anthropologist, used participant observation to study interpreters’ roles in different medical settings in French-speaking Switzerland. Her observations were part of a larger project examining the introduction of trained community interpreters in these institutions (Guex & Singy 2003). Many of these settings involved work with asylum seekers. In the first medical visit upon arriving in Switzerland, nurses had the administrative task of completing a medical file for each new asylum seeker. According to the nurses, this “written relation” to health care required a word-for-word translation of the patient’s history. The main interpreter role was that of Translator. This emphasis on literal translation was not the case in an outpatient clinic, where the interpreters tended to play the role of Cultural Informants. The interpreters often added contextual details that helped the physician give a medical meaning to what had happened to the patient. Grin (2003) did not specify whether this cultural interpretation was one-way only or if it also involved giving the patient some contextual information for a better understanding of the medical discourse. In the obstetrics and gynecology clinics, where an interpreter was regularly present in follow-up visits by pregnant women, Grin found the interpreter playing the role of Bilingual Professional, acting almost autonomously. In this case, the physician and the interpreter had an agreement about the goals and procedure of the consultation. The interpreter conducted the interview in the patient’s language and then reported the findings to the physician.

Grin also made some observations regarding a psychotherapeutic setting, in which interpreters were sometimes explicitly asked to be co-therapists: their involvement in the emotional work of therapy was considered crucial for patients’ progress. In one case, Grin observed a therapist using an interpreter to do hypnosis. This observation is consistent with other research done in the psychotherapeutic milieu. The importance of the emotional and symbolic work done in psychotherapy may encourage a broadening of the interpreter’s role to include a bridge-building process (Goguikian Ratcliff & Changkakoti 2004).

These studies make it clear that interpreters' roles differ widely from one context to another. Where there is an institutional need for cultural information or mediation, interpreters will be asked to perform these tasks, moving beyond their specific linguistic skills. But these studies have emphasized context-based analyses of the roles of interpreters and have not given attention to interpersonal factors — that is, to the quality and process of the relationship between the healthcare provider and the interpreter. Nor have they examined what happens in encounters where a value conflict appears or when the interpreter plays a role other than the one expected by the clinician (e.g., as Mediator or Advocate instead of Translator or Bilingual Professional). Many other interesting questions remain to be examined, including: How do different medical institutions create space for these new collaborators? What is their institutional status? Are they viewed as professionals in their own right or as a “tool” at hand, waiting to be used at the healthcare provider's will? Taken together, previous studies seem to suggest that in most settings involving medical interpreting, the institution's discourse remains the dominant one. The asymmetric relationship between patient and healthcare provider is rarely challenged by the presence of interpreters.

In summary, when researchers observe what happens in medical interactions involving an interpreter, they generally find that the dominant discourse of the institution is confirmed by the intervention of the interpreter (see also Bolden 2000; Davidson 2000; Wadensjö 1998). Where a shift in power and expression occurs, it reflects an institutional history and willingness to provide health care beyond the traditional biomedical standards, as was seen for example in Grin's observations for the psychotherapeutic setting. As pediatrics often defines itself as a specialization focused not only on the biomedical needs of the child but also on the psychosocial issues of child development and health, it is interesting to examine interpreting and cross-cultural issues in this particular context.

The “Education, pediatrics and culture” study

The study entitled “Education, pediatrics and culture” (Leanza 2003) was designed to examine not only interpreters' roles, but the whole experience of working with cultural differences in a pediatric setting, first from the perspective of the physicians and second from the interpreters' view, as they showed an interest in the research process. Methods included participant observation

in a pediatric outpatient clinic in French-speaking Switzerland, videotaping of consultations for subsequent analysis of communication and the interpreter's role, and stimulated recall interviews with physicians and interpreters.

Preventive pediatrics

The pediatric consultations observed and analyzed were well-child visits, also called preventive consultations. In these encounters, the pediatrician not only explores the physical well-being of the child, but also monitors the psychosocial conditions of the child's development. She checks with the parents on how the child eats, sleeps and socializes. These topics, which are deeply rooted in cultures and psychosocial contexts, constitute the focus of interest in this study. As many cross-cultural developmental studies have shown, they are key factors in a child's enculturation and socialization (Dasen 2003). Preventive consultations should enable parents to pose questions and express concerns about their child's development. It is also a privileged opportunity to observe how psychosocial and cultural issues are dealt with in pediatrics. Before giving more details about the interpreters' roles in these encounters, I will briefly summarize the main results from the analyses of the context, of pediatricians' representations of their work, and of the child-rearing practices with which they were confronted.

