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Functions and transmission of humour in interpreter-mediated healthcare consultations: An exploratory study

Cristina Álvaro Aranda
cristina.alvaroa@uah.es
University of Alcalá

Abstract: This paper presents an exploratory study of humour in multilingual, multicultural healthcare interactions with an interpreter. Data are part of a dataset of healthcare encounters observed in a hospital in Madrid (Spain) for a period of five months, which included the participation of six interpreters. Four aspects were analysed: (1) who initiates humour, (2) who receives humour, (3) what the functions of humour are, and (4) how interpreters behave vis-à-vis humour occurrences. Preliminary findings indicate that humour allows patients, healthcare providers and interpreters to pursue relational and transactional goals similar to those present in monolingual healthcare interactions, such as handling negative emotions. Interpreters are active co-constructors of humour, and all participants in the triad work together towards the establishment and recognition of a humorous frame, where hierarchical relationships seem to exist. Together with linguistic and cultural differences between participants, interpreters must appropriately render background and contextual knowledge to ensure humour maintains its intended function, which emphasises the healthcare interpreter's active role in interaction. These findings call for greater attention to research on humour, as well as specific training for interpreters to highlight its relational power and, thus, ensure successful communication in multicultural, multilingual (healthcare) settings.

Keywords: humour, healthcare interpreter, healthcare interpreting, language-discordant consultations, healthcare settings, foreign patients, doctor–patient communication

1. Introduction

Humour and its manifestations have been at the heart of research in several disciplines. Linguistic, sociological, transcultural, psychological and medical approaches focus on humour in varying contexts, ranging from informal meetings to professional working settings, including healthcare. Within this field, humour seems to have experienced an increased interest, since it has proved to be useful for both patients and healthcare providers to build rapport (Holmes & Major, 2002), achieve a smoother interaction (Scholl & Ragan, 2003), create an informal atmosphere (McCabe, 2004) and attain a series of therapeutic goals (Goriup et al., 2017).

However, for humour to be successful, the participants involved need to share a framework, as supporting humour in interaction implies recognising a humorous frame, understanding and appreciating humour, and also agreeing with the messages linked to it (Hay, 2001). This is because humour is a universal phenomenon, but also specific to a community. It is rooted in a social, cultural and historical context, and influenced by one's personal background (Hardy, 2019). For this reason, constructing and supporting humour may be challenging when doctors and patients do not share a language or identify themselves with different cultural groups. Linguistic and cultural resources may not be shared and grasped between participants, and this affects the extent to which they can engage in humour (Bell, 2006). The landscape of healthcare provision has changed severely due to globalisation and immigration, and language-discordant consultations are a frequent reality, where the assistance of healthcare interpreters is increasingly needed to facilitate communication. In these cases, transmission

of humour relies heavily on interpreters, who have been reported to operate as co-constructors and active participants in healthcare interactions (Angelelli, 2004).

Adopting an exploratory approach, this paper analyses (a) how humour occurrences surface in interpreter-mediated healthcare consultations, as well as its (b) functions and (c) transmission by interpreters in these communication exchanges. With this purpose, a theoretical framework presenting an intersection between humour and healthcare interpreting is first developed in Sections 2 and 3. The methods, participants and procedure for analysis are described in Section 4, whereas Section 5 offers a quantitative and qualitative analysis of humour occurrences found in the sample, with inclusion of illustrative excerpts. Section 6 presents a discussion of the main results and, finally, Section 7 lays down the conclusions, limitations and paths for future research.

2. An overview of research on humour

Identifying humour is a complex task, and researchers often face a definitional problem. Following Francis (1994), humour is considered as a social phenomenon, an expert cultural performance that aims to reinforce the feeling norms of a given situation and to create positive sentiments among an interactive group by bonding them or downgrading an external threat, frequently at the expense of an excluded object, event or person. Literature on humour gives way to several theories related to this definition. For example, the superiority theory states that humour occurs when someone achieves superiority over other interlocutors, whereas the incongruity theory claims that humour emerges when something contradicts our expectations (Goriup et al., 2017). Contextual and linguistic clues (e.g., laughter, smiling, speaker's tone and audience's discoursal and auditory responses) are pertinent to identifying humorous utterances (Holmes, 2000). Humour can be intentional or unintentional according to the speaker's behaviour, and may be successful or unsuccessful depending on the addressees' reaction (Mullany, 2004). This implies that humour is jointly constructed by participants in an ongoing interaction (Murata, 2014).

The cultural dimension of humour inherently contributes to its definitional difficulties. Culture shapes situations and topics (in)appropriate for laughter (Attardo, 1994), since humour manifestations and usage vary among cultures and interactions between specific sets of individuals (Granek-Catarivas et al., 2005). Despite acknowledging how cultural background influences usage of and reactions to humour, Jiang et al. (2020) suggest that potentially beneficial and detrimental humour styles are universal. To illustrate this, Martin et al. (2003) previously discussed the categories of self-enhancing, self-defeating, affiliative and aggressive humour, which allow individuals to enhance or put down the self and favour or disparage relationships with others. These uses of humour play an important part in interactions, regardless of the context or situational frame. In this vein, Holmes and Major (2002) describe humour as an area of social talk, but they also observe its use in the workplace. Humour usage in different occupational fields has been addressed extensively over the years (Collinson, 2002; Duncan et al., 1990; Holmes, 2000; Holmes & Marra, 2002; Schnurr, 2009), including in healthcare settings.

2.1 Relevance of humour in healthcare provider–patient encounters

A growing number of studies provide evidence of the benefit of humour use in healthcare settings, which seems to be of particular interest in nurse–patient interactions. Regardless of the healthcare provider involved, humour is used by either patients or providers to pursue a series of goals classifiable into two groups: relationship-building humour and relationship-protecting humour (Schöpf et al., 2015). These categories are useful as a starting point to organise the results of a sample of illustrative studies.

Thus, and so as to build a therapeutic relationship, humour helps to soothe patients and to create a more relaxed atmosphere, which has a positive impact on patient satisfaction (McCabe, 2004). Furthermore, Scholl and Ragan (2003) indicate that humour allows for the creation of a patient-centred environment, which Scholl (2007) takes further by establishing a link between humour and patient-

centred care in three dimensions: taking a comprehensive patient profile, minimising power disparities and releasing patients from the label of 'bad patient'.

On the other hand, humour can function as a strategy to protect the provider–patient relationship. Patients can turn to humour to distance themselves from the threat of diagnosis or impending treatment (Francis et al., 1999), to minimise stress in potentially painful or uncomfortable situations, to tone down criticism (Holmes & Major, 2002) and to manage challenging and disturbing circumstances that may cause anxiety, fear or embarrassment (Beach & Prickett, 2016). Moreover, McCreaddie & Payne (2014) suggest that humour allows patients to express or encode concerns. Humour is indeed useful when discussing embarrassing or sensitive topics such as illness and death, as it may involve a certain degree of ambiguity that gives speakers an opportunity to retract utterances (Semino et al., 2018). Lastly, it serves as a defence mechanism and helps to ease tension and aggression in conflictive situations (Goriup et al., 2017).

It is important to highlight that humour in healthcare settings is likewise linked to issues of power and, thus, underlines the existence of hierarchical relationships in institutional contexts (Argaman, 2009). As expressed by Fairclough (1989), individuals in positions of power choose what is (in)appropriate in an interaction. Similarly, and in the context of employment interviews, Glenn (2010) suggests that shared laughter brings participants closer, but it also reveals existing asymmetries, as these manifestations are orchestrated by the interviewer (doctor), whilst the interviewer (patient) laughs along.

For all the functions it fulfils, it is thus not surprising that healthcare providers commonly resort to humour in encounters with patients, and some authors even suggest that physicians should receive training on its usage, effectiveness and appropriateness (Grant, 2017). This is particularly important in the light of evidence suggesting that patients and providers use and decode humour differently (Goriup et al., 2017; Granek-Catarivas et al., 2005). These varying perceptions imply that humour needs to be tailored for each individual, as it can become a double-edged sword. Despite its benefits, when used inappropriately humour can mock, embarrass or hurt patients through prejudice (Oczkowski, 2015), sarcasm, ethnic or sexist jokes (Scholl & Ragan, 2003), etc. When poorly directed towards a patient, humour can be disrespectful, unprofessional and dehumanising (Dharamsi et al., 2010; Gildberg et al., 2016). This may be even more relevant in interlinguistic and intercultural consultations, where healthcare interpreters offer their services.

3. An overview of healthcare interpreting

Healthcare interpreting takes place when patients and providers from different cultural and linguistic backgrounds need to communicate in healthcare settings, such as hospitals, clinics or medical centres. Despite the ever-increasing number of interpreters needed in medical facilities, healthcare interpreting is still an underregulated activity in many countries, and the provision of professional services is thus scarce and intermittent (Lázaro Gutiérrez, 2018). To date, there is no official higher education requirement to enter the field (Angelelli, 2019), which translates into a considerable number of individuals acting as healthcare interpreters without any training. Propelled by the realities of our diverse societies, healthcare interpreting has increasingly attracted interest over the years, with a particular focus on issues of role (Angelelli, 2004; Parrilla Gómez & Postigo Pinazo, 2018), professionalisation, training and ethical codes (Kalina, 2015; Swabey & Malcolm, 2012), specialised contexts (Lázaro Gutiérrez, 2018), interprofessional collaboration (Álvaro Aranda et al., 2021) and technological developments (Yabex, 2020).

