Bending the Rules: An Interpreter's Stand in Medical and Mental Health Settings

It is widely held that interpreters' are ethically bound to neutrality, impartiality, and a responsibility to avoid allying with either the majority or minority language user in interpreted encounters. The code of ethics promulgated by the Registry of Interpreters for the Deaf (2003) includes the tenet: "Interpreters/transliterators shall not counsel, advise or interject personal opinions." That this is intended to impose neutrality and impartiality on interpreters is shown by its expansion in the code's revision (Registry of Interpreters for the Deaf, 2003):

> Interpreters remain neutral while providing interpreting services and refrain from providing counsel, advice, or personal opinions or promoting a religious or spiritual faith while performing professional duties.

and:

> Before accepting assignments, interpreters should determine whether they are qualified, assessing their current skill level, ability to remain impartial, knowledge of the subject and the consumers involved.

The Massachusetts Medical Interpreters Association (2003) asks that interpreters maintain impartiality but they also "maintain a low profile so as not to interfere with triadic communication." The code ofthe National Council on Interpreting in Health Care (2003) describes what it means to be impartial. "Interpreters remain impartial by suspending judgment and making no personal comment, verbal or non-verbal, on the content of the communication." This code outlines professional boundaries as well, "Interpreters need to avoid getting personally involved with the people for whom they interpret. This does not mean that interpreters cannot be friendly and caring. The development of rapport with patients and providers during a pre-session is a part of the interpreter's professional role and does not

necessarily represent personal involvement." The Association of Visual Language Interpreters of Canada (2000) requires that members "remain neutral, impartial, and objective." The California Healthcare Interpreters Association (2002), in contrast, discusses only an obligation to prevent "preferential behavior or bias affecting the quality and accuracy of the interpreting performance." Associated performance measures describe demonstration of skills purporting to maintain impartiality.

Clearly, there is confusion between "neutrality" and "impartiality"; they are used interchangeably. It is possible to clarify the differences.

One dictionary (Microsoft Corp., 2003) defines "neutral" as "not taking sides: not belonging to, favoring, or assisting any side in a war, dispute, contest, or controversy." Neutrality, then, is "the condition of not taking sides: the state of being neutral, especially as regards noninvolvement in wars and disputes, not taking sides, and not joining alliances. This same dictionary defines "impartial" as: "not biased: having no direct involvement or interest and not favoring one person or side more than another." Simple definitions do not do justice to the strength of these two ideas that have become so central to interpreting ethics.

A recent article (Donald, 2003) thoroughly examines neutrality and impartiality as political concepts. It notes "[a] neutral party is far more impassive than an impartial one." In the case of a war, a neutral party is indifferent to the outcome and remains inactive with relation to the belligerents. An impartial actor, on the other hand, is one who is just, fair, and whose position is not attached to either party.

The two terms are not synonymous. To be neutral is to refuse to take sides, perhaps out of indecision; it is refraining from positive action. Synonyms include indifferent, indefiniteness, indecisiveness, ineffectualness. Fair, equitable, unbiased, objective, aloof, just, dispassionate, and uncolored are synonyms for impartial. Thus, "neutrality is a passive policy, without a core principle other than the avoidance of trouble." Impartiality? "A coherent position predicated on a judgment of the

protagonists." Impartiality requires independent activity "for without that capability how can an impartial entity judge, be fair, or demonstrate an absence of prejudice, favoritism, and bias?"

The notion of an interpreter as a neutral actor — one who remains passively indifferent to, and refrains from positive action for, the people for whom they interpret — is not acceptable. It seems equally problematic for an interpreter to be impartial, that is, an independent actor whose primary interest is to be fair, just, and objective. Equity is no guarantee of equal representation of the interlocutors in an interpreted event. An impartial interpreter could independently intervene on behalf of one client in order to demonstrate the absence of prejudice, favoritism, or bias. An impartial interpreter could feel compelled to speak out against a system that appears to discriminate against minority-language-using patients.

A thoughtful discussion of these possibilities is a part of the *California Standards for Healthcare Interpreters* (2002). After explaining the conduit model, wherein the interpreter, "should disappear from the interaction leaving only their physical voice presenting the correctly converted message in the right language," these notes continue:

> From a more current philosophical standpoint, the interpreter is obviously physically and intellectually present in the interaction. At the same time, there is not an exact one-to-one relationship between words and concepts across cultures and languages. This gives rise to the possibility that the interpreter becomes a third party in the conversation between patient and provider for a number of very specific communication and cultural issues. These roles have also been discussed in various literature (Angelelli, 2001; Metzger, 1999; Roy, 2000; Wadensjö, 1998). Some studies suggest that the "participation" or "intervention" of the interpreter is due to the nature of the medical encounter where the interpreter may be the only person able to identify the emergence of potentially critical patient health and safety issues (Kaufert & Koolage, 1984; Kaufert, Koolage, Kaufert, & D., 1984; Kaufert, Medd, & Mills, 1981; Kaufert &

Putsch, 1997; Kaufert, Putsch, & Lavalee, 1999; Putsch, 1985). Other studies, bridging from communication studies, sociology and sociolinguistics, consider interpreters as "co-participants" in the interaction and look at various instances of this role in typical interactions (Angelelli, 2001, 2002; Davidson, 2000; Metzger, 1999; Prince, 1996; Roy, 2000; Wadensjö, 1992, 1998).