Observations of the context revealed tensions between a willingness for change and an implicit desire to maintain the status quo. The highest levels of the hierarchy expressed their willingness to change how the institution dealt with these migrant populations. For example, this was expressed by the presence of interpreters and by monthly symposia for healthcare providers on "migration, cultures and care." But this willingness seemed to be in constant conflict with the operational realities of the hospital. For example, follow-up consultations were not necessarily performed by the same resident, and this lack of continuity was clearly counter-productive. Moreover, the resident's evaluation neglected the relational and socio-cultural dimensions of clinical practice. Thus, while there was a willingness to innovate, to make the whole pediatric practice more open to the subjectivity and social worlds of the patient, there was also inertia common to all institutions. The result was a tendency to break the very links that the practice innovations had attempted to create.

Two types of care providers' representations were examined: practice models, and norms relating to education that had to be transmitted to the families. These representations were not varied with respect to the diversity of the

patient population. The procedure of the consultations inexorably followed the same sequence, whatever the parents' requests or the interpreters' interventions. Educational norms were also rigidly transmitted. For example, a chart describing the sequence for introducing solid food was distributed to the parents. This chart came from a pediatrics manual and was translated literally into Albanian and Tamil without any adaptation. It contained details of every meal measured to the gram, and implicitly suggested that breastfeeding was to be stopped at four months.

Communication analyses of these consultations revealed systematic interruptions, and apparent unawareness of socio-cultural dimensions of the child's development (Leanza 2004). The analyses of clinical practices and representations revealed that, despite the intention to develop a culturally responsive and innovative practice, pediatrics as practiced in this institution was quite conventional, in that it was not very patient-centric and excluded attention to socio-cultural and emotional factors.

Nevertheless, the clinic did provide interpreting services and I will examine some specific questions about the role of interpreters in pediatric consultations:

- (1) How did pediatricians see interpreters' activities?
- (2) How did interpreters see their own activities?
- (3) Did the interpreter allow for or seek out cultural factors? What kind of interventions did the interpreter make?

The first and second questions are answered by using material from the stimulated recall interviews (as it is the experience of each participant which is sought) and the third by analyzing the actual role of interpreters in videotaped consultations (as it is the practice itself that is analyzed).

The pediatricians' view

Participants, data and methodology

The physicians participating in the study were eight pediatrics residents. Seven were female. All but one were training to become pediatricians; one was in a GP program completing the required residency in pediatrics. Participants had an average working experience of two years, except for the "GP resident," who was doing pediatrics for the first time. None of them had had any experience with such preventive consultations before starting their residency in this

hospital. None had received any specific training in cross-cultural medicine or patient-physician relations.

One-on-one stimulated recall interviews based on the video recordings were conducted in the hospital. As the resident was watching herself (and only herself, not a colleague) doing a consultation, she was asked to react to what was representative for her about these preventive consultations with migrant families. At the same time, if the physician would not react to a phenomenon that was of importance to this study (such as an interpreter giving her opinion on a parental practice), I would introduce it by asking an open question (e.g., “What is it like to work with interpreters?”), orienting our dialogue toward these specific issues. On average, the interviews lasted between ninety minutes and two hours. They were transcribed and analyzed using N’Vivo 1 software (Nud*ist vivo 1998–1999), which supports content analysis (with preconceived and emerging categories) as well as theory building. The account of pediatricians’ experience of working with cultural difference is presented in another paper (Leanza 2005). The results presented here are only a (consistent) fragment of the broader analysis, focusing on interpreters.

The interpreter as a “neutral ally”

Residents’ comments about the videotaped consultations revealed two trends. The strongest one was to say that communication with parents and children was more difficult when an interpreter was present. These physicians found it very hard to get the information needed to do their work properly and manage time appropriately (according to institution rules). They felt a loss of control in their consultation and at times also felt excluded from the interaction with the parent. Pediatricians generally referred to the interpreter as a Translator, i.e., as “invisible,” or as “allied” with the clinician, thus serving to get the biomedical message across to the parents. In residents’ view, the interpreter may be a Cultural Informant, but only in the direction of physician to parent, and sometimes a Bilingual Professional, conveying the proper child nutrition instructions.

