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DISSERTATION

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

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To my mother

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Contents

Figures

Tables

Abbreviations and acronyms

ABG	arterial blood gases
AC	antecubital
A-fib	atrial fibrillation
AITI	*Associazione Italiana Traduttori e Interpreti* (Italian Translators and Interpreters Association)
BID	twice a day (from Latin *bis in die*)
BM	bowel movement
CABG	coronary artery bypass graft
CAD	coronary artery disease
CI	community interpreting
CL	Critical Link
CV	cardiovascular
CVP	central venous pressure
D5W	5% dextrose in water
DC	discontinue
DI	dialogic discourse-based interaction
EJ	external jugular
EKG	electrocardiogram
GI	gastrointestinal
GU	genitourinary
HBV	hepatitis B virus
HCI	healthcare interpreting
HCV	hepatitis C virus
I and O	intake and output
IATIS	International Association for Translation and Intercultural Studies
ICU	intensive care unit
IJ	internal jugular
IMIA	International Medical Interpreters Association
INR	international normalized ratio

ISMETT	*Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione* (Mediterranean Institute for Transplantation and Advanced Specialized Therapies)
IV	intravenous
JP	Jackson-Pratt (drain)
LAD	left anterior descending
LS	Language Services
NPO	nothing by mouth (from Latin *nihil per os*)
OR	operating room
PA	pulmonary artery
PICC	peripherally inserted central catheter
PO	by mouth (from Latin *per os*)
PRN	as per need (from Latin *pro re nata*)
PT	physical therapy
Q	every (from Latin *quoque*)
QOD	every other day
RA	right atrium
RCA	right coronary artery
SCD	sequential compression device
SDU	step-down unit
T&I	translation and interpreting
TEDS	thrombo-embolic deterrent stockings
TEE	transesophageal echocardiogram
TID	three times a day (from Latin *ter in die*)
TILS	Translation, Interpreting and Languages for Special Purposes
TIPS	transjugular intrahepatic portosystemic shunt
UPMC	University of Pittsburgh Medical Center
VBG	venous blood gases

0. Introduction

> *So who can I call my mentor? Who inspired me to be a nurse? Who continues to inspire me? [...] Was it the nurse of my childhood, the one with the white shoes and stockings? My heroic and energetic sister? My legendary mother, the one who taught me first about providing care? Gail, who took such a risk to bring me into the emergency room? The other ER nurses? [...] The psych nurse peer group I've met with monthly for 25 years? My colleagues at the hospital? The staff nurses on my unit? The nurse writers I've met and write with? Yes, I think so. They all inspire me, and we all inspire each other.*
>
> Joan Stack Kovach, "My Many Mentors" (2009: 29)

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

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

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

Running counter to this trend, the present study is concerned with interpreting in a bilingual hospital in Southern Italy, ISMETT, whose US and Italian employees interact not only with patients, but also with each other supported by a team of English-Italian in-house interpreters. The most frequent ISMETT users of the interpreting service are

nursing staff members of all ranks: in fact, the quotation above has also been chosen because the main protagonists of this study are interpreters *and* nurses.

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

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

main research strategy, the study can be placed within the DI research paradigm of interpreting studies (Pöchhacker 2004, 2007).

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

1. Healthcare interpreting: Review of the research literature

1.1 Healthcare interpreting within interpreting studies

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

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

A landmark event in the development of HCI was the first international congress on community-based interpreting (CI) organized at Geneva Park near Toronto, Canada, in 1995 by "The Critical Link", a network of specialists in the field summoned in 1992 by Brian Harris of the University of Ottawa and subsequently turned into a non-profit organization committed to the advancement of CI (Critical Link 2010). Significantly, the title of the congress – "Interpreting in Legal, Health and Social Service Settings" – made explicit reference to 'health' as one of the key areas of practice acknowledged by the heterogeneous Critical Link community. More specifically, one of the conference

organizers, Roda Roberts, further supported this inclusion in her opening keynote speech: quoting Collard-Abbas (1989: 81), she defined CI as the "type of ad hoc interpreting done to assist those immigrants who are not native speakers of the language to gain full and equal access to statutory services (legal, *health*, education, local government, social services)" (Roberts 1997: 8; emphasis added).

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

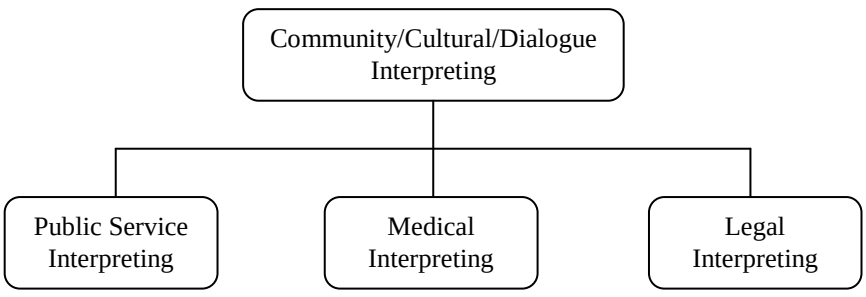

Figure 1.1 Roberts' varieties of CI (from Roberts 1997: 9)

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

An alternative conceptual model was developed by Garber (2000) and presented at the Second Critical Link Conference[1] (Figure 1.2). Its peculiarities are twofold: first of all, it includes not only interpreting varieties representative of CI, i.e. "court", "police", and "medical", but also "conference" interpreting. Secondly, interpreting types are represented by overlapping circles, rather than being hierarchically separated. Indeed, Garber moved from the assumption that all types of interpreting, despite their unique and distinctive features, shared the same ethical common ground, namely "the fundamental commitment to accuracy or fidelity" (2000: 15), graphically symbolized by the areas of overlap. However, despite its innovative approach, Garber's model did not

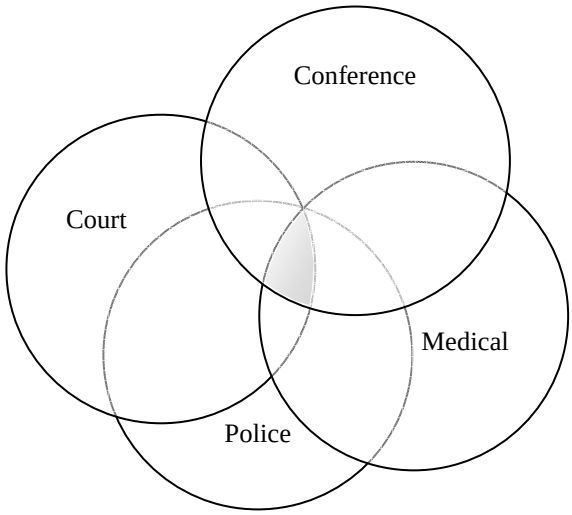

Figure 1.2 Garber's model of interpreting types (from Garber 2000: 15)

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

take into account any other parameters that could meaningfully link HCI to the other domains.

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

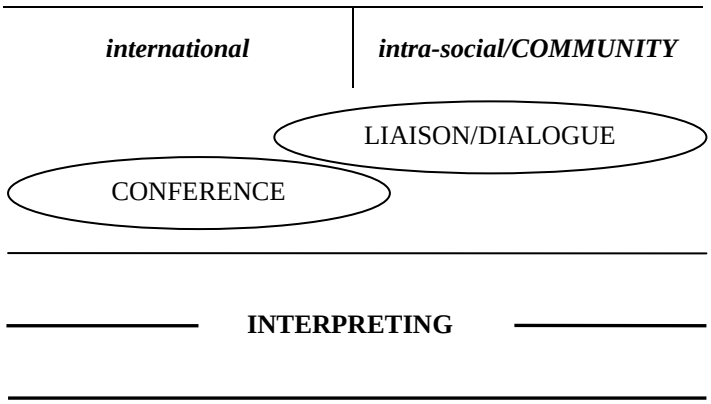

Figure 1.3 Pöchhacker's conceptual spectrum of interpreting (from Pöchhacker 2007: 12)

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

While warning against the interpretation of the chart as a map of features that can coalesce, Pöchhacker (2004: 25) also adds that the interaction of the first seven dimensions offers an overview of the leading issues in the diverse interpreting domains. Bearing these suggestions in mind, an attempt can be made at describing the typical conception of HCI: in general terms, HCI can be defined as a type of (human) interpreting, both spoken and signed, that occurs in an intra-social setting, more specifically in healthcare, where a (usually) semi-professional or (sometimes) natural interpreter uses the (short) consecutive mode to interpret face-to-face talk between an individual speaking a migrant language and an institutional representative. Undoubtedly, this broad definition confirms that HCI shares numerous features with similar CI types in other intra-social contexts. Nonetheless, it can be said that the 'healthcare' setting does not make the difference *per se*, but gains significance insofar as it entails an array of additional, specific issues that cannot be found in any other CI

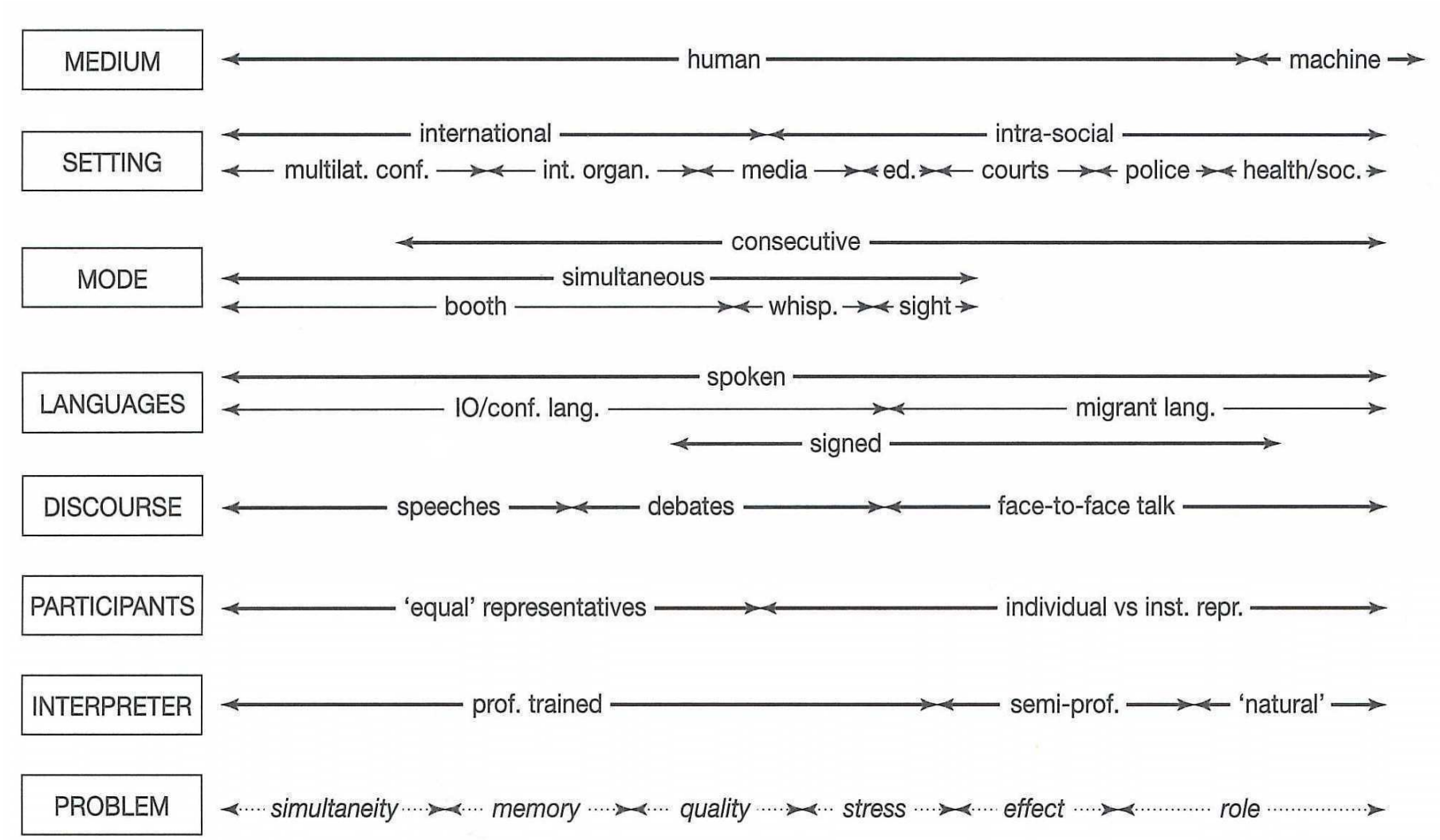

Figure 1.4 Domains and dimensions in interpreting theory (from Pöchhacker 2004: 24)

environment with the same intensity (e.g. emotional problems, relation with the concepts of death and illness, notion of empathy, etc.). Such issues should thus be placed as a subgroup along the eighth dimension in the diagram – the one indicating 'problems' – though not as a continuum affecting all interpreting types, but rather as setting-specific concerns.

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

1.2 Issues in healthcare interpreters' product and performance

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

The focus of interest in the empirical part of the present study will be the development of interpreted encounters, rather than the organization of interpreting services and the impact thereof. Hence the current review will only take account of overriding concerns regarding healthcare interpreters' linguistic output, or 'product', and their communicative 'performance' in this function – two concepts that are closely

interrelated (cf. Pöchhacker 2004: 137ff). More specifically, while exploring mediated communication from a translational as well as interactional viewpoint, the following recurrent themes will be considered: source-target correspondence (cf. Pöchhacker 2004: 141ff); the heated debate on the interpreter's role; and the joint management of the interactive discourse, i.e. the effects of the peculiar constellation of interaction on the conversational dynamics, especially in terms of footing and turn-taking.

1.2.1 Source-target correspondence

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

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

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

[2] For an overview of the main classifications put forward in the literature, see Pöchhacker (2004: 142-143).

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

Another qualitative investigation was conducted in the outpatient clinic of a Nigerian hospital by Launer (1978) in his dual capacity as language expert and clinician. Looking for deviations from a word-for-word translation, he analysed the transcribed recordings of consultations interpreted by seven medical orderlies, with the involvement of thirty local patients speaking Hausa and four English-speaking doctors. Deviations during history taking were then classified as "legitimate", e.g. appropriate clarifications and paraphrases of the original utterances; "illegitimate" (mistranslations or omissions); or "due to the interpreter acting as independent questioner" with patients (1978: 934). Notably, the similarity between his own findings and those obtained by Lang was read by Launer as a proof that, regardless of geographical factors, the nature of history taking and the demands of interpreting were the same across cultures (1978: 935).[3]

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

[3] It should be noted that Launer commented on the interpreting activity as a whole. Undoubtedly, he was somewhat biased towards clinicians, who – in his opinion – should be in charge of the interaction, whereas interpreters were viewed as mere tools. Nevertheless, his guidelines for an adequate interpreting service were strikingly modern: "[…] I would recommend that interpreters should have *no conflicting duties* during consultations, such as checking documents. They should have formal *training* in language and the rudiments of interpretation. Doctors should be *taught how to use them*. The service should be checked continuously with the help of native-speaking doctors, language tests, and *recorded tapes*. I would also suggest some rules for any doctor who has to use an interpreter. Greet the patient to *establish direct contact*. […] Give only *short sentences* for translation, and get the interpreter to explain that the patient must do the same. […] Finally, use the interpreter to tell the patient everything you would tell him if he could speak your language." (Launer 1978: 935; emphasis added).

interpreters was found to increase miscommunication. More specifically, questioning patterns leading to incorrect answers in mediated interactions were attributed to five interpreter behaviours: answering instead of translating questions, translating information incompletely, translating incorrectly, mishearing, and displaying a limited linguistic competence (the last two occurrences were observed also among the physicians).

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

Also Marcos (1979) looked at interpreter-related distortions in the psychopathological assessment of non-English-speaking patients, though from a qualitative rather than quantitative perspective. The first part of his study, conducted at two New York City hospitals, hinged upon discussions with English-speaking psychiatrists and (untrained but experienced) healthcare interpreters, in order to compare their major concerns. He then analysed the transcribed and translated recordings of eight psychiatric evaluations concerning patients speaking Spanish, Cantonese, and the Chinese dialect Toisanese. The interviews were mediated by ad hoc interpreters, namely a bilingual psychiatric nurse (in four cases), a nurse's aide with no psychiatric knowledge (in two), and two patients' relatives. Distortions consisted primarily of omissions, condensations, substitutions, additions, and content normalizations, i.e. attempts to make sense of patients' utterances instead of providing

exact translations. According to the researcher, most errors were due to the interpreters' lack of language proficiency, translation skills, and psychiatric expertise; as for patients' relatives, some alterations were also associated with their personal views, as in their tendency to either minimize or emphasize psychopathological attitudes. Marcos concluded that pre- and post-session briefings between clinicians and interpreters could help reduce deviations and the related misdiagnoses. This notion that misinterpretation by untrained interpreters can lead to misevaluation of patients' mental status – especially in terms of attenuation or exaggeration – was also supported by Vasquez and Javier (1991) through two case examples. Notably, in their classification of error types, the researchers included the category of "role exchange" for those cases in which interpreters took over the interaction and replaced the interviewers' questions with their own.

Going back to error quantification, faults analogous to those found in Price (1975) are present in the frequently-cited study by Ebden *et al.* (1988). Four interviews between English-speaking doctors and patients speaking Gujarati – an Indian language – were videotaped in the outpatient department of an English hospital, with patients' relatives as interpreters. According to the authors, interviews were conducted as if they were first visits, which might imply that they were run as simulations (Pöchhacker 2006: 144). Attention was focused on three main features: the translation of physicians' questions, the management of medical terminology, and the influence of cultural aspects. To start with, complex questions – requiring more cognitive processing – and serial questions – likely to test the interpreter's memory – were found to be regularly mistranslated or omitted, with the relevant percentages provided for each interpreter. Yet no explicit reference was made to the method of verbal data analysis (e.g. who carried out the assessment, how an incorrect rendition was distinguished from an appropriate paraphrase, etc.). Similar remarks can be made about the quantification of mistranslations and omissions of medical terms. Finally, physicians' references to cultural taboos were either eliminated in the Gujarati rendition or handled ambiguously. Leaving aside the methodological issues, Ebden *et al.* significantly concluded that linguistic and cultural problems went unnoticed by physicians, thus potentially compromising the accuracy of initial diagnoses.

More recently, Flores *et al.* (2003) examined thirteen tape-recorded Spanish-English encounters in the paediatric outpatient clinic of a Massachusetts hospital, as part of a larger research project. Staff interpreters with limited training were used in six encounters, while the others were mediated by three ad hoc interpreters (three by a nurse, three by a social worker, and one by a sibling aged eleven). The goal was to establish the incidence of interpreters' mistakes, classify them, and evaluate their potential clinical effects. Unlike Price (1975) and Ebden *et al.* (1988), the methodology applied for recording, transcription, transcript translation, review, and error assessment was described in detail. Partially drawing on the categories devised by Barik (1969) and Hornberger *et al.* (1996), errors were classified as omissions, additions, substitutions, editorializations (i.e. provision of personal views in the translation), and false fluencies (i.e. use of incorrect or non-existing expressions). The quantification showed an overall high frequency of mistakes both for hospital and ad hoc interpreters – particularly of omissions, which accounted for more than half of all errors. Although hospital interpreters committed fewer errors of potential clinical consequence, their error total was higher than that of ad hoc interpreters. Also false fluencies were common in staff interpreters' renditions, and mainly involved medical terminology. Therefore, the findings called for the need not only to avoid using improvised interpreters, but also to adequately train those employed by healthcare facilities. The same corpus was examined by Laws *et al.* (2004) with the goal of creating a quality assessment method for medical interpreting. In this case, the transcripts were divided into conversation segments, each consisting of continuous monolingual turns by the same primary speaker and the subsequent purported translation into the other language. Segments were then coded to indicate their translation accuracy, partly following the above-mentioned classification by Vasquez and Javier (1991). In 66.1% of segments, the translation featured considerable errors or omissions, or was not present at all, although needed. Moreover, 29.8% of segments saw interpreters engaged in autonomous and potentially deleterious speech acts unrelated to interpretation, defined as instances of "role exchange" (cf. Vasquez and Javier 1991).

It should be noted that few studies on healthcare interpreters' output have taken into specific account the management of medical terminology. Aside from the limited interest by Ebden *et al.* (1988; see above), the linguistic investigation carried out by

Meyer (2001) within a wider research project in German hospitals is worthy of note. He considered the transcribed recording of three authentic interactions between German-speaking clinicians and Portuguese migrants, mediated by a patient's relative and two different nurses. Lexical substitutions were a noticeable occurrence: for instance, the use of everyday language instead of professional terms, or vice versa, and recourse to additions as autonomous professional explanations by the clinical personnel acting as interpreters. Interestingly, the pragmatics analysis revealed that such easily predictable deviations were not merely informed by the interpreters' knowledge – or lack of it – of the correct terminology. Rather, Meyer ascribed them to the peculiar speech situation, the pre-existing relationship between interpreter and primary participants (in terms of closeness versus distance), and the organization of the source discourse.

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

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

Other scholars have focused on the communicative effect produced by deviations, especially when unqualified interpreters are used. Pöchhacker and Kadrić (1999) examined the voice therapy session of a Bosnian child and the subsequent briefing with his parents, taking place at a Vienna hospital. The encounters, both videotaped and transcribed, were managed by two German-speaking speech therapists through the mediation of a Serbian-speaking cleaner. Despite the apparent successful outcome of the sessions, the case study analysis revealed that the interpreter frequently adopted a covert

"co-therapeutic attitude" (1999: 175) through significant shifts in the form and substance of the exchanges. The indirect effect was that the two therapists – though unaware of it – failed to maintain control over the session. Along similar lines, Jan Cambridge (1999) explored seven simulated English-Spanish medical consultations mediated by two untrained interpreters. She showed that these tended to occupy inappropriate interlocutor roles, which led them to omit information, add content (including opinions and advice), and alter meanings. The ensuing miscommunication affected not only the physicians' ability to establish rapport with their patients, but, more importantly, the transmission of diagnostically relevant data.

The increased employment of professional healthcare interpreters in the last few years has paved the way to new research trends, first developed – once again – in conference interpreting. Attention has been shifted towards a reading of interpreters' departures not necessarily as errors, but rather as deliberate 'strategies' for dealing with varying pragmatic factors, such as the situation and the recipients of the interpretation (cf. Kopczynski 1994; Viezzi 1996).[4] Though undoubtedly significant in conference interpreting, these contextual elements are all the more crucial in face-to-face encounters. As suggested by Hsieh (2003: 19) from the perspective of communication studies:

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

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

[4] In conference interpreting, a number of authors have stressed not only the frequency, but also the advisability of interpreters' specific deviations. For instance, Palazzi Gubertini (1998) pointed out that, on occasion, additions may be required for clarity purposes. Along the same lines, Falbo (1999) distinguished between "loss" and "omission", considering the latter a conscious interpreting choice. In the field of sign language interpreting, a noteworthy contribution to this topic was Jemina Napier's (2002, 2004) classification of omissions in relation to interpreters' linguistic coping strategies.

these correlations, Wadensjö devised a taxonomy of renditions, in order to detect their potential functions at the interactional level. She drew a main distinction between renditions that are "close" to their originals, in terms of propositional content and style, and those that are "divergent". The latter were then grouped into seven categories: "expanded renditions", if the information contained is verbalized more explicitly than in the preceding originals; "reduced", in the opposite case; "substituted", when an expanded rendition and a reduced one are combined; "summarized", matching two or more preceding originals; "two-part or multi-part", should two or more renditions correspond to one original; "non-renditions", i.e. interpreter's autonomous interventions; finally, "zero renditions", if primary speakers' utterances are not translated (Wadensjö 1998: 107-108; for a more exhaustive review of Wadensjö's theoretical framework, see §1.2.2 and 1.2.3).

Out of the categories put forward by Wadensjö, five – namely close, expanded, reduced, zero, and non-renditions – were borrowed and further subdivided by Rosenberg (2001) in his quantitative study conducted in a Texan primary-care clinic.[5] The transcribed corpus consisted of eleven paediatric interviews whose participants were Spanish-speaking young patients and their relatives, English-speaking medical staff, and the author himself as both researcher and interpreter. The findings revealed that, although 40.8% of the 1,334 interpreter utterances were close renditions, zero renditions and non-renditions were frequent occurrences too (26.9% and 19.5% respectively). Despite Rosenberg's initial bafflement at these results (2001: 105), closer scrutiny proved that discrepancies between source texts and target texts did not necessarily indicate unskilled or unscrupulous behaviour on the part of the interpreter. Rather, they were indispensable tools – under specific circumstances – to ensure the successful outcome of the medical encounter as a whole, given the complex nature of mediated events.

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

[5] Rosenberg did not take into account Wadensjö's summarized, substituted, and two-part/multi-part renditions as he found them less suitable for a quantitative analysis (2001: 101).

functions), emphatic (repetitions), explanatory, and other, i.e. Wadensjö's non-renditions, which were further subdivided into seven groups (see also §1.2.3).

Undoubtedly, the first studies on medical interpreters' product have gradually achieved a remarkable goal: they have contributed towards stepping up awareness about the potentially dangerous use of ad hoc interpreters, whether family members[6] or unqualified bilinguals. At the same time, they have triggered further research projects, aimed at fostering the systematic provision of healthcare interpreting services, as well as ensuring interpreters' thorough training. A detailed account of these issues is beyond the scope of this review, as already underscored. Nevertheless, it is worth stressing that these outcomes and the subsequent increasing professionalization of healthcare interpreters have directed attention to previously overlooked features, namely the communicative and discursive functions of interpreters' departures. This shift from the textual product to the context of mediated interactions – or, rather, to the discourse level – will be the subject matter of the following section.

1.2.2 Role definition

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

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

analogous accounts by clinical experts (e.g. Westermeyer 1990; Drennan and Swartz 1999).

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

At the opposite end of the spectrum, research routes with sociological and sociolinguistic approaches stressed the need for the interpreter's direct involvement in the interaction. This thematic orientation was strongly supported by medical anthropologists studying indigenous populations, such as Joseph Kaufert and fellow scholars at the University of Manitoba (Winnipeg, Canada). Challenging the notion of invisibility, they argued that the interpreter's role cannot but include cultural brokerage and community advocacy, especially when the ethnomedical model (based on patients' cultural beliefs about illness) clashes with the biomedical model (i.e. the healthcare professionals' notion of disease). For instance, Kaufert and Koolage (1984) used participant-observation data, as well as audio-taped interviews with medical interpreters speaking Cree and Saulteaux (two native North American languages) and their clients, to describe interpreters' divided loyalties. Conflicts arose in particular when mutual needs and expectations were ignored: for instance, if clinicians disregarded cultural customs, or patients did not comply with the recommended treatment. More specifically, the authors identified four main roles performed by interpreters: "direct linguistic translators" (or "conduits"), converting terminology from the source language into the target language; "culture-broker informants", explaining cultural matters regarding native patients to clinicians; "culture broker-biomedical interpreters", explaining medical terms and procedures to patients; finally, "patient advocates", siding

with patients and their cultural values. Along the same lines, Kaufert and Putsch (1997) reported case examples about informed consent and end-of-life issues in interpreter-mediated hospital encounters that involved English-speaking physicians, patients from ethnic communities, and their relatives. They showed how the model of the neutral, objective interpreter – called for by most medical interpreting codes of conduct – was often not complied with in actual practice: interpreters were not only witnesses to, but also participants in a health delivery process informed by class divisions, different family practices, and contrasting beliefs. Yet the two authors maintained the need for further thorough studies before the interpreter's role as intermediary could be acknowledged and legitimized, in order to avoid the premature and risky development of groundless specifications.

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

> In an interpreter-mediated conversation, the progression and substance of talk, the distribution of responsibility for this among co-interlocutors, and what, as a result of

> interaction, becomes mutual and shared understanding – all will to some extent depend on the interpreter's words and deeds. (1998: 195)

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

Angelelli (2004a) carried out an ethnographic study in a large Californian hospital that employed a team of Spanish-English medical interpreters who had all been trained on the job. Looking at the social aspects of the profession through a combined set of "lenses" provided by social psychology, sociological theory, and linguistic anthropology (2004a: 26ff), the author collected a remarkably large and diverse corpus of data over a two-year period: the audio-recordings of 392 interpreter-mediated encounters between healthcare practitioners and patients (381 over the speakerphone and the others in face-to-face interviews) were complemented by field notes, interviews with the interpreters and their Service Manager, survey data, as well as by what Angelelli called "artifacts" from the site (2004a: 59), i.e. information material on the

hospital interpreting services, or even the handwritten messages the interpreters sent to each other. Discourse data were coded and analysed based on a set of categories to describe the level of interpreters' visibility – defined as a continuum ranging from high visibility (e.g. production of autonomous utterances) to low visibility (such as the control over the flow of information) – and in relation to the generated outcome. Angelelli's findings (2004a: 129ff) confirmed that interpreters – who ultimately described themselves using suggestive metaphors such as "detectives", "multi-purpose bridges", or "miners" – were visible co-participants in the mediated interaction, exercising their agency when triggered "by the interplay of social factors".

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

expedite the consultations. However, the author argued that this preferential use of the "voice of medicine" to the detriment of the "voice of the lifeworld" (cf. Mishler 1984) might affect the quality of the medical care received, not only in terms of humanity, but also because essential information could inadvertently be omitted due to interpreters' lack of medical expertise.

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

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

1.2.3 Management of the interactive discourse

Valuable insights into the dynamics of interpreter-mediated communication in healthcare have been provided within the DI paradigm of interpreting studies. Also in this regard, Cecilia Wadensjö's input has been crucial. Her analysis was largely based upon the notion of "participation framework", first developed by the Canadian sociologist Erving Goffman (1981) to indicate that all individuals have a specific status or level of involvement in communicative interaction.[7] With reference to hearers, Goffman had drawn a distinction between "unratified recipients" ("overhearers" and "eavesdroppers") and "ratified recipients" ("addressed", "unaddressed", and "bystanders"). As for the speakers' stance, or "production format", he had identified three main categories to specify an increasing ownership of the words uttered: the "animator" is the "talking machine" who produces the speech sounds; the "author"

[7] More precisely, Goffman explained that "when a word is spoken, all those who happen to be in perceptual range of the event will have some sort of participation status relative to it" (1981: 3).

formulates the utterance; finally, the "principal" bears responsibility for the viewpoint or position expressed – though a single speaker may well embody all three roles at the same time (1981: 124ff). Moving from the assumption that interpreting is just another 'form of talk' – to draw on the title of Goffman's opus – Wadensjö (1992, 1998) applied this model to interpreters, in their simultaneous capacity as hearers and speakers in face-to-face encounters. For these purposes, she matched Goffman's production format with a corresponding classification of recipientship, namely the "reception format", which consisted of three modes: "reporter" (expected to repeat the words heard without assuming any responsibility for them); "recapitulator" (listening in order to give an account, through an authorized voice, of what was said); and "responder" (listening with the purpose of speaking as a primary participant; 1998: 91-92). Significantly, Wadensjö emphasized that the interpreter's listening activity is not passive: moving from the role of listener to that of speaker, the subsequent linguistic production is informed by the previous reception, based on the correlations in Table 1.1. It should be understood that interlocutors' participation status in interaction is subject to constant negotiation and redefinition: hence Wadensjö also adopted Goffman's notion of footing, that is to say "a person's alignment (as speaker *and* hearer) to a particular utterance" (Wadensjö 1998: 87),[8] which allowed for an utterance-to-utterance analysis of interpreters' changes in terms of production and reception.

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

Production format / **Reception format**	Animator	Author	Principal
Reporter[9]	✓		
Recapitulator	✓	✓	
Responder	✓	✓	✓

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

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

[9] For the sake of simplicity, the mode of 'reporter' has been matched with the production format of 'animator' alone, although Wadensjö specified that interpreters necessarily produce linguistically different versions of the original utterances (1998: 93), thus constantly acting also as 'authors'.

her model, such as Merlini and Favaron (2007) in the aforementioned study on interpreter-mediated speech pathology sessions. Viewing the "voice of interpreting" as oscillating between the professional's "voice of medicine" and the patient's "voice of the lifeworld" (cf. Mishler 1984), the authors focused on a selection of linguistic features, including footing. More precisely, they developed a pattern based on the primary participants' mutual alignment, their alignment to the interpreter, and the interpreter's attitude as subsequent speaker. The seven resulting categories of interpreter's footing are exemplified in Table 1.2, in which the utterances of an English-speaking clinician as primary interlocutor are translated into Italian. To start with, when the speaker addresses the other participant, the interpreter can choose among three options: the "reporter" (use of the first person); the "pseudo-co-principal" (use of the first person plural, to signal commonality of purposes); and the "narrator" (use of the third person). If, on the other hand, the primary speaker addresses the interpreter, explicitly asking to translate for the other party, the interpreter's choice is between the two categories of "direct" and "indirect recapitulator", i.e. between, once again, the first person and the third person. Finally, while the footing of "responder" sees the

Primary Speaker	**Interpreter**		**FOOTING**
Now I'll ask you some questions	Translator – unaddressed	Ora ti farò delle domande *Now I will ask you some questions*	REPORTER
		Ora ti faremo delle domande *Now we will ask you some questions*	PSEUDO-CO-PRINCIPAL
		(Dice che) ora ti farà delle domande *(She says) she will ask you some questions*	NARRATOR
(Tell her) I'll ask her some questions now	Translator – addressed	Ora ti farò delle domande *Now I will ask you some questions*	DIRECT RECAPITULATOR
		(Dice che) ora ti farà delle domande *(She says) she will ask you some questions*	INDIRECT RECAPITULATOR
Will you go with the patient?	Interlocutor	Yes, I will	RESPONDER
	Initiator	Will you move over there, please?	PRINCIPAL

Table 1.2 Categories of footing (cf. Merlini and Favaron 2007: 117)

interpreter relating as interlocutor to a primary speaker's utterance, the category of "principal" indicates the interpreter as autonomous producer. The analysis of the three recordings showed that the interpreters' marked involvement in the interactions contributed to reinforce the voice of the lifeworld: under specific circumstances, this was also achieved through the adoption of the footings of principal, responder and, occasionally, pseudo-co-principal.

The same volume in which this paper was published – entirely devoted to discourse and interaction in medical settings (Pöchhacker and Shlesinger 2007) – featured another two contributions on interpreters' footing, with specific regard to the choice between direct or indirect speech. Dubslaff and Martinsen (2007) carried out a quantitative analysis of pronoun shifts in four simulated medical interviews, based on the same script and mediated by untrained Arabic interpreters who worked for a Danish agency. The rationale behind their study was the traditional equation of the use of the first person with qualified interpreting, as opposed to the frequent employment of the third person by non-professionals. The four interpreters adopted different styles of address: two preferred the direct one, while the others used the indirect style more frequently. Some general remarks could nevertheless be made: firstly, all interpreters tended to personalize the indefinite pronoun 'one' when translating into the patient's language, probably to express solidarity or identify with the client; secondly, the other pronoun shifts were found either to convey distance, or to act as compensating strategies, especially when the interpreters' lack of medical knowledge brought about interactional problems; as a result, indirect speech was often found to ensure seamless communication and resolve ambiguities. The other research study was conducted by Hanneke Bot (2007), a psychotherapist specialized in treating asylum seekers and refugees, thus working with interpreters on a regular basis. To examine reported speech, she videotaped two consecutive psychotherapy sessions of three different groups, each consisting of a Dutch therapist, a patient speaking Dari and Persian, and an interpreter recruited by a government-funded interpreting agency on completion of a specific exam. In Bot's analysis, the three interpreters displayed diverse strategies for indicating detachment from their translations, which mainly hinged upon turn length or structure, complexity, and assumptions about the recipient's understanding. More specifically, she

Perspective / Reporting verb	Perspective unchanged	Perspective changed
Yes	1. Direct representation *he says I went to school*	2. Indirect representation *he says (that) he went to school*
No	3. Direct translation *I went to school*	4. Indirect translation *he went to school*

Table 1.3 Bot's taxonomy of change of perspective of person (original utterance: "I went to school"; from Bot 2007: 85)

could identify four types of changes in the perspective of person, summarized in Table 1.3: what is particularly noteworthy about her taxonomy is the category of "direct representation", in which the interpreter maintains the primary speaker's first person pronoun, yet prefaces the rendition with a reporting verb (e.g. "he says"). Bot concluded that interpreters' perspective shifts should not be viewed as shortcomings, but rather as natural occurrences stemming from the very nature of dialogue interpreting as three-party talk.[10]

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

[10] A more extensive investigation into the communication processes in interpreter-mediated psychotherapeutic dialogue can be found in Bot (2005).

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

2. Interpreting at ISMETT

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

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

2.1 The institutional context

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

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

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

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

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

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

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

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

[14] It should be underlined that patients who are referred to ISMETT are treated within Italy's National Health System.

[15] Throughout the years, freelance interpreters have been provided, for instance, for Albanian, Arabic, Chinese, French, Greek, and Spanish.

to this concern (next to the more common living donor kidney transplants), the latest challenge consists in advancing the frontiers of clinical and biomedical research. In particular, pioneering studies in the field of regenerative medicine and cell therapy are currently conducted in the laboratories of the ISMETT cell factory, inaugurated in 2007 with the purpose of processing human cells to repair damaged organs (Di Bartolo 2008; UPMC 2008: 60-62; Terapie Cellulari 2010). Close ties also exist between the Institute and Ri.MED, a Foundation resulting from a more recent partnership between Italian bodies and UPMC to undertake biotech and biomedical research projects.[16]

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

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

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

2.2 An unusual language contact situation

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

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

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

Significantly, just as the innovative professional profile of "unit interpreter" was introduced at ISMETT based on the hospital's initial requirements (ISMETT 2002: 32;

UPMC 2008: 22), the strength of the LS has been the ability to adjust to the company's evolution (Mucè and Schillaci 2007). The main stages of this process will now be examined in detail.

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

In an extensive presentation given by two members of the LS at the Critical Link 5 Conference in Sydney (Mucè and Schillaci 2007), three main stages were identified in the history of the Department: the "creation", the "consolidation", and the "evolution" proper. The authors show how the LS increased the number of components, modified the set-up of tasks, developed further technical and interpersonal skills, and acquired new working tools to meet the shifts in corporate needs, expectations, and users. Interestingly, each phase did not replace the preceding one, but rather enriched it, as a result of the additional duties and areas of competence. Table 2.1 sums up the key features characterizing each phase, whereas Table 2.2 presents demographic data on the interpreters employed at ISMETT since 1999.[17] For the sake of simplicity, interpreters have been given fictitious names beginning with consecutive letters of the alphabet. The guidelines provided by the LS Department to its customers are included in Appendix One (see also Putignano 2002; Díez 2003; Tomassini 2005).

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

[17] Although the LS Department was established in 2000, some of its prospective members started to work in 1999 either as freelancers or under fixed-term contracts. For further information, see §4.2.

	Phase 1: Creation	Phase 2: Consolidation	Phase 3: Evolution
Time	From 2000 to mid-2003	From mid-2003 to mid-2006	From mid-2006
Staff	1 Department Head 5 junior interpreters 1 senior interpreter	1 Department Head 1 Coordinator 7 interpreters	1 Coordinator 5 interpreters* 1 English language instructor** 1 International Patient Services Coordinator***
Requirements	English and Italian proficiency	Education and/or experience in T&I	Degree in T&I
Languages	Italian English	Italian English	Italian English French (2 staff members)
Activities	Interpreting Translation Proofreading	Interpreting Translation Proofreading Support services	Interpreting Translation Proofreading Support services Arabic tutorials (organization) Italian tutorials (organization & teaching) English tutorials (organization & teaching) English proficiency test HCI seminar (organization & teaching)
Users	Italian/US clinical and administrative staff Italian patients	Italian/US clinical and administrative staff Italian/international patients ISMETT BoD Italian/US third parties	Italian/US clinical and administrative staff Italian/international patients French-speaking patients ISMETT BoD Ri.MED BoD Italian/US third parties
Tools		CAT tool (SDLX)	CAT tool (SDLX)
Research		Alcalá Conference (April 2005) IATIS Conference (July 2006)	CL5 Conference (April 2007) IMIA Conference (October 2007) TILS Conference (February 2008) Genova Workshop (May 2009)
Continuing Education		Dialogue interpreting	Simultaneous interpreting Consecutive interpreting

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

Table 2.1 Evolution of the LS Department (cf. Mucè and Schillaci 2007)

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

The phase of "consolidation" (from mid-2003 to mid-2006) corresponded not only to the complete standardization of processes and workflows, but also to an increase in interpreters' "job consciousness" and "self-awareness" (Mucè and Schillaci 2007). The transfer to the new facility led to an upsurge in hospital activities and, consequently, in translation and interpreting needs, to the extent that another three interpreters – graduated in Translation or Interpreting – were employed. The establishment of further connections between the hospital and third parties, such as Palermo's University and Municipality, created new users for the LS. Moreover, interpreters were now involved in executive meetings, institutional events, medical conferences requiring simultaneous interpreting, as well as in the provision of on-site support to Italian clinical staff sent to Pittsburgh for educational purposes. Instructions on the use of translation and interpreting services began to be offered on a regular basis to newly-hired staff through specific workshops, which comprised simulations of interpreter-mediated encounters. Following the acknowledgement of the Department's status within the company, significant steps were also taken in the field of training and research, such as continuing education sessions in dialogue interpreting, with the support of an external trainer; internship programmes for undergraduate and graduate students in translation and interpreting; and the participation in international conferences both as audience (in

Interpreters	Mother tongue	University education	Job-related experience	Employment period at ISMETT LS
Aldo (LS Department Head until mid-2006)	Italian	Hispanic Languages and Literatures	UPMC Staff Associate	1999-2006
Barbara (senior interpreter)	Italian	Interpreting	Freelance interpreter and translator	2000-2004
Christian (LS Coordinator as of mid-2005)	Italian/English	Architecture	Freelance architect	1999-
Dario (International Patient Services Coordinator as of Feb 2008)	Italian	Interpreting	Freelance interpreter and translator	1999-2008
Eric (English Language Instructor as of Feb 2008)	English/Italian	Modern Languages and Literatures	Consultant at Italian-Canadian association	1999-
Francesca	Italian	Translation	Tourist entertainer	1999-
Georgia	English/Italian	Marketing and Communication	Assistant buyer	2000-
Henry	English/Italian	Interpreting	Freelance interpreter and translator	2004-
Italo	Italian	Interpreting	Airline customer care consultant for UK/IE	2004-
Julia	Italian	Translation	Italian teacher	2004-2008

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

Alcalá de Henares, Madrid, in 2005)[28] and as speakers (for instance, at the IATIS Conference in 2006).[29]

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

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

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

[29] "Intervention in Translation, Interpreting and Intercultural Encounters" was the topic of the Second Conference of the International Association for Translation and Intercultural Studies, held at the University of the Western Cape, Cape Town, South Africa (July 12-14, 2006).

[30] Night shifts, originally scheduled to support US personnel in the wards, had become like exhausting daytime shifts, almost entirely devoted to written translations.

[31] English teaching is provided by a member of the LS Department in collaboration with an external consultant; they are also responsible for testing the proficiency gained by the personnel, in compliance with a recent company policy sponsored by the LS (see Appendix Two). As for the US staff, other members of the Department currently hold Italian classes on a regular basis.

Translators and Interpreters Association) and entirely taught by department members, also offered a chance to explore the potential to generate company profits; similar experiments are likely to be repeated in the near future with the provision of translation and interpreting services to third parties.

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

2.4 Domains and dimensions of interpreting at ISMETT

The atypical nature of interpreting activities at ISMETT arises from a combination of factors, partially suggested in the previous sections. An attempt will now be made to recapitulate them, using Pöchhacker's diagram of interpreting domains and dimensions as a point of reference (2004: 24; see §1.1). As illustrated in Table 2.3,[32] some adjustments have been made to his model in order to suit the context under study: firstly, for the sake of simplicity, only four of the eight dimensions are taken into account, namely communicative genre, participants, discourse, and mode; secondly, a new dimension has been devised and labelled as 'constraints'; thirdly, the subdomains of interpreting practice identifiable along the vertical axis are inverted as compared to the original diagram, i.e. the features specified on the left-hand side – and thus foregrounded – add up to healthcare interpreting as it is traditionally conceived of, while those on the right-hand side relate primarily to conference interpreting.

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

[32] The labels "status differential", "equal status", "dialogue", and "monologue" used in the chart were devised by Raffaela Merlini in an unpublished revision of Pöchhacker's (2004: 24) diagram.

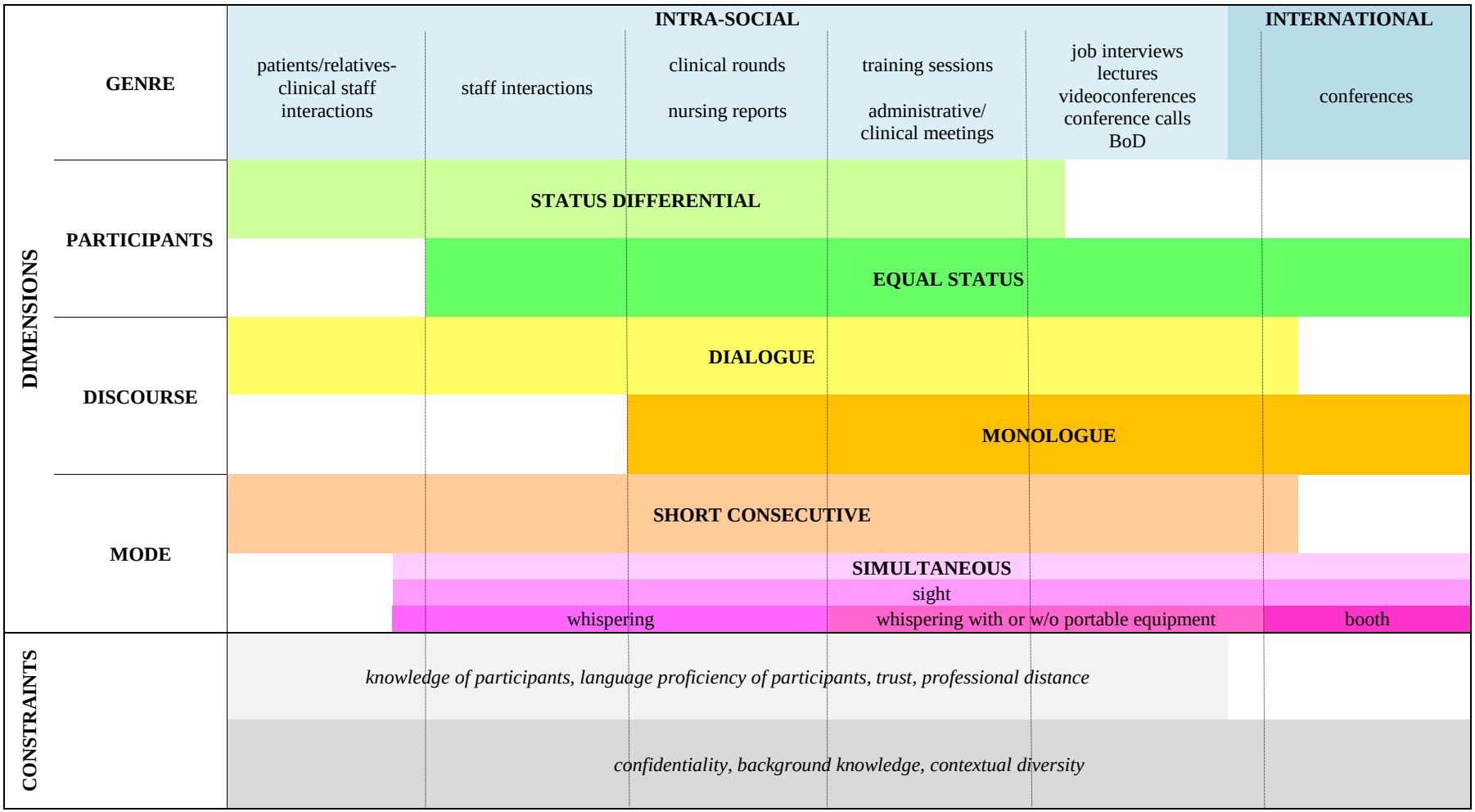

Table 2.3 Domains and dimensions of interpreting at ISMETT (adapted from Pöchhacker 2004: 24)

overall activities beside the broad range of encounters involving staff members: for instance, extemporaneous interactions to settle organizational or emergency issues; medical rounds; end-of-shift nursing reports; training courses, mainly held by US educators; clinical meetings, e.g. hospital committees or discussions of clinical cases; administrative meetings, including ISMETT and Ri.MED Boards of Directors; conference calls and videoconferences between Palermo and Pittsburgh; intra-social or inter-social job interviews, gatherings, and lectures held at ISMETT (where there are no booths); finally, international medical congresses taking place in fully equipped conference venues.

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

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

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

[33] In general, consecutive interpreting with note-taking is not employed by ISMETT interpreters.

frequently adopted. Different modes may also alternate during the same event: for instance, when an English-speaking department head meets with a number of Italian-speaking employees, the same interpreter adopts whispering for the US interlocutor and whispering through microphone and headset receivers for the Italian participants. Simultaneous interpretation in the booth is limited to medical congresses organized in other venues, given the aforementioned lack of booths on the hospital premises.

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

[34] While the lack of reference material and last-minute assignments were major issues for the LS in the first years of activity, ISMETT users have gradually become more sensitive to interpreting needs. Nevertheless, unexpected events can never be ruled out – especially in a hospital.

workers display varying levels of foreign 'language proficiency', which call for varying levels of intervention: situations requiring interpreting proper alternate with those in which the interpreter is simply asked to assist in case of misunderstanding. However, the opposite side of the coin is that this closeness may hamper the neutral stance of interpreters during mediated encounters: thus keeping a 'professional distance' is of the essence not only during interactions involving patients, but also to separate the role of colleague from that of interpreter.

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

2.5 Typical interpreting scenarios in medical interactions

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

It should be understood that nursing staff have always played a major role at ISMETT. Ever since the establishment of the hospital, one of the main goals has been to train highly specialized nurses who act autonomously, think critically, make decisions, and advocate for the patient (Stitt 2000: 34). This has primarily been accomplished through a corporate teaching and mentoring programme, which has entailed Italian nurses being sent to Pittsburgh and American nursing staff stationed in Palermo on rotations (Stitt 2000: 34; Dubois *et al.* 2006). As a result, nowadays nurses far outnumber any other professional group in the hospital, given that the complex clinical cases require a high patient/nurse ratio. Moreover, they have established a multi-layered hierarchy with various levels of responsibility and skills, in line with the model adopted

at UPMC. Therefore, it is not surprising that nurses have been among the most frequent users of the interpreting service.

2.5.1 Nursing assessments

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

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

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

2.5.2 Nursing reports

The change-of-shift report is the transfer of information on patient's conditions, nursing practices and relevant therapies that takes place between nurses to guarantee continuity of care across the shifts (Miller 1998; Lally 1999). Reports at ISMETT occur in three dedicated time frames during the day (7 a.m., 2 p.m., and 9 p.m.), when all nursing staff gather at the nurses' stations and the noise level in the unit reaches its peak; incoming

and outgoing colleagues sit or stand next to each other and discuss the status of their assigned patients in sequence. Should the report involve an American and an Italian nurse, an interpreter may be requested to ensure communication. The main features of this interpreting setting are summarised in Table 2.3, third column.

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

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

At first sight, nursing reports might seem cold and impersonal interactions, whose only function is sheer data transmission. However, a large number of research studies on this topic (cf. Lally 1999) have identified an array of other, less evident social functions, which can be summed up in the definition of shift report as a nursing "ritual", a practice passed on within the nursing group's cultural system and thus reflecting and transmitting nursing values, beliefs, and rules of conduct (Wolf 1988, 1989). It is a forum for socialization where nurses "learn the ropes" of their profession (Lally 1999): there is room for teaching, team-building and cohesion, since nurses warn about possible errors, acknowledge mistakes, and set the standards of nursing care (Wolf

1989). But it is even more than that: taking place away from the patient, nursing report is also a safe environment for "staff catharsis", where frustrations, worries, complaints as well as emotions such as grief, anxiety or amusement are shared and released (Lally 1999). Effective communication during nursing reports is therefore of crucial importance for two main reasons: first, to accurately transfer information, thus ensuring patients' safety; secondly, to strengthen and support the camaraderie among nurses.

2.5.3 Training sessions

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

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

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

Interpreting in this context partially differs from the traditional notion of 'educational interpreting' or 'classroom interpreting': for many years, these expressions have been used exclusively to indicate sign language interpreting for deaf students at all

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

lecturer's power is channelled to the interpreter and, consequently, to the interpreter's audience).

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

3. Methodology

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

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

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

Research period	Phase One: Aug-Sept 2003 (internship) Phase Two: Sept 2004-Aug 2008 (employment)
Research paradigm	DI (= dialogic discourse-based interaction)
Mode of inquiry	Induction
Nature of the data	Qualitative
Purpose of inquiry	Description
Overall methodological strategy	Observation
Research strategy	Fieldwork
Theoretical approach	Ethnography and discourse analysis
Data collection techniques	1. Participant observation 2. Semi-structured interviews 3. Audio-recordings 4. ISMETT and LS documentation

Table 3.1 Research methodology (cf. Pöchhacker 2004: 62-65; 78-79)

on the hospital and its LS Department (e.g. information material, company policies and procedures, and LS guidelines), along with the audio-recordings of authentic interpreter-mediated encounters in the medical field. These data collection techniques were jointly used during both Phase One and Phase Two.

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

3.1 Ethnography

3.1.1 The double role as co-worker and researcher

By and large, conducting an ethnography of a bilingual healthcare facility means entering the study site "without a hypothesis" and "being present to observe, record, and write down what [is] seen and heard" (Angelelli 2004a: 4). In this specific case, however, the researcher is not an external observer, but an insider who directly experiences the same problems or difficulties as the other employees and can even turn into one of the informants (e.g. occasionally acting as interpreter during recorded events; cf. Rosenberg 2001). It is still debated whether healthcare interpreting researchers are able to engage in inductive studies without their personal and theoretical background informing data collection and analysis (Pöchhacker 2006: 154); hence the possibility of maintaining an objective stance should be all the more contentious in the present study, calling for a discussion about the implications of this peculiar situation.

With reference to data collection, a valuable insight is provided by Labov (1972). While discussing the methodology for gathering linguistic data, he highlighted the paradoxical need to "observe how people speak when they are not being observed" (1972: 113): in other words, the mere presence of the researcher would distort the authenticity of the phenomenon under study. Yet this "observer's paradox" does not fully apply to the ISMETT case study, given that the status of staff member turned the researcher into a less invasive observer of the LS Department and, particularly, of interpreter-mediated interactions. To start with, the crucial "trust-building process" (Angelelli 2004a: 45) with the interpreters and the whole healthcare team developed naturally and smoothly: it easily began in Phase One favoured by the physical location, i.e. the old, temporary facility – a restricted environment with few employees – and it was further strengthened during Phase Two. Although this process occurred regardless of the research study, the establishment of friendly or even very close relationships undoubtedly fostered a cooperative attitude towards the researcher and the project. The fellow interpreters agreed to become an 'object of study', to the extent that, throughout the years, many of them have been encouraged in their turn to look at translation and interpreting duties from a research perspective (see §2.3); by the same token, they showed no hostility towards the observation and recording of interpreted encounters, understanding that these were not meant to assess interpreting accuracy or lack thereof (cf. Angelelli 2004a: 45). Also hospital employees readily lent their support; furthermore, they were never unsettled by the presence of a silent colleague watching them, given that they are used to the presence of two interpreters during the same event, not only when the service is provided in both language directions (e.g. during debates), but also when newly-hired staff shadow senior interpreters. In fact, preceptoring and mentoring are a common occurrence at ISMETT for many professionals – from physicians to nurses and physical therapists – who all undergo a period of 'orientation' in the ward before entering the shift system; therefore, even patients are accustomed to such pairings. As a result, the observed exchanges featured a high degree of spontaneity by all interaction participants.

Somewhat different considerations apply to the interviews with the LS members, given that the close bonds between interviewer and interviewees had twofold implications. On the one hand, while in some fields it is difficult to obtain cooperation

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

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

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

3.1.2 Interviews with the interpreters

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

minutes each; they were conducted in English upon request of the researcher, who nevertheless specified that answers could also be provided in Italian, should this have been more comfortable for the respondents.

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

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

interpreter and to describe their own. In the "closure" any additional remarks were explicitly requested, to avoid the "hand on the door phenomenon" suggested by Robson (1993: 235). The schedule followed during the interviewing process and the full transcribed interviews are included in Appendix Three.

3.2 Discourse-based analysis

3.2.1 The corpus of interpreter-mediated encounters

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

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

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

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

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

[50] More precisely, some of the recorded and transcribed interactions of the corpus were discussed in: Scardulla (2005-2006), using conversation analysis tools; Iacono (2005-2006), placing emphasis on politeness strategies; Orefice (2005-2006), from the point of view of footing; Romeres and Favaron (2006) and Di Fresco (2007a, 2007b), focusing on nursing reports; Favaron (2009), on repair activities; Merlini and Favaron (2009), on norm behaviour.