As an activity, healthcare interpreting presents distinctive features deserving attention. For example, it entails interacting with patients from different cultural backgrounds that are generally at a disadvantaged position educationally, economically and socially, as well as with providers embodying the healthcare institution and, more generally, the host society. This translates into a power imbalance that manifests itself in a variety of ways, including different registers, use of language, expert and institutional knowledge, and understanding of cultural and social norms, which may influence humour

usage. Cultural groups conceive humour objectives and frequency of use in medical consultations differently (Fernández López, 2010). For example, its usage in medical consultations in the USA increases patient satisfaction and favours the development of the provider–patient relationship, but it may be perceived as insensitive or patronising in Japanese culture (Hsieh, 2016). Another distinctive feature of healthcare interpreting is that providers follow their own set of ethical principles and agendas to provide optimal care to patients. These can be assisted by discourse strategies and pragmatic elements such as humour, which makes this phenomenon a relevant object of research in healthcare interpreting.

3.1 Rendering humour in intercultural and interlinguistic interpreter-mediated (healthcare) interactions

Humour relies on a solid linguistic and cultural basis that may entail difficulties for translators and interpreters to maintain its originally intended functions. Humour research seems to be particularly fruitful in the field of audiovisual translation, but there is still a lack of a much-needed body of research and awareness in translation studies in general (Mateo & Zabalbeascoa, 2019). In interpreting studies, where further investigation is also required (Martínez Sierra & Zabalbeascoa, 2017), contributions seem to focus on conference interpreting (e.g., González & Mejias, 2013; Liendo, 2013; Pavliek & Pöchhacker, 2002; Vymětalová, 2017) and media ceremonies (e.g., Amato & Mack, 2011; Antonini, 2010). There are some exceptions focusing on public service settings; for example, Dickinson (2017) studies workplace humour in social services, education and social living meetings, and suggests that the interpreter's management of the interaction and translation of humour occurrences affects the degree to which deaf employees can integrate into the workplace.

Literature on humour in healthcare interpreting appears to be rather scarce. This may be attributed to a generalised difficulty to track scholarly contributions on humour, where existing labels sometimes do not reflect this phenomenon as the main research goal or it is simply treated as a minor subject within a more easily defined point of interest (Martínez Sierra & Zabalbeascoa, 2017). Similarly, our literature review suggests that research on humour in interpreter-mediated medical encounters is rather limited or treated as a secondary goal within broader studies. To illustrate this, jokes and humorous anecdotes have been approached as a residual category within the analysis of small talk in monolingual and interpreter-mediated medical consultations (Álvaro Aranda & Lázaro Gutiérrez, 2017). Other contributions touch upon the behaviour of different stakeholders partaking in interpreter-mediated communication exchanges in healthcare settings; for instance, Jill Benson et al. (2009) observe that a correct use of interpreters allows for more humour. Other examples suggest that when a healthcare interpreter joins to facilitate communication, patients and providers seem to introduce less humour (Kai, 2013; Seale et al., 2013).

4. Method

When interpreters participate in language-discordant medical consultations, transmission of humour becomes part of their responsibilities. This paper examines how humour emerges in these communication exchanges, together with its functions and transmission, in a sample of six healthcare interpreters. We use an exploratory approach, which allows us to examine data with no prior hypotheses or assumptions. Our analysis thus presents limitations and does not seek to claim scientific validity, but must be understood as a first step to developing more sophisticated research in the future.

4.1 Data

Data presented in this paper are part of a larger dataset of interpreter-mediated healthcare interactions gathered in a hospital in Madrid (Spain) with an on-site team of healthcare interpreters over a period of five months (February–June 2017) for a PhD dissertation (Álvaro Aranda, 2020). A series of interpreter-mediated events ranging from administrative procedures to X-ray examinations were observed. However, for the purposes of this paper, our analysis will focus on the subset of nurse– and doctor–

patient interactions. Data was collected using different qualitative techniques (e.g., observation protocol, interviews, and fieldnotes). Permission was granted to conduct participant observation after presenting the research proposal to individuals in positions of responsibility at the interpreters' organisation and signing a confidentiality form. All participants made informed decisions on their involvement, as they were provided with explicit provisions regarding the aim of the research, privacy, confidentiality and the right to withdraw consent. Furthermore, all individuals involved in the study granted verbal permission before proceeding to data collection in every session, which was conveniently registered. Due to the sensitive nature of the setting, full transcriptions of medical conversations could not be made, but participant observation allowed writing down pertinent excerpts that were subsequently used for analysis.

4.2 Participants

Interpreters have their own office next to the Tropical Medicine area, which receives a considerable number of non-Spanish speaking patients daily. Six healthcare interpreters with different levels of training and professional experience took part in the study (Table 1). Interpreter 1 had been working at the hospital in Madrid where research was conducted for four years. She held a university degree in Translation and Interpreting (T&I) and received on-the-job training covering healthcare interpreting and intercultural mediation for a month. Interpreters 2, 3, 4 and 5 were students with no prior professional experience completing a month-long internship. They were enrolled in the MA in Intercultural Communication, Interpreting and Translation in Public Services (University of Alcalá), where they received specialised training in healthcare translation and interpreting. Interpreter 6 had three years of professional experience and no training in healthcare interpreting or intercultural mediation.

Table 1: Interpreters' profiles

	Age	Gender	Country of origin	Mother language	Working languages	Level of general education (university)	Level of specialised education in healthcare interpreting	Professional experience in healthcare interpreting
Interpreter 1	28	F	Spain	Spanish	FR/EN/AR-SP	T&I	On-the-job training	4 years
Interpreter 2	23	F	Spain	Spanish	FR-SP	Modern Languages	MA	N/A
Interpreter 3	22	F	Spain	Spanish	FR-SP	T&I	MA	N/A
Interpreter 4	23	F	Spain	Spanish	FR-SP	Modern Languages & Translation	MA	N/A
Interpreter 5	22	M	Spain	Spanish	FR-SP	Modern Languages & Translation	MA	N/A
Interpreter 6	37	M	Guinea	Diakanke	Bambara/Broken English/Diakanke/Pulaar/Susu/Malenke/Koniake/ FR-SP	Mechanical and Electrical Engineering	N/A	3 years

Source: Álvaro Aranda (2020)

Patients were primarily young (15–30 years old) male refugees, asylum seekers and economic migrants from sub-Saharan Africa. They were native speakers of different languages, such as Bambara, Pulaar, Malinke, Koniake, Swahili or Susu. Most patients also spoke French. This is not unexpected considering

that a good number of their countries of origin used to be French colonies and, as such, French is an official language taught in schools. Thus, most consultations took part using French as a lingua franca, since it was spoken by most patients and all six interpreters. Reasons for hospital visits ranged from first encounters to follow-ups, referrals and delivery of tests.

Healthcare providers were native speakers of Spanish with expertise in different medical areas who needed linguistic and cultural support to communicate with patients. Both resident physicians and consultants took part in the study. A total number of 27 nursing consultations and 74 medical consultations were observed, distributed in Tropical Medicine (n=65), Urology (n=2), A&E (n=1), Gynaecology (n=1), Nephrology (n=1), Traumatology (n=1) and Sexual Health (n=3). As stated earlier, Tropical Medicine doctors have a significant need for healthcare interpreting services, since a considerable number of consultations involve non-Spanish speaking patients. Consequently, they become familiar with interpreters.

4.3 Analysis

The first step was to isolate humour occurrences in the dataset. In this paper we followed Schöpf et al. (2015), who resort to a comprehensive literature review to identify humour occurrences with a series of fixed criteria, including laughter and smiling; exaggeration and absurdities; animated, exaggerated or smiling intonation; verbal cues (e.g., 'I'm joking'); and comments standing out from the co-text. Events were first classified according to participants initiating and receiving humour. Subsequently, humour occurrences were assigned a category depending on their intended function by means of thematic analysis (Boyatzis, 1998). Some occurrences presented overlapping boundaries between two or more categories, as they served several functions. In these cases, overlapping categories were combined into one dominant category depending on the main intended function. Specific examples were selected for their illustrative potential and examined using a conversation-analytical approach (Heritage, 2003). Finally, four patterns were proposed to categorise interpreter behaviour towards humour occurrences. Criteria for classification consisted of two main factors: (a) level of transference and effect of humour events and (b) interpreters' autonomous contributions or non-renditions (Wandensjö, 1998).

5. Results

This section presents and discusses the main results in three different sections: humour dynamics, functions of humour and interpreter behaviour.

5.1 Humour dynamics in interpreter-mediated healthcare interactions

Seventy-four humour occurrences were found, distributed in nurse tests (n=5), Tropical Medicine (n=58), Urology (n=2), Sexual Health (n=7) and Nephrology (n=2) consultations. Figure 1 and Figure 2 show specific information concerning humour initiators and recipients per participant profile. Healthcare providers initiated humour in 48 instances, whereas patient-initiated humour occurred in 23 instances and interpreter-initiated humour was present in a modest 3 instances. Focusing on the intended recipient of humour events in the dataset, more balanced figures are observed, corresponding to 28 instances where healthcare providers act as humour recipients, 32 for patients and 14 for interpreters. At this point, it is interesting to highlight that humour occurrences only took place in interactions with interpreters that had received specialised training.