The second trend was much less pronounced than the first. It appeared in the comments of two residents. For these pediatricians, the contact with interpreters provided an opportunity to modify their representations of child rearing. They had tried to adapt their discourse to the reality and customs of the parents. In this perspective, the interpreter is not only a Translator or a medium for transmitting biomedical norms. The interpreter can also teach the

professional something meaningful and thus serves as a two-way Cultural Informant. These pediatricians also see a “new” role for the interpreter, not noted in Jalbert’s typology: they are aware that the interpreter has an important role outside the consultation room as a Support for the families. They mention the informal follow-up interpreters do in the community, for example by repeating explanations for prescriptions to the parents.

Neither Mediator nor Advocate roles are ever noted or acknowledged by the clinicians. They appear to see interpreters in the manner presupposed by the official code of ethics: as a neutral “translating machine” or neutral ally in the consultation. Such perceptions may well pose a challenge to the physician’s position, ethics, knowledge and power. Overall, it seems that for the pediatrician, the interpreter is mainly an instrument for obtaining or transmitting information, and is only rarely seen as a real actor in the clinical interaction with whom beneficial collaboration may occur.

The interpreters’ view

Participants, data and methodology

There were four interpreters involved in the study. Three of them were female and had been hired part-time by the hospital (two for Albanian patients and one for Tamil) four years earlier; the fourth was male and worked as a substitute for one of the Albanian-speaking interpreters. They were all from the cultural communities for which they interpreted and had a more or less difficult history of migration to Switzerland. All four had children (from newborn to adolescent). The three hired interpreters had received professional training from a local association, *Appartenances*. This training was based on three principles: (1) working on personal experiences; (2) interpreting techniques; and (3) knowledge about institutions (Métraux & Fleury 1997). It involved about 80 hours of classroom work, plus some supervised experience. The substitute interpreter had not received any training. Observed consultations were always interpreted by one of these four interpreters. Because of personal difficulties, only two interviews could be done, one with the Tamil interpreter and one with an Albanian interpreter, both trained as community interpreters.

The interviews were conducted in French, following the same procedure as the one followed with the pediatricians. The consultations or extracts of consultations shown to interpreters were the same as those shown to the physicians,

provided that the interview partner was the interpreter of the consultation. Content analysis was performed with N'Vivo 1.

Ambivalences

The interviews with the interpreters identified two additional roles not included in Jalbert's typology. The first one was welcoming: the interpreters acted as "Welcomers" of patients to the hospital. According to the interpreters, their presence gave parents and patients confidence to face and navigate through this unfamiliar environment. As confirmed by participant observation, both parents and children felt more welcome in an institution that hired people from their own community and in this way showed some acknowledgement of their difference. Interpreters also performed the greeting rituals at the beginning of the clinical consultation. Often, the physician gave the patient a quick handshake and then just walked to her desk and opened the patient's file. Some parents waited to be invited to take a seat. This is when the interpreter played a welcoming role, making up for the lack of culturally appropriate greeting rituals. Interpreters also did this before the physician came in, when families were asked to wait in the consultation room.

The second role played by the interpreter was Family Support outside the hospital, as noted also by a few of the physicians. The two new roles indicate that community interpreters work toward social integration also before and after the consultation.

Interpreters felt that the Translator role was the one most frequently requested and enacted, but that was also the most frustrating role for them. They agreed that they sometimes served as Cultural Informants, but only in a "one-way" mode (from physician to patient). If they tried to work in the other direction (from patient to physician) they found they were unable to influence the physicians' discourse.

The role of the Bilingual Professional as described by Jalbert (1998) was used from time to time, principally when the consultation involved nutrition issues. The interpreters enjoyed this role which allowed them to experience a different symbolic position, closer to that of the physician than the migrant. This position was usually approved by the healthcare provider. One interpreter described this role as "reciting her poetry," particularly on the topic of nutrition. This metaphor informs us about the meaning of the activity for the interpreter. First, she knows what to say by heart; it can be understood as quite a mechanical activity proving her professional skill. On the other hand, reciting

poetry can be seen as a very enjoyable activity, because of the beauty of the language (though this may hardly apply to biomedical specialized language) and because of the pleasure of expressing prestigious knowledge and making a good impression on others.

