Introduction

During the fall that we were reviewing and editing this volume, Melanie's seven-year-old daughter Bonnie Rose ended up in the emergency room late at night, the evening before the American Thanksgiving holiday. Bonnie Rose had been suffering from a cold and cough, and woke up at 10:00 P.M. unable to stop coughing, and unable, really, to breathe. Concerned that she might have pneumonia, Melanie and her husband called their pediatrician, who recommended an immediate visit to an urgent care clinic for a chest x-ray. In route from the car, they called to request an appointment, only to discover they were being re-routed to the hospital for emergency room care.

In the emergency room they were fortunate—the waiting room was not crowded and there were intake and insurance experts available to acquire the needed legal information, medical history, and to check Bonnie Rose's pulse oxgen level (which was very low) simultaneously. Within the next three hours, their young daughter had blood tests, chest x-rays, nebulizer treatments, IV fluids, and was diagnosed as having not only walking pneumonia, but also her first-ever asthmatic reaction as well. After some discussion about antibiotics and related medications, they were sent home at 2:00 A.M. with prescriptions, medications, and instructions to address both their daugher's diagnosed problems.

Across North America, this type of medical experience is relatively common for many families, though the age, gender, and diagnoses of the patient vary greatly. Navigating the complex tapestry of healthcare professionals via a home phone, cell phone while driving, and face-to-face in the emergency room, while experiencing the emotional distress of having a loved one struggling with her health, raises a number of communicative challenges. All the factors that impact people's ability to coconstruct meaningful discourse, including gender, education, regional variation in language, conversational style, and so forth, are at play as always, but within a context of increased risk and tension. In the situation above, all the participants shared a common language. Added complexities are faced when healthcare interactions are mediated through an interpreter and a new set of issues comes into play with the discourse.

Early studies of doctor-patient discourse focused on a variety of issues, including the complex process of eliciting adequate medical history to accurately diagnose a patient (Shuy, 1972, 1976, 1983). Research that examined the discourse of medical interviews (even without the stress of emergency care) identified numerous problems including language use differences, cultural differences, and divergent goals between doctors and patients. Further, healthcare providers often use medical jargon and specialized vocabulary that created challenges for patients' comprehension, despite sharing a common language (Shuy, 1972, 1976, 1979, 1983; Ford, 1976; Fisher, 1983).

Research also revealed that doctor-patient communication was hampered by different backgrounds, lifestyles, and world experiences (Cicourel, 1983; Mishler, 1984; Tannen & Wallat, 1983, 1993). Moreover, studies pointed out that the communication situation itself occurs in a place and with topics very familiar to the healthcare practitioner (e.g., the environment, the symptoms, and health issues), whereas the patient is often in a weakened state, in an unfamiliar place, and facing decisions that could impact their life routines or even whether they will live or die (Bonanno, 1995; Fisher, 1983).

The critical importance of successful healthcare interaction, as well as the implications should communication go awry, may well account for its ongoing study, even in communicative events that take place with a shared language. Studies continue to this day, focused on the complex communication that occurs in monolingual healthcare situations, updating earlier findings and examining the more current uses of eHealth technology, including doctor-patient communication via electronic messaging (see, for example, Leong et al., 2005; Wallwiener et al., 2009).

Given the documented challenges faced by healthcare practitioners and patients, it is not surprising that a growing body of evidence-based research focuses on bilingual or multilingual healthcare contexts, and issues of accessibility and communication when healthcare is mediated through interpreters. As Pöchhacker and Shlesinger's (2007) volume on discourse-based research in healthcare interpreting brings to light, the issues faced by interpreters, patients, and healthcare providers include not only the communication issues common in a monolingual healthcare discourse encounter, but also interpreters' performance standards and issues related to the participation framework and alignment of participants in medical encounters.

The current volume is intended to add to the dialogue about medical interpreting by providing evidence-based studies of interpreted health care on several critical issues. In Chapter 1, Angelelli reports on an ethnographic examination of the coconstruction of understanding between Spanish-speaking healthcare patients and English-speaking healthcare providers in a public hospital in California, in the United States. Her study has practical and theoretical implications for interpreting studies in general and for the education of healthcare interpreters and healthcare providers in particular.

