

**Chinese whispers in Turkish hospitals:  
Doctors' views of non-professional interpreting in Eastern Turkey<sup>1</sup>**

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**Abstract**

Previous quantitative studies of healthcare interactions in Diyarbakır, the largest Kurdish metropolis in Turkey, have revealed widespread use of ad hoc interpreters. This article delves into the practice of non-professional interpreting across Eastern Turkey by examining the findings of a mixed-methods online survey conducted in 2014 among doctors working in the region. It focusses on doctors' answers to questions concerning the advantages and disadvantages of informal interpreting. The 32 respondents demonstrate overall dissatisfaction with ad hoc interpreters, complaining especially that they omit and change information and undertake primary interlocutor actions. One of the few advantages doctors mention is that patients view non-professional interpreters as trustworthy, which enhances doctor-patient rapport. Although some doctors generalise that any form of interpreting undermines the privacy of the doctor-patient interaction, the vast majority would welcome the institutionalisation of professional interpreting and do not reject this as an undesirable alternative to language-concordant care, the strategy championed by certain local organisations and activists in Eastern Turkey. Many of the claims these Turkish doctors make concerning non-professional interpreting resemble arguments familiar from comparable studies abroad. Some findings, however, need to be considered against the local background, a point that no doubt holds true for other studies of attitudes towards interpreting.

**Keywords**

Interpreting, healthcare interpreting, non-professional interpreting, Turkey, Kurds

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<sup>1</sup> This article is a heavily modified version of a Turkish article published in 2019 in issue 11 of the *Istanbul University Journal of Translation Studies* (Ross, 2019). I would like to thank the two anonymous reviewers of the present article for their meticulous and constructive criticism of its earlier drafts.

## 1. Introduction

In October 2019, a junior doctor at a hospital in South-Eastern Anatolia posted the following Tweet about an incident he had witnessed:

The patient just knows Kurdish. Her husband speaks Kurdish and Arabic, the interpreter Arabic and Turkish. The patient tells her husband what's wrong in Kurdish, then the husband relays this to the interpreter in Arabic, and finally the interpreter translates it into Turkish for the doctor. In Urfa, dealing with patients is like a game of Chinese Whispers. The patient was constipated, but the doctor was informed that she had diarrhoea. (fakultemagduru, 2019)<sup>2</sup>

As 'exotic' as this episode might seem to some readers, certain aspects will be familiar to those well-versed in the literature on community interpreting. The incident involves the very widespread phenomenon of non-professional, *ad hoc* interpreting, that is, interpreting provided by "whoever is immediately available" (Antonini, Cirillo, Rossato & Torresi, 2017, p. 7), albeit here combined with the use of an in-house interpreter. The distortion of information, moreover, exemplifies the risks posed by the use of incompetent, untrained interpreters in medical settings, which scholars in various countries (e.g., Cambridge, 1999; Flores *et al.*, 2003) have exposed.

Other dimensions of the incident offer an insight into the distinct linguistic demographics and language politics of early 21<sup>st</sup> century Turkey. Its location is a case in point. The province of Şanlıurfa, where this event occurred, has always been markedly multilingual, with large populations of Kurdish and Arabic native-speakers, alongside the Turkish mother-tongue minority. This linguistic heterogeneity and the challenges to communication it engenders have been amplified by the arrival in the area since 2011 of hundreds of thousands of people fleeing the civil war in Syria. The in-house interpreter who appears in this anecdote has presumably been employed within the framework of one of the schemes (e.g., the EU-funded Sihat Project, see [www.sihatproject.org](http://www.sihatproject.org)) introduced by the Turkish Ministry of Health and its international backers in response to the Syrian refugee crisis; previously, the use of professional interpreters had been a rarity within the Turkish health system. Given that most Syrian refugees in Şanlıurfa are Arabic-speakers, it is understandable that the in-house interpreter caters to the language combination Arabic-Turkish. In contrast, there is no interpreter for Kurdish, which is why the first link in the 'game' of Chinese Whispers needs to be provided by the husband of the patient, a non-professional interpreter. The absence of a Kurdish interpreter may simply reflect a lack of demand, but it could also be interpreted as falling into a pattern of the denial of language services for that language, a phenomenon that shall be expanded on in the following section. Although there is ample anecdotal evidence of the use of non-professional interpreting in Turkish hospitals and clinics, remarkably little systematic, empirical research has addressed this phenomenon. As shall be shown, three studies conducted in Diyarbakır have pointed to the prevalence of non-professional interpreting. None of them, though, have furnished a detailed picture of what actually happens in non-professionally-interpreted doctor-patient interactions in Eastern Turkey<sup>3</sup> or sought to examine how the use of informal interpreting affects medical encounters. This article therefore presents some of the findings of an online survey on informal interpreting that was distributed among doctors in the region in the summer of 2014. Being exploratory in nature, the survey aimed to elicit responses on a wide range of topics, such as

<sup>2</sup> I am grateful to Dr. Ramazan Basut for providing me with further details about this story. The translation of the Turkish Tweet, like that of all the Turkish material used in this article, is by the author.

<sup>3</sup> The terms "Eastern Turkey" and "the East of Turkey" will be used in this article to encompass the geographical regions of Eastern Anatolia and South-Eastern Anatolia.

the frequency with which doctors face difficulties communicating with patients, the profile of the patients with whom such difficulties tend to occur and the actions seemingly undertaken by informal interpreters. The present article, however, draws principally on the answers to the five open-ended questions in the survey that concern doctors' experiences of, and views on, the advantages and disadvantages of informal interpreting. It will consider the responses of doctors in Eastern Turkey against the background of the existing international literature on non-professional healthcare interpreting. In addition, the paper will discuss the phenomenon of informal healthcare interpreting in Eastern Turkey, and doctors' views thereon, within the framework of the distinct local socio-political setting.

