Interpreting beyond words: The impact of nonverbal communication on healthcare interpreting standards

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The present paper seeks to underscore the importance of nonverbal cues in the interpreting processes occurring in healthcare settings and to investigate how these are addressed in a sample of guidelines for actual practice. Given the relevance of nonverbal elements in most types of oral communication and the significance of language, paralanguage, and kinesics in face-to-face mediated interactions, it is necessary for interpreters to have or gain solid knowledge on nonverbal cues so that they can be capable of identifying and handling them effectively. In this vein, both medical interpreting standards and working with interpreters' guidelines tend to address several issues intrinsically related to nonverbal language. However, it is still difficult to find a specific and detailed section that strictly focuses on the relevance of nonverbal communication in these sorts of interactions. In order to delve into the latter assertion, this paper conducts a comparative analysis of different manuals on healthcare interpreting that encompasses several phases: studying their approach to a series of specific nonverbal cues, pinpointing their strengths and weaknesses in this regard, expanding on those aspects that need further exploration, and finally, laying out a list of suggestions that may help improve interpreters' overall performance in healthcare settings by honing their skills for dealing with nonverbal language.

Keywords : intercultural communication, healthcare interpreting, nonverbal communication, interpreting standards of practice, interpreters' performance

1. Introduction

Despite certain persistence to treat verbal and nonverbal communication as distinct, separable aspects, research has thoroughly proven this separation as misleading and obsolete (LeBaron, Mandelbaum, and Glenn, 2003). Furthermore, several studies defend that 70% of our communication is nonverbal (Qureshi, Revollo, Collazos, Würth, and el Harrak, 2009), giving these elements an undeniable weight in any kind of face-to-face interaction. Obviously, interpreting processes do not escape this rule, but quite the contrary: bilingual mediated interactions draw a more complex scenario, since the meaning of nonverbal cues changes across cultures (Qureshi, 2009) and the interpreter should thus be the link that decodes their meaning appropriately (Qureshi, 2009). The importance of this task may be even bigger in contexts such as medical settings where people's health is the issue at stake and, accordingly, a good, efficient communication between patient and provider is essential for a satisfying outcome (Trummer, Mueller, Nowak, Stidl, and Pelikan, 2006; Street, Makoul, Arora, and Epstein, 2009).

Many works have already studied the relevance of nonverbal elements in healthcare communication. In this vein, we can easily find evolving and relevant bibliography approaching these issues in different manners. From groundbreaking studies such as Rosenthal, Hall, DiMatteo, Rogers, and Archer's (1979) to reference materials for professionals like Silvermans, Kurt, and Draper's (2005) through papers like de Castro's and da Silva's (2001), Preston's (2005), or D'Agostino's (2014), several authors have tackled and discussed the relevance of nonverbal cues in healthcare face-to-face interactions. However, the situation is significantly different when it comes to connect these elements to the actual practice of interpreting in medical settings.

Implementing all these elements in a triadic face-to-face interaction is not an easy task: it requires specific abilities and a particular approach to healthcare interpreting. In this regard, researchers like Angelelli, Davidson, and Clifford (as cited in Jacobson, 2009: 54) or the group formed by Miletic, Piu, Minas, Stankovska, Stolk, and Kimidis (2006) advocated the need to include interactional competence in the

interpreting process, portraying the inadequacy of word-for- word interpreting when the objective is (or at least should be) rendering the message including all its nuances of meaning.

These and other authors have already created a scarce albeit solid literature connecting interpreting in healthcare settings and nonverbal cues. Besides the abovementioned works, other examples range from overall approaches such as Poyatos' (1997) almost seminal work to research aimed at specific contexts such as mental health (Bot, 2005). In addition, books like Angelleli's (2004) or Riggio and Feldman's (2005) devoted some of their chapters to approach nonverbal communication in healthcare mediated interactions, whereas papers such as Hsieh and Nicodemus' (2015) focused on how interpreters tackle specific nonverbal cues as, in this particular example, emotions. However, although the aforementioned works have created a sound basis defending the implementation of elements beyond mere words in the interpreter's task in healthcare settings, the actual amount of research should still be extended in order to cement the importance of nonverbal aspects in interpreter-mediated interactions in these contexts.