Transcript	Place	Date	Time	Duration	Interpreter	Prevailing interpreting mode	Recorded by	Transcribed by	Previous research
NA.FL	Floor*	18/09/2003	9 a.m.	00:13:20	Barbara	Short consecutive	R	R, CS	CS, LS
NR.FL.01	Floor	22/01/2006	2 p.m.	00:18:34	Dario	Short consecutive/whispering	R, EI	R, EI	EI, LS, R + RM
NR.FL.02	Floor	22/01/2006	2:30 p.m.	00:04:05	Dario	Short consecutive	R, EI	R	-
NR.FL.03	Floor	24/01/2006	7 a.m.	00:03:21	Georgia	Short consecutive	R, SO	R, SO	SO, LS
NR.FL.04	Floor	24/01/2006	7 a.m.	00:06:38	Georgia	Short consecutive	R, SO	R, SO	SO, LS
NR.FL.05	Floor	24/01/2006	7 a.m.	00:05:00	Georgia	Short consecutive	R, SO	R, SO	SO, LS
NR.FL.06	Floor	25/01/2006	2 p.m.	00:07:26	Italo	Whispering	R, EI	R	-
NR.FL.07	Floor	30/01/2006	2 p.m.	00:08:32	Julia	Short consecutive	R, EI	R, EI	EI, LS
NR.FL.08	Floor	07/03/2006	2 p.m.	00:09:55	Henry	Short consecutive	R, SO	R, SO	SO, LS, R + RM
NR.FL.09	Floor	11/03/2006	7 a.m.	00:04:57	Italo	Short consecutive	R, EI	R, EI	EI, LS
NR.SDU.01	SDU	21/01/2006	2 p.m.	00:08:26	Eric	Short consecutive	R, EI	R, EI	EI, LS
NR.SDU.02	SDU	23/01/2006	7 a.m.	00:08:43	Georgia	Short consecutive	R, SO	R, SO	SO, LS, R + RM
NR.ICU.01	ICU	23/01/2006	2 p.m.	00:09:36	Francesca	Short consecutive	R, EI	R, EI	EI, LS
NR.ICU.02	ICU	16/03/2006	9 p.m.	00:07:55	Henry	Short consecutive	R, SO	R, SO	SO, LS
TS.01	Conference room*	27/08/2003	10 a.m.	01:03:55	Christian	Short consecutive	R	R	R
TS.02	Conference room	28/11/2007	1 p.m.	00:18:52	Italo	Whispering (microphone)	R	R	-

*Sessions taking place in the old facility

Legend

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

Table 3.2 Summary information about the corpus

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

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

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

With reference to the training courses, a fortunate combination of mutual needs enabled the researcher to carry out the recordings, which were also stored by the nursing educators as future reference material. Hence, although all trainees were informed about the recording at the beginning of the session, no written authorization was necessary and arrangements were rather made with the instructors on a case-by-case basis. Nevertheless, a comprehensive research project was drafted by the Department in order to regulate and provide a framework for future research activities of the LS.

A few words should be spent on the recording process. While a cassette tape recorder was initially used, as of mid-2006 audio quality was significantly improved by recourse to one or even two digital recorders – one next to the primary participants and one for the interpreter when the working mode was whispering through microphone. However, also analogue recordings were later converted into audio files, thus enabling digital archiving of the whole corpus.

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

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

3.2.2 Categories of study

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

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

Although Bolden specifically addressed the notion of role, her view of "interpreter's moment by moment decisions" was borrowed and transposed to the scrutiny of the ISMETT corpus, by applying the model summarized in Table 3.3.

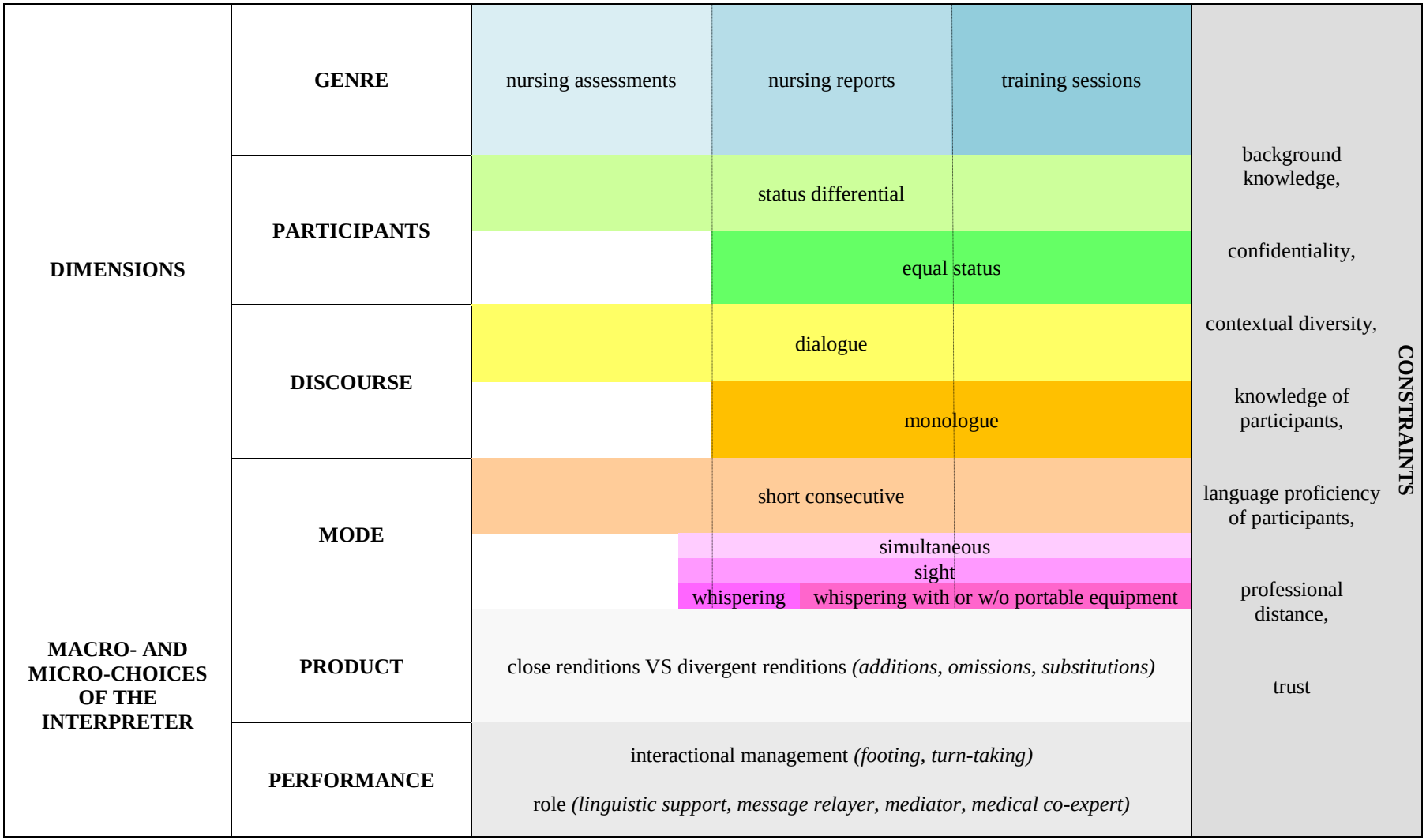

Table 3.3 Categories of study

Taking as a point of departure the illustration of interpreting domains and dimensions at ISMETT presented above (see §2.4 and Table 2.3), the new diagram focuses exclusively on the (intra-social) interpreter-mediated encounters featured in the recordings. Each interaction is viewed as essentially shaped by the combination of the dimensions specified in the first three rows, namely communicative 'genre' (nursing assessment, nursing report, or training session), 'participants' (of either equal or unequal status),[51] and 'discourse' (dialogic versus monologic). Whereas these three components are externally given factors, the working 'mode', though influenced by contextual requirements, is also intentionally selected; moreover, it may be subject to shifts during the encounter. Hence the use of short consecutive versus simultaneous interpreting, the latter including sight, whispering, or whispering with portable equipment, occupies an intermediate position in the diagram, on the border between the three dimensions and the interpreter's autonomous decisions. These are depicted in the last two rows under the headings of 'product' (see §1.2.1) and 'performance' (see §1.2.2 and 1.2.3): as the interaction unfolds, the interpreter generates a linguistic output and a specific performance that are a result not only of situation-based macro-choices, but also of adaptations in terms of ongoing micro-choices among the multiple options available. Based on the theoretical framework provided by the DI paradigm and illustrated in Chapter One, in the model product is viewed as a manifestation of the interpreter's use of close versus divergent renditions. More specifically, the departures from the speakers' original utterances are classified as additions, omissions and substitutions, following Merlini and Favaron (2007), as summarized in Table 3.4. On the other hand, performance is regarded as a function of the interpreter's interactional management, especially in terms of footing and turn-taking. With regard to footing, the analysis will place emphasis on shifts in the use of direct or indirect speech by the interpreter. Reference will mostly be made to the categories devised by Merlini and Favaron (2007) whenever the primary speakers' addressees are explicitly stated, though bearing in mind that their taxonomy does not cover all possible occurrences but only those found in the corpus they examined; also the change of perspective of person suggested by Bot (2007) will be considered. As for the distribution of talking turns among the participants, marked patterns in the succession of "smooth transitions", "pauses", and "overlaps"

[51] For the sake of simplicity, the number of participants has not been taken into account in the diagram.

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

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

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

4. The interpreters' perspective

4.1 *Habitus* and norms

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

According to Bourdieu (1977: 72), the *habitus* consists of "systems of durable, transposable dispositions" moulded by the experiences of the social actors ("structured structures") and, at the same time, able to produce practices and representations of the world ("structuring structures"). Thus, as the term 'disposition' suggests, the *habitus* is, on the one hand, "the result of an organizing action", while, on the other, it identifies "a way of being, a habitual state […], a predisposition, tendency, propensity, or inclination" (1977: 214). Such dispositions are not stringent rules governing deeds or choices, but rather loose guidelines that orient actors while remaining flexible and allowing for improvisation, in order to suit new or different contexts. Moreover, although these propensities are deeply rooted, individuals are mostly unaware of them, as the *habitus* is a form of "embodied history, internalized as a second nature and so forgotten as history", and thus "a spontaneity without consciousness or will" (Bourdieu 1990: 56; see also Calhoun *et al*. 2007: 259-266).

A pivotal role in the process of inculcation of the *habitus* is played by 'norms'. Defined as "the social reality of correctness notions" (Bartsch 1987: xii), norms can be viewed as shared, conventional assumptions about what is appropriate and expected in a given community (Schäffner 1999: 1). This notion was again borrowed from sociological theory and introduced in the field of translation studies by Gideon Toury (e.g. 1980) to identify "regularities in translational behaviour, resulting from internalised socio-cultural constraints" (Merlini and Favaron 2009: 190; see also Schäffner 1999; Baker 2009). Although to a more limited extent, norms have also been adopted in interpreting research (e.g. Shlesinger 1989; Harris 1990; Schjoldager [1995]/2002; Gile 1999; Garzone 2002; Marzocchi 2005).

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

4.2 Profiles of the interviewees

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

Christian has been Coordinator of the LS since mid-2005. Although much of his time is currently devoted to translation revision and administrative duties, the interview did not focus on his institutional role, but rather on his extensive experience in the hospital. Despite a degree in Architecture, Christian was the first interpreter to be hired

in 1999 thanks to his native-like proficiency in both Italian and English, as he grew up in Palermo, but his mother comes from England. Therefore, he was trained solely on the job, learning the ropes from the former Department Head (Aldo in Table 2.2), to whom he largely owes his professional development.

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

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

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

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

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

to the new job and environment in comparison with the other colleagues, despite his more recent hiring date.

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

4.3 Key issues from the interviews

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

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

4.3.1 Learning

Although none of the interviewees had formerly worked in a healthcare facility, dealing with medical interpreting was not traumatic at all for Dario and Henry, by virtue of their university education in interpreting and their experience in the private sector. Dario had no major difficulties from a technical or linguistic point of view; along the same lines,

Henry thinks that "the challenge actually was over after the first year or so" (I-6, 49),[55] given that working at ISMETT is not as stressful as freelancing, but chiefly entails the acquisition of a specific jargon, as in any other field.

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

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

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

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

[55] For easier reference, the abbreviations I-1, I-2, I-3, I-4, I-5, I-6, and I-7 identify the transcribed interview from which a given excerpt has been taken; line numbers in the transcript are also specified in brackets (see Appendix Three for the full transcripts).

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

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

4.3.2 Job organization

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

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

> **I-6 (96-107)**
> They had the terribly bad habit of wanting an interpreter at the lectures, so they would just call upstairs: "We need an interpreter". So take the headphones, take the microphones, go downstairs, without having any material, and just having to translate straightaway with the room full of physicians who anyway do understand some English. It is more like the pressure, the scrutiny of those listening to you. I mean, if you work in the field, you understand how difficult it is: they call you in, you do not have any prior knowledge, you have not had any chance to study, to do any research, or whatever, but then whoever is listening to you expects that you come up with a perfectly suitable and appropriate translation, which is not always the case. […] There was a lot of pressure on those occasions.

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

[56] The final Service Level Agreement of the Language Services was approved and published in the company Intranet in October 2009.

Incidentally, it should be noted that Dario and Henry are the only interviewees who commented on shift work. According to Dario, the hectic night shifts of the first years, with a considerable number of Americans in the units, made the job exhausting in the long run, although the situation was partially enhanced by the employment of new staff members. Henry pointed out that the pressure did not ease off when nights were devoted to written translations, adding that shifts in general inevitably affected his regular life.

4.3.3 Teamwork

The idea of 'team' was a recurrent topic in the interviews, suggested by the interpreters from different perspectives.

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

'Team' also stands for the healthcare team, a group that actually includes the LS. In Italo's words: "Even though we do not have a medical background, we are not nurses, we are not physicians, we are very well integrated in the clinical setting, and we are seen as a part of the clinical staff in that sense" (I-7, 159-162). Both Italo and Georgia think that this 'sense of belonging' goes hand in hand with the notion of 'trust'. Over the years, Georgia has understood that gaining the trust of the colleagues was the most helpful key to successful interpreting, probably because when you work in a hospital "there is also a human level involved [...] in every exchange" (I-5, 115; 117-118). In her opinion, the customers need to look at the interpreters and feel comfortable and reassured by their reliability, which should entail not only properly conveying messages, but also being loyal and ensuring confidentiality. Georgia explained that the establishment of this mutual trust was not a seamless process: for example,

terminological inaccuracy in interpreting was initially read by the healthcare staff as a lack of professionalism. But a major change has occurred with time: "the scepticism becomes trust [...] you do not know when exactly it happens, but it happens" (I-5, 126-127), and trust yields collaboration, so that, at present, physicians are the first to prompt a word that does not come to the interpreter. Interestingly, even interacting with the newly-hired staff is a constantly appealing endeavour for Georgia, "a shorter way to build up the trust and the bond" (I-5, 240) developed at the beginning, yet taking advantage now of the consolidated position of the LS Department within the hospital.

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

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

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

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

4.3.4 Versatility

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

> **I-2 (87-93)**
> […] the variety probably allowed us to become more familiar with all the aspects of the medical care that was being provided at ISMETT. So, if you were aware of some aspects, you could use those aspects even in different situations. For instance, if you knew the psychological background of a patient from a previous event, and then you had to deal between a surgeon and the same patient, maybe you could use the psychological background that you had acquired on that patient.

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

> **I-4 (60-65; emphasis added)**
> Maybe contact with the patients, of course, so when you have to face sickness or suffering of other people; *unexpected events*, when you feel unprepared, so you need to study as quickly

> as possible the subjects you are going to translate; meetings, when people speak all at the same time, so you need to manage the situation, you need to take control of the situation […]; and then maybe *variety*, as you never know what you are going to do before doing it.

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

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

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

4.3.5 Interpreting style

Confronted with the concept of interpreting style for the first time, the interviewees had some initial doubts as to its definition and provided their answers after a momentary

hesitation. First of all, Italo seemed to match the notion of interpreting style with the expression 'having style', which carries a positive connotation: he believes that an interpreter with a nice style is very clear and easy to follow, as well as comfortable with the setting and the situation, notwithstanding difficulties. Also Christian defined style as a distinctive feature of a good interpreter, i.e. of an interpreter who makes the "correct choice" (I-1, 200); in particular, he placed emphasis on the "choice of the words", the ability of "adjusting" (I-1, 188-189) the register to the speakers and the situation (e.g. a doctor-patient interview versus a meeting between physicians), and on "the choice of positioning" between the two parties (I-1, 199).

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

familiar scenarios such as gatherings among nurses, in which they know everybody on a personal basis, interpreters have more leeway: thus making humorous comments into the microphone, joking with the co-workers, or being asked to express an opinion become likely and accepted occurrences, given that the participants themselves "involve the interpreter as an active part of the interaction" (I-5, 376-377). More importantly, whenever the service is provided in this fashion, the users unambiguously show their appreciation.

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

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

Defining their own interpreting styles was even more challenging for the respondents, with Eric and Christian providing the most indefinite descriptions. The style of Eric is not the product of an academic pathway, but was rather developed by experience, and, as a result, he regards it as "probably naïve" and "out of the ordinary", "certainly full of imperfections" (I-3, 150-151). When encouraged to further elaborate

on this, Eric added: "I make do with my own resources. For example, I tend to summarize, and I have strategies to try to bridge difficulties when I encounter them." (I-3, 146-148). As for Christian, his style consists of two components, the first of a procedural nature – "getting help from most of the resources available, be they physicians or slides" (I-1, 207-208) – and the second referring to the interpreting product – "choosing words" and "trying to leave very few gaps" in his renditions (I-1, 207). The relation to the target text lies also at the heart of Henry's style, described as "rather aggressive" (I-6, 196) by using a vivid image: "I am like a bulldog. […] I bite the text and I stick to it. [...] It is like throwing a bone to a bulldog, and it starts chewing and playing with it, and it does not give up." (I-6, 192; 194; 209-210).

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

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

For the same reason, Italo specified that whispered interpreting was his preferred working mode, especially during meetings: as he can only be heard by the person he is interpreting for, he feels more at ease and thinks it is "more transparent, less invasive" (I-7, 112-113). On the other hand, Francesca and Georgia are inclined to expose, rather than conceal, their personalities while interpreting. Although initially doubtful about her style, upon reflection Francesca concluded that she tried "to be sympathetic" (I-4, 116), whereas Georgia's interpreting style hinges upon the attempt to "have fun if possible" (I-5, 401): she explained that this could be read as a cathartic release, a method to defuse tension and stress, which counterbalanced the heavier and stricter aspects of the interpreting job ("Today we are serious, today we can joke around a little bit", I-5, 414-415).

4.3.6 Empathy

The years spent at ISMETT have gradually enhanced the ability of the LS members to control their emotions, although to varying degrees. Initially, the contact with the sick – especially children – and their relatives was hard to handle for Christian, while Italo was "scared" (I-7, 29) by medical interpreting scenarios, as they required not only language skills and specialized knowledge, but also an adequate training "from an emotional point of view" (I-7, 81). Francesca explained that in most cases, despite her initial concerns, she was unexpectedly able to detach herself from the poignant stories of the patients, with the exception of a few heartbreaking cases. At the opposite end of the spectrum, the first contact with the sick had no major implications for Dario and Henry; incidentally, Henry stressed that the years of work in the units have generated his utmost respect for those patients who face illness with dignity and appreciate the efforts of the staff taking care of them. Also for Eric the possibility of interacting with the patients and providing his own support was not traumatic at all, but pleasing and gratifying.

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

4.3.7 Cultural mediation

Although conflicts between the US and Italian staff have always existed, their nature has changed over the years. At the beginning, job-related tasks and methods were a major source of friction: Italians – or, better yet, Sicilians, whose culture "is not similar to any other in the world" (I-4, 83), according to Francesca – were not keen to accept the 'imposition' of the American healthcare model, especially on more experienced

nurses. In Henry's opinion, there is an unconscious competition between the US and Italian staff: while the former can rely on their better technology and organization, Italians usually have a more complete and comprehensive training and are better at improvising. Henry believes that, at times, the two approaches are equally needed, so that "the real problem is managing the advantages and disadvantages of both, trying to strike the right balance" (I-6, 161-162).

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

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

The LS Department has established good relationships with both cultural groups, although on different grounds. Georgia thinks that the strong bonds with the Italian co-workers have been formed over time, as these are the regular users of the interpreting service; conversely, the US staff members rotate, so that the contacts with them

inevitably last for short periods of time, yet they are more intense. More specifically, Henry could identify diverse approaches of the US and Italian personnel to the LS. During their stay, the Americans are heavily dependent not only on translation and interpreting services, but also on the logistical support occasionally provided by the Department. Henry pointed out that there have been occasions in which this assistance even went beyond the interpreters' duties, for instance when

> **I-6 (138-143)**
> [...] they had towed away the Chief Nursing Officer's car: she called us and we managed to find where the car was and to tell her "Go there", not to worry, and whatever, and that if she needed anything, she could always call us. So, it is something that goes beyond [...]. And we have always been very open, and willing to provide this sort of support.

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

4.3.8 Conclusions

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

First of all, the respondents highlighted the marked difference between interpreted interactions among co-workers and those including also outsiders. Next to the variation in the level of formality, it can be said that the familiarity with the participants informs the development and nature of the encounters. Once the organizational difficulties had been overcome, the joint accomplishment of routine activities gradually led to the

establishment of close bonds between the LS and their ISMETT users, to the extent that interpreters are now perceived as part of the clinical staff. This friendliness translates, first of all, into mutual collaboration: the interpreters ensure proactiveness and reliability, which at times transcend the mere interpreting duties, especially with the US staff, while the healthcare team serves as 'linguistic resource', for instance by explaining obscure concepts and terms. More significantly, in intra-social settings the users do not regard the interpreters as 'transparent' or 'invisible' conduits, but rather as active participants in the interactions (cf. §1.2.2), who can be involved in jokes, or, under specific circumstances, even asked for an opinion. Notably, the ability to build relationships of mutual trust with the other departments and services was also a prerequisite for the successful cultural mediation in the clashes between US and Italian professional approaches.

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

Variety and LS members' sense of belonging can be seen as two sides of the same coin: interpreters have a privileged position in the organization, which gives them a leeway that would hardly be granted to freelancers, yet this status constantly exposes them to testing situations. The following chapter will take into account the recordings of authentic interpreter-mediated medical interactions in order to describe the effects of this twofold condition on the product and performance of ISMETT interpreters.

5. Transcript analysis

5.1 Tailor-made services: The chameleon interpreter

5.1.1 Adjusting to the communicative context

The exploration of the transcribed recordings of interpreter-mediated encounters will begin with a comparison of prototypical excerpts belonging to the three communicative genres featured in the corpus, namely nursing assessments, nursing reports, and training sessions.[30]

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

Excerpt 1 (NA.FL, 1; 4)[32]

1 I *((to the patient))* buongiorno
good morning

[…]

4 I io sono l'interprete
I am the interpreter

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

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[30] Table 3.2 provides concise data about the corpus, whereas the three medical interpreting scenarios are described in detail in §2.5.

[31] For further information about the interactions under study and their participants, see Appendix Six, in which the full transcripts are accompanied by summary tables.

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

Excerpt 2 (NA.FL, 53-84)

53 N I would like to listen if I may
54 I può:: auscultarla↑
may she listen to you

55 P *sì*
yes

56 N okay >if you would ask him< to take a deep breath
57 I faccia un respiro profondo
take a deep breath

58 *((pause)) ((the nurse listens to the patient's chest)) ((background voices))*
59 N oka::y (.) **I would like to listen back here if I may** (.) ***((making the***
60 ***patient bend slightly forward))*** another deep breath
61 I profondo↑
deep

62 *((pause)) ((the nurse listens to the patient's back)) ((background voices))*
63 N °okay° is **he** a cigarette smoker↑
64 I lei fuma↑
do you smoke

65 P **poco**
a bit

66 I >a bit<=
67 N =**un poco**↑ (.) how many cigarettes [a day]
a bit
68 I [quante] sigarette al giorno
how many cigarettes a day

69 P umm:: dieci
ten

70 I ten↑
71 N >ten okay< (.) may I listen to **his** belly↑
72 I **può** ascoltarle la pa::ncia↑
may she listen to your belly

73 P *((amused))* sì sì *((soft chuckle))*
yes yes

74 *((pause)) ((the nurse listens to the patient's abdomen))*
75 P **non sono incinto** (.) sicuro
I'm not pregnant for sure

76 N [°perfetto°]
perfect
77 I [*((smiling))* **he**'s not] pregnant (.) [that's for sure
78 P [*((wholehearted laugh))*
79 N *((smiling))* **does he have regular bowel movements**↑
80 I va di corpo regolarmente↑=
do you move your bowels regularly

81 P =sì sì
yes yes

82 N and does **he** have any difficulty (.) urinating
83 I ha difficoltà a urinare↑
do you have difficulties urinating

84 P no no
no no

For the most[33] part of the encounter, a dialogic discourse occurs between two primary speakers of a different status who meet for the first time; given the nature of the interaction, the topic development is mainly controlled by the nurse, with a prevalence of the question-answer pattern. Although the patient occasionally brings up new subjects, for instance when he jokes about his large belly (line 75: "non sono incinto/I'm not pregnant"), the nurse gently keeps him on track (79). As for the interpreter, despite her lack of background knowledge about the clinical conditions of the patient, she is familiar with the nurse and knows how a nursing assessment is usually carried out. Moreover, Barbara is aware that the American nurse can understand some Italian, as this is also evident from the transcript: at the beginning of line 67, while talking about the patient's smoking habits, the nurse uses the Italian phrase "un poco", thus echoing the answer provided by the patient (65: "poco"), rather than Barbara's translation into English (66: "a bit"; see also §5.1.2 and 5.1.4).

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

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

[33] During the assessment, an Italian nurse briefly enters the room to discuss patient-related information with the US colleague.

and the patient, who remains alone with the interpreter, asks her for information about his 'missing pillow', as the following exchange shows:

Excerpt 3 (NA.FL, 140-143)

140 P *((to the interpreter))* il cuscino ancora non lo porta↑
the pillow she doesn't bring it yet

141 I ah il cuscino↑ >aspetta il cuscino↑< °giustamente° (.) **ora glielo dico**
the pillow you are waiting for the pillow rightly **now I'll tell her about it**

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

(147)

147 I [...] ^**he's still waiting for his pillow**^

The patient is still waiting for the nurse to bring him a pillow and shares his concern with the interpreter (line 140): while acknowledging his requirement by adopting the footing of responder (141), Barbara also underscores that the nurse should be the actual recipient of the information ("ora glielo dico/now I'll tell her about it"). Indeed, she immediately conveys the message to the US nurse as soon as she returns (147), thus showing consideration both for the patient's need and for the nurse's momentary exclusion from the exchange.

The patterns of interaction are different when it comes to peer-to-peer communication during a nursing report. Given the nature of the encounter – a transmission of data concerning patient conditions and related therapies – the discourse is mainly monologic: the outgoing nurse provides the information, thus establishing the topic progression, while the incoming colleague stores it by jotting down the relevant notes (see §2.5.2). Only occasionally does the latter intervene asking for further clarification or adding comments. A representative example is provided by a session taking place at ISMETT's intensive care unit between an outgoing US nurse and her incoming Italian colleague (INF), with the mediation of interpreter Henry (Excerpt 4). No introductions are needed; therefore, as soon as the interpreter reaches the nurses' station, the report starts with the patient data (name, age, allergies, blood type, lines 4-12) and the identification of the main disease (a malignant cancer, 13-15). The interaction is briefly interrupted when Henry receives a phone call from another US nurse who requires the interpreting service (14-17):

Excerpt 4 (NR.ICU.02, 1-17)

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

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

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

26	N	metastas(e)s in=
27	I	=c'è una metastasi there is a metastasis
28	N	the:: uh left kidney↑
29	I	al:: rene sinistro to the left kidney
30	N	and liver
31	I	**sorry**↑
32	N	and also to the liver
33	I	e anche al ┌ fegato and also to the liver
34	N	└ °it's spreading°
35	I	si sta diffondendo it's spreading
36	INF	**okay**
37	N	so they resected the left kidney

38	I	le hanno fatto una resezione del: e::hm rene sinistro they did her a resection of the left kidney	
39	N	>okay< and she was brought here	[two days ago
40	I		[ed è stata portata qui] due giorni fa and she was brought here two days ago

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

However, the interpreting choices identified in this standard nursing report cannot be applied to all exchanges of the same genre, given that, under specific circumstances, monologue is replaced by dialogic sequences. This is best exemplified by one of the reports mediated by Dario in the regular admission unit, which at ISMETT is known as the 'Floor'. In the initial part of the interaction (Excerpt 6 below) a misunderstanding occurs about the names of the patients to be discussed between the outgoing US nurse, who wants to start with Mr "Patenno" (line 1), and her incoming Italian colleague, who would rather receive information about Mr "Porrato" (23). The reason behind the confusion is that the two co-workers have different patient assignments, but reaching this conclusion is no easy task. At first, the US nurse, looking puzzled, wants the interpreter to repeat the name of the patient just mentioned by the colleague (24: "who she wanna start with"); Dario replies, thus acting as responder, and adds "it should be one of yours" (25). Prompted by this remark, the nurse checks her notes, yet she repeatedly asks why Mr Patenno cannot be the first to be discussed (27-28). It is only when the co-worker clarifies that the man is not one of her patients (line 30 and translated in line 31) that the US nurse concedes that they have different assignments. However, her reiterations of the same concept (32-33, 35, and 38) are initially left

untranslated, as Dario gives prominence to the new piece of information simultaneously provided by the other interlocutor (34 and 36-37: the nurse who will take care of the patient Patenno might be "Irene"). Subsequently, the interpreter condenses the comments of the American nurse by using the reporting mode (39: "quelli non ce li ha lei/she doesn't have those") and compensates the previous omissions by syntactically expanding her words and nonverbal behaviour of lines 40-41 ("that one nah nah" is translated as "questo non ce l'ha/this she doesn't have him", line 42). The identification of the other different assignment (the Italian nurse needs to receive report from her colleague "Ivo" on the patient "Porta", lines 44 and 46) leads to the closing acknowledgments of both participants (lines 50 and 53 for the US nurse, line 52 for the Italian nurse):

Excerpt 6 (NR.FL.01, 1)

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

(23-53)

23 INF {Porrato}
24 N *((puzzled))* who °**she** wanna start (with)↑°=
25 I =°mister° *{Porrato}* (.) **>it should be one of yours<**
26 *((pause)) ((the US nurse checks her notes))*
27 N you wan – you don't want to start with (.) {Patenno} eh↑ (.)
28 **[do you want to start with {Patenno}↑**
29 I [vuoi cominciare con *{Patenna}*] o *{Patenno}*
do you want to start with Patenna or Patenno

30 INF ma non è mio {Patenno} *((chuckle))*
but Patenno is not mine

31 I that's not [°**her** patient°
32 N [**oh that's**] **not yours↑ oh okay all right (.) okay**
33 **[>then you have the other four<**
34 INF [**deve** darglielo::] forse a {Irene}=
she has to give him to maybe to Irene

35 N =**you don't have [all my people then**
36 I [maybe {Irene:}] is the nurse °who needs to get
37 the other report°
38 N **you don't have all my people then** (.) I don't have them=
39 I =no allora forse sono diversi perché **quelli non ce li ha lei**
no so maybe they are different because **she doesn't have those**

40 N °that one° *((pointing at one patient's medical record and shaking her*
41 *head))* [nah nah
42 I [questo **non**] **ce l'ha↑**
this **she doesn't** **have him**

43 N °nah°=

44 INF =e infatti ┌ *{Porta}*=
and indeed │ Porta
45 N └ nah
46 INF =me lo deve dare {Ivo}
Ivo has to give him to me
47 I yeah {Porta} ┌ is::::┐
48 INF └ e gli┘ altri lei
and the others she (has to)
49 I °**she** needs to get report ┌ on him°=
50 N └ **good okay**
51 I =°from ┌ *{Ivo}*°
52 INF └ **okay**
53 N **okay**

The most conspicuous feature of this rapid exchange is the lack of an orderly distribution of talking turns. The frequent overlaps, which are also attributable to the equal status of the two primary speakers, lead to considerable confusion and hinder a smooth development of the interaction. Moreover, although the US nurse mainly addresses the Italian colleague (except for the question in line 24), the other tends to talk to the interpreter rather than through him; Dario himself uses the indirect speech in this part of the interaction. Along the same lines, by omitting repetitive comments or providing explanatory additions, he attempts to pinpoint the underlying issue in order to solve the deadlock, thus foregrounding his mediating function.

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

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

71 N okay↑ regular diet (.) according to that *((pointing at the Kardex))*[34] he is
72 allergic
73 ┌ to an antibiotic but they don't know – they don't know what kind
74 I └ **seco::ndo questo è allergico a un antibiotico però non *sa*** ┘
according to this he is allergic to an antibiotic but she doesn't know
75 *quale* °antibiotico°
which antibiotic

[34] Kardex is a trade name for a flip-over card that contains a condensed version of the patient's medical record. In addition to patient data and indication of the current diagnosis, it provides the healthcare staff with the most important information concerning the daily care (e.g. diagnostic tests and treatments, diet, level of ambulation, bathing schedule, etc.). The Kardex is usually written in pencil, so that it can easily be updated, should the needs or conditions of the patient change (cf. Carter 2007: 79).

76	INF	okay
77	N	okay↑ uh (.) *he is* (.) neurologically intact
78	I	*((whispering))* °neurologico intatto° neurological intact
79	N	he gets up in the chair without assist
80	I	sta:: si mette da solo sulla se::dia (.) °senza bisogno di aiu::to° he stays he sits down in the chair on his own without needing any help
81	N	independent
82	I	°è indipendente° he's independent

Dario's choices in terms of footing are also worthy of note. Soon after the initial misunderstanding, he continues using the third person (as in Excerpt 7, line 74: "non sa/she doesn't know"), then he gradually changes to the footing of reporter, in conjunction with his shift from the role of mediator to that of message relayer. Instances of first-person interpreting can be found in Excerpt 8, lines 211-213 ("I gave him the IV potassium" is translated as "gliel'ho dato endovena/I gave it to him intravenously") and Excerpt 9 ("ho preso i parametri/I took the vitals", line 537):

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

208	N	his potassium was *low* (.) this morning
209	I	stamattina il potassio era: (.) ba:sso this morning the potassium was low
210	INF	°mhm°
211	N	and (.) this afternoon **I gave** him the – (.) I V (.) [potassium
212	I	[poco fa a short while ago
213		gliel'**ho dato** endovena **I gave** it to him intravenously

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

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

Although as a general rule nursing reports are two-party or, when interpreter-mediated, three-party encounters, the situational constellation of interaction may occasionally include additional participants. This is what happens, for instance, in one of the exchanges mediated by Italo (NR.FL.06) between one English-speaking and two Italian-speaking participants. The US nurse involved, a woman in her forties recently

arrived at ISMETT, is engaged in the initial period of shadowing and orientation, in order to familiarize herself with the model of care delivered at the hospital; her temporary supervisor, called 'preceptor', is an Italian nurse with a basic competence in English (INF_2). At the beginning of their afternoon shift, in which they will jointly take care of the same patients, the two colleagues need to receive report from another Italian nurse (INF_1), who requests the assistance of the interpreter. As a result, during the interaction two parallel conversations develop, as Excerpt 10 illustrates: the column on the left shows the progression of the ordinary nursing report between the two Italian nurses, whereas the column on the right shows the interpreter whispering the contents into English to the US co-worker. In order to set the atmosphere, it should be stressed that the exchange takes place on a particularly hectic day for the unit with all participants standing at a crowded nurses' station, unfortunately to the detriment of the audio quality in some passages (see lines 27-28, left column). The outgoing nurse explains that the assigned patient, who was submitted to a liver transplant, is extremely agitated and keeps shouting or ringing the call bell:

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

1	INF_1	[°allora° so		
2	INF_2	{Perotti}↑] {Perotti}↑		
3			I	{Perotti}
4	INF_1	allora il signor {Perotti} so mister Perotti		
5		praticamente il {ventitré} basically on the twenty-third		
6		{dodici} ha fatto un twelve he had a	I	mister {Perotti} on the
7		trapianto di::: (.) transplant of		{twenty-third} he had a:
8		*((looking at her notes))*		
9		fegato da vivent – living donor liver		
10			I	liver
11	INF_1	^da::^ (.) cadavere cadaveric		
12			I	°cadaveric liver° (.) cadaveric
13				*donor* liver transplant↑
14	INF_1	allora lui praticamente so he basically		

15		psicologicamente psychologically		
16		è *mo::lto* nervoso he's very nervous	I	psychosocial
17				he's *very* nervous
18	INF2	ah **pure idda**[35] **m'ha** °( )° also this to me		
19	INF1	e:::: and		
20		suona sempre he always rings		
21	INF2	*((ironically))* a:::h	I	and he's
22	INF1	gli **ho spiegato** **I explained** to him		very demanding and he
23		le prossime volte di next times to		always rings the::
24		suonare ring		bell
25		il campanello e di non gridare the bell and not to shout		
26		perché mi chiamava (un sacco because he called me (lots	I	**she** was trying to explain tell
27		di volte**) ( )** of times)		him to not scream to not
28		**( )**		shout
29				for help

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

[35] Sicilian dialect for the Italian *questa*, meaning 'this'.

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

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

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

60	N	he was oriented [yesterday	
61	INF1	[ehm	
62	I	comunque **dice** era orientato ieri si orientava anyway **she says** he was oriented yesterday he oriented	
63	INF1	*((to the US nurse))* no	
64	N	not today	
65	I	[non oggi not today	
66	INF1	[questa notte completamente [guarda last night at all you see	
67	I	[(not) last night [at all	
68	INF1	[alla collega the colleague	
69		l’ha fatta impazzire i pazienti si sono tutti [lamentati= went crazy the patients all complained	
70	I	[nurse –	
71	INF1	=perché non ha [riposato nessuno because nobody rested	
72	I	[nurses and patients were complaining about him	
73	N	**really**↑	
74	INF1	[**yes**	
75	I	[that they were not able [to rest	
76	INF2	[*((willing to continue))* ***pa::in***	
77	INF1	dolore no pain no	
78		con me non l’ha avuto	I pain no pain
79		with me he didn’t have it	**with her**

A number of shifts in the interpreting product and performance can be identified. First of all, although the interjection in line 61 signals that INF_1 is about to continue with her report, Italo steps into the flow of talk as soon as the US nurse intervenes, thus momentarily moving to the short consecutive mode (line 62: "comunque dice era orientato ieri/anyway she says he was oriented yesterday"). Interestingly, as underlined by Bot (2007: 86), the use of the reporting verb ("dice/she says") acts as a turn-entry device to indicate the interpreter's need for turn transfer and his simultaneous intention to avoid information loss caused by overlapping talk. Moreover, in this section of the exchange no additions or omissions can be identified, as Italo's renditions are essentially close to the originals. The sum of all these adjustments paves the way for a brief direct exchange between the outgoing Italian nurse and her American colleague: when the latter exclaims "really" (line 73), INF_1 replies in English (74: "yes"). At this point, INF_2 asks about the pain condition of the patient, thus introducing a new topic (76): although she does it in English, her tone of voice denotes the intention to resume the orderly progression of patient data rather than prolong the four-party interaction (see also §5.1.2 about the use of English medical terminology by the Italian healthcare staff). Hence the previous communication pattern is restored as of line 77.

The last interaction type in the corpus includes two training sessions. The first to be recorded, labelled as TS.01, is part of the specialized orientation to critical care provided by an American instructor (N) to three young nurses (INF_1, INF_2, and INF_3) just hired to work in the hospital's intensive care unit (ICU). More specifically, the lesson concerns an invasive method used to assess and diagnose cardiopulmonary function in ICU patients. While the first part of the session is mainly theoretical, the second is of a more practical nature and deals primarily with the interpretation of the values measured through specific catheters. At the time of the recording, the interpreter involved, Christian, was still refining his interpreting technique, especially in the simultaneous mode (see §4.3.1); therefore, as he confirmed in a post-assignment interview, during the lesson he opted for the short consecutive mode, as he felt more confident about it.

Excerpts 12 and 13 illustrate two different interaction patterns: the first is an instance of monologic discourse, i.e. of the speech produced by the instructor during most of the lesson, whereas the second passage is of a dialogic nature. Both excerpts

show that the session unfolds seamlessly. The trainer's elocution is noteworthy: the frequent intraturn pauses (as in Excerpt 12, lines 65-67; 72-74) and the lengthened vowel or consonant sounds (as in Excerpt 13, line 257: "for a lo:::ng time") result in a very low speech rate. She also regularly emphasises significant expressions, a typical feature of instructors' speech that here is often emulated by Christian (e.g. in Excerpt 12 the English "anticipate", line 66, and the Italian "anticipare", 69; the English "task-oriented", line 73, and the Italian "esecutore/performer", 77). Moreover, the US nurse is used to working with interpreters, so she generally pauses spontaneously to allow for the interpretation, as Excerpt 12 shows:

Excerpt 12 (TS.01, 65-78)

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

Moving to the dialogic sequence in Excerpt 13, the familiarity with the interpreting service emerges also in terms of conversational alignment: trainer and trainees address each other directly (see line 246, "you can tell me"), and the same stance is maintained by the interpreter's marked preference for the direct speech, as in line 251 ("ditemelo/you can tell me this"). Excerpt 13 consists of a typical "question with known answer" that follows the three-turn sequence of initiation-reply-evalution, or IRE (Macbeth 2004: 703-704). The instructor wants the students to explain the risks

of leaving air in the small balloon at one extremity of the catheter they are examining, when this is inserted in the pulmonary artery of a patient (lines 246-247); interestingly, she specifies that the nurses can answer in Italian (246: "you can tell me in Italian", translated as "anche in italiano ditemelo che io lo capisco/you can tell me this even in Italian as I can understand it", line 251). Indeed, the educator has a good passive knowledge of Italian, after three years spent in Palermo, but she is not confident enough to actively use it for the lesson:

Excerpt 13 (TS.01, 246-257)

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

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

5.1.2 Adjusting to the linguistic requirements

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

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

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

136	N	okay↑ (.) he's no *more* on **N P O**
137	I	non è più in **N P [ɔ]** he's no more on NPO
138	N	I don't know why they haven't ( )
139	I	non sa perché è ancora ┌ °è segnato qui° she doesn't know why it's still ┌ it's written here
140	N	└ from yesterday

141 INF [**reg[u]lar**↑]
142 N [he wen –] (.) he went [down
143 I [**regular diet**↑
144 N yes yes
145 I **regular**

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

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

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

In terms of interpreting product, the options available in the Italian renditions are either to use the standard translation or to preserve the English terminology, although the latter occurrence is perhaps the most common at ISMETT. On the other hand, when the report is provided in Italian to an American staff member, the interpreter has a wider range of choices. In this regard, significant sequences can be identified during the report

of an Italian nurse at the end of his exhausting night shift in the step-down – or semi-intensive care – unit (SDU). Excerpt 16 refers to the cardiovascular assessment of the patient:

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

44	INF	**cardiovascular**↑ ehm la signora è: [in:: the lady is in
45	I	*((whispering))* °**C**] **V**°=
46	INF	=è **in normal s[i]nus rh[i][t]m** she's
47	I	**she is in normal sinus rhythm**

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

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

48	INF	c'ha un **left antecubital** (.) **numero venti** (.) come accesso she has a number twenty as an access
49	I	*((whispering))* °**number twenty**°

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

Excerpt 18 (NR.SDU.02, 76-78)

76	INF	genitourinario::↑ (.) **voids urina::**= genitourinary she voids
77	I	=*((whispering))* °**she voids spontaneously**°=
78	INF	=°tranquillamente° […] easily

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

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

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

28	INF	=non è andata ancora di corpo= she didn't move her bowels
29	I	=no B Ms=
30	INF	=ha fatto aria comunque she passed flatus anyway
31	I	*but* flatus
32	INF	**ha un:** right lower quadrant J P (.) to bulb suction (.) serosanguineous she has a
33		°(with me)° one hundred °with me° (.) e:::hm D C teds (.) **avev –** edema she had... edema
34		agli arti superiori infatti:: ┌ è difficile prendere:: accessi venosi ┐ to the upper extremities indeed it's hard to find IV accesses
35	I	└ **upper – to – to the arms –** ┘ edema
36		┌ to the arms=
37	N	└ *((writing down her notes))* edema
38	I	=so it's:: (.) *hard* to find an I V access=

In lines 32-33 the outgoing Italian nurse begins the sentence with an Italian verb ("ha un/she has a"), but then she shifts to English in order to describe the type of drainage of the patient (called Jackson-Pratt or "JP"), its location ("right lower quadrant"), how it works ("to bulb suction"), what it produced ("serosanguineous" drainage), and in what amount ("one hundred"). She also adds that the thrombo-embolic deterrent stockings,

commonly known under the acronym TEDS, have to be discontinued ("DC teds"), and finally goes back to the Italian language. Interpreter Julia first interrupts her translation (after line 31), since it would sound superfluous, and then resumes it at the end of the sequence in English (line 35).

Although the linguistic production of the primary speakers is largely the outcome of unconscious shifts, nurses occasionally display a certain degree of awareness of their foreign language use. This happens, for instance, in the four-party interaction (NR.FL.06) described in the previous section (see Excerpts 10 and 11). The nurse preceptor who is taking report (INF_2) prompts the Italian outgoing colleague (INF_1) to provide patient information in English by asking her close-ended questions in the same language (Excerpt 20 below, lines 296-312, left column). Then she ironically addresses the interpreter to point out that she is temporarily relieving him of the interpreting duty (line 313: "ti diciamo risparmio un po' di lavoro/let's say I save you some work"). Italo expresses his appreciation (315: "grazie/thank you", followed by a chuckle) by using the footing of responder:

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

296	INF_2	>°(mhm)°< (.) quindi so		
297		integumentary abdominal		
298		in[tʃ]ision		
299	INF_1	yes ┌ open to air		
300	INF_2	└ open to air		
301			I	**abdominal incision open to**
302				**°(air)°**
303	INF_1	dry intact		
304	INF_2	dry (ed) intact (and)		
305	INF_1	°yes°		
306			I	***dry* and intact**
307	INF_2	ismett one ┌ and=		
308	INF_1	└ domani tomorrow		
309	INF_2	=F K for tomorrow↑ *((INF_1*		
310		*nods))*		
311	*((pause))*	*((INF_2 goes on writing her*		
312	*notes))*			
313	INF_2	*((to the interpreter))* >t – t – < **ti::: diciamo risparmio un po' di lavoro** **let's say I save you some work**		

314		┌ °diciamo° └ let's say	
315	I	└ **grazie** *((chuckle))* **thank you**	
316	INF1	( ) *((chuckle))*	
317	INF2	chest [iks]-ray do::ne all done↑	
318		*((INF1 nods))* done done	
319		┌ done done=	
320	INF1	└ sì: ce:rto yes sure	

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

5.1.3 'Back-up' interpreting

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

Excerpt 21 (NR.SDU.01, 13-22)

13	N	[…] uh psychosocially she's (.) anxious: she's okay
14		(.) unless: someone's (.) *bothering* her
15	INF	**>mhm<**
16	N	like her family but oth – but otherwise she's quiet (.) she was sitting
17		at the side of bed today
18	INF	**mhm**
19	N	a::nd (.) no pain (.) she can move around (.) fine
20	INF	**okay** (.) **he hav::e** (.) **need** (.) **P R N no[t]ing**↑=
21	N	=no:
22	INF	**okay**

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

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

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

23	N	uh (.) she does sometimes have this headache *((touching her forehead*
24		*with the right hand))*=
25	INF	=>mhm<
26	N	and her eyes hurt (.) which her (.) mum said it's chronic (.) she's had it
27		for years 'cause she's blind (.) from one eye she's blind ***((the Italian***
28		***nurse looks at the interpreter))*** and then (.) causes her to have a
29		headache and ⌜(troubles)=
30	I	⌞**è cieca**
		she's blind
31	N	=(reading)
32	I	**è cieca in un occhio e questo le causa mal di** ⌜**te:sta**
		she's blind in one eye and this causes her a **headache**
33	INF	⌞il mal di testa⌟ è per
		is the headache due to
34		questo↑
		this
35	I	sì e anche dolore agli occhi (.) °proprio°
		yes and also pain to her eyes exactly
36	N	so I mentioned it to the doctors (.) °but° (.) no order for pain med when
37		I asked
38	INF	°okay°

Eric, who so far has not been involved in the interaction, is silently called to intervene by the Italian nurse looking at him (lines 27-28): whereas the feedback tokens had previously signalled that the translation was unnecessary, the nonverbal cue now functions as a request for help. Indeed Eric translates (lines 30 and 32), responds to the additional question (33-34) of the Italian nurse and finally concludes his intervention by summing up other information (the patients' eyes hurt, line 35) that the Italian nurse might have missed. The interaction then moves back to English and the new piece of information requires no translation (36-38). The passage continues with the review of the cardiovascular and pulmonary systems:

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

39	N	uh (.) normal sinus rhythm=
40	INF	=>mhm<
41	N	she has a left (.) *((pointing at the left arm))* A C twenty gauge (.) with D
42		five and W (.) at a: (.) fifteen M Ls (.) >no blood return<
43	INF	*((to the interpreter))* **fifteen**↑
44	I	quindici fifteen
45	N	u:h (.) no edema
46	I	*((to the US nurse))* °you said *fifteen* right↑°
47	N	°yeah° (.) u::::h↑ respiratory she's trach-mask twenty-eight percent and
48		five liters of (.) oxygen
49	INF	*((to the interpreter))* **[a]t**↑
50	I	ventotto per cento twenty-eight per cent
51	INF	mhm
52	I	e l – e cinque litri di ossigeno and... and five litres of oxygen

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

The difficulties with less technical terminology identified in this report find confirmation in the second exchange under study (NR.FL.02), which involves a step-down unit nurse coming from the US and an Italian one who works in the regular admission unit; it does not occur at the change of shift, but during the afternoon, when a transplant patient needs to be transferred from the SDU to the Floor. Also in this case, the interaction is chiefly in English, given that the Italian nurse has some knowledge of the foreign language; nevertheless, the two women request the support of interpreter Dario to prevent communication gaps. As in Excerpt 23 above, the comprehension of

numbers may be problematic: in the following example (Excerpt 24), the Floor nurse easily understands most information concerning pain and vital signs (lines 14-18), except for the indication of the patient's heart rate (line 18), perhaps owing to the quicker speaking pace of the colleague and the unusual wording ("like in the seventies and eighties"). The Italian nurse thus calls Dario's attention to this passage (19: "non ho capito qua la frequenza/I didn't understand here the rate"), so that he supplies the relevant translation (lines 20-21 and 23):

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

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

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

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

36	N	she (.) is on a regular (.) diet (.) diabetic but **she's allowed to have** (.)
37		**her sugars if she wants them** (.) doctor said
38		*((the Italian nurse looks at the interpreter with a puzzled expression))*
39	INF	*((to the interpreter))* >°**(che ha detto)**↑°< (what did she say)

40 I **che può::** ┌ **mangiare anche** (ad esempio)=
that she can **eat also** (for instance)
41 N └ she eats what she wants
42 I =**i do::lci può mangiare quello che vuole non c'è** ┌ **controllo**=
sweets she can eat what she wants there is no **restriction**
43 INF └ okay
44 I =**degli zuccheri**
of sugars

It should be noted that the function of linguistic support usually corresponds to a less active involvement of the interpreter in the encounter and in the service provision (cf. Merlini 2009). However, the peculiar language situation at ISMETT and the corporate goal of fostering staff proficiency in both Italian and English often turn this ancillary task into a most welcome asset to the interaction. In addition, this fluctuation between involvement and non-involvement, between stepping aside as an observer and moving back into the turn-taking sequence when required, is more demanding than it might appear. 'Understanding whether the person has understood' entails a constant monitoring of the interaction in all its components, both verbal and nonverbal, in order to assess how and when to translate: a 'back-up interpreter' must select the right timing and attitude, to make sure that the intervention is not perceived as interference.

This is best exemplified by an excerpt from one of the training sessions in the corpus (TS.02). The main speaker is an American visiting instructor who discusses the role of nurses and other healthcare providers in the event of a patient crisis. The session is attended by ISMETT nursing educators, clinical coordinators, physical therapy and respiratory therapy coordinators, as well as by exchange nursing students from the US. The interpreters, Italo (I_1) and Georgia (I_2), are sitting on one side of the conference room, with a microphone each: headsets have been distributed to the Italian staff who need the translation and to all US attendees, so that Italo can interpret in whispering mode from English into Italian and Georgia from Italian into English, should the Italian participants intervene.[36] Given that all comments are eventually made by those participants who are fluent in English, the role of Georgia is chiefly confined to helping Italo as if they were in the booth. And yet she is physically present in the room. The passage to be examined concerns the final debate and, more precisely, the involvement

[36] As a general rule, for less formal events there is only one interpreter who alternates between one microphone and the other, each for a language direction. However, on this occasion Georgia and Italo kindly offered to provide the interpreting service as a team.

