

# THE PUBLIC SERVICE INTERPRETER'S FACE: RISING TO THE CHALLENGE OF EXPRESSING POWERFUL EMOTION FOR OTHERS

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## ABSTRACT

This article discusses the practical realities of working as an interpreter in Britain's public services. It gives a brief outline of current practices, to set the ideas in context. It then looks at the demands made on the personal, emotional, professional and linguistic resources of the people, often called to hospitals or police stations in the night, whose task is to convey meaning between the authorities and the disempowered, bewildered and afraid. Goffman ("Footing"), and later H.H. Clark, developed a theory of interlocutor roles based on monolingual dialogue. This describes the roles occupied by interlocutors during the activities of speaking and listening. I apply that to the interpreting triad, and suggest that there are two roles described which the interpreter ought not to occupy, in order to protect their face, and guard against inadvertent alterations.

**KEY WORDS:** Interpreting, public service, emotional weight, rudeness register, politeness, code mixing, training, idiolect, multidisciplinary team.

## RESUMEN

Este artículo trata la realidad práctica del trabajo de un intérprete en los servicios públicos del Reino Unido, presentando una breve descripción de la actualidad para contextualizar las ideas. Posteriormente comenta las exigencias a nivel emocional, profesional y lingüístico que se requieren de estos profesionales, a los que a menudo se les pide que acudan a una comisaría o un hospital durante la noche. Su labor consiste en transmitir el mensaje íntegro entre personas que representan la autoridad y otras que se encuentran desprovistas de poder, perplejas y asustadas. Goffman ("Footing") inicialmente, y luego H.H. Clark, desarrollaron una teoría sobre los papeles que desempeñan los interlocutores en un diálogo monolingüe. En este trabajo, se aplica este modelo a la situación triádica de los encuentros mediados por intérpretes, y se sugiere que dos de los roles señalados por Clark deben ser evitados por el intérprete con la finalidad de proteger su autoestima y evitar cambios inadvertidos en el mensaje.

**PALABRAS CLAVE:** interpretación, servicios públicos, carga emocional, mezcla de códigos, idiolecto, equipo multidisciplinar.



## 1. THE PROFESSIONAL FIELD

In my world, the phone can ring at any time of any day. A Custody Sergeant has a Spanish-speaking person in custody and needs me to be there as soon as I am able. The Police and Criminal Evidence Act (PACE) specifies the number of hours during which a person may be detained while enquiries are carried out. Nothing can be done until an interpreter is present, hence the hurry. Interpreters registered with the National Register of Public Service Interpreters (NRPSI) are still too few in the northwest of England, where I live. Since all the criminal justice agencies (CJAs) have signed an agreement whereby they will always engage NRPSI interpreters where possible, as a minimum safe practicing standard, I very rarely set off for a police station I know the way to. I often drive for several hours in each direction. I have learned things in the last 20 years. Never drink the coffee in a custody suite, is one thing. Always have something to eat, and an engaging novel in your bag, is another thing. Custody suites are not hotels, but once an interpreter arrives he or she is there for the long haul. Shifts change, and police officers come and go, but interpreters hang in there. So we read the man his rights, we ask if he wants a lawyer, he does, we phone one, and we wait. At times I find either that I have been called to somebody with whom I do not share language at all or, almost worse, that my non-English-speaking client is a) drunk, and b) code mixing. The Venezuelan sailor who had grown up until his early teenage years in Portugal and, after emigrating, married a Venezuelan woman of Italian descent was among the most difficult assignments I have ever interpreted for. Having alerted the police to my difficulties and made sure that my having done so was properly recorded, I complied with the police request to ask the detained person if he understood me, and was willing to continue with this interview. It was a long night.

I once heard a communication skills trainer say, “communication is communication, it’s all the same.” That isn’t so, as linguists have always known. You might just as well say, “cancer is cancer, it’s all the same.” However, as Public Service or Community Interpreters (PSIs) we always work in a multi-disciplinary team, and it is common for us to meet non-linguists who don’t understand what we’re doing, or what it takes to do it. We need to understand very clearly why we are trained to do the things we do. Understanding why it is important to employ the Impartial Model, or why interpreters need to be briefed, and to debrief, means that we can ask clearly and assertively to have our professional needs met.

Many people think that “interpreting is interpreting, it’s all the same.” I think Public Service interpreting is different from other types of interpreting, in very significant ways. In fact, in medical settings I think we have more in common with allied health professions (AHPs) than we do with other interpreting specialists.