Using some of the works cited in previous paragraphs as the main theoretical grounds, I decided to undertake a comparative content analysis of three manuals addressed to healthcare interpreters: Working with Interpreters: Guidelines (Queensland Health, 2007), the *Medical Interpreting Standards of Practice* (IMIA, 2007), and the *National Standard Guide for Community Interpreting Services* (Healthcare Interpretation Network, 2007). This analysis is aimed at contributing to widen the bibliography described before and also at achieving the goals described in the following section.

2. Objectives

As the following pages will corroborate, healthcare interpreting standards are neither "blind nor deaf" to the importance of nonverbal communication, and they do take into consideration other elements beyond mere words. However, these features

should be analyzed in greater depth for a subsequent implementation of increasingly improved suggestions and guidelines (Jacobson, 2009). In this vein, this paper will investigate whether the importance of non-verbal communication in healthcare interpreting is appropriately addressed in a sample of manuals and standards of practice.

For this purpose, the three manuals introduced in the preceding section will be contrasted so as to reach several objectives. The following list presents the two main purposes of this work together with the secondary aims that stem from the first one:

1) To determine how nonverbal communication is reflected in different manuals addressed to healthcare interpreters, to check whether they take interactional competence into consideration or not and, in the latter case, to examine to what extent they do so.

In order to achieve this primary goal, it will be necessary to assess the approach of the manuals to a series of specific nonverbal communication cues in order to explore which ones are properly addressed, which ones are tackled superficially, and which ones are overlooked outright.

2) To provide some suggestions and guidelines that may help healthcare interpreters deal with nonverbal elements during their task.

3. Methodology

The present project combines different types of analyses that divide the paper into three main stages. During the first one, a comparative content analysis of some of the most relevant manuals related to interpreting in healthcare settings was conducted. In order to do so, different standards of practice and working-with-interpreters' guidelines within this field were consulted. Given their leading role in healthcare interpreting services, the focus was put on selecting manuals from Australia, the United States, and Canada. After considering different options, the manuals chosen were:

1) IMIA's (2007) *Medical Interpreting Standards* of Practice. One of the most renowned manuals worldwide, IMIA's standards of practice are probably amongst the most thorough approaches to interpreting in healthcare services. It was one of the first manuals to be developed addressing language interpreting in healthcare settings. Nowadays, it remains a reference in United States medical institutions, and its popularity has turned this guide into a landmark used as training bases beyond the US for establishing the competence of interpreters working in this context.
2) Queensland Health's (2007) *Working with Interpreters: Guidelines.* A guide including suggestions for an effective coordination between interpreters and providers, aimed at improving the dynamics of interpreter-mediated interactions and the information obtained in this sort of dialogue. Issued in one of Australia's larger states, the selection of this manual is aimed at including a relevant guide which combines interpreter's potential performance with the viewpoint of healthcare professionals. This manual complies with the requirements established by the Australian Institute of Interpreters and Translators (AUSIT) regarding conduct, privacy, and confidentiality.
3) *National Standard Guide for Community Interpreting Services*[1] by the Healthcare Interpretation Network (2007). A national manual which spans the most relevant guidelines used in dialogue-like mediated interactions in Canada. It is built on the opinions and contributions of several professional organizations, and contrary to the Canadian trend of establishing regional standards, it is aimed at being used and distributed nationwide. In addition, it seeks to boost interpreters' recognition and professionalization while, at the same time, tries to raise awareness among the general public of interpreters' tasks and duties.

Beyond their relevance, their focus on healthcare interpreting, and the necessary approach to nonverbal communicative features that, to a greater or lesser extent, they all share, selecting these manuals instead of other alternatives serves a further purpose: it allowed me to compare suggestions and guidelines from different

1) In order to avoid redundancies, manuals will be hereafter referred as manuals 1, 2, and 3.

countries with strong interpreting networks. In this regard, Australia, Canada and the United States (the regions were these guides were originally edited and published) were, together with the United Kingdom, pioneers in cementing the role of the interpreter within their Public Services system, a long tradition that makes them a reference for latecomer countries (Navaza, Estévez, and Serrano, 2009).

In this vein, the solid training programs for interpreters offered in these countries are another reason to validate the choice. Australia, for example, is one of the most advanced regions in this regard. In Australia, community interpreting (and consequently, healthcare interpreting as well) was established in the mid-1970s to give response to an increasing multicultural society (Hlavac, 2016). This initiative paved the way for Australia's most distinctive feature: the National Accreditation Authority for Translators and Interpreters (NAATI), created in 1977 (Hlavac, 2016). The creation of this system was later reinforced by the founding of the Australian Institute of Interpreters and Translators (Valero, 2014). In parallel, university programs bloomed during the 80s, faded in the 90s (Valero, 2014), and regained their strength afterwards via institutions as the Middlebury Institute of International Studies at Monterrey or the Western Sydney University. Nowadays, the strongest interpreting courses of tertiary education coexist with private initiatives from different agencies aimed at covering the linguistic needs of citizens in public institutions, including healthcare services (Valero, 2014).