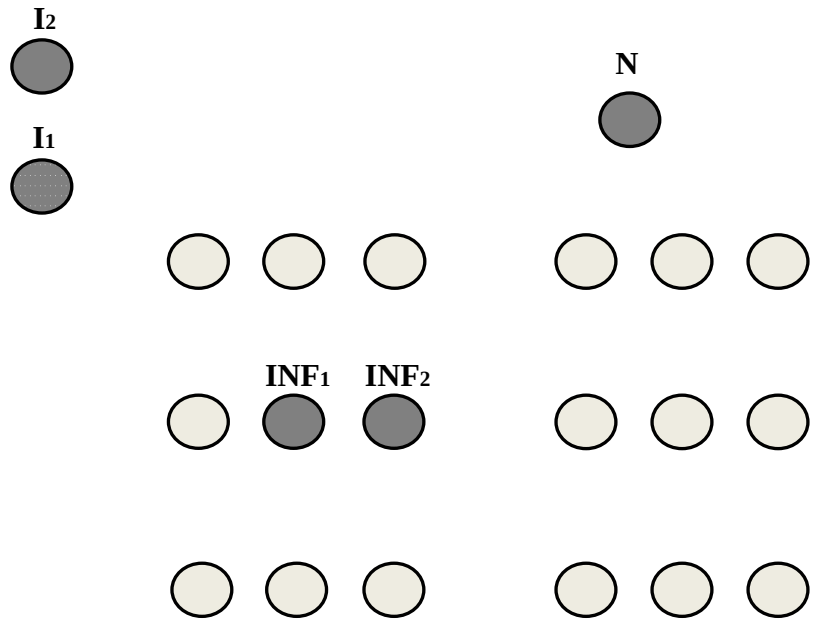

Figure 5.1 Spatial distribution of participants during TS.02

of two Italian nurses (INF1 and INF2). For the sake of clarity, the mutual positions of the relevant parties – without taking into account the other audience members – is illustrated in Figure 5.1. In Excerpt 26 the column on the left shows the turns in English of the primary speakers, whilst Italo's rendition appears on the right. One of the two Italian nurses (INF1) would like to know who set the criteria that must be met for a code to be called in the UPMC hospital of the instructor (lines 435-437). A 'code' is an emergency situation, such as a cardiac arrest or respiratory failure, requiring a specific medical team to immediately reach the pertinent location and provide support, for instance to resuscitate the patient. The nurse, who talks in English, has some trouble formulating the question; at first, the other Italian colleague (INF2) comes to the rescue (left column, lines 438 and 440), but then INF1 tries to complete the sentence autonomously (441-443):

Excerpt 26 (TS.02, 435-448)

435	INF1	who decide about the:: (.)	I1	chi decide (.)
436		u:::h (.) calling criteria there is		pe::r – chi decide i
437		a C P R committee↑ who:::		criteri:: da:: (.)
438	INF2	which are the=		
439	INF1	=which are=		

440	INF2	=the criteria	I1	quali sono comunque i
441	INF1	you – we read about the calling		criteri (.)
442		criteria that you have for a		tu parlavi appunto dei
443		code=		criteri per chiama::re una
444	N	=mhm=		condition (.)
445	INF1	=okay↑ and who decide those		*chi* decide
446		criteria		questi criteri
447		***((the US nurse looks puzzled))***		
448	N	**°o::h° we::**		

As the US nurse hesitates about answering (444 and 448), Georgia decides to intervene 'off mic' and clarify the message by rephrasing the inquiry (Excerpt 27, left column, lines 449-450):

Excerpt 27 (TS.02, 449-460)

449	I2	*((off mic to the US nurse))* **who**		
450		**defines them**		
451	N	*((looking at I2))* °who defines		
452		them° *((looking at INF2))* we::		
453	INF1	who define – **sorry** (.) who		
454		define		
455	N	we:: got those from our uh	I1	allora
456		crisis team		noi li abbiamo:: (.)
457	INF1	okay		presi
458	N	so it's our crisis team that=		dal nostro team di risposta
459	INF1	=okay=		è il team di risposta
460		=put those together [...]		che li definisce

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

5.1.4 Language teaching

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

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

144	N	[…] you can increase the free water on that
145		(.) feeding pump can you↑
146	INF	mhm
147	N	will you show me↑ can you increase (.) the water on the feeding tube
148		( )↑ –
149	INF	we can – (.) *((to the interpreter))* **provare è try vero↑** **to try is** **right**
150	I	**provare e** ***tentare*** (.) >**lei – lei vuol sapere**< ⌜ se si può fa::re= **try and** **attempt** **she... she wants to know** ⌞ whether it can be done
151	INF	⌞ **possiamo provare** **we can try**
152	I	=sì se si può provare yes if it is possible to try
153	INF	⌜ °**possiamo provare**° ⌞ **we can try** ⌟
154	I	⌞ vorrebbe vedere come si fa sostanzialmente she would like to see how to do it basically
155	N	can you↑
156	INF	**possiamo provare** *((chuckle))* **we can try**
157	I	**we can try**
158	N	°okay° (.) ‘cause I didn’t know how to do it so it’s still at twenty-five (.)
159		M Ls
160	INF	*((to the interpreter))* **come↑** **what**
161	I	**dice io non sapevo come fare** allora è sempre a venticinque M L **she says I didn’t know how to do it** so it’s still at twenty-five mls
162	N	that’s it
163	INF	°okay°

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

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

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

30	N	[...] she has a **clamshell** (.) **incision** °( )° and that looks fine
31		(.) no °(opening)° no drainage
32	INF	*((to the interpreter))* ehm **me lo puoi dire com’è lo spelling di clam** **can you tell me what is the spelling of**
33		e::hm [**incisione** **incision**
34	I	**C L A**] **M** *((background voices))*
35	INF	°C L A M° *((writing down her notes))* clam (.) in[t͡ʃ]i[z]ion (.) okay

A significant occurrence of language teaching can also be found during the nursing assessment mediated by Barbara. As already pointed out (see §5.1.1), the US healthcare practitioner involved in the interaction speaks some Italian. While checking the sublingual temperature of the patient, the nurse hears the phrase “sotto la lingua/under the tongue”, used by Barbara in her rendition for the patient (Excerpt 30, line 192), and tries to echo it, although incorrectly (195: “sopra lingua/upon tongue”). The interpreter reacts immediately by correcting her (196: “sotto/under”) and repeatedly stressing that “sotto” means “under” (198 and 200) rather than “low” (199), although she concedes that the expression “sotto voce” can be translated as “low voice” (201):

Excerpt 30 (NA.FL, 190-201)

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

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

5.2 A multifaceted teamwork

5.2.1 Meaning negotiation

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

In an 'unmarked' sequence (Excerpt 31) taken from the four-party nursing report (NR.FL.06), a doubt about the content of the interaction is raised by one of the primary speakers, namely by the US nurse, rather than by the interpreter. With reference to the genitourinary assessment of the patient, the outgoing nurse (INF_1) explains that she carried out the so-called "bladder training" (mispronounced in lines 203-204, left column, and adjusted by Italo in lines 205-206, right column; cf. Excerpt 20). The American colleague is not familiar with this concept, and asks for explanation (217, on the right: "what is that", further reinforced in line 219); however, it is not clear whether she is addressing the interpreter or the Italian nurses, given the twofold development of the entire interaction described in detail above (see §5.1.1 and 5.1.2). Italo opts for interrupting the report by translating this technical inquiry into Italian (lines 218 and 222, in which the use of the reporting verb "dice/she says" serves as a turn-entry device; cf. Excerpt 11):

Excerpt 31 (NR.FL.06, 203-223)

203	INF1	però ho fatto il **bl[a][d]** but I did the		
204		**training**		
205			I	he has been doing the
206				***bladder* training**
207	INF1	anche se *((chuckle))* even if		
208		scientificamente forse scientifically maybe	N	°( )°
209		dicono che non è provato ma they say that it is not proved but		
210		°( )°	I	even though they say
211				scientifically speaking isn't –
212	INF1	e io l'ho fatto and I did it		this thing is not approved
213		aveva lo stimolo he had the stimulus		
214			I	>it hasn't been approved the
215				bladder training that **she**'s
216				done<
217			N	**what is that**
218	I	**cos'è↑ questo::: la::** what is this... the...		
219	N	**bladder training °what is bladder training°**		
220	I	vesc – = blad...		
221	INF1	=what↑		
222	I	la ginnastica vescicale **dice** che cos'è= the training of the bladder **she says** what is it		
223	INF1	what↑ ginnastica ve – training of the bl...		

The nurse preceptor (INF2) provides an exhaustive answer, which is only partially reported here (Excerpt 32, lines 225-242). In brief, the bladder training refers to the need to re-educate the bladder to contract and dilate soon after the removal of the urinary catheter (or "Foley" catheter, line 226). What needs to be highlighted is that the communication gap is bridged as a result of a joint effort of the four participants, and that, more specifically, direct contact is, once again, established between primary parties. Indeed, this section of the exchange closes with the mutual acknowledgment of the two incoming nurses (lines 263 and 266):

Excerpt 32 (NR.FL.06, 225-242)

225 INF2 *((to the US nurse))* e:::hm praticamente quando un paziente tiene per
basically when the patient has for
226 molto tempo il **Foley**
a long time the **Foley**
227 INF1 [la vescica –]
the bladder
228 I [when the] patient has the Foley for l – [keep=
229 INF2 [e::hm
230 I =*has* [the Foley=
231 INF2 [l'urina –
the urine
232 I =for a long time
233 INF2 l'urina esce sempre
the urine pours out constantly
234 I so he just urid – voids [spontaneously=
235 INF2 [quindi la vescica
so the bladder
236 I =(has) always °( )°
237 INF1 non ha più
has no longer
238 INF2 la vescica non si [allena più nella=
the bladder is no longer trained in the
239 I [and so the::
240 INF2 dilatazione [e nel restringimento]
dilation and in the contraction
241 I [bladder is no longer] trained in contracting and –
242 *((the US nurse nods))*

(263; 266)

263 INF2 ***((to the US nurse))*** **okay↑**
[…]
266 N ***((to INF2))*** **°thank you°**

In the following excerpt (33) a content-related query is raised both by one of the primary interlocutors and by the interpreter. During a nursing report taking place in the ICU and mediated by Francesca, the outgoing American nurse explains that her assigned patient underwent an interventional radiology procedure because of a liver disorder, but at first she is not able to specify the name of the disease. She therefore checks the electronic medical record, and finds out that the woman was affected by "Budd-Chiari" (line 45). Francesca asks the nurse to repeat the name of the disorder (47: "what does she have") and then attempts to report it, yet with an uncertain tone of voice (49). Given that doubts are expressed also by the Italian nurse (50: "cos'è/what is

it"), the American co-worker explains that the illness is related to portal hypertension (52). Although the incoming healthcare practitioner makes comments (54 and 56: he will look for further information in the documentation) and suggests hypotheses (58: perhaps the patient was affected by a "K", i.e. by a cancer), these turns are left untranslated, and only the final outcome of his reflections is conveyed into English ("ho capito/I've understood", line 62). Moreover, in the rendition (65: "he knows what it is"), both the footing of narrator and the word choice – the verb 'to understand' is substituted for 'to know' – create a distance between the interpreter and the Italian-speaking party: Francesca foregrounds her mediating role, thus implicitly stressing that it is the nurse who should take responsibility for grasping the concept. Similarly to the occurrences discussed above (Excerpts 31 and 32), it can be said that the ultimate goal of the report, i.e. the information transfer, is eventually achieved:

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

45 N so *((reading from the electronic medical record))* she had **Budd Chiari**
46 that's what °it was°
47 I **what does she have↑**
48 N Bu:dd (.) *Chia:::ri:*
49 I ***((doubtful))*** **il B[a]dd Chiari↑**
the
50 INF °**cos'è↑**°
what is it
51 I [what is it
52 N [>with the<] uh (.) **portal hypertensio::n::**
53 I iper – ipertensione portale↑=
hyper... portal hypertension
54 INF =^ah^ (.) >molto probabilmente ha avut – < può – [d:arsi che::=
most likely she had... it might... be that
55 N [oh –
56 INF =vabbè ora la – [la cerco io la (notizia) probabilmente ci sarà stato=
alright now... I look for the (piece of information) probably there was
57 N [°( )°
58 INF o un [**K** –]
either a [**Ca**]
59 I [ah] ^B[a][t]^ Chiari
60 N °Budd Chiari::°
61 *((pause)) ((background voices))*
62 INF e:::h (.) >sì sì sì< (.) >°**ho capito**°<
yes yes yes **I've understood**
63 N okay↑
64 INF °sì°
yes
65 I **he knows what it is**

66 N okay then [...]

Providential assistance in enabling communication is occasionally offered not only by the healthcare team, but also by written tools such as medical records and Kardex sheets. Excerpt 34 below illustrates one such example. The interpreter is Italo; the Italian nurse who is giving report specifies that a patient, in addition to other medications, has a skin patch called "duragesic", and points at its name written on the Kardex (line 26). As already shown while discussing the diverse requirements of ISMETT users, medical terms that are potentially problematic for interpreters may be transparent across languages when it comes to the healthcare personnel, so that often there is no need for translation or repetition by the interpreter (see §5.1.2 and 5.1.3). Hence Italo first verifies whether the name of the patch – that he has probably missed – is clear to the US nurse (27); given that the woman sounds confused (28), he uses the deictic pronoun "this", while pointing at the item on the Kardex (29) and replacing the term with the phrase "the one she is showing to you" (31). Once again, the message is conveyed (line 30):

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

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

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

(677: “it’s a ten maybe”). The nurse is thus able to comprehend the whole order (678-679):

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

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

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

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

363 N *((reading from the medical record))* *a::ngio C T scan* (.) for a:
364 I una tac: [a:
a CT scan [to
365 N [*((doubtful))* **>°what’s** **that°< (.) I can’t even read it↑**
366 I *((getting closer to the US nurse))* non riesce a leggere
she cannot read

367 N ***((trying to read from the medical record))*** agree:: with doctor (.)
368 something for an agree:: (.) something with doctor (.) *((misreading the*
369 *name))* {Darti} (.) I agree↑
370 I ***((reading from the medical record))*** **as for agreement** [**with doctor=**
371 N [with doctor
372 I **=*{Darbedo}***
373 N *{Darbedo}*
374 INF >cioè deve fare< [una::
that is he has to do [a
375 I [**come da** [**accordi con** [**il dotto:r::**=
as for [agreement with [doctor
376 N [angio C T [(scan) tomorrow
377 INF [scan °okay°
378 I =**{Darbedo}**

A new interpreting function can thus be identified, namely that of medical co-expert, although with two variants. Whereas in Excerpt 35 it is one of the primary speakers who

casts Dario in this role, as confirmed by the interpreter's footing of "responder", in Excerpt 36 Henry assumes the same position of his own accord, acting as "principal" (Merlini and Favaron 2007). In either case, it can be said that the attitude of all participants is evidence for the spirit of comradeship among ISMETT co-workers.

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

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

123	INF	[…] la signora non è the lady is not
124		diabetica però ha i controlli [della::] diabetic but she has the checks [of the
125	I	[she's] not a diabetic [patient=
126	INF	[della glicemia of the blood sugar
127	I	=but we have to check her blood sugar levels
128		*((pause)) ((the Italian nurse looks at the medical record))*
129	INF	okay (.) passia:mo adesso↑ (.) *((looking at his notes))* a {Pampinato} let's move now to Pampinato
130	I	**insulina ne prende↑** **insulin does she take it**
131	INF	>come↑< pardon

132 I insulina ne prende↑
insulin does she take it

133 INF °c'ha una scala se non mi sbaglio° *((looking at the Kardex))*
she has a scale if I'm not mistaken

134 >°vediamo↑°< (.) >**sì**< [**ha una scala**
let's see **yes** **she has a scale**

135 I [the lady has a scale] of insulin

136 INF ha una scala
she has a scale

137 I *((looking at the Kardex))* **che scala è**↑ >**medium**<
what scale is it

138 *((child crying in the distance))*

139 INF **medium** [...]

The atypical behaviour exhibited by Georgia seems in line with her idea of 'tailor-made services' that ISMETT interpreters should offer to their users (see §4.3.4 and 4.3.5). In a post-assignment interview, Georgia explained that, after many years of experience in the units, she was able to predict what data nurses needed, and she felt that it was her duty to make sure that they were all accurately transmitted. Notably, with reference to the second report given during this interaction, the Italian nurse spontaneously includes information on the insulin scale of the patient (lines 219 and 221):

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

213 INF […] è diabetico il [signore
he is diabetic the mister

214 I [*he is*] a diabetic patient

215 INF ha il controllo della glicemia↑
he has the check of blood sugar

216 I blood sugar=

217 INF =schedulato↑
scheduled

218 I accu-chek is scheduled

219 INF **e anche una scala**
and also a scale

220 I and he too has a scale

221 INF °**d'insulina**°
of insulin

222 I *((whispering))* °an insulin scale°

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

5.2.2 Repair activities

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

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

In the field of interpreting, the concept of repair is found in Bot (2005), with reference to the resolution of communication problems in interpreter-mediated mental health sessions. In this context, repair strategies are generically indicated as those applied by the interpreter to re-integrate previously lost information, either in later turns during the same encounter or in subsequent therapy sessions. More specifically, repair activities are detected by Birgit Apfelbaum (2007) during the training of technical translation students as dialogue interpreters. In their simulated interactions, the researcher underscores that setting-specific tasks, such as the negotiation of technical terms, are often achieved through self- and other-repair, to the extent that repair activities are recommended as a standard instructional resource in interpreter training.

	Self-repair	**Other-repair**
Self-initiation	S Mark Smith has – sorry, John Smith has just arrived.	S John… what's his surname… O Smith? S Yeah, Smith. He's just arrived.
Other-initiation	S Mark Smith has just arrived. O Mark Smith? S No, sorry. John Smith.	S Mark Smi – O It's John Smith. S Right, John Smith has just arrived.

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

Significantly, most instances of repair in the ISMETT corpus are to be found in the training session on critical care nursing (TS.01; see §5.1.1, Excerpts 12-13), which bears marked similarities to the framework of Apfelbaum's research study. As explained above, this lesson is an instance of on-the-job training also for the interpreter, Christian; in other words, during the session both trainees and interpreter are engaged in the acquisition of knowledge and skills in their respective fields. Hence the same categories used by Apfelbalum, i.e. those devised by Schegloff *et al.* (1977), have been applied to the instances of interpreter's repair in the session under study. Predictably, self-correction, signalled by hesitations or false starts, is by far the most frequent occurrence, being a typical feature of the interpreter's impromptu speech (e.g. Enkvist 1982), as in Excerpt 12, lines 68-70. However, attention will be focused here on instances of self-initiated other-repair, i.e. on those repairs initiated by the interpreter and accomplished by one of the primary speakers.

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

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

Self-initiation	**Other-repair**
Exposed	S John… **what's his surname…** O Smith? S Yeah, Smith. He's just arrived.
Embedded	S John… **uh… John…** O Smith? S Yeah, John Smith has just arrived.

Table 5.2 Exposed and embedded self-initiation and other-repair (from Favaron 2009: 446)

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

Excerpt 39 (TS.01, 47-58)

47	N	and then hemodynamics three which is *supposed* to be today this is
48		the third day u::h goes into more (.) u:h (.) *parameters* looking at
49		mo::re u::h (.) >we say< in addition to the >pulmonary artery< pressure
50		numbers we look at (.) u:::h (.) **systemic vascular resistances** we look
51		at **cardiac output cardiac index**
52	I	quindi guardiamo il – l'output cardiaco – questo è quello che si – so we look at the... the cardiac output... this is what will...
53		dovremmo trattare oggi nella terza parte= we should do today in the third part
54	INF1	=mhm=
55	I	=quindi l'output cardiaco i vari indici e::: *((to the educator))* °**what was** so cardiac output different indexes and
56		**the other thing**°
57	N	cardiac index cardiac output **systemic vascular resistance**=
58	I	=la re – resistenza vascolare sistemica °eccetera°= systemic vascular re... resistance et cetera

In contrast, 'embedded' self-initiation is a much more remarkable case, especially when the 'others' who accomplish the repair are the newly-hired nurses, ready to assist, in particular, if the interpreter is in trouble with the technical terminology. Notably, the three nurses are already graduated, and the orientation course is primarily aimed at reviewing subjects studied at university. Therefore, they are familiar with the contents and are able, for instance, to complete the sentences left 'unfinished' by Christian, as shown in the following excerpt:

Excerpt 40 (TS.01, 89-95)

89	N	[...] let's do the wedge first (.)
90		and then we come back up to:: the effects of:: *respiration* (.) on:: this
91		catheter that – that's *in* your heart and (.) close to the lungs
92	I	°okay° (.) tratteremo la – l – l'operazione del wedge we are going to deal with the... th... the wedge procedure
93		**da ora in poi dirò wedge è praticamente::**= **from now on I'll say it's basically**
94	INF1	=>**l'incuneamento**< **wedging**
95	I	**sì** °l'incuneamento° **yes** wedging

The instructor explains a specific procedure, called "wedge" procedure, performed by inserting a catheter in the pulmonary artery (lines 89-91). Interestingly, the interpreter first states his intention to use the English word "wedge" also in the translation into Italian (93: "da ora in poi dirò wegde/from now on I'll say wedge"), a common choice at ISMETT, where the medical jargon of the Italian staff features plenty of English terms. For the sake of clarity, however, he decides to specify the Italian equivalent (93: "è praticamente/it's basically"): his final ellipsis, signalled by the lengthened vowel sound, is a cue for one of the trainees (INF_1) to intervene and supply the correct term (94: "incuneamento"), immediately ratified by Christian (95).

On some occasions, the nurses provide their help when the interpreter's word search is related to slips of the tongue or issues of linguistic appropriateness. For instance, in the hands-on part of the lesson, the instructor is holding a sample catheter and showing how to deflate the small balloon placed at one end, to prevent its rupture (Excerpt 41, lines 274, 276, and 278). While explaining this in Italian, the word "funzionamento/functioning" does not come to Christian. Also in this case, the embedded self-initiation of repair is signalled by the lengthened vowel sound and the hesitation (284: "diciamo ehm la – la:::/let's say the... the..."). INF_3 comes to the rescue (285):

Excerpt 41 (TS.01, 274-286)

274	N	=>okay< the reason why you don't *actively* (.) pull back
275	INF2	mhm=
276	N	=to *de*flate the balloon the company says that creates *wear* and tear
277	I	mhm=
278	N	=*on* the balloon and it might cause it to rupture

279 I lo fai sgonfiare ┌ da solo=
you let it deflate │ on its own
280 N └ °( )°
281 I =senza tu tirare via l'aria=
without you pulling out the air
282 INF3 =mhm=
283 I =perché la:: la compagnia che produce questo catetere sostiene che può
because the... the company that produces this catheter says that it can
284 deteriorare a lungo: (.) °**diciamo ehm la – la:::**°
compromise in the long run **let's say** **the... the...**
285 INF3 °**il funzionamento**°=
the functioning
286 I =°sì↑°
yes

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

Excerpt 42 (TS.01, 660-664)

660 N […] or you:: Emtek and it
661 takes it from the (.) the screen it's – if they are (.) u::h (.) *((to the*
662 *interpreter))* °**what's the word** ┌ **inter –**°
663 I └ **interfaced**
664 N interfaced °**thank you**°

It can be said that no issues of social distance, power or subordination come to the fore during the lesson. Similarly, no self-image concerns emerge, given that in this peculiar context what is at stake is the flow of correct information. This is why requests for help and corrections can be 'exposed' or, rather, transparent, and the organization of talk in the interaction is achieved by means of mutual cooperation among all members of the constellation. This lack of constraints mainly results from the fact that competences are being acquired. Both the novice nurses and the novice interpreter could be subsumed

under the category of "not-yet-competent in some domain", as stated by Schegloff *et al.* (1977: 381), who interestingly add that, in this context:

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

5.2.3 Team-building

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

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

Excerpt 43 (TS.01, 379-389)

379	N	=as – nurses **we** tend to see *air* in I V tubings and we get nervous like
380		***((mocking a worried voice))*** **ah there's an air bubble**=
381	I	=mhm=
382	N	=*((mocking a worried voice))* it's going to kill the patient
383	I	mhm *((soft chuckle))* **a noi** succede per esempio di vedere delle – delle **to us** it happens for instance to see some... some
384		bolle d'aria nelle – nei tubi delle – delle medicazioni endovenose air bubbles in the... in the tubes of the... of the intravenous meds

385 magari ci preoccupiamo ***((mocking a worried voice))*** **c'è una bolla**
maybe we get worried **there's a bubble**

386 **d'a::ria**
of air

387 INF1 ⌈
388 INF2 ⌊ ***((soft chuckle))***
389 INF3

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

Excerpt 44 (TS.01, 1049-1066)

1049 N >you – you're not – it's not like you're going fishing< ***((mimicking a***
1050 ***fisherman with a fishing rod))*** >and like you're like<
1051 ⌈ ***((emphatically))*** o::h my Go::d a *bi:g* one ***((chuckle))***
1052 INF2 ⌊ ***((wholehearted laugh))***
1053 I è come quando vai a pesca no↑ ⌈ vai a pescare=
it's like when you go fishing isn't it ⌊ you go fishing
1054 N °( ) that°
1055 I =e ti abbocca l'amo e ti::ra=
and it bites the fishook and it pulls

1056 N =a l( ) of your *tricuspid* valve ^which [you *don't* – ^
1057 I [sei *attaccato*] alla
you're stuck to the

1058 valvola tricuspide che è una cosa che non – [non deve succedere
tricuspid valve which is something that should not happen
1059 N [want to
1060 come out with us (.) **this** *((pointing at the tip of the catheter))* **should**
1061 **come out *empty***
1062 I evitare di **scippare** pure la:: [la valvola °(tricuspide)°
try not to **grab** also the the (tricuspid) valve
1063 N [°right so°
1064 INF1
1065 INF3 [***((soft chuckle))***]
1066 INF2 […]

More frequent team-building efforts are featured in the reports. Notably, change-of-shift reporting is one of the "rituals" of the nursing profession (Wolf 1998), given that, next to its primary function of data transmission, it performs specific social tasks (see §2.5.2). For instance, the report's scenario can become a sanctuary for "staff catharsis" (Lally 1999), in which irony and humour help exorcise the most unpleasant duties. The interaction mediated by Francesca (NR.ICU.01) is a typical example of this, as the primary speakers engage in a number of witticisms, such as the one in Excerpt 45. In this case, the joke between the two colleagues is triggered by the double meaning of the verb 'to order'. Although here it clearly refers to a medical prescription (line 199), the Italian co-worker plays on the second meaning of 'asking for food at the restaurant' (205 and 207):

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

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

202 **ordinato::** un:: clistere di lattulosio=
ordered a lactulose enema

203 INF =*((disgusted))* oh::: oh::=
204 N =ah=
205 INF =*((ironically))* °**buo::no**° **co:me**↑ [**col parmigiano**↑=
good **how** **with Parmesan**
206 N [too much lactulose
207 INF =*((ironically))* >**scaglie di parmigiano**↑<
Parmesan flakes

208 I **can we put some Parmesan cheese on top**↑
209 N *((chuckle))* *((ironically))* stop i::t *((chuckle))* […]

In her rendition (208: “can we put some Parmesan cheese on top”), Francesca maintains the metaphor and further expands it, by making more explicit the culture-bound image of a (pasta) dish seasoned with some Parmesan cheese.

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

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

47	INF2	*((to the interpreter))* come si what	[...]
48		chiama lei↑ *((pointing at the US* is her name	[...]
49		*nurse))* come si chiama lei↑ what is her name	
50			I what’s your name
51	INF2	*((to the US nurse))* **your name sorry**↑	
52	N	Helen	
53	INF2	Helen (.) [e]len **ora ci armiamo così *((clapping her hands and then*** **now we arm ourselves like this**	
54		***rubbing them together))***	
55		⌜facciamo (ah) mi raccomando dobbiamo calmare tutti we do we must calm everybody down	
56	I	⌞so **we**’re going to work and ***((chuckle))*** and calm every –	
57	INF1	allora so	
58	N	*((chuckle))*	

59 I everybody down

It is no accident that the first words of the US nurse during the interaction (see Excerpt 11 above) are uttered immediately after this exchange: the amusing comments of the preceptor, as well as her caring attitude, build up team spirit among the staff and enable the foreign colleague to overcome the initial embarrassment. A noteworthy feature of Italo's rendition is the footing of reporter (line 56), in contrast to the prevailing use of the indirect style throughout the encounter (see right columns in Excerpt 10, line 26; Excerpt 11, line 79; Excerpt 31, lines 215-216). He actually shifts from the footing of narrator to that of reporter whenever the primary speakers express themselves in the first person plural, or even in conjunction with impersonal forms. In Excerpt 47 below, "non si riesce a capire/it is not possible to understand" (line 98, left column) becomes "we cannot understand" (100, right column):

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

97	INF1	anche also			
98		**non si riesce** a capire se **it is not possible** to understand if	[...]		
99		ha veramente dolore he has really			
100		fo::rte o se è pigro strong pain or if he is lazy	I	**we cannot** understand if it's the	
101				pain or if	
102	[…]			he's lazy just lazy	

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

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

11	INF	il gruppo sanguigno è noto↑ the blood type **is known**	⌜ […]	
12	I		⌞ **we know** the blood type ⌟	[...]

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

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

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

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

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

Excerpt 50 (NR.FL.08, 245-251)

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

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

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

202	INF	è ma:::gra >magra magra magra magra ┌ magra magra magra °magra°< she's skinny skinny skinny skinny skinny │ skinny skinny skinny skinny
203	I	└ she's *very very* skinny
204	N	skinny↑
205	I	yeah
206	N	o::h
207		*((pause))*
208	INF	*((ironically))* >^metà:::^< *((indicating half of her leg))*= half
209	N	=oh↑
210	I	half
211	N	well *((laugh))* **so skinny↑** ***((pointing at the interpreter))***
212	INF	^no::^ no ┌ lei:: *((chuckle))* is ┌ good she │ │
213	N	└ *((laugh))* │ *((laugh))*
214	I	└ *((chuckle))* **more more skinny**
215	N	*((chuckle))* okay=

The LS members can occasionally take off their interpreting hats and become a source of amusement to the other co-workers through their own words and deeds, as Dario does in Excerpt 52. When the report begins (line 1; see also Excerpt 6), the two nurses are sitting next to each other, while the interpreter is standing; since also Dario would like to sit down, he interrupts the exchange to grab a chair. In doing so, he jokes with the US nurse, acting as principal (as of line 2):

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

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

5.2.4 The interpreter's divided loyalties

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

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

Excerpt 53 (NR.FL.09, 68-71)

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

(91-96)

91	N	**the patient fell (though)**↑ °in my°=
92	I	=^**no no no**^ **the**=
93	N	=oh:: the tube [fell out
94	I	] **stiamo parlando** **del::** [>**tube**< **we are talking** **about the**
95	INF	] drena::ggio drainage
96	I	°**the tube**° […]

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

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

97	INF	[…] ***((chuckle)) ((ironically)) ((to the interpreter))***
98		°**che c'entra lei dice (in poche parole)**° **what does she have to do with it she says (basically)**
99	I	°**aveva capito che il** [**paziente::**° **she understood that the** **patient...**
100	N	] so::] it didn't fall completely out (.)
101		°it – °
102	I	ma *non* completamente but not completely
103	INF	^no::^

The turns of the American nurse and of Italo in Excerpt 53 (lines 91-92) can be read as an instance of Davidson's (1998, 2002) collaborative model of turn-taking, i.e. an attempt to establish common ground between interpreter and interpretee. On the other hand, Italo's omission of the remark made by the Italian nurse in the last excerpt (line 98) aims at defusing a potential source of friction and foregrounds his mediating function.

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

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

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

Unlike Italo in the previous example (Excerpt 54), Julia was not the addressee of the remark, nor did it concern the other nurse; yet the "slow cardiologists" belong to the Italian establishment within the hospital. The assumption that the words of the US nurse could sound hostile towards the Italian colleague may have led the interpreter to leave them out.

The most noticeable role of mediator is played by interpreter Dario in the only nursing report of the corpus (NR.FL.01) that features a serious disagreement between the two primary parties. In this situation, the same American nurse involved in Excerpt 55 above has not carried out some of her assignments, given that, incidentally, the physicians wrote down the relevant orders only towards the end of her shift. Therefore, the incoming Italian colleague feels annoyed, since she will have to do extra work. For instance, in Excerpt 56, she reads from the medical record the last of several unaccomplished duties ("check body weight", line 488) and does not hide her incredulity. In this part of the session, Dario faithfully renders the turns of both primary parties using the direct speech (490: "should I also do this"; 493: "posso rimanere un po' di più e lo faccio io/I can stay a bit longer and I will do it"; see also Excerpts 8 and 9):

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

488	INF	[...] ehm check b[a]dy weight↑ *((no*
489		*longer reading))* no:: quindi (.) *((amazed))* la devo pesare↑ no so shall I weigh her
490	I	should **I** also do this↑
491	N	okay unless you want me to s – I mean
492		⌜I can stay and I can do all this⌝
493	I	⌞oh vabbè **posso** rimanere⌟ un po' di più e lo **faccio io**= okay **I can** stay a bit longer and **I will do** it

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

herself") and those of the Italian colleague (727: "she believes you"), in an attempt to reconcile the two parties:

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

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

It should be noted that the third person is often used by interpreters to distance themselves from the words uttered by primary interlocutors (e.g. Excerpt 33, line 65). In this specific situation of conflict, however, Dario's shift in footing strengthens his efforts at pacifying the two nurses: while making him appear as a more detached

participant, the indirect style also enables him to foreground his presence as a third party that both colleagues know and can trust. Conversely, as soon as the argument is settled and rapport re-established, Dario can shift back to first-person interpreting (Excerpt 57, line 729: “glielo dirò io stessa a questo medico/I will talk personally to this physician”; see also Merlini and Favaron 2009).

5.3 Summary

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

With reference to the variety of settings and users, the most noticeable outcome was the need for the LS members to constantly act as ‘chameleons’ not only across genres but also within the same exchange. The specific combination of dimensions and overall constraints of any encounter, whether a nursing assessment, an end-of-shift report, or a training session, necessarily informed the choices made by interpreters at a macro-level at the outset of the sessions. On the whole, they opted for the role of message relayer and produced close renditions; short consecutive was the dominant working mode, although whispering was also adopted under specific circumstances, e.g. in conjunction with monologic discourse in nursing reports or training sessions; during the latter, a high number of participants or a larger venue could also allow for the use of microphone and headset receivers; as for footing, the selection of direct or indirect speech largely depended on the personal preferences of the interpreters. However, as the interactions unfolded, the conversational dynamics and requirements of the participants were often subject to changes, hence leading also the interpreters to continuous adjustments: for instance, variations in the interactional stance of the participants and thus in the discourse required shifts in the working mode and footing; similarly, the lack of orderly turns-at-talk called for interpreters to act as mediators, which entailed also the use of divergent renditions or a more marked adoption of the indirect speech.

It also emerged that, in this specific bilingual setting, a crucial role was played by one of the overarching constraints, namely the diverse linguistic requirements of the co-workers involved in the interactions. Given the frequency of codeswitching phenomena, the use of bivalent expressions, and the fact that medical jargon at ISMETT is largely based upon the English language, the LS members often dealt with a "partially transparent bilingual constellation" (Meyer 2002: 167). This necessarily moulded the interpreting product: first of all, interpreters needed to adapt to the word choices of the primary parties, for instance by keeping English medical terms across languages instead of translating them; secondly, information and data that had already been provided in the language of the other interlocutors were often echoed by the interpreters, especially to compensate for any unclear enunciation; thirdly, omissions were recorded whenever the translation was deemed unnecessary owing to the proficiency of the speakers. Consequently, also the interpreting performance had to adjust accordingly, as (more or less) temporary shifts from the role of message relayer to that of linguistic support could be identified. These fluctuations between stepping aside as observers and moving back into the turn-taking sequence entailed a constant monitoring of verbal and nonverbal cues: interpreters had not only to assess if and when the translations of "chosen parts" of the discourse (Meyer 2001: 101) were required, but also to select the right timing, using tact and diplomacy to ensure that their intervention was not perceived as interference. Notably, in conjunction with the back-up interpreting function, short consecutive mode and third-person interpreting were most frequently selected to clarify who had performed a certain task or expressed a specific thought, given that many turns were left untranslated. Occasionally, the LS members acted also in their capacity as language experts and engaged in metalinguistic dialogues with the primary interlocutors. These additions to the source texts were often a result of explicit requests by the other participants, who cast the interpreters in this role and led them to use the footing of "responder"; only seldom did the LS members autonomously decide to step in by adopting the footing of "principal" (Merlini and Favaron 2007) with the purpose of supplying linguistic explanations.

When considering the effects of the status of in-house Department on the interpreting activity, teamwork proved to be an underlying leitmotif in intra-social settings. To start with, the close, two-sided cooperation between interpreters and

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

In a chicken and egg situation, the camaraderie among ISMETT co-workers appeared to be both the reason for and the outcome of this successful co-production of interactions, given that mediated encounters were also occasions to build up team spirit by sharing laughs and small jokes; particularly during change-of-shift reports, irony and humour often helped exorcise the most unpleasant duties of the nursing profession. The language used in these cases was not technical at all, but rather featured slang expressions, metaphors, or puns; hence interpreters generally opted to act as faithful message relayers, transferring also tone of voice and register of the primary speakers. In addition, the LS members occasionally took off their interpreting hats to become a

source of amusement to the other co-workers through their own quips, although never to the detriment of a professional behaviour and rendition.

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

6. Discussion and conclusions

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

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

Against this background, the direct observation of participants, the interviews with the interpreters, and the corpus of authentic interactions in the empirical part of the study have served to further explore interpreting at multiple levels: more specifically,

from the negotiation of norms, to the ensuing acquisition of a specific 'corporate *habitus*' and its subsequent translation into the daily practice. On the one hand, the analysis of the interviews has shed light on the conscious behavioural regularities in the interpreting activities. Despite the differences in the educational and professional backgrounds of the respondents, the leitmotivs in their answers further exemplify the dimensions and constraints that are foregrounded in the earlier part of the study. Issues mainly centre around two closely related macro-areas, namely the privileged position of the LS as internal Department and the multifaceted nature of interpreting in the hospital. On the other hand, in the light of this twofold condition, the dispositions to act of the LS members, that is, their (somewhat unconscious) "*lex insita*" (Bourdieu 1990: 59), were taken into account in the transcript analysis.

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

that would hardly be granted to freelancers, as they are often perceived by their co-workers as members of the healthcare team; hence their professional profile can at times be defined as 'hybrid', given that it overlaps with that of the clinical personnel. Similarly, the *habitus* of ISMETT interpreters is to be viewed as 'hybrid' as well: it is not representative of interpreting or HCI as such, but its shifting contours are rather a function of the peculiar ISMETT microcosm in which it was developed.

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

Finally, by foregrounding peer-to-peer interactions, this study showed that interpreters play a crucial role in the medical field not only when they mediate between healthcare practitioners and their patients, but also among clinical staff members. As hinted at in the Introduction to this dissertation, only through effective communication

can medical co-workers “inspire each other” (Stack Kovach 2009: 29) and work as a cohesive team for the benefit of the ultimate goal of all their efforts: the patient.

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Appendix One: ISMETT Language Services Tips

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

Communicating with Patients and Family

1. **If you need an interpreter let us know in advance the event for which you require support**
   Tell the interpreter what you need to communicate to the patient/family member before the event. This helps us to prepare for the event and allows a more effective service.
2. **Communicate time/place of event**
   This allows the interpreter to arrive on site with accurate timing.
3. **Always introduce the interpreter to patients and family**
   Introducing the interpreter allows patients and families to immediately identify the people around them. This makes them feel more at ease. While you are talking to the patient/family member, the interpreter will position him/herself in the best place to allow the patient/family member to focus the attention on you throughout the conversation. It is also important you address the person directly (see next paragraph).
4. **Address the patient directly in first person: privilege the patient for your attention**
   If you are in a room with the interpreter, address patients directly in your own language as if they understood you fully. Remember the patient is the person you are communicating with, so keep your eyes and attention focused on him/her – not on the interpreter – despite the language barrier. The interpreter will generally translate using the first person. Occasionally, some explaining is appropriate and the interpreter will resort to the 3rd person (e.g. "s/he is saying that ….").

Communicating with Staff

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

An example:

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

A suggestion:

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

Meetings/In-Services

1. **Request in advance, communicate topics, forward us any available material**
   It is highly appreciated when you can inform the interpreter in advance about the meeting for which you require support. This is particularly important if you are the person holding the meeting or presenting the in-service. Communicate time/place, topics, presenting language and – if possible – the number of participants. In order to make the service more effective, forward any related material (presentation, handouts, etc.) to Language Services along with your request.
2. **Seat and positioning**
   Please follow the interpreter's indications on placing and seating. The position of participants is crucial for a good outcome of the meeting (it helps to hear the speaker, prevents distraction to others etc…). It also avoids the interpreter having difficulty hearing the speaker, heavy over-voicing and other distracting situations.
3. **Delivery of speech**
   Please make an effort to speak loudly, clearly, and at a moderate pace. At times, the interpreter may ask you to slow down or to speak up or might ask people to speak one at a time. Please understand this is by no means a form of disrespect towards you or the people who are attending the meeting. On the contrary, it allows us to perform a better service and facilitate improved communication.
4. **Interpreter's suggestions**
   You may at any time consult with an interpreter on how interpreting during an event should take place (headphones vs. over-voicing, etc.). We strongly recommend you follow these suggestions for a more effective service.

Written Translations

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

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

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

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

(Reviewed: March 2009)

Appendix Two: ISMETT policy on English proficiency standards for the clinical and administrative staff

Policy & Procedures Manual

For

Istituto Mediterraneo per i Trapianti e Terapie ad Alta Specializzazione

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

I. POLICY

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

II. GOAL

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

III. SCOPE OF APPLICATION

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

IV. PROCEDURE

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

    Skills are assessed through a mandatory English Proficiency Test.

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

3. ISMETT Language Services will differentiate course levels on the basis of test scores, in order to promote the successful outcome of the language proficiency test as

needed, and the achievement of predetermined language proficiency standards at corporate, departmental and individual levels.

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

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

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

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

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

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

Table 1

Area	Role	Test level
Administration & Support	Security Staff / Clerk	1
Administration & Support	Administrative Assistant / Unit Clerk / Switchboard Operator / Junior Administrative Clerk	2
Administration & Support	Administrative Specialist / Administrative Coordinator / Senior Administrative Clerk	3
Administration & Support	Department Head / Assistant to the director general and medical-scientific director	4
Clinical (not medical)	Aide/OSS	1
Clinical (not medical)	Nurse - Tech - Therapist – Dietitian	2
Clinical (not medical)	Nurse Educator – Clinical Coordinator - Biologist - Pharmacist – Psychologist	3

Appendix Three: Interviews with ISMETT interpreters

Interview schedule

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

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

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

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

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

Transcripts of the interviews

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

I-1 Christian

R Thank you very much for taking part in this interview, which is an integral part of my PhD research project.
C You are welcome.
R The interview will be recorded and then transcribed, but I can assure you that you will remain completely anonymous.
C Okay.
R It will be carried out in English, but please feel free to switch to Italian at any time, especially if you think that this might help you to make your point clearer, okay?
C Okay.
R First of all, what can you tell me about your personal and educational background?
C Well, strangely enough, my educational background is basically a degree in Architecture. I finished my studies in 1997 and after two years of working as a freelance architect, for a series of coincidences, I heard about ISMETT, because my sister was working here and she told me that they were looking for people bilingual and who spoke good English. As I was not making much money as an architect, I decided to give it a try and eventually I was hired as a consultant for just over a year and then my position was turned into a no-term position. And I have been here ever since, which is roughly eight years now. Which makes it kind of strange, because I have always thought of myself as something else, either a musician or then, eventually, an architect, and then turned out to be something quite different altogether. So I had to really learn this new job. I did do some translations in the past, but never so technical as the ones that we do here. I had to learn to be an interpreter, which I still have not learnt, but I am doing my best.
R How come that you speak both Italian and English?
C Because I was lucky enough to have an English mother and I was born in London, England, and raised by my mother who always spoke English to me and my sister, despite the fact that we were brought up here in Palermo. So I have heard English since I was a very small kid, a baby, basically, and then Italian growing up in Italy. So I quickly became bilingual, with perfectly no effort, which is something I should be doing with my kids, but I am not, because I have two very small kids and all my situation is different, because the mother is Italian and she spends most of the time with them. But it is obvious to me that I should make the effort and talk to them in English.
R So you said you started working at ISMETT in 1999.
C I started in 1999, yes.
R Okay. And you have already told me that you had no previous similar professional experience, and that you were trained on the job. Let's focus on this on-the-job training. So, how was it carried out?
C Well, I was lucky enough to be one of the first people to actually be part of the team which is the Language Services. Initially there was just myself and my then boss. I was lucky enough because he was a very talented person in his field. He basically taught me everything, because I remember it was just himself, he was alone and I came here, then a couple of other people came after me, but afterwards just maybe another person. So I learned everything from him, which is something I have never

told him, but I should be grateful, because I have never done interpreting in my life, let alone going into an interpreting booth, or doing simultaneous interpretation, which is something I feared very much. I never thought I could to it. But watching him and trying a little at a time basically made me gradually more and more confident. Again, I am still not a hundred percent confident, but I do things now which I never thought I would do, like the things we do here. So it is thanks to him that I learnt everything within the scope of this job.

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

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

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

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

R Well, talking about medical interpreting.

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

education material, so it was not easy, I had to learn a lot, a lot in terms of terminology.

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

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

R Or what helps?

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

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

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

R Do you have any preference?

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

[37] The Italian for 'note-taking'.

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

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

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

R Does this create problems among staff members?

C Oh, yes, occasionally.

R Maybe at the beginning?

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

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

C The style? That is an awfully difficult question. The style… I do not know. I can tell a good interpreter from a bad one, now, and the style, I should say, is in the choice of the words you use and in the ability of adjusting your register to the situation you find yourself in, to adopt certain words, certain terminology based on the context, on the people you have in front of you. That is, to make a stupid example, to use simple words if you, obviously, are in front of a family of not terribly well-educated people, I would choose some words; if I am in a consult between physicians I would use others, because I have the ability – thank God – to do so, I have a wide enough vocabulary in Italian certainly, in English mostly, to be able to adjust. In this setting, in this particular setting, I think that is probably the most difficult thing, otherwise it sounds strange to the ear if you are using too pompous words in a more down-to-earth setting. So, yes, the choice of words, and, obviously, the setting, how you place yourself between the two parties, and the way you stand, you sit, the choice of positioning, as I said, lots, lots of things, which, by now, I can tell if they are a correct choice or if the interpreter is making mistakes. But again, this is restricted to this particular

environment: I have by no means any general knowledge of interpreting as a general profession. My experience is quite limited to this, so my answers should be taken for what they are.

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

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

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

C Any aspects of what I do here?

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

C I cannot think of anything...

R Okay, thank you.

C You are welcome.

I-2 Dario

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

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

R When did you start working at ISMETT?

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

R Why did you apply at ISMETT?

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

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

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

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

D Yes, sure.

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

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

But it was quite exciting. My first impact was very… I was really interested in this experience.

R You said that you were already a professional interpreter, right?

D Yes.

R So you were not trained on the job.

D No, no.

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

D At ISMETT?

R Yes.

D It is hard to say now, because nine years later everything seems to be like normal now. So I should go back and think…

R I do not know: language issues, technical issues, interpersonal issues, emotional ones?

D Probably, the fact that… I mean, in any field there are language issues, in any field: if you deal with lawyers, for sure there are words that you have to study beforehand, if you deal with, I do not know, port engineering, I am sure that probably language problems are even worse, because in medical English they come from Latin, so probably it is less difficult than in other fields. Maybe the most difficult thing was to have the other staff understand what the role of an interpreter is. So, everybody else at ISMETT took for granted that since you are an interpreter, since you are ISMETT staff, you have to be ready any minute. So they would call you thirty seconds before the event and they would expect that you know how to deal with that event. Well, we know that that is not always true, I think. Very often you do not know what the situation is going to be, what the topic is going to be, so this is probably the most challenging thing. I am not talking about myself, but about the whole Department. And, in fact, a Service Level Agreement was discussed for several years because we wanted to make it clear that there should be some standards to use our services. That was probably the most difficult thing. Not language issues, just the work organization. It was total chaos at the beginning, total chaos.

R What can you tell me about the variety of settings and participants in the medical events?

D Events?

R I am talking about medical interpreting in the broadest sense, so doctor-patient interviews, nursing reports, medical meetings, or conferences. Does this variety affect the interpreting activity? And if so, in what way, in your opinion?

D I do not think that the variety affected. Actually, the variety probably allowed us to become more familiar with all the aspects of the medical care that was being provided at ISMETT. So, if you were aware of some aspects, you could use those aspects even in different situations. For instance, if you knew the psychological background of a patient from a previous event, and then you had to deal between a surgeon and the same patient, maybe you could use the psychological background that you had acquired on that patient. So… No, I do not think that was difficult.

R Do you think that you have to use different strategies according to the setting?

D Well, sure, that is for sure. As we know, it depends, first of all, on the number of participants, and the situations vary, so that was an issue. Stressful conditions, clearly, that was also an issue: sometimes you had to deal with urgent conditions, like patients being intubated immediately, or with the need of a defibrillator, so things in which there is even no time to think, so even without a language barrier, even between two people speaking the same language, there would be no time to speak. They just have to act and this is why there are protocols, there are policies, there are regulations already, and people practice these situations in order for them to be ready to act without speaking in those situations. So just imagine somebody who has to translate. So, yes, for sure a situation like that would oblige the interpreter to use some kind of

strategy, which I do not think can follow any rule, it is just instinct. But of course, regarding strategies, there are strategies to translate. In the medical field at ISMETT you can work in a conference, you can work in a medical meeting, in meetings between peers, between physicians, and on that occasion you would use a strategy. Then you can have an exchange between a doctor and a patient, and the strategies would be totally different. So, yes, for sure, variety did not imply, in my opinion, any difficulty, but it implied for sure different strategies.

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

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

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

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

R What do you mean?

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

R Not the patient, but the interpreter?

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

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

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

R So, you mean that style is like accuracy?

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

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

D Well, based on what I have just said in this respect, I probably sometimes tend to translate too much, meaning that I never try to be myself when I translate. I am just trying to disappear as much as possible**.** But, with regard to other aspects of style, I need to know what you mean by style.

R I do not know yet, so that is why I am asking!
D Okay, we can also define style as trying to keep the same register as the speaker, so if the speaker is calm, the interpreter should be calm, if the speaker is speaking in a loud voice, then the interpreter should probably speak in a loud voice, with respect, and so on! Also, not just relaying the message, but also the way all the message is reported is really important, and the way should reflect the speaker's way, so that is also part of style, I guess.
R Thank you very much. That was it. Would you like to add anything else?
D No, not really.

I-3 Eric

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

E Okay.

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

E What do you mean?

R When, how, why did you apply…

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

R When was that?

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

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

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

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

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

R Especially in the medical field?

E Especially in the medical field, yes.

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

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

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

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

R Okay. And this helped here at ISMETT…

E Yes, it certainly helped. Actually, it was probably my only real asset as an interpreter. I had cross-cultural experiences in general, so I did have other assets that have nothing to do with languages *per se*, but my biggest asset was my bilingualism and that is what really allowed me to get the job, I think. Of course, I had also other experiences: I have published a book and some articles both in English and Italian, I think that interested the recruiters at the time, but my knowledge of both English and Italian certainly made the difference.

R Okay. Going back to the activity at ISMETT, what can you tell me about your first impact with medical interpreting?

E Interpreting or translating?

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

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

R You had no emotional issues or interpersonal issues…

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

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

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

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

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

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

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

R Anything else that you would like to mention? Anything else you can think of?

E Nothing in particular comes to my mind at the moment. I probably take for granted a lot of things that do not come to mind at the moment.

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

E Between the Language Services and the US staff?

R And the Italian staff.

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

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

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

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

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

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

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

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

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

R Just one thing. You mentioned again strategies: are you referring to the ones you mentioned before, like trying to explain a term that you do not know or asking, or are you referring to other strategies?

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

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

E Not particularly.

R Okay. Thank you.

E You are welcome.

I-4 Francesca

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

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

R When was that?

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

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

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

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

F Yes, my very first.

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

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

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

F Yes.

R So you were trained on the job?

F Yes.

R What can you tell me about it?

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

R In what sense?

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

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

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

R And what about terminology, language issues?

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

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

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

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

F You mean between the two different countries?

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

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

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

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

R I do not know either, so I would like you to tell me! I would like to find out whether it is possible to talk about the style of an interpreter, if each interpreter has his or her own peculiar style or not, so I would like to have your opinion.

F I think so. We have sort of guidelines we need to follow, we try to be able to do the same things. I mean, that is the goal: every single member of the Department should be able to do the same things as the others. Actually, of course, there are people who are more structured – I do not know how to say… In this particular environment I think everybody has a personal style, which is based maybe on personality, first of all. I can tell everybody has a personal way of working in the environment. The goal is to transmit the faithful message, and then everybody has his way of doing it.

R And how would you describe your interpreting style?

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

R Okay. Thank you very much!

F You are welcome! It was a pleasure!

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

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

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

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

I-5 Georgia

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

G For interpreting, as in interpretation, right, that was my first ever experience. I had never verbally interpreted anything for anyone. I had worked on translation, such as the handbooks. I translated a couple of handbooks, and they were for a company called Amplifon, the hearing aid company. So it was fairly technical. And another handbook was also about information technology, but I cannot remember whom that one was for. And then I translated a website, it was a website about Sicily and all the touristic places one could visit, so to speak. But that was the limit, the extent of my experience, so I had never done anything else, really.

R So how did you become an interpreter?

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

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

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

R What do you mean by 'set up'?

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

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

G Yes, that was one of the main obstacles, and not during the first year, but during the first years. I mean, it is a never-ending process anyway. I do not know every single medical term today, I know the terms that I need to work. But, even today, every time they add a new program to the list of ISMETT programs, there is always something new to go study and learn. When they started adding the cardiac program, the heart

transplant program, there was something else to learn; they added the lung transplant program… Who knew anything about the anatomy of the lung? We did not! So it is an ongoing process, really! That was the far most greatest obstacle ever.

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

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

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

G Impossible!

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

G Medical terminology?

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

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

R Yes.

G Be flexible, as flexible as possible. Be prepared for everything and anything. And if you think about it, you really cannot be prepared for everything. I am talking about being mentally ready for it, you know. You do not know what is going to hit you and when it is going to hit you. As long as you do not fear it, you know, and just realize: "This is part of the daily activities of this hospital, and I am here to help them go smoother, so do not panic!". That is also very important: not to panic! I am a very relaxed person: I can get very stressed-out when the workload is too much, but then, when there is a crisis or difficult situations, I become automatically very relaxed,

because otherwise I cannot think. As long as you can keep your cool, I think that is like one of the most important tools for working at ISMETT. Keep your cool, be flexible, and be prepared, mentally ready to understand, because anything can happen, you just do not know what every day is going to bring you. You do not know.

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

G Yes, definitely stress management.

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

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

R Yeah, sure: from your point of view.

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

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

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

R You are talking about consecutive interpreting.

G Yes, I would probably fall asleep! I am not saying it doubles the time, but at least it becomes a time and a half, and as there is so much work to do, and so many translations to get to, I do not have that kind of time to spare. I do not. Plus it just

annoys me when I start thinking about how much time I am wasting doing the short consecutive technique, whereas I could be whispering and saving everybody's time!

R Sometimes, for instance, the clients do not like the headphones...

G I really do not care.

R ... or just the fact of hearing the two voices at the same time. You do not care?

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

R What is the most challenging aspect of being a medical interpreter at ISMETT?

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

R Just a couple of questions about the cultural aspects at ISMETT. In your opinion, what are the relations of the LS Department with the US and with the Italian staff?

G Again, am I supposed to be speaking for the overall Department or for myself?

R No, no. Your opinions, for yourself.

G Well, that I know of, each one of us has very good relationships with both Italian and American staff. I mean, the Italian staff sees us every day, and most of them have worked with us by their side, so there are strong bonds there. As for the American staff, we have known them for sure for periods of time, but they rely on us so much, they depend on us so much, that the bond goes strong in a short amount of time, but just there is more intensity there. So, from what I have experienced myself and from what I have seen, you know, watching my colleagues, the relationship is really good with both sides. Yet there have been problems when both sides were face to face and the interpreter in the middle, we have all been there. I actually find that quite amusing, you know, like the conflict between the US staff and the Italian staff, that is like a

refresher during the day to me, because I belong to both cultures, I have personally experienced both cultures, and habits, and ways of life, and when I see them conflicting – you know, Italian nurses versus American nurses and vice versa – I actually have a chuckle, I laugh, because I perfectly understand what is supporting the American mentality, what is in the back of their heads, and what is supporting the Italian mentality! So, you know, thank God I am not the kind of person... I am not intimidated by conflict, I am not – especially other people's conflict. You know, I am just the kind of person who likes watching, and of course we cannot just let things get out of hand. I have found it very easy to intervene in cultural conflict, maybe because – now that I am thinking about it – maybe it is because I know both sides.

R So there are conflicts...

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

R Before moving to the very last part of the interview, I wanted to ask you something which is not scheduled. You hardly mentioned any emotional issues, when we were

talking about being a medical interpreter: is it because at the moment we are no longer working with patients, so that did not come to your mind?

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

R It is perfectly clear.

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

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

G Style as in what style?

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

G Well, no, not so focused on it, no. What I can say is that I do not like... I like it when an interpreter has personality... Okay, wait, that is difficult to explain, like... I hate monotone interpreters, you know, like... I do not know how to explain this... I have a very bubbly personality, okay, so first of all, if I am interpreting for somebody, I will make sure that the tone and the volume of my voice and my body language reflect that person's body language and tone, because I just feel that that makes the message more complete. Sometimes, what I do have a hard time with is my attitude and my personality, because I can become very bubbly, and, you know, I live out of pure adrenaline and sometimes... I do not think I overdue it, but I actually fear the possibility of overdoing it. But then, when I look at the customers, the audience, it is nice, because everybody is smiling and everybody is relaxed, so I do not know if you

can define that style, or not. Maybe yes, maybe no. Here at ISMETT there is also another thing to say: I, my colleagues, we are allowed a certain degree of freedom of action, so to speak, you know. If there are outsiders, or depending on which physician is involved in the interaction, of course I am going to behave in one way, be extremely professional, go by the book, not make a single mistake, because that is the way it should be. But it is also true... Let's say there is a meeting among nurses, where the whole environment is a lot more relaxed, you know everybody on a personal basis. You know, it has happened before to make comments in the microphone, or to joke with them, because they actually involve you, they involve the interpreter as an active part of the interaction. Now, can you call that style? I do not know. Is that kind of my imprinting, my signature, or my colleagues' signature? I have no idea. I have never given the concept of style that kind of specific thought.

R So you mentioned tone, volume of voice...

G Yes, the volume is important.

R But then you added that, in your opinion, the style of the same interpreter can change, according to the setting?

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

R So that is your interpreting style: have fun if possible.

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

R Okay, so thank you very much for helping me...

G You are very welcome!

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

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

I-6 Henry

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

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

R When was that?

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

R Okay. So why did you apply, basically?

H A new experience.

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

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

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

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

R After your university education?

H Mhm.

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

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

R In what sense easier?

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

R So it is less pressing working here.

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

R So, I think you have already answered my next question, that your first impact with medical interpreting was quite good. Is that what you are saying?

H Well, I mean, as I was saying, once you learn the jargon, it is always the same. And, of course, like in every other field, there are always new words that pop up, but then, of course, if you are a good translator, a good interpreter, you know how to do your job, you know how to find what you are looking for. That's it.

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

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

R You were overwhelming?

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

R At the beginning, you mean?

H Yeah, by our former Chief.

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

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

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

H I do not know… Probably, the most challenging part was actually years ago. They had the terribly bad habit of wanting an interpreter at the lectures, so they would just call upstairs: "We need an interpreter". So take the headphones, take the microphones, go downstairs, without having any material, and just having to translate straightaway with the room full of physicians who anyway do understand some English. It is more like the pressure, the scrutiny of those listening to you. I mean, if you work in the field, you understand how difficult it is: they call you in, you do not have any prior knowledge, you have not had any chance to study, to do any research, or whatever, but then whoever is listening to you expects that you come up with a perfectly suitable

and appropriate translation, which is not always the case. So you are there, trying to do your best, and… I mean, that was a bit… There was a lot of pressure on those occasions. But those days are now sort of gone, things are much more consolidated, the whole machinery, the whole mechanism is well-oiled, and it is running smoothly.