Nathan Garber has described the six major aspects of our field of work that set it apart from Conference or Diplomatic interpreting, or interpreting in Commerce and Industry.



## 1. INTERVIEW SETTING

We are not sitting in the isolation of a booth; PSIs are up close, among the sights, sounds and smells of one-to-one discourse between doctor and patient or lawyer and client. PSIs are constantly performing the delicate balancing act of attempting to maintain a professional detachment while displaying empathy in situations that are intensely personal and private for the other two parties.

## 2. LIFE CRISIS

Nobody asks for a PSI because they want to go shopping. Only when a person is accused of shoplifting or is taken suddenly ill does a PSI become involved. Crisis involves feeling out of control and vulnerable. Interaction with public services in countries other than one's own, means deciphering all manner of codes besides the language: the uniforms are meaningless, text can be un-readable, the system a mystery. Our personal emergency support systems—family, friends, known lawyers and advisers—are all back at home, and out of reach.

## 3. SIGNIFICANT RISK

All this means that the person who does not speak the dominant language has extremely limited strategies available for managing their situation. Any small command of the dominant language they may have is under severe pressure. Fear and distress inhibit our ability to understand even our mother tongue. They also severely limit our normal ability to express ourselves in a second language, especially in formal or technical situations. Other interpreters' clients are unlikely to lose their lives, limbs, liberty or family. They may lose a lot of money—but PSIs on the whole see their work as involving the price-less.

## 4. THE PUBLIC SERVICE PROVIDER (PSP) IS A GATEKEEPER

He or she can decide whether to grant or withhold a service or assistance of some kind. The client knows that, but has no way to know how best to negotiate for what they believe they need. They do not even know what is available, or what their rights are. There is a real danger of assumptions being made that might be valid with regard to a client from the dominant culture, but which are completely inappropriate to a foreign client. PSIs must be alert to obvious missed cultural inferences that might cause *misunderstandings*. Where there is non-understanding the parties are immediately aware of it and may ask for clarification. Only the interpreter can know if there is *misunderstanding*, where one or the other party believes that they have understood, but in fact they have not.

There is a little refrain, popular in England, which illustrates *misunderstanding*: “I know that you believe you understand what you think I said, but I’m not sure you realise that what you heard is not what I meant.”

The PSI’s job is to ensure that this doesn’t happen.

## 5. UNEQUAL POWER

Knowledge is power. Most people interacting with the Public Services, who were brought up in the country where they are trying to access healthcare, the law, etc., know at least something about how to operate within the system and they have a personal support network of some kind quickly available to back them up.

Few things are lonelier, or more frightening than foreign jails or hospitals, where one is not in a position to walk away at will. An accused person, detained on remand in prison while awaiting trial, or detained by the police during an investigation, deserves fair treatment. But while justice must be seen to be done, the authorities, the public, and the detained person/patient must share that perception of justice being done in order to believe in it.

Patients deserve to receive medical care and assistance in a language they understand and can express themselves in freely—and that is not a job for Nice Ladies with Time on Their Hands. Even bilingual medical personnel should have extra training to enhance their language-switching skills and instil the concept of “alter ego” if they’re going to operate as interpreters.<sup>1</sup>

## 6. NO CULTURAL POINT OF CONTACT

It is probable in PSI situations that the two main interlocutors (doctor/patient, lawyer/client) will know little or nothing of each other’s culture. Our normal speech is strewn with embedded messages, mutual assumptions, things that “go without saying.” Culturally insensitive phrasing can easily result from a simple lack of information. The two main interlocutors may not be aware of cross cultural differences in the meanings attributable to body language and paralinguistic signals such as loudness, intonation, gesture, or eye contact. Interpreters must be alert to any need to inform the parties of possible false attribution that could lead to offence being taken without cause. Many formal situations such as the diagnostic or investigative interview have a very clearly defined format within a given culture. The question is, does the foreign language speaker know the “rules of engagement”? After all, many native patients/clients don’t really know them. These are not conversations that most people hold often, it is only the practitioners who are com-

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<sup>1</sup> See framework of competencies in E. Hertog.

pletely comfortable with them. Communication style is different for different purposes and among the unwritten social rules is the fact that many Public Service Providers assume their client to understand the “rules” of the conversation they are about to hold. These are the rules about turn taking, topic choice, time allowed, and the doctor/lawyer/police officer’s goals. Yet the PSP doesn’t usually signal changes in the type of conversation they want to hold. Interpreters need to be aware of all this, in order to keep their footing within each interaction and be able to inform the PSP if the client loses theirs.

