Communication through Interpreters in Healthcare: Ethical Dilemmas Arising from Differences in Class, Culture, Language, and Power

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INTRODUCTION

In this article, we will consider the problems faced by medical interpreters as they facilitate communication between individual patients, healthcare providers, and family members. After we consider day-to-day workplace pressures and ethical dilemmas, we will focus on informed consent and end-of-life decisions. We will examine the roles interpreters may play when differences in cultural beliefs and frameworks cause participants to disagree. We will discuss cultural conflicts as well as power relationships between participants.

Problems arise when the participants in healthcare settings have different interpretations of illness and treatment, hold disparate values in relation to death and dying, and use language or decision-making frameworks differently. We will illustrate these problems by cases drawn from our ethnographic research on the roles of Aboriginal health interpreters in Winnipeg, Canada and observations of healthcare interpreters and healthcare providers in Seattle in which interpreters deal with questions of clarifying values, the mediation of cultural differences, autonomy in consent agreements, and truth-telling in end-of-life decisions. Finally, we will discuss the ethical dimension of the work of interpreters, and consider the evolution and regulation of the role of the healthcare interpreter and their relationships with other healthcare providers.

DISPARATE PROVIDER-PATIENT VIEWS ABOUT THE QUESTION "WHAT'S WRONG?"

Even within the same culture, healthcare providers and patients may disagree. Kleinman describes an academic physician-psychiatrist who cared for another academic physician who shared similar professional training, class origins, and culture. The psychiatrist used current professional standards and logic to reframe his patient's story and views of what it was that had gone awry in his life. After their meeting, the physician-patient recorded the following reflection in his

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personal diary: "I don't think he heard me. I wanted him to listen not for the diagnosis but for my story . . . I know I'm depressed, but I wanted him to hear what is wrong . . . I need to talk to someone about my whole world not just one part of it."

Despite sharing the same culture, language, class, and professional values, the two physicians failed to communicate, in part because healthcare providers reframe human realities according to learned practices, rules, and guidelines as well as their own biases.

Patients and healthcare providers, however, often come from different educational, cultural, or class backgrounds. They may hold disparate views of illness and treatment, and may not agree on a common set of cultural values regarding decision making. This is the interface at which interpreters in healthcare do their work, and disparate views as well as disparate expectations are the basis for the dilemmas that they often face. The work of the interpreter is further complicated by the unequal distribution of power in the relationship between the parties involved.

POWER AND DOMINANCE IN CLINICAL COMMUNICATION

The ethnomedical literature has been criticized for its failure to consider the dynamic of power between healthcare providers and their clients.\(^4\) Medical sociologists have focused on issues of power and dominance in clinical communication,\(^5\) and have described the clinician-patient relationship as one in which the clinician has the ultimate responsibility for developing conclusions and proposing alternative treatments. The dominance of healthcare providers affects the role of the interpreter both directly and through its impact on patients.\(^6\)

The dynamics of the physician-interpreter-patient relationship are also influenced by wider institutional, professional, and structural forces, such as a hospital's program directives, its funding arrangements, and how interpretation programs are represented at the management level. How interpreters interact with healthcare providers and patients is also influenced by health policies that may directly impact the definition of the role of, and power of, the interpreter; and these policies are subject to change. Generally these external forces impose the values of a dominant group or class on the work-a-day process of providing healthcare. In addition, interpreter programs may have been created to meet governmental regulations or to mediate institutional problems rather than to solve problems for patients.

The literature about communication has emphasized language and culture as "barriers." Interpreters or bilingual healthcare workers are usually represented as ancillary members of the healthcare team who enable clinicians and patients to communicate using mutually intelligible terminology and concepts.\(^7\) Some researchers recognize the power of an interpreter as a gatekeeper who has the power to elicit, clarify, translate, omit, or distort messages.\(^8\) Most often, however, the neutrality, completeness, and accuracy of interpreters are discussed. These issues, however, fail to account for sources of power and control or dominance in this triadic relationship. Ethical guidelines that are based on neutrality, completeness, and accuracy often fail to take into account issues such as class, power, disparate beliefs, lack of linguistic equivalence, or the disparate use of language. We have observed situations that could not be resolved by the adoption of more culturally "sensitive" communication styles or by educating the healthcare provider on the cultural beliefs of patients and families.