In the United States, interpreting began with sign language interpreters back in the mid-1960s, but it soon expanded to other fields (Mikkelson, 2014). Healthcare interpreting bloomed in the 1990s and solidified in the 21st century with the demographic trends and legal pressure that "forced" the country into implementing linguistic services in every hospital (Roat and Crezee, 2015). To ensure the quality of these services, the National Council on Interpreting in Healthcare established a tough list of standards connected to items such as accuracy, privacy, or cultural awareness (NCIHC, 2005) that every medical interpreter must meet (Mikkelson, 2016). In order to achieve this level, interpreters could be trained at several universities or via different agencies and organizations such as the American Translators Association or the International Medical Interpreters Associations

(Mikkelson, 2016). All these elements combined have created a strong healthcare interpreting system in most regions of the country that has Spanish as its most notable second language.

Finally, Canada's case is slightly different. In this country, accreditation programs are mainly organized at a regional level (Valero, 2014). Thus, regions can establish different criteria according to their needs. Training programs are galvanized and promoted by local entities, but also by universities with interpreting degrees and even translation and interpreting schools such as those at the University of Ottawa and at the University of Vancouver. Healthcare interpreting occupies a prominent place in these programs, since most Canadian hospitals offer language and interpreting services (Valero, 2014) and professional Canadian interpreters should be solidly qualified to cover these needs.

Considering the aforementioned data, it seemed relevant to focus the analysis on a sample of standards of practice coming from three pioneering countries with an overarching approach to interpreters' training both in general and specific fields like the one at the focal point of this paper.

Once the corpus was delimited to the three manuals described above, the next stage of this undertaking was conducting a comparative content analysis of the selected corpus. In this vein, a qualitative analysis was conducted in several stages. The process started with a close reading of the manuals selected: during this stage, each reference to paralanguage and nonverbal communication was marked on a printout of the manuals. The underlined segments were assessed in order to determine their thoroughness and identify their strengths and weaknesses (if present) afterwards. Subsequently, all references to nonverbal communication included in the manuals (body language, eye contact, spatial arrangements, voice features) were listed.

A review of relevant literature related to nonverbal communication as a whole and to its influence/use in healthcare settings followed these stages. This step helped in identifying some critical elements that were not present in the analyzed texts. Consequently, the discussion crafted after perusing the corpus was divided into two sections: elements included in the manuals and elements missing in the manuals.

The first section aims to describe the manner in which these documents address nonverbal communication in healthcare interpreting in order to determine its appropriateness and highlight its flaws if necessary. The second part of this analysis focuses on nonverbal cues that the three manuals fail to include in spite of their undeniable potential impact on a triadic dialogue. In this vein, further nonverbal elements and their relevance for communication are explained.

The final section of the project takes a normative approach which intends to suggest a list of guidelines with the purpose of improving the current state of affairs and the insufficient emphasis on the importance of nonverbal cues spotted in the three manuals analyzed. In this regard, the problems underscored and itemized during the analytical stage led to a thorough research on academic works that zeroed in on the relationship between nonverbal communication and interpreting. This process seeks to find and put forward several solutions that may give an appropriate response to the difficulties of including definite nonverbal cues in the interpreting process, while they also emphasize the benefits of conveying such aspects during interpreter-mediated interactions occurring in healthcare settings.

4. Nonverbal elements included in the manuals

4.1. Seating configuration and visual contact

These first two points are intrinsically interrelated. Both visual contact and seating configuration are primary elements in all manuals, and the guidelines suggested mostly concur. In this regard, manuals 1, 2 and 3 encourage direct communication between both parties while they recommend interpreters to I) pay attention to interactants' body language and gestures and II) convey the meaning of such cues appropriately. In line with the above, manuals 1 (: 23) and 2 (: 18) advocate that the ideal arrangement is the one where interpreters are able to see both patient and provider whereas they can also be seen and heard by interactants as well.