## 2. WHAT KIND OF DISCOURSE?

Let us think briefly about types of conversation: what kind of interaction is the diagnostic or the police interview? It’s a transaction, but of a specialised sort. There are three principal elements to transaction. These are asymmetry of power, social distance and an external goal. In normal transaction the client holds the money therefore the client holds the power. In legal or medical transaction, since knowledge is power, the client is power-less, relative to the PSP. Therefore, if there should be any difference of opinion, the client will usually defer to the PSP: social distance. The goal of the interaction is external to the interaction itself. The goal may be patient education or the need to establish the sequence of past events for example. The important thing is that the power dynamic of normal transaction is reversed and it is the client not the provider who is relatively power-less. Conversely, phatic discourse is designed to establish or enhance solidarity, its goal is the conversation itself, and it is usually mainly aimed at discussing feelings. There is no social distance, or power differential. Befrienders International, an organisation closely related to Samaritans in the UK, use a specialised form of phatic discourse, to encourage their callers to talk about painful feelings. Most ordinary people engage in less specialised phatic conversation very often, with family and friends, to talk about their daily lives and relationships. This is likely to be the type of discourse the client is best at and most comfortable engaging in.

So if a doctor’s intention is to shift from one style to another or if they find that the patient is thwarting their purpose by trying to engage in story telling when the doctor wanted short answers, they should wonder if they have signalled clearly what kind of conversation they want to hold. Then, perhaps, they could usefully wonder why the other person needs to engage in a different kind of discourse, and how such a need can be accommodated?

## 3. DIALOGUE AS JOINT ACTION

In any kind of discourse, each main interlocutor is taking part in his or her own right. Like dancing a polka together, they need to coordinate turn taking and topics. Each interlocutor is negotiating the matter of “face” at every stage of the conversation. In his 1979 article on “footing” within monolingual dialogue, Goffman



discussed the shifting positions that each speaker adopted in response to the other, in order to preserve one another's "face." "Face," here, means one's sense of autonomy, of self-esteem. Every society considers it important to preserve each other's face in normal social interactions and goes to some lengths to do so. These are the politeness behaviours that keep community life running smoothly. When an individual fails to take account of such behaviours they are perceived as arrogant, rude or unfeeling. Politeness is universal (Brown & Levinson 1987), but the manifestations of courtesy formulae vary from one culture to another. Is it polite to look one another in the eye, or is it an insult? Is it courteous to kiss on greeting, or not, and if so who may one kiss, and how many times? What is the proper distance from which one may salute another person in the street? Does one wave, or bow?

As well as an individual sense of "face," we all also have a collective "face," based on a group or groups with whom we identify strongly. So, while a man may occasionally be fairly disparaging about his own brother, for others to be rude about the brother would be taken as a personal insult. The man identifies himself with his family group and shares its collective sense of self-esteem. It is the same with national, cultural or linguistic grouping. Goffman's work (*Forms*), was taken up by H.H. Clark, and a theory describing interlocutor roles developed, which considered the activities involved in monolingual dialogue. In this model, each interlocutor is engaged alternately in listening and speaking. Within each of these two activities are three interlocutor roles which follow very rapidly upon each other or may to some extent occur simultaneously. When person A speaks, first he occupies Principal role in which he has an idea or concept that he wants to transport into the mind of person B. He must then occupy Formulator role and choose words which he believes will convey his meaning, and then speak, in Vocaliser role. Meanwhile person B will be in Attender role, receiving the stream of sound; moving into Identifier role to break that stream into units of meaning; and then into Respondent role in which he attributes overall meaning and intention to the whole message. All this allows rapid checking between the two and if understanding appears to be elusive, corrective action can be taken in the next turn at talk

So there are two roles within this joint action that embrace the individual personalities and sense of self of the interlocutors involved: Principal (having an idea) and Respondent (attributing overall meaning and intention)

#### 4. DIALOGUE DE-COUPLED

When a language-switcher is needed, instead of being able to make an instant check on each other's understanding of messages sent, each main interlocutor has to wait for several turns at talk to take corrective action, and may never know that a *mis*understanding took place.

In monolingual dialogue, each interlocutor owns their own messages. Each fully engages their personality and takes responsibility for their intended and perceived meanings. If, however, the interpreter engages their own personality functions, the others' messages will be tainted in the relay. Every message will have been



passed through the switcher's Respondent and Principal. He or she will be engaged as a full interlocutor in his or her own right, his or her "face" will be as much at risk as the others'. All this puts pressure on the interpreter, who may be identifying with one or the other speaker as a member of the same speech community, for example, or of the same professional community, and feel protective of them.