## **2. The Eastern Turkish context**

Demographic realities, anecdotal evidence and the little research available all point to the potential need for interpreting in Eastern Anatolia. A significant part of the indigenous population, in many places the majority, are native speakers of languages other than Turkish, above all the Kurmandji dialect of Kurdish but also (to a lesser extent) Zazaki, Arabic and other rarer languages. Since 1965, the Turkish national census has not recorded information about ethnicity or mother-tongue (Mutlu, 1996, p. 519), so demographic statistics for these need to be generated by extrapolating from historical data or using sampling. In 2004, for instance, based on field research among 2,401 inhabitants of Eastern Turkey, scholars at Istanbul's Bahçeşehir University found that 55.1% of respondents in that region identified their mother-tongue as Kurdish, 33.5% as Turkish, 6.1% Zazaki and 5.4% Arabic (Bahçeşehir Üniversitesi Stratejik Araştırmalar Merkezi, 2009, p. 82). In the summer of 2014, the demographics of Turkey and South-Eastern Anatolia in particular had not yet been reshaped as they soon would be by the mass arrival of refugees from Syria. In May 2014, more than 900,000 Syrians were registered in Turkey, with many living in the East of the country (AFAD, 2014, p. 14), yet this number was small compared to the current size of the Syrian population, 3, 594, 981 (Göç İdaresi Genel Müdürlüğü, 2020).

Of course, not everyone in Turkey whose mother-tongue is not Turkish needs an interpreter to communicate with Turkish-speakers. Anyone who has attended school, done their military service, has regular contact with the authorities and/or works and lives in an environment where Turkish is widely spoken is likely to acquire at least rudimentary Turkish competence. Because Kurdish-speaking women have been particularly cut-off from public life, often having no or little education, lack of competence in Turkish is more marked among them than any other indigenous demographic group. According to one of the few published estimates of knowledge of Turkish among Kurds, in 2003 approximately 70% of a sample of Kurdish native-speakers in Eastern Turkey were found not to have completed primary education and 33% of these uneducated Kurdish-speaking respondents claimed to have no knowledge of Turkish, with women making up 90% of the total (Gürsel, Uysal-Kolaşın & Altındağ, 2009). Even if the number of young females in Eastern Turkey learning Turkish has increased since 2003, a considerable number of women (and some men) are still likely not to have acquired Turkish skills.

In Turkey, issues around language have long been highly sensitive and politicised. Following the demise of the Ottoman Empire, the country's Republican leadership propagated a civic nationalist ideology, according to which anyone living within the borders of the Republic of Turkey should be considered a 'Turk'. Increasingly, though, "ethnic" or "cultural" conceptions of Turkishness also found their way into official discourse and legislation (Saraçoğlu, 2011, p. 51). To propagate a common Turkish identity, the use of Turkish was promoted throughout the country while recourse to other heritage languages was strongly discouraged. As the coun-

try's largest indigenous linguistic minority by far, the Kurds were particularly affected by this monolingualist ideology and policy. Up into the 2000s, calls for greater acceptance of the use of Kurdish in the public sphere were condemned as covert moves towards political separatism and suppressed in the name of the anti-terrorist struggle against the Kurdish Workers' Party, the PKK (Zeydanlıoğlu, 2012, p. 112). In such a climate, people speaking Kurdish could find themselves victims of harassment. A newspaper article on doctors who were persecuted for speaking Kurdish with their patients gives a sense of the conditions that once impinged on the use of Kurdish within the healthcare sector (Mavioğlu, 2010, p. 20).

The situation changed markedly at the end of the 1990s, when measures were taken that appeared to herald a more tolerant approach to the use of local languages within Turkish society (cf. Zeydanlıoğlu, 2012, pp. 113-120). These were initially driven by Turkey's attempt to gain accession to the EU and later by the Justice and Development Party (AKP) government's so-called "Kurdish Initiative" (launched in 2009) and its subsequent "Democratisation Packet" (2013). In the healthcare sphere, civil society organisations in Eastern Turkey seized on the relatively *laissez-faire* climate that prevailed with respect to the Kurdish issue until the summer of 2015 and undertook research, organised meetings and produced publications that would have been unthinkable a decade before. One argument repeatedly advanced was that the optimal strategy for healthy communication between healthcare providers and patients with no knowledge of Turkish was "language-concordant care" (Diamond, Schenker, Curry, Bradley & Fernandez, 2008, p. 261), i.e., the doctor should speak the language of the patient. The Diyarbakır Chamber of Medicine backed this strategy by producing and distributing a book *Kürtçe Anamnez: Anamneza bi Kurmancî* (Anamnesis in Kurdish), which combines introductory chapters on Kurmandji grammar and pronunciation with sets of questions in Kurmandji (together with their Turkish translations) that doctors with various specialisations are supposed to follow in order to take their patients' histories (Bülbül, Bülbül & Avcıkıran, 2009)<sup>4</sup>.

Clearly, in the years leading up to the point at which I conducted my survey, the issue of language in healthcare was being discussed more openly in Turkey than it ever had been. The initiative, though, mostly seemed to be taken by non-governmental bodies, while the state was more hesitant and reactive. In 2010, responding to the Chamber of Medicine's call for medical services in Kurdish, the then Minister of Health Recep Akdağ commented that it would be wrong to deliberately appoint doctors who knew Kurdish since the number of elderly people and women in Eastern Turkey who did not know Turkish was actually very limited, bilingual staff were using Kurdish anyway to communicate with patients and, when a doctor or nurse did not know Kurdish, there was always someone else around who did (Akdağ sağlık hizmetlerinde, 2010). In other words, Akdağ was backing *ad hoc* solutions as a way of dealing with what was allegedly a minor problem.