However, a problem arises when defining a specific seating structure since, although appropriate and effective in principle, the measures proposed so far open different possibilities. For instance, manual number 2 (: 14) suggests several viable arrangements but emphasizes two as the most appropriate ones (: 18):

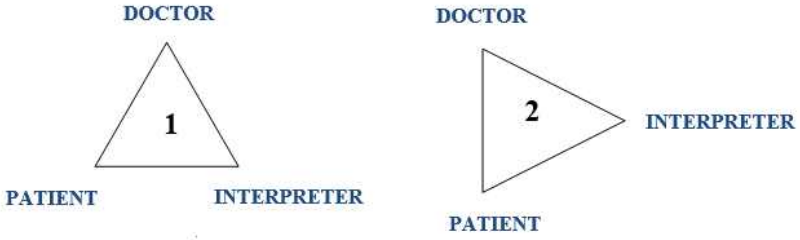

Figure 1. Seating arrangements

Even if they look rather alike, the implications that stem from each arrangement vary, and so does its effectiveness. In this regard, the first configuration entails a potential loss of the nuances conveyed through gestures, since the interpreter only has a partial vision of the patient. Therefore, according to the arguments introduced hitherto, option 2 would be the one meeting most communication requirements, for it allows interpreters to observe both parties properly and subsequently decode and render the meaning of the body language and gestures they make. In addition, it would be advisable for interpreters to encourage the other interactants to establish eye contact between them, trying to obviate the presence of a third party: thus, they may foster direct communication among patient and provider, and prevent some of the problems derived from those interpreters' practices a layperson may consider strange or unexpected (Hsieh, 2006).

In short, it is not seeing both parties but seeing them in a way that allows the interpreter to perceive their nonverbal messages completely that matters. In accordance, we may infer that, considering its impact on several angles of communication and interpreting processes, more specific guidelines regarding seating arrangements would help to enhance interpreters' performance. For instance, together with a less

ambiguous explanation such as the one presented in the previous paragraph, other situations with different dynamics (e.g., positioning during a physical examination) should have been additionally addressed to cover a wider range of scenarios.

4.2 Personal voice features

Nonverbal communication goes way beyond gestures since it includes many other elements such as voice adaptors and modifiers, manners, turn-change behaviors, acoustic and visual pauses, etcetera (Poyatos, 2002a; Poyatos 2002b). In accordance with this fact, in the following lines I intend to approach one of its most important branches: personal voice features. According to Poyatos (2002a: 2), "these are the voice characteristics that differentiate individuals", including pitch, timbre, resonance, loudness or rhythm among other features. The manuals here discussed partly reflect their relevance, but they do it in a too general manner while they do not take several key elements into consideration: manual 3 (: 22) only advises interpreters to make sure tone of voice is not lost; manual 2 (: 14) includes a rather similar guideline and recommends them to preserve speakers' tone of voice in order to maintain the emotional nuances of the message; finally manual 1 (: 27) advocates taking voice affect into consideration when transmitting the message. In addition, the same manual highlights the importance of recognizing specific verbalization showing distress, discomfort or lack of understanding.

The problem regarding these guidelines is their vagueness. Concepts such as tone and affect seem to stand for too many features for it is not clear whether they refer us to specific voice characteristics such as intonation range, loudness, pitch and timbre or they intend to bring all these elements together. Besides, it is important to consider other personal voice features beyond tone, since elements such as tempo or syllabic duration among others may have a strong impact on discourse content (Poyatos, 2002a). Focusing on the two aspects mentioned above, syllabic duration may serve very different functions since lengthening or shortening syllables can affect meaning in several ways –e.g., a long "ye-es" expressing reluctance (Poyatos, 2002a: 16-17)–; in the same vein, tempo (a feature related to speech rate)

can be indicative of certain disorders such as a manic episode that makes patients talk very quickly and without stopping (Miletic, Piu, Minas, Stankovska, Stolk, and Kimidis, 2006). Therefore, when interpreters decide to reproduce such elements, they may be reinforcing their impact on discourse while limiting the encoding-decoding problems and the potential loss of meaning nuances so frequently attached to interpreting processes (Poyatos, 1997).

In light of the above and given their influence in aspects that exceed the linguistic field and tally with clinical considerations, it may be advisable to develop additional or more exhaustive guidelines where personal voice features can be thoroughly addressed; awareness of their importance may therefore raise among interpreters and lead to a more accurate performance through the disclosure of chunks of information otherwise undetected.