It is at this level that things can begin to go wrong. If an interpreter is inserted into this communication loop, the relationship between roles is decoupled. It is very easy for each interlocutor to attribute meaning and intention to the interpreter and not to the other speaker. More critically, there is risk to the interpreter's face. The Principal and Respondent roles described by Goffman are the moment when one's personality is most fully engaged. Concept and attribution express the individual's belief systems, political and religious opinions, emotional needs and wants; all that they are as a person. They are engaged as full interlocutors in their own right, and their "face" can be threatened. If an interpreter also sees themselves as fully engaged in their own right, identifying as a member of one or the other cultural or linguistic group, for example or with their belief system in play, their face is under threat too. And that is when errors such as "filtering" and "adding" creep in.

SAMPLE DIALOGUE 1. FEMALE PATIENT, COMPLAINING  
OF INSOMNIA AND STOMACH PAIN

Untrained language switcher	<p>¿Consideras tú que te estaría una ayuda una consejera por ejemplo que te ayude a, a, a dis...hablar de tus problemas que estás experimentando en este momento?</p> <p><i>(Do you think it would be helpful to you to see a counsellor for example who could help you to, to, to dis... to talk about the problems you're experiencing at the moment?)</i> <i>(There is a short discussion about the counsellor being Spanish-speaking.)</i></p>
Patient	<p>Quizá eso me ayudaría porque tengo problemas con mi marido, que, que, no puedo hablar con nadie y eso me angustia porque no lo puedo transmitir y quizá eso sea una buena idea pero no sabía que había este servicio.</p> <p><i>(Maybe mm that would help because I have problems with my husband that, that, I can't talk about with anybody and that makes me anxious because I can't communicate it and maybe that would be a good idea but I didn't know there was that service)</i></p>
Untrained language switcher	<p>Right. She wasn't aware of this service...</p>
Doctor	<p>I'm not sure that there is, but we need, I can ask around, we can try and find that out, I just wanted to know if it's worth us exploring so, it sounds as though it is, so we, we can think about that</p>
Untrained language switcher	<p>She, she thinks it would be a good idea.</p>
Doctor	<p>Okay... How long has she had the problems with her stomach, to go back to that?</p>

(Cambridge, "Information" 128)

Why the interpreter has left out the whole statement about marital problems is open to conjecture. Perhaps she thought it irrelevant. Perhaps she thought it was addressed privately to her and should be kept quiet. Perhaps she forgot it. Perhaps she thought it would be taken up by the counsellor and therefore was not important at this time. Whatever her reason, she is operating as a full interlocutor with opinions, and the right to guide and control the conversation, and so the doctor lacks information that the patient tried to convey.

SAMPLE DIALOGUE 2. MALE PATIENT, COMPLAINING  
OF SUDDEN UNEXPLAINED WEIGHT LOSS

Doctor	In someone of yo/he younger person with the change that you have described, it's very likely to be related to worry, the weight loss. I wonder if we should check your way to gain them, and talk again, after the exams... How does that sound?
Untrained language switcher	El mm piensa que sería bien pasar los exámenes porque a esta edad con la presión de los exámenes, el trabajo y presiones exteriores y personales, puede ser un síntoma todo ese peso perder. Entonces le gustaría volverte a ver una vez que se relajen ciertas partes de las preocupaciones, y volver a ver el tema. ¿Bien?:  <i>He mmm thinks that it would be good to finish the exams because at your age with the pressure of exams, the work and outside and personal pressures, all that weight you lost could be a symptom. Then he would like to see you once some of your worries over, and look at the matter again. All right?</i>
Doctor	If that sounds all right to you?
Untrained language switcher	¿Qué te parece? ¿Quieres hacer algo más, o (...) esperar un poco más hasta que pase la situación. Quieres algún tipo de vitamina quieres/  <i>How does it seem to you? Do you want to do something more, or (...) wait a bit until the situation's over. Do you want some kind of vitamin, do you want.</i>
Patient	Yo creo, no sé. Si él ve que, que está bien, que, que no hay ningún problema pues de acuerdo. Si me manda alguna vitamina y funciona pues no sé..., se lo agradezco.  <i>I think, I don't know. If he thinks that, that it's okay, that, that there's no problem, well I agree. If he orders to some vitamins and it works well I don't know... I'll be grateful.</i>
Untrained language switcher	He thinks what you decide is right unless you want to give him some vitamins or something you reckon is going to help, he will be happy to wait for a while and come back to you.
Doctor	Right. I don't think vitamins will help. I think that there are some simple things you could do about the sleep at night that might help.