Akdağ's successor, Mehmet Müezzinoğlu, likewise stated that the Ministry had no plans to assign Kurdish-speaking medical personnel to areas of Turkey with sizeable Kurdish populations. An innovation he did mention, though, was the employment of Kurdish interpreters in the East as well as in parts of Western Turkey with large Kurdish populations (Hastanelere Kürtçe tercüman, 2013). However, there is no evidence that such an interpreting service ever materialised, and telephone calls to human resources departments within the Ministry of Health and to individual public hospitals have failed to clarify the matter. Among the language services certainly established in the last decade was the provision of Kurdish-language support

<sup>4</sup> It is debatable how effective this book could be in preparing doctors to perform anamnesis in Kurdish, a new language for many of them. The book actually includes only a very limited range of possible responses from patients, so unless doctors supplemented their reading of *Kürtçe Anamnez* with other language-learning activities, they could well face difficulties comprehending their patients.

on the ambulance emergency helpline (112) in at least two regions (see 112 Acil'de Kürtçe, 2013; Hakkari 112, 2013). When compared to the treatment of language issues in Turkey prior to around 2005, the fact that a unit connected to the Ministry could offer such a service in Kurdish was a breakthrough. On the other hand, one could argue that these were limited, local services rather than major interventions, since the 112 line was merely allowing people working there to make use of language skills they already possessed. By means of contrast, in February 2012 an "International Patient Assistance Unit" was established within the Ministry of Health, offering nationwide telephone interpreting in four foreign languages (English, Arabic, German, Russian), with the later addition of French and Persian (Dayıoğlu, 2015); such a service has never existed for Kurdish.

### 3. Literature review

It is only in the last decade that stakeholders in the Turkish health sector have acknowledged the problem of language mismatch between healthcare providers and patients, whether the latter be, for example, Kurdish citizens of Turkey or medical tourists. Similarly, interpreting scholars in Turkey have been quite late to take up the subject of healthcare interpreting. Several researchers have outlined its legal framework and provision (e.g., Diriker, 2015; Duman and Ataseven, 2018), two MA theses and one PhD dissertation have examined the working conditions and role self-definitions of interpreters in private hospitals (Öztürk, 2015; Şener, 2017; Duman, 2018), and a monograph (Turan, 2016) offers the first Turkish-language introduction to this subject, albeit drawing more on the international scholarly literature than on research data from Turkey. So far, a single publication has presented authentic data related to non-professional healthcare interpreting in Turkey. This was Schouten, Ross, Zendedel and Meeuwesen's (2012) interview-based comparative study of informal interpreters in the Netherlands and Turkey.

That said, non-governmental organisations in Turkey have undertaken research to gauge the extent and characteristics of the language problem in the health sector in Eastern Turkey. Back in 1994, the Turkish Medical Association published a report that touched on the severity of this problem (Türk Tabipleri Birliği, 1994). In 2009, the Diyarbakır Chamber of Medicine implemented a questionnaire-based study of working conditions of doctors (Diyarbakır Tabip Odası, 2009), which included several questions related to language. When asked whether they ever experienced a language problem with patients, 49.8% of the 253 respondents answered "I know the language spoken by the patient" but 48.6% admitted that, to communicate, "I get help from staff or from a family-member of the patient". In these two studies undertaken 15 years apart, around 50% of doctors admitted that they were dependent on non-professional interpretation.

A quite similar finding emerged from a much more focused survey carried out in 2012 by DİTAM, an independent think-tank. For their research on "Language-based Problems in Communication between Patients, Doctors and Chemists in Diyarbakır", DİTAM interviewed 270 doctors and 42 pharmacists. When asked how they communicated with patients who did not know Turkish, 45.5% of doctors (including both ethnic Kurds and ethnic Turks) said that they were able to speak the language of the patient, 25.6% of doctors relied on the mediation of a patient-companion, and 13% asked other medical personnel to mediate (DİTAM, 2012, p. 18). The study I conducted in the summer of 2014 intended to fill some of the gaps left by the previous research. Whereas the three earlier studies had concentrated on Diyarbakır, I hoped to reach doctors across Eastern Anatolia. Moreover, my study was intended to be innovative in furnishing rich data, qualitative and quantitative, about non-professional interpreting as seen through the eyes of doctors, as opposed to just quantifying its frequency, which is what



the previous research had principally done. Unfortunately, despite extensive efforts to reach a large number of doctors across the region, the eventual number of respondents (32) was disappointing and my first aim was not achieved. Although the findings from this sample are in no sense representative, the sometimes quite striking narratives and comments of individual doctors do offer compelling insight into doctors' perceptions of the characteristics, pros and cons of non-professional interpreting.

## 4. Methodology

### 4.1. Survey design

To arrive at underlying research questions for this exploratory survey and to formulate corresponding questionnaire-items, I reviewed the three local surveys mentioned above, as well as the international literature related to healthcare providers' satisfaction with interpreting services (e.g., Hornberger, Itakura & Wilson, 1997; Pöschhacker, 2000; Diamond *et al.*, 2008). Following this, I drafted the questionnaire in English and elicited feedback from two prominent members of the Interpreting Studies community, one Turkish, one foreign. With the help of colleagues, I translated the questions into Turkish before uploading them to a survey website. To pilot the online survey, I sent its link to the chief physicians of two public hospitals in Eastern Anatolia. I asked them to complete the survey, which included additional questions about the length and accessibility of the questionnaire as a whole and the appropriateness, arrangement and wording of the questions. I also requested them to share the link with three colleagues each. The feedback I received from the six doctors who responded was largely positive, but because two objected to the length of the questionnaire, I omitted two questions, bringing the total to 38.