THE CHALLENGE OF MONOLINGUALISM IN MULTICULTURAL PRACTICE

There is great potential for value conflict when caregivers and patients come from different cultural, language, and class groups. Jecser et al. discuss the issue of diversity in multi-cultural practice settings.\(^9\) In acknowledging that differences in values exist within a shared culture, they concurred with Ware and Kleinman, who state, "across class, caste, gender, age, religious and political lines—cross-cultural conflicts may be more deeply rooted, for such differences embody

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not just different opinions or beliefs, but different ways of every day living and different systems of meaning."

If the healthcare providers’ views on the ethical principles that govern decision making are in conflict with the values that are held by patients, their families, or their communities, disagreement over cultural values may lead to confrontation. These disagreements are often most intense when healthcare providers evoke the principles of patient’s autonomy and truth-telling. The Decisions Near the End of Life Program identified a number of sensitive ethical, legal, and psychosocial issues in the treatment of terminally ill patients in situations that involved cultural and ethnic diversity. Jennings describes cultural differences that may block efforts to behave in accordance with “good” ethical principles: “If we don’t overcome linguistic, educational and emotional barriers to effective communication, informed consent becomes a sham. We must find culturally sensitive ways to involve patients and family members in decision making. All this is hard enough when physician, nurse and patient share a common culture; widely divergent cultural backgrounds at the bedside make the challenge much harder.” The dilemmas Jennings identified may be inherent in all provider-patient relationships.

Jecker et al. suggest that conflict that is based on cultural difference can be mediated using strategies that allow both the patient and the healthcare provider the opportunity to clarify their values. Others have recommended the use of review panels and consultants who have special expertise in cross-cultural communication. We have found that the idealized model–neutral communication that is facilitated by an interpreter–often diverges from actual practice. We found that interpreters not only serve as helpers and educators, but also as cultural consultants, or mediators between conflicting value systems. We also found that interpreters sometimes function as witnesses when the conflicts in values were fundamental and could not be resolved simply by adopting “culturally sensitive” methods of communication.

LANGUAGE INTERMEDIARIES, INSTITUTIONAL RESPONSES, AND THE USE OF LANGUAGE

The literature on communication seems to imply that conflicts can be resolved by altering how one approaches communication, and seems to assume that language intermediaries play a neutral role that does not influence decision making. In fact, the literature that describes cross-cultural encounters treats language intermediaries as if they were invisible. For example, Jennings suggested that clinicians may accommodate cultural differences that “impinge on good ethical and medical decisions” by changing their style of providing care and by developing more appropriate ways of demonstrating respect for patients’ rights and autonomy. However, Jennings does not discuss the role of interpreters, bilingual healthworkers, or family members, although these intermediaries often play major roles in cross-cultural encounters.

Healthcare institutions often treat and describe language and culture as “barriers” or “problems.” The literature treats culture and language as “barriers” to be overcome by training clinicians to alter their communication “style,” and by improving clinicians’ understandings of the cultural inventory of the patient, the patient’s family, and his or her community. Approaches to communication that are culturally appropriate enable a clinician to hear a patient and his or her views about illness, and to negotiate options for treatment.

Cross-cultural methodologies, including Kleinman’s explanatory model, assume that it is the responsibility of the practitioner to elicit the patient’s views of his or her illness and to negotiate a plan for treatment that is mutually acceptable. An appropriate plan will reconcile the patient’s understanding of his or her illness with treatment that is offered by the healthcare provider. We have found that many exchanges are triadic, rather than dyadic, in that they include an interpreter as an active participant. An interpreter may hear discrepant views that reflect the alternative perceptions of “What’s wrong?” An interpreter is exposed to, and is variably aware of,
patients' and practitioners' criteria for decision making, and may be asked to mediate between a patient's and family's understanding and a professional's explanations of illness and proposals for treatment. Plans for treatment that are mutually acceptable do not always evolve, even when a patient and a healthcare provider can respectfully share their views and issues.