(Cambridge, "Information" 214)

We can see in this extract that the untrained language switcher's face is fully engaged, and she is identifying closely with the patient, which leads her to add the vitamin suggestion thus exposing the patient to a face threatening refusal. The doctor is not in a position to know that this request had not come directly from the patient.



## 5. IMPARTIAL MODEL

And so the impartial model of interpreting was born, with which PSIs are so familiar. Interpreters using the impartial model relay messages accurately, completely and in as closely as possible the same style as the original. They:

- Do not give personal advice or opinions
- Do not add or omit parts of the message
- Do make every effort to foster the full, accurate transfer of information
- Do maintain strict confidentiality

They will intervene only when:

- They need clarification of part of a message
- They cannot hear what is being said
- They believe a cultural inference has been missed
- They believe there is a *mis*understanding

## 6. RISKS WITHIN THE TRIAD

### 1. TILTING THE MESSAGE

In the triadic situation, even where the interpreter is using the impartial model, there are risks. The lawyer, doctor, police officer is working in a single language. It is they, or their client/patient who control:

- Topic choice
- Topic change (with or without warning)
- The pace they choose to speak at
- The “catch-up” pauses allowed
- The register, style and variety of words chosen
- They know their goal at each stage. The interpreter does not

The more pressure there is on the interpreter’s short-term memory and processing ability while assimilation, word-search, and language switching go on, the more difficult it is for an interpreter to keep a filter in place that keeps out—not so much the inappropriate, overt expression of confidences, but the shadows of them, the nuance; assumptions about meaning based on information given at another time, during a different conversation. It is one thing to control a single language to that level, and another to control not only two, but the process as well. The process, as an influencing factor, is ignored at too many levels.

In the past it has been common practice, for instance, for defence lawyers to “borrow” the Court’s interpreter during a recess in order to take instructions from their client in the cells. It has taken many years to get the concept of contamination in terms of linguists understood by legal practitioners, whose common re-



tort was once “we rely on the integrity of the interpreter,” or “well, if you’re a professional you observe confidentiality.” This has nothing whatever to do with integrity and I have often likened the confidentiality issue to the presence of one rogue, red sock sneaking into the whites wash. If the interpreter is exposed to the private conversations of the defendant with their barrister then, when they return to court, given the pressure they are under, colour may easily leak in unexpected and unwelcome ways. Tiny things, such as the use of *tú* or *usted* where the English word was *you* might be taken to indicate a closer knowledge of the relationships involved than the Court interpreter ought to have. It is telling that, according to my BSL colleagues, their language has no generic sign for murder. Similarly, the phrase “he walked up to the door” must describe the route he took. All these sound like peripheral and inconsequential things but if there are two defendants running a cutthroat defence they can be critical. For this reason interpreters should never be left alone in the company of a witness or defendant, but should be given somewhere to wait where the defendant and/or their supporters cannot gain access to him or her.

Interpreters should not be given extraneous, irrelevant, but confidential and/or potentially damaging information. Particularly in legal settings (less so in healthcare, but the concept is still relevant), care should be taken not to damage the *client’s perception* of interpreter impartiality or confidentiality. It must be remembered that many interpreters are members of the linguistic minorities that they interpret for and are very visible and well known in their own communities. If defendants have access to them before a trial, away from the presence of a third party who can be kept in the information loop by constant interpreting, they will quite naturally want to “make friends.” All manner of indiscretion will be foisted onto the interpreter, before, during, or after attempts elicit his or her life history and personal circumstances. This is phatic interaction, an attempt to make friends, and is not appropriate to the situation. A friend is not impartial. The opposite can occur as well, and interpreters have been threatened and made to feel unsafe by a defendant’s supporters.

## 2. COLOURING THE MESSAGE

If an untrained language switcher is making the language switch, then the risks are greater. How will the doctor, say, acting as interpreter for another doctor, ensure that the messages relayed are uncoloured by their own professional view on the case? How, therefore, can the doctor whose case it is be sure whose opinion, or whose question they are listening to?