The final version of the questionnaire opened with a header message assuring respondents that their answers would remain confidential and that their anonymity would be preserved in any subsequent publications. Four types of questions were used: paired-choice, multiple-choice, Likert-scale and open-ended. Together, they elicited information about the professional and linguistic backgrounds of doctors and about their experiences and opinions regarding the following issues:

- The frequency of communication problems between doctors and patients,
- The frequency of such problems among certain groups,
- The reasons for such problems,
- The solutions deployed by doctors to overcome communication problems,
- The effectiveness of these solutions,
- The behaviours exhibited by non-professional interpreters,
- The effectiveness of non-professional interpreters,
- The perceived advantages and disadvantages of non-professional interpreting,
- Doctors' preferences regarding solutions to communication problems.

### 4.2. Survey administration

Since my aim was to reach doctors across Eastern Turkey, I opted to conduct the survey via the Internet. Another advantage of using an online survey engine was that quantitative data could be analysed automatically. I initially tried to access doctors by contacting the 13 Chambers of Medicine in Eastern Turkey and asking them to share the link to my survey with their members. However, only three Chambers (Mardin, Bitlis and Diyarbakır) agreed to help. It soon became clear that I would not be able to realise my goal of accessing a substantial and representative

sample of physicians across Eastern Turkey, so I had to suffice with a non-probabilistic convenience sample and rely on the assistance of my own contacts in the healthcare sector. The survey remained live for three months in the summer of 2014.

#### **4.3. Data analysis**

The quantitative data were processed by the survey website. Since the response rate was relatively low and there were only seven open-ended questions, which were not all answered by every one of the respondents (and rarely at much length), I saw no need to apply electronic textual analysis to process the qualitative data. Instead, for each open-ended question, I read through the responses at least three times and drew up a tentative list of all the themes that they appeared to contain, whereby themes could be expressed in textual units of varying lengths. Once a list was completed, I scrutinised it to see if there was any repetition or any overlap between themes. Where there was, I merged themes to create somewhat broader, discrete categories. As will be demonstrated in Section 5.4, I also carried out second-level coding (Saldanha & O'Brien, 2013, p. 190) and formed thematic clusters, to allow for a more general overview. To improve intersubjective reliability, this process was then audited by a colleague. Following this, I read through the answers to the open questions again, coded chunks as belonging to certain themes and at the same time kept a tally of the number of chunks associated with these themes, so that I could gauge the popularity of certain themes and opinions. My colleague monitored this aspect of data analysis too by selecting numerous random chunks from the answers, assigning them to the thematic categories created earlier and then comparing his choices to those I had made. We concurred on every decision, suggesting that I was not proceeding in an overly subjective manner.

### **5. Results**

#### **5.1. Demographics**

Of the 32 respondents, 25 (78%) were male and 7 (22%) female. Through my personal contacts, I reached a reasonable number of doctors in the cities of Mardin and Bitlis ( $n=18$  and six respectively, accounting for 56% and 19% of the total number of respondents); the eight other respondents were spread across six other provinces. Notwithstanding the small size of the sample, the statistics concerning the linguistic knowledge of doctors were remarkably similar to those in the studies carried out by the Chamber of Medicine and DiTAM. Just as around half of the respondents in these studies had stated that their knowledge of the mother-tongue of patients who did not speak Turkish meant that they experienced fewer communication problems, slightly more than 50% of my respondents (17) said that they knew a local language other than Turkish; of this 50%, 82% (14) knew Kurmandji.

#### **5.2. Prevalence of, and reasons for, communication problems**

The majority of respondents admitted facing difficulties communicating with patients. Just one doctor (3%) reported "Never or almost never" experiencing such difficulties, nine (28%) said that this occurred "Rarely", another nine (28%) "Sometimes", 10 (31%) "Often" and three (9%) "Always or almost always". As for the types of patients with whom communication was especially challenging, the responses to an open-ended question yielded very similar answers to the Chamber of Medicine and DiTAM studies, i.e., elderly Kurdish-speakers, but women more than men.

Another Likert-scale question sought doctors' opinions concerning the reasons for such communication problems:

What factors do you think contribute most to the communication problems you face? Answer this question by choosing scores between 1 and 5 in the table below, where 1 means that a factor has no influence and 5 means a factor has a great amount of influence.

FACTOR	1				5
Insufficient time for communication	7 (22%)	4 (13%)	6 (19%)	4 (13%)	<b>11 (34%)</b>
Cultural gap between doctor and patient	6 (19%)	9 (28%)	5 (16%)	6 (19%)	6 (19%)
Lack of trust between patient and doctor	7 (22%)	4 (13%)	13 (41%)	6 (19%)	2 (6%)
Reluctance of patient to talk	11 (34%)	10 (31%)	9 (28%)	2 (6%)	0 (0%)
Doctor's difficulty in understanding patient's ideas about health & sickness	8 (25%)	6 (19%)	6 (19%)	6 (19%)	6 (19%)
Patient's difficulty in understanding information given by the doctor	1 (3%)	6 (19%)	6 (19%)	<b>8 (25%)</b>	<b>11 (34%)</b>
Doctor's and patient's lack of a common language	8 (25%)	3 (9%)	4 (13%)	<b>8 (25%)</b>	<b>9 (28%)</b>

**Table 1.** Factors contributing to communication problems

Again, given the size of the sample, one should be wary of reading too much into the statistics. Nonetheless, it is clear that a lot of doctors perceived the lack of a common language as a major source of communication problems. The fact that more than half of the doctors professed some knowledge of Kurdish presumably goes some way to explaining why eight doctors (25%) did not perceive "lack of a common language" as an influential source of communication problems. What is more, for many doctors, at least as salient factors as language are the lack of time they can spend talking with patients and the inability of patients to comprehend the information they have been given.