Another key to developing less ethnocentric ethical analysis of healthcare decisions in multicultural settings is understanding the differences in the use of language. For example, one should consider what Navajos believe and how they use language when one approaches the issue of truth-telling. This consideration should include the basic understanding that how one uses language affects one's perception of reality. Carrese and Rhodes reported that the core values held by many Navajos prohibit the discussion of "bad news." These core values and language use conflict with the ethical imperative to openly discuss surgical risks and mortality in obtaining a patient's informed consent and in discussing a terminal prognosis when working with a patient to write an advance directive. It is of interest that other groups hold a parallel belief, that telling the truth to the affected individual is disrespectful, may be dangerous, and/or may shorten his or her life. These groups include communities from the Horn of Africa, as well as Italy, Greece, China, Korea, and Mexican-Americans. These views operate at the interface in which interpreters do their work. We believe that this concrete way of using language may affect individuals from many cultures, especially around episodes of illness.

An ethnomedical approach to understanding the role of an interpreter in negotiating with patients must consider values and the ways that the process of making decisions are shaped by one's culture. In clinical situations that involve making decisions, the role of the interpreter is not simply to interpret ethical issues in an objective and linguistically accurate manner. We have found, in our research on the work of Canadian Aboriginal interpreter/advocates, that interpreters may influence the interaction with patients more directly, serving as mediators between clinicians and patients, explaining patients' values, and assisting in negotiating an ethical contract. In addition, in examining transcripts, some interpreters introduce a variety of biases into the messages that they give to patients and to providers. This is a clear departure from the "ideal" concept of an objective, uninvolved intermediary. However, we believe that this is a reality that challenges the notion that interpretation can be consistently neutral.

THE ROLE OF THE INTERPRETER

Policies that restrict the role of the interpreter and emphasize cultural neutrality and invisibility may ignore other dimensions of the interpreters' activities in healthcare. Legislation and professional codes of ethics have emphasized how important it is for interpreters to remain objective. This emphasis may limit how an interpreter serves as a cultural informant—one who explains the patient and community context, and acts as a broker or mediator in situations that involve culturally based conflict. Interpreters often facilitate trust between patients, families, communities, healthcare providers, and healthcare programs. They may improve the continuity of a patient's care, when the patient encounters multiple practitioners, and, with a patient's consent and participation, may provide caregivers information on a patient's family and community. Interpreters may also provide patients with information about the biomedical culture of the health system. Interpreters may facilitate patients' access to healthcare by providing culturally appropriate explanations of how a health system works and by explaining the patient's rights.

These roles have evolved in programs that have recognized the potential contribution of interpreters to improving health education, the compliance of patients, and increasing the effectiveness and efficacy of health services. Many innovative cross-cultural health programs in the United States, Europe, and Canada have developed roles for interpreters that support and legitimate their involvement in mediation, explaining
cultural differences/practices ("culture brokerage"), and advocacy.26 In other programs, interpreters work as bilingual medical assistants or as case managers who coordinate services, and act as advocates and counselors.27

The work of interpreters in culture brokerage and community advocacy has been incorporated into the interpreter services at the Harborview Medical Center in Seattle, which uses interpreter-mediators to work with patients, families, ethnic communities, and health institutions.28 In different programs around the country, bilingual health workers/interpreters serve as mediators, advocates, culture brokers, medical assistants, and in some cases, case managers.29

CODES OF ETHICS FOR INTERPRETERS IN HEALTHCARE

We collected codes of ethics developed for healthcare interpreters from more than 20 institutions and organizations. Many of these codes emphasize a mode of interpretation that calls for an objective, neutral role for interpreters that is similar to the interpreter's role that evolved in American Sign Language (ASL) programs and in court interpretation programs, where training and codes of conduct for interpreters have been legislated. Using the model of objective language interpretation from in the ASL and court systems, many programs have carried these approaches and assumptions into medical care settings. Because of the powerful influence of these codes, we will briefly discuss them using the Washington Legal Code as an example.

The Washington State Supreme Court's Code of Conduct for Court Interpreters (GR 11.1), adopted in 1989, includes extensive commentary published by the Court Interpreter Task Force in 1986. The preamble to GR 11.1 makes clear the risk of failure to comply with the rules and the nature of discourse in court: "A language interpreter who violates any of the provisions of this code is subject to a citation for contempt, disciplinary action or any other sanction that may be imposed by law. . . ."30 Under the following provision of GR 11.1 is a precise commentary about discourse in court:

A language interpreter shall interpret or translate the material thoroughly and precisely, adding and omitting nothing. . . . [Then the commentary enlarges on the situation.] Unless the interpreter is faithful to this concept of accurate interpretation, he or she may act as a filter or buffer in the communication process. This could damage the integrity of the trial process which is based on an adversarial system with vigorous examination and cross-examination (1986; abbreviated).31

Medical discourse has, as a basic goal, mutual understanding; it is not normally adversarial. Healthcare interpretation often occurs across major gulfs of culture, class, and language; and therefore it is unlike interpretation in the courts or in business or international negotiation. Attempts to encourage mutually shared understanding require the healthcare interpreter to engage in explanation, cultural brokerage, and mediation—when these actions are necessary.