## 3. BEING PREPARED

This is Major Difference number 7, and is my own addition to the list. On top of all the above demands being made on us, PSIs work in the same sorts of

potentially distressing situations as the other professional disciplines in their work teams. However, we only rarely have the support of an organisation behind us if we are distressed. Ours is a newly emerging profession, unlike those we routinely work alongside. Professionals such as nurses, police officers and ambulance crews almost certainly see more situations that are traumatic for the client than we do. What may seem a fairly routine event to those professionals might come as an unexpected shock to a PSI. A lot of our time is spent discussing housing benefits, childcare, routine medical situations. Only sometimes are we plunged into dramas. For that reason, and over many years, nurses and police officers have developed strategies and systems, both formal and informal, for supporting one another. The informal ones are often based on regular work teams, and are so deeply embedded in normal practice that the practitioners concerned have probably stopped noticing them. Difficulties can arise for PSIs for two main reasons. Firstly we are often not seen as “belonging,” as being a part of the professional group we have been working with on this assignment, or of being likely to need support. Secondly, we tend as a group to think that it is unprofessional to admit to being endowed with emotions. We behave professionally while we’re working, of course; but we are not deaf, nor fools, nor made of stone. Sometimes we need a chance to debrief in a safe, confidential environment. We don’t usually have the luxury of a regular work-team environment to fall back on. There are no every-day colleagues among interpreters. We’re usually free-lance and almost always work alone. I arrive at your unit, slot into your multi-disciplinary team, do my job during necessary interactions with that one patient/detainee or whoever it might be, and I leave. I will probably have gone before the end of your shift. I cannot go home and say to my family “guess what happened to me today?” because it was all confidential. If you think there’s even a small chance that I might have been upset by something I have relayed during your interview —please try to give me five minutes at the end of it to “unpack,” or the burden of confidentiality can get pretty heavy and is bound to impact negatively on the work I do tomorrow, or next week.

## 7. THE INTERPRETER’S ROLE

The public service interpreter’s job is to act as alter ego or other self to each speaker in turn. The aim is to put each speaker on the same footing as they would be on if they shared a language with the other. The interpreter should be trying to have the same effect on the listener as the original speaker intended, and to relay information as fully and accurately as possible, in the same register.

Using the Impartial Model means working in the first person when relaying each speaker’s utterances. This encourages principal interlocutors to maintain ownership of what they are saying and keeps the interpreter’s impartiality in the frame. However, it means that interventions, as described above, have to be begun in the third person so as to ensure that neither interlocutor believes that the interpreter is still interpreting the other person’s words. The most important, and most difficult thing to get across to student interpreters is very often the idea that they



must not take on other people's responsibilities. This is exacerbated by the fact that when they go to work they will inevitably find that co-workers in other professions, who know next to nothing about the interpreter's code of conduct or professional needs, will try to offload parts of their professional responsibility onto the interpreter. Police officers will try to persuade the unwary interpreter to take a written witness statement on their own, with no police officer present, because they have not been trained in, or provided with suitable guidance about, the proper procedures to follow. Nursing staff will presume that an interpreter who is apparently of the same ethnic group, and speaks the same language as the patient, is therefore a relative and can reasonably be asked to take the patient to the toilet, fetch case notes, explain procedures directly, without reference to the clinician, and so on. It is not uncommon for an interpreter to be asked to "pop out and fetch the x-rays." Even though standards of training for PSIs are being driven constantly upwards and professional codes of ethics are in place with attendant disciplinary procedures, those we work with are too busy to listen and too accustomed to taking the risks involved in using relatives and passers-by as language switchers.

I once arrived at an Accident and Emergency Department (A&E), at the request of the police, following a road traffic collision. The patient had suspected spinal and cranial injuries and was strapped to a spinal board. I walked into A&E and announced myself to the first nurse I met. Overhearing me, a doctor said brightly, "Oh, you can go home. We don't need you now. The patient's friend has arrived from the village, and she *is* Spanish." I replied that they were going to have to pay me whether I stayed or went, since I had responded to the call, and was present, and available to work. I suggested, therefore, that we ask the patient whether or not she wanted her friend to interpret for her in a potentially intimate situation. Grudgingly, the doctor agreed and we approached the bed. I said, in Spanish "I'm here to be your interpreter," whereupon the friend looked up and said, also in Spanish, "thank God for that! I've only been in the country eight weeks and I don't understand a word any of these women say, they are all speaking Welsh." Actually, they were speaking English, but the hospital was in Wales and the accent was Welsh. Nevertheless, they were perfectly happy to ask an untested and, as it turned out, unwilling passer by to interpret between them and their patient while they investigated the possibility of a fractured skull and internal injuries.