Extending previous studies that suggest the importance of an interpreter's interactional skills for accurate communication in medical settings, Major's study in c Chapter 2 examines interpreters' requests for clarification, and their interpretation of requests for clarification by the interlocutors.

Based on 15 years of data and the growing literature on bilingual health communication, Hsieh provides a description of emerging trends on interpreter-mediated healthcare in Chapter 3. Her chapter focuses on four trends: (a) recognizing interpreters as active participants in medical encounters, (b) examining medical interpreting as a coordinated accomplishment, (c) identifying the complexity of clinical demands, and (d) exploring contextual factors in bilingual health care.

Swabey, Nicodemus, and Moreland look at deaf bilingual physicians discourse in Chapter 4. This investigation focuses on how typical medical questions are translated into ASL, while also providing an overview of the current state of ASL-English healthcare interpreting. The authors examine the linguistic challenges in creating ASL translations of common medical interview questions, provide descriptions and samples of the ASL translations, and discuss patterns in the data as a step toward the ultimate goal of improving healthcare communication for deaf patients.

In Chapter 5, Brueck, Rode, Hessmann, Meinicke, Unruh, and Bergmann offer insights of five practicing signed language interpreters into the conditions and factors that characterize medical interpreting in Austria and Germany. One hundred and forty two healthcare assignments, delivered by the five interpreters in 2012, were documented and analyzed. After considering general challenges offered by the medical setting and outlining field-specific conditions in the two countries, recurrent features of medical encounters between deaf patients and hearing doctors that involve a signed language interpreter are discussed in detail with reference to the data.

Leeson, Sheikh, Rozanes, Grehan and Matthews' work on healthcare interpreting stems from cooperation in a European Commission funded project called Medisigns (2010–2012), and is addressed in Chapter 6.

Medisigns is an award-winning project that represents a ground-breaking initiative focused on providing a better understanding of the impact that interpreted interaction in medical contexts within the framework of a blended learning program for deaf people, interpreters, and those in the medical profession.

Driven by studies that document miscommunication and misunderstandings among monolingual healthcare patients and practitioners, and given that Deaf patients often lack access to healthcare information in an accessible form, In Chapter 7, Napier and Sabolcec report on a qualitative examination of access to healthcare information for deaf people in Australia.

In Chapter 8, Smeijers, van den Bogaerde, Ens-Dokkum, and Oudesluys-Murphy introduce guidelines for adapting internationally validated questionnaires found in specialized psychological and psychiatric health care and translating them into Sign Language of the Netherlands (*Nederlandse Gebarentaal*, NGT). The authors describe the selection and translation process of research instruments for use with deaf and hard of hearing individuals. The problems, dilemmas and ethical issues encountered are also discussed.

In Austria, amid a persistent lack of policy on reliable communication support services for patients with an insufficient command of German, an initiative was taken to jump-start professional interpreting service provision by harnessing videoconferencing technology. In Chapter 9, Pöchhacker describes and analyzes a field test carried out in preparation for a pilot project on video interpreting for Austrian healthcare institutions. The discussion of the field test data links up various dimensions, highlighting how social forces such as public and professional attitudes and policy considerations are as critical to successful project implementation as human and technological resources.

In Chapter 10, in an exploratory study, van den Bogaerde and de Lange, questioned deaf clients (*n*=276) as well as medical healthcare workers (*n*=445) about their experiences about accessibility of healthcare for patients. The authors also present the results for a subgroup of eight sign language interpreters (SLIs) and four deaf communication experts that were involved in the survey and relate their results to the answers provided by deaf clients and hearing medical professionals. Their results indicate a discrepancy between groups, and therefore add support to previous calls for deaf awareness training for hearing healthcare staff as a necessary part of accessibility.

Our hope for the current volume is to bring together these empirical studies of healthcare interpretation in deaf and hearing bilingual or multilingual encounters that incorporate interpreters, to address the ongoing issues faced by all of us as we negotiate the complexities of communication in healthcare settings.

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