5. Nonverbal elements missing in the manuals

Nonverbal communication includes so many different features that it would be impossible to address them all in a few pages. In accordance and given their mere guidance purposes, it is perfectly understandable that healthcare interpreting manuals and standards of practice fail to provide a totally comprehensive repertoire of these items and how to handle them during the communicative process. Therefore, the following description of (some) nonverbal missing elements should not be perceived as a critique, but as a reasoned proposal to assist the interpreters' task and provide a series of theoretical grounds to at least gauge the convenience of considering and/or including them in the interpreting process when necessary.

5.1. Hesitations

Hesitations are a relevant element that should be considered in greater depth. This communicative aspect, defined by Leon Rose (1998: 4) as "disfluent features that

slow the transfer of lexicalized information", includes false starts, repetitions, restarts, or filled pauses, among others. In order to respect the content of this paper I intend to focus on the latter, especially on those cases when they are formed by interjections of phonetic combinations[2] (*ah, hum, erm, uh*, and so forth).

Filled pauses —and hesitations in general— may impact communication from several angles (Brennan and Williams, 1995). To begin with, it is pertinent to state that the same verbalization may have different meanings. For example, an expression like *hum*, besides a sign of doubt or uncertainty, could also denote approval, disapproval, interest, curiosity or admiration among others (Poyatos, 2002b). Their importance from a strictly clinical perspective is also remarkable, since filled pauses may be, for instance, an indicative of anxiety (Leon Rose, 1998). In the same way, they may have different implications on upcoming speech, discourse structure, the perception of linguistic material and so forth (Benus, Enos, Hirschberg, and Shriberg, 2006). In accordance, an expression like *all right* preceded by a long uh would not have the same meaning if the phonetic combination were missing (Brennan and Williams, 1995).

The functions of hesitations do not stop here but permeate other conversational aspects such as holding a turn or gaining time for speakers to choose their following words (Jokinen and Allwood, 2010). All things considered, we should assume hesitations play a significant role in determining speakers' communicative intentions and the entire meaning of their discourse, both in general and specific contexts such as healthcare. Therefore, interpreters seeking for a better and more accurate performance should not obviate their presence, pay them due attention and if possible, share their observations and disclose their implications to healthcare professionals in a subsequent meeting.

5.2. Silence and stillness

When applied to discourse dimension, silence and stillness (or lack of response)

2) Filled pauses may also be lexicalized (Leon Rose, 1998, p. 9), but this paper focuses only on nonverbal forms.

could be defined as the absence of sound or movement which entails different communicative meanings / intentions (Poyatos, 2002a). Regarding our current context of study, authors like Rober (2002) stated that the situation is not any different and, in consequence, silence and stillness in healthcare settings may have very diverse meanings as well. The following paragraphs seek to provide an overview of their most common functions so that the reader can grasp the role both elements may play in a mediated face-to-face interaction.

Despite what we may think at first, these elements are not always supplementary facts; sometimes, they can carry the main content of the message whereas the other communicative features act as supporters of meaning (Poyatos, 2002a). Think for a second of a person who is dumbfounded after receiving bad news; in this case, motionless carries most part of the communicative meaning and other discourse features would be accessory.

However, as stated above, this is not the only situation where silence and stillness influence the interaction. On the one hand, they can act as zero signs. This situation implies a lack of response when sound and/or movement is/are expected (Poyatos, 1997; Poyatos, 2002a). It is not difficult to think about some examples fitting this pattern: I) a patient who does not answer a question; this may denote shame, annoyance, doubt...depending on the context; II) several ellipses interspersed within utterances, e.g., "*That may be difficult considering...you know...*" Silence here may be filled in with a piece of information previously mentioned in the conversation or with a chunk of personal knowledge that patient and provider share. Nevertheless, silence in this case could also be a cultural marker or specific cue that may have been understood by the interpreter but not by the practitioner (hence the importance of considering this fact in intercultural communication).

On the other hand, silence and stillness may determine the meaning of previous or following utterances. In this vein, these elements can cause meaning alterations on both previous and upcoming discourse (Poyatos, 2002a); besides, the relevance of such changes may vary, ranging from subtle to relevant connotative differences.

For instance, answers to a common opening-consultation question like "*How are you doing today?*" may provide useful initial information; a response like "*I'm*

doing fine" may not carry the same meaning with or without a previous silence that can enhance or undermine the truthfulness of such a statement and, therefore, give us a clue about the patient's current and real mood; in the same vein, when a rotund "*That's a lie!*" is followed by a long pause, those words continue to have a deep impact on our minds and a greater effect on the listener than if the person had just kept talking (Poyatos, 2002a).