Cynthia E. Roat, editor of a training manual for medical interpreters, wrote a code of ethics for interpreters in healthcare that was first published by Region 10 of the U.S. Public Health Service in 1995 (an abbreviated version is presented in figure 1).32 The code combines codes of ethics from three health interpretation programs in the United States. As the code is being used in training interpreters, there has been a remarkable opportunity to listen to experienced interpreters discuss each item in the code, drawing on their past experience. Many of these discussions have been passionate and have focused on the type of dilemmas these individuals face in their work, particularly in the areas of confidentiality and client self-determination. Other issues have included the value they place on always appearing non-judgmental and respectful of the values of their clients. Following are some of the issues that these bilingual healthcare workers have raised about ethical dilemmas that they have recalled...
during reviews of the ethical code. In discussing problems of maintaining confidentiality, one interpreter presented the following problematic case example.

Confidentiality. A young patient was known to an interpreter from an interaction in a clinic for sexually transmitted diseases (STDs). While he interpreted for the patient during an evaluation and physical exam at a second clinic, the interpreter heard the patient twice respond negatively to questions about prior STDs. What if the prior diagnosis of an STD (as known to the interpreter) had an implication for the patient's current problem? What should the interpreter have done? Other interpreters who listened as he related this case recalled similar cases in which important prior diagnoses, especially alcoholism, were denied by patients. The confidentiality of a medical encounter is privileged and protected. It is clear, however, that some of the knowledge that interpreters may have about patients has been gained in other medical encounters or even outside of a medical setting. This is especially true in small communities.

Dilemmas raised by healthcare interpreters abound in other areas, and we will briefly highlight some of these here.

Accuracy and completeness. Interpreters asked: How do you deal with questions or comments by a healthcare provider or a patient that may be per-

A Code of Ethics for Interpreters in Health Care

Confidentiality
Interpreters must treat all information learned during the interpretation as confidential, divulging nothing without the full approval of the patient and his/her physician.

Accuracy: conveying the content and spirit of what is said
Interpreters must transmit the messages in a thorough and faithful manner, omitting or adding nothing, giving consideration to linguistic variations in both languages and conveying the tone and spirit of the message. Word for word interpretation may not convey the intended idea. The interpreter must determine the relevant concept and say it in language that is readily understandable... to the person being helped.

Completeness: conveying everything that is said
Interpreters must interpret everything that is said by all peoples in the interaction but should inform the health professional if the content... might be perceived as offensive, insensitive, or harmful to the dignity and well-being of the patient.

Conveying cultural frameworks
When appropriate, interpreters shall explain cultural differences to health providers and patients.

Non-judgmental attitude
An interpreter's function is to facilitate communication. Just as interpreters should not omit anything being said, they should also not add their own personal opinions, advice, or judgment.

Client self-determination
The client may ask the interpreter for his or her opinion... The interpreter should not influence the opinion of patients or families by telling them what action to take.

Attitude toward clients
The interpreter should strive to develop a relationship of trust and respect at all times with the patient by adopting a caring, attentive,... impartial attitude toward the patient, toward his or her questions, concerns, and needs.

Acceptance of assignments
Interpreters should disclose any real or perceived conflict of interest that would affect their objectivity in delivery of service. Additionally, if level of experience or personal sentiments make it difficult to abide by any of the above conditions, the interpreter should decline or withdraw from the assignment.

Compensation
The fee or salary paid by the agency is the only compensation that the interpreter should accept. Interpreters should not accept additional money, considerations, or favors for services.