## 8. FACE AND EMOTIONAL LANGUAGE

In fulfilling our duty to relay the whole of the message, not just the semantic content of speech, we have many signals to attend to. All the non-verbal signals that make up what we call "body language," from posture and gaze to tone of voice and loudness, send signals about meaning and intention. But these meanings differ from one culture to another. Interpreters must pay attention to all this and see to it that no misunderstanding occurs because a cultural inference has been missed or misread. But more complex, even than that, is the issue of emotional language. Only in PSI work is this subject so central. When human beings are afraid, in pain,



or feeling ill they communicate less well than usual, even in their mother tongue. They will often revert not simply to the dialect of their own village, but even to idiolect: personal, childhood words. Clinicians will routinely use what they see as “simpler language” in an attempt to make their speech more listener-friendly, less technical or difficult. This on its own can present the unfortunate interpreter with major challenges. Take the following two expressions as an example:

*Example 1.*

Senior nurse (arriving for work, she walks into the handover meeting and says):  
“How many poorlies have we got?”

*Example 2.*

Mrs Thompson (on the phone to her son’s primary school teacher):  
“Ian is poorly today, so I’m going to keep him at home.”

In the first example the word “poorly” means “likely to die,” and in the second it means “mildly unwell.” These two widely disparate meanings are indicated by context. “Poorly” is used by British clinical staff as a euphemism for “very seriously ill,” while ladies like Ian’s mum use it to mean “will be fully recovered by tomorrow morning.”

Monolingual medical discourse is full of language that clinical practitioners believe to be friendly, comforting, and reassuring such as “tummy,” and “slip your pants off and pop onto the couch.” No doubt there are patients who find this kind of language helpful. Others might retort “pants never slip, and I haven’t popped anywhere since I was four,” as this is an example of baby talk being used inappropriately to an adult. The patient who shares a language with the clinician is in a position to respond as they see fit. The interpreter’s grasp of both languages involved will need to be at near-native level, since anybody who has not experienced childbirth in the language will find it very difficult to deal with expressions like “I’m just going to pop couple of little stitches in your tail dear.” British midwives really do say that sort of thing.

Curse words are words, words with semantic meanings and syntactic constraints. Curse words are also symbols and they may operate like gestures, more so than other words... The single-word nature and the gesture-like quality of cursing are not sufficient to deny it language status. What is unique to curse words is the deep emotional intensification. (Jay 254)

The challenge for very many public services interpreters new to the field is that cursing is not socially acceptable. While they may succeed in overcoming difficulties in using the proper names for intimate body parts and activities, they often find the idea of relaying curse words an insuperable barrier. There is no getting away from it; public service interpreting is a “rude” profession. As Jay remarks, the fundamental and most significant aspect of cursing is that it expresses a depth of emotion that is an intrinsic and indispensable part of the whole message. Any pub-

lic service provider be they police officer, doctor, immigration officer or social worker, needs to take account of their client's state of mind during any interview they may hold with them. This issue must therefore be addressed, and trainee interpreters must be taught to develop and deploy the necessary resources to convey the strength of meaning, or level of threat, implied by such language. We are the alter ego of the speaker concerned, not their mother. If there is an issue of mental capacity it is not the interpreter's role to act as the advocate. It is the interpreter's role to interpret.

Capacity is the pivotal issue in balancing the right to the autonomy in decision making and the right to protection from harm. [...] The Law Commission for England and Wales has stated that people should be "enabled and encouraged to take for themselves those decisions which they are able to take." (British Medical Association and The Law Society 3)

It should be borne in mind that others also have professional codes of conduct to abide by. The Nursing and Midwifery Council's code of professional conduct instructs nurses in professional practice in Britain that:

2.2 You are personally accountable for ensuring that you promote and protect the interests and dignity of patients and clients, irrespective of gender, age, race, ability, sexuality, economic status, lifestyle, culture and religious or political beliefs.

2.4 You must promote the interests of patients and clients. This includes helping individuals and groups gain access to health and social care, information and support relevant to their needs. (Nursing and Midwifery Council)

Guidance to doctors, from the General Medical Council includes injunctions to

- listen to patients and respect their views;
- give patients information in a way they can understand;
- respect the rights of patients to be fully involved in decisions about their care.

And is very clear that Good Practice means:

- listening to patients and respecting their views and beliefs;
- giving patients the information they ask for or need about their condition, its treatment and prognosis, in a way they can understand, including, for any drug you prescribe, information about any serious side effects and, where appropriate, dosage. (General Medical Council)

Clearly, the responsibility for making sure that clients or patients have the mental capacity to make their own decisions, and have sufficient information available to them in a form that they understand, lies with the clinical professionals. The duty of the interpreter is to see to it that the whole message sent by each speaker is accurately relayed, without making value judgements about the content. That is such a complex, subtle, and demanding task on its own, that we should not even consider straying into the role of collaborating professionals as well.