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

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

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

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

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

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

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

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

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

H Well, I mean, it has always been good, but then there is always this sort of competition. They do not do it deliberately, but there is a sort of competition, so the Americans, of course, can rely on their better technology, better organization, and so on, they are very professional. From a certain point of view they are more professional

because they are more serious. Whereas Italians, I mean, they have got a more complete, more comprehensive training, they are better at improvising, but, in general, they make a lot of confusion, basically. So it is this sort of competition where you actually need both at times. So I think the real problem is managing the advantages and disadvantages of both, trying to strike the right balance.

R Before moving to the next question of the questionnaire, let me ask you another thing: to be, let's say, a good interpreter at ISMETT, what are the main features of an interpreter?

H Versatility, of course: you have to be flexible, proactive, you have to be open… I think those are the main features.

R To conclude, let's talk about a particular concept: interpreting style. In your opinion, what makes the style of an interpreter?

H Well, I can talk to you about my own style, and what I have been able to see…

R That was the next question, so no problem!

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

R But from which point of view? You said that every interpreter has a personal style, but what does this style imply? How can you describe the style of an interpreter?

H There are those who get more carried away when they are translating, they are more vigorous; there are others who are calmer in their enunciation, while they are speaking, they have an even tone; there are others who are like more vigorous, more forceful; there are some who listen more, who have a longer *décalage*, others who prefer sticking closer to the speaker.

R So you mentioned like, let's say, tone of voice, or elocution…

H Yeah.

R ... and you also mentioned something more technical, the *décalage*. So you think that these are some of the features.

H I mean, what someone can actually see, perceive, when you are working with an interpreter: the style basically goes down to that, I mean, whether someone has a more monotonous tone, someone who has a more lively tone, someone who is like on top of the speaker, someone who is like more relaxed and, you know, waits a bit more before speaking…

R What about your interpreting style?

H I am like a bulldog.

R What does it mean?

H I bite the text and I stick to it!

R Do you mean you are aggressive or precise?

H Rather aggressive. Well, precise… I mean, precision…

R No, no, to understand what you meant.

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

R I mentioned that just because I wanted to understand what you meant by being a bulldog and biting the text.

H It is like throwing a bone to a bulldog, and it starts chewing and playing with it, and it does not give up.

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

215 H No, not really.

R Okay.

I-7 Italo

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

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

R So which year was that?

I It was in the summer 2004.

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

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

R But have you ever worked as a medical interpreter?

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

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

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

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

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

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

I I have to say that you get used after a while. At first it is very difficult because you are not prepared, you are not a doctor, so at first it is very difficult having to deal with

very sick patients. But then you kind of get used to deal with your emotions, even if it is still difficult sometimes, but with time you get used to being in a hospital.

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

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

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

I The key features…

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

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

R Do you mean from a technical point of view?

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

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

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

R In what terms?

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

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

I The most challenging… I would say medical conferences, because medical conferences, especially those organized by our hospital, are very technical, so you need to be very well prepared for all the conferences. I would say that medical conferences are the most challenging, because of the difficulty of the level of the interpreting, and also because the conferences are attended by a variety of people and

physicians from all over the world, especially physicians that do not know you and rely on you to understand, and also because of the technical level and difficulty of all the conferences. In all the conferences that I interpreted for, the level, the difficulty was very high, so this makes it very challenging.

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

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

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

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

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

I The style of an interpreter?

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

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

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

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

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

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

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

I Yeah, I would like to stress the fact that at ISMETT we work as a team, so we, as a Department, we are not seen, most of the time, as individuals, but as a Department, and we do great teamwork. Even talking widely, at ISMETT it is very nice that, even though we do not have a medical background, we are not nurses, we are not physicians, we are very well integrated in the clinical setting, and we are seen as a part of the clinical staff in that sense. Even though we deal with the linguistic aspect, we are seen as part of the clinical team, and that is very nice.

R Okay, thank you.

I You are welcome.

Appendix Four: Recording authorization form

AUTORIZZAZIONE ALLA REGISTRAZIONE

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

Firma Palermo,

AUTHORIZATION TO RECORD

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

Signature Palermo,

Appendix Five: Transcription key

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

Fillers		Meaning
English	*Italian*	
umm	umm	doubt
ah	ah; eh	emphasis
mhm	mhm	expression or request of agreement
nah	nah	negation
eh	eh	query
uh	ehm	staller
oh	oh	surprise

Abbreviations**	Meaning	
EI	Eleonora Iacono	(second researcher)
I	interpreter	
INF	Italian nurse	(from the Italian *infermiere*, nurse)
N	US nurse	
SO	Simona Orefice	(second researcher)

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

** If, within the same transcript, there is more than one speaker in the same professional capacity (e.g. two or more Italian nurses), abbreviations are followed by consecutive numbers (e.g. INF, INF_1, INF_2, etc.).

Appendix Six: Transcripts

Nursing assessments

NA.FL

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

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

I ha disa:gi::: disturbi::
((the patient shakes his head)) ((background voices))
N °okay° (.) any difficulties breathing
I ha difficoltà a respirare
P no no le dica che sono un trapiantato io di fegato
I he's a liver transplant °to say the truth°
N oh he i:s↑ how many years ago
I da quanti anni
P cinque anni
I five=
N =cinqu[o]↑
P Marsiglia
I in Marsiglia °in France°
N *((enthusiastically))* oh in France↑ in Marseille okay (.) why did he go to France↑ [*((laugh))*
I [perché è andato in Francia
P perché allora qua:: s – non c'era l'ismett
I because at those times ismett=
N =ismett=
I =did not exist=
N =did not exist right right >I was gonna say when we are so good why did he go to France< *((laugh))* okay may I look at his chest↑
I può:: dare un'occhiata al:: suo [petto↑
P [°sì°=
N =grazie
((pause)) ((the patient unbuttons the top of his pyjamas; the incision is visible on his abdomen))
N *((enthusiastically))* beautiful incision
I una bellissima incisio::ne °dice°
N I would like to listen if I may
I può:: auscultarla↑
P *sì*
N okay >if you would ask him< to take a deep breath
I faccia un respiro profondo
((pause)) ((the nurse listens to the patient's chest)) ((background voices))
N oka::y (.) I would like to listen back here if I may (.) *((making the patient bend slightly forward))* another deep breath
I profondo↑
((pause)) ((the nurse listens to the patient's back)) ((background voices))
N °okay° is he a cigarette smoker↑
I lei fuma↑
P poco
I >a bit<=
N =un poco↑ (.) how many cigarettes [a day]
I [quante] sigarette al giorno
P u::mm dieci
I ten↑
N >ten okay< (.) may I listen to his belly↑
I può ascoltarle la pa::ncia↑
P *((amused))* sì sì *((soft chuckle))*
((pause)) ((the nurse listens to the patient's abdomen))
P non sono incinto (.) sicuro

N [°perfetto°
I *((smiling))* he's not] pregnant (.) [that's for sure
P [*((wholehearted laugh))*
N *((smiling))* does he have regular bowel movements↑
I va di corpo regolarmente↑=
P =sì sì
N and does he have any difficulty (.) urinating
I ha difficoltà a urinare↑
P no no
N °okay° (.) °oka:y° does he take any medici::ne u::h
I prende farmaci↑
P >sì< il prograf (.) antirigetto
N ah sì sì sì=
P =e una pi[n:][u]la=
N =tacrolimus↑
P mhm e una pinnula=
I =*prograf*
N prograf↑ °okay°=
P =e:::
N tacrolimus °mhm mhm°
P e una:: pinn – tre quarti di pi[n:][u]la per la pressione
I a:nd three quarters of a pill for (.) for pressure °for arterial
N [pressure°] for his] blood pressure↑
I >yeah<
((pause)) ((the nurse checks the patient's pulse))
N *((enthusiastically))* he has wonderful pulses
I i battiti sono:::
P °( )°=
I =>°splendidi°< (.) °le pulsazioni°
N and his belly has lots of good gurgles
I e nella pancia ci sono dei bei gorgoglii
P che si – ci sono↑
I ^bei gorgoglii^ [°ha detto°
N [*((laugh))*
P ah sì sì (.) [abbastanza=
N [and I would like to –
P =la notte [sembra che parla
N [*((laugh))*
I at night
P *((laugh))* [*((laugh))*
N [it keeps him awake] *((laugh))*
I *((amused))* it speaks
((laughs))
N >it speaks to him< uh (.) I would just like to measure his oxygen saturation and his pulse rate
I adesso le misura la:: saturazione d'ossigeno e il polso
((pause)) ((the nurse measures oxygen saturation; piercing, intermittent sound of the machine))
N °(ninety)° it's (very) slo::w↑
((long pause)) ((the nurse measures the pulse rate)) ((background voices))
N °>okay< fifty six that's not bad° and if I ma:::y I would like to check his blood pressure↑

I cinquantasei >non è male< adesso:: vorrebbe misurarle la pressione
((pause)) ((the nurse starts to prepare the blood pressure equipment))
P l'avrò alta
I it's certainly high
P perché non ho preso la pillola
I because he didn't take the pill
N oh >it's gonna be up [a little bit he thinks<
I [yeah
N let me just write this down before I forget *((leaving the room)) ((voice fading out))* because you know I have no brain↑
((pause)) ((interpreter and researcher remain in the room with the patient))
P *((to the interpreter))* il cuscino ancora non lo porta↑
I ah il cuscino↑ >aspetta il cuscino↑< °giustamente° (.) ora glielo dico
((short pause)) ((the nurse returns to the room, but she stops on the threshold reading the patient's medical record))
P [me l'ha detto la signorina]
I [°( )] (un minuto libero)°=
P sì si vede [che ha –]
I [^he's still] waiting for [his pillow^]
P [ha avuto] da fare
N *((getting closer to the patient))* oh (.) we don't have any I have to find (.) the au[ks]ilia:rio=
I =oh=
N =to get you one because
I [we have *none* *((laugh))* / m::hm mhm really↑ *((to the patient))* non ne hanno] deve trovare un ausilia:rio che gliene:: >procuri uno<
N I'm very sorry tell him *((laugh))*
I le dispiace molto
N I looked in – tell him I went a:ll the way >to the end of the unit< I looked in *every* room
I ho cercato in tutte le [sta:nze]
N [unless] I was to *steal* one there is no way I could get one *((laugh))* >steal one from another patient<
I pote – poteva soltanto [rubarne uno a un altro pazie:nte]
N [*((laugh))*] and I know he wouldn't want me to do that
P no:
I [°non sarebbe stato (carino) farlo°]
N [*((laugh))*]
((pause))
N >you know what↑<
((pause)) ((the nurse prepares the blood pressure equipment))
N has he had cardiac catheterization >or what<
I ha avuto la catete – ha fatto la cateterizzazione cardi:aca↑
((sound of the blood pressure cuff being inflated))
P °no°
((sound of the blood pressure cuff being inflated))
((long pause)) ((the nurse measures the patient's blood pressure)) ((background voices))
N *((removing the blood pressure cuff))* okay his pressure is one sixty over eighty >which is not bad considering he didn't take his medicine<

I la pressione è centosessanta su ottant – su ottanta (.) non è male considerato che non ha preso:: la pillola
((pause)) ((the nurse puts the blood pressure equipment away))
N °okay now if I just° (.) °may check his° (.) temperature >did I check your temperature just now↑<
I le ha misurato la temperatura↑=
N =no=
P =no=
N =no I didn't °no°
((pause)) ((the nurse takes the thermometer))
N >°( ) this°< under – under his tongue
I >sotto la lingua< °lo metta°=
N =yeah
((the patient opens his mouth and the nurse sticks the thermometer tip into it))
N °sopra li:ngua°
I *sotto*
N *sotto* li:ngua (.) °sì° (.) *((to the interpreter))* ┌ sotto=
I └ under
N =is low yeah ┌ sotto=
I └ °under°
N =sotto voce is low voice↑ *((the interpreter nods))* sì
((pause))
N tell him while we are (throu::gh) u::h (.) >the reason I was asking about the catheterization is that he has a< *small* incision there *((pointing at the elbow fold))* and >I thought maybe< (.) u::h
I le ha chiesto della cateterizzazione perché siccome ha un'incisione qua: *((pointing at the elbow fold))* (.) *((high-pitched sound of the thermometer)) ((the nurse removes the thermometer))* pensava che potesse °essere questo°=
N =*((enthusiastically))* >his temperature is thirty six point seven↑< (.) which is perfect↑
I temperatura trentasei e sette=
P =eh mi – mi hanno fatto: (.) la scintigrafi:a la tac::[e]
I he had ┌ a C T scan a scintiscan
P └ un (piccolo) sforzo fisico::
N °m::hm°=
I =the:: test
P >ma più di un (mia)< (.) più di un mese
I one month ago (.) >he had C T scan and scintiscan<
N I see I see (.) u::h (.) would you tell him please {Barbara} that I will need to put in a couple of *small* catheters (.) for intravenous fluids antibiotics whatever he may need
((an Italian nurse enters the room and approaches the US colleague))
I dovrà inserire un paio di cateteri=
N =*((to the Italian nurse))* hi ┌ {Ilaria} ┐
I └ pe::r ┘ (.) l'infusione di
INF ┌ antibio::tici o di liquidi=
└ *((to the US nurse))* E K G:: done↑
I ┌ °di cui può avere bisogno° ┐
= │ │
N └ *((to the Italian nurse))* on this ┘ one↑ no::: >we'll do it< (.)
((background voices)) >we'll do it *right* now< adesso=
INF =*((to the US nurse))* e:::hm (.) before O R

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

((the Italian nurse is about to leave the room))

N *((to the interpreter))* ^ask {Ilaria}^ if he's going to surgery today

((pause)) ((the Italian nurse comes back))

I *((to the Italian nurse))* vai da –

INF *((to the interpreter))* no:: >gli ho detto che deve fare l'elettrocardiogramma< o:ra (.) °lo sto dicendo ora° (.) °okay↑°

((the Italian nurse leaves the room))

N *((to the interpreter))* >°what did she say°<=

I =he – she told him that he's supposed to do an E K G now

N *((to the interpreter))* °o:h° (.) yeah but she told *me* before O R and I wanted you to ask her if he was going to surgery today she – she didn't say↑

I °u::mm no no she didn't°

N go ask if he's going to surgery today

I °later°

N >okay< uh I would like him then to u::h *((looking at the tape recorder))* >are we finished recording no we're recording< I would like him then to come and lie on the bed so I can do the E K G

I adesso se si può distendere a le:tto↑ così (.) fa l'elettrocardiogramma

N *((sorrowful))* and I'm so sorry we don't have a pillow

I e si scusa – >le dispiace molto< [per il °cuscino°]

N [*((laugh))*] *((laugh))* a:::h (.) and he needs to take off hi:s uh (.) actually if I could give him a camic[i:] (.) ^actually^ if you – >if he could come over here and I could weigh (him)<

I se viene [qua la pesa

N [then I'll get him a gown

I e poi le dà un camice

((the nurse moves the scales)) ((piercing sound)) ((the interpreter leaves the room to look for the Italian nurse))

N *((moving the scales))* ah (.) so:: (.) °too much°

((long pause)) ((sequence of piercing sounds))

((the interpreter returns to the room))

I so he needs to have an E K G now [( )]

N [(instead)] (of getting directly) to the surgery=

I = yes (.) [he's going=

N [when he's going↑

I =this afternoon=

N =oka::y (.) °I understand°

((pause)) ((long, piercing sound)) ((the patient stands up on the scales))

N °all right° so: am I able to read this from the (back) no *((moving to the front of the scales))* so that's seventy:: so it's gonna be like seventy three [point –

P [settantaquattro] e °cinquecento°

((the patient gets off the scales and goes back to his chair))

N seventy three point one eh↑

I [settantatré e uno fa

N [seventy three point one] (.) *((writing down))* °seventy three point one kilos° okay and now we'll get the E K G

I adesso facciamo l'elettrocardiogramma=
N =*((leaving the room))* I'll get you a clean gown
I le porta un ca:mice↑
((pause)) ((interpreter and researcher remain in the room with the patient)) ((background voices))
P ma non è che mi devono operare
I oggi pomeriggio↑
P ma mi devono fare solo una puntura
I sì ma in sala operatoria
((pause))
I magari comunque per la ( ) –
((interruption in the recording)) ((interpreter and researcher leave the room and then come back with the US nurse))
P ( )
I >uh< is he supposed to take his (.) pyjama off↑
N please
I sì
P (mi [leo]) il pigiama↑
N sì=
I =sì (.) °noi ci spostiamo di là° *((interpreter and researcher are about to move))*
N and *ma::ybe* >if he could put it on< this way *((pointing at the back))* ( )
I *((going back next to the patient))* mettendoselo:: (.) [di spalle
N [put it on
((showing how to wear the gown)) this way↑=
I =così vede↑
N just for a moment↑ like this↑=
P =°okay°
I per un attimo
((long pause)) ((the patient wears the gown)) ((piercing sounds in the distance))
N °can he just lie down a little bit°
I può coricarsi↑=
N =°andiamo a letto°
((pause)) ((the patient tries to tie the gown))
N I – I'll tie this *((pointing at the gown))* after I get the E K G *((laugh))* °okay↑°
P ci pensa dopo↑=
I =dopo l'elettrocardiogramma lo:: rile:ga °dice° (.) lo °riallaccia°
((pause)) ((background voices and sounds))
N >okay<

Nursing reports

NR.FL.01

Typology	End-of-shift nursing report (reported cases: 3 out of 4)		
Place	ISMETT regular admission unit (Floor)		
Date	January 22, 2006		
Time	2:00 p.m.		
Duration	00:18:34		
Interpreter	Dario		I
Primary speakers	Incoming nurse, Italian	(female, aged 31-35)	INF
	Nurse, Italian	(female, aged 26-30)	INF1
	Outgoing nurse, US	(female, aged 51-55)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station, while the interpreter, who is initially standing, sits down between them as soon as the interaction begins. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical records and patient Kardex sheets. ▪ At some point, another Italian nurse who needs to take report from the US colleague comes and sits down near them waiting for her turn.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive/whispering		

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

N [who↑
INF [{Porrato}
N *((puzzled))* who °she wanna start (with)↑°=
I =°mister° *{Porrato}* (.) >it should be one of yours<
((pause)) ((the US nurse checks her notes))
N you wan – you don't want to start with (.) {Patenno} eh↑ (.)
I [do you want to start with {Patenno}↑] [vuoi cominciare con *{Patenna}*] o *{Patenno}*
INF ma non è mio {Patenno} *((chuckle))*
I that's not [°her patient°]
N [oh that's] not yours↑ oh okay all right (.) okay
INF [>then you have the other four<] [deve darglielo::] forse a {Irene}=
N =you don't have [all my people then]
I [maybe {Irene:}] is the nurse °who needs to get the other report°
N you don't have all my people then (.) I don't have them=
I =no allora forse sono diversi perché quelli non ce li ha lei
N °that one° *((pointing at one patient's medical record and shaking her head))* [nah nah]
I [questo non] ce l'ha↑
N °nah°=
INF =e infatti [*{Porta}*=]
N [nah]
INF =me lo deve dare {Ivo}
I yeah {Porta} [is::::]
INF [e gli] altri lei
I °she needs to get report [on him°=]
N [good okay]
I =°from [*{Ivo}*°]
INF [okay]
N okay
INF [{Porrato}]
N [okay {Piero}] {Porrato} (.) {six eighteen}
I {seicentodiciotto}
INF okay=
N =on {three} {nineteenth} (.) donated the right lobe (.) liver=
I =il {diciannove} ha:: donato la parte destra del fegato
INF {Porrato} è donatore↑
I so he is a donor
N *((nodding))* he is a donor=
I =sì
INF *((looking at the Kardex))* cos'ha donato↑
I *((whispering))* °lo – lobo destro del fegato° (.)
INF [*((to the US nurse))* right lobe=] [okay]
I =of the liver right↑
N *((nodding))* mhm
INF mhm (.) okay
N okay↑ regular diet (.) according to that *((pointing at the Kardex))* he is allergic

I [to an antibiotic but they don't know – they don't know what kind]
[seco::ndo questo è allergico a un antibiotico però non *sa*]
quale °antibiotico°
INF okay
N okay↑ (.) u:h (.) *he is* (.) neurologically intact
I *((whispering))* °neurologico intatto°
N he gets up in the chair without assist
I sta:: si mette da solo sulla se::dia (.) °senza bisogno di aiu::to°
N independent
I °è indipendente°
N mhm uh::
I *((ironically))* mhm
((pause))
N room air sats [ninety-four percent
INF [°non lo posso fare° *((chuckle))*
I è::: non ha:: (.) ehm dunque respira >autono( )mamente)< la saturazione è [novantacinque
INF [che cosa hai de:tto↑
I saturazione *novantacinque*
INF cioè [è in room air↑]
I [respira °( )mente] sì in room air°=
INF =okay
N lungs clear
I suono chiaro polmonare
N slight edema in lower extremities=
I =un po' nelle gambe ha degli edemi
INF mhm
((pause))
N no no edema
I no aspetta [non ne ha no no no=
N [scratches no edema no edema
I =si gra – si gratta ma non ha edemi
N okay abdominal incision with staples (.) *((announcement over the intercom))* dry 'n' intact [open to air]
I [incisione] addo:minale con punti: metallici intatta asciutta e:: aperta (.) °senza garze°
INF va b:ene
N has two J Ps left
I *((whispering))* °ha due J P°=
N =on the right side
I *((whispering))* °*left* or right side↑°
N on the right side
I tutte e due [sono a destra=
INF [°che ha detto↑°
I *both* on the right side↑
N both on the right side=
I =tutte e due sul:: lato destro=
INF =A e B↑
I A and B↑
N [A and B
INF [°C°
I sì=
INF =°C e D°=

I =A e B
N the one on the left's gone [>they took it out<
I [quello che c'era a sinistra] l'hanno tolto
INF >quindi<=
N =and that's actually trace
INF a sinistra [ne aveva uno
I [e: drena qualcosa] delle tracce
N two [two more
I [he ha –] he had one on the left↑
N he had
I ne aveva °un – °=
N =he had *three*
I ne aveva tre [in tutto↑]
N [earlier] (.) but one
[was taken out]
I [però quello] [a sinistra è stato tolto]
INF [°oh okay°] [u:no a sini::stra] e due a destra è stato tolto oggi↑
I did they remove it today↑
N yes [sì
I [sì
INF okay drenano molto questi↑
I do they drain a lot↑
N no (.) trace
I no un po' – un pochino °alcune *tracce*°
N >we're talking of< *big* (.) *((opening her arms))* big J Ps
INF okay=
N =>and not the little ones<
INF [okay
I [sono:: i J P [grossi=
N [*grande*
I non [sono quelli piccoli]
INF [sì sì sì] °okay°=
N =okay↑
INF °okay°
((background voice of another nurse))
N ha – has not had an X-ray yet they said to me this
[morning he would have an X – X-ray]
I [gli avevano detto stamattina che:] doveva fare una radiografia
ma non l'ha fatta ancora
N [°but it's not in ( )°
INF [*((writing down her notes))* una radiografia dove
I *((whispering))* °where° (.) °what kind of X-ray↑°
N thoracic X-ray
I *((whispering))* °tora:cica°
INF okay
N he voids spontaneously
I urina spontaneame::nte
INF okay
N u::h (.) he had a fleets enema yesterday morning
I ie::ri [matti:na gli è stato fatto un=
N [for a sma::ll amount of output
I =cliste::re ma: ha prodotto poco

N [so he=
180 INF [°mhm°
N =was concerned today
I quindi oggi c'era un po' di [preoccupazio::ne]
N [so we got the] doctor to order
[him
185 I [e allora –
N another fleets enema and [>I've just done giving it to him<]
I [abbiamo chiesto al medico di] (.)
ordinarne* un altro °di fare un'altra: un altro clistere°
INF *((writing down her notes))* l'ha fatto↑
190 I >did you do it↑<
N yes
I sì
INF °okay°
N [I've just done doing it
195 INF [con esito positivo↑
I sì ora ora adesso adesso (.) *((to the US nurse))* what about the [output
N [okay
INF è giovane questo:::=
N =I don't know if he is going yet he wou – [he]
200 I [*non so*] se
[l'ha fatto]
N [^he did not] go^ as of yet (.) °from the fleets°=
I =ancora non ha avuto effetto il °clistere°
((the Italian nurse makes a gesture of disappointment))
205 N I just got them doing it
I l'ho fatto in questo istante
INF o::kay
N his potassium was *low* (.) this morning
I stamattina il potassio era: (.) ba:sso
210 INF °mhm°
N and (.) this afternoon I gave him the – (.) I V (.) [potassium]
I [poco fa]
gliel'ho dato endovena
N °(from the doctor)° [which is a order=
215 INF [quindi ce l'ha in °corso°
N [on that on that *((pointing at the medical record))* °okay°]
= [
I [ed è già ordinato] lo
troverai:: °negli ordini°
220 INF *((taking the patient's medical record))* >dico< (.) allora:: l'ha in corso
I so is the potassium still running↑
((the Italian nurse starts shuffling the medical record))
N *((shuffling of pages))* no is done
I no finito
225 N finito °done°
((pause)) ((the Italian nurse starts reading the orders from the medical record; the US nurse reaches her hand out to take the medical record))
INF °(un attimo)° aspetta
((pause)) ((the Italian nurse reads the orders in a low voice))
230 INF °questi li ha fatti↑° *((pointing at the written orders))*
I °what about the other orders↑°

((the US nurse takes the medical record and starts reading the orders))
N the potassium D C the ( ) yeah=
INF =okay
N okay ismett tomorrow
INF mhm
N enoxaparin I *gave* at noon
I *((whispering))* °gliel'ha data [a mezzogiorno°
N [too] I started at noon so I
wi – I still have to chart >all this<=
I =lo devo ancora:: caricare [ma l'ho fatto
N [and this was –] this is an enema (.) and D
C (.) I don't know what this J P – well *C* [which they did=
INF [okay
N =>they did that<
INF okay [°okay°]
N [°( )] ( )° okay↑
INF okay
N any questions
I domande↑
INF °no°
((the US nurse signs off the medical record and closes it))
N [next
INF [firmo pure io *((pointing at the medical record))*
I she has to sign
N *((giving the medical record to the Italian nurse))* oh
((pause)) ((the Italian nurse reads again the orders in a low voice and then signs them off))
I *((looking at the two researchers))* ^terza^ persona
INF okay no seconda
N °okay° no::w –
I *ho usato* la terza persona
N {Persito}
INF *((chuckle))*
N {Pamela}
((INF1 approaches them))
INF1 *((to the Italian nurse))* ehi (.) devo prendere l'ultima consegna
N [coronary artery disease
INF [*((to INF1))* ( ) (devi) aspettare un pochettino] *((chuckle)) ((to the US nurse))* {Persito}
((INF1 sits down near them))
N has a cabg times three
I wait wait (.) {Persito} is that right *((the US nurse nods))* yes
((background voice of INF1))
INF ehm
I cabg per tre
N cabg times three and mitral valve repair
I riparazione valvola mitra:lica
N and left ventricle reconstruction
I ricostruzione ventricolo sini:stro
INF *((writing down her notes))* °aspetta° (.) ricostruzio::ne ventricolo sinistro↑

((the interpreter nods)) ((another Italian nurse who is sitting at a workstation nearby asks the Italian colleague for information about a computer program; inaudible question))

N she's on a [regular diet
INF [*((to the Italian colleague))* >io non<] ci so andare in questo [programma
N [no known allergies
I [dieta regolare non ha allergie
INF [però vorrei imparare] ventricolo sini:stro (.) regola:re
N psychologically she gets depressed [and cries=
I [è un po'
N =when her family [is not around
I [depre::ssa
INF °mhm°
I ogni tanto pia:nge
INF è diabetica↑
I °has she diabetes↑°
N yes
I sì
INF quindi ha l'accu-chek ogni sei ore↑
I *((whispering))* °so:: she has to check the: blood sugar every six hours↑°
N oh (.) yeah they are doing it at six and twelve and six and twelve that's what they are doing=
I =per adesso stiamo facendo [se – =
N [six –
I =>alle sei< e alle dodici alle sei e alle dodici
N six A M it was one [fourteen
I [alle sei di::] stamattina era:::
INF quindi ogni dodici ore↑=
I =centoquattordici
N twelve [it was two eleven]
I [°no alle sei] e alle dodici° (.)
[^alle dodici^ era:: duecento undici]
INF [alle sei e alle – ma qua] *((pointing at the Kardex))* c'è scritto ogni sei ore

((the interpreter looks at the Kardex with a puzzled expression))

I °ogni sei ore e alle sei e alle dodici ogni sei ore è°
INF *((sarcastically))* alle sei alle dodici alle dicio:tto *((chuckle))*
I mhm
INF [
INF1 [e a mezzanotte
I mhm
INF [*così* è ogni sei ore=
N [every six hours I know
INF =alle sei e alle dodici sembra *alle* sei=
N =it's stupid=
INF =*e* [alle dodici *punto*]
I [no:: lo fa] lo fanno [ogni sei ore
N [°all right°
I >^so^ every six hours< right↑=
N =you're right and it's stupid because she's eating and it should be

335 [>seven eleven four nine<]
I [^è strano^] però perché [sta:: mangiando=
INF [°( )°
I =e dovrebbe – *((slightly annoyed))* >ah però parlate uno alla volta okay↑<
340 N *((long laugh))* °a:h° (.) two eleven at lunch time
I a:: ora di pranzo [era °duecento [undici°=
N [I covered her [with eight units
INF [okay
I =l'ho coperta con otto [unità
345 N [but she is] not on [any=
INF [mhm
N =regular insulin (.) [at all]
I [*non] fa* insulina:: regolare
N okay↑
350 INF *((slightly annoyed))* e quale fa↑
I so [what insuline is she on]
N [what↑ she's not] she's not on [any=
I [non ne fa:::↑
N =no no nothing nothing [*oral nothing* >just sliding scale<]
355 I [*nien* *te* ora::le] *niente* solamente la::: °sliding scale°
INF okay
N okay↑
INF va bene
360 N >anyhow it's like< (.) >getting back to – < she cries she's – she gets
I [*depressed* when her family is not (in it)
[quindi ogni tanto si depri::me] quando i parenti se ne vanno: pia:nge
N she doesn't want to be alone
365 I non vuole stare da sola *((ironically))* °non vuole rimanere tutta sola soletta°=
INF =va bene
N neuro she's up with assistant [one
I [*((whispering))* °neurologico°] (.) °con::
370 aiuto si::: [alza°
N [moves] all extremities
INF va [bene
I [>°(what)] did you say↑°<
N °moves all extremities°=
375 I =muove tutte le::: gli arti=
N =generalized [weakness
INF [okay
I è un po' debole
INF [mhm
380 N [(okay)] (.) cardiovascular
I *((whispering))* °dal punto di vista cardiovascolare°
N she has plus two to three edema [in her lower extremities]
I [edema più due più] (.) tre °nelle gambe°
385 *((pause))* *((background voices))*
N uh also has: incision (.) midsternal
I *((whispering))* °incisione° (.) °sternale°

N =open to air (.) and bilateral [lower extremities=
I [°non coperta°
N =right here *((pointing at her legs))* [I did the ^dressings^
I [nelle gambe
INF in entrambe↑=
I =ho [cambiato le medicazioni]
N [and I did the dressings] (.) >a little bit ago<
I poco fa
INF le ha me – [sono coperte↑]
N [because she *oozes*] sometimes so=
I =so those are covered↑
N >they are covered< yes those are covered
INF okay
N °oka:y↑° (.) u:h (.) she's a right forearm twenty gauge
I *((whispering))* °ha un acce:sso: all'a:vambraccio destro venti°
INF okay
N she has a Foley putting out an – uh (.) yellow urine
I dal Foley produce urina (.) giall:a
INF e:hm *((reading the orders from the medical record))* qui c'è scritto D C Foley
N [she >put out< five hundred –]
I [^there is an order^ to] discontinue the Foley=
N =oh okay >I didn't see that< [they just wrote=
I [non l'ho visto
N =down making their rounds
I l'hanno fatto probabilmente nei:: giri visite
N she still has the wires >up here< *((pointing at the chest))*
I *((whispering))* °ha ancora i:° (.) °ca:vi° (.) [°qui su°]
N [under] the two by twos
INF che cos'ha↑=
I [sotto i due per due]
N [°wires°] wires are still there
INF w[air]es↑ *((the interpreter nods))* va bene (.) *((writing down her notes))* okay
N ( ) (diluted) but I think I only give it to her I don't think you do (.) >nah nah< (.) *((pointing at a medication written on the Kardex))* this:=
I =poi io credo che tu non glielo debba dare ma io gliel'ho dato (.)
ques:to *((pointing at the medication written on the Kardex))*
N °is this (her)↑° *((looking at the Kardex))*
INF co:sa
N *((looking at the Kardex))* °did they get rid of it (.)°
[yes o:::h
I [*((whispering))* °è stato cancellato°
N good they got rid of the hydralazine did they say D C hydralazine↑
I c'è un ordine di discontinuo di:: °interrompere l'idralazina↑°
N does it say disc – >D C it↑<
((the two nurses take the medical record))
I c'è↑ [negli ordini↑]
INF [allo::ra] leggiamoli *((reading from the orders))*
[D C Foley=
I [let's read it °together°
INF =*((ironically))* quindi (.) lo devo togliere io
I so should I remove the Foley

N yeah yes yes
INF questo *((chuckle))* [*((reading))* change
N [( )
INF [dressings
445 N [°change dress – °] I did that [I did that=
I [questo l'ho fatto io
N =I did that
INF okay (.) *((reading))* [v]arfarin
N today [I didn't do that right=
450 INF [°questo okay°
I =*non* l'ho fatto
INF °mhm° *((reading))* ismett due tomorrow morning=
N =tomorrow
INF *((reading))* *((annoyed))* [e] K G↑
455 N I didn't do that [because – =
I [*non* l'ho fatto
N =I didn't do that yet
I °non ancora°
INF *((annoyed))* dodici e venti *((pointing at the time written on the medical*
460 *record))*
N for you know what↑ they've just made their rounds
I no hanno fatto il giro visite:: [poco fa
N [he did *not*] make his round at this
time
465 I non l'ha fatto: in quest'orario scritto °qui°
INF °mhm°
N *((looking at the medical record))* see↑ I don't see D C
((pause)) *((the US nurse continues shuffling the medical record))*
N *((puzzled))* °hydralazine°
470 I *((whispering))* °vedi non c'è idralazina°
INF *((reading from the medical record))* D C [i]dro::: [questo
I [oh *yes* there is]
°( )°
N what is that
475 INF *((reading))* [i]dr[o::]°lazin°
N is that hydralazine↑
((the interpreter nods))
N oh okay okay [good good because it comes in a phial=
INF [cos'è cosa mi vuole dire non l'ho capito
480 N =and you have to mix it [with water
I [perché è una fia::la] e la devi mi – miscelare
[con dell'acqua=
N [and she has to drink it
I =e:: poi lei se lo deve bere
485 INF ha [carvedilolo
N [yeah
INF =sei punto venticinque *((reading from the medical record))* >°( ) sei
punto venticinque P O B I D<° okay ehm check b[a]dy weight↑ *((no*
longer reading)) no:: quindi (.) *((amazed))* la devo pesare↑
490 I should I also do this↑
N okay unless you want me to s – I mean
[I can stay and I can do all this
I [oh vabbè posso rimanere] un po' di più e lo faccio io=

INF =no:: °dille di non preoccuparsi°
I no never mind
N yeah because (.) they [they rounded they sh – he sh – =
INF [°dove arrivo metto ( )°
N he (just got them rounding) (.) [( ) doc( )
I [l'hanno scritto] poco fa:: °hanno fatto il giro visite poco fa°=
INF =okay [va bene
N [okay
((pause))
N ^she's up walking^ (.) the halls
I lei si alza cammina:: [nel corridoio
N [with – with her family
I °con:: i pare:nti°
INF okay
((short pause))
N a::ll right now her next
I adesso↑ °chi facciamo°
N °let's see° {Paride}↑
INF °(un momento)° (.) [{Pastura}
N [{Paride}↑] {Pastura}↑ okay on {three} (.) {thirteenth}
I *((whispering))* °operato il {tredici}°
N cabg times two
I *((whispering))* °cabg per due°
INF mhm okay
I *((whispering))* °per *du:: e*°
N no known allergies
I ^non ha allergie^
((background noise))
INF okay
N regular diet (.) psychosocial okay
I *((whispering))* °psicosociale okay°
N generalized weakness throughout=
I =°debolezza un po' generalizza:ta ovunque°
N doctor wanted him to get up – out of bed to [eat his lunch
I [i medici] vo::levano che si:: [^*alzasse*^ per mangiare il pranzo
N [>a little bit ago< and he said no] *((making a gesture of annoyance with her hand))* I am not sitting
I ma non l'ha:: non ha voluto farlo
INF oh °va bene°
N uh (.) *((squeaking noise))* I did his vitals
I ho preso i parametri
INF mhm
N and (.) earlier and they were good at eighty=
I =erano [buo::ni::
N [pulse] (.) one twenty-seven [over seventy-three
I [ottanta] e centoventisette su:: (.) settantatré
N thirty-six eight ninety-nine [percent sats on three liters
I [trentasei e otto con saturazione] novantanove per cento con tre litri

INF a che ora li ha presi [questi parametri
I [what time did you take] these vitals↑
N and I did it between ten and eleven
I tra le dieci e le undici
INF °mhm va bene°
N he is on strict I and O
I controllo di:: bilancio idrico
N he did have three hundred in and three hundred out
I ha *pre:so* ha assunto trecento e ha: emesso trecento
INF ha il Foley↑
I *((whispering))* °does he have a Foley°
N Foley sì
((the Italian nurse looks at the medical record))
INF °mhm° *((sarcastically))* c'è scritto D C Foley
I also *this* patient should have been discontinued
N oh like I said *I'll do it*
I [se vuoi – se vuoi rimango lo faccio io
N [I'll stay just let me do my charts↑] then I'll go
[and make my rounds
INF [perché sono gli ordini] della mattina [questi
N [because] like [I said=
I [these are
N =I can't [read these if –
I [the orders were] written early in the morning
N they are *not* written early in the morning
[he just got down making it (a bit earlier)
I *((whispering))* °no non sono stati scritti stamattina presto] le::: hanno fatto poco fa il giro visite°
INF °oh°
N *((annoyed))* that's crazy (.) >I was looking at *this* early in the morning< (.) like [I said >just leave them there<]
I [di mattina li ho] guarda::ti
[non c'erano questi ordini
N [>put them aside<] I will do them=
I =comunque [se vuoi=
N [>before I go<
I =prima che se ne:: (.) [prima di andarmene=
N [don't even look at these orders
I =se vuoi li faccio io [°non ti preoccupare°
INF [come vuole lei=
N =I'll do that=
INF =a questo punto
I [as you wish if you want to stay
INF [deve decidere lei
N yeah I'll do that [don't even look=
INF [come dice lei
I =vabbé lo faccio io
INF va bene
N okay (.) he's on normal saline at thirty C Cs [an hour
I [fisiologica] a trenta C C all'ora
INF °m:hm°

N he's edema (.) bilateral (.) lower [extremities]
600 I [edemi] (.) bilaterali (.) alle gambe
((pause))
INF okay
N he has decreased in the bases in his [lungs with some ronchi]
605 I [suoni diminuiti alle basi] con dei ronchi
INF °mhm°
N his V B G I did it (.) one o'clock
I °ho preso il V B G ho fatto il V B G all'una°
610 INF perché è Q shift↑
N three point three
I ehm tre=
N =°right°=
I =virgola tre
615 N three point three↑ (.) I *told* the doctor when he was [walking]
I [l'ho detto] al medico che [stava passando poco fa e >il medico mi ha detto<=
N [and he says cover him with twenty milligrams
I =co::prilo [con venti milligramm – =
620 N [M E Qs of potassium
I =venti millequivalenti di potassio
INF P O
N [P O
I [P O
625 N mhm (.) [>and I gave it<
INF [okay
I gliel'ho dato
INF okay
N he has a sternal incision (.) dry 'n' intact
630 INF °m:hm°
N and he ha::s
((pause)) ((mobile phone ringing in the distance))
INF °mhm°
N an *abdominal binder* (.) over it
635 I ha una fascia:: una panciera
N and [the doctor says=
I [°una fascia addominale°
N =*what is this* and then he put it back over on and he walked by *((making a gesture of annoyance with her hand))*
640 I il medico lui stesso se n'è meravigliato [(e poi gliel'ha rimessa)]
INF [la:: l'incisione sternale] è aperta↑
I *((whispering))* °is the incision open to air°
N open to air except for a little piece like this *((indicating the size with her*
645 *hand))*
I tranne che [per un=
N [^but^
I =pezzettino piccolo così=
N =again (.) this abdominal [binder=
650 INF [°va bene°
N =is crossing *((crossing her arms))*=

INF =ha ancora i w[air]es↑
I *((whispering))* °wires still on↑°
N wires no (.) but there is a little [four by four it could be a wire=
[non ce li ha però c'è una garza:::
N =but there is only *one* [there's not two]
I [^c'è una garza^] quattro per quattro però
(ma) quindi forse ce n'è uno ma due sicuramente no
INF °mhm° (.) va bene
N right leg incision *((pointing at her right leg))*
I *((whispering))* °incisione gamba de:stra°
INF mhm [okay]
N [(only)] dry
I *((whispering))* °asciutta°
INF okay
N no drainage
I *((whispering))* °(non) drena niente°
INF questi ordini: quindi: *((looking at the medical record))* °( )°
N >here< °let me see°
((pause)) ((the two nurses look at the medical record))
N what is this↑ *((pointing at an item on the medical record))*
I cos'è questo↑
INF de:dralen
((pause)) ((the US nurse goes on reading))
N *((to the interpreter))* >what is it↑< *((pointing at an item on the medical record))*
I *((whispering))* °ah it's a ten maybe°
N *((reading from the medical record))* °( ) ten D C captopril start enapril D C coumadin° (.) °chest X-ray tomorrow mobilize° yeah he is not gonna mobilize D C Foley
I non si m::uove [°non può (scendere)°
N [°so::°
((pause))
N *((aside))* °I'll tell you what°
INF non si muove come↑=
N =*((aside))* °( )° (.) [°Foley°
I [*((whispering))* °what] do you mean° (.) °by that – °=
INF =ah ho capito
N ^he wouldn't >get out of the bed<^=
I =non si vuole alzare=
INF =mhm
N °umm° (.) °who else D C↑°
I quali erano [quelli a cui togliere il Foley↑
N [*((looking at her notes))* °{fifteen} D C Foley°]
{fifteen} (.) D C Foley °yeah°=
INF =m::hm {Persito} (.) {Pastura}=
I =pazienti {quindici} e {sedici}↑
INF *((worried))* no ma [non è il Foley=
N [*((aside))* °( ) (first)°
INF =il problema è: tutto l'insieme *((making a circle with her hands))*=
N =no I – I'm gonna [finish this=
INF [°non è per il Foley°

N =now I'm [staying and I'm doing this
705 I [vabbè lei vuole – li toglie lei] questi [Foley↑
N [don't –] (.) don't
even ( ) [°( )°
INF [per me] è lo stesso=
N =I've got it
710 INF *((annoyed))* però c'è l'e – l'[e] K G da fa::re °insomma°
I it's not just discontinuing the Foley °there is also an E K G
[which needs to be done°
INF [per me è lo stesso però
N yes fine [I'll do it I'll do it
715 INF [°( )°
I °lo può fare anche lei°
N *((annoyed))* the doctor'd better [*write* all the time he *rounds*=
INF [okay okay
N =next time because this is not [the time that he rounded<
720 I [la prossima volt –] cioè il
medico dovrebbe scrivere l'orario in cui – perché questo *non è*
l'orario in cui le ha scritte le cose eh↑=
N =but that's=
INF =ma le credo [dille che le credo
725 N [between me and the doctor] that's
[between me and the doctor
I *((whispering))* °she believes you°
INF dille che le credo
I glielo di:rò: (.) [io stessa a questo medico
730 INF [ehm volevo sapere perché ha questa] (.) perché ha
questa normal saline *((pointing at an item on the Kardex))*
I why is this↑ – *((pointing at the item on the Kardex))*
N thirty C Cs an hour
I trenta C C
735 N they *had* him going at thirty C Cs an hour
I *((whispering))* °lo vogliono a trenta C C°
INF ah ma il motivo::
I why↑ [what is=
INF [lo sa
740 I =>the reason<
((the US nurse shakes her head))
INF °va b::ene°
N >I don't know<
INF okay (.) okay (.) °va bene°
745 N nurse didn't tell me why it was on [thirty C Cs nah nah
I [non mi è stato detto in consegna]
[perché=
INF [okay
I =*((whispering))* °doveva farlo a trenta C C°=
750 INF okay

NR.FL.02

Typology	Patient-transfer nursing report (reported cases: 1)		
Place	ISMETT regular admission unit (Floor)		
Date	January 22, 2006		
Time	2:30 p.m.		
Duration	00:04:05		
Interpreter	Dario		I
Primary speakers	Floor nurse, Italian	(female, aged 31-35)	INF
	SDU nurse, US	(female, aged 41-45)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The two nurses are standing next to each other at the nurses' station, while the interpreter is standing between them. ▪ The report concerns a patient who is being transferred from the step-down unit to the Floor. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They also check the medical record and patient Kardex.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

N this patient is {Pasqualina}↑ {Porrinello}↑ (.) she's a *bilateral* (.) lung transplant↑ (.) on the {twentieth} (.) of – (.) {December}
INF *((to the interpreter))* double [°giusto↑°
I il {venti}] {dicembre} (.) *((to the US nurse))* uh *double* transplant↑
N mhm
I sì
INF mhm (.) *((writing down her notes))* *((background voices))* mhm
N u:h she's A positive and she's allergic to multiple antibiotics=
INF =mhm (.) *((writing down her notes))* °okay°
N neurowise she's intact (.) she's up (ad-lib)↑ in her room↑ to the bathroom↑ without any problem↑
INF mhm
N u:h complains of no pain↑ (.) *((background voices))* she – (.) has been off the monitor (.) down in step-down (.) doctor said that was fine↑
INF °okay°=
N =u:h vital signs have been stable blood pressure is like in the one twenty one thirties (.) u::h >heart rate's like in the seventies and eighties<
INF *((to the interpreter))* °no non ho capito (qua)° la [frequenza
I [la frequenza] sui settanta=
INF =oh=
I =ottanta
INF okay=
N =u::h (.) she has a number twenty in her left hand
INF mhm
N and right now she has an antibiotic still infusing (.) through it °u::h° (.) she's on room air

INF mhm
N she's clear (.) she has a clamshell (.) incision °( )° and that looks fine (.) no °(opening)° no drainage
INF *((to the interpreter))* ehm me lo puoi dire com'è lo spelling di clam e::hm [incisione
I [C L A] M *((background voices))*
INF °C L A M° *((writing down her notes))* clam (.) in[tʃ]i[z]ion (.) okay
N she (.) is on a regular (.) diet (.) diabetic but she's allowed to have (.) her sugars if she wants them (.) doctor said
((the Italian nurse looks at the interpreter with a puzzled expression))
INF *((to the interpreter))* >°(che ha detto)↑°<
I che può:: [mangiare anche (ad esempio)=
N [she eats what she wants
I =i do::lci può mangiare quello che vuole non c'è [controllo=
INF [okay
I =degli zuccheri
N uh she's on accu-cheks (.) before meals (.) and at bedtime (.) and she was one thirty-four (.) and one ninety-three when she got eight units from me today
INF mhm=
I =°centotrentaquattro e centonovantatré [( )°
[and she is up and about ( )
((the US nurse moves her notes and accidentally covers the tape recorder; inaudible exchange for 10 seconds))
((pause)) ((background voices))
INF it's okay=
N =>( )< is very nice
INF e::hm the order (.) this morning↑
((pause)) ((background voices)) ((the US nurse opens the medical record))
N she gets a chest X-ray in the morning↑ (.) she ( ) ismett=
INF =done↑=
N =*((nodding))* two and her F – (.) K
INF *((reading from the medical record in a low voice))* °( )°
N *((pointing at items on the medical record))* >°and this blood work°< (.)
INF [>°I don't know what it is°<=
[*((reading in a low voice))* °( )°
N =a::nd this was done this was a sputum (.) °umm°
INF okay
N *((shuffling the medical record))* >°( ) change°< a:nd this is from her blood work or *((the LS mobile starts ringing))* that's for that
INF oh=
N =F K
INF okay
N medication uh (.) the other thing –
((the mobile rings louder and louder and the two nurses look at it amused))
N *((chuckle))* (.) I changed=
I =*((answering the mobile))* sì↑=
N =her (.) antibiotic that she has now she ( ) [get it=
I [*((on the mobile))* hello↑
((moving slightly away while the report continues))
N =a little early 'cause she doesn't like to be woken at ten (.) to get an antibiotic (.) so the doctor said –

((the Italian nurse gestures for the US colleague to pause and wait for the interpreter)) ((the interpreter hangs up and returns to the two nurses))

N she's on – (.) *((chuckle))*
INF *((to the interpreter))* °( ) non avevo capito quello ( )°
N she's on an antibiotic one of – one of her antibiotics
I [she gets every eight hours / °ha un antibiotico°] che prende ogni otto ore
INF mhm
N but (.) she doe – it – it was due (it) like at ten o'clock at night
I doveva prenderlo alle *dieci* di [se::ra / she] complained of being awoken for it
N
I ^last night^ you mean↑
N yeah (.) every night [*((chuckle))* so:: / sì tutte le sere alle dieci:: di sera] però ehm
I
INF °è saltata°
I so [she didn't= / so she –
N
I =have it
N no (.) no no so: the doctor said we'll give it to her earlier then=
I =quindi=
N =so it's – [it's in there for / il medico >(ha detto di)< darglielo prima]
I
N six in the morning
I quindi adesso è *sei* di mattina
N two in the afternoon
I *due* di pomeriggio
N and *eight* at night
I e *otto* (.) [di sera / instead] of ten
N
I invece che alle dieci [°di sera° / va bene] °d'accordo°
INF
I così può dormire tranquillamente
INF [*((ironically))* insomma alle due di mattina= / okay so it's sort of eight eight six]
N
INF =non [può dormire *((soft laugh))* / actually if she has the –] if she has to wake up at two
I
N no no (.) no that would be two in the afternoon
I *due del pomeriggio*
INF o::h=
I =*((ironically))* *eh*=
INF =alle due del °pomeriggio°=
N =yeah so it would be=
INF =oh=
N =eight and then *six* in the morning=
INF =e – =
N ='cause she is=
I =quindi [due poi sei di – / e alle due] le è stata fatta=
INF
I =sc – (.) sc – (.) quindi sei del matti:no poi *((to the US nurse))* did you give the one at two
INF mhm
N yeah °( )°

I alle due è stato fatto
135 INF mhm okay

NR.FL.03

Typology	End-of-shift nursing report (reported cases: 1)		
Place	ISMETT regular admission unit (Floor)		
Date	January 24, 2006		
Time	7:00 a.m.		
Duration	00:03:21		
Interpreter	Georgia		I
Primary speakers	Outgoing nurse, Italian	(female, aged 31-35)	INF
	Incoming nurse, US	(female, aged 51-55)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station, while the interpreter is sitting between them. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical record and patient Kardex.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

((background voices))
INF °allora {Pizzuto}↑°
I okay the patient is {Pizzuto}↑
INF e:::hm ha riposa::to tutta la no::tte↑
I rested all night↑
((short pause))
INF le dico soltanto le novità
I >she's only gonna tell you< about the new stuff
INF >ha riposato tutta la notte<
I >right< the patient rested >(all) night< –
INF [scusami è un uomo o una donna
h(o) fatto: il –] (.) [come↑
I uomo o donna↑]
INF no è uomo
I >uomo okay< he rested all night
N mhm
INF ehm l'H 'n' H che aveva ogni otto ore=
I =he had an H and H scheduled that every eight hours=
INF =corrispondeva:: all'incirca alle tre di notte
I it was >approximately [she sh( ) it at around< *three* A M]
INF [quindi non gliel'ho fa::tto] perché alle ci::nque ho fatto l'ismett uno
I she didn't do it at that time uh [because it was scheduled=
INF [quindi quando::
I =for ismett one at five *A M↑*
INF quindi:: quando arriva l'ismett uno e:hm deve guardare l'emoglobina e l'ematocrito=
I =okay so when ismett one results come back look at the H and H haemoglobin and hematocrit
INF *((chuckle))* ehm ha urinato pochino (.) [trecento
I [he voided] *very* little=

INF =concentrate
I cento↑
INF trecento=
I =three hundred (.) *concentrated*
INF Jackson-Pratt e::hm cinquanta
I Jackson-Pratt drained fifty↑
INF l'N G tube cinquecento↑
I the N G tube five hundred
INF non si è ancora canalizzato comunque è normale perché
I [è presti::no / he hasn't had any] bowel movement ye – *yet* but it's normal – perché:↑
INF è prestino [e – ieri è andato in sala
I [oh it's still too soon] okay (.)
INF [>apparently the procedure was done< yesterday / ha bevuto un po'] di::: acqua
I he drank a >little bit of water<
INF e::hm ha sempre il normosol a ottanta [M L l'o::ra
I [he has normosol] at eighty M L per hour
INF la drip è finita
I the drip is done
INF quindi ho tolto tutto
I so she removed everything
INF perché: e::hm c'era: l'ordine: di toglierla:: e::hm quando finiv(o)
I the order – there was an order to remove everything to D C everything once the drip was over
INF quindi se dovesse avere dolore
I mhm
INF e::hm deve chiedere al medico perché P R N per il dolore non ha niente=
I =okay >if he should complain of any pain you need to ask a physician because he doesn't have anything scheduled P R N for pain<
INF ha soltanto:: l'antiemetico P R N
I >he only has °the antihaemetic drug< (.) P R N°
INF ho messo tutto:: ha una gomma↑ chiedi se ha una gomma
I do you have – do you have something (to er –) >she can erase that word↑<
((the US nurse looks for her rubber))
INF ehm in Emtek è tutto:: (.) m::esso in D C
I she D Ced everything in Emtek
INF °cancelliamo qua° (.) *((taking the rubber that the US nurse is handing to her))* [t]anks
((pause)) ((the Italian nurse erases some data from the Kardex))
INF ha sempre:: le teds e l'S C D che:
I [*((erasing the Kardex))* °(forse tolgono) oggi° / he's still wearing teds and S C Ds] maybe today they'll decide to remove them
INF e niente per il resto::: (.) è andato tutto bene
I everything else was fine
((pause)) ((the Italian nurse hands the rubber back to the US nurse))
((background voices))
N *((roughly))* >(now who else)↑< (.) >°(is that it)↑°<

85	INF	ha – d – dubbi↑
	I	eh↑ (.) come (.) {Irma}↑
	INF	ha dubbi↑
	I	do you have any doubts or problems with this pa – patient↑
	N	*((roughly))* no who (.) who's next↑
90	I	no chi è il prossimo↑
	INF	*((looking at her notes))* u::mm (.) ^dei miei:^ nessu:no
	I	of mine none
	N	>okay<
	INF	grazie
95	I	mhm prego

NR.FL.04

Typology	End-of-shift nursing report (reported cases: 3)		
Place	ISMETT regular admission unit (Floor)		
Date	January 24, 2006		
Time	7:00 a.m.		
Duration	00:06:38		
Interpreter	Georgia		I
Primary speakers	Outgoing nurse, Italian	(female, aged 31-35)	INF
	Incoming nurse, US	(female, aged 51-55)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station in front of a monitor viewing the patients' electronic medical records, while the interpreter is sitting between them. ▪ During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

INF {Pollina} ieri:::: (.) me lo ha dato le:i [in consegna↑
I [did you give me] the patient
{Pollina} yesterday during report↑=
((the US nurse nods))
INF =sì=
N =°yes°=
INF =quindi le dirò solo le novità
I so >she's only giv – giving you the new stuff< (.) °the new information°=
INF =allora ha dormito tutta la notte↑=
I =the patient slept all night – *((to the Italian nurse))* scusami uomo o donna↑ {Pollina} {Pasquale} hai detto↑ *((the Italian nurse nods))* °okay° *((to the US nurse))* he slept all night
INF e::hm intorno alle tre >però< s'è voluto alza:re perché:: ed è stato un'oretta in:: sedia
I around three he wanted to get up he was in the chair for an hour (.) *approximately* an hour
INF la colostomi::a non ha fatto nulla
I *((to the Italian nurse))* >colostomia↑< *((the Italian nurse nods))* noth – nothing from the colostomy
INF il pigtail ha drenato::: (.) un po' e ho svuotato il sacche:tto↑
I the pigtail >drained a little bit< she emptied out the bag
INF è un ple – è un::: (.) un pigtail pleurico
I he's got a pleural pigtail that's a pl – uh uh pl – u::h (.) *((to the Italian nurse))* per un versamento *pleurico↑* *((the Italian nurse nods))* >he's got a pleural effusion that's why he's got a pigtail in<
N °okay°
INF e:hm (.) ha urinato::: [dal Fo::ley
I [the patient] voided↑ (.) from the Foley catheter
((pause)) *((background voices))*