Source: C.E. Roc, ed., *Bridging the Gap: A Basic Training for Medical Interpreters, 40 hours, for Multilingual Groups, ver. 2* (Seattle, Wash.: Cross-Cultural Health Care Program, January 1996, originally published by the U.S. Public Health Service Region 10, Seattle, Wash., 1995), 30-31. Used with permission. This code is a combination of the codes of ethics from the Hospital Interpretation Program, Seattle, Wash.; Boston City Hospital, Boston, Mass.; and the American Medical Interpreters and Translators Association (AMITAS), Stanford, Calif. The figure does not include sections on self-evaluation, ethical violations, and professionalism.

Figure 1
ceived as offensive? Rude? What if a healthcare provider is disrespectful of a patient’s reference to commonly held beliefs or practices?

**Non-judgmental.** Interpreters recognize that the code prohibits them from imposing their own personal values on others. However, they emphasize that neutrality is difficult to maintain when, in the interpreter’s judgment, there seems to be a clear failure on the part of one of the parties to understand basic, relevant information.

**Clients’ self-determination.** Discussing approaches to maintain patients’ autonomy, interpreters asked: What if a patient asks for an interpreter’s opinion (and patients frequently do), and rejects the interpreter’s response that he or she is not allowed to express an opinion to the patient? Interpreters also commented on the need to provide supplementary information to patients and to create opportunities in which a patient is presented the opportunity to choose between clearly explained alternatives. Doing this may maximize a patient’s capacity for self-determination in a medical system that the patient might otherwise find difficult to understand. In doing this, an interpreter may technically violate the ethical code—especially if he or she is prohibited from explaining medical culture and process to patients.

The code of ethics does not formally address instances when interpreters act as advocates for patients. A number of job descriptions written for bilingual healthcare workers include advocacy as an expected part of their function. It is interesting to contrast a widely held negative response to the idea that interpreters in healthcare may need to advocate for a patient with the common institutional standard that “the patient comes first.” Healthcare visits that include an interpreter represent an unusual circumstance, in that the interpreter is a witness to the healthcare process. Over the past years both of the authors have looked at problematic cases that involved patients, families, and interpreters. Interpreters clearly are at risk when they act on a patient’s behalf, or as an advocate, as this case selected from a large number of similar instances, demonstrates.

An elderly Russian woman commented to the interpreter that her health coverage had been terminated. “How will I pay for this?” she asked. The interpreter sequentially mentioned her inquiry to the physician, the registered nurse, and the clinic clerk. No one responded or provided direction or advice. Acting on his own, the interpreter took the patient to the finance office to discuss a discount payment program. The interpreter’s action was reported to the clinic’s administrator. The interpreter’s contract to interpret was withdrawn on the basis that he had undertaken to advocate for the patient.

The work of interpreters is often performed under pressure—i.e., it is subject to most of the same constraints felt by other members of a healthcare team. Time with patients is limited, and decision making must be nearly spontaneous. Not all communication problems and dilemmas can be resolved by negotiation, and some patients—as well as healthcare providers—can be quite rigid in their views of “What’s wrong?” “Who’s in control?” and “How should disagreements be negotiated?” Community pressures and expectations, however, differ. Many interpreters have ongoing community responsibilities that are hard to separate from work-related obligations, especially in small linguistic groups that have an extensive interactive community process in place.

The issue of explaining cultural differences/practices, described as “culture frameworks” in figure 1, is one of the more controversial areas. Major controversies, even formal complaints against interpreters, have arisen when an interpreter has attempted to explain a culture-bound issue to a healthcare provider. These controversies increase in the areas of disclosure, informed consent, truth-telling, and in circumstances that relate to death and dying. We will illustrate these (referring to the items listed in figure 1) in the detailed case studies that follow. The first case concerns interpretation in the negotiation of an informed-consent agreement between an Aboriginal Cree-speaking health interpreter, a patient, and a specialist in a Winnipeg hospital. The
study illustrates: (1) the communication issues that arise in interpreting the different values and cultural models of illness and treatment of the patient, the practitioner, and the interpreter; and (2) the impact of the interpreter in facilitating interaction between the participants.