If, therefore, a client or patient chooses to use language that they must be aware will cause shock or offence in the mother tongue and home culture, that choice must be respected and the integrity of what they said must be preserved. Suppose the following conversation takes place:

*Immigration officer:* “what was it that finally drove you to leave your country?”

*Applicant:* “Four men came to my work place and dragged me into the street. They beat me, they humiliated me, and they said terrible things to me.”

What is the obvious, inevitable next question? It has to be, “what did they say?”

If the interpreter relays the response to that question as, “they said I’m a horrible person and my mother isn’t married,” how much harm to an asylum seekers case might that inaccuracy have done? Certainly, the speaker’s intention was not to make the immigration officer smile, but to convey to him or her reason for their great fear.

A man accused of Assault and Grievous Bodily Harm was giving his evidence in chief to an English jury. When he got to the part of his story where the woman he was alleged to have assaulted was beating on the outside of the pub door and shouting, he was asked what she was shouting. He demurred, saying that he didn’t like to use such bad language in a court of law especially since there were ladies present. He was eventually persuaded by the judge to tell the jury exactly what had been shouted. His reply was: “Echad a ese hijo de puta extranjero fuera y juro que lo mato,” or, “Send that bastard bloody foreigner out here, I’m going to fucking kill him.” The interpreter may not permit herself a prissy hissy-fit at this point. The job is to relay what was meant. The jury will decide its weight and relevance.

Similarly, a different man, accused of rape, was asked by the Prosecutor, “did your penis penetrate the woman’s vagina?” To which he replied, “no lo tenía muy confidente,” or “I couldn’t get it up.” Yes, it’s embarrassing to say in open court, but the jury has a job to do and so does the interpreter.

## 9. A RUDENESS REGISTER: A WAY TO THINK ABOUT THE PROBLEM

In order to provide a framework within which to think about this transfer of meaning, it can be helpful to think about curse words as sitting somewhere on a scale of 0 to 5 in which 0 represents language that would be perfectly acceptable at one’s grandmother’s tea table. Level 5 represents fighting talk. There are three aspects of emotional language that one could try to match:

- emotional weight
- pragmatic function
- semantic equivalence



Emotional weight is represented on the scale between 0 and 5. Pragmatic function refers for example to whether the word is being used as a descriptor, an exclamation, or in name-calling. Semantic equivalence is rarely useful since the meaning of curses lies in the strength of emotion expressed by them. So for example in the following exchange:

*Passenger.* "Take care, my suitcase is very heavy"

*Taxi Driver.* "¡Coño, qué maleta!"

If an interpreter were to insist upon semantic equivalence, and render the taxi driver's words into English as "cunt, what a suitcase," not only would there be the bad match on pragmatic and emotional weight grounds, but the poor man could find himself embroiled in a fight that he had not sought and did not deserve. One nation's rude body part, as a mild exclamation, is another nation's fighting talk and is name-calling.

The same principle applies to blasphemy. The significance of such an utterance has little to do with religious convictions, and everything to do with strength of feeling or a desire to cause affront. So there is no reason why an interpreter cannot find an expression in their other language, which meets the criteria of matching emotional weight and pragmatic function while avoiding blasphemy. It is unlikely, in any case, that there will be an available semantic match.

## 10. CONCLUSION

There are three main implications, which deserve greater attention, for the training and deployment of interpreters in the public services. First of all training itself. If a doctor and nurse, working in the same multidisciplinary team, do not understand and respect one another's purposes, knowledge domains, responsibilities and codes of conduct, chaos will result and the patient will suffer. For one to assume greater knowledge by the other of some aspect of care, and on that basis to abdicate responsibility for it, may lead to vital precautions not being taken because the doctor thought the nurse would do it, and the nurse thought the doctor would. The same is true where doctors and nurses have no idea what interpreters know, are responsible for, and so on. Members of the other professional disciplines in the multidisciplinary teams that we work in should all receive training and guidance on these issues as a matter of course, just as clinicians are taught about asepsis. Secondly role boundaries should be transparent, known, and adhered to. This is a training issue on all sides, but also calls for some national and even pan-European protocols to be developed so that expectations do not vary from hospital to hospital, court to court, or country to country, throughout the public service sector. Thirdly, and most importantly, embedded messages, especially the emotional state conveyed by word choice, are a vital part of the whole message to be relayed, and must be afforded the proper degree of care and attention in the relay.





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