5.3 Body-Adaptors

Defined by Poyatos (2002b: 211) as "those objects and substances attached to the body that carry sociocultural information", these elements may be a good source of useful tips to explain certain patients' behaviors or beliefs. It is not without reason that the same author includes the implications of objects such as clothes, classes, pipes, or jewelry (Poyatos, 1997; Poyatos 2002b,) as one of the elements interpreters should take into account while performing their task. According to Eicher (1999), dress could even be considered a code *per se* within nonverbal communication, since it includes a wide range of features —from visual to other sensory modifiers— which are important information carriers shaping the identity (ethnic and otherwise) of the individual; thus, awareness of such elements may hinder or facilitate communication among interactants. In the same way, Tilley (1994: 70) stated that material culture is "a communicative meaning involved in social practice that may be indicative of social relations, [...] meaning, knowledge and action".

As it has been previously suggested, body-adaptors could be used as cues to obtain very different kinds of information. People's personality and attitude is a complex geometric shape divided into several edges including social status, family background, beliefs, mood, and so forth. According to Poyatos's work (2002b), these and many other elements may be partly externalized through body-adaptors; thus, if appropriately understood, these elements can be valuable sources of information for healthcare professionals.

Every day, easily recognizable examples prove the aforementioned statement to be true. In the same way a particular attire may indicate person's belonging to a specific

African region or country (Eicher and Sumberg, 1999), the Arab veil or hijab (Poyatos, 2002b), a rosary or a *kippah* may point out the religious orientations of the patient; likewise, other accessories or body ornaments may provide important clues to the interpreter about the person's background – the mark in Hindu married women's forehead (Poyatos, 2002b), the many tattoos worn by Maoris and their different meanings, and so forth —or the patient's mood— wearing a black crape or other objects related to mourning—and therefore, may allow them to explain certain behaviors.

Besides these examples, there are many other objects and related elements that could give us pertinent sociocultural clues; consequently, raising awareness of their potential informative value and trying to disclose their meaning during face-to-face interactions may help both interpreters and healthcare providers to build a more detailed portrait of the patient.

5.4 Transcultural diversity

Another element which is not present in the manuals is a clear attention to the "diverse diversity" of the three countries at the focal point of this study. As stated in previous sections, some nonverbal elements are somewhat culture-specific, i.e., they change from one culture to another. Since the demography of the United States, Australia, and Canada is not equally constructed, selecting materials from different countries gave me the chance to analyze whether manuals 1, 2, and 3 pay attention to the specifics of their nations' demographics. In this vein, it has been possible to determine that the answer is "no": none of them approaches nonverbal elements considering the potential particularities of any specific foreign communities long and strongly settled on their soil.

6. Addressing nonverbal cues

Given all the reasons explained in sections 4 and 5, I believe additional suggestions

complementing the ones already included in the corpus may lead to more thorough approaches to healthcare interpreting and, therefore, to more successful outcomes. As Poyatos (2002b) claimed, given their recurrent function as emphasizers and/or de-emphasizers of content, and the subsequent implications this fact may have on meaning, interpreters should convey speaker's message with the appropriate verbal-nonverbal construct.

Following Poyatos' ideas, I consider interpreting at a pragmatic level would be the best solution to handle nonverbal cues in the type of mediated interactions this paper focuses on. This approach implies understanding literal words, speakers' intentions, context, potential reactions, and cultural features first in order to provide an appropriate rendering encompassing all the previous aspects later (Hale, 2007). Additionally, this approach should span Leech's (1983) and Thomas' (1983) seminal concepts of pragmalinguistic and sociopragmatic elements: whereas the former relate to the differences amongst languages when performing a specific illocutionary act (e.g., an emphasis via silence that may not work in the target language), the latter refers to dissimilarities in action-relevant social features that may have an impact in a communicative process (e.g., the different meaning of body-adaptors depending on the interactants' culture). Most of the problems presented in previous sections could be solved by raising awareness and enhancing interpreters' competence in these two fields. On these bases, I hereafter try to gather a series of guidelines aimed at facilitating interpreters' approach to these issues.

The importance of nonverbal elements advocated throughout this paper implies a directly proportional relevance of seating arrangements. Thus, whenever they are allowed to establish these conditions, interpreters should try to organize the setting so they can equally see the other parties involved. In this respect, Bischoff (2009) claimed that a triangular, equidistant structure may be the most efficient arrangement, since it favors direct communication between patient and provider, reinforces interpreters' neutrality and allows them to perceive nonverbal cues.