INF °novità nessu::na°
I nothing else new:: *((chuckle))* °( )°
N no↑ (.) he's still depressed I'm sure
I >sono sicura che sia ancora depresso↑< il paziente↑
INF sì: sì: uguale a ieri [>non< c'è nessuna novità]
I [just as yesterday] nothing new::
((pause))
INF poi abbia:mo (.) {Porta} {Patrizio}↑
I is {Porta} {Patrizio} your patient↑
N {Porta::} *((looking at her notes))* yes
((pause)) *((background voices))*
INF >me l'ha dato pure lei< penso
I you gave him – her report on this patient >as well< right=
N =[mhm]
INF [>novità<]
I ^sì^
INF allora andrà in sala operatoria come primo caso=
I =he's the first O R case this morning
INF per:: un:: ehm:: (.) per togliere il pacemaker attua:le
I [e riposizionarne=
[they're gonna remove –
INF =un altro
I they're gonna remove the current pacemaker and place another one a new one
INF sarà un intervento a cuore aperto
I >°it's gonna be an open heart surgery°<
INF ho fatto lo shaving total body
I >°she did the total body shaving°<
INF e:::: la doccia per le sue:: difficoltà motorie non l'ha fatta
I he couldn't shower because of his: (.) difficu – >his difficulties in moving<
N °( ) [( )°]
INF [però:] l'ho lavato a letto
I she did wash him °at the bedside°
INF N P [ɔ] da mezzanott::e↑
I N P O as of midnight↑
N °mhm°=
INF =ha un normosol a *c:ento↑*
I normosol running at one hundred
INF stamattina:: ha::: tolto::: casualmen::te l'accesso periferico
I che vuol dire casualmente↑
INF >nel senso che< se l'è tirato
I oh by – uh it was an accident he removed >he accidentally< removed his peripheral I V access=
INF =[ehm l'ho r –]
N [*((chuckle))*]
INF l'ho rimesso↑
I she placed a new one *((chuckle))*
N [*((ironically))* (I'll bet he) >didn't *get*< a new one ah↑ *((chuckle))*]
INF [*right* antecubital venti]
I right antecubital >number twenty<

INF però non è *ben* posizionato=
85 N =mhm=
I =it's not well placed °though°
INF l'ho lasciato perché comunque in sala ne prenderanno di altri
I [se non addirittura una linea centra::le e quindi non è importante
[she left it because either way they are gonna get other I V accesses]
90 in the *O R↑* perhaps even a central line so it isn't that important
INF un V B G l'ho fatto stamattina alle se::i
I [e:: va be:ne *((looking at her notes))* °no scusami°
[at six A M she did a V B G and >everything was fi – <
INF °era [lui↑° parliamo=
95 I [fi:::ne no wait
INF =di {Porta}↑ sì=
I =are we talking about {Porta}↑
INF sì sì {Porta} [°scusami°=
N [yes °( )°
100 INF =°{Porta} {Porta}°
INF e andava be::ne °questo [l'ho fatto°]
I [the V B G] was fine *((losing her balance and nearly falling from the chair))* °ouch°=
N =*((to the interpreter))* °(yeah)°=
105 INF =^e::^ ho messo peso e altezza che mancavano↑
I *((as she sits back in the chair))* I – I (.) included=
N =*((to the interpreter))* °this chair is not good°=
I =weight and height be – cause they were missing that information
N [°( )°]
110 INF [okay↑] >continua ad avere< la nasocannula a due li::tri↑
I he still has a nasal cannula at two litres
INF e::hm stop ha il ca::mice ed è pronto per scendere
I he's – wearing his gown >and< he's ready to go down
N >°okay°< (.) pre-op (.) list (.) done (.) pre-op
115 I la lista preoperatoria delle – [delle::=
INF [sì l'ho fatta
I =degli ordini [preoperatori *((to the US nurse))* (it's) done]
INF [di lui non c'è:::] antibiotico
[on call [non l'hanno prescritto]
120 N [°okay [he doesn't have ( )↑°]
I [he doesn't ha::ve] an on call antibiotic they did not prescribe [an – an on call – =
N [°right (teeth)°↑
I =ha:: [protesi dentarie ( )↑]
125 INF [( )↑ no] ma già gliel'ho detto di togliere tutto
I no >I already told him to remove everything<
INF [>deve< mettere solo=
N [°okay okay°
INF =il cappellino:: [e i calzari se vuole]
130 N [guess his family will take it] [>°(that's okay)°<]
I [he only nee –]
needs to wear his – (.) he – the: covers↑ for his feet and the ( )↑
INF mhm↑
N *((yawning))* okay (.) okay
135 INF e poi ci sono due sacche di sangue in sala operatoria=
I =there are >two units< of blood in the O R

INF ^circa i consen::si^ ha firmato solo quello all'intervento chirurgico↑
I >as far as consents are concerned< he only s:igned the one for the O R procedure
N °okay°
INF gli altri due sono da firma::re però li ho messi
I [nel frontespizio della cartella / there are another two consents↑] (.) to be si:gned↑ (.) he still has to sign th – *((to the Italian nurse))* dove li hai messi scusa↑
INF nel frontespizio della cartella
I she put them in the front part – front cover of the:: of his medical record
N okay
((pause)) ((the two nurses look at the informed contents))
I *((ironically))* >there's two to go<
((pause))
N °okay°
((pause)) ((the US nurse goes on writing her notes))
N °okay° (.) next↑ ( ) (.) ( )↑
INF {Pozzo} {Pierina}↑
I *{Pozzo}↑* (.) *{Pierina}*
((the Italian nurse opens the medical record)) ((shuffling of pages))
INF la signora va in sala *domani* [°non oggi°
I [she's going to] the O R tomorrow not today=
N =I didn't think she [she was going °today°]
INF [e quindi rima:ne] [in dieta regola –
I [^non^ pensavo] che l'avrebbero mandata oggi
INF °infatti° per cui rimane in [dieta regola:re↑]
I [so she remains] on a regular diet
INF non ho fatto lo *sha:ving* si farà sta:: [se:ra o doma::ni]
I [she didn::'t do] the shaving 'cause they're doing it d – during tonight's night shift
INF °okay↑° (.) ha dormito tutta la nott:e↑
I slept all night
INF la pressio::ne ieri se:ra era centotrenta
I the blood pressure was one thirty:: la:st night=
INF =questo me l'ha dato i – ieri (.) lei↑ [perché non mi ricordo
I [did you give her this] patient yesterday↑ she can't remember
N [*((nodding))* yeah yeah yeah yeah
INF [ah okay quindi la::] conosce per questo °( )°=
I =so you know the patient
N °yeah°
INF invece stamattina era centocinquantasei su settanta=
I =>the pressure this morning was one fifty-six over seventy<
N °that's good°
I va b:e:ne↑ *((smiling))*
INF [sì sì sì
N [*((chuckle))*
I yeah↑
INF ho fatto il prelievo↑
I (she) drew the blood↑
INF deve fare lei un [e] K G↑

190	I	she – she's due – you have to g – give her an E K G:
	INF	come da protocollo per il cardiac ca[t]
	I	*as* per protocol for cardiac cath
	N	>okay she's having a card – < she's not having a cardiac cath – >okay< (.) *((erasing her notes))* today
195	I	no tomorrow
	N	okay no: cardiac cath she had
	INF	ha fatto ┌ un cardiac cath=
	N	└ °yesterday°
	INF	=*ie::ri*
200	I	oh o::kay↑ ┌ I'm sorry (then) l::=
	INF	└ e domani va in sala
	I	=l'errore è mio pensavo lo av – l – l'ave – lo dovesse ancora fare
	INF	°okay↑° e poi deve fare l'[u]ltrasoun::d d:ei vasi del collo
	I	she's also here for an ultrasound of her neck vessels
205	INF	non ha lamentato dolo::re↑ ┌ ha dormito
	I	└ she has not complained ┘ about pain↑ she slept↑ everything was fine
		((pause)) ((background voices)) ((the two nurses look at the medical record))
	INF	quest'enema ieri sera non l'ho fatto↑ naturalmente↑
210	I	of course she didn't give her – give her an enema °last night° *((louder background voices))* (.) >she wasn't going to the O R this morning<
	N	right
		((pause)) ((background voices))
	INF	okay↑ (.) domande dubbi
215	I	questions↑ doubts↑
	N	no
	N	no:::

NR.FL.05

Typology	End-of-shift nursing report (reported cases: 1)		
Place	ISMETT regular admission unit (Floor)		
Date	January 24, 2006		
Time	7:00 a.m.		
Duration	00:05:00		
Interpreter	Georgia		I
Primary speakers	Outgoing nurse, Italian	(male, aged 31-35)	INF
	Nurse, Italian	(female, aged 31-35)	INF1
	Incoming nurse, US	(female, aged 51-55)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station; the interpreter is sitting next to the US nurse. ▪ During the interaction the Italian nurse reads from his notes and the US colleague jots down the information. They often check the medical record and patient Kardex. ▪ At the end of the interaction, another Italian nurse asks for his colleague's help with other working matters.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

((background voices))
I okay (.) [{Pizzuto}
INF [allora] {Pizzello}=
I =*{Pizzello}*
INF stanza {seicento::ventidue}
I room *{six two two}*
INF pazie:nte trapiantata di fegato
I had a liver transplant↑
INF è tornata per *febbre*
I she came back for fever
INF il gruppo sanguigno è noto↑ [la paziente è allergica –
I [we know the blood type] the patient is allergic
INF a un bel po' di farmaci [tramado::lo
I [to several drugs
N *((looking at the Kardex))* no what's this↑
INF ciprofloxacin=
I =which one↑=
INF =magnesio
I >aspetta un attimo< *((pointing at an item on the Kardex))* cos'è questo↑
INF mezzo di contrasto
I *((looking at the Kardex))* that's a contrast medium
N *((pointing at another item on the Kardex))* this is a contrast
I *((pointing at an item on the Kardex))* no sopra questo mero:::
INF [penem >meropenem<] l'antibiotico
I uh it's an antibiotic
N me – *mero:pe::nem*

I mhm
N okay when did they have the transplant↑
I quando ha fatto il trapianto↑=
INF =ma:: un po' di tempo fa↑
I some time ago
INF non è:: la >paziente< è stata *dimessa* e poi è >rientrata per la febbre<
I sh::e was discharged and then [readmitted for fe:ver
INF [non è:: non è questo] il ricovero del trapianto è un ricovero precedente=
I =yeah the transplant was a previous admission [this is a new=
INF [°(e allora)°
I =admission
INF il gruppo sanguigno è noto↑ le allergie [le conoscia::mo↑
I [we know the blood t –] type we know [what she's allergic to]
INF [psicosociale] (.) [tutto sommato va bene]
I [psychosocially] overall she's fine
INF neurologicamente
I [è un po'debole ma va bene (d)i:: è::: autosufficiente
[neurologically she's a little bit weak but that's – it's fine] she's self-sufficient
INF e::hm cardiovascolare i vitals vanno [bene↑]
I [C::] V the vital signs are
INF [fine↑] [e ha] un left [v]rist numero venti↑=
I =she's got a left wrist number twenty
INF ed è in regular diet=
I =she's on a regular diet
INF urina spontaneamente=
I =she voids spontaneously↑
INF anche se le urine sono:: [molto:: concentrate dark amber
I [even if her urine is very °concentrated°] *concentrated* colour dark amber
INF ehm la feri::ta↑ (.) ha una ferita:: (.) >la – < la vecchia ferita
I [sua che ormai è asciutta
[she's got the old incision] which now is dry=
INF =ehm (.) brutti::na
I it's ugly
INF poi quando lei la vedrà ehm [( )l'addome che=
I [you'll see this
INF =si è:: questa ferita si è:: chiusa forse per seconda intenzione °perché:: è bruttina°
I it's – on the way the – the lesion closes ugly *((phone ringing))* he s – he said something – *((to the Italian nurse))* seconda *intenzione↑*
INF mhm
I d – do you say the same thing in America it's called it heals *second* (.) *intention↑* (.) *((the US nurse looks puzzled))* that's what they – *((to the Italian nurse))* che significa↑
INF significa che non si è chiusa con la sutura (.) dopo i sette dieci giorni classici

80 I it didn't heal after the seven te – ten classic days apparently (.) you know with the stitches it's just the way it normally heals that didn't happen *((the US nurse nods))*
INF va bene – niente io non: praticamente non ho altro da aggiungere le ho fatto l'ismett [uno stamattina=
85 I [°nothing else to a:dd°
INF =e l'F K levels – =
I =so he – (.) >he did ismett one this morning and F K level↑<
N okay normal saline yesterday bolus↑
INF >( )< [un bolo sì ha fatto=
90 I [ieri ha fatto un bolo di >soluzione salina↑<
INF =un bolo sì per la::
I yes:
INF per la pressione
I for the pressure
95 INF (e ora) va ben – e [anche per la febbre perché ieri aveva:]
I [and now everything is f –] and also for fever because yesterday the [temperature
INF [avuto trentotto –] trentotto e qualcosa=
I =was thirty eight point [something
100 INF [quindi gli hanno fatto] il [paracetamolo↑]
I [they gave her] paracetamol↑
INF e:: il bolo di salina↑=
N =°okay°=
105 I =and the saline bolus
N [and the vanco level]
INF [( )] ieri sera↑ –
I e il livello di vancomicina↑
INF il livello di vancomicina↑ è stato fatto stamattina e
110 [°aspettiamo i risultati°
I [it was done this morning
N this morning [okay
I [*((to the Italian nurse))* eh↑
INF aspettiamo i risultati
115 I we're waiting for the results
N *((looking at the Kardex))* okay (.) so do I have to wait before I hang up the vanco↑
I quin – quindi devo aspettare prima di ri – rimettere la vancomicina↑
INF no la vancomicina non l'abbiamo – abbiamo fatto l'*F K* il::
120 I we didn't do the vancomycin [we did the F K=
INF [(la) vancomicina si può fare
I =okay we can do the *vancomycin*
INF *((pointing at an item on the Kardex))* quest' [ordine di quand'è
125 N [*((reading from the Kardex))* before dose on] the twenty-third
I wait when was this order written↑=
N =*((reading from the Kardex))* before the dose on the twenty-third=
I =c'è scritto prima della [dose il ventitré
INF [fatto fatto fatto
130 I [done]
INF [la –] la vancomicina le – la – il livello di vancomicina andava fatto

I pri:ma di somministrare [la vancomicina::: ma –
I [the – vancomycin level] was to be done
[before administering the=
135 N [°yeah (that's true) ( ) – °
I vancomycin
I =[ ]
INF [già è stato –] è stato [fatto
N [okay
140 I [it was done]
INF [done done] done done
N ah okay
INF tutto fatto
N okay
145 I everything was done
N I thought *maybe* I had to do it again 'cause (here) *((pointing at the Kardex))* it's written twice=
I =mhm pensava che dovesse essere fatto un'altra volta >perché l'ha visto scritto due [volte<
150 INF [>no no] no no no no< ehm=
I =no no
INF °non c'è [bisogno°]
N [*((sneeze))*] ah=
I =no need=
155 N =excuse me (.) all right
I bless you
INF e basta
I that's all=
INF =basta=
160 N =okay
INF la paziente è tranquilla
I [it's a tranquil patient
N [*((reading from the Kardex))* °please do not°
INF °(molto carina)°
165 I eh↑ what↑
N *((reading from the Kardex))* administer
INF1 *((in the distance))* {Ivo::}↑
INF *((to INF1))* sì::↑
N *((reading from the Kardex))* till we get the (.) results
170 I [non ammi –
N [( )
I c'è scritto non somministrare prima di ricev – di::: ottenere i risultati↑
INF aspetta aspetta dammi che lo [cancelliamo questo]
I [°hold on a second°] let me cancel that=
175 INF =lo cancello perché fa solo confusione °( )° *((to INF1))* °hai una gomma°=
I =it's just creating confusion it shouldn't even be there
((the Italian nurse stands up looking for a rubber and starts talking to INF1; inaudible exchange))
180 N so we shouldn't be giving it (.) right
I I don't know::
N every other day it says *((yawning))*
I what was that the vancomycin↑
N F K

185 I F K↑
((pause))
I >do you want me to ask↑<
N no I'll get to the bottom of it somehow *((yawning))*
I you're all right↑
190 N >yeah<
((background voices of the two Italian nurses))
INF *((in the distance))* sì lo so lo so ma oggi che cos'è↑ oggi è martedì↑ *((returning to his chair))* e ne abbia – *((background voice of INF1 talking to him)) ((annoyed))* vabbè ma scriviamolo qua:: oggi ne
195 abbiamo ventiquattro↑
I sì
INF1 *((in the distance))* sì::
INF ventiquattro: allora facciamo così (.) *((writing down on the Kardex))* ventidu::e:: (.) venticinque lo deve fare (.) il ventise::tte >eccetera
200 eccetera<=
I =quindi lo fa ogni altro [giorno↑]
INF [è Q O] D *Q O D*
I [quindi / yes] [>un giorno sì (e uno no)< / it's every= / °right°]
205 N
I =other day=
N =right=
INF =il venticinque *sì* il ventisette *sì*
I she's due on the twenty-fifth=
210 INF =°okay↑°=
I =on the twenty- [seventh]
INF [oggi] *no*=
I = [today= / okay]
215 N
I =*no ( )*
INF okay↑
N okay
I mhm
220 N that's fine↑
I bene I guess we did get to the bottom of it

NR.FL.06

Typology	End-of-shift nursing report (reported cases: 1)		
Place	ISMETT regular admission unit (Floor)		
Date	January 25, 2006		
Time	2:00 p.m.		
Duration	00:07:26		
Interpreter	Italo		I
Primary speakers	Outgoing nurse, Italian	(female, aged 26-30)	INF_1
	Incoming nurse, Italian	(female, aged 31-35)	INF_2
	Incoming nurse, US	(female, aged 46-50)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The US nurse has recently arrived at ISMETT and is now engaged in her period of shadowing and orientation. Her preceptor is the other incoming Italian nurse. ▪ The three nurses are standing next to each other at the nurses' station, while the interpreter is standing between the two Italian nurses and the US colleague. ▪ During the interaction the outgoing Italian nurse reads from her notes and the other two colleagues jot down the information. They often check the medical record and patient Kardex.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Whispering		

1	INF_1	[°allora°		
	INF_2	[{Perotti}↑] {Perotti}↑		
			I	{Perotti}
	INF_1	allora il signor {Perotti}		
5		praticamente il {ventitré}		
		{dodici} ha fatto un	I	mister {Perotti} on the
		trapianto di::: (.)		{twenty-third} he had a:
		((looking at her notes))		
		fegato da vivent –		
10			I	liver
	INF_1	^da::^ (.) cadavere		
			I	°cadaveric liver° (.) cadaveric
				donor liver transplant↑
	INF_1	allora lui praticamente		
15		psicologicamente		
		è *mo::lto* nervoso	I	psychosocial
				he's *very* nervous
	INF_2	ah pure idda m'ha [°( )°]		
	INF_1	[e::::]		
20		suona sempre		
	INF_2	*((ironically))* a:::h	I	and he's
	INF_1	gli ho spiegato		very demanding and he
		le prossime volte di		always rings the::
		suonare		bell
25		il campanello e di non gridare		

		perché: mi chiamava (un sacco di volte) ( )	I	she was trying to explain tell him to not scream to not shout
		( )		for help
30	INF2	oggi gri – faccio io quattro gridi		
	INF1	[( ) [però:::]	I	so she's going to shout
		è un po' disorientato		this day – today so
35		nel tempo		
		e lo è stato=	I	and he is a:: (.)
	INF2	=mhm		a little
	INF1	e::hm		not oriented
		questa notte e questa		
40		mattina però adesso	I	on his three dimensions
		lì c'è la moglie		
		( )	I	but=
		( )	N	=he is or [he's not
		la moglie	I	[he's *not*
45		comunque è molto collaborante	I	but his wife is here
	INF2	*((to the interpreter))* come si chiama lei↑ *((pointing at the US nurse))* come si chiama lei↑		so she's going to help
50			I	what's your name
	INF2	*((to the US nurse))* your name sorry↑		
	N	Helen		
	INF2	Helen (.) [e]len ora ci armiamo così *((clapping her hands and then rubbing them together))*		
55		[facciamo (ah) mi raccomando dobbiamo calmare tutti		
	I	[so we're going to work and *((chuckle))* and calm every –		
	INF1	allora		
	N	*((chuckle))*		
	I	everybody down		
60	N	he was oriented [yesterday		
	INF1	[ehm		
	I	comunque dice era orientato ieri si orientava		
	INF1	*((to the US nurse))* no		
	N	not today		
65	I	[non oggi		
	INF1	[questa notte] completamente [guarda		
	I	[(not)] last night [at all		
	INF1	[alla collega]		
		l'ha fatta impazzire i pazienti si sono tutti [lamentati=		
70	I	[nurse –		
	INF1	=perché non ha [riposato nessuno		
	I	[nurses and patients] were complaining about him		
	N	really↑		
	INF1	[yes		
75	I	[that] they were not able [to rest		
	INF2	[*((willing to continue))* *pa::in*		
	INF1	dolore no		
		con me non l'ha avuto	I	pain no pain

				with her
80	INF1	⌜e::::=		
	INF2	⌞neurologico		
	INF1	=neurologico	I	neuro
		ti ho detto di – è un po'		
		disorientato	I	he's not
85	INF2	ma cammina		oriented
	INF1	e::hm con i fisioterapisti sì		
		ha camminato	I	and he's –
	INF2	disorientato però		has been walking with the
	INF1	è stanco		physical
90	INF2	però (se)		therapists
		cammina wa[l]king ( )		
	INF1	no è debole		
		è un po' debole	I	but he's very weak
		e si lamenta perché::		he's weak and
95	INF2	è pigro forse		
			I	is he lazy↑
	INF1	anche		
		non si riesce a capire se	I	yes a little bit
		ha veramente dolore		
100		fo::rte o se è pigro	I	we cannot understand if it's the pain or if
	INF2	polmonare non c'è da dire niente		he's lazy just lazy
	INF1	sì è in room [i][e][i]r		
105	INF2	room air	I	room air
	INF1	e:::hm aspetta		
		>te lo dico io<	I	he's in room air
		allora cardiovascola::re		
			I	cardiovascular
110	INF1	e:hm vanno bene i segni		
		vitali ha un right forearm	I	vital signs are fine
		numero venti		
		((phone ringing))	I	right forearm (.)
	INF2	°( )° ⌜°( )°		twenty gauge
115	INF1	⌞aspetta⌟ (.) lui		
		praticamente::: e::hm >fa< (.)		
		°queste immunoglobuline°	I	he has
		((pointing at the item on the Kardex))		
120			I	he's doing these
				immo – immuno-globulins
	INF1	H big da cinquemila unità		
		perché ha ricevuto u::n fegato	I	five thousand units
		da:: un paziente H – e::hm *B*		
125		positivo		
			I	because he's received a
	INF2	e lui è↑ (.)*zero* positivo		liver from a B positive patient
				and
	INF1	B positivo H B V positivo		
130	INF1	*((announcement over the intercom))* a:::h H B V		

		a::h a::::h [°bellissimo°]	I	he's H B positive
	INF2	[e quindi] fa		
		le:: immunoglobuline *anti*		
135		epatite B		
			I	so he's doing the immuno-
	INF1	ce l'ha		globulins
		in corso		
			I	and
140	INF1	allora dal punto di vista		they are running right now
		gastrointestinale		
	INF2	e quando le fa ogni giorno a		
		mezzogiorno↑		
	INF1	sì °sì°		
145		*((INF2 looks at the Kardex))*	I	every day at twelve (.) midday
	INF2	quindi è allergico al – al mezzo		
		di contrasto	I	allergic to contrast dye
	INF1	e all'aspirina		
	INF2	questo è importante	I	and aspirin
150	INF1	da un punto di vista		
		gastrointestinale		
			I	G I
	INF1	è in soft diet		
			I	°he's on a soft diet°
155	INF2	è in soft↑		
	INF1	diet in right lower quadrant		
		e::hm ha un J P		
			I	°he has a J P°
	INF1	che drena tracce		
160		J P B perché A l'ha tolto	I	right lower quadrant draining
		questa mattina		traces J P B J –
	INF2	tra – tracce↑		
	INF1	sì tracce e anche in left lower	I	uh – A was discontinued toda –
		quadrant ha un		this morning
165		J P C		
		che drena ( ) pure tracce	I	and also has a J P
				C in the left
	INF1	ha l'accu-chek before		draining some traces
		meals		
170			I	°accu-chek° (.)
	INF2	pure		°before
	INF1	sì		meals°
		i bowel movement sono		
		presenti (.)		
175		e::: i suoni intest –	I	bowel movements
	INF2	anche alle ventidue		are present
		scusami↑		
			I	active
	INF2	°( )°		
180	INF1	*((looking at her notes))* no		
	INF2	no↑		
	INF1	no		
	INF2	dimmi		
	INF2	e::hm fa l'accu-chek perché		

185		fanno:: cortisone ( ) e quindi e:::	I	he does accu-chek because they are doing cortisone
			I	he's on cortisone
	INF1	però		so
190		ha fatto aria ha sempre lo stimolo di andare in bagno vuole andare in bagno però è aria quindi ha canalizzato (un po' d') aria	I	and he is passing gas he feels he has to go he has to move his bowels
195				but (.) it's just (.) >gas<
	INF1	aveva il Foley l'abbiamo – l'ho tolto		
			I	Foley
	INF2	ha urinato↑		was discontinued
200	INF1	no dopo che ho tolto il Foley no	I	he hasn't – (.) voided since then °so°
	INF1	però ho fatto il bl[a][d] training		
205			I	he has been doing the *bladder* training
	INF1	anche se *((chuckle))* scientificamente forse dicono che non è provato ma	N	°( )°
210		°( )°	I	even though they say scientifically speaking isn't –
	INF1	e io l'ho fatto aveva lo stimolo		this thing is not approved
			I	>it hasn't been approved the
215				bladder training that she's done<
			N	what is that
	I	cos'è↑ (.) questo::: la::		
	N	bladder training °what is bladder training°		
220	I	vesc – =		
	INF1	=what↑		
	I	la ginnastica ⌜vescicale dice che cos'è=		
	INF1	⌞what↑ ginnastica ve –		
	I	=che:::		
225	INF2	*((to the US nurse))* e:::hm praticamente quando un paziente tiene per molto tempo il Foley		
	INF1	⌜la vescica – ⌝		
	I	⌞when the ⌟ patient has the Foley for l – ⌜keep=		
	INF2	⌞e::hm		
230	I	=*has* ⌜the Foley=		
	INF2	⌞l'urina –		
	I	=for a long time		
	INF2	l'urina esce sempre		
	I	so he just urid – voids ⌜spontaneously=		
235	INF2	⌞quindi la vescica		
	I	=(has) always °( )°		
	INF1	non ha più		

INF2 la vescica non si [allena più nella=
I [and so the::
240 INF2 dilatazione [e nel restringimento]
I [bladder is no longer] trained in contracting and –
((the US nurse nods))
INF2 okay e quindi ehm si *chiude* il – il sacchetto
[del catetere per far riempire la vescica]
245 I [and so we clamp the bag] so that the:: bladder
INF2 non appena [il paziente=
I [gets full
INF2 =ha lo stimolo
I so as soon as [he has the
250 INF1 [si apre
I [stimulus if he has to pee
= [ ]
INF2 [stacchiamo e si apre e senti] *((making the sound of a deflating balloon))* [e si sgonfia]
255 I [we unclamp] it and (.) and (.) [it deflates]
INF2 [però questo] più che
altro è previsto quando i pazienti
[tengono più di una settimana il:: catetere vescicale]
I [usually we do this when they have the Foley for more than a]
260 [week]
INF1 [lui] [l'ha messo il ( )]
N [°(he had it) three days°]
INF2 [*((to the US nurse))* okay↑]
I [lui] l'ha avuto per tre giorni
265 INF1 praticamente
N *((to INF2))* °thank you°

INF1	questo paziente dopo aver f – è tre giorni che ha fatto il trapianto e già tu lo vedi::		
270		I	he::: this is his third
INF1	si è ripreso benissimo non è che ha °( )° però		uh post-op day and he's doing well
INF2	probabilmente è l'F K	N	( ) *((soft chuckle))*
275 INF1	infatti	I	*((soft chuckle))*
INF2	il paziente è nervoso perché (.) può essere una delle probabilità	I	but he's nervous
	può essere	I	because
280	anche dovuta all'F K=		
INF1	=al – =		
INF2	=al:: prograf	I	maybe he's also nervous because of the prograf
INF2	l'antirigetto		the F K the:: uh
285			anti::
INF1	sì (è vero)		rejection:: drug
INF2	è il farmaco:: il farmaco antirigetto		
		I	so he's nervous
290 INF1	°tra l'altro è un sintomo		because of this drug

		della tossicità da farmaco ( )		anti – anti-rejection
		( ) tra l'altro questo fa::°		
	INF2	vabbè questa è una cosa in più va' (.) poi vabbè		
295	INF1	lo studio allora		
	INF2	>°(mhm)°< (.) quindi integumentary abdominal in[tʃ]ision		
	INF1	yes ┌ open to air		
300	INF2	└ open to air		
			I	abdominal incision open to °(air)°
	INF1	dry intact		
	INF2	dry (ed) intact		
305	INF1	°yes°		
			I	*dry* and intact
	INF2	ismett one ┌ and=		
	INF1	└ domani		
	INF2	=F K for tomorrow↑ *((INF1 nods))*		
310				
	((pause)) ((INF2 goes on writing her notes))			
	INF2	*((to the interpreter))* >t – t – < ti::: diciamo risparmio un po' di lavoro		
		┌ °diciamo°		
315	I	└ grazie *((chuckle))*		
	INF1	( ) *((chuckle))*		
	INF2	chest [iks]-ray do::ne all done↑ *((INF1 nods))* done done		
		┌ done done=		
320	INF1	└ sì: ce:rto		
	INF2	=done (.) *((erasing items from the Kardex))* cancelliamo tutto		
		┌ sì:: brava=		
	INF1	└ mhm mhm mhm		
325	INF2	=precisa °brava°	I	all done *((chuckle))*
			N	( ) ┌ ( )
			I	└ ( ) *((chuckle))*
	INF2	yes yes yes		
	I	cancella dice *((soft chuckle))*		
330	INF2	*((to the US nurse))* non mi interessa neanche sapere cos'ha fatto		
	I	she doesn't even want ┌ to (know) what he has done ┐		
	INF2	└ perché:: ci confondiamo ┘ di più		
	I	we don't want to get more confused		
	INF2	si guarda in cartella ┌ che=		
335	I	└ so		
	INF2	=c'è scritto		
	I	we just need to look in the chart		
	((short pause))			
	INF2	okay↑		
340	N	okay (.) *((writing down her notes)) ((background voices))* o:::kay		
	INF1	ha il tramadol:: (.) °( )°=		
	INF2	=P R N e cos'è questo↑	I	tramadol P R N

		((pointing at an item on the Kardex))		(.) and what is this
345	INF1	allora lui ieri pomeriggio ha avuto una reazione allergica agli occhi pensavamo che era il::: *deursil*	I	he had yesterday an allergic reaction (.) in his eyes *((pointing at the item on the Kardex))* we thought it was this
350				
	INF1	ma::: stamattina l'ha preso e con me non l'ha	I	but
355		avuto		
			I	this morning he was fine
	INF1	quindi hanno prescritto queste goccine per gli occhi perché lui non l'ha mai fatto		he:: took the same drug and he didn't have any reaction
360	*((background voices))*			
			I	so he has been using this *((pointing at the item on the Kardex))* he's using this for
	INF1	(forse) è allergico ai guanti non		this allergic reaction
365		abbiamo ancora capito		
			I	maybe it's the
	INF1	non riusciamo a capire che cosa c'ha °( )°		gloves
			I	but we do not understand what
370				(.) °it's
	INF1	io ho avuto la reazione quando io gli ho dato deursil e poi gli ho messo in		causing the: reaction°
		corso la – il °( )°	I	the reaction was after she gave
375				deursil (.) and –
	INF1	dice che l'ha avuto anche la mattina ma in consegne non me l'ha detto nessuno (.) e::		°the other drug°
380		( )	I	I wasn't told about that in the
		( )		( ) but –
		la fisiologica è venuta {Irma} {Isabella} (e gli abbiamo messo) questo – questo collirio		
385		però stamattina		
		io gliel'ho dato	I	so they've been using that
	INF1	a mezzogiorno		
		però alle otto	I	drug a medication
390		l'ho sospeso il deursil a mezzogiorno		
		gliel'ho	I	this –
		dato e non ha avuto nessuna		
		reazione allergica e neanche	I	the drug was then suspended
395		quando ha fatto gli antibiotici		and after he hasn't

		quindi io presumo che siano i guanti che noi usiamo al lattice		had any allergic reaction so they think she thinks it's the gloves the latex gloves
	INF1	ho usato gli altri		
400		(.) quelli là:: di vinile e ha avuto meno lacrimazione		
			I	( ) – she suggested not using
	INF1	quindi credo che siano i guanti		those gloves
				and the reaction was:: (.) a little
405	INF1	quindi		bit less
		non tanto allergico – =		
	INF2	=ma i medici lo sanno questo		
	INF1	sì non hanno prescritto niente	I	do doctors know↑ yes:::
				but they haven't prescribed
410				ordered not – anything
	INF2	okay		
	((an Italian nurse passes by and greets INF2))			
	INF2	*((to the Italian colleague))* ciao		
415		(.) okay		

((the three nurses look at the orders in the medical record))

NR.FL.07

Typology	End-of-shift nursing report (reported cases: 2 out of 3)		
Place	ISMETT regular admission unit (Floor)		
Date	January 30, 2006		
Time	2:00 p.m.		
Duration	00:08:32		
Interpreter	Julia		I
Primary speakers	Outgoing nurse, Italian	(female, aged 31-35)	INF
	Incoming nurse, US	(female, aged 51-55)	N
Observers	Second researcher (EI)		
Situation	▪ The US nurse is sitting at the nurses' station in front of a monitor viewing the patients' electronic medical records, while the Italian nurse and the interpreter are standing next to her, with the interpreter between them. ▪ During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets. ▪ When the interpreter arrives, the report on the first patient is almost over. Therefore, the transcribed recording only concerns the other two patients.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

((background voices))
INF poi {Pellizzari} (.) resezione gastric – gastrica per ca – per un:: carcinoma e::hm gastrico
I gastric resection for gastric carcinoma
INF però lei non lo sa che aveva un carcinoma
I the patient doesn't know that she had a cancer
INF °sapeva che aveva un'ulcera°
I she knew:: that she had an ulcer
INF lei è in N P [ɔ] (.) solo: un poco d'acqua per prendere i farmaci
I just some water u::h with medications
INF ha questa right intrajugular due lumi
I *((louder background voices))* °( )°
INF appena finisce il (.) potassio e il fosforo che stanno andando
I uh potassium and phosphorus↑ uh are running at the moment
INF appena finiscono si deve togliere
I when they finish it has to be pulled out
INF poi ha un:: (.) left (.) antecubital number ehm (.) twenty dove sta andando normosol↑
I normosol is running
INF a cento C C orari
I one hundred C C an hour
N in the art (.) >hep-lock<
I °in the (left) A C yeah°
INF le ho tolto il Foley ora
I Foley just now discontinued=
INF =quindi deve vedere se urina da sola=

I =you have to *check* whether she is voiding (.) by herself=
INF =non è andata ancora di corpo=
I =no B Ms=
INF =ha fatto aria comunque
I *but* flatus
INF ha un: right lower quadrant J P (.) to bulb suction (.) serosanguineous °(with me)° one hundred °with me° (.) e:::hm D C teds (.) avev – edema agli arti superiori infatti:: [è difficile prendere:: accessi venosi
I [upper – to – to the arms –] edema
[to the arms=
N [*((writing down her notes))* edema
I =so it's:: (.) *hard* to find an I V access=
N =mhm
INF anche lei è diabetica e ha [l'accu-chek=
I [(she's) diabetic
INF =ogni sei ore
N *((writing down her notes))* diabetic
I accu-chek Q six hours=
INF =sì (.) alle:: dodici non ha avuto bisogno perché era centotrentanove
[la glicemia]
I [she::::] didn't need anything at noon >blood sugar was< one hundred and thirty-nine
INF gli tocca ora a: diciotto a lei
I so no::w (.) it will be at six P M
INF e:: seguire la scala
I and you've to (.) follow the scale
INF potassio e esafosfina *messi* tutti e due quindi appena finisce può togliere tutte cose
INt: e::hm (.) cioè messi >nel senso che sono in corso↑<=
INF =sì nel senso che – [sì è l'ultima sacca del potassio
I [the potassium and esafosfina are running] the last bag is running right now and you can [°discontinue them°
INF [e sono stati] scaricati e tutto
[no V B G]
N [they have] already been charted (.) e::hm=
I
INF =dom – =
I =niente V B G↑
INF no no
N °okay°
INF lei domani deve fare un: gastrograph[in] del:: (.)
[dell'apparato gastrico]
I [she has to do] *((reading from the Kardex))* gastro –
[ga:::strograph[in]]
INF [per vedere – sì] (.) se – per vedere [se può mangiare=
I [tomorrow
INF =poi domani
[tomorrow
N [tomorrow
I
INF yes
I to see whether she will be able to *eat* tomorrow
N >okay<
INF okay↑ e: basta le faccio vedere:: gli ordini

I >that's it< °I'll show you the orders°
((the Italian nurse opens the medical record)) ((shuffling of pages))
INF *((reading from the medical record))* R X gastrograph[in] (.) domani (.) in A M (.) ehm:: (.) per:: gastrodigiuno e::hm anastomosi D C teds D C central line D C Foley ismett due esafosfina quarantasette millimoli and potassium quaranta milliequivalenti (.) done=
N =°done°
INF okay↑=
N =°okay°=
INF =°okay°
N °all right° next↑
I °il prossimo°
((pause))
INF e chi ha ora↑
((pause)) ((the Italian nurse looks at her notes))
INF ehm {Porrinello}↑
I what – the next one is °{Porrinello}↑°
N yeah
INF la ragazza {Porrinello} lei è stata trapiantata:: di polmoni per la fibrosi cistica
I she had a lung trasplant because of cystic fibrosis
N when
I quando↑
INF ehm giorno::: eh (.) °boh° *((looking at the Kardex))* °{venti} qua c'è scritto° quindi [penso giorno {ventuno} ^penso giorno {ventuno}^]
I [there is written the {twentieth}]
but I *think* on the {twenty-first}
INF *((looking at the Kardex))* °non c'è scritto° (.) *((background voices))* >allora< ^lei::^ psicosociale è un po' depressa [però va bene]
I [psychosocially] she is
a bit *depressed * [°but it's okay°]
INF [neurological] è debole però è indipendente=
I =neurological she is *weak* but independent
INF è in regular diet con la calorie count
I *((whispering))* °regular diet°
INF però::=
I =*((whispering))* °calorie count°
INF ho dimenticato di metterlo in stanza oggi [°(quindi –)°]
I [di mettere] scusami↑
INF *((smiling))* >ho dimenticato di mettere il foglio< della calorie count in stanza
I oh I forgot to place the *sheet* with the calorie count:: in the room
INF *((sounding tired))* ora gliela porto=
I =I'm gonna (.) bring it (.) °now°
N *((chuckle))* >you can write down what you get for lunch< *((chuckle))*
I >I'm [sorry↑<]
N [>lunch lunch] what you (have) for lunch< *((chuckle))*
I basta che scrivi cosa *((chuckle))* hai mangia::to per pranzo↑
N *((laugh))* >I don't know↑< okay
INF e::hm (.) >quindi< lei è diabetica↑
I *((whispering))* °she's diabetic°=
N =diabetic
INF fa l'accu-chek prima dei pasti e alle ventidue

I [>quindi< a lei tocca alle diciotto
I [accu – chek before meals] and at ten P M >so the next one<
135 at (.) six P M
INF è e::hm allergica a questi antibiotici *((pointing at the items on the Kardex))* meropenem amoxicillina °( )°floxacina (.) *però* (.) nonostante sia allergica al *meropenem↑* (.) siccome lo *deve* fare indispensabilmente infatti gliel'ho attaccato ora=
140 I =>okay< she's allergic also to this antibiotic *((pointing at the item on the Kardex))* right↑ *but* she absolutely *needs* it
INF meropenem
I *((reading from the Kardex))* me:: ro::pe::nem
N so:: what are we doing=
145 I =so=
N =( ) her some pre-meds↑ or –
I quindi cosa bisogna fare=
INF =niente gliel'ho messo io alle quattordici
I [ma metterlo >*lento lento lento lento lento lento lento lento lento*<=
150 I [I've jus::t hu::ng it no::w
INF =>lento<=
I =at uh two P M but it has to be *really really really* slow
((pause)) *((the US nurse goes on writing her notes))*
N °okay°
155 *((short pause))*
INF ha:: un'incisione qua *((pointing at the exact position on her chest))* °sottomammaria↑°
I u::h underbreast [incision
INF [toracica] *((chuckle))*
160 I *((smiling))* *((whispering))* °thoracic incision°=
INF =open to a[i]r dry e intact (.) ha un sacco di farmaci strani (.) che però trova tutti nel senso [che sono divisi
I [she has many] (.) *weird* medications but >you'll find< (.) them all [in the –
165 INF [sono divisi tra] il frigo – nel bin nel frigo e il bin *fuori* dal [frigo
I [some are –] some of them are in the *bin* in the: refrigerator and others are in the bin *outside* the refrigerator=
N =in hers in her own okay
170 I nel *suo* bin=
INF >sì sì sì sì< li trova tutti sono un po' [strani ma li=
I [you'll find
INF =trova tutti=
I =them all
175 N °okay°
INF e::hm (.) basta (.) >non ci sono stati ordini perché lei non l'ha vista nessuno< [°ancora non l'ha vista nessuno°]
I [there were no orders] be::cause the physicians haven't seen her yet
180 N >°right°< *((background voice))* (.) that's the slow cardiologists >°(it always ends up this way)°<
INF i toracici non hanno fatto nessun giro *((background voices))* ancora=
I =there was no thoracic u:::h *round*=
N =okay (.) °okay° (.) so she is on F K too
185 I sta facendo anche l'F K↑

INF no ehm cioè l'ha fatto stamattina [sì fa l'F K
I [she did it this] morning
N >okay<=
INF =però siccome nessuno li ha controllati dei – dei medici
I yeah no physician [checked –
N [°right°] the levels
I the levels=
INF =quindi non han scritto ordini per domani=
I =so no orders have been written for tomorrow
N >°okay°<
INF non so quando lo faranno st[u] giro (.) di pomeriggio=
I =I don't kno::w when (.) they are going to round maybe=
N =>okay<=
I =in the afternoon
INF mhm (.) e basta↑
N that's okay
INF è ma:::gra >magra magra magra magra [magra magra magra °magra°<
I [she's *very very* skinny
N skinny↑
I yeah
N o::h
((pause))
INF *((ironically))* >^metà:::^< *((indicating half of her leg))*=
N =oh↑
I half
N well *((laugh))* so skinny↑ *((pointing at the interpreter))*
INF ^no::^ no [lei:: *((chuckle))* is [good
N [*((laugh))* [*((laugh))*
I [*((chuckle))* more more skinny
N *((chuckle))* okay=
INF =i medici guarda *ora* sono °saliti°
I i medici scusa↑
INF sono ora nella stanza *((pointing at the patient's room))*=
N =>(so)<
I physicians [are=
N [yeah
I =>right now< °in (her) room°=
N =yeah [okay
INF [okay] basta
N ^now^
INF *((ironically))* a::h ba::sta↑
N *((pointing at her notes))* these (.) {six fifteen} [{six thirty}=
INF [allora
N =no↑ (.) neither one↑=
INF =no no ( ) (you)
N okay [°ah okay °]
I [nessuno↑] (.) dei due↑
INF questo *((pointing at the patient name in the US nurse's notes))* c'è::
perché [aspetta::=
I [this::
INF =i: vestiti (.) però già c'è la lettera di [dimissioni pronta]
I [oh there is –] (.) the –
discharge letter is ready↑ he's just waiting for his clothes

N °oh okay {six thirty}↑°
240 INF [gli deve – non gli] ho tolto l'acceso venoso
I >I didn't< (.) pull out the I V access=
INF =perché ho detto non vorrei che si sentisse ma:le prima che se ne vada=
I =because I was: afraid he could feel:
245 INF [sick before leaving
quando è pronto pronto che se ne va] glielo leva
I when he is:: >*ready* to go< jus:t (.) pull it out
N *((writing down her notes))* D C
INF aveva fatto un cabg per tre
I [he had a cabg times three
250 N okay is there a new person coming in↑
I quindi c'è una nuova persona che arriverà [nella sua stanza↑=
INF [penso di sì
I =I think so
N °okay° all right
255 INF va bene↑=
N =okay (.) all right

NR.FL.08

Typology	End-of-shift nursing report (reported cases: 2)		
Place	ISMETT regular admission unit (Floor)		
Date	March 7, 2006		
Time	2:00 p.m.		
Duration	00:09:55		
Interpreter	Henry		I
Primary speakers	Incoming nurse, Italian	(female, aged 21-25)	INF
	Nurse, Italian	(female, aged 21-25)	INF1
	Outgoing nurse, US	(female, aged 51-55)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station in front of a monitor viewing the patients' electronic medical records, while the interpreter is sitting between them. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical records and patient Kardex sheets. ▪ At some point, another Italian nurse approaches them and addresses the Italian colleague.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

((background voices))
N […] (this) afternoon↑
I è venu – è arrivato questo pomeriggio=
N =okay↑ (.) doctors wrote *orders*=
I =i medici [hanno scritto gli=
N [^a little bit ago↑^
I =ordini
INF mhm=
N [°okay°]
= [ ]
I [giusto:] un:: (.) p – =
N =>he was in<=
I =poco fa=
N =*outpatient* (.) before here
I era giù in ambulatorio prima di venire su
N had type 'n' screen done and labs done
I gli hanno fatto il type 'n' screen e tutti gli esami:: (.) tutti i [prelievi]
N [he came] up here and they *ca::lled* for him and said (.) need to go to *cardiac cath*
I è arrivato su: (.) l'hanno chiamato su >per dire che doveva andare giù a fare< la: >cate(te)rizzazione<
INF mhm
N so *of course* I told him (.) get undressed↑
I quindi gli ha detto spogliati
N >I threw in< an eighteen here *((pointing at the exact spot on the arm))*
I ha messo dentro un:: diciotto

N (and) took him down°stairs°
I e l'ha portato giù
N I show::ed (.) the people *downstairs↑* (.) the orders
I ha fatto vedere gli ordini a quelli giù:
N I said for after *midnight↑*
I >e ha detto per – <=
N =°cardiac cath°=
I =>la cateterizzazione< per dopo mezzanotte
N 'cause they said no shave↑ I said *no*=
I =>perché< non è stato:: non l'hanno raso
N >they just had orders written↑< *((sarcastic chuckle))*
I hanno appena scritto gli ordini:↑ °appena adesso quindi::°
N they said fine °the cath is ( )°
I hanno detto va bene °allora lo faremo ( )°
N they're *crazy*
I son – sono pazzi
N *((laugh))*
INF allergie ne ha↑
I [any allergies↑
N [we didn't even –] we didn't – *here* *((pointing at the Kardex))* I got (.) no known allergies
I niente allergie
INF vabbè
N I got to write *everything* he's in with L A D
I è qui per – lo con ale – al – L A D *((to the US nurse))* and that is to say↑
N L A D and R C A
I e R C A
N coronary artery disease
((the Italian nurse nods))
I una:: [°( )°
N [°coronary artery disease°] C A D (.) okay↑ N P O: and he *left*
I °yeah° okay [è in N P [ɔ]↑=
N [he's down
I =e poi è giù – [ed è giù a=
N [he's down there
I =fare i:l [cateterismo
INF [cioè è venuto] solo per il cateterismo giusto↑
I he's just here for that basically for the:=
N =I guess=
I =cardiac cath=
N =*yea::h*
INF okay (.) {Piana} {Pasquale}
I [{Piana}↑
N [but it –] but it was supposed to be written for tomorrow so::
I [there is orders
[ma difatti doveva essere domani] quindi ci sono tutti gli ordini difatti
N [troverai
[°okay] there's orders on that° (.) >I think it's a work-up< my personally (.) for transplant
I forse magari un work-up per il trapianto
N >°but I don't know°<
INF >okay<

N okay↑ (.) a::ll right
((the Italian nurse checks the patient's electronic medical record; sound of the enter key))
INF {Piana} {Pasquale} è pure suo↑
I chi scusa↑
INF >{Piana} {Piana}<
I >{Piana}< is {Piana} yours↑
N *((looking at her notes))* °{Piana(si)}° ^no::^
I no
N *((looking at her notes))* >what< I don't know (.) no:: (.) no
INF [no ^this guy's gone^=
INF [letto uno è vuoto↑
N =this – this guy was *in that bed* [this is like=
INF [ah se n'è anda:to
N =*((sound indicating departure))*
I [°(he's gone)°=
INF [°(va bene)°
I =okay
INF *((deleting the name from her notes))* °( )°
N okay who else [>that's it↑<
INF [okay
I poi↑
INF {Pavano} {Patrizio}
I {Pavano}
N o::kay {Pavano} (.) mister {Pavano} {Patrizio} ^*watch*^ there's due:: (.) {Pavanos} on the [>floor now<]
I [ci sono] d:: due {Pavano} qui
N okay↑
INF okay=
N =>there's one right up here *((pointing at the patient's room))*
INF [°(it's here)°<
INF [noi abbiamo {Patrizio:::}
I ce n'è uno anche uno qua
N >okay↑<=
I =she has {Patrizio}
N °okay° *in* with heart failure↑
I è qui per insufficienza cardiaca
N he was a work-up for cardiac transplant
I era qui per il work-up per:: il trapianto per:: di cuore
N found he had a mass on the right
I hanno trovato un:: una *ma:ssa* (.) sul lato destro
N so they did a *thoracotomy*
I hanno fatto una:: [toracotomia]
N [°I don't know] when°
I non sa [quando]
N [in the past] (.) *((looking at her notes))* I didn't write it down↑
I non l'ha:: [segnato comunque]
N [*((pointing at the Kardex))* ah >right there<] >right there<=
I =lì *((pointing at the Kardex))*
N on on the *eight*
I *((pointing at the item on the Kardex))* °qui° (.) i::::
INF {trentuno}=
N =yes=

INF ={gennaio}=
I =the [{thirty-}=
N [okay
I ={first} °of {January}°
N okay↑ (.) he's no *more* on N P O
I non è più in N P [ɔ]
N I don't know why they haven't ( )
I non sa perché è ancora [°è segnato qui°
N [from yesterday
INF [reg[u]lar↑]
N [he wen –] (.) he went [down
I [regular diet↑
N yes yes
I regular
N he went down yesterday
I è andato giù ieri
N for *cardiac cath*
I per fare il >cateterismo<
INF l'ha fatto↑ °(il cateterismo)↑°
I ha fatto il cateterismo
N >they went through< his right groin
I sono entrati:: dentro l'inguine destro
N okay needless to say he's alert and oriented
I quindi è all'e:rta e:: [orientato]
N [good] spirits
I di b::uon umore
N *walked* (.) >in the room<
I cam::mina nell: nella stanza
INF >mhm<
N ha:::s a:: a chest tube
I ha un chest tube
N to twenty C M water seal
I quan – a:: venti (.) water seal
N I did the dressing (.) this morning
I ha cambiato la medicazione [stamattina]
INF [°mhm°] destra↑
I right right↑
N °yeah° (.) put a new whole chest tube (.) [*container*=
I [ha messo
N =yesterday
I ha messo un: nuovo contenitore per il chest tube ieri
INF mhm
N has *staples* above (.) chest tube
I c'ha gli staples *sopra:* il chest tube
N open to air
I sono open to air
INF nell'incisione↑ [°( )°=
I [this is
INF =°staples°=
I =on the incision for the incision:: [the staples↑]
N [no abov –] (.) above

	I	[above it above it= [sopra °sopra°
185	INF	[°ah proprio sul chest tube°
	N	=okay↑ (.) *((background voices))* it's only like this much *((showing the size with her hand))*
	INF	[okay]
	I	[è un] tratto più o meno:: grande:: >saranno una decina< di centimetri
190	N	okay (.) u:h (.) *((whispering aside))* °ah what else did I want to say°
	INF	e drena↑
	I	is it draining anything↑
	N	*yes yes* (.) *somehow::↑* he went down to chest X-ray today
	I	è andato giù a fare l:la:: radiografia (.) al torace=
195	N	=and I *noticed* that (.) all the *chambers*
	I	e ha visto che (.) tutte le::=
	N	=have stuff in it so I had to mark ninety [for the one↑]
	I	[che tutte] le camere
		[avevano:: qualcosa:: più di novanta=
200	N	[a hundred and ten for the other and sixty for the other
	I	=cento*dieci* e sessanta
	N	so he actually had that
	I	quindi difatti
	N	*((aside))* *((looking at her notes))* °ninety:: (.) zero:: (.) nine ten six° *((to the*
205		*Italian nurse))* *two* (.) *sixty*
	I	ha fatto ha drenato [due e sessanta]
	N	[°two sixty°] and I put *lines*
	I	[e quindi ha metto
	INF	[in tutta la matti::na
210	I	over the whole morn – during the whole morning↑
	N	yes yes
	INF	okay [qua ha scaricato *((pointing at the electronic medical record))*
	N	[^I put lines::^
	I	ha [mes – =
215	N	[there
	I	=ha segnato *do::ve* i vari: [livelli
	INF	[oh °okay°
	N	'cause *somehow* [°it must° I said they must have fallen
	I	[perché in qualche modo forse nel trasporto
220	INF	mhm
	I	magari sarà cadu:to e quindi=
	INF	=mhm
	I	il drenaggio si è distribuito nei [vari::]
	INF	[ed è in] grado di quantificare:: (.) °qui
225		*((pointing at the electronic medical record))* [c'è°]
	N	[^I] didn't write anything in^
		[here yet don't – I'm – I'm not even near done=
	I	[lei non: ha messo:: niente in Emtek °ancora°
	N	=ready to go [home *((sarcastic chuckle))*
230	I	[perché non – non ne ha fat –] deve ancora far:tta la:: (.)
		[°('sta cosa)°]
	N	[I have] to write
	I	deve ancora aggiornare Emtek=
	INF	=mhm=
235	I	=fra tutte le cose

N I haven't even written *meds* all day (.) I think – =
I =cioè non ha manco avuto modo di:: segnare i m:: le medicazio:ni
N *((ironically))* you're gonna be *busy*
((chuckle))
240 I *((ironically))* avrai un pomeriggio::] pieno
N okay *so*
INF *((ironically))* che simpatica *((wholehearted laugh))*
((wholehearted laugh))=
I *((chuckle))* *((ironically))* you're so nice *((wholehearted laugh))*
245 INF = *((laugh))*
N I was busy fourteen hours yesterday
I *ieri* ha avuto d – è stata qui per quattordici ore
N and came back into the same mess *((banging her head against the*
250 *interpreter's shoulder))* *((laugh))=*
I ed è tornata qui e ha trovato lo stesso casino
N =okay *so* any(hows)
I comunque
N >(and where was I at now see)< umm
255 *((background voices))*
I the:: the drains
N *edema* (.) bilaterally↑
I c'ha edema bilate –
N ^*left*^
260 I nei:: due lati=
N =a little bit more swollen than right
I la sinistra un po'più gon:fia rispetto alla destra
N now ( ) a couple of days ago
I qualche giorno fa::
265 N *crepitus* in the arm
I ehm
N has *decreased*
I ehm ha le:: ehm cre:piti nel::: nel braccio:: e adess –
N since chest tube was
270 placed
I da quando gli avevano messo il chest tube ma
adesso no – non ce l'ha più
N °in the arm° *(it) has decreased*
I =e:::hm=
275 N =*swelling* has decreased
I anche il gonfiore:: si è °ridotto°=
N =had crepitus here *((pointing at her side))* too
I anche qui::
N but it's ^*gone*^ I haven't=
280 I ma è scomparso
N =noticed any more (.) >°(that)°<
I cioè non ne ha visto più
N okay↑ over the last two days °it's disappeared° (.) °okay↑°=
I =negli ultimi due giorni
285 N uh (.) voids spontaneously
I urina spontaneame::nte
N now (.) his blood pressure