Rather than being uninvolved, Roy (1993) makes clear, "the only participant who can… maintain, adjust, and if necessary, repair differences in structure and use in these situations is the interpreter." As a result, she holds that "[t]his means means that the interpreter is an active, third participant with the potential to influence both the direction and outcome of the event…." As active participants along with the parties for whom they are interpreting, "the interpreter is not solely responsible for either the success or failure of an interpreting event. All three participants jointly produce this event, and all three are responsible, in differing degrees, for its communicative success or failure." This interactionist view of interpreted events is replacing mechanistic, conduit-like models in the literature although interpreter education and practice still lag behind.

A study by Davidson (2001) examined the impact of the involved interpreter specifically in hospital settings and identified competing constraints imposed on interpreters. The first "was an administrative order to interpret 'all and only' what was said by patients and physicians" growing out of the mistaken idea that interpreting is unplugging one set of words and substituting another language's set. The second mandate, implied by the clinicians' manner, was to keep interactions from taking too much time. Physicians expected interpreters to heavily edit, cutting irrelevant, non-medical details to keep interviews moving. The expectation, evidently ratified by the interpreters' actions, was that they act as pre-diagnosticians, sifting through patient speech to sort out what may be important or of interest.

Interestingly, physician-patient interactions, even when monolingual, are identified by the author as

a kind of interpreted speech act. Physicians consider interpretation to mean, not the transfer of meaning from language to language (which they call translating) but “the process of deciphering physical and verbal signs, by passing them through a grid of medical signification, and re-analyzing them as symbols or symptoms of known disease processes". In order to elicit these signs, physicians ask a large number of direct, closed-end questions, thereby determining what will be talked about in an interview and for how long.

In contrast, patients generally ask few questions. Direct questions convey patients’ interest in their own conditions. Physicians take note of the number of direct questions asked by patients. In Davidson's study English-speaking patients with English-speaking doctors asked a total of 55 direct questions, 53 of which were answered by the doctor and only 2 of which were left unanswered. Spanish-speaking patients through interpreters asked only 33 direct questions of their English-speaking questions. Of these only 15 were passed to the physicians and 12 answered; 18 questions were never passed to the doctor and 17 of these were answered by the interpreter.

While it can be argued that these interpreters were behaving unethically, it could be argued that they were working under a different ethic. Davidson concluded that these interpreters were acting in tacit coordination with physicians as gatekeepers to the medical system. As such they assured that recent immigrants’ health concerns were “important enough to be addressed and resolved by the means at the institution’s disposal.” Their behavior was as part of a system with little time and precious few resources for its non-English-speaking patients.

Another paper (Bahadir 2001) reports on interviews with interpreters working in a variety of settings, including medical. They maintained that they perform from a neutral and unbiased position, interpreting everything said. From the interviews it became clear that they adjusted their work with specific aims in mind, according to the demands of the settings and needs of their clients. The paper concludes that theoretical discussions on professional standards in community interpreting are often

idle as they do not reflect the reality of the work. "A more flexible, dynamic and situation-oriented approach to the position and role of the interpreter and the activities they perform is required. It is time to close the period of interpreters feeling guilty of their visibility and being traumatized by the fear of taking the initiative or of resisting."

In an early discussion of interpreter roles and power (Anderson, 1976) three possibilities are posited. The first is that an interpreter will "orient himself toward the listener as if he were echoing the other client with utmost fidelity. This orientation would presumably be the same when translating in either direction — always characterized by apparent personal detachment from the content of his translations. Under this façade would be considerable manipulation of communicative content in the direction of moderation and rationality. Hidden losses in fidelity would blunt angered words and soften rigid stances." This sort of nonpartisanship — equal interest in the ends of both parties — is the result of the interpreter's attempt "to manipulate the interaction in the direction of a 'just' outcome whereby both clients would believe that they had maximized their own gains." This is what Donald would call an impartial interpreter.

The second is that "the interpreter's nonpartisanship might result from his total personal detachment from the situation. Rather than being equally pulled in both directions, he might be pulled in neither." Instead of false fidelity to content, even gesture and intonation are reproduced leaving clients to sort out their differences because any outcome of the interaction is equally acceptable to the interpreter. The interpreter is merely a passive element. This is Donald's neutral interpreter.

The third possibility is that "the interpreter may choose, for whatever reasons, to ally himself with one rather than the other client."

While this third alternative may seem ethically untenable, we believe that in medical and mental health settings it is the only reasonable recommendation. We believe that it is the reality in these

settings. It is instructive to look at relevant work done on doctor-patient interaction done in monolingual settings.