According to the interviews with both the pediatric residents and the interpreters, much more weight was given to the institutional discourse (biomedicine) than to that of the parents. Although interpreters were sometimes frustrated by not playing more of a Mediator role, they found some satisfaction in playing the role of Bilingual Professional, which allowed them to experience a status quite different from that of their fellow migrant patients (Weber & Molina 2003). Here we see some ambivalence in the interpreters' roles, as they claim to be Culture Brokers, but appear to very much enjoy the role of the cultural assimilator.

Analysis of the recordings: The perspective of the researcher

Data and methodology

As stated earlier, the study is rooted in a complementarist epistemology, which implies different views of the same object through complementary analytical lenses. It is a way of not only giving an account of the complexity of the object under study, but also achieving internal validity by triangulation of sources (here: participants' views and actual practice) and methods (here: interviews along with content analysis and observations along with role analysis) (Lincoln & Guba 1985: 305–307). From this perspective, 36 critical incidents, drawn from the 21 videotaped preventive consultations, were used for the analysis of interpreter roles. I considered a sequence of the consultation as a critical incident when the area under discussion was an educational topic such as nutrition or sleep. They were “critical” in the sense that they matched the study interest (discourses about educational issues in a multicultural pediatric setting).

The critical incidents were transcribed in standard orthography, as the goal of the analysis was to identify roles at a macro-level of discourse and not in the micro-linguistic details of the interaction. Thus the transcriptions look like theater dialogues allowing the researcher to explore the roles of the interpreter “character.” Roles are defined by how the interpreter positioned herself symbolically toward the object of the medical intervention (child education topics). This positioning can be done in many different ways, which can be seen as more or less active (e.g., Translator being a passive⁵ role as the interpreter does

not add any personal opinion/knowledge to the interaction, and Advocate being an active one, as she will give her own personal opinion/knowledge about the migrant family situation). The interpreter could intervene about parenting practices and knowledge from a particular symbolic perspective, identifying either with the institution (the system perspective, e.g., Bilingual Professional) or with her community (the community perspective, e.g., Cultural Informant). As the initial focus of my study was on the pediatricians' experience, only the French portions of the interaction were transcribed and coded. Interpreters' utterances were coded according to Jalbert's role definitions. A particular coding instance could be a single sentence (or a part of it) or several turns, depending on whether the interpreter maintained a particular stance toward the educational issue.

I considered the interpreter as acting in the Translator role mainly when she converted speech directly from Albanian or Tamil into French, and waited for a reaction from the physician without engaging actively in a same-language dialogue. The other roles usually appeared when interpreter and physician spoke French among themselves — described by Davidson (2002) as an “optional same-language turn” between the interpreter and the interpretee in the interpreted discourse. Jalbert's typology was not always sufficient to account for the interpreter's stance. Therefore, I added two more roles.

Interpreters' polyvalence

I first noticed that the interpreter could also be an Active Translator, which means that, before interpreting anything, she actively engages the physician to clarify what is to be transmitted to the parent. Her questions are meant to help her understand minor points or linguistic details, but they do not address meanings of biomedical interventions or parental practices. In this sense, the interpreter maintains a passive stance regarding the object of the consultation (child education). This is illustrated by the following dialogue from a consultation for a one-year-old girl from Sri Lanka (I stands for interpreter, D for doctor/physician and P for parents; the utterance coded as Active Translator is in bold).

Extract 1

D: Maintenant ils peuvent commencer à lui donner du lait de vache... Je sais qu'à la Migros maintenant il y a des nouveaux
Now they can start to give her cow milk... I know that now at the Migros [a Swiss grocery store] there are new... (hesitates)

I: Nouveau ? Du lait de vache ?

New? Cow milk?

[...]

D: Oui, c'est des petits laits pour enfants à partir d'un mois. Je crois que c'est Milupa, mais c'est vendu à la Migros. Puis ça je pense que c'est bien pour commencer.

Yes, it's small milks for children from a month old. I believe it's Milupa [brand name for baby food], but it is sold at Migros. Then, I think it's good to start with.