### 5.3. Solutions to communication problems tried by doctors: Frequency and satisfaction

When faced with patients who did not know Turkish, doctors had various options. At the time the survey was conducted, using an in-house or freelance professional face-to-face interpreter was not one of them. Questions sought to ascertain which solutions doctors tended to choose and how satisfied they were with their choices:

How frequently do you use the strategies described below to deal with the communication problem that may emerge when a patient does not appear to speak Turkish?



	Never or almost never	Rarely	Sometimes	Often	Always or almost always
I persist in trying to communicate with the patient in Turkish.	18 (56%)	8 (25%)	1 (3%)	5 (16%)	0 (0%)
If I speak the patient's first language, I start speaking in that language.	10 (31%)	2 (6%)	5 (16%)	8 (25%)	7 (22%)
I try to conduct the conversation in Kurmandji with the help of the <i>Kürtçe Anamnez</i> (2009) book.	<b>30 (94%)</b>	1 (3%)	0 (0%)	1 (3%)	0 (0%)
I use the Ministry of Health's 'Interpreting Line for International Patients'	<b>31 (97%)</b>	0 (0%)	1 (3%)	0 (0%)	0 (0%)
I ask a member of staff who speaks the patient's first language to function as an interpreter.	1 (3%)	3 (9%)	5 (16%)	<b>13 (41%)</b>	<b>10 (31%)</b>
If the patient has a companion with them, I ask the companion to function as an interpreter.	0 (0%)	3 (9%)	3 (9%)	<b>12 (38%)</b>	<b>14 (44%)</b>
I send the patient to a colleague of mine who I believe can communicate more effectively with them.	<b>23 (72%)</b>	<b>9 (28%)</b>	0 (0%)	0 (0%)	0 (0%)

**Table 2.** Frequency with which doctors faced with communication problems resort to certain language solutions

As indicated by previous research, while some doctors make use of their knowledge of the patient's language if they possess that, others frequently draw on non-professional interpreters. Like the interviewees in the DiTAM survey (2012, p. 18), my respondents appeared to deploy companions of the patient slightly more than they did medical personnel. Unlike the participants in the previous surveys, the doctors who completed my questionnaire were also requested to reflect on the effectiveness of the various communication solutions. One question asked them to rate the success of numerous solutions on a 5-point Likert-scale. With respect to non-professional interpreting, 79% of respondents described this choice of strategy as "Successful" or "Very successful" when the interpreter was another healthcare worker, with slightly fewer (75%) expressing some degree of satisfaction with the use of a patient-companion. Strangely, these results contradict the responses to two other multiple-choice questions on satisfaction that only pertained to non-professional interpreting:

How satisfied are you generally with the level of communication in consultations involving an informal interpreter?

Very unsatisfied	8 (25%)
Unsatisfied	8 (25%)
Neither satisfied nor unsatisfied	11 (34%)
Satisfied	5 (16%)
Very satisfied	0 (0%)

How satisfied are you generally with the clinical outcomes from consultations involving an informal interpreter?

Very unsatisfied	4 (13%)
Unsatisfied	12 (38%)
Neither satisfied nor unsatisfied	11 (34%)
Satisfied	5 (16%)
Very satisfied	0 (0%)

In these responses, a much smaller proportion of the respondents expressed satisfaction with the outcomes of non-professional interpretation: only five (16%) doctors stated that they were content to some degree with the communication and clinical outcomes enabled by non-professional interpreting, whereas half of the doctors expressed some degree of dissatisfaction.

#### 5.4. Negative consequences of non-professional interpreting

The responses to open-ended questions about the negative and positive consequences of non-professional interpreting appear to corroborate the finding from the Likert-scale questions just mentioned, namely that respondents are inclined to have a negative view of this form of interpreting. The answers to the questions “What negative outcomes do you think result from the use of informal interpreters?” and “What positive outcomes do you think result from the use of informal interpreters?” were analysed using the method explained in Section 4.3. In the first case, the 29 respondents who gave meaningful answers to this question made a total of 73 negative points regarding amateur interpreting, which I subsumed under 42 different themes, which in turn were sorted into 10 theme-clusters (see Table 3). Some doctors, such as this one from Mardin, offered a strikingly long list of objections to informal interpreting: “Violation of patient privacy, not being able to elicit an appropriate answer, communication breakdown, low patient satisfaction, low doctor satisfaction, time loss, anxiety, misunderstandings, etc.”