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Figure 1: Interlocutor initiating humour (n=74)

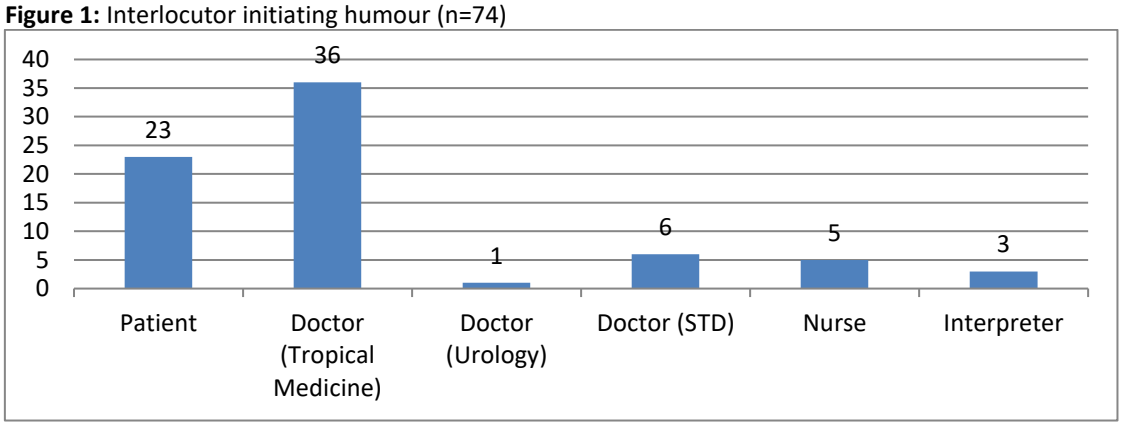
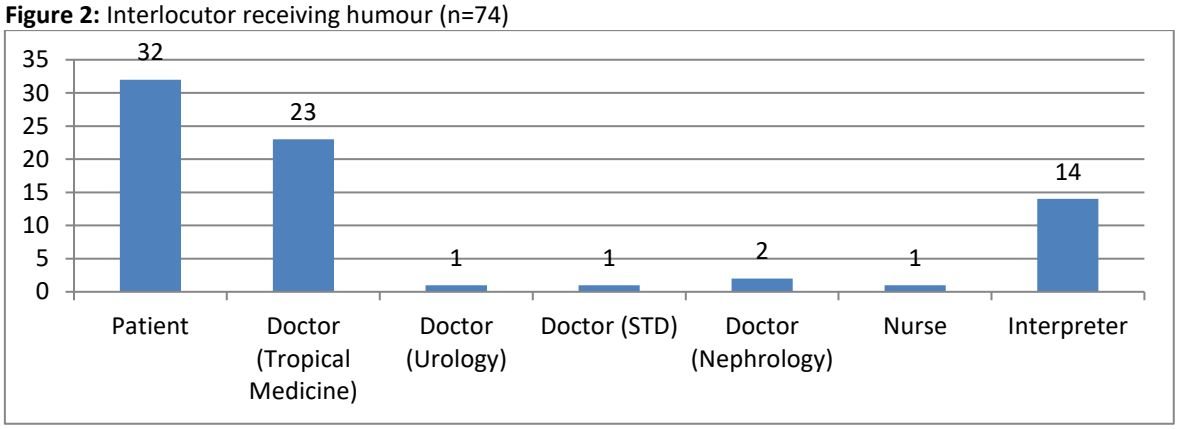


Figure 2: Interlocutor receiving humour (n=74)



Having established humour initiators and humour recipients as the two main elements in humour dynamics, seven different patterns are observed in interpreter-mediated healthcare interactions: healthcare provider directing humour to patient (n=31), healthcare provider directing humour to interpreter (n=10), healthcare provider directing humour to another healthcare provider (n=7), patient directing humour to healthcare provider (n=19), patient directing humour to interpreter (n=4), interpreter directing humour to healthcare provider (n=2) and interpreter directing humour to patient (n=1), as seen in Figure 3.

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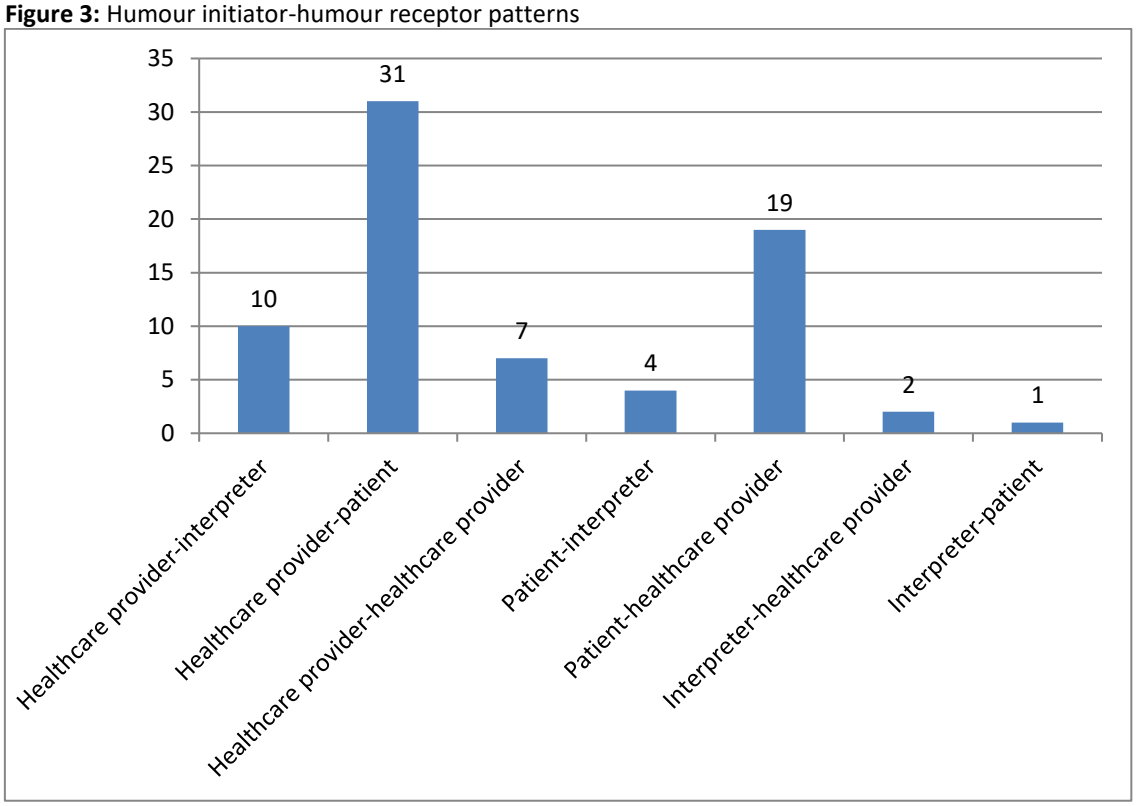
Figure 3: Humour initiator-humour receptor patterns



A preliminary observation that can be inferred from Figures 1, 2 and 3 is that most humour occurrences are initiated by healthcare providers, regardless of whether these are directed to patients or, less frequently, healthcare interpreters. This resonates with the hierarchical healthcare provider–patient relationship and the existing asymmetries in institutional settings that are well recognised in the literature (Argaman, 2009; Lidz, 2010; Parsons, 2013), as providers appear to exert power and legitimise their dominant role through the use of humour. For their part, patients take the lead in starting humour in a considerable number of cases, which may be related to the healthcare interpreters' presence and their subsequent ability to communicate humorous messages through them. Regarding the group of interpreters, only one of the participants in the sample initiates humour in a few isolated cases. However, all six interpreters become the target of humour by both healthcare providers and patients in a fair number of examples.

5.2 Functions of humour in interpreter-mediated healthcare interactions

Detailed examination of humour occurrences allows for classification in categories according to their function. Echoing the discourse present in the existing literature (see Section 2.1), these occurrences have been classified into the following umbrella functions: (a) creating a relaxed atmosphere; (b) handling negative emotions; (c) helping another participant to handle negative emotions; (d) communicating criticism, rejection or disagreement; (e) managing power asymmetry; and (f) saving face. Table 2 describes the prevalence of said functions in different groups of participants. As stated earlier in the paper, some examples may fall under two different categories, but to facilitate analysis we decided to classify them based on their main function.

Table 2: Humour occurrences and functions per participant profile

Function	**Initiator of humour occurrences**		
	Healthcare provider	Patient	Interpreter
Creating a relaxed atmosphere (n=27)	24	3	-
Handling negative emotions (n=25)	6	17	2

Helping another participant to handle negative emotions (n=9)	9	-	-
Communicating criticism, rejection or disagreement (n=6)	3	3	-
Managing power asymmetry (n=6)	5	-	1
Saving face (n=1)	1	-	-

Brief descriptions are provided to further explain these categories, together with a sample of excerpts selected for discussion based on their illustrative potential. Patient interventions take place in French, whereas healthcare professionals speak Spanish and interpreters switch between both languages. For the sake of clarity, all examples have been translated into English. Due to space constraints, the label (Interpretation to [language]) is used to indicate close renditions (Wadensjö, 1998), that is, close (if not identical) rendition in meaning and form the original humour occurrences. However, interpreters' authored interventions are conveniently identified. Lastly, brackets indicate non-verbal behaviour, body language or actions.