I: A la Migros il y en a ?

One finds them at the Migros?

D: Oui, à la Migros.

Yes, at Migros.

[The interpreter finally translates to the parents]

The second new role, Monolingual Professional, occurred when the interpreter displayed her knowledge about health matters in a very biomedical way. The same applies to displays of her knowledge about migration issues. In this case, the community interpreter acted as an equal-status professional and expressed her view on a particular aspect of the situation to the physician (as shown by Traverso 2002). The example in Extract 2, taken from a consultation with a one-year-old boy from Kosovo, illustrates this (the utterance coded as Monolingual Professional is in bold).

Extract 2

P: [in Albanian]

I: Des fois il mange bien, des fois il mange moins bien. Des soupes... ils donnent la soupe, les viandes que je prépare pour nous il mange.

Sometimes he eats well, sometimes less well. Soups... they give soup, meats that I prepare for us, he eats.

D: Bon, insiste sur le fait qu'il faut pas qu'il boivent que du lait. Parce que s'ils le bourrent de lait, le reste il ne va pas vouloir manger. Puis maintenant à 1 an, il faut qu'il mange de tout. Le lait est important mais pas aussi important qu'avant. Il faudrait pas qu'il boivent que ça.

Okay, insist on the fact that he shouldn't drink milk only. Because if they fill him up with milk, he is not going to want to eat the rest. Then, he is one year old now, he must eat everything. Milk is important, but not as important as before. He shouldn't be drinking only this.

I: Je lui demande quelle sorte de viande elle lui donne ou bien combien de fois par semaine ?

Do I ask her what kind of meat she's giving him or how many times a week?

- D: Oui... et puis tu lui avais donné à elle la feuille?
Yes... and then did you give her the sheet [the chart of solid food introduction]?
- I: Je me rappelle pas je vais lui demander.
I don't remember I will ask her.
- D: Si jamais tu lui donnes.
If not give it to her.

Instead of translating directly what the physician just said, the interpreter engages her by asking a question. This question shows, first, that the interpreter possesses biomedical knowledge relating to the educational issue under discussion (nutrition), and second, that she would like to ask the mother more than what the physician is requesting, as would a healthcare professional needing information to make her own judgment. However, she asks the physician's permission before speaking with the mother. Here, the interpreter gains the physician's approval in this professional role, in the sense that he accepts her initiative and even asks her about the nutrition sheet, implying that it is the interpreter's responsibility to make sure parents get this information (which is not the case according to hospital rules).

Sometimes the interpreter does not wait for the physician's approval to give her "professional opinion" on an educational topic, as illustrated in Extract 3 from the transcript of a consultation with the parents of an 18-month-old Albanian boy. The family was refused asylum in Switzerland and had only a few days left before leaving for Kosovo. At this time the mother asks some questions about the attendant consequences for her child's health:

Extract 3

[After a relatively long discussion between I and P in Albanian]

- I: Elle pense qu'on va lui donner des vaccins pour le climat, le changement de climat. **Ça je lui ai dit non ça n'existe pas de ça, mais on va lui donner des vaccins...**
She thinks that we will give him vaccines for the climate, for the climate change. This I told her no [D approves with a head nod] this does not exist, but we will give him vaccines...
- D: Contre les maladies d'enfant.
Against childhood diseases.

In this brief exchange one learns that the interpreter has already given her "medical" opinion to the mother. This is confirmed by the physician, first by her head nod and then by completing the interpreter's sentence before she can finish it herself. The interpreter puts herself in the position of a Bilingual

Professional (in bold in the excerpt). In doing so, she interrupts the mother's request even before it is transmitted to the physician, which is slightly different from the previous role (Monolingual Professional), but the symbolic identification stays the same: the interpreter is positioning herself as a healthcare representative.

Another phenomenon is that of the interpreter choosing to give the physician information about the parents' practices, this time positioning herself as a community agent. She is then acting as a Cultural Informant, as shown in Extract 4, involving a nine-month-old Albanian boy (the utterance coded as Cultural Informant is in bold).

Extract 4

P: [in Albanian]

I: La maman dit: la journée il tète très peu et il boit que les jus de fruit et c'est la nuit qu'il tète tout le temps.