Thematic cluster	Theme	No. of related points	as % of total points
<b><i>Problems in message transfer</i></b>		<b>23</b>	<b>32%</b>
	Incomplete rendition/ Omission of details	8	11%
	Distortion of message	7	10%
	Primary interlocutor actions	4	5%
<b><i>Consequences for communication</i></b>		<b>12</b>	<b>16%</b>
	Quality of interpreting makes anamnesis / examination impossible or deficient	4	5%
	Communication undermined	3	4%
<b><i>Consequences for doctor-patient relationship and rapport</i></b>		<b>12</b>	<b>16%</b>
	Threat to patient privacy	4	5%
	Doctor-patient relationship undermined	3	4%

	Aggression of patient towards doctor	2	3%
<b>Affective impact on patient</b>		<b>8</b>	<b>11%</b>
	Patient stress / anxiety	3	4%
<b>Medical consequences</b>		<b>7</b>	<b>10%</b>
	Difficulty in identifying medical problem	2	3%
<b>Problems in message reception</b>		<b>3</b>	<b>4%</b>
	Patient's inadequate understanding of treatment	2	3%
<b>Unspecified negative consequences</b>		<b>3</b>	<b>4%</b>
<b>Affective impact on doctor</b>		<b>2</b>	<b>3%</b>
<b>Time-related problems</b>		<b>2</b>	<b>3%</b>
<b>Problem of accessibility to interpreters</b>		<b>1</b>	<b>1%</b>

**Table 3.** Overview analysis of answers to question about negative consequences of non-professional interpreting (only showing themes mentioned twice or more)

By far the most frequently mentioned criticism was that informal interpreters failed to convey information accurately between the patient and the healthcare provider. First of all, non-professional interpreters omitted information (eight instances, 11% of the total number of points), and they also distorted messages (seven, 10%). Four doctors (5%) referred disapprovingly to the phenomenon of non-professional interpreters performing what Meyer terms “primary interlocutor actions” (1998, p. 3), i.e., producing utterances that were not renditions of previous utterances but unsolicited comments or responses to the other interlocutors. Doctors also drew attention to a number of ways in which the presence of an incompetent interpreter undermined communication between themselves and the patient, even making anamnesis entirely or partially impossible.

As common as points about the threat that informal interpreting poses to communication were those about its impact on the doctor-patient relationship. One theme raised on four occasions (5%) was that the presence of an interpreter violated the privacy (*mahremiyet*) of the doctor-patient interaction, which was thought to be particularly problematic where the patient was female and issues under discussion were obstetric or gynaecological. Particularly striking was the claim made twice (3%) that poor communication between the healthcare provider and the patient as a result of incompetent interpreting can make the patient aggressive or even violent towards the doctor. This frustration finds poignant expression in a quotation from an ENT-specialist:

Miscommunication makes treatment less effective. Because you can't inform the patient thoroughly about their illness or the treatment process, the patient might have unrealistic expectations or be anxious. When you warn the patient about a possible complication but the person interpreting doesn't convey this, the patient may react in a much more animated, even aggressive way than would have been the case if (s)he had been informed. The lack of communication between us precipitates hatred and confusion.

### 5.5. Positive consequences of non-professional interpreting

The responses to the question about positive outcomes were more limited in number and range. Doctors made a total of 32 positive points about the use of informal interpreting, far fewer than the 73 negative observations. While these points can be categorised into 17 different themes and eight thematic categories (see Table 4), slightly less than half of them, i.e., 15 (47%) fall into the cluster “Minimal benefit”. They include expressions like “It’s better than nothing” and “Something can get done”.

Thematic cluster	Theme	No. of related points	as % of total points
<b><i>Minimal benefit</i></b>		<b>15</b>	<b>47%</b>
	“Better than nothing”	6	19%
	“Something can get done”	5	16%
	No other option	4	13%
<b><i>Communication enabled</i></b>		<b>5</b>	<b>16%</b>
<b><i>Improved rapport &amp; relationship between doctor and patient</i></b>		<b>5</b>	<b>16%</b>
	Patient feels more secure and at ease when the interpreter is family member	2	6%
<b><i>Patient autonomy</i></b>		<b>2</b>	<b>6%</b>
<b><i>Timing</i></b>		<b>2</b>	<b>6%</b>
<b><i>Accessibility of interpreters</i></b>		<b>1</b>	<b>3%</b>
<b><i>Message transfer</i></b>		<b>1</b>	<b>3%</b>

**Table 4.** Overview analysis of answers to question about positive consequences of non-professional interpreting (only showing themes mentioned twice or more)

The joint-second most populous cluster included two (6%) utterances indicating that (as far as the doctors in question were concerned) patients perceive non-professional interpreters as familiar and trustworthy. Their mediation appears to relax the patient, enables more information to be conveyed and helps the doctor to obtain patient compliance. As the ENT-specialist put it,

Since everyone in this region is either related to, or a friend of, one another, the fact that it’s my secretary doing the interpreting inspires trust. When someone is interpreting for their own child, neighbour or spouse, they tend to defend or support the treatment you’re recommending or the things you’re saying, out of a sense of responsibility I suppose. This is more convincing for the patient. Even if professional interpreters were available, I would still prefer the husband of my patient to translate for her. They don’t trust me, I’m a stranger, but they do trust their husbands.

### 5.6. Doctors' views on solutions to the medical communication problem

The final Likert-scale question in the survey elicited doctors' assessments of various measures that could be taken to improve communication between non-Turkish-native-speaker patients and their healthcare providers:

To what extent do you agree with the following statements related to possible solutions to the problem of medical communication in Turkey?