CASE ONE: MEDIATION OF THE INFORMED-CONSENT AND DIAGNOSTIC PROCESSES

The patient was a 46-year-old, female Cree speaker, who consulted with a gastroenterologist for a problem with anemia and to request an evaluation of possible sites of blood loss in her upper and lower bowel. The interaction involved obtaining informed consent for a gastroscopy and a colonoscopy. An interpreter/advocate, who worked for the hospital’s Native Services Program, attended the meeting between the patient and the clinician. During the visit, a real-time videotape record and verbatim translation into non-idiomatic English was made, in order to document the exchange in which the interpreter translated information from the clinician on the problem of anemia and the possible linkage to gastrointestinal blood loss. The physician was initially most concerned that the patient should understand the association between her feelings of “weakness” and the anemia. Later in the meeting, he introduced a more complex explanation that linked anemia with her loss of blood, and her darkened stool with her use of an anti-inflammatory medication. Throughout this interchange, the interpreter tried to ensure that the patient understood her options and was aware of her right to refuse treatment.14

**Doctor:** She’s anemic and pale, which means she must be losing blood.
**Interpreter (in Cree):** This is what he says about you. You are pale, you have no blood.15

**Doctor:** Has she had any bleeding from the bowel when she’s had a bowel movement?
**Interpreter (in Cree):** When you have a bowel movement, do you notice any blood?
**Patient (in Cree):** I’m not sure.

**Interpreter (in Cree):** Is your stool ever black or very light? What does it look like?
**Patient (in Cree):** Sometimes dark.

The interpreter’s statements provide links for the patient, links between her feelings of weakness and possible gastrointestinal symptoms; she also asks the patient to recall the changes she herself had observed in the color of her stool. By helping the patient understand that her anemia is based on changes she had herself observed in her body, the interpreter is laying the groundwork for an explanation of the procedures to be used by the clinician. The interpreter has injected her own knowledge of taking a gastrointestinal history by asking—un-cued by the physician—about black or very light stools. In so doing, she has conveyed a message that helps interpret the physician’s meaning, but has injected her own explanation of the questions, without informing the physician. Training programs for interpreters often encourage interpreters to achieve “transparency”—to make certain that monolingual participants are aware of any added material or commentary that they add during the exchanges. In this case, the interpreter could have done so by informing the physician of the meaning of the added questions about the color of the patient’s stool.

**Interpreter (in Cree):** We want to know, he says, why it is that you are lacking blood, that’s why he asked you what your stool looks like. Sometimes you lose blood from “there” when your stool is black.

In the continuing exchange, the interpreter translated a direct statement from the clinician, but also explained why he should have asked the question about an apparently unconnected issue, namely the color of the patient’s stool. In her final statement, the interpreter provided an unprompted clarification of the relationship between blood loss and the appearance of the stool. This further explanation of meaning across boundaries of culture, language, training, and class illustrates the interpreter’s role regarding ac-
curacy and conveying cultural frameworks, that is, expanding on, and explaining, meaning. In so doing, she violated the principle of maintaining transparency (which is not included in the code).

In the next exchange (not reproduced here), the interpreter provided another unprompted explanation that linked the clinician’s earlier questions about the patient’s use of anti-inflammatory medications with the concept of the loss of blood. These elaborated and simplified explanations were made in Cree and were not translated into English for the physician. The pattern of communication that emerges in this exchange is clearly triadic, and illustrates the capacity of the interpreter to introduce new information. This illustrates how an interpreter can serve as a broker in the emerging relationship between a clinician and a patient. This also raises the ethical question of whether the interpreter followed formal guidelines for interpreters that require that she more systematically “back translate” her summary to the patient for the physician (thereby maintaining transparency). This strategy would have provided feedback to the physician, which would have enabled him to clarify, or further share his message, and to explore the patient’s understanding of it.

On the following day, colonoscopic and radiological examination revealed that the patient had a polyp in her colon. The physician recommended that the polyp be cauterized, and worked with the interpreter to negotiate a second consent with the patient.

*Interpreter (in Cree):* Do you want to have this procedure done? Will you consent to have this growth removed, burned?
*Patient (in Cree):* I don’t want.
*Interpreter (in Cree):* You know, if it’s not removed it may bleed. It may cause problems. *Interpreter:* Dr. , isn’t it true that if it’s not removed, it can bleed and she can become anemic?
*Physician:* That’s correct, we feel that your anemia may result from the bleeding of the polyp.
*Interpreter (in Cree):* If it’s not removed, you may end up with cancer. You know? And you will not have the operation [that is, the proposed colonoscopy does not involve invasive surgery]. It’s harder when a person has an operation. You know? This procedure [colonoscopy] that he’s going to do will get it on time. Before it begins to bleed or starts to grow. You’re lucky it’s caught on time. And it will bother you when you have had a bowel movement. This way there’s no danger that this growth will bleed.
*Patient (in Cree):* I don’t know.
*Interpreter (in Cree):* Well if you want to come in for the procedure while you are here . . . [the patient lived at a distance, in a rural community]. It’s all up to you to think about.