[With a big smile] *The mother says: during the day he nurses very little, and he only drinks fruit juices, and it's only at night that he nurses all the time.*

D: Alors, moi je commencerai par arrêter de lui donner la tétée. Première chose il faut faire ça! Puis après essayer de lui donner un horaire, puis quand il aura faim, il mangera. C'est que là il a pas faim.

[After a disappointed gesture and a complicit smile to I] *So, I would start by stopping to nurse him. That's the first thing to do! Then try to get him on a schedule, then when he will be hungry, he will eat. The problem is he is not hungry.*

I-P [Exchange in Albanian]

I: Elle a l'impression qu'elle n'a pas assez de lait.

She has the impression that she does not have enough milk.

D: Mais ça ne m'étonne pas!

But that doesn't surprise me!

I: Et c'est pour ça, elle dit, je... le garde toute... la nuit au sein.

And that's why, she says, I... keep him all... night long at my breast.

D (sigh)

I: Tu sais chez nous y a pas d'horaire. Tous les... le jour, la nuit...

You know with us there is no schedule. All... day, night...

D: Je sais.

I know.

I: La nuit même c'est même pas compté, hein. Si on lui demande s'il mange la nuit et ils répondent que la journée...

Even night is not even taken into account, hm. If one asks her if he eats at night and they answer only about the day...

[Someone from administration comes into the consultation room, interrupting the dialogue. I walks out to interpret for someone else. When she comes back, nutrition is not addressed any more].

Information transmitted here to the physician (the practice of breastfeeding at night) does not change at all the standard prescription that the healthcare provider gives to the parent (stop breastfeeding as the child is already 9 months old and give him a nutrition schedule). The physician says she is already aware of this parental practice, but this awareness does not seem to help her take some distance from the biomedical norms. Certainly, there may be a real nutrition problem, given that the child does not seem to consume anything other than fruit juices and breast milk. However, the child's development was assessed as completely normal. Throughout, the physician remains in the position of an expert trying to correct the deficient knowledge base of the parents. She does not enter into a negotiation process, or, with interpreter's help, try to understand the parents' perspective and so identify a strategy to help the mother change her nutritional practices.

Quantified results: The dominant stays dominant

The results of the coding of all the critical incidents are shown in Figure 1. Out of 187 interpreters' utterances, 167 (i.e. roughly 90%) were in one of the two Translator roles. The remaining 20 utterances (i.e. roughly 10%) were distributed among Bilingual Professional, Monolingual Professional and Cultural Informant. In the sequences analyzed, the interpreters never played the Mediator or Advocate roles.

These quantified results are consistent not only with the physicians' and interpreters' points of view, as expressed in the research interviews, but also with the interpreters' code of ethics⁶, which emphasizes "neutrality." It appears then that this "neutrality" is based on the tacit agreement between the interpreter, on the one hand, and the professional and the institution, on the other — and it serves the dominant discourse. The main task that physicians expected from the interpreters was translation, and sometimes the transmission of biomedical norms about educational topics. That is what the interpreters felt they were doing, even if they found it frustrating, and systematic observation indicates that this was what indeed happened in the consultations.

The actual proportion of utterances in the critical passages that were spent in translation as opposed to more personal and active interventions (90% versus 10%) is to be expected, given that the interpreter is in the consultation