5.2.1 Creating a relaxed atmosphere: You're not pregnant

Despite a small number of cases where patients resort to humour to generate an informal atmosphere (n=3), most examples under this first category are initiated by healthcare providers (n=24). In this sense, humour favours developing a relationship between both participants, which is important for communicating results, anticipating a potentially negative reaction, approaching one of the participants or contributing to a light-hearted environment in the interaction. Thus, it is not surprising that this type of humour occurrence usually takes place before the consultation starts, at initial or opening stages or prior to the communication of test results. Excerpt 1 illustrates this category:

> Excerpt 1. Humour to construct a therapeutic relationship and prevent a negative reaction
> Doctor: La ecografía está bien. No estás embarazado (The ultrasound is fine. You're not pregnant)
> (*Interpretation to French*)
> [The patient laughs]
> Doctor: Tienes que tomarte una pastilla durante seis meses (You need to take a pill for six months)
> (*Interpretation to French*)
> Patient: Six mois?! (Six months?!)
> (*Interpretation to Spanish*)
> Doctor: Es un poco rollete, pero muerto el perro se acabó la rabia (It's a bit of a pain, but dead dogs don't bite)
> Interpreter 1: C'est un peu lourd, mais mort le chien, mort le venin. C'est une phrase en espagnol qui veut dire que quand le chien meurt, la rage disparaît (It's a bit of a pain, but when the dog dies, the poison dies. It's a sentence in Spanish that means that when the dog is dead, the rabies disappears)
> Doctor: No puedes beber durante seis meses (You can't drink for six months)
> (*Interpretation to French*)
> Patient: Je ne bois pas (I don't drink)
> (*Interpretation to Spanish*)
> Doctor: Bueno, imagínate que descubres el vino español y te da por beberte todos los días una botella (Well, imagine you discover Spanish wine and you feel like drinking a bottle every day)
> (*Interpretation to French*)
> Patient: Mais je ne bois pas (But I don't drink)
> (*Interpretation to Spanish*)
> Doctor: Muy bien, así me gusta. Si sigues así vas a vivir doscientos años (Very good, that's the spirit. If you carry on like that you're gonna live two hundred years)
> (*Interpretation to French*)

[The patient and the doctor smile]

Excerpt 1 takes place within a follow-up appointment in Tropical Medicine with an Ivorian male patient that attends the consultation to learn about the results of some tests. Interpreter 1 facilitates communication, whereas Interpreter 4 observes the event to learn from her colleague's performance. After a series of initial greetings and pleasantries, the healthcare provider, a male consultant, communicates the result of an ultrasound examination to the patient. He introduces a joke that triggers laughter due to its absurdity and transgression of mental expectations, in line with the incongruity theory (Goriup et al., 2017). The patient is male and, as such, he cannot be pregnant. This first humour occurrence helps to bring both participants closer and favours creating a relaxed atmosphere that may be useful before the doctor moves on to more serious topics related to the patient's condition. Duration of treatment is met with surprise on the part of the patient, as reflected by his incredulous tone and rising intonation. The physician introduces another humorous remark to prevent a negative reaction from the patient when informed about the need to abstain from drinking alcohol during treatment. As seen in the patient's response, the doctor's initiation of humour is not taken up by the patient, who refuses to engage in the humorous frame and replies bluntly ('But I don't drink'). In this case, failure of humour is not directly related to the interpreter's performance, but to the patient's negative attitude. To overcome this failed attempt at humour, the physician initiates another one approving of the patient's lifestyle. This is successfully met by the patient, as reflected in non-verbal cues (i.e., smiling), and the consultation proceeds.

5.2.2 Handing negative emotions: Blood? I'll need to fast and then I'm hungry

The second category of analysis is present in humour occurrences from all three groups of participants, with 6 instances for healthcare providers, 17 for patients and 2 for interpreters. Humour serves as a tool to buffer or manage negative emotions that arise in the course of healthcare interactions, such as anxiety, anger, fear, embarrassment, frustration, uncertainty, nervousness, concern and impatience. As the interlocutors whose health is directly affected in this type of institutional encounter, it is not surprising that most occurrences grouped under this category are primarily conducted by patients, who turn to humour to voice messages peppered with emotional concerns, as in Excerpt 2. Nonetheless, healthcare providers and interpreters also experience these types of emotions and turn to humour to handle them.

Excerpt 2. Humour to handle fear
Doctor: Tienes que volver este día para que te hagan unos análisis de sangre (You need to come back this day to get some blood tests done)
(*Interpretation to French*)
Patient: De sang? Encore? À chaque fois je dois revenir à jeun et j'ai faim [Smiling intonation] Pourquoi est-ce que tu veux de sang? (Blood? Again? Every time I need to come back I must fast and I'm hungry. What do you want the blood for?)
[The patient chuckles]
(*Interpretation to Spanish*)
Doctor: Tranquilo, es muy poquita (Don't worry, it's just a little bit)
(*Interpretation to French*)

A male and a female doctor completing their residency programme in Tropical Medicine and a sub-Saharan African male patient participate in this follow-up consultation. The patient learns about the results of some tests and he is informed that additional testing is required. He introduces a humorous comment to express concern about getting another blood test, which is in line with the sacred value attributed to blood in many African cultures' (Navaza et al., 2012). Humour is expressed by means of prosodic features: a smiling intonation and a chuckle. In this particular case, the female doctor does not meet the patient's humorous disposition and introduces a comment to ease the patient, which puts an end to a potential humour frame. In contrast with Excerpt 1, the doctor's intervention seems to be more task-related rather than an attempt to safeguard the relationship with the patient. Furthermore, Excerpt

2 is in line with Haakana (2002), who points out that patients laugh more frequently than doctors and laughter is hardly reciprocated.

5.2.3 Helping another participant to handle negative emotions: Even my soul would hurt!

Closely related to the previous subsection, all 9 instances of the category under examination are performed by healthcare providers. These participants pursue a series of objectives, including making patients comfortable to disclose personal information, assuaging patients, distracting them from painful or invasive tests and creating a sense of solidarity, as seen in Excerpt 3:

> Excerpt 3. Humour to distract a patient from painful procedure
> [The doctors perform the procedure]
> Doctor: Tienes las manos muy frías y la piel muy dura (Your hands are very cold and your skin is very hard)
> (*Interpretation to French*)
> [The patient smiles]
> Patient: C'est normal, je suis africain (It's normal, I'm African)
> (*Interpretation to Spanish*)
> Doctor: No te sale mucha sangre (Not a lot of blood is coming out)
> (*Interpretation to French*)
> [Smiling voice]
> Patient: C'est normal. Ils ont retiré beaucoup de sang l'autre fois. Ils ont pris tout mon sang et je n'en ai plus (It's normal. They drew a lot of blood from me the other time. They took out all my blood and I have none left)
> [Interpreter 4 laughs]
> (*Interpretation to Spanish*)
> Doctor: Bueno, y cuéntanos eso de que estabas cansado. ¿Te duelen las piernas? (Well, and talk to us about that thing about being tired. Do your legs hurt?)
> (*Interpretation to French*)
> Patient: Oui, parce que j'ai couru dix kilomètres (Yes, because I ran ten kilometres)
> (*Interpretation to Spanish*)
> Doctor: Bueno, ¡a mí me dolería hasta el alma! ¿Pero tú corres normalmente? (Well, even my soul would hurt! But do you run normally?)
> (*Interpretation to French*)
> Patient: Avant oui, mais pas non plus [Before yes, but not anymore]
> *(Interpretation to Spanish)*

In this follow-up appointment, a sub-Saharan African male patient is informed about the results of certain tests indicating that he has malaria and a 'Strongyloides stercoralis' infection. He also undergoes a thick blood film examination. There are two female professionals performing said procedures: a Tropical Medicine consultant and a resident. The patient shows visible signs of discomfort disguised in humour occurrences that would be classified as handling negative emotions ('It's normal, I'm African' and 'They took out all my blood and I have none left'). These utterances reveal an underlying cultural conflict related to traditional beliefs attributed to blood, which the patient uses to initiate humour. Interestingly, the interpreter contributes to the humorous atmosphere when she laughs. The consultant, however, ignores these humour events and initiates small talk in hopes to distract the patient from the procedure ('Talk to us about being tired'). Despite an appropriate transmission of the message by the healthcare interpreter, the doctor deviates from the humorous frame and initiates an alternative strategy to distract him by resorting to small talk. The patient reacts positively and partakes in this conversation. After assessing his positive reaction, the consultant introduces a humorous event based on the exaggeration that even her soul would hurt had she run such a distance, trying to divert the patient's attention from the pain. Thus, Excerpt 3 helps to illustrate how individuals in positions of power decide what is appropriate or not in an interaction (Fairclough, 1989), which in this paper specifically applies to healthcare providers and use of humour.

5.2.4 Communicating criticism, rejection or disagreement: We're under the control of law and authority here

Humour serves patients (n=3) and healthcare providers (n=3) to communicate criticism, rejection or disagreement in both open and subtle ways. By introducing humour events or showing a humorous disposition, these interlocutors can soften negative opinions and disguise the real nature of serious messages. In this sense, contextualisation cues are key elements to establish a common frame of understanding for participants involved in the interaction, as humour recipients need to comprehend both the humour event and the underlying message behind it. Excerpt 4 provides insight into this category:

> Excerpt 4. Humour to deliver criticism
> Doctor: Entonces… ¿No le hablo en francés? (So... I don't Speak French to him?)
> Interpreter 1: Bueno, eso depende del nivel de usted. Si usted tiene un nivel C1 dentro del Marco de Referencia Europeo, adelante. El riesgo de no trabajar con un intérprete profesional es que usted crea que el paciente le entiende y que el paciente crea que usted le entiende, pero si cree que puede hacerlo, adelante, no hay problema (Well, that depends on your level. If you have a level C1 according to the Common European Framework of Reference, go ahead. The risk of not working with a professional interpreter is that you believe that the patient understands you and the patient believes that you understand him, but if you think that you can do it, go ahead, there's no problem)
> [Sarcastic intonation]
> Doctor: Bueno, aquí estamos bajo el peso de la ley y la autoridad (Well, we're under the control of law and authority here)
> (Interpretation to French)
> [The patient displays a small smile]

This follow-up consultation involves a Guinean male patient, a male urologist, a female nurse and two healthcare interpreters. Interpreter 1 facilitates communication, whereas Interpreter 4 observes. Excerpt 4 occurs immediately after Interpreter 1 introduces herself to the doctor at the beginning of the consultation, explains how turn management works and goes over some ethical considerations. Subsequently, she briefly informs the patient that she has introduced herself to the doctor, but does not repeat the instructions to him, as he is familiar with them due to previous interpreter-mediated consultations. As shown in the excerpt, the doctor's initial intention is to communicate in French, but the interpreter warns him about the consequences of ineffective communication and implies that he should reconsider and use her services. Following her advice, the physician complies with the interpreter's suggestion, but first makes a snide remark that seems to criticise the implication that she is questioning his French language skills. Instead of reciprocating the doctor's attitude, Interpreter 1 adopts a conduit role. In so doing, she redirects the conversation towards the patient, who had been relegated to a second position. The doctor's use of aggressive humour (Martin et al., 2003), which aims 'to create distance in relational bonds' (Miczo et al., 2009, p.445), does not involve the patient directly, as it concerns a side conversation in Spanish that the patient could not understand. When the interpreter renders a message that the doctor is directing towards her and not the patient ('Well, we're under the control of law and authority here'), the latter just smiles in response. Considering the language barrier, this could be a sign of social acknowledgement rather than actual understanding of the situation.