I la [pressione
N [is] *low* (.) [a::ll the time
290 I [è bassa] sempre bassa
N eighty something [over eighty-six=
I [ottanti::na
N =for me [this morning °you can look° okay↑
I [su ottantasei puoi vede::re
295 N *still* [we need to=
I [comunque
N =give his captopril
I >bisogna dargli captopril<
N because if he goes high
300 I perché se dovesse salire
N >his heart will stop<
I >il cuore si blocca<
N that is why (.) they need (.) him to keep getting
[°the captopril°]
305 I [ecco] perché deve continuare a prendersi – °a prendere
[il captopril°]
N [a::nd what] we did was (.) *((gesticulating))* switch *captopril* and *furosemi::de* every couple of hours=
I =quindi ogni paio [di ore=
310 N [not together
I =si::: (.) si fa:: il captopril poi il [furosemi::de=
INF [sì °(lo so)°
I =ma non insieme
N if his blood pressure for you all nights is low low under eighty you have to
315 call – =
I =se la pressione dovesse scendere *so:tto* ottanta
N you have to call the doctor ^*but*^
I devi chiamare il me::dico *però*
N *((gesticulating))* ^you might^ (.) >turn around< *wait* >a little time< a little
320 bit of *ti:me* [it goes up
I [può succedere che] aspetti un po' e sale da solo
INF okay
((INF1 approaches them))
N >okay↑< he will get (.) new orders on [him↑]
325 I [ci] saranno nuovi
[ordini]
N [he will get] [warfarin tonight
INF1 [*((to the Italian nurse))* >sì< (ho fatto) alcuni R N G] che mancavano°
330 I dovrà fare la:: [v]arfarin [°stanotte°
INF [*((to INF1))* sì ho] [visto
N [>tonight<
((the Italian nurse opens the medical record)) *((shuffling of pages))*
INF1 *((to the Italian nurse))* ho inserito gli R N G [°che mancavano°]
335 N [he got it] *la:st* night
I l'ha fatto ieri no – no::tte *((shuffling of pages))* °pure°
N *((shuffling of pages))* °for me° (.) I gave him – =
INF =*((reading from the medical record))* chest [iks]-ray tomorrow↑

I [chest X-ray tomorrow↑]
340 N [chest X-ray tomorrow] sì (.) *((reading from the medical record))* I N R and lyte tomorrow morning
I [I N R=
INF [I N R::
I =e elettroli::ti domani mattina
345 N and give the warfarin (.) five milligrams
I dare [v]arfari:na↑ (.) cinque miligrammi↑
N they want *decrease* his *furo::semide*
I e >vogliono – < (.) [svezzar – lo]
INF [cinquanta] la matti::na↑=
350 I =ridurre la:: il furosemi::de
N °yes° (.) see↑ fifty in the morning
I cinquanta di matti:na
N >right< a:nd (.) twenty-*fi:ve* (.) and twenty-five [°(yes that's it)°]
I [e venticinque]
355 [e poi=
INF [okay
I =venticinque di nuovo=
N =°yes yes° (.) oka::y↑ and (.) *((looking at the medical record))* what is
[this↑]
360 INF [*((reading from the medical record))* (ves) tomorrow↑]
N (V) E S tomorrow: (.) morning
I poi c'è questo *((pointing at the item on the medical record))* domani mattina
N *((reading from the medical record))* *a::ngio C T scan* (.) for a:
I una tac: [a:
365 N [*((doubtful))* >°what's] that°< (.) I can't even read it↑
I *((getting closer to the US nurse))* non riesce a leggere
N *((trying to read from the medical record))* agree:: with doctor (.) something for an agree:: (.) something with doctor (.) *((misreading the name))* {Darti} (.) I agree↑
370 I *((reading from the medical record))* as for agreement [with doctor=
N [with doctor
I =*{Darbedo}*
N *{Darbedo}*
INF >cioè deve fare< [una::
375 I [come da [accordi con [il dotto:r::=
N [angio C T [(scan) tomorrow
INF [scan °okay°
I ={Darbedo}
N >so he's gonna have to be< – if it's a cardiac (.) >(there isn't) he's gonna have
380 to be< [N P O again↑]
I [non dovrebbe] essere di nuovo messo in N P [ɔ] di nuovo
N °after (.) [midnight↑ ( )°]
INF [umm (.) sì lo] penso pure io
I probably
385 N °okay° (.) 'cause I didn't know if they go in through here (.) *((pointing at the exact spot))* ^sometimes^ when they go in
[through here they don't have to °but I don't know°=
I [perché a volte quando entrano per di qua non serve
N =we'll have to find out
390 I comunque

N *((ironically))* a:h a::h I'm here again tomorrow↑
I [*((shaking her head))* ah no a::h no a::h God=
I [*((ironically))* lei sarà qui domani *((chuckle))* di nuovo domani
N =not me tomorrow (.) it'll be my last day I'm gonna bring – =
395 I =domani è l'ultimo giorno
N I'll bring a bottle of wine tomorrow
I porta una [bottiglia di vino *((laugh))*]
INF [questo potassio] delle tredici l'ha dato↑
I did you do the potassium at (.) [one o'clock]
400 N [^yes yes^] but I have to –
INF [se lo firmerà]
I [l'ha fatto] deve deve fare tutto
INF okay
N *((emphatically))* ( ) I haven't got( ) to do anything
405 I non ha avuto modo di fare:=
INF =okay
N okay

NR.FL.09

Typology	End-of-shift nursing report (reported cases: 1)		
Place	ISMETT regular admission unit (Floor)		
Date	March 11, 2006		
Time	7:00 a.m.		
Duration	00:04:57		
Interpreter	Italo		I
Primary speakers	Outgoing nurse, Italian	(female, aged 26-30)	INF
	Incoming nurse, US	(female, aged 46-50)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The two nurses are standing next to each other at the nurses' station; the interpreter is standing between them. ▪ During the interaction the Italian nurse reads from her notes and the US colleague jots down the information. They often check the medical record and patient Kardex.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

((background voices))
N no way to get organized (in there) *((chuckle))*
I >(difficile)< organizza::rsi *((embarrassed chuckle))*
INF ehm lei ha tol – *lui* (.) ha tolto u:::n (.) ehm dei::: linfonodi
I so [he had=
INF [( )
I =lymph nodes removed *((the LS mobile starts ringing; the Italian nurse mimics dancing))* scusate un attimo↑ *((Italo talks on the mobile and then hangs up))* °scusa sorry°
INF e::::hm (.) non ha avuto dol – *((louder background voices))* cioè ha av – ha dol – ha un po' di dolore perché lui ha [un right:::]
I [just a little bit] of pain
because he ha::s a::
INF >right chest tube<
I a right chest tube
INF to gravity
I °to gravity°
INF ehm però ha il tramadol in terapia
I and he also has *tramadol* (.) [on his therapy]
INF [infatti l'ho fatto] alle undici si è addormentato non ha avuto problemi=
I =he had it at eleven (.) P M and he *slept* °and everything was fine°
INF in più ha il cero::tto:: il du:=
I =plus he also has
((pause)) *((the Italian nurse looks at the Kardex))*
INF *((pointing at the item on the Kardex))* il duragesic
((the interpreter looks at the US nurse to see whether she understands))
N °has what↑° *((looking at the Kardex))*
I *((pointing at the item on the Kardex))* this=

30 N =ah [>duragesic<]
I [the one s –] she is showing to you↑
INF *((cough))*
I [*((chuckle))*
INF [neur=
35 N *((to the interpreter))* that's *((pointing at the paperwork))* not very good for the tape [*((chuckle))*
I [*((chuckle))*
INF [neurologico::: va be:::ne
I neuro she is oka::y
40 INF psicosociale v – va [beniss:imo=
I [psycho
INF orienta::to=
I =socially very well (.) he is oriented
INF ehm segni vita:li:: [vanno be:ne]
45 I [vital signs::] are okay↑
INF non ha edema
I no edema↑
INF ha u::n right hand numero venti↑
I right hand number twenty
50 INF ^è::^ >ancorato con una serie di cerotti< perché (.) e –
[*esce* praticamente
I [it's secured with
N mhm
I some (.) plasters [some=
55 INF [>ho messo – <
I =bands (.) °because it's not very well placed (by) the::°
N *((nodding))* mhm
INF polmonare [e::hm=
I [pulmonary
60 INF =s::tarebbe in room air [>normalmente satura<=
I [he is in room air
INF =novantadue novantatré
[>però per la notte gli ho messo la nasocannula<]
I [saturation is ninety-two ninety-] three but he had a
65 nasal cannula for the night
N °mhm okay okay° (.) *((looking at the medical record))* °here is an order°
INF il *chest tube* stanotte non ha dato nulla=
I =chest tube (.) no drainage (.) last night
70 INF *però* è caduto
I but it fell
INF e quindi praticamente=
I =*((whispering))* °it was misplaced°
INF e::hm ci sono le quattro colonne che sono *riempite* una per uno
75 I there are the four lines that a::re *filled* (.) the four lines – *((to the Italian nurse))* le quattro colonne hai detto↑
INF sì=
I =the four columns (.) that are (.) f – full
INF perché si è riversato il liquido quindi sono un po' °un po' un po'°=
80 N =the doctor knows↑
I e il dottore lo sa↑

INF no vabbè non c'è bisogno [però:: le ho segnate=
I [it's not necessary
INF =tutte quante c'è una [linea nera]
85 I [but ^she:^] mar – she labelled it with a (.) u::h
black sign (.) °with a black marker↑°
INF >tutto quello che sale nella seconda colonna< è [suo]
I [so] whatever it's
in – in the second column (.) *((the US nurse looks puzzled))* is yours (.)
90 °does it make sense↑°
N the patient fell (though)↑ °in my°=
I =^no no no^ the=
N =o::h the tube [fell out
I [stiamo parlando] del:: [>tube<
95 INF [drena::ggio
I °the tube [>sorry<°]
INF [sì sì] sì *((chuckle)) ((ironically)) ((to the interpreter))*
°che c'entra lei dice (in poche parole)°
I °aveva capito che il [paziente::°]
100 N [so::] it didn't fall completely out (.)
°it – °
I ma *non* completamente
INF ^no::^
I questo – il:: il drena:: cioè parlavi del tubo che::=
105 INF =il – *no* è caduto il – il:: water seal
I [the water seal
INF [si è riversato [quindi=
N [o:::h
INF =il liquido delle colonne=
110 I =it actually – (.) properly *spelt*
N °( )° *((chuckle))*
I *((laugh))*
INF *((chuckle))* e:::hm è in regular diet=
I =he is on a regular diet
115 N >wait< I wanna go back to the chest tube=
I =aspetta un attimino:: vuole ritornare sul: [chest=
INF [>sì<
I =tube
INF [>okay<]
120 N [so] (.) so just the (.) [the=
I [quind –
N =*suction* [the::: water seal=
I [quindi soltanto::
N =part [fell over↑ >is that what you mean↑<]
125 I [la *parte* del water seal
[che è caduto *((to the US nurse))* °yes°]
INF [sì sì solo] la parte del water seal
N °all right°=
I =okay so (.) only [this]
130 N [the] chest [tube in is fine
INF [se vuole adesso lo andiamo a] vedere
sì
I comunque il chest tube va:: [bene]
INF [sì] [sì sì sì=

135 N └ °no problem°
INF =sì sì *((chuckle))*
I if you want she can show it ┌ to you ┐
N └ no that's ┘ okay=
I =ah va bene=
140 INF =okay va bene
((pause)) ((the US nurse goes on writing her notes))
N okay ┌ *((laugh))* >I feel better< ┐
INF └ è in regula – *((laugh))* ┘ >è in regular diet<
I regular diet
145 INF ha il Foley
I Foley (.) ┌ on ┐
INF └ ha urinato ┘ *mille* comunque=
I =and he voided (.) one thousand (.) °ten° (.) ten hundred
N he – he does have a Foley↑
150 I he has a Foley
((pause)) ((the US nurse goes on writing her notes))
INF e::: e poi c'ha l'incisione::: nel chest tube che è coperta ed è pulita=
I =he has the chest tube incision (.) and it's covered and clean
((pause)) ((the US nurse goes on writing her notes)) ((background voices))
155 INF °a posto↑°
I that's it for him
INF domande↑
I ┌ any questions↑
N └ >does he get out the bed<↑
160 I si alza °cammina↑°
INF ehm è stato salito ieri alle dieci dallo step-down=
I =actually (.) he came here at ten (.) P M from the step-down=
INF =m'hanno detto che (.) neurologicamene (.) ┌ è a posto ┐
I └ °and she was told° ┘ she
165 was ^told^ that neuro he is okay↑
INF cioè ha dormi:to lui ┌ (con me) ┐
I └ and he slept ┘ basically (.) he slept °all night°
((pause)) ((the US nurse goes on writing her notes)) ((background voices))
N thank you=
170 INF =>okay<=
I =grazie

NR.SDU.01

Typology	End-of-shift nursing report (reported cases: 1 out of 2)		
Place	ISMETT step-down unit (SDU)		
Date	January 21, 2006		
Time	2:00 p.m.		
Duration	00:08:26		
Interpreter	Eric		I
Primary speakers	Incoming nurse, Italian	(female, aged 26-30)	INF
	Outgoing nurse, US	(female, aged 21-25)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station, while the interpreter is standing between them. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the patient's medical record. ▪ In the background there is the piercing sound of the monitors.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

((background voices))
INF a long shift (.) ago
N >long time ago< (.) okay so you know her history↑
INF °(yes)°
N *((embarrassed))* oh I'm sort of like – *((chuckle))* not ready *((chuckle))*
INF okay *((chuckle))*
N anyway *((chuckle))* (.) aortic va::lve (.) repair (.) and then like *((overlapping voice of another nurse))* ( )
INF mhm↑
N *((overlapping voice of another nurse))* ( ) after complications
INF okay
N *((overlapping voices of other nurses))* ( ) months ago (.) okay *((the Italian nurse nods))* (.) u:h psychosocially she's (.) anxious: she's okay (.) unless: someone's (.) *bothering* her
INF >mhm<
N like her family (.) but oth – but otherwise she's quiet (.) she was sitting at the side of bed today
INF >mhm<
N a::nd (.) no pain (.) she can move around (.) fine
INF okay (.) he hav::e (.) need (.) P R N no[t]ling↑=
N =no:
INF °okay°
N uh (.) she does sometimes have this headache *((touching her forehead with the right hand))*=
INF =>mhm<
N and her eyes hurt (.) which her (.) mum said it's chronic (.) she's had it for years 'cause she's blind (.) from one eye she's blind *((the Italian nurse looks at the interpreter))* and then (.) causes her to have a headache and [(troubles)=
I [è cieca

N =(reading)
I è cieca in un occhio e questo le causa mal di [te:sta
INF [il mal di testa] è per questo↑
I sì e anche dolore agli occhi (.) °proprio°
N so I mentioned it to the doctors (.) °but° (.) no order for pain med when I asked
INF °okay°
N u:h (.) normal sinus rhythm=
INF =>mhm<
N she has a left (.) *((pointing at the left arm))* A C twenty gauge (.) with D five and W (.) at a: (.) fifteen M Ls (.) >no blood return<
INF *((to the interpreter))* fifteen↑
I quindici
N u:h (.) no edema
I *((to the US nurse))* °you said *fifteen* right↑°
N °yeah° (.) u::::h↑ respiratory she's trach-mask twenty-eight percent and five liters of (.) oxygen
INF *((to the interpreter))* [a]t↑
I ventotto per cento
INF mhm
I e l – e cinque litri di ossigeno
N she:: s:::uctions for *thick* yellow (.) blood-tinged s – secretions (.) °(very thick)° (.) yuck
INF one time↑
N three
((pause))
N ^not a lot^ each time but it's just really °thick°
((the Italian nurse looks at the interpreter))
I sono molto dense gialle e aveva detto anche tinte di sangue
N and she (.) drops her sats when (.) she has:: (.) mucus *((pointing at her throat))* like a (leap) but otherwise they're ninety-nine percent
INF °okay°
N she's rhonchorous throughout and diminished (.) she has her (.) speaking valve on↑
INF >mhm<
N so she's talking (.) (always) *((making the blah-blah gesture with her hand))* blah blah blah [*((chuckle))*
INF
N she:: (.) G I she's on (.) has frebusin original through her feeding tube (.) at sixty M Ls *((overlapping voice of another nurse))* it's with the – it's::=
INF =and the rate↑
I [sessanta
N [sixty
INF oh (.) *original*=
N =*((nodding))* °yeah°=
INF =fresubin °original°
N °mhm° and (.) it ha – it's the system with the water flush °with the –° (.) you know the (.) wate:r and – =
INF =ah okay

N she *((mobile phone ringing))* also eats a pureed diet (.) but she eats (.) °small° babyfood (.) and doesn't eat very much
((pause)) ((background voices))
N she:: (.) >had a small bowel movement< overnight (.) she has her diaper on
I *((whispering))* °ha il pannolone ha avuto una piccola:: ( )°
((overlapping voice of another nurse))
N active bowel sounds (.) she has the Foley↑ (.) good urine output (.) Foley uh:: clear urine (.) she has *((announcement over the intercom; the Italian nurse moves closer to the US nurse to hear better))* a ulcer on her back (.) a decubitus ulcer (.) stage two
INF two↑
((the US nurse nods))
N and she has (.) on the back of her head like an *o::ld* ulcer (.) but it's healed °very ( )°
((pause))
N she needs to have a (.) transesophageal (.) echo (.) a T E E
I un ec – *((to the US nurse))* echocardiogram↑
N °transesophageal°
I un ecocardiogramma *transesofageo*
INF quando lo deve fare
I when is that
N I asked no one knows I'm assuming probably Monday↑
I ho chiesto ma nessuno lo sa=
N =she=
I =imma:gino (.) lunedì=
N =she was supposed to have it yesterday [°they never°=
I [dove –
N =did it
I doveva farlo ieri ma [non l'ha fatto]
N [I asked the doctor] today and he said wh – wh – whatever
I ho chiesto al medico oggi ma non – non mi ha dato una risposta precisa
N and then (.) and also an ultrasound of the (.) where the stent is and the (ureter)
INF mhm
N she also needs that (.) to check (.) the T E E is to check her pro – sthetic valve (.) *((the Italian nurse looks at the interpreter))* and then the (.) ultrasound is to check her stent °and the (ureter)°
INF serve per controllare lo stent↑
I la tac
N because she:: they want to make sure that she's fine 'cause she will be transferred to a different hospital (.) °this week sometime°
INF okay
N °that's i::t°
INF °there is order↑°
N yes
((the US nurse takes the medical record; the two nurses look at the orders))
N *((reading from the medical record))* ismett two tomorrow and I N R
((pause))
N *((reading from the medical record))* warfarin >one point two five milligram< P O once
INF mhm

N *((reading from the medical record))* start (.) acetam – (.) (lo::ma::zol) uh I can't say this *((pointing at the name of a drug on the medical record))* (acetazolamol) (.) (acetazolamol)↑ >I don't know how to say this< *((soft chuckle))* (.) A C E T (.) >turn to fifty milligrams P O< Q
140 eight
INF mhm
N *((reading from the medical record))* start (pola) – (polas) – B (M) two drops T I D (.) *((overlapping voice of another nurse))* °D C normal saline° (.) *((no longer reading))* you can increase the free water on that
145 (.) feeding pump can you↑
INF >mhm<
N will you show me↑ can you increase (.) the water on the feeding tube ( )↑ –
INF we can – (.) *((to the interpreter))* provare è try vero↑
150 I provare e *tentare* (.) >lei – lei vuol sapere< [se si può fa::re=
INF [possiamo provare
I =sì se si può provare
INF [°possiamo provare°]
I [vorrebbe vedere] come si fa sostanzialmente
155 N can you↑
INF possiamo provare *((chuckle))*
I we can try
N °okay° (.) 'cause I didn't know how to do it so it's still at twenty-five (.) M Ls
160 INF *((to the interpreter))* come↑
I dice io non sapevo come fare allora è sempre a venticinque M L
N that's it
INF °okay°
((pause)) *((the Italian nurse looks at the orders in the medical record))*
165 INF questi ordini li ha scritti ( )↑ *((pointing at a physician passing by))*
I *((whispering))* °did he write these orders ( )↑°
N °did he what↑°
I *((whispering))* °( )°
((pause))
170 INF *((pointing at the physician))* °li ha scritti lui questi ordini↑°
I did he write these orders↑
N one of them him and his friend
I *((whispering))* °lui e il suo amico°
INF *((laugh))*
175 N *((chuckle))*
I °( ) suo amico° *((chuckle))*
INF ehm (.) >io non capisco che cos'è questo farmaco<
N oh °let me see° *((looking at the medical record))*
((the Italian nurse asks an Italian colleague for advice about the medication;
180 *inaudible exchange))*
INF °oka:::y°
N okay↑

NR.SDU.02

Typology	End-of-shift nursing report (reported cases: 2)		
Place	ISMETT step-down unit (SDU)		
Date	January 23, 2006		
Time	7:00 a.m.		
Duration	00:08:43		
Interpreter	Georgia		I
Primary speakers	Outgoing nurse, Italian	(male, aged 21-25)	INF
	Incoming nurse, US	(female, aged 41-45)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The US nurse is sitting at the nurses' station, with the interpreter at her side. The Italian nurse is standing in front of them. ▪ During the interaction the Italian nurse reads from his notes and the US colleague jots down the information. They often check the medical records and patient Kardex sheets.		
Language direction	Italian > English / (English > Italian)		
Prevailing mode	Short consecutive		

N *((grabbing the tape recorder and singing))* [*((laugh))*
I [*((laugh))*
INF *((soft chuckle))* allora iniziamo
[con:::
5 N [*((pointing at the tape recorder))* >is that on] yet↑<
((the interpreter checks whether the tape recorder is on))
I yes it is↑ [*((wholehearted laugh))*
N [*((wholehearted laugh))*
INF *((chuckle))* >°allora°< ehm iniziamo con *{Poletto::}* {Patrizia}
10 I °we're starting° with {Poletto} {Patrizia}
N °okay°
INF {Poletto} {Patrizia} si trova alla stanza {quattrocento}
[{undici}
I [*((whispering))* °she's in] room {four hundred}° *((squeaking noise))*
15 °{eleven}°
INF letto {tre}
I bed {three}
INF non ha allergie la signora
I *((whispering))* °she does not have allergies°
20 INF il {quindici} {dicembre}
I *((whispering))* °on {December} {fifteenth}°
INF ha fatto il trapianto: di fegato=
I =*((whispering))* °liver transplant°
INF da donatore vivente
25 I *((whispering))* °it was a living related liver transplant°=
INF =°mhm° la signora era affetta da cirrosi alcolica
I *((whispering))* °she – alcoholic – she's affected by alcohol-related cirrhosis°
((pause))

30 INF ps[i]chological [okay=
I [*((whispering))* °psycho – °
INF =è orientata
I *((whispering))* °she is okay psychologically he thinks she is oriented°
INF neurological *out of bed* infatti si è [alzata pure
35 I [*((whispering))* °neurologically]
she's out of bed↑°
INF è andata in bagno
I she got (.) [into the bathroom]
INF [°andata in bagno°] per quanto riguarda il dolo:re↑
40 I as far as pain is concerned=
INF =ehm non ha avuto dolore (.) [con me]
I [she: has] not complained of any pain
with me
INF cardiovascular↑ ehm la signora è: [in::
45 I [*((whispering))* °C] V°=
INF =è in normal s[i]nus rh[i][t]m
I she is in normal sinus rhythm
INF c'ha un left antecubital (.) numero venti (.) come accesso
I *((whispering))* °number twenty°
50 INF c'ha il ritorno venoso↑
I there's a blood return
INF non sta facendo infusioni
I *((whispering))* °no infusions running at the moment°
INF non c'ha edema
55 I *((whispering))* °no edemas°
INF le pressioni sono buone
I *((whispering))* °the pressur – the blood pressures are good°
INF ha una frequenza cardiaca che si mantiene tra i
[cinquanta=
60 I [*((whispering))* °her heartbeat°
INF =e i sessanta [battiti al minuto
I [*((whispering))* °is between fifty] and sixty° (.) °per
minute°
INF pulmonary [è in room air=
65 I [°pulmonary°
INF =la signora (.) la saturazione è adeguata↑
I *((whispering))* °the saturation is fine°
INF gastrointestinal è in soft diet
I *((whispering))* °G I° (.) °soft diet°
70 INF con me non ha evacuato
I *((whispering))* °no bowel movements with me°
INF i suoni sono attivi però
I attivi↑
((the Italian nurse nods))
75 I *active* bowel sounds
INF genitourinario::↑ (.) voids urina::=
I =*((whispering))* °she voids spontaneously°=
INF =°tranquillamente° (.) è andata in bagno l'ho accompagnata in bagno io
sta – stanotte a [fare:: >pipì<
80 I [*((whispering))* °during the night] she – he actually
helped her out of bed and brought to the bathroom she did void°
INF per quanto riguarda *gastrointestinal*

I as far as the G I [system is concerned↑]
INF [gastrointestinal] (.) c'ha due Jackson-Pratt
I there're two J Ps
INF in the right upper quadrant↑ (.) Jackson-Pratt *A*
I *((whispering))* °Jackson-Pratt A° (.) °right upper quadrant°
INF ha drenato poco
I *((whispering))* °it drained [ve:ry°=
INF [°po:co°
I =°little°
INF mentre a sinistra↑
I on the [left
INF [left –] left °upper –° [qua::drant↑
I [*((whispering))* °( )°
INF B Jackson-Pratt *B* ha drenato di più
I the latter drained [more
INF [ottanta::] ha drenato
I eightish
INF s[ie]ros[a]nguin[o]s °però°=
I =serosanguineous drainage
INF mhm (.) >mhm↑< la signora >{Poletto}< sempre↑ ha anche u:n *T* tube (.) °T t[u]be° (.) a destra=
I =*((whispering))* °on the right° *((clears throat))*
INF e ho svuotato la sacca >va bene↑< ho *segnato* la
I [quantità e ho svuotato la sacca] *he::* (.) emptied out the bag] he marked the quantity=
INF =°(okay)°
I =and then he emptied out the °bag°
INF poi integumentary (.) [l'incisione::=
I [°integumentary°
INF =addominale
I >abdominal incision<
((pause)) ((the US nurse looks at the tape recorder and asks the interpreter: "Did you tape me singing?"; inaudible question))
I you *are* actually [on this=
INF [la signora
N *((to the interpreter))* eh↑
I *((chuckle))* you are↑ on this
INF la signora – *((chuckle))*
N *((chuckle))*
I il suo canto di prima è sulla [registrazione – *((chuckle))*
INF [*((nodding))* la signora] non è diabetica però ha i controlli [della::
I [she's] not a diabetic [patient=
INF [della glicemia
I =but we have to check her blood sugar levels
((pause)) ((the Italian nurse looks at the medical record))
INF okay (.) passia:mo adesso↑ (.) *((looking at his notes))* a {Pampinato}
I insulina ne prende↑
INF >come↑<
I insulina ne prende↑
INF °c'ha una scala se non mi sbaglio° *((looking at the Kardex))* >°vediamo↑°< (.) >sì< [ha una scala
I [the lady has a scale] of insulin

INF ha una scala
I *((looking at the Kardex))* che scala è↑ >medium<
((child crying in the distance))
INF medium (.) le sp – le spunta in automatico appena::
((pause)) ((background voices and sounds))
N is she on tramadol::
I prende tramadol↑
N °( )°
INF al bisogno però
I al bisogno↑ he says (at) P R N
((child crying in the distance))
N *((looking at the medical record))* °yeah yeah° (.) °yeah yeah okay° (.) *((closing the medical record))* >°(ready)↑°<
I va be::ne
INF allo::ra (.) passiamo al signor {Pampinato} {Pancrazio}
I mister *{Pampinato}*=
INF =ehm hai visto gli ordini [( ) did you] see the orders did you find any questions↑
N °no no°
INF okay >allora< {Pampinato} {Pancrazio}↑ si trova alla stanza {quattrocento} [{quattordici} *((whispering))* °he is in room] {four fourteen}°
INF letto {uno}
I bed {one}↑
INF non ha allergie
I no known allergies
INF ehm si è ricoverato:: il {dieci}
I [ha fatto un trapianto di fegato *((whispering))* °admitted on the {tenth}] he too had a liver transplant
INF [è ( )°] H C V positivo
I H C V positive
INF ps[i]chological (.) okay (.) °tranquillo°
I *((whispering))* °he's a tranquil patient°=
INF =°mhm° neurological (.) è out of bed cioè ieri (.) ha detto che è stato *fuori* dal letto però con *me:* è stato:::
I he was told [the patient was out of bed yesterday but=
INF cioè n – nel mio tu:rno è stato a letto lui
I =during his shift for – for all the time he was in bed
INF >è stato a letto< ehm questa notte ha avuto dolore↑
I he complained of pain during the night [*((clears throat))*
INF e gli] ho fatto il tramadol=
I =gave him tramadol=
INF =tramadol cento milligrammi I V
I one hundred [milligrams I V
INF ogni otto ore
I [Q eight hours
INF ce l'ha al bisogno
I come↑
INF al bisogno [°l'ha fatto° ogni=
I ce l'ha al bisogno↑

INF =otto ore
190 I he's got it – it as per *need* >but he does have it scheduled every eight hours<
INF cardiovascular normal s[i]nus rh[i][t]m (.) afebbrile
I afebrile
INF ha una right internal jugular tre lumi
195 I triple lumen
INF e non sta facendo infusioni
I *((whispering))* °no infusions at the moment°
INF p[u]lmonary due litri nasocannula↑
I *((whispering))* °two litres nasal cannula >as far as pulmonary is
200 concerned<°
INF e la saturazione è:: buona
I good saturation
INF gastrointestinal è in soft [diet
I [G I] (.) soft diet °( )↑°
205 N °okay°
INF no bowel movement (.) i suoni so – ci so:no sono [presenti
I [*active*] bowel sounds
INF però ancora non ha: neanche:: (.) buttato aria
210 I but he did – *((to the Italian nurse))* no↑
INF no [no per niente
I [no flatus yet
INF °no° (.) °perfe:tto° è diabetico il [signore
I [*he is*] a diabetic patient
215 INF ha il controllo della glicemia↑
I blood sugar=
INF =schedulato↑
I accu-chek is scheduled
INF e anche una scala
220 I and he too has a scale
INF °d'insulina°
I *((whispering))* °an insulin scale°
INF mhm (.) dopo di che per quanto riguarda genitourinario (.) lui:: *non ha* il Foley [e urina=
225 I [no Foley
INF =tranquillamente [nel pappagallo]
I [he voids in] (.) in the urinal
INF °qua abbiamo finito° (allora) (.) sempre in gastrointestinal
I one – one more thing (as for) the G I system
230 INF gastrointestinal (.) right upper quadrant (.) ha due Jackson-Pratt A e B s[ie]ros[a]nguin[o]s [che hanno drenato s[ie]ros[a]nguin[o]s]
I [he's got a Jackson-Pratt] *A* and *B* and both in the right upper quadrant and both draining serosanguineous (.) *((to the Italian nurse))* tutt'e due stanno drenando
235 sierosanguinoso↑
INF sì [sì sì]
I [yes] both of them
INF poi c'è un altro Jackson-Pra – Pratt in left upper quadrant [che è *C*
I [a third J P
240 INF [s[ie]ros[a]nguin[o]s=
I [letter C

INF =°sempre°
I in the (.) *left* upper quadrant serosanguineous drainage as well
INF integumentary c'ha l'incisione addomina:le
((pause)) ((the interpreter makes gestures to the Italian nurse indicating that he should not keep eye contact with her but rather with the US nurse))
INF *((to the interpreter))* >perché devo guardare lei↑<
I perché non stai parlando=
INF =oh=
I =con me
INF *((looking at the US nurse))* integumentary:: there is a:: –
((chuckle)) an abdominal in[tʃ]ision: *((chuckle))*
I °an incision° *((chuckle))* he said why do I have to look at her
'cause you're not talking to me
INF that I changed (.) okay↑ *((chuckle))*
N >okay<
INF *((chuckle))* okay *((to the interpreter))* giusto↑
I beautiful
INF ehm e poi:: e basta e nient'altro (.) che ho cambiato °(durante la notte)°=
I =nothing else I haven't changed anything else that I haven't told you already
N °okay°
((background voices))
INF °ordini non ci sono ordini°
N °( )°
I ho fatto i prelie::vi
I c'è da fare i preliev – ah li hai fatti
he did the ( ) (blood) ismett one
INF li ho fa:tti: ismett uno e l'F K
I =and F K level
INF °li ho fatti i prelievi°
I he's already ( )
N *((looking at the medical record))* >°( ) A B G ( )°<
I *((to the US nurse))* eh↑
N >(I saw) the A B G Q two hours< *((chuckle))* (I was like) >(thanks ah)<=
I =mhm mhm
N >°( ) that one (I guess they just didn't erase them)°<
I mhm mhm >quelle cose< (.) semplicemente non sono state cancella:te quelle dell'A B G ogni due ore
INF °sì sì°
I okay yes °it is they didn't erase it but ( ) not ( ) it every two hours° (.) *((to the Italian nurse))* in ambedue c'è ancora scritto A B G Q due ore
INF °non penso°
I infatti anche lei ha detto non penso >proprio< *((chuckle))*
N *((pointing at an item on the medical record))* °that was done right°
I *((pointing at the item on the medical record))* questo è stato fatto no↑
INF *((looking at the medical record))* sì sì sì sì sì
I °( )°
INF sì sì *((cough))*
((pausa)) ((child crying in the distance)) ((the two nurses look at the medical record))

	INF	*((looking at the medical record))* ah il maalox è vero *((chuckle))*
295	I	^the maalox^
	INF	*((chuckle))*
	N	was he complaining of like uh (.) reflux↑ or something
	I	e::hm il maalox perché >si lamentava di qualche cosa<
		⌜del reflusso
300	INF	⌞aveva un po'di:::⌟ sì sì po – ma poco
	I	yeah ⌜>a little bit<⌝
	INF	⌞*bruciore* ⌟ perché aveva bruciore=
	I	=>heartburn< (.) va bene↑
	N	°( )°
305	I	questions↑
	N	nope
	I	a posto
	INF	a posto↑
	I	va bene

NR.ICU.01

Typology	End-of-shift nursing report (reported cases: 1 out of 2)		
Place	ISMETT intensive care unit (ICU)		
Date	January 23, 2006		
Time	2:00 p.m.		
Duration	00:09:36		
Interpreter	Francesca		I
Primary speakers	Incoming nurse, Italian	(male, aged 26-30)	INF
	Outgoing nurse, US	(female, aged 26-30)	N
Observers	Researcher Second researcher (EI)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station in front of a monitor viewing the patients' electronic medical records, while the interpreter is sitting between them. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the medical record of the patient, both on paper and in electronic format. ▪ Although report is given for two patients, the transcribed recording only concerns the second one.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

N all right (.) now (.) ^this^ lady (.) *{Pritti}↑*
INF >{Pritti}<=
I =un'altra signora↑ *((to the US nurse))* it's another one
INF sì due
I *{Pritti}*
N uh (.) she:: (.) came in:: (.) °when did she come in° *((looking at her notes))*
INF ┌ °I don't know°
└ che ha fatto↑
I what did she have
N she got the tips
I ha fatto una tips
INF m:hm
N u::h (.) and right now they're just (.) we are just – kind of letting her stabilized she had the tips she bled (.) now she is –
I si sta stabilizzando ha fatto la tips poi ha sanguinato:↑
INF è lì↑ *((pointing at the patient's room))* la ┌ signora::
I └ where is she
N here at {four four two}↑
INF yes=
I ={quattrocentoquarantadue}↑
INF °sì°
N °yeah°
((pause))
N uh=

INF =ha fatto la tips per: quale problema al fegato:: [un tumore::
I [why did she have]
this tips did she have a tumour or what
N I don't know why she needed it=
INF =°(mhm)°
I non lo sa=
N =°honestly°
INF il – è in:: [epatite (la signora)
I [°onestamente°] does she have hepatitis↑
N *((ironically))* ^they didn't tell me^ so [but I would assume so
I [non me l'hanno detto] *però*
è po – è possibile
INF quando è stato ammessa qua in I C U↑
I when did she come in the I C U
N *((looking at the electronic medical record))* °a couple of days ago::°
[^report^ >was like – <=
I [un paio di giorni fa
N =pretty vague (.) this morning
I ehm le consegne sono state un po' vaghe stamattina
INF mhm
N so *((reading from the electronic medical record))* she had Budd Chiari
that's what °it was°
I what does she have↑
N Bu:dd (.) *Chia:::ri:*
I *((doubtful))* il B[a]dd Chiari↑
INF °cos'è↑°
I [what is it
N [>with the<] uh (.) portal hypertensio::n::
I iper – ipertensione portale↑=
INF =^ah^ (.) >molto probabilmente ha avut – < può – [d:arsi che::=
N [oh –
INF =vabbè ora la – [la cerco io la (notizia) probabilmente ci sarà stato=
N [°( )°
INF o un [K –]
I [ah] ^B[a][t]^ Chiari
N °Budd Chiari::°
((pause)) ((background voices))
INF e:::h (.) >sì sì sì< (.) >°ho capito°<
N okay↑
INF °sì°
I he knows what it is
N okay then *((laugh))* take it easy honey
I meglio
N uh (.) neuro (.) drowsy but arousable↑
I ehm neurologicamente è un po' intontita
N intact↑
I però intatta
N u::h (.) follows all commands↑
I segue i comandi
N there's nothing to °(add)° really [u::h
I [nient'] altro più o meno::
N normal s – low sinu – normal sinus rhythm to sinus tach °low sinus
tach°=

I =va da: ritmo sinusale norma::le a: leggera tachicardia
N u:h blood pressure's been sta::ble around one thirty↑
I pressione stabile circa centotrenta
N they want to keep her C V P: around: *ten*
I >vogliono tenere la C V P< a die:ci (.) circa
N *((looking at the electronic medical record))* they wrote – you can bolus her (.) u::h (.) it doesn't say (.) if – give albumin five per cent or normal saline so I guess [°five hundred°]
I [caso ma::i le] puoi fare un bolo
INF [c'è scritto albumina o: se scende al di sotto di dieci↑] (.) >al [cinque per cento<]
I [normal saline] *((to the US nurse))* if it goes:: what *below::* (.) ten↑
N >they want it around< ten °so::°
I la vorrebbero mantenere a dieci
INF °mhm°
N >she's< (.) usually between nine and twelve °so::°
I generalmente tra nove e dodici dovrebbe stare
((brief interruption: another Italian nurse addresses his Italian colleague, while two anaesthesiologists ask the US nurse for information on the PO lactulose administered to the patient)) ((the two physicians leave))
N u:::h
((background voices))
INF *((to the Italian colleague))* °( )°
N *((slightly annoyed))* lines
INF *((to the Italian colleague))* °( )° (.) [°( )° *((chuckle))*=
I [linee
INF =*((chuckle))*
((the Italian colleague leaves))
N (she has the) right I J triple↑
I ha l:::a I J destro triplo lume↑
N uh (.) left E J number sixteen gauge↑
I un ^*E*^ J (.) *((background voices))* numero sedici↑
N uh right antecubital (.) angiocath sixteen °gauge°
I angiocatetere sedici (.) ante – a:nte:cubitale destro↑ *((chuckle))*
N *((laughing))* and right femoral art line
INF *((laughing))* ( )
I and what↑ *((chuckle))*
N right femoral art line
I ah e pure una:: arteria femorale destra
N okay (.) u::h=
INF =ci sono ordini di gas: e::hm [visto che magari forse ha sanguinato
I [are blood gases:: orders:: test since she bled
N I know they were – (.) u:h drawing blood gases like every *three* four hours
I so che hanno fatto prelievi per l'emogas ogni tre quattro o:re
N uh (.) I haven't had time to do one since nine
I però dalle nove lei non ha avuto il tempo di farlo
N been to busy so: just – =
I =ha avuto troppe cose da fare
INF °mhm°=
N =there is no like written order though °so::°

I però non c'è scritto niente
INF °okay° e:: sa se durante la procedura lei ha sang – ehm la signora ha sanguinato↑
I did she bleed during the procedure↑ [>°do you know°<
N [I:] believe so::
I credo di sì
N uh her (.) *crit* is hanging around twenty-two now and °they are okay [with that°
I [the creati::ne↑
N crit – uh (.) °hema – ° *hema*tocrit=
I =l'ematocrito è stato:: *((to the US nurse))* around↑
N twenty-two
I circa ventidue
N so::
INF °mhm°
N they're okay with that u::h
I quindi dovrebbe andar be::ne
N I don't know how low her crit ever actually went
I non so quanto è sceso
N >°(just)°< it looks okay
I perché fin qua è tutto a posto
((pause)) ((background voices)) ((in the distance, an ICU physician is scolding a nurse))
INF [°okay°]
N [yeah] (.) uh (.) so anyway (.) °what else can I tell you↑°
((pause))
N uh
I *((whispering to the Italian nurse))* ( ) così tanto il dottore {Darso}↑
INF *((to the interpreter))* °no non lo so°
N u::h=
INF =quindi l'ultimo che lei ha fatto è stato alle nove e mezza::
I so last blood gas was done at nine↑ thirty↑ about↑
N nine
I sì verso le nove=
INF =°mhm°
((pause)) ((background voices)) ((in the distance, the ICU physician who is scolding a nurse keeps repeating the word 'cannula'))
N uh (.) *two liters* nasal cannula *((laugh))* [*((amused))* that's what=
I [nasocannula due litri
N =( ) trying to ( ) *((chuckle))*
N lungs are clear
I polmoni chia::ri
N u:h=
I =suoni polmonari chia:ri
N *((tapping her pencil on the board))* no cough no secretion
I non ha tosse né secrezioni
N u:h (.) that's it really G I she is *N P O:*
I G I↑ (.) a digiuno↑
N she ca:n take her lactulo:s:e (.) P O though [that's the only °(case)°]
I [e quindi può]
prendere il lattulosio per bocca (.) l'unica cosa
INF *((leaning out of his chair to see the electronic medical record))* sta facendo una D fiv:e a:: quaranta M L ora↑

I u:::h is she::=
185 N =°yes°=
I =having a D five forty M L per hour↑
N yes
I sì
INF ci vedo bene allora *((pointing at the monitor))*
190 I so: it means I can see that well
INF *((straightening himself on the chair and taking off his glasses))* °così non:: non vedo niente così°=
N =^good eyes good eyes^
I >buon – < hai una buona vista
195 INF *((soft chuckle))*
N u::h=
I =occhio di lince
((the Italian nurse puts his glasses back on))
N °what else° other than – then they ordered en – lactulose enemas
200 *((looking at the medical record))* [>°(I don't know how much)°<]
I [hanno] ordinato:: un:: clistere di lattulosio=
INF =*((disgusted))* oh::: oh::=
N =ah=
205 INF =*((ironically))* °buo::no° co:me↑ [col parmigiano↑=]
N [too much lactulose]
INF =*((ironically))* >scaglie di parmigiano↑<
I can we put (.) some Parmesan cheese on top↑
N *((chuckle))* *((ironically))* stop i::t *((chuckle))* (.) u::h (.) *((ironically annoyed, tapping her pencil on the board))* I just want to go *home*
210 Gian – °( )° *((laugh))*
INF °che ha detto°=
N =I'm so::rry
I *((to the Italian nurse))* hurry up
215 N u::h=
INF =°che ha detto°
I che se ne vuole andare a casa
INF [okay=]
I [che è stanca]
220 INF =sì (.) gli dici che mi saluta a {Nancy}quando::
I yeah please say hallo to {Nancy} when you hear from her
N *((doubtful))* {Nancy::}↑
INF {Nadine} (.) >°{Nancy}°<
I *((doubtful))* {Nancy} o {Nadine}↑
225 INF *((laughing))* no::: [io a=]
N [which one]
INF =[{Nadine} la chiamo {Nancy}]
I oh [that's {Nadine}]
INF [e si incazza] >°(ogni volta)°< *((chuckle))*
230 I but he calls her {Nancy} (.) and she gets upset
[°( )°]
N [*((ironically))* ^I know why^]
INF *((chuckle))*
I ah lo so perché

INF [*((wholehearted laugh))*
N [I know why Gi[ɔ:]n {Ivo::} *((with a heavy US accent))*
I *((mimicking the accent of the US nurse))* Gi[ɔ:]n {Ivo::}
N [*((wholehearted laugh))*
INF [John Wayne John Way::ne *((laugh))*
((all laugh))
INF oka::y da::i basta
N >wait< *((tapping her pencil on the board))* Foley she was on a lasix drip
INF mhm
I e::hm ha preso il las:ix ha il Foley
INF twenty milligrams↑
N I don't know it was yesterday before I was here (.) [°( )°]
I [ieri] prima che
lei arrivasse
INF mhm
I [°quindi° non lo sa]
N [they D –] D Ced that
INF [>mhm<]
I [l'hanno] ehm::: (.) interro:tto
N [so:=
INF [*((ironically))* yes↑
N =now her – she's also (.) *o: li:gu:ric*
INF mhm
I e quindi è anche questa: (.) *oligurica*
INF oh:::
N so:: (.) I don't know what they want to do with that
I non so che cosa hanno intenzione di fare con questo
INF mhm
N and they wrote to D C (.) the (.) peripheral line↑
I hanno anche scritto di staccare le linee periferiche
N and I didn't do it
I però lei non l'ha fatto *((smiling))*
INF °mhm°
N *((ironically))* so just deal with it during ( ) *((smiling))*
I *((ironically))* quindi lo farai tu *((smiling))*
INF non c'è problema guarda
((all laugh)) ((background noises of ICU monitors))
N uh (.) °that's it° [any questions
INF [*((amazed))* le linee periferiche↑
I domande↑ (.) *((to the US nurse))* peripheral lines which ones
((the two nurses take the medical record and look at the orders))
INF o::h e:: chi è il: suo medico >{Denis}↑<
I who's::: his doctor (.) *her* doctor
INF {Denis}↑
I {Denis}↑
N he's today
I e:h↑
N *he is* today (.) *to::day* (.) ^I^ – I don't know (.) I don't know
{Dan} – {Damiani} (.) is that – (.) hepatologist right↑=
INF =no il medico che l'ha seguita qua in I C U {Denis} forse=
I =uh who followed her in the I C U {Denis}↑
N today yeah *((nodding))*

INF ⌜°okay va bene°
I ⌞sì oggi sì
INF e anche {Parlato}↑
I also mister {Parlato}↑
N {Darso} was here with –
INF mhm
N {Denis} was – and {Daniela}
INF °okay okay°
N okay
INF okay
N ⌜they were all here
I ⌞{Darso} {Denis} e {Daniela}
INF perfetto
((pause)) *((the Italian nurse goes on reading the medical record))*
INF *((closing the medical record))* va bene okay
N okay (.) *((relieved))* thank goodness
I grazie al cielo abbiamo finito
INF *((chuckle))*

NR.ICU.02

Typology	End-of-shift nursing report (reported cases: 1 out of 2)		
Place	ISMETT intensive care unit (ICU)		
Date	March 16, 2006		
Time	9:00 p.m.		
Duration	00:07:55		
Interpreter	Henry		I
Primary speakers	Incoming nurse, Italian	(female, aged 26-30)	INF
	Outgoing nurse, US	(female, aged 26-30)	N
Observers	Researcher Second researcher (SO)		
Situation	▪ The two nurses are sitting next to each other at the nurses' station in front of a monitor viewing the patients' electronic medical records, while the interpreter is standing between them. ▪ During the interaction the US nurse reads from her notes and the Italian colleague jots down the information. They often check the patient's medical record, both on paper and in electronic format, as well as the Kardex.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

((background voices))
N °let's start with her° *((pointing at the patient's room))*
I cominciamo da:: [lei *((pointing at the patient's room))*
INF [>la signora<] {Pontardi}
°okay°
((pause)) ((the Italian nurse starts writing down her notes))
N uh twenty years old
I vent'anni
N allergic to: (.) pollen and dust
I allergica alla polvere e al polline
N >O positive<
I O positivo
N uh has malig – malignant cancer
((the LS mobile starts ringing))
I ha un tumore maligno (.) *((answering the mobile))* scusa::te
((the interpreter talks on the phone with another US nurse requiring the interpreting service and then hangs up)) ((background voices))
N °uh::°
INF *((reading from the Kardex))* °adrenalectomi::a°
N adrenal gland °( )°
I ( ) la:: ghiandola::
INF *((to the interpreter))* adrenalectomi::a=
I =>mhm<
INF si traduce adrenalectomia↑
I I guess so (.) suppongo *((chuckle))*
N metastas(e)s in=
I =c'è una metastasi
N the:: uh left kidney↑

I al:: rene sinistro
N and liver
I sorry↑
N and also to the liver
I e anche al [fegato
N [°it's spreading°
I si sta diffondendo
INF okay
N so they resected the left kidney
I le hanno fatto una resezione del: e::hm rene sinistro
N >okay< and she was brought here [two days ago
I [ed è stata portata qui] due giorni fa
((brief interruption; an anaesthesiologist gives the Italian nurse some instructions concerning another patient; the recording is interrupted and then resumed))
N [they resected the left kidney (so she's) ( )
I [ecco perché è qui perché hanno fatto la resezione del:=
INF =>del rene sinistro<
I del rene sinistro
N neurologically [she's:
I [>neurologico<
N alert and [oriented=
I [è all'er –
N =times three
I orientato (.) per tre
N u:h (.) she has an epidural
I ha un epidurale
N with *((pointing at an item on the electronic medical record))* °I can't say this (ever)° *((chuckle))*
I *((reading from the medical record))* c:on la:: bibucaina
N and that goes at eight milli – millilitres an hour
I a otto millilitri: all'ora
N complaining of pain
I si lamenta:: di dolore
N a little bit moderate pain in the: incision
I e nell'incisione
N uh cardiac (.) she *was* in normal [sinus:
I [cardiovascolare::] n – era:: >normal sinus rhythm<
N normal (.) sinus (.) tachy but after=
I =a=
N =they placed a picc line
I >ma dopo che hanno messo la li – la picc line<
N left arm
I nel braccio sinistro
N shortly after went to A fib
I è andato in:: °(ha fatto in)° *fibrillazione* atriale (.) >poco dopo<
N rate has been about one te::n↑
I la frequenza è stata (.) centodie::ci=
N =one ten to one thirties
I centotrenta:↑
INF °okay°

N u:h (.) her potassium has been low:: [all day:
I [il potassio↑] è stato un po' basso tutto il giorno↑
N because >I'll get to it later< but she's putting a lot of (.) N G drainage
85 and [stool
I [sta drenando] molto dall'N G tube
N >that's probably where she is losing her potassium<
I ed è:: probabilmente è da lì che::: [perde=
INF [°perde°
90 I =tutto il potassio
N so they gave her a lot of potassium during the day [and the night↑
I [(quindi) le hanno] dato *molto* potassio durante il giorno la notte
N and I got a P R N order↑ (.) for potassium:↑
95 I e c'è un ordine *P R N* (.) sempre per il potassio
N and I gave – when I checked it it was three point zero and I gave sixty↑
I era: tre punto zero quando l'ha controllato: e gl – (gliene) ha dato sessanta↑
N and I rechecked it at eight o'clock [and it was: three point=
100 I [l'ha controllato alle venti
N =six [I gave her twenty]
I [era: a tre] punto sei quindi le ha dato venti
N and it just finished so:: if she wants [to check sometime later]
I [è appena finito quindi] magari
105 più tardi: controlla
N u:h she also got magnesium this:: (.) during the day she got
[three::: grams]
I [ha fatto: magnesio:] circa tre grammi durante il giorno=
N =>and at like six P M I gave her another two grams when she
110 [was in A fib<]
I [e verso le] s::ei le ha dato altri (.) *((to the US nurse))* >two grams you said↑<=
N =>°*two* grams°<=
I =du – due grammi ed era in fibrillazione atriale
115 N u::h=
INF =è *ancora* [in fibrillazione atriale↑]
I [so she's still] in A fib↑
N *((nodding))* and I told them (.) [she's still in A fib] (.) [>they<]
I [lo è anco::ra] (.) [*lei*] ha
120 informato i medici
N they wanted me to do an E K G which I did and I showed the doctor
I le hanno detto di fare un E K G e l'ha fa:tto↑ l'hanno fatto vedere al me:dico↑
N and she looked at it and (.) walked away she didn't say anything to do
125 [*((chuckle))*]
I [l'ha visto::] l'ha l::: se n'è andata senza dire niente (.) il medico
N >so< *((chuckle))* *they know* >°I mean [(I checked it)°<
I [>quindi lo sanno<
INF °va bene°
130 N u:h (.) blood pressure has been stable
I la pressione è stata: stabile
N she had a lot of lines that I D Ced
I aveva parecchie::: (.) l:inee che lei ha fatto il D C

N radial
135 I aveva la linea [radiale
N [arterial line] (.) D Ced
INF °okay°
N uh right I J triple D Ced
I right I J tre lumi [°D C°
140 N [two peripherals] D Ced
I [due –
INF [vabbè –] adesso *((chuckle))*
I ^due accessi periferici^
INF adesso solo il left wr – [wrist:
145 N [°so just°] [the picc line
I [so what does she have↑
N just the picc=
I =ha soltanto l:::a [la picc line
N [after] they put the picc in we removed the
150 triple lumen
I dopo che hanno – prima – >ehm< dopo che hanno messo la picc hanno tolto la: i tre lumi
INF °va bene°=
N =blood return is good (.) [°in the picc°
155 I [il ritorno:: va bene
N X-ray was done and [it's ( )
I [radiografia fa::tto
N uh (.) D five (.) water at twenty C Cs↑
I D five water a venti C C
160 N electrolitic at sixty↑
I elettrolitica a: sessanta↑
N she was:: on a:: >I'm sorry for the blood pressure norepinephrine a couple of days ago (it) was stopped<
I sta facendo una – per la pressio::ne la: neuro::pinefri:na qualche giorno
165 fa ma ora –
INF °okay°
N u::h=
I =non più
N no edema
170 I [niente e:demi]
N [(pu –)] pulmonary [ehm=
I [polmonare
N =uh equally clear
I sono:: chiari:↑ (.) da entrambi i lati
175 N room air
I è su room air↑
N saturation is good
I [la saturazione va bene
N [>ninety-eight to a hundred<
180 I tra:: novantotto e cento
N extubated yesterday
I è stata estubata ieri
N G I [u:h belly=
I [gastrointestinale
185 N =is not distended
I non è disteso:::

N very tender
I molto te – e::hm molle
N ehm [m –
190 INF [è in] N P [ɔ]↑
I [is she –
N [N P O] N G to low continuous suction
I ha il sondino nasogastrico a low continuous suction
N I changed the:: the – canister↑ *((to the interpreter))* >is that how you
195 call it here↑<
I *((nodding))* ha – ha cambiato il: contenitore↑
N twice [because
I [due volte
N =she keep – she can drink water [and she drinks
200 I [perché può bere ac –] qua
[quindi beve in continuazione]
N [continuously and it just] (.) drains *((chuckle))*
I e quindi continua a drenare in continuazione °pure°
N so I j – it – (.) I marked like a litre that I [°took out°]
205 I [quindi lei] ha segnato un
li::tro↑=
INF =°va bene°
N it's filling up again but °( )° *((chuckle))*
I e si sta riempiendo di nuovo
210 INF °okay°
N J P times two [A and B]
I [J::::] J P due A e B
N serous (.) both
I siero:so tutti e due↑
215 N emptied once for a – [during my shift °for a hundred°]
I [ha svuotato: una volta] durante il suo:
turno *((to the US nurse))* how much sorry↑
N a hundred↑
INF cento
220 N a hundred ( )=
INF =questo (.) flexi-seal:↑
N flexi-seal uh=
I =what's that↑
N it's a::=
225 INF =*((reading from the medical record))* *((amazed))* rectal t[u]be↑
N >rectal tube< (.) >I hate it< *((chuckle))*
I lo odia *((chuckle))*
INF °okay°
N because it leaks continuously
230 I perché *perde* in continuazione
N it's – I've probably changed it like (.) four times [*((chuckle))*]
I [l'avrà cambiata]
quattro volte
INF °okay°
235 N and I – I put more water in it↑
I e ha messo più a:cqua
INF mhm
N and it still is leaking so:

I ma continua a perdere comunque
N it's just continuous there's just a little bit the pad is a little bit dirty not – she's not – =
I =la:::=
N =it's just wet
I lei non è sporca è un po:::' un po' bagnata [la:::
N [because it's –] it's continuous [*((chuckle))*]
I [perché::] è continuo
N °so:: u::h° it – (.) and she's putting out for me:: two hundred my shift
I ha fatto duecento durante il suo turno
N liquid brown [diarrhoea]
I [marro:ne] (.) diarre:a:: (.) marrone liquido
N u::h (.) G U *Foley* (.) it's adequate
I il Foley:: e::hm [va bene]
N [eighty] to a hundred (.) [°( )°]
I [da ottanta] a cento
N clear yellow
I giallo::=
INF =°okay°=
I chiaro
N *((taking the medical record))* the only orders was=
I =gli unici ordini
((the two nurses look at the medical record))
N potassium
INF sono quelli per il potassio
N P R N
I P R N
N magnesium
I il magnesio
N and then this *((pointing at an item on the medical record))* was:: during rounds
I e poi questi sono gli ordini:: durante::
N *((reading from the medical record))* ismett one=
I =il giro
N *((reading from the medical record))* ( ) P T consult *((no longer reading))* she was out of bed
I è: è uscita dal letto
N *((reading from the medical record))* uh respiratory consult (.) (at) – (.) *((no longer reading))* o:h they did this for the: u:h=
I =hanno fatto::=
N =for the J P (.) [once=
I [per il J P °( )°
N *((reading from the medical record))* ( ) (.) D C (.) arterial line (.) *((no longer reading))* they gave three grams of magnesium
I le hanno dato il magnesio tre grammi↑
N and then this is chest [(X-ray for the picc)]
I [e poi:: e:::hm] la chest X-ray
[è stata fatta]
N [D C central line]
INF il::: l'E K G è qui:↑
I and the (.) ehm >is the E K G here<=