	Totally disagree	Somewhat disagree	Neutral	Somewhat agree	Totally agree
1) In areas where local languages other than Turkish are spoken, the state should appoint medical personnel who know these languages	2 (6%)	5 (16%)	2 (6%)	<b>12 (38%)</b>	<b>11 (34%)</b>
2) In areas where local languages other than Turkish are spoken, the state should encourage the medical personnel working there to learn these languages	2 (6%)	9 (28%)	2 (6%)	<b>13 (41%)</b>	6 (19%)
3) In areas where local languages other than Turkish are spoken, the state should employ interpreters in healthcare institutions	0 (0%)	1 (3%)	4 (13%)	<b>14 (44%)</b>	<b>13 (41%)</b>
4) The telephone interpreting service provided by the Ministry of Health should be expanded to include local languages	1 (3%)	0 (0%)	12 (38%)	<b>11 (34%)</b>	8 (25%)
5) The state should publish educational materials on health in local languages other than Turkish	0 (0%)	4 (13%)	4 (13%)	<b>15 (47%)</b>	9 (28%)
6) It should be the patient's responsibility to arrange an interpreter	<b>13 (41%)</b>	6 (19%)	9 (28%)	3 (9%)	1 (3%)
7) It should be the hospital's responsibility to arrange an interpreter	2 (6%)	3 (9%)	7 (22%)	13 (41%)	7 (22%)
8) Patients should be encouraged to communicate using Turkish	9 (28%)	11 (34%)	4 (13%)	6 (19%)	2 (6%)

**Table 5.** Doctors' preferred solutions to the communication problem

While the figures for the "Somewhat agree" and "Totally agree" responses to solutions 1, 2 and 5 can be interpreted as a measure of support for language-concordant healthcare, those for solutions 3 and 4 reflect a positive attitude to organised interpreting services. A quick glance at the numbers and percentages in bold tells us that, as a group, the respondents appear to approve of these to approximately the same degree. What we cannot see from the table is the preferences of individual doctors. However, a cross-check of individual respondents' opinions on 1 and 3 indicates that, with very few exceptions, doctors in favour of language-concordant



care would also welcome the introduction of professional interpreting: of the 23 out of 32 (72%) respondents who opted for either "I agree" or "I strongly agree" with respect to solution 1, no less than 20 (87%) made a similar choice when it came to solution 3.

## 6. Discussion

Many of the findings emerging from this survey will be quite familiar to readers acquainted with the international literature on non-professional interpreting in healthcare settings; others will be more eye-opening. One familiar feature is the prevalence of *ad hoc* interpreting in medical settings. Most of the literature on this subject derives from wealthier Western nations and furnishes evidence of the use of non-professional interpreting there too, even when formal interpreting services are available, free and prescribed by legislation. The current study is one of few to look at the situation in an economically less-developed country where there is no or little infrastructure for the formal provision of interpreting (cf. Lang, 1976 on Papua New Guinea; Ticca, 2017 on Mexico).

Another, somewhat predictable finding is doctors' dissatisfaction with the quality of informal interpreters' performance. As we have seen, doctors were particularly critical of the semantic omissions and distortions committed by interpreters. Their responses also corroborate the claim made in the literature (e.g., Meyer, 1998) that non-professional interpreters are especially likely to slip into the role of primary interlocutors. In a Likert-scale question that elicited doctors' views on the frequency with which interpreters performed the five kinds of translation 'errors' pinpointed by Flores *et al.*, 2003, no less than 50% (16) of doctors said that, when addressing the doctor, informal interpreters frequently, always or almost always added their opinions to those expressed by the patient.

A further question in which the problem of interpreter quality surfaced was when respondents were asked to give an example of when they had experienced difficulties due to the use of an amateur interpreter. An emergency physician in the city of Batman offered the following striking anecdote:

An old woman came to A & E. For about 2 minutes she talked about her complaints. I know some Kurdish, that is, I can understand a bit though I can't speak it. The interpreter started to interpret, saying "There's nothing wrong with mum; she's fed up. Just give her an injection and she'll be fine." I scolded the interpreter and dealt with the complaints one by one. The results showed that she had pulmonary edema caused by heart failure and she had to stay in intensive care for around five days.

This example is a stark reminder of how an *ad hoc* interpreter's familiarity with a patient may prove a disadvantage. On the basis of a comparative study of professional and family interpreters in Montreal, Rosenberg, Seller & Leanza (2008, p. 92) argue that

Family interpreters represent a distinct sub-group of 'ad hoc' or lay interpreters. They have privileged access to patient health information. As such they can be invaluable healthcare partners and they are less likely to commit the translation errors made by untrained hospital volunteers

In the Batman example, the son is anything but a reliable source of information and his rendition is evidently not devoid of "translation errors". One can only speculate as to the background to this behaviour, but one possibility is that the mother is something of a hypochondriac and regularly takes her son (whom she may well live with) with her to the hospital to interpret, a situation that frustrates the son. If this interpreter were more patient, had a better grasp of bodily and medical issues and appreciated that his role was to enable a thorough and frank exchange of messages between the doctor and the patient, his familiarity with the

patient and his knowledge about her “natural setting” (cf. Rosenberg, Leanza & Seller, 2007, p. 290) might turn out to be benefits. This anecdote, however, epitomises the risks involved in non-professional interpretation by a family member; if the doctor had not known any Kurdish and had been guided by the interpreter’s recommendation alone, the consequences could have been fatal.

That said, the responses to the question on positive consequences of informal interpreting revealed that some doctors felt that *ad hoc* interpreters who were family members could improve the rapport between the doctor and the patient. Indeed, one ophthalmologist made a thought-provoking observation, which I have not encountered elsewhere in the literature, about the advantages offered by different sub-types of informal interpreters: while family interpreters enabled more effective communication and thus greater patient compliance, the use of ancillary staff increased the likelihood of information being conveyed accurately. According to this and other doctors, family interpreters helped create an atmosphere of trust (cf. Edwards, Temple & Alexander, 2005), put patients at ease, emphasised the importance of the information the doctor was providing and tried to persuade the patient that the treatment or procedure being prescribed by the physician was necessary and beneficial. Informal interpreters who act this way could be said to be performing the role of health system agents (Leanza, 2005).