5.2.5 Managing power asymmetry: This is a medical consultation, not a supermarket

Healthcare providers (n=5) and interpreters (n=1) turn to humour events as tools to manage power asymmetries in medical consultations. More precisely, humour is used to increase or reduce power asymmetries and social distances, and to provide or soften instructions. An example can be found in Excerpt 5:

Excerpt 5. Humour to increase doctor-patient distance
Patient: Est-ce que vous pouvez me prescrire une lotion après-rasage? (Can you prescribe me an aftershave?)
Interpreter 4: Dice que si puedes prescribirle una crema para después del afeitado (He says if you can prescribe him an aftershave)
Doctor: Esto es una consulta médica, no un supermercado, y no funciona así (This is a medical consultation, not a supermarket, and it doesn't work like that)
(*Interpretation to French*)

Excerpt 5 is a prime example of how humour occurrences can function to establish a barrier to increase the social distance between doctor and patient. The Guinean male patient that attends this follow-up appointment in Tropical Medicine is undergoing treatment for a latent tuberculosis infection. The physician, a female resident, asks the patient a series of questions to assess his adherence to treatment. The patient takes the initiative on several occasions to request prescriptions. Whereas some of them are justified (i.e., a prescription for ongoing treatment), certain requests have little to no medical relevance (e.g., aftershave) and, rather than pleas, they are perceived as demands. For this reason, the physician uses a humorous comparison that seeks to remind the patient that she is in charge of the consultation and, as such, makes decisions regarding prescriptions and treatment ('This is a medical consultation, not a supermarket, and it doesn't work like that'). Humour is used as a power-claiming discourse strategy, which allows the doctor to activate interactional control. She is reminding the patient that the interaction is taking place in an institutional setting where underlying norms apply, which resonates with scholarship on power imbalance in institutional settings (Argaman, 2009; Fairclough, 1989), social roles and expectations in medical contexts (Bach & Grant, 2010; Norton & Smith, 1994; Parsons, 2013).

5.2.6 Saving face: But I need to ask anyway

Lastly, there was 1 isolated instance of using humour as a way to save face in situations that put an interlocutor's reputation and status, in this case the healthcare provider's, at risk, as seen in Excerpt 6:

Excerpt 6. Humour to save face
Doctor: ¿Alguna vez has tenido relaciones sexuales sin preservativo? (Have you ever had sexual relations without a prophylactic?)
(*Interpretation to French*)
Patient: Non, avec mon mari non (No, not with my husband)
[Surprised tone]

Interpreter 3: No, con mi marido no. Creo que quiere decir que solo con su marido. Claro, si tiene hijos... (No, not with my husband. I think she wants to say that only with her husband. Of course, if she has children…)
Doctor: Sí [Laugh] Entiendo que si tiene hijos obviamente ha tenido relaciones sexuales sin preservativo, pero tengo que preguntarlo de todos modos (Yes. I understand that if she has children she has obviously had sexual relationships without a prophylactic, but I need to ask anyway)

Excerpt 6 is taken from a Guinean female patient's first visit to Tropical Medicine. The healthcare provider is a female resident who follows a protocol of questions about the patient's medical history. To inquire about any possible STDs, the doctor asks the patient if she has ever had unprotected sexual intercourse. Her reply seems to disconcert the interpreter, as the patient has already mentioned her children in previous stages of the medical interview. For this reason, the interpreter chooses to add a clarification when she renders the message. In this scenario, the doctor justifies posing what seems to be an obvious question to the patient by means of a humorous occurrence. She alludes to the medical history protocol she must follow to assess her health status. Thus, humour allows the healthcare provider to save face and maintain her status.

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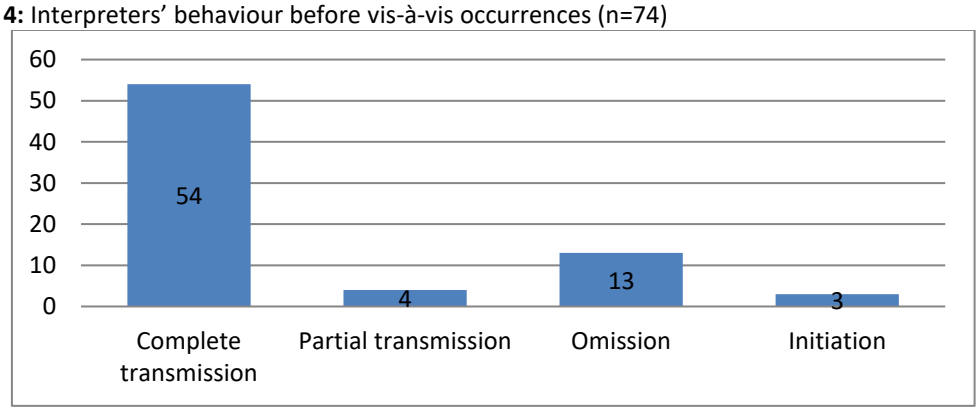
5.3 Interpreter behaviours vis-à-vis humour in interpreter-mediated healthcare interactions

Having classified humour occurrences into a simplified taxonomy, the next step of the analysis examined interpreter behaviour regarding such events. Four patterns are found: complete transmission, partial transmission, omission and initiation of humour. Complete transmission involves reproducing a humorous occurrence and maintaining its intended function in the target language, whereas in partial transmission, this is only achieved to some extent. Omission of humour covers uninterpreted events, whilst initiation of humour serves to describe interpreters' humorous contributions. Figure 4 shows specific numbers for each category:

Figure 4: Interpreters' behaviour before vis-à-vis occurrences (n=74)



To illustrate each of these patterns, specific examples are examined below.

5.3.1 Complete transmission of humour

Humour events are completely transmitted in most of the cases (n=54). Interpreters turn to different strategies, such as explaining cultural or linguistic elements (e.g., rhymes). Thus, it must be highlighted that interpreters participating in the study are very much aware of the importance of humour in medical consultations and its functions, and they consequently strive to render its meaning. Notwithstanding this, there are a small number of occurrences where the interpreter's initial reaction is to ignore humour, but they eventually channel these messages after the healthcare provider insists on their transmission, as in Excerpt 7:

> Excerpt 7. Complete transmission of humour at the doctor's request
> Doctor: Quítate el pantalón (Remove your trousers)
> (*Interpretation to French*)
> Patient: Enlever mon pantalon!? (Remove my trousers!?)
> (*Interpretation to Spanish*)
> Doctor: Te voy a quitar piel del culo (I'm going to remove skin from your butt)
> (*Interpretation to French*)
> Patient: Non! Je ne pourrai pas m'assoir après (No! I won't be able to sit down later)
> (*Interpretation to Spanish*)
> [The doctors start to perform the procedure behind a curtain]
> (…)
> Patient: Aïe, aïe, aïe… (Ouch, ouch, ouch…)
> Doctor: Ahora te hago el segundo. Venga, ya casi la mitad (Now I make the second (cut). Come on, I'm halfway there)
> (*Interpretation to French*)
> Doctor: Venga, que estamos sacando unos filetes muy buenos (Come on, we're getting some really good steaks)
> [Silence]
> Doctor: Eso no se lo has traducido… (You didn't translate that for him)

(*Interpretation to French*)
Patient: Aïe… (Ouch)

In Excerpt 7, a male Tropical Medicine consultant and two residents are taking skin snips from a Cameroonian male patient for the diagnosis of onchocerciasis. Interpreter 2 facilitates communication whilst Interpreter 6 observes. The patient voices his embarrassment and discomfort, and later on complains about pain. To ease him, the consultant reassures him the first half of the procedure is almost over and also includes a humorous component based on a comparison between the patient's flesh and meat. This occurrence is classified under the category of humour usage to help another participant to handle negative emotions (see subsection 5.2.3). In this case, the interpreter opts to ignore the provider's remark. The physician notices the silence and prompts the interpreter to render the joke. The healthcare provider and the interpreter conceive humour in a different way. Following Hardy (2019), this might be explained because healthcare providers interpret humour usage differently from those outside their profession. Whilst the physician considers that humour will minimise the patient's discomfort, the interpreter seems to believe that it may intensify negative feelings and, accordingly, she initially remains silent. However, when encouraged by the doctor, she complies, which once again reveals a hierarchical relationship among participants in healthcare settings.

5.3.2 Partial transmission of humour

Contrary to the previous category, there are a modest 4 instances of partial transmission of humour occurrences. In some cases, interpreters in the sample seem to simply forget to render part of a message, but it is another type of occurrence that deserves special attention. Specifically, interpreters transmit part of the message, but they do not seem to succeed in doing it fully, as the recipient of humour does not have enough background knowledge to ultimately understand what is going on in a particular interaction. Excerpt 8 lends some insight into this category:

Excerpt 8. Partial transmission of humour
[The consultant opens the door of the consultation room and sees there is an interaction taking place. He makes a face of surprise]
Doctor: Uy, perdón. Pensé que no estabas, solo será un minuto [Oops, sorry. I thought you weren't here, it'll only be a minute]
[The doctor and the interpreters laugh]
Interpreter 5: La docteur croyait qu'il n'était pas ici, c'est pourquoi nous sommes rentrés ici (The doctor thought he wasn't here, that's why we've come here)
Patient: Ah, O.K.