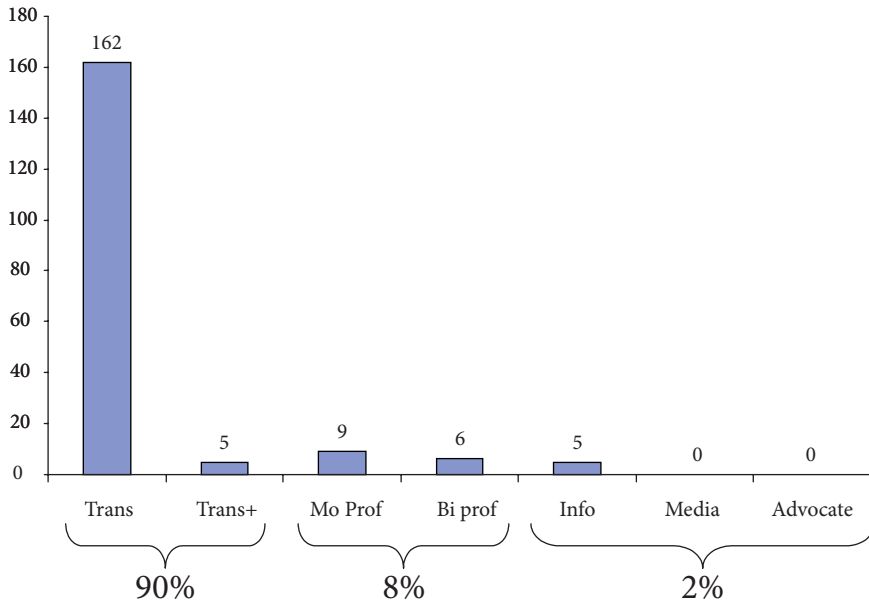


Figure 1. Number of coding instances of interpreters' roles in sequences about education topics

Note: Trans = Translator; Trans+ = Active Translator; Mo Prof = Monolingual Professional; Bi Prof = Bilingual Professional; Info = Cultural Informant; Media = Cultural Mediator

room first to overcome the language barrier. What is more surprising is the considerable proportion (8%) of utterances as health system agent, compared to only 2% as Cultural Informant. Evidently, the only roles the interpreter can play outside the health-related ones are those that do not pose a challenge to the physicians' power and position. This means, however, that interpreters are not able to help build a two-way bridge of communication between the physician and patient.

This failure to build a full partnership can be explained by three factors. First, the pediatric residents were not trained to work with interpreters. Some of them were not even aware of the different skills a community interpreter has, such as being able to give some information about cultural practices and values. Two of the physicians only became aware of this during the research interview when they were asked where they could find information about a particular practice. In a way, clinicians were inclined toward a mechanical effort to get the information across rather than engage in negotiation or broader discussion, because they lacked confidence and wanted to achieve a basic level of competence, narrowly defined by their perception of their own role as

trainees. Second, the interpreters are not trained to be assertive in the face of institutional authority. For example, the Advocate role was not addressed in their training. As stated, they had an ambiguous relationship with medicine, which allowed them to temporarily experience a higher status than that of their fellow countrymen. Third, the whole outpatient-clinic context is struggling to introduce effective changes in clinical routines. However, this is not clearly supportive of practicing a more socio-culturally oriented pediatrics. The assimilative process going on in the consultation (and institution) is consistent with the non-participative assimilationist socio-cultural insertion which Switzerland “offers” to migrants (Bolzman 2001).

Conclusion: A new typology of roles and recommendations for training

Based on my empirical findings, I propose a synthesis and new organization of interpreters’ roles. Each of the squares in Figure 2 is a particular way of approaching cultural difference for the community interpreter:

- As a *system agent*, the interpreter transmits the dominant discourse, norms and values to the patient. Cultural difference is denied in favor of the dominant culture. Cultural difference tends to be elided or assimilated.
- As a *community agent*, the interpreter plays the reverse role: the minority (migrant) norms and values are presented as potentially equally valid. Cultural difference is acknowledged. This role can be played in various ways, more or less nuanced.
- When acting as an *integration agent*, the interpreter finds resources to help migrants (and people from the receiving society) to make sense, negotiate meanings and find an “in-between” way of behaving. These roles take place outside consultations in everyday life.

<p>System agent Bilingual Professional Monolingual Professional</p>	<p>Integration agent Welcoming Support - Follow up</p>
<p>Community interpreter</p>	
<p>Community agent Cultural Informant Culture Broker Advocate</p>	<p>Linguistic agent Translator (±Active)</p>

Figure 2. Community interpreter’s roles according to their relation to cultural difference

- As a *linguistic agent*, the interpreter attempts to maintain an impartial position (to the extent that this is possible). The relationship with cultural difference is more technical, in that the interpreter has to find the proper translation on the fly. The cognitive and symbolic process does not require her to intervene on any level other than that of language (in other words, she does not intervene about the object of the interaction).