N =I gave it to the doctor [she walked away with it]
I [l'ha dato al medico] che se n'è andato con::
INF *((ironically))* vabbè *((chuckle))*=
295 I =con il tracciato
INF *((ironically))* è sparito↑

Training sessions

TS.01

Typology	Nursing training session (Title: "Hemodynamic monitoring – Part II: Pulmonary Artery Pressure Monitoring")		
Place	ISMETT Conference Room, old facility		
Date	August 27, 2003		
Time	10:00 a.m.		
Duration	01:03:55		
Interpreter	Christian		I
Primary speakers	ICU nurse, Italian	(female, aged 20-25)	INF_1
	ICU nurse, Italian	(male, aged 20-25)	INF_2
	ICU nurse, Italian	(male, aged 26-30)	INF_3
	Nursing educator, US	(female, aged 36-40)	N
Observers	Researcher		
Situation	▪ The lesson is part of the specialized orientation to critical care provided by an American instructor to three newly-hired ICU nurses. It focuses on an invasive method used to assess and diagnose cardiopulmonary function in ICU patients. ▪ INF_3 did not attend the lesson the day before, so the instructor starts the new lesson with a brief summary of the topics already dealt with. ▪ While the first part of the session is mainly theoretical, the second is of a more practical nature and deals primarily with the interpretation of the values recorded through specific catheters. ▪ The nursing educator uses transparencies and an overhead projector to show students the tracings they are discussing. Students are also provided with handouts.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Short consecutive		

((educator, nurses and interpreter are getting ready for the lesson))

N *((to INF_1))* a:::h (.) okay we (.) left off (.) °( )° (.) >yesterday just to catch< (.) to catch you up

I allora per farti capire dove:: (.) dove siamo arriva:ti ieri ci siamo fermati a questo punto

N uh we: do hemodynamics uh >for critical care nurses< in *three* phases

I noi l'emodinamica per in – fermieri di area critica di terapia intensiva la dividiamo: sostanzialmente in tre fasi

INF_1 >mhm<=

N =°in three classes° in our first – >we say< hemodynamics one the first day

I °quindi° (.) in tre classi °ufficialmente° emodinamica *u:no*↑

N it's fo:r (.) arterial (.) waveforms and looking at peripheral waveforms↑ and (.) what you're looking at on the monitor↑

I è per le onde: periferiche insomma quello che ve – >guardi< – vedi sul monitor in questi casi

N u::h (.) a::nd (.) then the *second* day we (.) uh (.) focus on *pulmonary* artery catheters and the readings what the C V P reading and the P A (.) *pressure* readings (.) are what they mean °how they
20 >tell us information about the heart< through lines°
I e poi il secondo giorno invece sulle onde di tipo:: °po –° polmonare periferico quindi la – la C V P che sarebbe la: (.) ehm la pressione::: del – *((to the educator))* what's the C V P
N [u::h pulmonary artery
25 INF2 [°pressione venosa centrale°
I sì della – della – arteria centrale e:: e tutti:: i fenomeni collegati
N u::h (.) a::nd we actually *looked* at the pulmonary artery catheters↑ (.)
I [the different=
[quindi
30 N =*pieces* that are necessary u:h (.) *for* that catheter↑
I quindi le: le varie parti del catetere polmonare
N what the ports are used fo::r
I a cosa vengono – a cosa servono i vari ingressi del °catetere°
N u::h (.) insertion pre-insertion during insertion post-insertion nursing
35 responsibilities=
I =quindi l'attività prima dell'inserimento=
INF1 =>mhm<=
I =durante l'inserimento diciamo e le:: le relative: azioni del – dell'infermiere
40 N and then what – (.) we did *not* get to finish is actually taking a look at *readings* (.) u::h during a wedge (.) wedging °the balloon°
I quello che ancora=
N =( )=
I =non abbiamo fatto e forse faremo oggi è:: >°(proprio il)°< wedge cioè
45 il gonfiamento del palloncino e anche °di::° fare una valutazione dei °risultati°
N and then hemodynamics three which is *supposed* to be today this is the third day u::h goes into more (.) u:h (.) *parameters* looking at mo::re u::h (.) >we say< in addition to the >pulmonary artery< pressure
50 numbers we look at (.) u:::h (.) systemic vascular resistances we look at cardiac output cardiac index
I quindi guardiamo il – l'output cardiaco – questo è quello che si – dovremmo trattare oggi nella terza parte=
INF1 =mhm=
55 I =quindi l'output cardiaco i vari indici e::: *((to the educator))* °what was the other thing°
N cardiac index cardiac output systemic vascular resistance=
I =la re – resistenza vascolare sistemica °eccetera°=
N =u:::h (.) *how* (.) these numbers are calculated (.) u:::h how (.) the
60 *drips* the therapies are used to::: (.) correct change these
I [°parameters°] e come vengono letti i parametri interpretati e poi
[sì]
come vengono usate le – le drip cioè le:: (.) e::hm (.) le flebo anche per (.) casomai:: modificare e sistemare questi parametri
65 N and our (.) approach at giving (.) nurses (.) all of this information is it so: they can *anticipate* and critically *think* (.) what will the orders be what is the physician going to:: (.) uh write u:h
I >tutto questo viene fatto< anche per – per sviluppare nel – nell'infermiere la capacità in un certo senso di *anticipare* quelli che

saranno gli ordini scritti o verbali del – del medico quindi:: diventerà anche una forma mentis capace di anticipare quello che succederà

N °okay↑° (.) °all right and° (.) u::h it just helps the – >the nurses have a very – < become not just *ta::sk* (.) *oriented* (.) uh in the I C U >but understand< (.) why they are doing what they are doing why the physician is doing what he or she is – °is doing°

I quindi l'importanza per l'infermiere in terapia intensiva non soltanto di essere u:n – semplicemente un *esecutore* (.) degli ordini ma anche di capire (.) perché stai facendo una cosa o i motivi che ci sono °dietro°

N °okay° and I can make copies of this *((pointing at the handouts))* for you

I e comunque ti faccio delle copie [°di questo°

N [so that you can] use (.) >this as ( ) of reference< unfortunately it's in English though *((clears throat))*

I è in inglese però ti serve sempre come [°riferimento°]

N [it might] be better just writing things as you (.) hear things

I oppure puoi prendere appunti °mentre parliamo°

N okay (.) where we sto::pped was (.) >we wanted take a look at< (.) u:h >a couple of things< during a *wedge* (.) let's do the wedge first (.) and then we come back up to:: the effects of:: *respiration* (.) on:: this catheter that – that's *in* your heart and (.) close to the lungs

I °okay° (.) tratteremo la – l – l'operazione del wedge
da ora in poi dirò wedge è praticamente::=

INF1 =>l'incuneamento<

I sì °l'incuneamento°

N >°okay°< so we'll do that first it makes more sense to (.) uh °do that° (.) *((grabbing a sample catheter kit))* okay uh (.) when we do (.) when we perform a – a wedge we had said yesterday that you should come (.) across your patients *always* with this (.) catheter ah >sorry< with this balloon and a syringe in the *locked* (.) position=

INF2 =mhm

N and without anything °in here° *((pointing at a part of the equipment))*

I °allora° bisogna arrivare dal paziente senza niente qui *((pointing at the same part of the equipment))* ovviamente e poi deve avere una posizione di chiusura=

N =and=

I =°dev'essere chiuso°

N the syringe that comes packaged with (.) the:: Swan-Ganz catheter has a *stop* point (of) only (.) you can only pull up one and a half C Cs °uno ( ) C C°

I uno virgola cinque è il massimo che si può tirare perché c'è un meccanismo di bloccaggio e questa: è la – la siringa che viene nel – nel *set* del – dello Swan-Ganz

N so I *can't* inflate (.) any more than one and a half C Cs

I in pratica la pressione di incuneamento no – non posso mettere più di uno virgola cinque C C

N °and – ° and if I *di:d* (.) inflate more the balloon would rapture

I *se* dovessi metterne ancora si – scoppierebbe il °palloncino°

N so we pull up the one and a half C Cs of air↑ attach this

I quindi tiriamo – e:hm riempiamo uno virgola cinque di a::ria↑ attacchia:mo↑ (.) la siringa↑ *((clears throat))*

N and then I unlock (.) the:: u::h locking device

I si sblocca:: i:l meccanismo di apertu::ra↑
N and each of my catheters °the balloon is broken so I can't show you°=
I =>mhm<=
N =°the balloon actually inflating°
I ora il palloncino: che ho qua sfortunatamente s – si è rotto quindi non – non ve lo posso fare vedere proprio: il meccanismo di gonfiaggio però *((clears throat))*
N u::h
((pause)) ((the US nurse prepares the equipment for the demonstration))
N and what you do is *slo::wly* (.) *((inflating the balloon))* inflate the balloon↑
I si gonfia il palloncino *lentamente↑* [*((clears throat))*
N [whi:::le] you are watching (.) the monitor
I e nel frattempo si guarda il monitor mentre [lo °( )°]
N [because] what I want to see (.) and (.) I want to see this:: change from this P A (.) tracing (.) *((pointing at the tracing on the transparency))* to this *wedge* >it looks like a C V P do you remember< yesterday we said this is a *left* (.) *heart* C V P (.) a wedge
I quindi devo passare da una formazione del genere (.) a questa *((pointing at the tracing on the transparency))* che è una C V P che abbiamo visto ieri
N °so° to change into this characteristic *wedge* (.) *tracing*
I [a wedge=
[>si chiama<]
N =°waveform°
I un classico *traccia:to* di:: (.) di forma di incuneamento
N °okay↑° u::h when you *see* this↑ when you're inflating the balloon (.) and you see this *change* on (.) your (.) patient stop that's all you need to do↑ that's as far as you need to inflate
I >quindi quando state gonfiando guardate il monitor< appena – vedete che l'onda:: cambia in questo – comincia a diventare di quella forma là a quel punto vi ferma:te (.) quello sapete che è:: il – (.) il livello che dovete raggiungere
N maybe it doesn't take one and a half C Cs maybe it's only one C C
I magari non c'è bisogno di mettere tutti uno virgola cinque magari solo uno basta
N °okay↑° u::h (.) if you were to:: (.) inflate the balloon *fully* (.) u::h it won't rapture the balloon (.) a one and a half C Cs *will not* rapture the balloon
I se glieli metti tutti:: (.) uno virgola cinque di aria il pallone non scoppia (.) >il palloncino non scoppia<=
N =but if it only takes one C C to achieve a we:dge and I:: use one and a half (.) I can do:: (.) something that's called *over*wedging
I però se la pressione è adeguata e l'incuneamento io lo raggiungo con soltanto u – u – un C C di aria (.) ^e^ mi spingo oltre (.) arrivo a una situazione di °ehm° overwedging cioè di sovra – (.) sovraincuneamento
N and (.) this catheter the balloon has a little – uh (.) the tip of the catheter (.) has a little sensing (.) has a little sensing (.) uh (.) *point* on it (.) that will – (.) >wander here< so this is my balloon that's inflated↑
I questo è il palloncino che si gonfia no↑ e sulla punta c'è una – una sorta di senso:re che è alla – alla fi:ne alla punta del catetere

N a:nd >it's just a very small tip< if you *over*inflate this (.) what will happen is (.) the balloon (.) will inflate (.) but the tip of the catheter might get=
INF2 =°mhm°=
INF1 =mhm=
N =in this direction in the *wall*=
INF2 =mhm=
N =of the pulmonary artery=
I =quindi se lo gonfi troppo >ehm< lui continua a gonfiarsi però può succedere che la punta del catetere va a finire contro la *parete* (.) dell'arteria
N it will take the shape (.) but it might distort (.) where the – (.) tip of the catheter is pointing
I >quindi< si gonfia ancora però >diciamo< la posizione della punta potrebbe essere devia::ta
N >°okay↑°< so you just use the amount of air (.) ne – *needed* to achieve your – your waveform
I quindi è importante inserire la quantità d'aria necessaria e non superiore a:: (.) a ottenere una – una formazione – un'onda di quel tipo
N °okay↑° u::h (.) you: (.) you get your reading↑ (.) we'll talk about the readings °soon° u::h we'll talk about looking at the monitor and getting your reading and then you want to *allow* the balloon (.) to *de::*flate
I >quindi< fai la lettura (.) ora vedremo come si fa e poi (.) fai sgonfiare il palloncino
N uh (.) you should only (.) leave the balloon inflated for like thirty seconds
I il palloncino va e::hm (.) rimane gonfio non oltre trenta °secondi°
N °okay° remember when this balloon is inflated this area *((pointing at the picture on the transparency))* the *lung* is going without blood supply
I ricordatevi che: quando è completamente gonfio questa *zona* del polmone in pratica non gli arriva aria
N °okay° so you wanna do the we:dge get the reading (.) *de*flate (.) and (.) allow for (.) for resumption of *oxygen* (.) >blood supply< to this (.) °zone°
I quindi (.) metti il palloncino lo gonfi fai la lettura che devi fare e poi lo sgonfi per permettere:: il flusso di aria normale
N okay↑
INF3 (sì) e::hm (.) °trenta secondi o sessanta°
INF2 [°trenta°]
N [thirty] seconds
I trenta=
N =°(trenta)° uh (.) when you (.) *de*flate this balloon (.) you *passively* >let it< *de::*flate (.) >°okay↑°< so: >the air gets pushed back< you just take your thumb off
I °mhm° (.) per sgonfiarlo togli il pollice e – e si sgonfia da solo in maniera passiva non devi [tirare]
N [°okay↑°] and then (.) >it – < the balloon will by itself – >I'm sorry< the syringe will by itself just come out (.) *close* to the one and a half C Cs=
I =poi vedi che la – la siringa esce so:la se tu togli la pressione del pollice [esce=]
N [°okay°]
I =da sola fino a raggiungere:: (.) uno virgola °cinque°

N and if you see that there's still >a little bit more< just pull it back
I se vedi [che ne manca=
N [°to one and a half°
I =ancora un po' per arrivare a uno virgola cinque: tiri piano piano
INF3 okay
((the nurse hands the catheter to INF3 so he can demonstrate the procedure))
N °okay° (.) lock it↑
I lo blocchi↑
((INF3 locks the device))
N take it o::ff↑
I e lo [togli
INF3 [*((performing the procedure))* mhm
N ( ) the air↑ (.) *((INF3 pushes the air out of the syringe))* °that's right°=
I =butti via l'aria
N °and put it back on°
I e la rimetti
((INF3 performs the procedure as requested))
N and you can tell me in Italian what's the *danger* of leaving the air in this↑ (.) why (.)
I [why is this that allora::] qual è – qual è il pericolo se lascio l'aria
N [qua dentro= and it's locked
I =ed è chiuso anche in italiano ditemelo [che io lo capisco sì *((cough))*] perché se
INF3 si apre la valvola di sicurezza e il paziente schiaccia il:: (.) la siringa↑=
I =mhm=
INF3 =spostandosi (.) può (.) fare:::
INF2 >entrare l'aria dentro<
N °yeah° and it could be there for a lo:::ng (.) time [°(in) that° e potrebbe] stare
I gonfio quest'aria per un bel po' [di tempo= dangerous
N
I = [e potrebbe essere pericoloso
INF2 [°( )°
INF3 [°( )°]
N [so] to prevent that we always tell you to *lock* (.) lock the (.) device↑
I >quindi<=
N =>get rid of the air< so *even* if this were unlocked there is no danger=
I =>quindi vi diciamo sempre di fare così< di blocca::re >togli la siringa elimini l'aria< e la rimetti così anche se si apre:: la – la sicurezza=
INF2 =mhm=
I =°no – non succede niente°=
N =>okay< the reason why you don't *actively* (.) pull back
INF2 mhm=
N =to *de*flate the balloon the company says that creates *wear* and tear
I mhm=
N =*on* the balloon and it might cause it to rupture
I lo fai sgonfiare [da solo=
N [°( )°
I =senza tu tirare via l'aria=

INF3 =mhm=
I =perché la:: la compagnia che produce questo catetere sostiene che può deteriorare a lungo: (.) °diciamo ehm la – la:::°
INF3 °il funzionamento°=
I =°sì↑°
N °okay°=
INF2 =ed è la pressione:: all'interno del polmone stesso che la fa ri::tornare indietro
I yes it's the – the pressure *inside* the lung that actually (.)
N [creates the –] [yeah] (.) and the
I [pressure in (the) blood yeah] [*cau:::ses* the air] to come out
N in the blood yeah
I e anche la:: il sangue
INF2 mhm
N okay (.) the frequency (.) we: (.) do this:: (.) *every four hours* (.) on the patients in the I C U
I per quanto riguarda la frequenza questa procedura la facciamo *ogni* quattro ore nei pazienti di terapia °intensiva°
N *or* (.) more frequently (.) *if* the physician has ordered
I oppure se c'è un ordine medico (.) ancora:: più spesso (.) °de – di quattro ore°
N *or* (.) if you think (.) that is (.) a piece of information (.) that will help you (.) >like if< if you see something is happening with the patient and their blood pressure's dropping and – you want to get an extra set of vital signs (.) but it's not four hours yet you can do that because it's gonna be information the physician is going to *ask* you
I oppure voi stessi (.) se:: vedete che la pressione del paziente sta calando e volete avere tutto un – un set di parametri vitali potete decidere voi stessi di fare questa procedu:ra e avere sotto mano delle informazioni che probabilmente il medico comunque vi chiederà::=
INF3 =°ce::rto°=
I =quando arriva
N °okay↑° u::h (.) the:: (.) problem with repeating this (.) >over and over and over again< every hour every thirty minutes↑ is this (.) is this (.) u::h period of – of ischemia (.)
I [°( )° il problema di] ripetere troppo spesso questa cosa è che c'è un pericolo di ischemia perché se lo ripeti ogni o::ra così:: troppo spesso
N all the other vital signs are every two hours but the wedge is every four
I tutti gli altri parametri vitali vanno presi ogni due ore invece la – questo in – la pressione di incuneamento ogni quattro
N and ( ) the procedure we told you the maximum volume of inflating we talked about overwedging
I allora questi li abbiamo visti la procedu::ra il volume massimo e:: diciamo il sovra incuneamento ne abbiamo parlato↑
N what would happen if – you – (.) you could not wedge (.) you inflated the balloon (.) and it doesn't do anything
I cosa succede se:: (.) si gonfia il palloncino e non succede niente cioè tu sul monitor non vedi che – il cambiamento della:: (.) dell'onda
N and it stays in this (.) pulmonary artery waveform tracing
INF3 [siamo::]
I [e con –] continua a rimanere in questa forma di::

335 INF3 significa che non siamo::: (.) nel posto giusto però siamo in ventricolo (.) [può essere che siamo
I [we're not] we're not in the right place (.) we're in the ventricle but not °in the right place°
N well=
340 INF3 =e leggiamo solo la::: la [°( )°
N [it wouldn't be] in the ventricle (.) because if it was in the ventricle
I non siamo nel ventricolo
N our waveform *((pointing at a waveform on the tracing))* would be
345 [this
I [perché] se fossimo nel ventricolo l'onda avrebbe [questa=
INF3 [°oh°
I =forma
N °okay° but all we see after trying to wedge=
350 INF2 =mhm=
N =is our [pulmonary
INF2 [oh siamo ( )] (.) siamo °( )°=
N =what – what might be wrong
I secondo te cosa – cosa può essere successo ^se – ^
355 INF2 >ehm< il palloncino::: è rotto=
N =yeah maybe the balloon is raptured=
I =esatto
INF2 e:::hm (.) the complication e:hm if the:: (.)
[palloncino si=
360 N [>°the balloon is raptured↑°<
INF2 =rompe:: (.) l'aria (.) [e::hm
N [it's air] (.) air [*is*=
INF2 [>°( )°<
N =a complication
365 INF2 embolia [gasso::sa
(INF3) [°(embol[i])°
N but – =
INF2 =embol[i]
N if you give one C C (.) [one=
370 INF2 [>mhm<
N =and a half C Cs (.) through here *((pointing at the syringe))* into the patient u:::h that small amount is not going to=
INF2 =°mhm°
N create >danger to the patient<=
375 INF2 =°mhm°
I è una quantità di aria ridotta [uno virgola cinque quindi comunque=
INF2 [°( ) (esatto) (è poco)°
I =non – non crea problemi al paziente=
N =as – nurses we tend to see *air* in I V tubings and we get nervous like
380 *((mocking a worried voice))* ah there's an air bubble=
I =mhm=
N =*((mocking a worried voice))* it's going to kill the patient
I mhm *((soft chuckle))* a noi succede per esempio di vedere delle – delle bolle d'aria nelle – nei tubi delle – delle medicazioni endovenose
385 magari ci preoccupiamo *((mocking a worried voice))* c'è una bolla d'a::ria

INF1
INF2 [*((soft chuckle))*
INF3 [
390 N i – i – it won't (.) but – (.) and you need (.) a very *lo::ng* (.) piece of I V tubing amount of air to do damage but ^I'm not^ gonna be the one
[who=
I [mhm
N =say
395 I dico in realtà [non c'è=
N [that won't °( )°
I =problema perché ci – ci vorrebbe una *gro::ssa* bolla d'aria nell'intero:: (.) tu:bo=
N =°okay°=
400 I =però
N but – you do need to worry about *air* [°u::h°
I [bisogna] comunque preoccuparsi
(INF3) mhm
405 N these one and a half C Cs won't be dangerous=
(INF2) =°mhm°=
N =if you say mhm I didn't – (.) didn't – (.) it did not uh (.) wedge
I comunque sappiate che questa minima quantità non è pericolosa se vi doves:te a – (.) accorgere che non – (.) non avete raggiunto ::: (.)
410 [lo °scopo°]
N [you can –] (.) try (.) one more time
I provate un'altra volta↑
N don't get every other I C U nurse to come (.) and try:: (.) wedging=
I =non chiedete a tutti i colleghi a ognuno da:: a provare
415 [così °perché°]
N [because] at that point *((ironically))* now you've *given* about ten C Cs of air [which]
I [perché] a quel punto gli hai dato già dieci C C di aria e allora::
420 INF2 *((soft chuckle))* °( )°
N if it's not wedging (.) u::h (.) notify the physician↑
I se non hai l'incuneamento chiama il medico↑
N probably in rounds the physician might try to wedge
I ci proverà lu::i durante il giro visite [probabilmente]
425 N [and say] well the balloon is *probably* raptured
I e ti dirà *fo::rse* è: bucato il palloncino
N uh we won't use this we will have to rely on the pulmonary artery:: (.) °what number↑°
430 I e quindi=
N =°if the wedge doesn't work↑°
I se non funziona questo – (.) il medico potrebbe dire ci basiamo su che cosa su quale:: su quale valo:re ditemelo voi
N the pulmonary ^*systolic↑*^ or *diastolic*
435 I sistolica↑ o diastolica polmonare
INF2 e::hm (.) diastolic=
INF3 =sarebbe la::=
INF2 =°e::hm°

N =*((enthusiastically))* >okay good< diastolic [( )
440 I [esa::tto] diastolica
N remember that your P A *diastolic* is a li::ttle bit higher↑
I ricordatevi che la diastolica polmonare [è *leggermente* più alta=
N [than your – wedge
I =rispetto al wedge
445 N and you can see they're very *close* to each other
I comunque [vedete che sono]
N [this is my] diastolic *((pointing at the transparency))*
I vedete che [sono=
INF2 [°mhm°
450 I =comunque:: vicine
INF2 [°mhm°]
N [°this is] my systolic° *((pointing at the transparency))*
I questa *((pointing at the transparency))* è la=
INF2 =°mhm°=
455 I =sisto::lica [quella *((pointing at the transparency))* più bassa=
N [here's my wedge *((pointing at the transparency))*
I =la diastolica e questa *((pointing at the transparency))* è la:: pressione di incuneamento
N those are *very* close (where) they should be
460 I quindi più o meno (.) comba:ciano quindi (.) potete usare °quella°
N we'll talk about this ( ) °right here right here° *((pointing at the transparency))* this is my wedge °right there°
I quindi qua *((pointing at the transparency))* questa parte s – evidenziata comunque è la:: >è quella relativa all'incuneamento<=
465 N =°okay↑° (.) when this is not functioning you should ta::pe it↑ or take this off and put a cap↑ or label it somewhere on here *and* in Emtek uh P A wedge *no:n* (.) *functional*
I allora se non – non – funziona o togli la:: la siringa e ci metti un cappuccio a chiudere o comunque in qualche maniera ci metti un un –
470 un::: un'etichetta dicendo che non funziona e comunque lo inserisci in Emtek
N you can *free* text in the little *box* where you enter the vital signs for the P A wedge you can actually we (.) like you to do N F non °fun( )°
475 I quindi ci sono del – delle parti in Emtek dove puoi inserire testo no↑
INF2 °mhm°
I e – ci metti N F cioè non funzionante
N if it's *very* important and the physicians *absolutely* want to have a wedge (.) pressure (.) they would change the catheter
480 I se il medico vuole assolutamente una pressione di incuneamento allora:: cambierà il catetere – verrà cambiato il catetere
((the US nurse changes the transparency on the overhead projector))
N °okay↑° (.) now let's talk about the effects of (.) *intrathoracic* pressure
485 I >ora< (.) parliamo degli effetti della:: pressione in – intratoracica
N o:n (.) the measurements
I e che:: (.) effetto hanno sui – sul – sulla – sulla lettura dei valori
N °okay° (.) we breath one or two ways in the I C U (.) spontaneously↑ (.) or with a mechanical ventilator
490 I in terapia intensi::va (.) si respira in due modi o spontaneamente o col respiratore

	N	°okay↑° (.) when I breath *spontaneously* (.) when I take a breath in (.) what that does in my pleural space is – even though my lungs are *inflating* (.) the *act* of taking a breath in creates *negative* (.)
495		pressure
	I	nello spazio:: *pleurale* quando ho una respirazione di tipo spontaneo gonfiandosi i polmo:ni ho una pressione negati:va
	N	°okay↑°
	INF2	°mhm°
500	N	so that °negative° pressure being exerted o::n (.) this catheter that's *in* my (.) cardiothoracic u::h (.) area (.) u::h reflects the *change* in that pressure °that negative pressure°
	I	quindi questa pressione si risente nel:: appunto nel catetere che è comunque nella zona cardiotoracica
505	N	and what happens [is
	I	[e questo] è quello che succede
	N	I take a breath in↑ (.) [negative pressure=
	I	[tiro dentro l'aria↑
	N	=is created↑
510	I	pressione negativa↑
	N	the waveform↑ (.) *((pointing at the transparency))* becomes negative (.)
	INF2	[on my – = [°mhm°
	N	on my monitor
515	I	e allora l'onda vedi che diventa negativa sul monitor
	N	°like that° *((pointing at the transparency))* >and then I< *exhale*
	INF2	°mhm°
	N	a::nd
	I	e poi (.) espiro
520	N	with my lungs collapsing (.) during (.) *exhalation*
	INF2	°mhm°
	N	it creates a *po:sitive* pressure
	I	quindi durante l'espirazione °c'è – ° i: polmoni si riducono e c'è la pressione positiva
525	N	°okay↑° then there is a period where (.) I'm not breathing in↑ and I'm not exhaling
	I	poi c'è un [momento in cui=
	N	[nothing is happening
	I	=non c'è *né* inspirazione né espirazione non succede [niente
530	N	[°okay↑°]
		(.) we call that period of nothing happening (.) *end* (.) *expiration*
	I	ora questo:: (.) questa frazione diciamo quel – questo tempo (.) in cui non succede niente la chiamiamo: *fi:ne* dell'espirazione
	N	and it's during this period of ^*end*^ (.) *expiration* that (.) you get (.)
535		your pulmonary (.) artery (.) pressure (.) readings
	I	ed è durante questo:: tempo no↑ di fine espirazione:: che bisogna leggere i parametri della pressione:: pol – arteriosa polmonare
	N	°okay° so (.) I take a breath in↑ spontaneously breath↑ this *((pointing at the transparency))* comes down I exhale (.) I take a breath in (.) and
540		then I exhale (.) so [this is
	I	[avete] seguito il mo – il movimento
	N	*end::* expiration
	I	quindi questa è proprio *fine* (.) espirazione questa::

N °okay° [this –
I [questo] momento
N °this period° so (.) when I look at my monitor to get (.) the *value* of this (.) wedge (.) tracing
((pause)) ((the US nurse examines the transparency))
N let's just for ease of – ig – ignore that forty *((pointing at the transparency))*
I allora per facilitare non tenete conto di quel quaranta che c'è °sopra° *((pointing at the transparency))* °fate finta che non c'è°
N °( )° >okay< make each of these lines *((pointing at the transparency))* be five (.) five millimeters of mercury=
I =diciamo che ognuna di questi:: linee sono cinque: (.) vale cinque
N *((pointing at the transparency))* this is zero (.) this is five *((measuring the waveform on the transparency))*
I [ten fifteen twenty=
[cinque dieci quindici venti eccetera
N =twenty-five (.) okay↑ so (.) *((measuring the waveform))* *zero* (.) five ten fifteen twenty twenty-five zero five ten (.) fifteen (.) it's between *ten* and *fifteen*
I quindi diciamo che siamo tra *dieci* e quindici [°qui°
N [°okay↑°] (.) so: we
can say seven↑ (.) eight↑ whatever (.) °okay↑° when you get the wedge you are *not* (.) looking at the s:ystolic and diastolic there isn't a systole and a diastole it's just a squiggly=
INF2 =°mhm°=
N =line
I ovviamente in questa fase non c'è una diastolica o una sistolica
N so you try to – (.) *average* (.) what that –
I si prende un valore me:dio
N measurement is (.) it's not like on the uh (.) *P A* where you have a systolic and a diastolic
I non è come nella – nell'arteria polmonare che c'è una:: e::hm
N [sistolica e una=
[*((pointing at the transparency))* very clear
I diastolica [ed è molto=
N [systole
I =chiaro no↑
N *((pointing at the transparency))* very clear [diastole
I [ed è –] ed è evidente
N [la sistolica e la diastolica
[this is *((pointing at a waveform on the transparency))* just] *((sound indicating oscillation))*
I =questa è soltanto una:: un'oscillazione↑
N so you can (take) on the monitor you have a cursor (.) a cursor line that you can move up and just kind of place right in the middle of this – *((pointing at the transparency))* [this line
I [quindi] nel monitor c'è un cursore che:: che – che puoi alza:re fino a raggiungere diciamo mediamente la: (.) il valore medio e misurarlo °in questo modo°
N °okay and get your [reading°]
I [ti metti] più o meno in una posizione intermedia
N °okay↑° (.) u:h (.) because the P A wedge (.) and:: the uh P A pressures

		are on a *sma::ller sca:le* (.) [their normal values
	I	[dato che la pressioned'incuneamento]
		e anche la – (.) pressione arte – arteriosa comunque sono su una – una scala molto ridotta
600	N	your (.) *margin* of *air* is=
	INF2	=°limitato°
	N	°very limited°
	I	il margine di aria è estremamente limitato
	N	so (.) if *I* say that my wedge is ten↑
605	I	quindi diciamo che io dico che la wedge è dieci
	N	and you think it's fifteen↑
	I	e tu dici che è quindici
	N	>well< ten is normal (.) but fifteen would kind of be elevated °in some
		[cases°
610	I	[>quindi<] dieci è normale quindici già comincia a essere alta in certi casi
	N	if I say the *systolic* pressure's twenty-five (.) and you say it's thirty (.) we've now gone from normal to:: (.) high (.) in some [cases
	I	[la]
615		sistolica se – °pe::° andiamo da venticinque a trenta già siamo in valori:: a::=
	INF2	=°mhm°=
	I	=in alcuni casi siamo (a) valori estremamente alti
	N	so we just – (.) you need to be very careful u:::h (.) a:nd (.) dedicate a
620		sense of *accuracy* (.) in doing your readings
	I	quindi quando fai la lettura:: (.) va fatta con attenzione
	N	which is why (.) we – (.) you need (.) to read (.) pulmonary artery pressure numbers (.) from (.) the screen (.) and *not* from the digital printout °(that's happening)°
625	I	per questo motivo la [pressione::=
	N	[>°the digital numbers°<
	I	=a::: arteriosa polmonare va misurata *sullo* schermo e non:: nel – sulla – sulla striscia che viene stampata
	N	because what is happening with this (.) that monitor doesn't know *end-
630		expiration* (.) >°okay↑°< it doesn't know that's the phase of end-expiration and ^that's^ the number I should put out here
	I	il monitor=
	N	=it just ^averages^ everything that sees coming across it
	I	il monitor fa una sorta di media di tutti i valori che riceve non è:: non è
635		che capisce che siamo nella fase di fine ispirazione:: *espirazione* ed è quella parte che mi interessa
	N	°okay↑° so it will see *this* *((pointing at the transparency))*
	I	non lo riconosce >°(quindi)°<=
	N	=it will see this it will see this (.) and (.) when it gets here it's gonna
640		give you:: this reading which is what (.) what if – (.) what if you make the mistake (.) u::h (.) oh °let's go back to this° (.) the monitor (.) will print out all of these – u:h numbers around the movement
	I	allora facciamo un passo indietro diciamo che il monitor ti stampa tutti – (.) tutte queste quantità no↑ in questa per esempio in questa
645		striscia
	N	and you decide to get your numbers from (.) the monitor
	I	e tu decidi di:: ricavare i valori direttamente dal monitor

N and let's say that that the – the time that *you* decide to take the number off the (.) digital num – numbers being printed is right here
when when the monitor reads *this* which is what zero five (.)
I [two / diciamo] che tu vuoi leggere [dal=
N [three
I =monitor un valore che corrisponde per esempio a quello che sta indicando lei (.) ze:ro:: zero uno [°(non so)° / you say] mhm three
INF2 mhm
N you write down [three / lo scrivi] però [non è quello che ti serve / or you:: Emtek] and it takes it from the (.) the screen it's – if they are (.) u::h (.) *((to the interpreter))* °what's the word [inter – ° / interfaced
I
N interfaced °thank you°
I oppure lo prendi da Emtek che è interfacciato con:=
INF2 =mhm=
I =col monitor
N it's not right
I ed è [sbagliato / (let's do) this ^three::↑^] *((mocking an upset tone))* a:::::::::h (.) give them *vo::lume* you know
I perché magari ti dà la lettura tre no↑ e allo:ra non è quella giusta è un risultato [bassiss::imo allora ti dice:: / but it's not three] it's – =
I =il medico ti dice dagli ancora del volume [e invece non è quello / between] seven and ten and: sevenish it could be tenish maybe
N
I invece è::
N >or maybe< *((squeaking noise))* between ten and fifteen
I è tra dieci e quindici quindi
N [dodici tredici / *((measuring the waveform on the transparency))* zero five] ten °fifteen° I'm sorry >I made a mistake °( )°< zero five ten >°fifteen°< between ten and fifteen
I invece [in realtà=
N °( )°
I =quello che ti interessa è tra dieci e
N [quindici do::dici *((to the US nurse))* I know / *((to the interpreter))* °( )° *((to the trainees))* °okay↑°] >°all right↑°<
INF2 mhm
N that's a *big* difference saying thirteen
INF2 mhm [°( )° / it's what it is] versus *three* [which= / >quindi<
N
I
N =is [not / °( )° / capite] bene che è una bella differenza no↑ da: tredici:
INF2
I

		quattordici: a scendere a tre [è:: °( )° – N °so:°] if you record *wrong* (.)
700		numbers (.) the physicians are going to give *wrong* (.) therapy *((squeaking noise))*
	I	>°(quindi)°< se voi immettete in Emtek valori sbagliati il medico darà una terapia sbagliata perché si baserà su quei valori che avete inserito
	N	°okay↑°
705	INF2	mhm
	N	it's the same thing for C V P reading↑
	I	la stessa:: cosa è quando leggi una C V P=
	N	=°okay↑° (.) all right let's take a look at what happens when you have (.) the opposite (.) when you have (.) *mechanical ventilation*
710	I	invece vediamo cosa succede nel caso della ventilazione meccanica col respiratore
	N	°okay↑° with *mechanical* ventilation (.) that's a *positive* pressure
	I	questa è una pressione positiva di tipo positivo
	N	a:nd (.) mechanical ventilation will:: *push* (.) pressures *into* your
715		lungs (.) creating (.) a positive pressure
	I	quindi praticamente è:: l'aria che entra nei polmo:ni↑ gonfiandoli↑ e creando una:: (.) una↑ *((looking puzzled))*
	INF2	°pressione°
	INF3	°( )°
720	I	una ^pressione^ >non mi veniva pressione< (.) >pressione positiva<
	N	so the *o:pposite* happens now
	I	praticamente è il processo inverso l'o – l'o – l'opposto
	N	so let's just reverse our thoughts let's – erase these black lines °( )°=
	I	=quindi=
725	N	=°(here)° *((pointing at the transparency))*
	I	cancellate mentalmente queste:: queste *((pointing at the transparency))* due
	N	°okay↑° so=
	I	=linee nere↑
730	N	we wedged the patient
	I	facciamo il wedge del paziente↑
	N	a::nd (.) we see (.) this *((pointing at the transparency))*
	I	fate finta che queste *((pointing at lines on the transparency))* non ci sono↑ e questo è quello che vediamo
735	N	ventilator cycles on (.) this is my wedge↑ (.) the ventilator cycles on↑ (.) it pushes *up* the waveform
	I	quindi i::l respiratore comincia:: continua a funzionare con un altro ci:clo e – e spinge in alto la pressione
	N	[come valore ventilator] cycles *off* (.)
740		and (.) you come back down to an *end* – the point of *end* (.) expiration
	I	il respiratore si ferma↑ nel ciclo:: (.) opposto↑ e:: siamo in quella posizione
	N	the ventilator will cycle on again↑
745	I	poi si ri – riattiva↑
	N	and then off
	I	e poi si rispegne
	N	now *in* (.) *this* scenario (.) what *is* your (.) wedge (.) reading

I ora in uno scenario *((squeaking noise))* del genere [qual è la le –
N [end-expiration] (.)
you can't (.) get your reading when the ventilator is cycling on
I non puoi: leggere la:: la pressione di incuneamento quando i: i: il respiratore è in – in ciclo attivo
N so your wedge reading (.) in this scenario (.) is gonna be >down here<
((pointing at the transparency)) this is a different patient °okay↑°
I °quindi è – ° (.) è un paziente diverso quindi tutta la – la situazione è diversa
INF1 °mhm°
I ti basi su quel – su quel valore
N if I see this with a mechanically ventilated patient (.) my true wedge is down here *((pointing at the transparency))*
I quindi in un paziente su respiratore la:: i:l valore di wedge che mi serve in realtà è questo qua in basso
N °okay° *and* if you make the mistake of reading (.) during *this* phase (.) uh during the phase when the mechanical ventilator's cycling on you're going to say *((mocking a puzzled tone of voice))* °oh the wedge is thirteen *((going back to a normal voice))* when the wedge is three°
I quindi qua è – faresti lo stess – l'errore opposto cioè se leggessi in quella – in quella zona leggeresti che c'è una pressione di incuneamento: di tredici mentre invece è tre
N the patient needs treatments here (.) but it's not – >he's not gonna be getting it< because your – (.) the picture you're painting for the physician is:: (.) that the wedge is okay
I quindi il paziente *ha* bisogno di un trattamento specifico ma tu gli dai un valore:: annoti un valore di tredici quindi: la terapia non scatta↑
N °okay° this patient's *hypovolemic* if you read – if they're g( ) a wedge of three (.) what other *signs* and symptoms would the patient have (.) of *hypovolemia*
I i:: (.) in caso di ipo:::
(INF1) °( )°
I sì volemia qual è – che altri:: *sintomi* avrebbe il paziente secondo voi se siamo in questa situazione
INF3 ipovolemia↑=
INF2 °m::hm°
I =sì
INF3 c'è un ridotto afflusso::
INF2 °( )°
INF3 [°di sangue ( )°
INF2 [°forse:: la pressione è ancora] più bassa°
I a low [low pressure]
INF2 [( )] lower
N >sure< blood pressure [would be=
I [*((clears throat))*
N =low
I [sì]
INF3 [>giustame – <] giustamente anche::
N how fast [>the heart rate< fa::st=
INF3 [la pulsazione arteriosa
N =tachycardia

800 INF2 [ah
I [la] tachicardi::a [frequenze cardiache elevate
INF3 [°( )°
INF2 mhm
N °okay↑° so you would see the(se) signs of hypovolemia [°okay↑°
805 I [quindi]
vedresti proprio i segni di una ipovolemia
N °all right° so uh (.) that might make you think mhm can the wedge be thirteen if my patient *looks* and *acts* like a hypovolemic
I quindi ti dovrebbero venire i dubbi no↑ com'è che ho un valore:: (.)
810 ^tredici^ se il paziente mi dà sintomi °di ipovolemia° (.) vi dovrebbe mettere un po' in guardia °questa cosa°
N this (.) is so: important with getting *accurate* readings [°( )°
I [questo è]
importante se vuoi avere delle letture::=
815 INF2 =mhm=
N =u:h [it –
I [corrette
N it applies for we:dge↑ it applies for C V P:↑ it applies for your pulmonary artery systolic and diastolic pressures
820 I quindi questo vale sia per le pressioni diastoliche che:: […]
((brief interruption in the recording in order to turn the tape; INF2 asks about the effects of breathing problems on the measurements))
N […] if they are breathing really (heavily) (.) I have an example of that
I cioè tu dici se respira in maniera [affannosa↑]
825 INF2 [>°sì°<] (.) e:::hm
N there is a period of [( )
INF2 [tachypnoic] or [e:::hm=
N [(tachypnea) yeah
INF2 =( ) superficial breathing °(questo è)°
830 I °mhm°
N in that situation (.) u::h (.) when they are really working at breathing↑ (.) working hard
I in una situazione simile quando il paziente:: si vede che
[fatica a respirare]
835 INF2 [mhm]
N [it's very] difficult to get your – it will be *very* difficult to get a – (.) the period of [time *((snapping her fingers))*=
INF2 [mhm
N =for their [wedge]
840 INF2 [yes] mhm=
N =it's very short
I è difficile trovare °il – ° il punto quello che dicev(a) di [fine=
INF2 [mhm
I =espirazione=
845 N =>it's gonna be<=
I =perché è molto breve
INF2 [infatti]
N [(it'll be)] (one) artefact with this (.) ^in that^ situation what becomes more *impo:rtant* is *no:t* (.) what their P A numbers are (.) but what
850 is their blood gas (.) showing=
INF2 =mhm=

N =and then they would need to be ventilated [u::h=
INF2 [°mhm°
N =and once they are ventilated and their breathing is – (.) *regulari::zed*
or regulated °then you can get true numbers°
I in quei casi è più::
INF2 °( )° (.) [importante]
I [utile] vedere l'emogas no↑ e poi vedere:: muoversi di conseguenza: e di cercare di *ristabilire* col – col:: respiratore la situazione e poi in un secondo tempo=
INF2 =mhm=
I =andare a vedere i valori=
INF2 =certo
N mhm↑ >so<=
INF2 =okay
N but – °it – ° that is – is – is good thinking (.) if they're breathing fast (.) you are not gonna get *accurate* (.) u::h (.) it'll be very difficult to get uh your P A [uh
INF2 [mhm
N numbers
INF2 mhm=
N =*and* the wedge
I °hai° – hai ragione tu se (hai) un paziente che respira così affannosamente diventa difficile vedere i valori esatti di – di pressione °arteriosa°
N °okay° let's take a look at (.) the *last* page *((grabbing the handouts and moving to the last page))* and then we are going to go into some of the: examples I want you to (.) feel comfortable with uh more waveform (.) readings of waveforms (.) °okay↑° (.) this last information was just u:h (.) we'll talk about complications we'll talk about ^*re*positioning^ (.) the P A catheter
I allora parliamo di (.) del:: *ri*posizionamento del catetere nell'arteria polmonare
N ^when does this catheter have to be repositioned^ because it's not *in* the right place
I allora quand'è che il catetere va *ri*posiziona:to perché non si trova nella posizione corretta
N it needs to be advanced (.) if it comes back into: the ventricle the right ventricle
I >allora< va *ri*posizionato se *torna* indietro nel ventricolo destro
N so physician needs to advance it *out* of the right ventricle
I quindi il::: (.) medico deve riposizionare di nuovo *fuo:ri* (.) dal ventricolo °destro°
N but you need to recognize that it's *in* (.) the right ventricle by looking at the °waveforms°
I però voi (.) dovete essere in grado a – gurdando la – la forma dell'onda [di *capi:re*=
INF3 [°( )°
I =che è andato a finire nel ventricolo destro=
N =°okay↑° what about when (.) it needs to be pulled back or withdrawn
I quand'è che dev'essere tolto ehm oppure arretrato
N °okay° (.) perhaps it goes into the wedge position it goes too far and the catheter >the tip of the catheter< (.) ^without^ being (.) infl – without

		being wedged the tip of the catheter has migrated *too* far and has
905		gone *into* a wedge position
	I	potrebbe essere che anche senza gonfiare il palloncino il catetere è avanzato troppo e la punta è andata in un – in un – in una zo:na (.) zona d'incuneamento
	N	the waveform that I will see will be a wedge waveform
910	I	vedrei una forma di questo tipo (.) di tipo: d'incunemento
	N	if you come into your patient's room and see this *((pointing at a waveform on the upper part of the transparency))* on the monitor and *you know* that you should be seeing *this* *((circling another waveform on the transparency))*
915	I	se entri nella stanza e sul monitor del paziente c'è – quella forma in alto *((pointing at the transparency))* mentre invece dovresti vedere quella↑ (.) quella che ha: °circolato°
	N	do some troubleshooting check to see if *maybe* the balloon *is* inflated
920	I	cosa fai (.) controlli (.) magari il palloncino non si è – non è gonfia:to
	N	°okay° I will see this↑ (.) I will – (.) just see if I can *de*flate the balloon if by chance somebody left it wedged
	I	oppure vedi se:: qualcuno l'ha lasciato gonfio allora cerco di sgonfiarlo
	N	°okay↑° u::h (.) and then I will notify the physician↑
925	I	avvertire il medico [a quel=
	N	[°( )°
	I	=punto
	N	when either of these (.) situations occur (.) and you're calling the physician °to come down° (.) you can try (and) position the patient *on*
930		their side a:nd possibly should (fit) (.) out of the dangerous (.) placement being in the ventricle °or being too far°
	I	allora e::hm (.) quando succede una di queste cose tu chiami il medico e nel frattempo che aspetti che arriva potresti cominciare a posizionare il paziente di lato (.) per:: fare un *tentati:vo* di – °di – di° >insomma< di
935		*smuovere* un po' la situazione=
	N	=here's a rule of thumb (.) if you recognize that it's in the right ventricle
	I	>allora< questa è una regola: (.) importante da ricordare
	N	*((holding the sample catheter))* because these catheters tend to *have* (.) a *natural* curvature (to) them
940	I	allora dato che questi cateteri come vedete hanno una sorta di:: (.)
	N	[curvatura naturale [because it goes into] the right ventricle (.) and then (.) goes into the: (.) pulmonary artery
	I	perché cosa fa entra [quasi naturalmente=
945	N	[this ( )
	I	=nel ventricolo destro e poi nella:: (.) arteria polmonare
	N	if it slips back into the right ventricle
	I	=se=
	INF_2	=>°mhm°<=
950	I	=torna indietro nel ventricolo
	N	if you turn the patient on their (.) *right* (.) *si::de*
	I	e tu i – il paziente lo gi:ri no↑ sul lato destro [sul fianco=
	N	[it might
	I	=destro
955	N	just allow it to:: (.) advance

I potrebbe:: (.) [potresti=
N [in the position
I =mettere in modo tale che: (.) il catetere avanza naturalmente=
INF2 =mhm=
I =nella °posizione°
N °if that doesn't work you can try the other side° but *I* would try the right side
I se non funziona puoi provare l'altro lato *io* personalmente proverei a posizionare il paziente prima sul lato destro
N °okay↑° let's say it advanced too far it's in a *wedge* position
I oppu:re (.) è avanzato troppo >quindi< è andato troppo avanti
N °okay↑° (.) guess what side (.) >you should try to turn them on< here you're trying to pull it back
I quindi se è andato troppo avanti da che lato lo giri il paziente
INF3 °destro°
INF1 °sinistro°
INF2 [sinistro]
N [( )] (wedge)=
INF2 =sinistro=
N =it might just be enough=
INF2 =mhm=
N =to pull it out of that position
I *potrebbe* essere abbastanza questo movimento per far uscire fuori:: (.) >cioè< a fare *arretrare* la punta
N that's – very – (.) typical of how these catheters (.) are placed they usually go *this* fashion (.) into the right
I >questo< è:: è:: cla:ssico no↑ anche dato dalla forma del catetere nell'inserimento se ne va quasi naturalmente da quel °lato°
N usually it does *not* get fed into the right ventricle and then (.) go to the left *that* way it's usually always [in this (curve)]
I [è difficile che] entra (da)l ventricolo destro e poi si si gira a::: verso sinistra
((long pause)) ((the US nurse changes the transparency on the overhead projector)) ((shuffling of transparencies))
N u:::hm
((pause))
N >°( )° okay< (.) the other time that it can be *withdrawn* or *pulled back* is when it's being pulled ^ba:ck^ *into* the C V P position (.) so we don't need to use this anymore (.) as a pulmonary artery catheter I can now (.) we're just gonna pull it back (.) into C V P position
I allora diciamo che non mi serve più in quella posizione e lo devo *ritirare* devo tirare indietro in una:: posizione per:: misurare la pressione (.) venosa centra:le questo è un altro caso per cui lo devo tirare °un pochettino indietro°
N when you do that (.) in o – in Pittsburgh (.) the:: nurses some of the nurses are trained to pull this back into (.) u::h the C V P position
I allora a Pittsburgh ad alcuni infermieri vien – viene fatta una formazione specifica dove:: °ehm° si insegna a: (.) tirare indietro (.) il catetere in questa posizione
N >so< it's basically that you are pulling this catheter without the b – with the balloon *de*flated
I ovviamente il palloncino è sgonfio
INF2 mhm

N you're pulling it back *past* the pulmonic valve
I e quindi lo stai:: tirando *fuori* dalla:: valvola polmonare↑
N *past* the tricuspid valve=
INF2 =mhm
I passando dalla valvola tricuspide
N hoping that you are not *damaging* (.) those valves (.) in pulling back
I con l'accortezza *e la speranza* (.) che non stai danneggiando le valvole [mentre lo tiri indietro
N [and hoping] (.) that this has *not* become knotted *((showing a knotted sample catheter))*
I e con la speranza che non si siano formati dei nodi come questo
N which you can do
I che può succedere
N and you'll know that because when you're pulling it back (.) >you're like< *((mimicking the attempt to pull back the catheter, which produces a piercing sound))* nah nah
I in questo caso te ne accorgi perché mentre lo stai tirando senti::
INF2 resistenza
I res – una [resistenza
N [it usually] happens in here not=
I =generalmente succede qua
N it usually happens because when it gets into here and with the – with the u:::h (.) the *contraction* of the ventricle (.) this can *((making the sound and the gesture of a whirlpool))* and get into a little little knot
I succede no↑ arrivati in quest'area qua con le *contrazioni* del [ventricolo=
INF2 [certo
I =quindi [muovendosi=
INF3 [°(giustamente)°
I =potrebbero formarsi dei [nodi]
N [so] (.) you end up (.) with (.) a situation like – like *this* [( )
I [quindi hai una] [situazione del genere]
INF2 [( )] la tricuspide
I stai cercando di tirarlo indietro e c'è questo nodo [che::
INF2 [*((soft chuckle))*
N and we – [we say
I [opp – opp – oppone] resistenza
INF2 mamma mia *((chuckle))*
N >you – you're not – it's not like you're going fishing< *((mimicking a fisherman with a fishing rod))* >and like you're like< [*((emphatically))* o::h my Go::d a *bi:g* one *((chuckle))*
INF2 [*((wholehearted laugh))*
I è come quando vai a pesca no↑ [vai a pescare=
N [°( ) that°
I =e ti abbocca l'amo e ti::ra=
N =a l( ) of your *tricuspid* valve (.) ^which [(we) *don't* – ^
I [sei *attaccato*] alla valvola tricuspide che è una cosa che non – [non deve succedere
N [want to] come out with us (.) this *((pointing at the tip of the catheter))* should come out *empty*

I evitare di scippare pure la:: [la valvola °(tricuspide)°
N [°right so°
INF1
1065 INF3 [*((soft chuckle))*] °ah [(mamma)°]
INF2 [^if that]
N happens^ (.) u::h (.) physicians:: (.) you – you have to stop and then physicians will need to °( )° sometimes if the knot isn't so tight it's kind of like a loose thing like
1070 that and (.) °they jus – ° they just have to try to work it
I in [questo=
N [but –
I =caso appunto interviene il me:dico perché [magari=
N [it's
1075 I =il nodo non è molto stretto quindi lui [un po' giocandoci=
N [very rare
I =così (.) riesce a scioglierlo=
N =if it's expected that there's a knot you – you don't wanna do this *at* the bedside usually we go into: uh interventional cardiology and
1080 *visualize* [this
INF2 [mhm mhm mhm
N [under fluoroscopy]
I [insomma comunque] (.) è una cosa con la: fluoroscopia in: nel reparto di cardiologia interventistica si fa lì non si fa a bordo letto
1085 INF2 certo
I se dovesse succedere ma è una cosa: rara
INF2 °il medico fa un miracolo e lo scioglie°
N I want it back in C V P position
I quando sei qua *((pointing at the transparency))* hai una posizione de –
1090 [per prendere=
N [and then pull back
I =la pressione venosa
N C V P position [for triple=
I [°pressione°
1095 N =lumen is just outside of the right atrium up here *((pointing at the transparency))* °( ) [( )°]
I [quindi] la posizione ideale per un triplo lume è qua *((pointing at the transparency))*
N °okay↑° a C V P catheter should *not* be *in* the right atrium (.)
1100 [°( )°]
I [quindi non] dovrebbe essere nell'atrio destro se stiamo parlando di un catetere per la pressione:::
N we only find [the catheter=
I [°venosa centrale°
1105 N =*in* the right atrium when you have your Swan-Ganz °catheter°
I >°quindi°< è soltanto quando:: ha:(i) un catetere di tipo Swan – Swan-Ganz che arrivi fino a giù
N u::h so (.) once it's in C V P position (.) u::h you can (.) *disconnect* you can pull it back from there
1110 I quindi una volta che [sei:: nella posizione=
N [°(disconnect)°
I =chiamiamola:: C V P lo puoi tirare indietro

N °okay° uh (.) usually what's going to happen though i:s (.) this needs to be left in (.) on – and they're going to put a *guide* wire↑ and ( ) uh
over the guide wire a triple lumen
I generalmente: quando è ancora in posizione mettono [una sorta di::]
N [°( )]
( ) [catheter°]
I [sì] di:: °di° (.) di guida (.) °no↑°=
INF2 =mhm
I se – inseriscono una guida:: e poi danno:: *((to the US nurse))* what do they give °to the::°
N they put a – a guide wire=
I =mhm=
N =through here and then (.) put a:: this *((pointing at the sample catheter))* comes out and then a triple lumen a new catheter triple lumen
I [( ) ah allora la guida] poi escono questa *((pointing at the sample catheter))* e inseriscono un triplo lume
N (okay) they – they change *over* (.) [uh]
I [si] cambiano in sostanza °i cateteri°
N u:h (.) when this *((pointing at the sample catheter))* is pulled back *into* C V P position (.) how do I know (.) which *ports* (.) I can use now
I allora quando – (.) lo tirate indietro in questa posizione che chiamiamo C V P come faccio a sapere i:: i ports cioè (.) gli:: (.) gli ingressi che posso utilizzare
N it's no longer a true Swan-Ganz catheter °it's (a) C V P°
I in realtà non – non:: (.) non è più un catetere Swan-Ganz no↑ è un: normale catetere:: C V P=
INF2 =venoso centrale
N °okay right let's go back to° (.) this is why you need to remember (there's lines) the markings on here↑
I questo è importante *((squeaking noise))* ricordare no↑ come vengono:: segnati::
INF2 mhm
N *((holding the sample catheter))* so here we go this is my introducer this is still in place [°with this°]
I [allora questo] diciamo che ancora è:: piazzato è ancora posizionato
N inside this is (on) this is *inside* the –
I questo è dentro
INF2 [°all'introduttore°]
N [°inside this introducer°] (.) [°(it goes through here)°]
I [dentro] qua dentro
N °and I ( )° so with this in place (.) °( )° usually we've got about like that much [so maybe=]
I [>°allora°<]
N =maybe °this°
I diciamo che questo è posizionato sono in questa posizione=
N =°all right° so (.) >guess what I can see< in the plastic
I allora nella nella *plastica* cosa:: cosa vedo
INF3 delle tacche=
INF2 =mhm