In this exchange, the interpreter became an active participant in the process of eliciting consent. She once again provided unprompted messages and interjected her opinions and views about risk. Her non-transparent commentary, however, shows how intermediaries play a pivotal role in patient/clinician interaction, based partly on their ability to be selective in interpreting what is said, but also through a process of embellishing meaning.

The interpreter in this exchange also used requests for clarification or further feedback as a way of becoming a more active participant in the process that led up to the solicitation of the patient’s consent. The interpreter’s un-cued intervention that introduced the association with the risk of cancer is an example of the power of the intermediary to introduce information. The interpreter’s intervention was based on previous experience in working with the same gastroenterologist in similar diagnostic evaluations. She was aware of the potential association between polyps and an increased risk of cancer. She used the same explanations that clinicians use to explain risk and to persuade patients to undergo procedures. However, she introduced this information without informing the clinician of the message she had passed. From an ethical perspective, the interpreter’s intervention might have been problematic, and this underscores the im-
portance of both understanding and controlling the interpretative process. Yet, from the perspective of the interpreter/advocate, the reference to cancer was made on the basis of her own understanding of the medical context of the exchange, coupled with her understanding of the meaningfulness of cancer to the patient.

The ability to introduce additional information into the decision-making process is a critical aspect of the informal power of interpreters as mediators in cross-cultural decisions. The power of the interpreter in controlling communication is exercised within a linguistic "black box," inaccessible to the other participants in the interaction. The only comprehensive way to access this "box" is through the use of formal protocols that require the presence of at least two interpreters at each interchange, each validating the other's interpretation. Another possible, but very protracted, alternative requires that the interpreter follows up each translation with a detailed, literal summary of how each component of the message was represented. Even when the patient is asked to summarize the message transmitted by the interpreter, there is no guarantee regarding the accuracy of the original interpretation. The process does, however, provide feedback to the interpreter.

TRUTH-TELLING, ADVANCED DIRECTIVES, AND ISSUES RELATING TO DEATH AND DYING

Recent research by medical anthropologists has examined the impact of culture in health communication that involves conflicting interpretations of values and frameworks for ethical decision making between patients, family members, and clinicians. At times, the conflict reflects culturally based differences in values and in approaches to end-of-life decision making. The principle of autonomy is at the center of the bioethical literature that deals with truth-telling, advanced directives, and informed consent. Recent literature starts from the premise that bioethics is, itself, a culturally constructed body of knowledge, reflecting the core values of biomedicine and Western philosophy. Bioethical principles reflect Western notions of the sovereignty of the individual person and of individual life. Similarly, the importance attached to respect for persons in consent law assumes the existence of autonomous decision makers who are, as Goslin stated, "capable of deliberation about personal goals and of acting under the direction of such deliberation."49

Currently, the principle of autonomy dominates other values and principles in discussions of informed consent. Alternative values, namely the good or primacy of the community and the family, take precedence over autonomy in many other cultures. Despite his recognition of disparate value systems, Goslin, in a recent editorial in the *Journal of the American Medical Association*, asserted: "The right of autonomy or self-determination is broadly perceived to be a morally necessary method of demonstrating genuine respect for human integrity."41

In our work with interpreters in Seattle and Winnipeg, we observed situations in which the different decision makers held irreconcilable positions on the need for patients' autonomy and on truth-telling. Trained interpreters or family intermediaries were sometimes placed in an untenable position of having to provide ambiguous—but conciliatory—interpretation. This approach placed professional interpreters in situations in which they were at risk of violating their ethical contracts with the patient and the practitioner. Asked to mediate between conflicting ethical perspectives, interpreters or family intermediaries often were placed in positions that involved intense role conflict. Our final two case studies illustrate situations in which differences in interpretation involved recognition of fundamental differences in cultural values that define the role of the family, the need to respect individual autonomy, and the need for truth-telling.