This follow-up appointment involves a Cameroonian male patient and a female resident physician. Interpreter 5 enables communication and Interpreter 1 assesses his performance. The resident doctor informs the patient about the results of some tests, which reveal that he has a blood parasite. The patient is also agitated because he has been experiencing abdominal pain for a few days and is requesting medication. After a few minutes, the male consultant based in that consulting room opens the door. To his surprise, an appointment is already taking place. This triggers laughter among participants aware of the hierarchical relationship between both providers. In this case, simply interpreting the resident's apology is not enough to transfer humour, as the humorous exchange does not directly involve doctor and patient. For this reason, the interpreter attempts to include the patient by providing a general explanation that, however, is not enough: he fails to make the patient understand that the resident physician works at the hospital only on a temporary basis, whereas the consultant has a permanent contract and an assigned consulting room. Consequently, the patient does not have enough background knowledge to comprehend the humorous situation and replies with a short and serious answer, which reveals an utter lack of understanding that may be accentuated by his agitated state. Transmission of humour is thus only partial. The patient has enough information to recognise a humorous atmosphere (i.e., the laughter of other participants), but not enough to engage or contribute to it, as he is not directly involved in the humorous frame shared among the rest of participants.

5.3.3 Omission of humour

With 13 instances, this category covers situations where humour occurrences are omitted completely in interpreting. In some examples, interpreter-mediated transmission of humour is not needed as interlocutors understand each other without the interpreter. There are other cases where interpreters deliberately decide not to render humour, as they do not seem to deem it essential for the purposes of the encounter. However, in some situations, omission of these occurrences can put several dimensions of the consultations at risk. In this sense, Excerpt 9 illustrates an interesting situation:

> Excerpt 9. Omission of humour
> Doctor: Voy a ver la hipertensión arterial, pero la función del riñón está un poquito deteriorada y hay que ver qué la daña porque es muy joven (I'm going to check your high blood pressure, but the function of the kidney is a little bit deteriorated and we need to see what's hurting it because you're very young)
> (*Interpretation to French*)
> Patient: C'est la mort, je vais mourir (It's death, I'm going to die)
> [Silence]
> [The doctor types in the computer and prints out a document. She hands it over to the patient]
> (…)
> Patient: C'est quoi ce papier? (What is this sheet?)
> (*Interpretation to Spanish*)
> Doctor: Para pedirte cita conmigo en mes y medio (To ask for an appointment with me in a month and a half)
> (*Interpretation to French*)
> Patient: Aujourd'hui? (Today?)
> Interpreter 4: Oui. Me ha preguntado si puedo pedirlo hoy (Yes. He asked me if I can ask for it today)
> Doctor: Sí, sí. Muy bien, [name of patient] (Yes, yes. Very good [name of patient])
> [The doctor and the patient shake hands]
> Doctor: ¿Este servicio es del hospital? Qué bien, qué bien. (…) (Is this a service of the hospital? That's great, that's great.)
> Patient: Es muy importante (It's very important)
> Doctor: Fundamental (Essential)
> Patient: Je vais mourir (I'm going to die)
> (*Interpretation to Spanish*)
> Doctor: No, no, no. Lo que pasa es que eres muy joven y tenemos que ver qué está ocasionando esto para que no vaya a más o que por lo menos se quede igual (No, no, no. What happens is that you are very young and we must see what's causing this so it doesn't become more serious or at least it stays the same)

An Ivorian male patient attends a Nephrology consultation because he has high blood pressure and his kidney function is slightly deteriorated. The female doctor involved in this interaction elicits information and explains the next steps to take, which causes the patient to react with a fatalistic tone in a humorous way ('I'm going to die'). As stated earlier, humour is sometimes used to discuss sensitive topics, including death (Semino et al., 2018). The interpreter, however, fails to render this message, and the medical consultation continues without acknowledging the patient's distress. Towards the end, patient and healthcare provider communicate directly without the interpreter. The patient then voices his concern again, using the same fatalistic, humorous tone. This time the interpreter renders the message, which gives the doctor a chance to recognise his emotional state and to reassure the patient. It can therefore be said that omitting humour in interpreting may leave the patients' concerns unattended and prevent professionals from establishing an affective, therapeutic relationship with them, which calls for the need to raise awareness about the importance of humour among healthcare interpreters to enhance successful communication.

5.3.4 Initiation of humour

Initiation of humour by the interpreter occurs in only 3 instances. Interestingly, the only interpreter that initiates humour is the one with both specialised training and professional experience in the hospital where the study takes place (Interpreter 1). Furthermore, these humour events take place in Tropical Medicine consultations, involving healthcare providers the interpreter works with on a daily basis, given the high number of medical consultations that require an interpreter in this area of medicine. These facts suggest that collaborative work between healthcare providers and interpreters in previous encounters with patients may make interpreters feel more comfortable and, thus, likely to initiate humour. Excerpt 10 sheds light on this specific situation:

> Excerpt 10. Interpreter initiates humour
> [The doctor takes a pen to sign a prescription for the patient]
> Doctor: Esto está más seco que la mojama (This is drier than tuna jerky)
> [The interpreter makes a face]
> Interpreter 1: C'est une autre phrase en espagnol qui veut dire qu'il est sec, "más seco que la mojama…" ¡La próxima vez haces tú de intérprete y yo de médico! (It's another phrase in Spanish that means that it's dry, "más seco que la mojama…" Next time you'll act as the interpreter and I'll be the doctor!)
> [The doctor laughs and the interpreter smiles]
> Interpreter: J'ai dit que la prochaine fois je serais le médecin et il sera l'interprète.
> [The patient smiles]

Excerpt 10 is taken from the follow-up appointment in tropical medicine already described in Subsection 5.2.1. The consultant uses a good number of colloquialisms, idioms and fixed phrases to create an informal atmosphere that challenge the interpreter. Towards the end of the encounter, the doctor turns to a fixed expression to complain about his pen and the interpreter struggles to render its meaning, which shows all over her face. She provides a general explanation and then repeats the utterance in Spanish, subsequently making a humorous comment subtly complaining about the doctor's choice of words. The doctor shows his appreciation for the interpreter's humour through laughter, and the interpreter includes a brief explanation to keep the patient in the loop. As seen in Excerpt 8, the humorous exchange appears not to involve the patient directly, and the interpreter tries to include him so he is aware of the interaction.

6. Discussion

This study aims to contribute to the body of research on humour in multilingual, multicultural healthcare settings. Humour in interpreter-mediated healthcare encounters arises as a multifaceted management tool and serves similar functions to those reported in monolingual interactions, since it allows all three members of the triad to build and protect their professional relationship (Schöpf et al., 2015). Following the results obtained in this study, humour allows patients, providers and interpreters to pursue a series of objectives reported in the literature focusing on monolingual encounters, particularly fruitful for creating a relaxed atmosphere (McCabe, 2004; Scholl, 2007; Scholl & Ragan, 2003) and handling negative emotions (Beach & Prickett, 2016; Holmes & Major, 2002; McCreaddie & Payne, 2014).

However, and unlike in language-concordant consultations, successful transfer of humour does not solely involve patient and provider, but falls heavily on interpreters, as the sole interlocutors with full access to all dimensions of communication. Consequently, interpreters partake in humour dynamics and contribute to its creation, together with the rest of interlocutors, which emphasises the interpreter's active participation in healthcare interactions (Angelelli, 2004). This joint construction of humour in

ongoing interactions (Murata, 2014) implies that all participating agents can initiate or receive humour, and they work collaboratively to establish a humorous frame.

This study also points to power management and hierarchical relationships among participants, as reported by Fairclough (1989) and Argaman (2009). In line with existing literature, providers usually initiate humour, which reveals the well-recognised hierarchy in doctor–patient relationships (Lidz, 2010; Parsons, 2013), with the additional participation of a healthcare interpreter. To illustrate this, on a number of occasions in the excerpts, the patient's humour is not taken up by the doctor (e.g., Excerpt 2), even if taken up by the interpreter (e.g., Excerpt 3) and, less frequently, the doctor's humour is not taken up by the patient (e.g., second half of Excerpt 1). This asymmetry is also shown in Figures 1 and 2, and explained by differences in status as discussed by Haakana (2002) and Glenn (2010). Patients are often humour recipients, but also initiate humour in a fair number of instances, which should not be overlooked. This seems to contradict other studies suggesting that interpreter-mediated interactions allow for less humour (Kai, 2013; Seale et al., 2013). In light of these findings, it could be hypothesised that the interpreter's participation may contribute to a more relaxed atmosphere, favouring humour initiation by both patients and healthcare providers.

Interpreters are sometimes targets of humour occurrences (see Figure 3). Moreover, Interpreter 1 also initiates humour in a modest number of cases. She is the participant with the most work experience in the hospital and usually interacts with the same healthcare providers and recurring patients in tropical medicine. Thus, it could be suggested that collaborative work and subsequent comfort levels around patients and doctors may increase the chances of an interpreter initiating humour. This could also apply to other participants, which makes a potential relationship between humour frequency and number of previous interactions worthy of further attention.