This study has implications for the training of interpreters. The future interpreter should explore all these potential roles during her training. Professionalization of interpreters must consider the ethical and pragmatic dimensions of these different roles and their implications for institutions, clients, and the interpreters themselves. The temptation for interpreters to differentiate themselves from their fellow countrymen by asserting their symbolic biomedical position should be challenged by giving them an official status distinct from that of the healthcare provider, acknowledged as professionals in their own right. One way to do this would be to give more autonomy to interpreters for this kind of work. This would also help contain the assimilative discourse and prevent it from being extended to all medical activity.

The study also points to the need for training healthcare providers (as well as other professionals) to work with interpreters. Although this would seem quite basic, in Switzerland at least there is either no training at all (in the majority of programs), or else exposure to a very technical set of guidelines (Bischoff & Loutan 1998). These guidelines concern what the professional should do before, during and after the interaction, and what he should not do. While this is a necessary framework, it is not sufficient. The interpreters' work is not only "passive" translation, which is usually implicit in this kind of technical training; it also involves active symbolic, affective and interactional dimensions which need to be understood as such by healthcare providers. These aspects of working with interpreters cannot be taught as a list of dos and don'ts.

Professional training for working with interpreters requires a follow-up in healthcare institutions, for example by setting up of what the French educational scientist Bourgeois (1996) calls a "safe training space," where professional identity can adapt to a new and challenging activity. This space must be one in which the medical professional's anxiety over losing control of the process and his/her feeling that "I won't get the right information to make a proper diagnostic" can be acknowledged without jeopardizing his/her evaluation. Such openness will in fact encourage the honing of skills and the consolidation of professional identity. This is a challenge for young professionals, as they have

to negotiate the complexity and uncertainty of working with interpreters with their efforts to acquire basic skills and expertise.

This study also identifies needs for further research. First, knowledge about interpreters' roles outside the institutions — that is, in the community, when they endorse the (almost unnoticed) *integration agent* roles — may be of interest in trying to capture the whole complexity of the interpreters' position in a multicultural society. Second, there is a need for more data-driven studies on what happens in interpreted interactions, and in particular on the roles interpreters play in specific contexts, and with what implications. This would include studies similar to the one presented here, conducted with experienced physicians with the aim of establishing whether their views of the interpreter's role(s) as *system agent* and as *community agent* are suitably balanced. Such analyses should also be extended to other socio-medical contexts, so as to permit comparisons and the identification of setting-specific relationships, like those seen in psychiatry or psychotherapy.

Notes

1. I am grateful to Laurence J. Kirmayer, Ellen Rosenberg, Kelly McKinney and Steven Cohen for their comments on the first draft of this paper and their linguistic help. I also thank Margalit Cohen-Emerique for her insightful comments on my work, and Melissa Dominicé Dao for our discussions on the topic and her bibliographic help. And a special thanks to the two anonymous reviewers who gave me very precise and constructive comments.
2. This “pathologizing” view of children interpreting has recently been challenged by the results of very interesting research (Green et al. 2005).
3. “In the most general sense, community interpreting refers to interpreting in institutional settings of a given society in which public service providers and individual clients do not speak the same language” (Pöchhacker 1999: 126). It is often opposed to “conference interpreting” (simultaneous interpreting) and sometimes compared to sign language interpreting as sign interpreters follow their clients in different institutional settings. Community interpreting does not refer to a universally standardized practice as many factors (such as politics and economics) shape this activity from one region to another. Sometimes, the community interpreter can hold a university degree, while at other times she will have received only 6 hours of training or none at all (see Pöchhacker 1999).
4. To differentiate this particular role and the whole interpreting practice, I keep the “translator” term, being aware it is not the best term because there is translation in each role and because this is the usual way to name people who do written translations.

5. The term passive does not imply that the interpreter is an “automatic translating machine” or a “conduit.” The use of this term is meant to qualify only the symbolic position, not all of the activities taking place, which, of course, implies numerous active processes, particularly at a cognitive and interactional level, as has been shown by many authors such as Angelelli (2000), Bélanger (2003), Davidson (2002) or Wadensjö (1998).
6. As of 4 June 2005, Swiss community interpreters do have a professional code. It was adopted at the general assembly of the INTERPRET’ association. In this code, neutrality is defined as an obligation as is interpreters’ contribution to “equality of chances and integration of migrants in a pluralistic society.” These two statements can be seen as contradictory: how can one be neutral and at the same time promote integration (not assimilation)?

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