When it comes to the theme of privacy, the opinions emerging from this study both converge with, and diverge from, those presented in other studies of informal interpreting. As we have seen, in the question about negative consequences of the use of interpreters, several doctors referred to the threat to privacy. In three other questions, doctors were asked to mark on a Likert scale from 1 to 5 how much impact they believed certain factors had in engendering negative outcomes in interpreted doctor-patient meetings. With respect to the factor “The interpreter not feeling comfortable talking about intimate matters”, 47% of doctors (15) gave this the maximum salience rating of 5, this being the highest number to choose “5” for any of the six factors related to the position of the interpreter. Likewise, more doctors selected “5” for the factor “The patient being reticent about discussing intimate matters in the presence of an interpreter”—13 (41%)—than they did for any of the other five patient-related factors.

In countries with a stronger tradition of community interpreting governed by professional and ethical norms, we generally encounter a differentiated approach on the matter of privacy. While healthcare professionals acknowledge the risk in using *ad hoc* interpreters, professional interpretation tends to be seen as an acceptable communication solution in situations involving sensitive matter. For example, having conducted interviews with physicians in the USA, Rosenberg *et al.* (2007) conclude that “Many physicians believed that patients were prepared to disclose aspects of their life to professional interpreters (obliged to maintain confidentiality) that they were reluctant to reveal to a family member”, although they add the caveat that in cases where the patient is a member of a very small community, he/she may prefer to divulge health information to a relative than to a professional interpreter (p. 289).

In my Eastern Turkish survey, several doctors stated that they felt the presence of informal interpreters inhibited patients from speaking about sensitive matters. However, some of them went further and generalised that any form of interpreting undermined the intimacy of the doctor-patient interaction. This resembles the discourse of those individuals and organisations in Eastern Turkey who have tried to promote language-concordant healthcare as the optimal solution. Introducing the book *Kürtçe Anamnez* (Anamnesis in Kurdish) to the press, for example, the then chair of the Diyarbakır Chamber of Medicine stated that the Chamber’s aim in publishing it was to dispense with the use of interpreters, which compromised patient privacy (Hekimlere Kürtçe kitap dağıtıldı, 2009). Such a view may well be motivated by the

political agenda of enabling local languages (especially Kurdish) to attain parity with Turkish, so that language-concordant care would become the norm and interpreters would be redundant. However, it is also feasible that healthcare professionals who have never witnessed interpreting done by professionals associate their experience of non-professional interpreting with interpreting in general, which they therefore come to regard as problematic.

That said, the responses to the Likert-scale question about possible solutions to the communication problem give the impression that most respondents are not opposed to interpreting on principal or see language-concordant healthcare as the only path to be followed. We will recall that the overwhelming majority of doctors who said they would welcome the appointment of personnel who spoke local languages or the introduction of language courses for newly-arrived staff also supported the employment of in-house interpreters. In short, most of the respondents appear to be pragmatic professionals who are open to a range of policies that could overcome the current situation, with its reliance on unsatisfactory *ad hoc* remedies.

## 7. Conclusion

This article has offered an insight into the rarely-documented reality of non-professional healthcare interpreting in Eastern Turkey, with an emphasis on doctors' perceptions of the positive and negative consequences of the use of *ad hoc* interpreters. The results of the survey have alerted me to two flaws that would need to be avoided if the study were replicated. For one thing, the low response rate suggests that an online survey may be an unreliable method for reaching a large sample, particularly when the population in question consists of very busy professionals. A preferable alternative would be to conduct the survey on site, either orally or by requesting doctors to complete a paper-version themselves. Secondly, although Likert scales typically contain a "Neutral" or "Indifferent" option, the existence of this option was arguably to the detriment of my survey; in view of the large number of single- or multiple-part questions in which the "Neutral" answer was the most popular response—23 out of 69 questions and question-items, i.e., one third—, the possibility emerges that answers like "Neither agree nor disagree" or "Sometimes" were seen as easy choices (Maitland, 2009, p. 2), sparing doctors the effort of reflecting on their experiences and attitudes, which could have compelled them to select either a positive or negative response, thus yielding less equivocal data.

Much has changed since 2014 in Eastern Turkey, and the broader context within which interactions take place there between Turkish-speaking healthcare providers and speakers of other languages is not what it was. On the one hand, the increased arrival of Syrian refugees has altered the linguistic and cultural composition of some cities and regions, heightening the potential for language mismatch between healthcare providers and patients. With backing from international organisations, the Turkish Ministry of Health has taken steps to provide Turkish-Arabic interpreting services, performed by employees trained for that purpose, as well as offering language-concordant health care. The situation with respect to Kurdish-speakers, however, appears not to have undergone such a positive transformation. As of the summer of 2015, in response to a resumption of attacks by the PKK on the Turkish armed forces, the Turkish government shelved its earlier more liberal stance and policies with respect to the Kurdish question. As far as I have been able to ascertain, it has not itself taken any more measures to overcome communication problems involving Kurdish in the healthcare sector, and it has certainly abandoned the *laissez faire* approach it followed between 2009 and 2015, from which the advocates of language-concordant healthcare benefited. Given these shifting circumstances, it would be interesting, if permitted, to rerun the survey, drawing on the meth-

odological lessons I have learned from the initial survey. Whatever its findings, a renewed survey, like the old one, would be certain to confirm the validity of Angelelli's simple but very salient claim that "the practice of interpreting is socially situated" (2004, p. 24).

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