Healthcare interpreters in the sample usually strive to transfer humorous messages completely. They must manoeuvre around linguistic and cultural differences, but background and contextual knowledge has also proved to be challenging and can lead to partial transmission of humour (e.g., Excerpt 8). This is closely related to the presence of three or more interlocutors. In these cases, humour exchanges appear not to involve patients directly, and interpreters act differently from those occasions in which the exchange does involve them. Interpreters' self-initiated explanations or non-renditions (Wadensjö, 1998) are provided to keep all participants in the loop and, thus, include them in the interaction. Behind this lies the fact that the three members of the triad must appreciate all mechanisms used to thread humour or they will be very restricted to participate (or even comprehend) the humorous frame, which may negatively impact on the trust relationship between doctor, patient and, by extension, interpreter.

Similarly, omission or partial transmission of humour may entail potentially negative consequences for the consultation, as it implies that one interlocutor is not aware of the humorous disposition and the underlying intention behind the other participant's humour is not achieved. However, interpreters deliberately omit humour in some cases, which can be related to different perceptions on humour usage influenced by professional (Hardy, 2019) and cultural background (Attardo, 1994). Finally, the fact that French is not the mother tongue of interpreters and most patients in the sample should not be underestimated, as this may influence the way they construct and decode humour occurrences in interactions.

7. Final remarks

Healthcare interpreters are key players in the co-construction of humour between patients and providers, and they allow establishing a shared humorous frame by transferring humour occurrences that point to hierarchical relationships and attainment of both relational and transactional goals. As derived from the results presented in this paper, humour is a useful discourse strategy that allows patients, providers and interpreters alike to create a relaxed atmosphere; communicate criticism, rejection or disagreement; manage power asymmetries; save face; and handle negative emotions or help another participant to cope with them. For humour to be successful, interpreters must not only

navigate linguistic and cultural differences, but also ensure that all participants grasp and comprehend contextual and background knowledge, which is essential for them to participate in and understand humorous occurrences governing the interaction at a given point. Healthcare interpreters must be aware of the interactional power humour holds in medical consultations, especially when they initiate or omit these occurrences, as it may have consequences for communication and trust in the professional relationship. For this reason, there is a need to raise awareness in the interpreting community about the role and importance of humour, perhaps by means of short explanatory videos or materials based on empirical data like the examples presented here.

Due to the sample size, results are only preliminary and must be validated against a much larger and varied dataset. For more comprehensive results, future studies should recruit participants from different countries, cultural backgrounds and workplaces, and interactions should ideally be filmed. Despite existing limitations, this study provides relevant input with regard to humour in interpreter-mediated medical consultations, serving as a starting point for other researchers to venture further into the line of research on humour presented here.

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References

Álvaro Aranda, C. 2020. Formación y experiencia profesional como diferenciadores en la actuación de intérpretes sanitarios: un estudio de caso desde la sociología de las profesiones [Training and professional experience as differentiators in the performance of healthcare interpreters: A case study from the sociology of the professions] [Unpublished doctoral dissertation, University of Alcalá]

Álvaro Aranda, C., & Lázaro Gutiérrez, R. 2017. Small talk as a communicative resource in monolingual and interpreted medical consultations: A comparative analysis. Czech and Slovak Linguistic Review, 1–2/2017, 25–37. Retrieved March 20, 2021, from http://upmedia .cz/TIFO2017_book.pdf

Álvaro Aranda, C., Lázaro Gutiérrez, R., & Li, S. 2021. Towards a collaborative structure of interpreter-mediated medical consultations: Complementing functions between healthcare interpreters and providers. Social Science & Medicine, 269, 113529. https://doi.org/10.1016/j.socscimed.2020.113529

Amato, A. & Mack, G. (2011). Interpreting the Oscar night on Italian TV: An interpreter's nightmare? *The Interpreter's Newsletter*, *16*, 37-61.

Angelelli, C. (2004). *Medical interpreting and cross-cultural communication*. Cambridge: Cambridge University Press.

Angelelli, C. (2019). *Healthcare interpreting explained*. Oxon & Nueva York: Routledge.

Antonioni, R. (2010). And the Oscar goes to….: A study of the simultaneous interpretation of humour at the Academy Awards Ceremony. In D. Chiaro (Ed.), *Translation, Humour and the Media: Translation and Humour, 2* (pp. 53-70). London: Continuum.

Argaman, E. (2009). Arguing within an institutional hierarchy: how argumentative talk and interlocutors' embodied practices preserve a superior–subordinate relationship. *Discourse Studies, 11*(5). doi:10.1177/1461445609340498

Arocha, I. S. & Joyce, L. (2013). Patient safety, professionalization, and reimbursement as primary drivers for national medical interpreter certification in the United States. *The International Journal of Translation and Interpreting Research, 5*(1), 127-142. http://www.trans-int.org/index.php/transint/article/view/233 (accessed December 2020)

Attardo, S. (1994). *Linguistic theories of humor*. Berlin: Mouton De Gruyter.

Attardo, S. (2002). Translation and humour. An approach based on the general theory of verbal humour (GTVH). *The Translator, 8*(2), 173-194. doi:10.1080/13556509.2002.10799131

Bach, S. y Grant, A. (2010). *Communication and interpersonal skills in nursing* (2nd ed.). Exeter: Learning Matters.

Beach, W. & Prickett, E. (2016). Laughter, humor, and cancer: Delicate moments and poignant interactional circumstances. *Health Communication*, *32*(7), 791-802. doi:10.1080/10410236.2016.1172291

Bell, N. (2006). Interactional adjustments in humorous intercultural communication. *Intercultural Pragmatics, 3*(1), 1–28. doi:10.1515/IP.2006.001

Benson, J., Thistlethwaite, J. & Moore, P. (2009). *Mental Health across Cultures: A Practical Guide for Health Professionals.* Radcliffe Oxford.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, London & New Delhi: Sage Publications.

Chiaro, D. (2006). Verbally expressed humour on screen: Reflections on translation and reception. *The Journal of Specialised Translation,* 6, 198-208. http://www.jostrans.org/issue06/art_chiaro.php (accessed January 2021)

Collinson, D. L. (2002). Managing humour. *Journal of Management Studies, 39*(3) 269-288. doi:10.1111/1467-6486.00292

Cox, A.; Rosenberg, E.; Thommeret-Carrière, A. S.; Huyghens, L.; Humblé, P. & Leanza, Y. (2019). Using patient companions as interpreters in the Emergency Department: An interdisciplinary quantitative and qualitative assessment. *Patient Education and Counseling, 102*(8), 1439-1445. doi:10.1016/j.pec.2019.03.004

Dharamsi, S., Whiteman, M. & Woollard, R. (2010). The use of cynical humor in medical staff: Implications for professionalism and the development of humanistic qualities in medicine. *Education for Health. Change in Learning & Practice, 23* (3), 533.

Díaz Pérez, F. J. (2017). The translation of humour based on culture-bound terms in Modern Family. A cognitive-pragmatic approach. *MonTI, 9*, 49-75. doi:10.6035/MonTI.2017.9.2

Dickinson, J. (2017). The signed language interpreter's role in team meeting discourse. In R. Lawson & d. Sayers (Eds.), *Sociolinguistic research: Application and impact.* Abingdon & New York: Routledge.

Duncan, W. J.; Smeltzer, L. R. & Leap, T. L. (1990). Humor and work: Applications of joking behavior to management. *Journal of Management, 16*(2), doi:10.1177/014920639001600203

Fairclough, N. L. (1989). *Language and power.* London: Longman.

Fernández López, M de la O. (2010). El humor como lengua de contacto. ¿Estrategia afiliativa o de autoafirmación? Estudio comparativo inglés-español del discurso institucional. *Odisea: Revista de Estudios Ingleses,* 11, 285-299. http://hdl.handle.net/10835/1149 (accessed 30 January 2020)

Francis, L. (1994). Laughter, the best mediation: Humor as emotion management in interaction. *Symbolic Interaction, 17 (2)*, 147-163.

Francis, L., Monahan, K. & Berger, C. (1999). A laughing matter? The uses of humor in medical interactions. *Motivation and emotion, 23*(2), 155-174.

Gildberg, F. A.; Paaske, K. J.; Rasmussen, V. L.; Nissen, R, D.; Bradley, S. K.; Hounsgaard, L. (2016). Humor: Power conveying social structures inside forensic mental health nursing. *Journal of Forensic Nursing, 12*(3), 120-128 doi:10.1097/JFN.0000000000000118

Glenn, P. (2010). Interviewer laughs: Shared laughter and asymmetries in employment interviews. *Journal of Pragmatics*, 42, 1485-1498.

González, L. D. & Mejias, G. M. (2013). The interpreter's ultimate challenge: Humor in conferences. *Translation Journal, 17*(4) https://www.translationjournal.net/Featured-Article/the-interpreter-s-ultimate-challenge-humor-in-conferences.html (accessed January 2021)

Goriup, J., Stričević, J. & Sruk, V. (2017). Is education for using humour in nursing needed? (Slovenian case study on sociological and ergonomic aspects on the impact of humour on nursing professionals). *Acta Educationis Generalis, 7*(3), 45-62. doi:10.1515/atd-2017-0023

Granek-Catarivas, M., Goldstein-Ferber, S., Azuri, Y., Vinker, S., & Kahan, E. (2005). Use of humour in primary care: Different perceptions among patients and physicians. *Postgraduate medical journal, 81*(952), 126-130.

Grant, W. M. (2017). *Humor in medicine: A literature review of humor's potential therapeutic value in health care*. University of Arkansas, AR: Undergraduate honors thesis.

Haakana, M. (2002). Laughter in medical interaction: From quantification to analysis, and back. *Journal of Sociolinguistics*, 6, 207-235.