Examining medical encounters, researchers have found that while some aspects are stressful, other interpersonal aspects of the physician-patient encounter are in and of themselves health promoting. These are typified as either *affective* or *instrumental communication*. Affective communication relates to the patient's feeling of being in a trusting environment that encourages disclosure. It includes engagement in social conversation, emotional support and empathy, patient-centeredness, setting of positive expectations, and continuation of role preferences. Instrumental communication concerns the provision of information to patients. Providing diagnostic and prognostic information to patients is associated with improvement in both symptoms and functional health status (van Dulmen and Bensing, 2002).

Similarly, Gallagher *et al.* (2001) divide physician-patient communication into two categories: *content*, related to information or the language used; and *relational communication*. The relational component is not an auxiliary to content but an integral stream indicating the regard the doctor and patient have for one another. The relational aspect of interactions is associated with patient satisfaction, understanding and recall of medical information, compliance with appointments and regimen, relief of distress, and symptom resolution.

With the importance accorded clinicians' affective communication skills, it is no surprise that these come in for special attention when working in medical and mental health settings. Baker(1981) describes social work with the "ideal" interpreter. "The key to effective interpreting is for the worker and interpreter to become a close team in their enterprise, using the best qualities of each to help clients more effectively." Again, focusing on relational communication, "[r]ather than adopting complementary roles in the interview, as is typical of cotherapists, they try to become one person, the interpreter reflecting the approach of the social worker. A gentle statement must be translated

gently, for example, a confrontation must be translated as such, and a supportive statement must reflect warmth in its mood as well as in its content. An interpreter ultimately attempts to convey the personal style of the social worker, modified rather than supplanted by his or her own style."

Another author (Freed, 1988) discusses the working relationship between a social worker and interpreter. "Because the art of social work interviewing requires rapport, an empathic interchange, and an emotional connection, the interpreter must have the capacity to act exactly as the interviewer acts — express the same feelings, use the same intonations to the extent possible in another language, and through verbal and nonverbal means convey what the interviewer expresses on several levels."

To summarize, an interpreter who operates only under a mechanistic model, exchanging information between the majority- and minority-language-users does not perform an adequate service in medical and mental health settings whether the model transfers lexical items, meaning-based messages, or cultural-adjusted information. To carry only these language-based forms of communication is to ignore the entire integral stream of affective communication. Losing affective communication at the expense of conveying content means a social worker fails to build rapport with a client. It means decreasing patient satisfaction and the probability of compliance with treatment. And it means losing the health-promoting benefits of physician-patient encounters leaving only the stressful elements in place. As Roy reminds us: "All three participants jointly produce this event, and all three are responsible, in differing degrees, for its communicative success or failure." By losing the affective aspect of clinician-to-patient communication the interpreter is not holding up their obligation to the other participants. Their claim of neutrality, of non-involvement, is invalid.

Where does this leave us?

It seems self-evident that patients enter medical and mental health systems because of some distress from which they seek relief. Even those who do not come in voluntarily, including minors brought in by

parents, others brought in during crisis or emergency, or those who come reluctantly, may, during the course of treatment, become convinced of its value. Their behavior in these settings, then, is not only goal-oriented but the goal is discernable. At the same time, while mundane motivations affect clinicians, they are also bound by humane and professional codes to help those coming to them for aid. Their behavior, too, is goal-oriented. As earlier discussed, an interpreter has three options: to impartially assist both parties toward the accomplishment of their goals; to neutrally allow the parties to work out for themselves whether they meet their goals or not; or to ally themselves with one party or the other, thus accepting the goals of that party as their own. If we accept that a medical or mental health encounter is successful (not merely as a communicative but as a therapeutic event) when the patient's goal of getting, and the clinician's goal of giving help are, to some degree, realized, the only acceptable stands for interpreters could be impartiality or alliance. We've already seen that impartiality doesn't work in these settings. All that is left is allying with either the clinician and the institution, or the patient.

It is important to recognize that that clinicians and their institutions have responsibilities toward patients that are not reciprocated. They are bound by the duty to seek what they believe to be in the patient's best interest. The principle of autonomy allows for a patient to state a preference for a particular course of treatment, even a refusal of treatment, in most cases and care is then co-ordinated around this choice. Even when there is disagreement between what course to follow, that recommended by the clinician or that preferred by the patient, the will of the patient and principle of autonomy takes precedence. Thus, allying with the clinician in an interpreted interaction affords interpreters the standing to subject themselves to the will of the patient. By practicing interpreting as a professional, helping discipline, interpreters are able to make rational choices about personal boundaries, the proscribed limits of their discipline, and appropriate behavior within these limits.

To conclude, then, we believe that neutrality and impartiality are widely misunderstood and wrongly

valued as guiding ethics for interpreters in medical and mental health settings. As agents of institutions and professionals that having fiduciary responsibilities, interpreters must be committed to patients' goals: providing quality care, developing coping skills, reducing distress, and improving health status. While working with the content of expressions of both doctors and patients, interpreters must pay particular attention to the affective and relational aspects of clinical communication as this is where the power to shape and change patient behavior lies.

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