When thinking of nonverbal communication, most people may immediately refer to its most obvious forms, to wit, body gestures, emotions, or facial expressions among others. Interpreters should, however, pay attention to further nonverbal

elements. Amongst the most relevant ones in this vein, we should list the interactants' posture, personal voice features such as tone, (Bischoff, 2009) and other nonverbal tips such as speech tempo and syllabic duration. Including these elements in the interpreting process and/or explaining their meaning when necessary may improve communication in two different ways. On the one hand, it provides a more accurate transmission of the real meaning of the message that may be helpful for diagnosis and other clinical considerations; on the other, it makes interpreting a more dynamic process, thus avoiding a monotonous rendering that may have a negative effect on interactants' perception of other interpreting aspects (Collados, 2002). To name but a single case, monotonous interpretation could result in the loss of meaning nuances, with the parties involved feeling slighted or assuming that some of their intentions are not being appropriately transmitted (Jacobson, 2009).

Silence and stillness are recurrent elements in every conversation, but their meaning may vary ostensibly, and it may be complicated to grasp oftentimes. For this reason, besides explaining their many functions in different communicative situations, Poyatos (2002a) also explored the potential implications of silence and stillness roles during interpreter-mediated interactions and suggested possible guidelines for interpreters to manage them properly (Poyatos, 2002b). For instance, if these elements signify in themselves without a reference to anything else, interpreters may have to explain them verbally, especially when they entail a substantial cultural difference; when working as "zero signs" and no sound or movement is perceived, interpreters should decide whether to fill or maintain this vacuum; finally, when they act as emphasizers of meaning, it is advisable for interpreters to respect silence and stillness as not to alter the connotations underlying the message: if appropriate, they may disclose their implicit meanings when rendering it or explain their effect on discourse if they think it may have a positive outcome on the information exchange.

The previous practice can also be extrapolated to the field of hesitations. However, in this particular case, it is worth stressing a crucial aspect: given the implications of filled pauses listed in section 5.1, it is important for interpreters to avoid the overuse of their own fillers (Ng as cited in Kurz, 2001: 399) in order to

prevent possible misunderstandings derived from "mixing" their voice with others'. As with personal voice features, including these elements when rendering other people's discourse may be beneficial to the communicative process, since it increases meaning accuracy while curbing monotony and its possible negative repercussions (Collados, 2002; Jacobson, 2009).

Finally, body adaptors are another aspect worth expanding on in interpreting manuals and interpreters' training. As explained in section 5.3, these elements may provide us with important information about different aspects representing patients' past and present, attitude, and mood. Thus, analyzing and understanding the potential meaning of body adaptors may give interpreters a more accurate perspective on the patient's situation, thus enabling him/her to decide the most appropriate approach for a specific interaction.

Furthermore, it should be underlined that there may be several transcultural changes of meaning when dealing with such features. For instance, purple clothes are associated with death in some Latin countries whereas red attire is associated with the same tragic situation in some African regions and with blasphemy in others (Ricks as cited in Newsom, 2007: 50). Therefore, when the possibility of holding the desirable pre/post-interview with practitioners (see manuals 1, 2 and 3) exists, interpreters should explain not only attitudes and physical behaviors, but also those personal sensible body related components (Poyatos, 2002a; Poyatos, 2002b) that may be or might have been relevant. Such variety also implies, in my view, that specific guidelines and standards of practice should probably be locally addressed, focusing on the body adaptors related to those communities with more weight on the demography of the country at hand.

It is also important to note that not only the last one but most of the reflections listed hitherto, reinforce the potential benefits of holding previous and succeeding interviews with healthcare providers in order to discuss nonverbal cues carrying different kinds of information. These meetings may lead to a more precise construction of patients' image together with a more accurate clinical approach and treatment. This line of work fits in with the approach suggested by experts and researchers such as Messent (2003) or Tribe and Sanders (2003), and it is another

example of how cooperative work may be a good instrument to bridge cultural and linguistic gaps in healthcare contexts.

According to the arguments presented throughout this section, a digest of specific guidelines connecting healthcare interpreting and nonverbal cues could be established. This summary could be used as the basis for honing certain practices and expanding on several points healthcare interpreting manuals (sometimes) do not address comprehensively.