Hardy, C. (2019). Humour and sympathy in medical practice. *Medicine, health care and philosophy*. doi:10.1007/s11019-019-09928-0

Hay, J. (2001). The pragmatics of humour support. *International journal of humour research, 14* (1) doi:10.1515/humr.14.1.55

Heritage, J. (2003). Conversation analysis and institutional talk. Analyzing data. In D. Silverman (Ed.), *Qualitative research: Theory, method and practice* (2nd ed.). London, Thousand Oaks & New Delhi: Sage Publications.

Holmes, H. & Marra, M. (2002). Having a laugh at work: How humour contributes to workplace culture. *Journal of Pragmatics, 34*(12), 1683-1710. doi:10.1016/S0378-2166(02)00032-2

Holmes, J. & Major, G. (2002). Communicating on the wards: A pilot study. *Language in the workplace occasional papers,* 7. University of Wellington. https://www.librarycat.org/lib/SLALS-VUW/item/101574893 (accessed 30 January 2020).

Holmes, J. (2000). Politeness, power and provocation: How humour functions in the workplace. *Discourse Studies, 2*(2), 159-185. doi:10.1177/1461445600002002002

Holmes, J. (2007). Making humour work: creativity on the job. *Applied Linguistics, 28*(4), 518-537. doi:10.1093/applin/amm048

Hsieh, E. & Kramer, E. M. (2012). Medical interpreters as tools: dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling, 89*(1), 158-162. doi:10.1016/j.pec.2012.07.001

Hsieh, E. (2016). *Bilingual health communication. Working with interpreters in cross-cultural care.* New York & London: Routledge.

Jiang, F.; Lu, S.; Jiang, T. & Jia, H. (2020). Does the relation between humor styles and subjective well-being vary across culture and age? A meta-analysis. *Frontiers in Psychology.* doi:10.3389/fpsyg.2020.02213

Kai, J. (2013). Enhancing consultations with interpreters: Leaning more about how. *British journal of general practice, 63*(607), 66-67. doi:10.3399/bjgp13X661039

Kalina, S. (2015). Ethical challenges in different interpreting settings. *MonTI Special Issue*, 63-86. Doi:10.6035/MonTI.2015.ne2.2

Krystallidou, D.; Langewitz, W. & van den Muijsenbergh, M. (2020). Multilingual healthcare communication: Stumbling blocks, solutions, recommendations. *Patient Education and Counseling*. doi:10.1016/j.pec.2020.09.015

Lako, C. (2021). From translation to transcreation of humorous items (memes) on Romanian social media channels. In M. Dore (Ed.), *Humour translation in the age of multimedia*. New York: Routledge.

Lázaro Gutiérrez, R. & Cabrera Méndez, G. (2019). Context and pragmatic meaning in telephone interpreting. In P. Garcés-Conejos Blitvich, L. Fernández-Amaya & M. de la O Hernández-López (Eds.), *Technology mediated service encounters* (pp. 45-68). doi:10.1075/pbns.300.02laz

Lázaro Gutiérrez, R. (2018). Interpretación sanitaria para víctimas de violencia de género. *Panace@, XIX*(47), 96-105. http://tremedica.org/panacea.html (accessed January 2021)

Lidz, V. (2010). Social control in doctor-patient relationships: Similarities and differences across medical specialties. In J. J. Chriss (Ed.), *Social control: Informal, legal, and medical* (pp. 149-169). Bingley: Emerald.

Liendo, P. J. (2013). The challenges of interpreting humour (a.k.a. "Don't kill the killjoy"). *Translation Journal, 17*(1). http://www.bokorlang.com/journal/63humor.htm (accessed December 2020).

Martin, R., Puhlik-Doris, P., Larsen, G., Gray, J. & Weir, K. (2003). Individual differences in uses of humor and their relation to psychological well-being: Development of the Humor Styles Questionnaire. *Journal of research in personality, 37* (1), 48-75. doi:10.1016/S0092-6566(02)00534-2

Martínez Sierra, J. J. & Zabalbeascoa, P. (2017). Humour as a symptom of research trends in translation studies. *MonTI, 9*, 9-27. doi:10.6035/MonTI.2017.9.1

Martínez Sierra, J. J. (2006). Translating audiovisual humour. A case study. *Studies in translation theory and practice, 13*(4), 286-296. doi:10.1080/09076760608668999

Mateo, M. & Zabalbeascoa, P. (2019). Translation and humour. In R. A. Valdeón, Á. Vidal & J. Muñoz-Basols (Eds.), *The Routledge Handbook of Spanish Translation Studies*. London: Routledge.

McCabe, C. (2004). Nurse-patient communication: An exploration of patients' experiences. *Journal of clinical nursing,* 13, 41-49. doi:10.1111/j.1365-2702.2004.00817.x

McCarthy, D., Buckey, B., Engel, K., Forth, V., Adams, J. & Cameron, K. (2013). Understanding patient-provider conversations: what are we talking about? *Academic emergency medicine, 20*(5), 441-448. doi:10.1111/acem.12138

McCreaddie, M. & Payne, S. (2014). Humour in health-care interactions: a risk worth taking. *Health expectations,* 17(3), 332-344. doi:10.1111/j.1369-7625.2011.00758.x

Miczo, N.; Averbeck, J. & Mariani, T. (2009). Affiliative and aggressive humor, attachment dimensions, and interaction goals. *Communication Studies, 60*(5), 443-459. doi:10.1080/10510970903260301

Mullany, L. (2004). Gender, politeness and institutional power roles: Humour as a tactic to gain compliance in workplace business meetings. *Multilingua, 23*, 13-37. doi: 10.1515/mult.2004.002

Murata, K. (2014). An empirical cross-cultural study of humour in business meetings in New Zealand and Japan. *Journal of Pragmatics, 60*, 251-265. doi:10.1016/j.pragma.2013.09.002

Navaza, B., Guionnet, A., Navarro, M., Estevez, L., Pérez Molina, J. A. y López Vélez, R. (2012). Reluctance to do blood testing limits HIV diagnosis and appropriate health care of sub-Saharan African migrants living in Spain. *AIDS Behav, 16*(1), 30-35. doi:10.1007/s10461-010-9871-0

Norton, K. & Smith, S. (1994). *Problem with patients: managing complicated transactions*. New York: Cambridge University Press.

Oczkowski, S. (2015). Virtuous laughter: We should teach medical learners the art of humor. *Clinical Care, 19*(222). doi:10.1186/s13054-015-0927-4

Parrilla Gómez, L. & Postigo Pinazo, E. (2018). Intercultural communication and interpreter's roles: widening taxonomies for effective interaction within the healthcare context. *Current trends in translation teaching and learning E, 5*, 236-314.

Parsons, T. (2013). *The social system* (2nd ed.). Abingdon: Routledge.

Pavlicek, M. & Pöchhacker, F. (2002). Humour in simultaneous conference interpreting. *The Translator, 8*(2), 385-400. doi:10.1080/13556509.2002.10799139

Rosenberg, E.; Seller, R. & Leanza, Y. (2008). Through interpreters' eyes: Comparing roles of professional and family interpreters. *Patient Education and Counseling, 70*(1), 87-93. doi:10.1016/j.pec.2007.09.015.

Schauffler, S. (2015). Wordplay in subtitled films – An audience study. In A. Zirker & E. Winter-Froemel (Eds.), *Wordplay and metalinguistic / Metadiscursive Reflection* (pp. 229-244). Berlin: De Gruyter. doi:10.1515/9783110406719-011

Schnurr, S. (2009). *Leadership and humour. An analysis of workplace discourse*. London: Palgrave Macmillan.

Scholl, J. & Ragan, S. (2003). The use of humour in promoting positive provider-patient interactions in a hospital rehabilitation unit. *Health Communication, 15*(3), 319-330. doi:10.1207/S15327027HC1503_4

Scholl, J. (2007). The use of humor to promote patient-centered care. *Journal of applied communication research, 35*. 156-176. doi:10.1080/00909880701262658

Schöpf, A., Martin, G. & Keating, M. (2015). Humor as a communication strategy in provider-patient communication in a chronic care setting. *Qualitative Health Research, 27*(3). doi:10.1177/1049732315620773

Seale, C., Rivas, C. & Kelly, M. (2013). The challenge of communication in interpreted consultations in diabetes care: A mixed methods study. *British Journal of General Practice, 63*(607), 125-133. doi:10.3399/bjgp13X663082

Semino, E.; Demjén, Z.; Hardie, A.; Payne, S. & Rayson, P. (2018). *Metaphor, cancer and the end of life: A corpus-based study*. New York: Routledge.

Swabey, L. & Malcolm, K. (2012). *In our hands: Educating healthcare interpreters*. Washington: Gallaudet University Press.

Toledano Buendía, C., Abril Martí, M. I., Del Pozo Triviño, M. y Aguilera Ávila, L. (2015). Hacia una especialización en interpretación en el ámbito de la violencia de género: investigación, formación y profesionalización. *MonTI,* 2, 139-160. https://doi.org/10.6035/MonTI.2015.ne2.5

Vandaele, J. (2002). Humor mechanisms in film comedy: Incongruity *and* superiority. *Poetics Today, 23*(2), 221-249.

Vymětalová, D. (2017). *Strategies of interpreting humour in the European Parliament*. University of Olomouc, Master's thesis.

Wadensjö, C. (1998). *Interpreting as interaction*. Londres & Nueva York: Routledge.

Yabe, M. (2020). Healthcare providers' and deaf patients' interpreting preferences for critical care and non-critical care: Video remote interpreting. *Disability and Health Journal, 13*(2). doi:10.1016/j.dhjo.2019.100870

Zabalbeascoa, P. (2021). Multilingual humour in audiovisual translation: multilingual realities, humour and translation in an ever-changing mediascape. In M. Dore (Ed.), *Humour translation in the age of multimedia*. New York: Routledge.