N °(true)°
I mhm
N °okay↑° what ports (.) exit (.) °right here° *((pointing at the ports of the sample catheter))*
I quali sono le::=
INF3 =C V P=
I =gli – gli ingressi che escono da qua
N C V P↑
INF2 mhm
I °C V P°
N that's not good any more (.) *((disconnecting a component of the sample catheter and making a squeaking noise))* we can [disconnect that
I [questo lo] possiamo:::=
N =put a cap on here
I ci mettiamo un tappo e lo [interrompiamo=
N [what else
I =e poi↑
INF2 e::hm=
INF3 =togliamo questo bianco
I the white one=
N the right A – yeah the R A °okay° (.) [°so we can°=
I [atrio destro
INF2 = [mhm] [disconnect]
N [the flush
INF3 [atrio destro
INF2 mhm
N I can't use these any more *((pointing at components of the sample catheter))*
I questi non li dobbiamo usare [più=
INF3 [°disc – °
I =quindi li [discontinuiamo]
N [( )] (.) [( )=
INF2 [( )
N =(caps) (.) okay↑
INF2 they use the p[a]d ehm (.) insomma [il lume=
N [>°say it in Italian°<
INF2 =il lume per la pressione pol – polmonare penso giusto↑
N okay yes (.) [the – the
INF2 [per la pressione] polmonare=
N =P A D=
INF2 =ah P A D=
N =the pulmonary artery the P A *distal*
I *distale*
INF2 ah è distale
INF3 distale
INF2 *((to INF3))* te lo ricordi (ieri)
INF3 *((to INF2))* >°sì°<
N okay (.) what has that become now what – the tip of this is my=
INF2 =mhm
N C V P (.) °okay↑° [so your –
INF3 [*((to INF2))* perché questo] non l'ha usato↑

N your P [A
1220 INF2 [*((to INF3))* perché] ci vuole l'ultimo
INF3 °l'ultimo°
N distal
INF3 mhm
N is now (.) my C V [P
1225 INF3 [okay
INF2 mhm
N so this has (.) the single stopcock from being a P A catheter we change and put a double stopcock *((changing the stopcock of the sample catheter))*
1230 I allora questo lo cambiamo e mettiamo un rubinetto a due
INF2 [mhm
N [>( ) (you see)<] we can use (it) now for – (.) °for anything°
I questo si può usare per tutto a questo punto
INF2 [mhm]
1235 N [°okay°] what about this (.) right ventricular
I invece questo↑=
N =infusion port
I questo ingresso ventricolare destro↑ cosa: cosa succede
INF2 e::hm is:: e::hm
1240 N ( ) [( ) an introducer
INF2 [( )
I è dentro no↑ l' [introduttore]
INF2 [for infusion] we can=
N =yeah so=
1245 INF2 =we can use for in – °for in – for infusion°
N if I don't see – if I only see *three* here *((pointing at the sample catheter))*
I se vedo solo tre *tacche* qui↑ *((pointing at the sample catheter))*
N (in) which markings will I find the exit port ( ) on here
1250 I come faccio a capire [quali –
N [how many] rings
I come faccio a capire quali:: quali ingressi devo [utilizzare=
N [remember
I =ancora
1255 INF2 u::mm
N how many ventricles do you have
I di quanti ventricoli::
INF2 right ventricle
INF3 °( )°
1260 N remember the way [I told you=
INF2 [infusion
N =yesterday ( )
I vi ricordate ieri=
N =>h( ) – <=
1265 I =che vi avev(o) [detto –
N [*where*] (.) on this catheter (.) does the right ventricle (.) port (.) exit
INF2 mhm
I allora il i:: (.) l'ingresso::: ventricolare *destro* (.) dov'è che esce (.)
1270 nel [catetere]
INF2 [o:h] u:::mm (.) *((to INF3))* °era il più alto

	INF3	[ha detto – ° *((to INF2))* °e –] era il più [alto (mi sa)° (allora) è::] (.) the [second il] secondo=
	INF2	=the second
	N	yeah it's easy >do you remember< I have *two::* ventricles↑
	I	[ricordate *due* ventricoli
	INF2	[( ) sì
	INF3	[( )] ( )=
	N	=so it's at a *two* ring mark
	I	e quindi=
	N	=>so<=
	I	=è al: segnale numero due
	N	if I don't see two rings in here *((pointing at the sample catheter))*
	INF2	mhm
	N	it means that somewhere
	I	se non vedo due tacche
	N	it's right there=
	INF3	=>ecco<
	INF2	ah [mhm
	I	[( ) qua
	N	so that means (.) it's still inside
	INF2	mhm
	I	questo significa [che è ancora=
	INF3	[°(capisco)°
	I	=dentro
	N	so you can use that
	I	e quindi=
	INF2	=mhm=
	I	=si può utilizzare
	N	okay↑
	((pause))	
	N	>so< I can use *this* *((pointing at one of the ports on the sample catheter))* for infusions↑
	I	posso usare *ques:to* *((pointing at the same port on the sample catheter))* per infusioni↑
	N	and I can use my P A (.) D port
	INF3	e quello=
	INF2	=mhm=
	I	=[e anche questo *((pointing at the PAD port))*
	INF3	[( )] distale=
	I	=questo P A
	INF3	mhm
	N	no more cardiac output(s)
	INF2	°( ) [( ) certo°
	I	[non ho più] l'output [cardiaco
	INF3	[okay
	N	okay↑
	(INF3)	okay=
	INF2	=mhm
	N	now (.) what makes us very angry is: (.) ^change-of-shift^ report (.) *((shuffling of pages))* okay↑

1325 I cos'è che ci fa arrabbiare (.) quando [ci sono::
N [at change] of shift what makes
us angry at physicians (.) [you come in
I [quando c'è] cambio:: cambio turno
N a::nd you look at your patient you got report pulmonary artery pressures
1330 have been twenty five over fifteen
I fai il cambio no↑ con la:: hai dato le consegne la pressione (del sangue)
è intorno a venti venticinque [nell'arteria polmonare
N [you come in do your] assessment on
your patient
1335 I cominci a fare la valutazione del tuo paziente *((squeaking noise))*
N >then look at the monitor< (you) see *this* *((pointing at a waveform on the transparency))* and not *this* *((pointing at another waveform))*
I e vedi *questo* non *quello* (.) [°sul monitor°
N [°where – where – °] where is my P
1340 A (.) where is my P A tracing
I e ti chiedi dov'è il mio tracciato:: (.) arterioso polmonare
N you automatically think somebody left it wedged or whatever you troubleshoot
I pensi automaticamente che qualcuno l'ha lasciato in posizione di
1345 incuneamento e quindi: (.) cominci a:: pensare a quale possa essere il problema
N we::ll physicians were talking about maybe discontinuing this in a day or two=
INF2 =mhm
1350 N you know this (.) [°( )°=
I [sai che
N =(before)
I il medico o i medici hanno l'intenzione comunque di interrompere
questa:: questa cosa:: tra uno o due giorni [°più o meno°
1355 N [>( )< you
troubleshot you looked and saw that it's not wedged
I allora cominci ad analizzare le cose vedi che *non è* in posizione d'incuneamento=
INF2 =mhm
1360 N then you look at this *((pointing at the sample catheter))*
I poi guardi –
N and you [notice=
I [il catetere
N =the tubing now is a lot longer
1365 INF2 mhm::=
N =on your patient's bed=
INF2 =mhm=
I =lo vedi no↑=
INF2 =mhm=
1370 I =che:: il tubo=
INF2 =è più lungo=
INF3 =°( ) lungo°=
I =è molto più lungo sul letto del paziente
N plus *inside* this plastic it's now filling with fluid
1375 I inoltre nella plastica vedi che si riempie di fluido

N because your seven o'clock your six A M antibiotic that was infusing (.) through here *((pointing at one of the ports on the sample catheter))* is now collecting °in here° *((pointing at the sample sheath))* [°okay°]
I [perché]
1380 l'antibiotico dato in infusione a partire [dalle sei o dalle sette=
INF3 [°( )°
I =del mattino sta cominciando a::
INF3 ad andare nel
I a andare in quest – =
1385 N =what happened was the physician came in
I cos'è successo [il medico è arrivato]
N [decided to::] discontinue this pull it back into C V P
I ha deciso di discontinuare [°questa cosa° l'ha tirato=
1390 N [without telling anyone
I =indietro [in posizione C V P=
N [( ) just walked out
I =senza dire niente a nessuno ha fatto questo e se n'è andato
[tranquillo]
1395 N [*or*] more importantly what happens is
INF2 ( )
N the blood pressure drops and you come in the room during report and you see the blood pressure's dropped
I oppure può succedere che tu entri pe – quando ti dai il cambio col
1400 collega ti dai le consegne e vedi che la pressione
N they are getting [dopamine=
I [è scesa di molto
N =and dobutamine through this port
I dobutamina e dopamina attraverso questo::
1405 N the [physician
I [°port°
N pulled it back to C V P position not even asking do you have anything infusing through this port↑
I il medico ciononostante l'ha tirato indietro in posizione C V
1410 [P senza neanche chiedere se c'era=
INF3 [°dopamina e dobutamina ( )°
I = qualcosa in [infusione]
N [( )] in here now not in the patient
I e vedi che questi:: elementi sono:: dopamina e dobutamina [sono=
1415 INF3 [°sono°
I =in questa [guaina di plastica]
INF3 [sì e non vengono più] infusi nel paziente
I °they are no – no longer infused°
N you have every right to go that physician say *((mocking an angry tone of voice))* don't ever pull why don't you ask first
1420 I a quel punto voi avete tutte le:: *((soft chuckle))* carte in [regola per andare dal medico=
N [*((mocking an angry tone of voice))* you (couldn't do this)
I =e dirgli *((with a disappointed tone of voice))* senti ma perché l'hai fatto
1425 N the dop – you can [tell them the dopamine]
I [la prossima volta chiedimi] prima
N and dobutamine is meant to be *in* the patient↑ (.) not the sheath

I digli tranquillamente guardi (.) la dobu – (.) dobutamina e la dopamina devono stare *dentro* il paziente non nella guaina di plastica
INF2 *((chuckle))*
N okay so uh physicians do do that °they just ( ) and then leave°
I succede no↑ che i medici arrivano tirano (indietro di là) e se ne vanno
N >all righ<
((pause)) ((the US nurse turns the pages of the handouts))
N all right and then *((shuffling of pages))* this ( ) with the removal of the P A catheter we've already talked about
I di quest'ultimo punto ne abbiamo parlato no↑ della:: la *rimozione* del catetere
N complications are fairly u::h (.) self-explanatory we talked about this throughout u:h the last few days
I allora le complicazioni non vado in dettaglio perché già ne abbiamo parlato no↑ °negli ultimi giorni°
N you can get a pulmonary artery rapture↑
I una rottura (.) dell'arteria [polmonare
N [pulmonary] infarction↑ [valve damage
I [un infarto]
polmonare
N uh [dys –
I [un] *danno* alla valvola
N dysrhythmias (.) ventricular tachicardia on insertion
I tachicardia ventricolare o delle disritmie nella fase di inserimento del catetere
N if the catheter comes back into the right ventricle=
I =o se il catetere torna indietro nel: ventricolo destro
N the catheter can u:::h (.) irritate this ventricular septum (.) ventricular septal *((squeaking noise))* irritation can occur
I oppure ci può essere che il catetere provoca una *irritazione*=
INF2 =°( )° [°( )°
N [and that] can cause bundle branch blocks
I e questo può creare un – un blocco
INF2 blocco di branca
N 'cause your septum is what houses the bundle branch system
I sapete che il setto è quello che include il=
INF2 =mhm=
I =il sistema::
N the balloon is raptured and you try no response you can get an air embolism
I oppure si può *rompere* il pallon – e il pallon – il palloncino e poi puoi anche avere anche un embolo
N all=
I =se ci provi tante volte
N all invasive monitoring has an infection risk
I ci sono dei rischi di infezione
N on insertion hematoma pneumothorax
I o pneumotorace o l'ematoma nella fase d'inserimento
N prolonged pulmonary artery wedge can cause the infarction
I questo wedge no: polmonare prolungato può creare un infarto
N microshock=
I =°( )°=

N =we're gonna talk about that next week whenever the – whenever we do uh *((clears throat))* E K G uh class
I questi dei microshock parleremo (.) [nelle – =
N [u::h
I =nelle [prossime=
N [this is
I =lezioni=
N =a saline filled *line* (.) [( )]
I [questa] è una linea:: do – dove viene inserita: soluzione salina
N and if you have electrical energy [*leaking*=
INF2 [mhm
N =somewhere near the patient
I se c'è una: dispersione di energia=
N =and=
I =in qualunque parte vicino al paziente
N these connections aren't tight (.) the saline can pick electricity and=
I =>ci può [essere – <]
N [*conduct*] the electricity [and °( )°
I [un fenomeno di conduzione] di energia elettrica attraverso la soluzione salina qualora:: le – le chiusure non sono fissate=
N =(what)=
I =adeguatamente=
N =electricity is invisibile (.) how do I know (.) that it's *around* my patient [how=
I [°( )°
N =do I see that
I naturalmente l'energia elettrica è qualcosa di invisibile quindi non – non posso essere sicuro che non ci siano dispersioni nelle – nelle vicinanze del – mio paziente
N what picks up surface electrical energy what monitoring (.) picks up surface energy [surface=
INF2 [°mhm°
N =electricity
I qual è il tipo di monitoraggio che::: riesce a rilevare la presenza dell' [energia
INF2 [[e] C G
INF3 ekg
N okay so your E C G picks up (.) cardiac (.) electrical activity *inside* (.) but it will also
INF2 mhm
N display energy on the *outside*
I esatto quindi l'elettrocardiogramma oltre a r::e – gi – strare l'attività cardiaca interna
INF2 [°( )°]
N [and what we] [see
I [registra] anche eventuali [presenze=
INF2 [°(esatto)°
I =di co – di energia elettrica *esterna*
N what you see on your E K G is a *very characteristic* u:h (.) this *((pointing at the transparency))* is my normal E K G

I allora [diciamo=
INF2 [okay↑
I =che questo è un elettrocardiogramma di tipo normale
1535 N this baseline is straight (.) straight (.) thin↑ [okay↑]
I [lu::ngo] sottile questa linea base °diciamo°
N when there's [electrical=
I [baseline
1540 N =current leaking around my patient maybe the:: (.) the – wires are ( ) on my E K G or maybe there's a lot of electrical equipment
I se c'è una perdita di corrente nelle vicinanze magari di qualche altro:: ehm strumento elettronico (.) [nelle vicinanze]
N [what I see] here *((pointing at the*
1545 *transparency))*
I vedo una cosa del genere
N is (.) alternating current you know electricity is alternating current↑
I vedi la corrente alternata
N and you see this *((pointing at the transparency))* little (.) very very (.)
1550 ( ) form (.) line where – where your isoelectric line is
I >in corrispondenza della linea isoelettrica vedi una cosa del genere< (.) lu::nga e abbastanza costante
N and you see your isoelectric line (.) looks (.) like this if I had a m(a)cro – if I had a magnifying glass
1555 I quindi diciamo *ingrandito* (.) so – come sotto una lente di ingrandimento questo è quello che vedrei
N °okay↑° and this is because it isn't >up down up down up down up down< it's alternating current which is – electricity is
I questo perché non è come su e giù su e giù è una cosa continua perché è
1560 una – fenomeno di *corrente alternata*
N if I take electrodes l – if I take E K G u:h leads (.) and hang them near like where – if I were to have a – the defibrillator up here
I diciamo che c'ho un defibrillatore
N and I [have –
1565 I [e ci avvicino] gli elettrodi del:: dell'elettrocardiogramma
N see how this is not snug in here
I lo vedi che questo non è – non è [infilato perfettamente]
N [( )] right here=
INF2 =mhm=
1570 N =I can tell you that there is electricity
I quindi stai sicuro che c'è una perdita di [corrente]
N [if I brought] a monitor up here and hung the electrodes near here
I stai sicuro che se avvicino gli elettodi all'elettrocardio [gramma]
1575 N [I'll see] this
I vedrei una cosa del genere
N okay we'll try to demonstrate that to you uh during the class the E K G class (.) we can show it on the defibrillator downstairs
I e questo possiamo fare una anche una dimostrazione di questo elettro
1580 [cardiogramma]
N [when you see] this on your patient (.) on your monitor just try to check all the electrical equipment around you make sure things are plugged in [( )
INF2 [mhm

1585 N everything is [°( )°
I [>quindi<] se doveste vedere una cosa del genere fate attenzione che tutti:: tutte le cose siano in – infilate bene nella presa tutti gli °elementi elettronici°=
N =°all right° we talked about this *((clears throat))* the first day what
1590 happens when your waveform becomes more *dampened* (.) and more *flat*
I questo l'abbiamo visto il primo giorno cosa succede se:: (.) l'onda ha una forma più *piatta*
N we wanna make sure you did the troubleshooting as we said the first
1595 day check your connections check air check line
I è importante fare queste – queste varie – questi vari:: (.) *pa::ssi* no↑ per cercare di capire qual è il problema
N okay uh make sure that your pressure bags a – have not become empty (in) the pressures
1600 I per esempio [controllare=
N [°( )°
I =che le le sacche del per la pressione siano piene
[che non siano vuote]
N [you can try to rezero] ( )
1605 I si può resettare tutto
N check the patient position
I controllare la posizione del paziente
N we talked yesterday about [false readings]
I [queste cose le abbiamo] viste ieri e anche
1610 delle letture::
N >all right< [let's take=
I [non corrette
N =a break and we're gonna practice uh looking at some of those strips that you have
1615 I allora ora facciamo una – una pausa di un – *((looking at the US nurse))*
N of fifteen minutes
I di quindici minuti e poi vediamo di di fare un po' di lettura di queste str – [di queste strisce
N [*((to the trainees))* is that okay↑
1620 *((the trainees nod))*
N okay thanks

TS.02

Typology	Training Session (Title: "What can I as a nurse do in the first five minutes?")		
Place	ISMETT Conference Room		
Date	November 28, 2007		
Time	1:00 p.m.		
Duration	00:18:52		
Interpreter	Italo		I_1
	Georgia		I_2
Primary speaker	Nursing educator, US	(female, aged 41-45)	N
Speaking audience	Nurse, Italian	(female, aged 41-45)	INF_1
	Nurse, Italian	(female, aged 41-45)	INF_2
Observers	Researcher		
Situation	▪ The training session is part of the exchange program between ISMETT and UPMC nursing staff: the main speaker is a US visiting nursing educator, who shows and discusses a PowerPoint presentation on the role of nurses and other healthcare providers in the event of a patient crisis. ▪ The session is attended by ISMETT nursing educators, clinical coordinators, physical therapy and respiratory therapy coordinators, as well as by exchange nursing students from UPMC. ▪ The US speaker is standing in front of the audience. The interpreters Italo and Georgia are sitting on one side of the conference room, with a microphone each. Headsets have been given to the Italian staff who need the translation into English and to all US attendees, so that Italo can interpret from English into Italian and Georgia from Italian into English, should the Italian participants intervene with questions and comments.		
Language direction	English > Italian / (Italian > English)		
Prevailing mode	Whispering with portable equipment		

	N	I_1
1	okay >today we're gonna talk about<	
	(.) what can I do: a – uh (.) as a nurse	>°allora°< oggi parleremo↑ (.) di cos:a
	in the first five minutes (.)	(.) posso fa:re in quanto infermiere nei
	some of our obj – objectives uh (.) are	primi cinque minuti (.) di una crisi (.)
5	to explore (.) *key* opportunities to	gli obiettivi so:no (.) quello di
	enhance patient outcomes from a	esplorare (.) le opportunità *chiave*
	crisis event↑ (.) identify interventions	per migliora:re l'esito di una *crisi* (.)
	(.) which medical surgical nurses (.) or	identificare gli interventi (.) che
	any healthcare provider can institute	l'infermiere (.) o >qualsiasi operatore
10	before arrival of the crisis responders↑	sanitario< può – (.) fa::re o istituire
	and discuss opportunities where crises	>prima dell'arrivo della crisi< e discus
	can be:: averted (.)	– tere (.) dell'opportunità (.) per
	so what constitutes a crisis (.)	*prevenire* una crisi (.) allora che cosa
	if you look at hemodynamic instability	(.) >costituisce una crisi< può essere
15	(.) we're looking at uh (.)	la:: instabilità emodinamica
	arrhythmia::s↑	(.)
	some vital sign change::s↑	aritmi::e (.) cambiamenti dei segni

haemorrhage::s↑ glucose abnormaliti::es↑ (.) and maybe (.) perhaps just – giving too many narcotics (.) uh neurological changes did they have any seizures or possibly a new onset of a stroke (.) respiratory alterations respiratory distress decreased pulse ox uh (.) brad – bradypnea (.) and then staff concern we pretty much know our patients when they come in and we *know* when we can say something is just *not right* I just don't feel comfortable and then *family* concern they also know when they're – well ( ) not the way it really should be (.) so we have different crises at UPMC and I know you guys have (.) a lot of these as well (.) but condition A obviously is the full cardiac arrest (.) condition C is anything else uh (.) where you need help (.) condition H is (.) the family or patient *can* initiate for any uncertain plan or to elevate for assistance and if you just want someone to listen to you (.) we:: uh have had a number of condition Hs where I Vs couldn't be placed and parents just (.) for our kids ( ) uh get the help they needed condition O is *obstetric* crisis condition M is mental health (.) and then condition S uh (.) we use it for security if we have a – (.) patient who is out of control or a family member (.) and uh (.) the other thing we started doing (.) especially with paediatrics and I know you guys have a number of (.) *paediatric patients* is condition pink and that is u:h if you find a child missing or you just don't know where they are sometimes kids tend to (.) go out find their own when uh (.) (they aren't with) their parents and don't tell anyone where they are going so (.) we've instituted that but all of these crises are a way to get the help you need as best as they – uh as the: (.) *crisis* team can get there (.) some of the criteria (.) for initiating a condition C (.) and I have cards that have this information on it as well I'll give to you guys uh (.) but you can see the

vitali (.)
nor – (.) °e::hm° (.) livelli irregolari di glucosio (.) o ma – (.) care – magari:: eccessive quantità di narcotici cambiamenti neurologici
(.)
epilessi::a o magari l'i::ctus (.) poi (.) difficoltà respirato::rie un::: diminuzione della: ossigenazione poi la:: – (.) magari la: (.) preoccupazione dello staff (.) ora n – magari (.) il personale >l'infermiere< si:: ha la sensazione che qualcosa *non va* >con il paziente< oppu::re (.) >anche la stessa famiglia si può accorgere °che qualcosa non va< qualcosa non è normale°(.)
ci sono diversi tipi di – *crisi* di condition a UPMC così come all'ismett la condition °*A*° ehm è per arresto cardiaco la condition *C* (.) un altro tipo di crisi dove comunque è necessario:: l'aiuto la condition H (.) s – sono appunto la: – i famiglia:ri o il paziente che: (.) appunto chiede: a:ssistenza (.) e quindi il paziente vuole essere ascoltato magari:: è un paziente che: aveva >dei problemi< con l'acce::sso (.) >appunto< comunque chiam – a::vano per (.) chiedere: (.) aiuto la condition O↑ crisi ostetrica condition M (.) crisi (.) neurolo::gica >mentale< la condition *S* is – ci – quando è necessario l'aiuto della sicurezza
(.) un'altra cosa che abbiamo iniziato a fare soprattutto con i pazienti pediatrici s:o che qui all'ISMETT avete: (.) un certo numero di pazienti pe:diatrici (.) la condition °P° (.) ad esempio se (.) c'è un bambino con
(.)
una:: condition *pink* chiamata pink ovvero rosa nel caso: appunto non si riesce a trovare il bambino e: lui se n'è andato da qualche altra parte
(.)
e così appunto si richiede l'intervento veloce per rispondere
alcuni dei *crite::ri(a)* per iniziare a chiamare una condition *C*
(.) ho queste appunto:: informazioni in una piccola (.) cartellina e in un

	respiratory rate (.) anything less than eight (.) or greater than thirty-six (.) a new (.) onset of difficulty breathing↑ (.) a new pulse oximeter reading	librettino questo qua che vi ho mostrato allora una frequenza minore di °otto° (.) serie di difficoltà respiratorie:: (.) l'ossimetro –
75	which is less than eighty-five percent (.) for more than five minutes (.) unless the patient suffers from chronic hypoxia (.) or a new requirement for more than fifty percent of oxygen (.)	l'^ossigenazione^ (.) minore del ottantacinque – meno dell' ottantacinque per cento (.) oppure è necessario più del cinquanta
80	in order to keep the saturations up to u::h above eighty-five percent (.) a heart rate (.) of less than forty (.) or one forty (.) uh >greater than one forty< with new symptoms (.) and	per cento di ossigeno per mantenere la:: saturazione sopra l'ottantacinque per cento la frequenza cardiaca: minore di quaranta o *cento*quaranta superiore a centoquaranta con: sintomi
85	*definitely* any rate over a hundred and sixty (.) you need to call a condition (.) if the blood pressure (.) of a patient is less than eighty or greater than two hundred systolic (.)	nuovi o comunque (.) qualsiasi frequenza superiore a centosessanta (.) se la pressione è (.) minore di ottanta o superiore a duece:nto↑ sistolica↑ (.)
90	or u::h one ten diastolic with symptoms such as neurological change::s chest pain or difficulty breathing (.) and then you can see the acute neurologic changes↑ loss of	o centodieci per la diastolica oppure cambiamenti neurolo:gici dolore toraci – co difficoltà a respirare (.) potete vedere appunto cambiamenti
95	consciousness↑ u:h very lethargic or difficulty waking↑ if they collapse suddenly↑ if they have a seizure and they are *not* in a unit that uh (.) a neurological unit (.) a sudden loss of	acuti neurologici mancan – >la:< perdita di coscienza: paziente letargico difficoltà a respirare o se c'è un collasso improvviso (.) appunto una
100	movement or weakness of the face arms and legs (.) and others uh (.) if you: (.) if it's more than one stat page required to assemble a team you need to respond to a crisis (.) patient	°crisi neurologica° (.) una: >crisi dei movimenti< o comunque debolezza del vi:so dei muscoli da:: del viso delle braccia delle gambe (.) °app – ° comunque è necessario appunto per::
105	complaint of chest pa::in unresponsive to nitroglycerine *or* if you can't get the doctor to call you back (.) colour changes in the patient's extremity or if they have become pale dusky grey or	>°( ) –° è necessario< *più* personale °( )° alla condition (.) la:: non risposta alla nitro –nitroglicerina o se il medico non è disponibile anche in questi casi può chiamare la: (.) condition se le: – il
110	blue↑ (.) unexplained agitation more than ten minutes (.) if they (.) have tried a suicide attempt↑ (.) they've uncontrolled bleeding especially bleeding into the airway↑ (.) narcan is	paziente cambia appunto ehm il colore del – del viso è un po' più pallido o il colore è cianotico (.) oppure u::n tentativo di suici:dio un sanguinamento (.) incontrollato (.) soprattutto per
115	used without immediate response↑ (.) or a large acute blood loss (.) and truly don't hesitate to call a:: condition C to get help (.) we've called uh (.) because we have had issues in the past where	quanto riguarda le vie respiratorie (.) e una (.) perdita di sangue (.) abbondante (.) ci sono stati problemi in passato
120	the ^crisis^ teams did not come quick enough↑ a:nd instead o:f getting into trouble or – (.) we:: called help – for help early and the team came in and	>quindi< (.) quando appunto il team di risposta non era (.) adeguato abbiamo appunto comunque chiam:ato la condition H e

	the patient actually (.) >didn't have to	il – (.) il paziente comunque non è
125	go to the I C U< (.) so what are priorities when dealing with a patient crisis (.) what do we think the first things we (.) do are (.)	dovuto andare in >I C U< in questo caso (.) allora (.) cos'è la prima cosa che facciamo (.) °nei primi cinque minuti°
	((pause)) ((waiting for the answer))	
130	the A B C's↑ *((someone from the audience says: "assess the patient"))*	*((pause))*
	assess yeah assess the patient do the A B C's and uh I don't know if you guys have this here but I noticed when	allora valutare appunto il paziente (.) quindi fare appunto la tattica dell'A B C (.) non so se c'abbiamo – l'avete la
135	crises are just kind of lurking (.) people suddenly decide to take a brea::k or they go to lu::nch and I know uh (.) a lot of people do that because of fear (.) and their lack of	stessa cosa *qui* quando le (.) l'annunzio di una cri::si – quando c'è comunque una crisi di solito il personale è a pranzo o sta facendo una pausa (.) e s – talvolta questo succede
140	confidence in their abilities (.) >but< (.) there are some key interventions that we can perform to enhance crisis response processes (.) and we need to be proactive to prevent the crisis in the	anche perché c'è una:: (.) perché le persone han paura comunque mancanza di sicurezza (.) bisogna essere comunque proattivi per
145	first place so looking a few steps – (.) being a few steps ahead of the patient problem well truly of our uh (.) any:: (.) problem that we could – uh (.) that we might have for a patient (.) so	prevenire (.) la *crisi* innanzitutto (.) fare appunto alcuni passi avanti (.) essere sempre un passo avanti (.) ca – capire appunto (.) quali potrebbero
150	what's the most important thing to know (.) we need to know what your (.) organization's crisis response process is (.) how do you get assistance is there a phone number	°essere i potenziali problemi° (.) cos'è la cosa più importante da sapere (.) bisogna sapere qual è il:: processo di risposta a una crisi l'organizzazione c'è un numero da chiama::re (.) ci sono
155	that you ca::ll↑ is there uh (.) equipment that you need to ge:t↑ or you know just how do you get that assistance and what are staff roles and s – responsibilities (.) perhaps – your	attrezzature particolari che bisogna (.) *prendere* >come appunto< si ottiene l'assistenza >e quali sono le responsabilità< dello staff >(magari)<
160	unit secretary makes the call↑ does the O S S bring the crash cart in↑ is there a n – nurse on the unit or an I C U nurse (.) I know uh (.) on the step-down unit I see people have different	il – il segretario di reparto deve chiama:re oppure l'O S S deve portare il crash cart l'infermiere del:: del reparto (.) o il personale di – terapia intensiva il – (.)
165	uh *code* responsibilities so that (.) is a very good thing to have in place and you wanna practice the process to improve (.) mock co – codes including all levels of staff whether be the unit	c'è – ogni – comunque – pers – ogni (.) persona ha delle diverse responsabilità bisogna fare anche appunto della:: *praticare* questo processo ci sono delle (.) mock code delle simulazioni per tutti i livelli dello staff manca un
170	secretary uh (.) the physical therapists (.) respiratory (.) bring all of those people together and the best way is to just keep practicing and standardizing your process↑ so that when a crisis	training appunto delle simulazioni per quanto riguarda il personale di segreteria: e gli infermie:ri la: cosa migliore appunto è fare pratica e *standardizzare* il processo (.)
175	happens everyone's in place and it's more organized (.) and I know uh (.)	bisogna avere appunto (.) così si appunto migliora l'organizzazione

with your simulation lab that's a *great* way to practice and to really get those processes in place uh (.) we: put together actually a crisis (.) team training (.) in our simulation department through U P M C a:nd different physicians nurses uh (.) physical therapists respiratory therapists all come and go through this training and (.) we – it's (.) much better to practice on a high-fidelity mannequin than (.) to deal with it in real life and not kind of know what to do and have complete chaos so:: it's – you know using the simulations and doing the mock codes is very important (.) >so what typically happens in a crisis< you really want >to set the scene< you wanna just take a look at the environment look at the site look at the atmosphere the situation what is truly going on *((I2 makes a gesture asking to slow down))* is it c –*((to I2))* °am I going too fast↑° *((I2 nods))* °okay° *((soft chuckle))* is it chaotic or is it very organized (.) is everyone knowledgeable of the patient (.) do you have what you need to address the problem do you have all of that information (.) you might even anticipate what the response team (.) may ask for and this is where – uh >as far as information goes< S bar could be (.) a very good ( ) to use and avoiding chaos is the goal we at Shadyside are focused on educating with a mnemonic (.) it's called O A B C and O stands for organized we wanna come in and get our team organized so that then (.) once everybody is in their role they can follow the A B Cs and uh hopefully (.) as (.) the process improves↑ everything'll work in a timely:: simultaneous fashion (.) so >once you identify a crisis< you wanna call for help get that help there as fast as you can some items uh to help the situation↑ a pulse oximeter obviously maybe you need a monitor↑ a defibrillator↑ A E D↑ (.) of some kind (.) does the patient have I V access↑ (.) oxygen↑ crash cart these are the

(.) voi avete un laboratorio di simulazione e questo è il: modo migliore appunto per fare °esperienza° e per fare pratica (.) abbiamo gestito (.)
la formazione di:: alcuni team di risposta alle crisi
(.) e diversi medici infermieri tera – (.) *pisti* della respirazione fisioterapisti sono stati coinvolti in una formazione ed è (.)
appunto la cosa migliore fare pratica con un mani – chino che invece improvvisarsi poi ehm in una vera e propria: crisi quindi la:: fare appunto: la simulazione simulare delle simulazioni è veramente importante (.)
cosa succede di solito durante una crisi bisogna comunque preparare (.)
la scena bisogna guardare l'ambiente:: guardare l'atmosfera: la situazione: che cosa sta succedendo in realtà

((pause))

se c'è troppo caos o veramente è un ambiente organizzato sono tutti infor – sono tutti informati sul paziente bisogna affrontare il problema avere tutte le informazioni potere appunto anticipa:re delle informazioni al team di risposta (.)
questo potrebbe essere anche una cosa molta importante evitare il caos questo è il nostro obiettivo a Shadyside noi cerchiamo di:: (.) noi formiamo con questo attr – con – usiamo questo acronimo O A B C noi vogliamo che il team sia organizzato quando: (.) tutti (.) sono nel proprio ruolo possono seguire appunto l'A B C il processo con::: non appena le:: appunto il processo migliora tutto funzionerà molto °in maniera più organizzata° (.) non appena viene identificata la crisi si chiede aiuto (.) arrivare al luogo della crisi il più velocemente possibile allora cos'è necessario (.) u::n
(.)
a – avere un defibrillato:re (.) un defibrillatore automatico esterno accesso venoso (.) il saturimetro (.)

basic things that are needed uh (.) for a crisis situation and these should all be in place by the time the crisis team will arrive or your code team and then	tutte queste sono cos:e materiale necessarie che (.) dovrebbero essere già comunque (.)
the medical record you guys have an advantage (.) here↑ because you have the ability to have those in the room unfortunately we are so *((soft chuckle))* a step behind and trying to	*pronte* quando arriva il team di risposta e in più la cartella clinica voi avete un vantaggio qua perché avete la possibilità di avere la: (.) cartella (.) nella stanza non è: la stessa cosa
get all of that (.) u::h in – to Shadyside (.) and good teamwork that's (.) obviously what is *so* important and *so* needed and I've seen so much of that in walking around the units here	(.) presso il nostro ospedale al Shadyside (.) poi (.) è necessario appunto (.) ho visto
at ismett you guys work together to get things done and to accomplish the goals and (.) it just seems that you guys are very organized and very focused on the patients (.) so things	appunto (.) qui all'ismett ehm c'è un *bel* lavoro di squadra di gruppo ehm il personale comunque lavora assieme e sembra appunto che abbia una buona organizzazione molto (.) concentrati
that any healthcare provider can do in the first five minutes and – by *any* healthcare provider I'm talking about O S Ss physical therapy physicians uh respiratory therapy and the nurse (.)	°sull'assistenza al paziente° (.) allora (.) cose che si possono fa:re >che l'operatore sanitario può fare nei primi cinque minuti< e io parlo appunto di: fisioterapisti medici ausiliari (.)
the first thing is to remain calm I know people tend to get all (.) *hyper* *((soft chuckle))* and excited during a uh (.) *code* situation (.) place the patient on a monitoring device make	terapisti della respirazione *e* gli infermieri la prima cosa è mantenere la calma di solito appunto si è veramente: nervo:si (.) quando c'è una:: condition posizionare il paziente attaccare il paziente al monitor per – assicurarsi
sure they have any A E D↑ (.) defibrillator↑ available↑ apply a pulse oximeter (.) and make sure the oxygen is in place (.) place a backboard a::nd you're probably wondering (.) >do we	che vi sia il defibrillato:re poi (.) avere il saturimetro e assicurarsi che l'ossigeno sia posizionato e poi usare
have to place that< and we have been educating uh through (.) basic life support *to* use the backboard uh (.) because you never know (.) when a patient is gonna decompensate and	appunto il backboard la tav – vola da posizionare sotto il paziente in ogni caso (.) perché comunque non – non bisogna
then at that point it's gonna be even harder to get that backboard either and as well you might have a patient who has decreased glucose but he's still awake (.) *but* again you never know	(posizionarla) quindi non si sa mai quando il paziente sarà scompensato quindi (.) ci potrebbe essere un paziente (.) che: ha: u:n abbassamento dei livelli di
we still encourage (.) the backboard to be placed so that in case uh – the patient will decompensate you're available and ready (.) and you're always gonna be thinking again a few	glucosio *ma* comunque non si sa *mai* incoraggiamo sempre l'utilizzo appunto il posizionamento della tavola in caso appunto il paziente (.) scompensa
steps *ahead* and begin C P R if indicated uh but make sure you have help first (.) if you're the first responder or the nurse in the room (.)	(.) e poi bisogna pensa:re sempre ess – essere un passo avanti e poi iniziare la: rianimazione cardiopolmonare (.)

	and then (.) things any nurse can do (.)	(.) >poi<
285	as assure (.) a functional (.) I V access	(.) cosa può fare appunto l'infermiere
	or place one (.) and (.) you probably	(.) assicurarsi che l'accesso:
	wonder (.) do I start I V fluids↑ I have	endovenoso sia posizionato (.) s – ci si
	not known (.) normal saline to kill	chiede magari inizio i fluidi:: non – la
	anybody so I would say start normal	– una soluzione fisiologica non ha mai
290	saline if the patient should be in	ucciso nessuno quindi magari iniziare
	congestive heart failure↑ or acute	appunto la: soluzione salina se – vi è
	renal failure↑ there is *always* the	una insufficienza cardiaca o renale c'è
	ability to diurese or dialyse after (.)	sempre – (.) appunto la possibilità
	the situation (.) have a crash cart at the	magari di dover dializzare il paziente
295	bedside (.) you always wanna make	al:: termine avere sempre il crash cart
	sure you have the equipment↑ obtain	nella stanza
	the patient chart (.) and medication	(.)
	administration record↑ (.) gather your	e – (.) sapere appunto quali farmaci
	thoughts of the important information	sono stati somministrati (.) appunto
300	the team will need (.) u::h this is the	raccogliere tutte le informazioni che
	down and dirty (.) the most recent	potrebbero >essere necessarie al team
	vital signs↑ any input and output and	di risposta< segni vita:li il bilancio
	follow (.) the – (.) we call the ample	idrico (.) eseguire
	(.) *A* is allergies (.) what – (.) are	questo: acronimo l'ample A allergie
305	their allergies and we're not – (.)	quindi sapere se ci sono allergie
	asking about dust (.) >we wanna know	(.)
	are they allergic< to I V dye↑ certain	oppure allergie al mezzo di constra –
	medications↑ M is medications	contrasto a certi farmaci
	whether – (.) have been – (.) been	(.)
310	ordered new medications in the last (.)	se sono stati ordinati farmaci nuo:vi (.)
	you know *twelve* hours have you	nelle ultime dodici – (.) o:re >se sono
	changed the dos::e↑ anything out of	state cambiate< le dosi (.) qualcosa che
	the ordinary with meds (.) P is past	che (non) è comunque – (.) fuori
	medical history we're not concerned if	dall'ordinario >poi<
315	the patient had – (.) a colic ten years	(.)
	ago (.) what we're concerned with is	M per la storia l'anamnesi noi s::iamo
	(.) did the patient have any aortic	interessati a sapere se il paziente ha
	valve replacement is the patient on	avuto una sostituzione della valvola
	heparin now (.) and do we think the	aortica per esempio (.) °se le::°
320	patient's G I bleeding (.) so those are	(.)
	the things we want to focus on (.) *L*	quindi sono alcune cose che dobbiamo
	is last meal when did they eat last and	sulle quali bisogna conci – con:: e::hm
	we're worried about uh *aspiration*	>concentrarsi< poi sapere ad esempio
	(.) as well as intubation so we're	qual è st – quand'è stato l'ultimo
325	worried about *that* °with that° and	pranzo l'ultimo (.) *pasto*
	then E u:h (.) is event what happened	(.)
	and how did you find the patient (.)	poi la E è per evento cosa è successo e
	and then >a lot of people wonder< (.)	come avete – in che condizioni avete
	should family be present and uh (.) it	trovato il paziente (.) allora ci si chiede
330	*truly* depends on your	se la famiglia doveva essere presente
	organization's process or policy↑ but	dipende comunque dalla – dalla policy
	they've done research over the last ten	dall'organizzazione del processo ma
	years (.) and have looked at different	negli ultimi dieci anni si sono: state
	(.) crisis situations and truly the family	analizzate diverse crisi diverse
335	members (.) just want to make sure (.)	condition di solito la famiglia vuole
	their family members uh (.) were	assicurarsi che (.)

	treated with – *respect* (.) were – had a pain – had a pain free death (.) died with dignity (.) and were just (.) given	che i loro pazienti vengano trattati con:: rispetto (.) se la – sono morti appunto in caso di
340	(.) every opportunity to live if they could they're not looking to (.) sue they're just looking for that closure (.) and (.) *if* the family chooses *to* stay >you always wanna make sure	morte che questa sia avvenuta con dignità e con rispetto (.) non – sono lì presenti per appunto (.) per colp – ehm – dare delle colpe addossare delle colpe se la famiglia
345	that you have someone assigned< to that family member or family members (.) and >if the family member comes in and is just out of control< then you need to (.) >escort	sceglie di essere *nella* stanza (.) >bisogna (assicurarsi)< che ci sia sempre qualcuno dedicato ad assistere (.) i parenti e in caso se (.) comunque: sono troppo nervosi o comunque e::hm
350	them out of the room< 'cause they are adding to the confusion in the room (.) >so can we as nurses prevent crises< (.) evaluation of code events revealed that subtle changes happened six to	non è possibile controllarli a invitarli a uscire dalla stanza allora possiamo prevenire una crisi↑ (.) nella valutazione degli eventi delle condition
355	eight hours prior to a crisis so early intervention obviously can: *prevent* a full blown crisis (.) obviously if a patient is short of breath the R N titrates o::xygen↑ maybe:: the patient	( ) e::hm tra l'altro che:: ci sono prima di una crisi nelle prime sei otto ore ci sono stati dei cambiamenti nelle condizioni dei (.) pazienti magari una:: ehm difficoltà respiratorie o: mancanza
360	gets a little better↑ *then* (.) becomes this – begins this cycle of demise and we had this huge time delay (.) the other problem is we can contact the	di ossigeno poi comunque c'è un miglioramen:::to e poi invece questo:: il paziente comincia a deteriorare a peggiorare (.)
365	doctor (.) and palliate the symptoms rather than be aggressive (.) the one thing (.) that (.) all of our patients have on our side – on – on *their* side is	in questo caso appunto possiamo comunque cont – chiamare il:: (.) dottore e e::hm trattare i sintomi invece che essere comunque aggressivi
370	our *astute* assessment skills (.) *and* uh (.) we just need to be *confident* in those assessment skills and know that we're (.) providing the	(.) è importante comunque la valutazione bisogna (.) essere:: sicuri della: valutazione e fornire la migliore assistenza per il paziente
375	best care for the patient (.) *((cough))* often – uh times >it seems like forever< (.) when you're waiting for help I know it does for me when I'm	(.) spesso (.) >hai – < sembrano che pochi minuti durino un'eternità (.)
380	in the situation so you always wanna stay as calm as possible keep the noise down (.) raising voices connotes anger and fear and can often increase the chaos *((chough))* and then events are	bisogna essere: rimanere più calmi possibili fare: il meno rumore possibile e:: comunque non fare troppo rumore per evitare il caos (.)
385	often a learning experience for many staff↑ so we don't want to be critical of e – of each other but rather what process potentially failed (.) we uh at U P M C (.) in Pittsburgh do brief –	spesso si *appre:nde* molto dalle crisi ( ) di:: non bisogna criticarsi l'un l'altro *ma* capire cosa non è andato bene e discutere (.)
	*de*briefing sessions and that happens about a month after we've had a code situation well we'd sit around and we look at it not as a	ciò (.) a Pittsburgh facciamo delle *riunioni* questo di solito appunto un mese dopo una ehm condition e non questo:: >non viene criticato nessuno

390		blaming session (.) but we're looking at *what failed* it's not usually a *people* failure it's a process failure if there wasn't – the crash cart wasn't supplied fully we didn't have all the	durante questi incontri< (.) ma di solito vogliamo vedere che cosa non ha funzionato nel processo magari: il crash cart non era ben attrezzato °non c'erano tutti i materiali presenti°
395		equipment we needed uh (.) maybe there was no backboard something but this is a way for us to learn and to improve our process and to make it better and uh (.) just to really focus on	(.) magari:: non c'era la tavola presente questo è un modo per noi per parlare e magari migliorare il processo concentrarsi appunto sul lavoro di
400		teamwork and if there was any (.) uh (.) *lack* of teamwork (.) and we really want to make sure that uh >it ends up being< a good debriefing session that everyone is learning	squadra (.) se c'è stata una mancanza (.) >per quanto riguarda il lavoro< di squadra (.) tutti apprendon – bisogna
405		everyone feels okay coming out and we always want to know how we can do it better (.) some final thoughts (.) are to share your expertise among the team welcome suggestions and	assicurarsi che tutti apprendano qualcosa durante queste riunioni e appunto è un (.) °modo per migliorare° (.) >ora< alcune
410		guidance (.) respect each other's knowledge and expertise (.) recognize that you're not alone (.) there's a team of people that are gonna come and help (.) so:: you're not by yourself and	considerazioni finali quindi *condividere* la propria esperienza con gli altri membri del team (.) e lavorare comunque in maniera collegiale e rispettosa capire che
415		be confident in your skills and education you worked very hard to get to the point were you are so truly (.) *cherish* those goals that you have and the knowledge (.) now you can go	comunque non si è da soli ed essere sicuri delle proprie capacità e della:: propria formazione quindi condividere queste appunto abilità e la propria esperienza con gli altri
420		and continue saving lives *((soft chuckle))* (.) and I have cards uh that I will give you that have uh (.) the	(.) così potrete continuare a salvare altre vi:te
		criteria for initiating a condition C and then there's *team rules* and goals on	(.) ho appunto qui sono:: dei bigliettini delle: (.) con i criteri appunto per
425		the other side so it talks about where – and I'm – sorry these aren't in (.) Italian but they are in English so *((chuckle))*	iniziare una condition C e ci sono i ruoli del team (.) mi sc – (.) scusate che non sono in italiano (.) però possono essere >°(tradotte)°<
430	INF_1	I have a question	I_1 una domanda (.)
	N	yes	
	INF_1	may I start with the question *((chuckle))* (.) who decide *((INF_1 is given a microphone))*	
435		who decide about the:: (.) u:::h (.) calling criteria there is a C P R committee↑ who:::	I_1 chi decide (.) pe::r – chi decide i criteri:: da:: (.)
	INF_2	which are the=	
	INF_1	=which are=	
440	INF_2	=the criteria	I_1 quali sono comunque i criteri (.)
	INF_1	you – we read about the calling criteria that you have for a	tu parlavi appunto dei

		code=		criteri per chiama::re una
	N	=mhm=		condition (.)
445	INF1	=okay↑ and who decide those criteria		*chi* decide questi criteri
		((the US nurse looks puzzled))		
	N	°o::h° we::		
	I2	*((off mic to the US nurse))* who		
450		defines them		
	N	*((looking at I2))* °who defines them° *((looking at INF2))* we::		
	INF1	who define – sorry (.) who define		
455	N	we:: got those from our uh crisis team	I1	allora noi li abbiamo:: (.)
	INF1	okay		presi
	N	so it's our crisis team that=		dal nostro team di risposta
	INF1	=okay=		è il team di risposta
460	N	=put those together and (.) we have a team of physician – on a team ( ) physicians nurses educators (.) so there's a number of people that decided		che li definisce ( ) là abbiamo un team di medici un team comunque composto
465		those criteria plus it goes along with uh (.) acute life support the A C L S and B L S (.) (advanced)		da medici educator infermieri e poi (.) è comunque conforme con i corsi di A C L S

Appendix Seven: Abstract (English)

Research on interpreting in the medical field typically focuses on asymmetric interpreter-mediated encounters between healthcare professionals and migrant patients, while devoting little attention to intercultural face-to-face communication among peers. Yet a quality healthcare system is also a result of accurate communication and productive relationships among medical co-workers. From an atypical perspective, this study explores interpreting in a bilingual hospital in Southern Italy, ISMETT, whose US and Italian employees interact not only with patients, but also with each other, supported by a team of English-Italian in-house interpreters.

The case-study project was developed from an insider's vantage point, first as graduate intern and subsequently as member of ISMETT Language Services (LS). Fieldwork was adopted as the main research strategy, while combining an inductive ethnographic approach with a discourse-analytical one; thus the prevailing research paradigm is the DI (*dialogic discourse-based interaction*) paradigm of interpreting, and the study uses multiple methods of collecting and analysing qualitative data.

Valuable insights are initially gained by modelling interpreting at the level of the healthcare institution; more specifically, a conceptual model is designed that accounts for the unpredictable nature of interpreting through a range of interacting dimensions, while offering a glimpse of the manifold subdomains in which interpreters operate. Narrowing the investigation down to the medical field, the genesis of the Department's normative behaviour as well as the resulting acquisition of a specific 'corporate *habitus*' is outlined on the basis of one-to-one semi-structured interviews with the LS members. The interpreting dispositions thus identified are compared with the activity proper as emerging from a corpus of recorded and transcribed interpreted interactions, featuring one nursing assessment, thirteen nursing reports, and two training sessions. The transcript analysis is guided by a theoretical model that correlates the linguistic production and communicative performance of ISMETT interpreters with the dimensions and constraints that shape each interaction of the corpus.

The study shows how the specific dimensions and constraints of different communicative events are reflected not only in the situation-based macro-choices made by the LS members at the beginning of the encounters, in terms of product, interactional

management, and role, but also in the constant micro-adjustments and shifts during the exchanges. The triangulation of data from the different sources also suggests an overall consistency between the *habitus* of ISMETT interpreters and the norms they have developed throughout the years, especially as a result of on-the-job training and professional socialization processes. Yet the *habitus* of the LS cannot be considered representative of interpreting or healthcare interpreting as such, but is rather a function of the peculiar institutional context in which it was developed. In particular, the privileged status of in-house interpreters and the multifaceted character of interpreting at ISMETT are found to call for the interpreters' flexibility and, more often than not, marked visibility, in order to provide each customer with the most suitable, 'tailor-made' interpreting service.

Appendix Eight: Abstract (German)

Untersuchungen zum Dolmetschen im medizinischen Bereich behandeln im allgemeinen die asymmetrische dolmetschervermittelte Kommunikation zwischen medizinischen Fachkräften und anderssprachigen Patienten. Der interkulturellen Verständigung zwischen Gleichgestellten wird dabei kaum Aufmerksamkeit gewidmet. Zu einem guten Gesundheitssystem gehören jedoch auch die fehlerfreie Verständigung und produktive Arbeitsbeziehungen innerhalb des medizinischen Fachpersonals. Aus einer atypischen Perspektive heraus untersucht diese Studie das Dolmetschen in einem zweisprachigen süditalienischen Krankenhaus, ISMETT, dessen amerikanische und italienische Mitarbeiter nicht nur gemeinsam ihre Patienten betreuen, sondern auch untereinander in verschiedenartiger Weise interagieren. Unterstützt werden sie hierbei von fest angestellten Dolmetschern im Sprachenpaar Englisch-Italienisch.

Diese Fallstudie wurde aus dem Blickwinkel einer Angehörigen der Institution verfasst, die zuerst als Praktikantin und anschließend als Mitarbeiterin des ISMETT-Sprachendienstes (LS – *Language Services*) tätig war. Die Studie verfolgt also methodisch den Ansatz der Feldforschung, wobei eine Kombination zwischen einer induktiv ethnografischen und einem diskursanalytischen Ansatz gewählt wurde. Die Arbeit versteht sich somit als Beitrag zum DI-Paradigma („dialogischer Diskurs und Interaktion“) der Dolmetschwissenschaft, basierend auf der Erhebung und Auswertung qualitativer Daten durch eine multimethodische Vorgehensweise.

Nützliche Einblicke werden eingangs durch das Erstellen einer Modellierung des Dolmetschens im Rahmen der Institution geschaffen. Dabei wird ein konzeptuelles Modell entworfen, das die Unvorhersehbarkeit des Dolmetschens im Einflussbereich verschiedener interagierender Bedingungsfaktoren berücksichtigt und zugleich einen Einblick in die zahlreichen Teilbereiche, in denen Dolmetscher arbeiten, ermöglicht. Im Bezug auf den medizinischen Einsatzbereich als solchen behandelt die Studie sowohl die Entwicklung der normativen Verhaltensstandards des Sprachendienstes als auch den Erwerb eines speziellen „Habitus” seiner Mitglieder. Dafür werden halbstandardisierte Einzelinterviews mit LS-Mitgliedern ausgewertet. Die so ermittelten Handlungs-dispositionen der Dolmetscher werden mit der konkreten Dolmetschpraxis verglichen, wie sie in einem Corpus von aufgezeichneten und transkribierten dolmetscher-

vermittelten Interaktionen dokumentiert ist. Das Corpus umfasst ein Aufnahmegespräch, dreizehn Krankenpflegeberichte und zwei Schulungseinheiten. Die transkriptbasierte Analyse orientiert sich an einem theoretischen Modell, das die sprachliche und kommunikative Leistung der ISMETT-Dolmetscher mit den die im Corpus erfassten Interaktionen bedingenden Einflussgrößen in Beziehung setzt.

Die Studie zeigt, wie sich die spezifischen Einflussgrößen und Bedingungsfaktoren der verschiedenen Gespräche nicht nur in den am Beginn der Interaktion getroffenen situationsbedingten Makro-Entscheidungen der LS-Mitglieder hinsichtlich Produkt, Interaktionssteuerung und Rolle widerspiegeln, sondern auch in ständigen Mikro-Anpassungen und Verschiebungen im Gesprächsverlauf zum Ausdruck kommen. Die Triangulierung der Daten aus den verschiedenen Quellen weist auch insgesamt auf eine Übereinstimmung zwischen dem Habitus der ISMETT-Dolmetscher und den von ihnen im Lauf der Jahre durch Praxiserfahrung und professionelle Sozialisierungsprozesse entwickelten Normen hin. Dennoch kann der Habitus der LS-Dolmetscher nicht als repräsentativ für das Dolmetschen im allgemeinen oder das Dolmetschen im Gesundheitswesen im speziellen angesehen werden sondern ist vielmehr eine Funktion des besonderen institutionellen Kontexts, in dem er sich herausgebildet hat. So ergibt sich aus dem privilegierten Status der angestellten Dolmetscher und der Vielfältigkeit der Dolmetschaufgaben am ISMETT die Notwendigkeit einer großen Flexibilität und vielfach auch einer deutlichen Sichtbarkeit der Dolmetscher, damit diese allen Klienten eine bedarfsgerechte, maßgeschneiderte Dolmetschdienstleistung bieten können.

Appendix Nine: Biographical sketch/Kurzbiographie

Roberta Favaron was born in Dolo (VE), Italy, on March 22nd, 1976. In 2002 she graduated in Translation from the School of Modern Languages for Interpreters and Translators (SSLMIT) of the University of Trieste, where she worked as lecturer in Italian to foreign students and researcher in the field of dubbing and subtitling from September 2002 to August 2004. She was employed as full-time Italian-English hospital interpreter at the Mediterranean Institute for Transplantation and Advanced Specialized Therapies (ISMETT) in Palermo from September 2004 to September 2008. She is currently collaborating with the National Institute for Health Migration and Poverty (NIHMP) in Rome as Italian-English translator. She has published in the field of dialogic interaction in medical interpreting.

Roberta Favaron wurde am 22. März 1976 in Dolo (Norditalien) geboren. 2002 schloss sie ihr Hochschulstudium in Übersetzung am Institut für Dolmetscher und Übersetzer (SSLMIT) an der Universität Triest ab. Von September 2002 bis August 2004 unterrichtete sie an der SSLMIT Italienisch für Ausländer und forschte im Bereich Synchronisation und Untertitelung. Von September 2004 bis September 2008 arbeitete sie als Vollzeitkraft am *Mediterranean Institute for Transplantation and Advanced Specialized Therapies* (ISMETT) in Palermo als Krankenhausdolmetscherin im Sprachenpaar Englisch-Italienisch. Zurzeit arbeitet sie für das *National Institute for Health Migration and Poverty* (NIHMP) in Rom als Italienisch-Englisch Übersetzerin. Sie ist Verfasserin mehrerer Veröffentlichungen im Bereich der dialogischen Interaktion beim Dolmetschen im Gesundheitswesen.

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