Firstly, issues related to the position of the three parties should be tackled thoroughly in order to encompass the different situations that may occur within a medical practice. As for the case of seated conversations, a triangular structure with practitioner and patient facing each other and the interpreter as a vertex aside may be the most appropriate choice.

Secondly, manuals should approach voice features in depth, listing the importance (or irrelevance) of several elements and not focusing only on the notion of "tone", normally used as an umbrella concept that encompasses many other voice features. In this vein, interpreters following a pragmatic approach should try to render a message that maintains the connotations the different uses of these elements may entail. In addition, manuals could also discourage monotonous rendering in order to avoid potential negative outcomes as those described a few paragraphs above.

As for silence and stillness, it would be necessary that reference materials discuss the different connotations they may carry so that interpreters become aware of their potential implications on the message, especially when they have culture-specific meanings attached. Appropriate information on these cues can contribute to build further knowledge on them as it helps interpreters determine those meanings that might be necessarily disclosed and those instances in which it is not necessary for them to step in. In like vein, manuals following a pragmatic approach to interpreting could advise to identify their significance on the original message and convey their meaning in those cases in which no intervention may result in a cultural clash or misunderstanding. Similarly, additional explanations could be given if appropriate as long as they are explained to both parties. The same rules could be applied to hesitations, keeping in mind the importance of avoiding the use of

our own fillers.

In addition to the abovementioned, this paper supports the importance of meetings before and after the interaction, where elements as nonverbal cues could be properly explained to healthcare professionals. But besides that, it also advocates in favor of empowering the interpreter when elements like body adaptors can have a strong impact on a mediated interaction. In this vein, a useful practice could be similar to the one suggested in the previous paragraph: briefing the patient about the intention of disclosing a specific chunk of information, provide the explanation to the practitioner, and interpret his/her response back to the patient.

In the same vein, it seems necessary that healthcare interpreting manuals include at least the most significant meanings attached to common body adaptors used by them. This measure should not be seen as a means to consolidate clichés, since it only provides chunks of information that interpreters will/can use when applicable. In my opinion, implementing measures like the ones listed before could benefit the three parties involved in this triangle: interpreters would render a more accurate message and practitioners may have a more comprehensive understanding of the patient's situation, thus enhancing the prospects of providing the most appropriate treatment.

7. Conclusions

In my viewpoint, the arguments presented hitherto meet the main purposes posited at the beginning of the article to a reasonable extent. On the one hand, the rationale built throughout this paper supports the importance of nonverbal communication in healthcare settings while, on the other, demonstrates the improvable approach taken by the manuals analyzed here. The comparative analysis conducted on the three documents has helped underscore their strengths and weaknesses, showing that even if they do address relevant factors like spatial arrangements, visual contact, or voice features, information and guidelines tend to be scarce and significant aspects related to nonverbal communication are neglected or

vaguely discussed. These findings have paved the way for suggesting several guidelines that could help provide further and meaningful information regarding nonverbal cues and assist interpreters when tackling certain issues that may arise from their presence during a triadic conversation. Essentially, the project as a whole advocates for an increasing importance of this field of communication in current and upcoming standards of practice.

The main fact supporting this point is the intrinsic relationship existing between verbal and nonverbal communication. Accordingly, the latter should be exhaustively addressed for a total communicative approach to interpreting in its multifarious modalities (Poyatos, 2002b) and settings, thus including healthcare. Despite current interpreting standards and guidelines evincing a growing and stronger focus on these elements of communication, a deeper approach briefing the importance of traditionally overshadowed elements may still be necessary on a path headed for an increasingly refined interpreting process. Likewise, emphasis on nonverbal elements in overall interpreting training programs may be a basic tool to raise awareness on the importance of these elements in interpreter-mediated interactions occurring in medical settings.

In this regard, the present paper intends to be another step towards foregrounding nonverbal elements in healthcare interpreting; but as any other project, it has its obvious limitations of time, scope, length, and resources. Thus, I would like to conclude by encouraging further research on this area which may lead to complementary or extension studies (encompassing for example, the analysis of other manuals) and additional suggestions that could boost and hone interpreting practice –in healthcare settings and other contexts– while preventing the negative effects derived from neglecting nonverbal cues. As Jacobson (2009) stated, serious miscommunications may occur if these elements are not accessible or understood during interpreter-mediated interactions. Furthermore, consequences when such cues are not taken into consideration may be devastating for members of minority groups (Schiffrin as cited in Jacobson, 2009: 56); and that is an outcome all professionals should try to avoid.

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