CASE TWO: COMMUNICATING A TERMINAL PROGNOSIS TO AN ELDERLY VIETNAMESE PATIENT

The second case study centers on the problem of communicating a terminal prognosis to a
64-year-old, monolingual Vietnamese-speaking man, hospitalized with far-advanced hepatocellular carcinoma. In spite of extensive liver involvement, the patient was generally cognitively alert and competent to make decisions regarding his treatment. Over the course of his protracted illness, several English-speaking family members spoke with the oncologist as well as with the patient’s primary care provider about the family’s unwillingness to discuss the diagnosis with the patient. They emphasized that direct communication with the patient that focused on his terminal prognosis and inquiry about his personal choices about palliative care was unacceptable. In the same meetings, the family members clearly communicated that they wanted “everything to be done.” Proxy decisions made by family members avoided making clear choices between palliative-care measures and more invasive, potentially life-prolonging interventions. On several occasions during the patient’s hospital stay, family conferences were held to describe the implications of the end stage of the patient’s disease. However, these meetings were held outside of the patient’s room and did not include him.

A trained Vietnamese-speaking medical interpreter was involved in the case. The practitioners attempted to use the interpreter to increase direct communication with the patient, to thereby resolve the impasse. The primary care provider spoke with the interpreter, and emphasized the medical futility of the more-invasive treatments and life-support measures that had been demanded by the family members. The physician asked the interpreter to communicate directly with the patient about his terminal prognosis and to explore the individual’s personal wishes for continued care. In discussing the treatment options that involved the potential referral of the patient to hospice care, the physician said, “If we do this we can spare him further discussions about therapy and can focus our efforts on comfort, on pain relief, and even begin to discuss his own wishes. For example, whether he would like to die here in hospital or at home.” The interpreter recognized that this action would ultimately involve more direct and explicit communication of the physician’s assessment that the patient was in the final stages of dying. The interpreter stated her discomfort with a role that involved telling the patient bad news, and refused to interpret this message for the physician. The interpreter stated, “I can’t tell him, it’s against our culture.” She explained her reluctance to communicate the terminal prognosis in terms of Vietnamese cultural beliefs, and emphasized the need to respect the family’s request.

The interpreter’s refusal to override the proxy decision-making power assumed by the family and her respect for their position remained unchanged. The rapid progression of the patient’s terminal illness ultimately precluded the use of another intermediary. The attending physicians decided that only comfort care would be provided, despite the family’s continuing focus on possible curative interventions. The patient’s obstructive jaundice progressed to hepatic failure and coma. The patient subsequently died without being directly informed of his diagnosis and its implications.

In deciding how to mediate between the conflicting values of the family and the healthcare providers regarding truth telling, the interpreter and healthcare providers were faced with a number of questions, some of which included: (1) Was the interpreter correct when she stated that the beliefs of traditional Vietnamese culture and North American Vietnamese immigrant culture prohibited disclosure of terminal prognosis? (2) Was this prohibition a reflection of the interpreter’s personal values and culturally based explanatory framework? (3) Was the interpreter’s refusal a reflection of the family’s demand for proxy decision making and commitment to maintaining power and control over the revelation of “bad news”? And was this position negotiated? (4) Should the interpreter have withdrawn, or should she have been asked to withdraw? (See acceptance of assignments, figure 1.) And was the healthcare providers’ position too unyielding? Too ethnocentric? (5) Or was this a reasonable role for the interpreter to play, considering the need for her to act as a cultural mediator, and the
need for both sides to negotiate. What about hospital policies that asserted that family members should not be used as interpreters?

The interpreter's and the family's control over access to the patient via language placed the healthcare providers in a position of having to accommodate the family's limits. Discourse and the ethical principles that emphasized truth-telling and autonomy were subordinated to cultural values that prohibited the telling of bad news and that emphasized the family's role as decision makers.

CASE THREE: COMMUNICATING TERMINAL PROGNOSIS TO AN IBO-SPEAKING PATIENT

The third case involves the communication of a diagnosis of dangerous disease with a likely terminal prognosis, and the risks of chemotherapy, to a 52-year-old Nigerian patient who had aggressive T-cell lymphoma. The patient, who was visiting his family in the U.S., underwent emergency surgery for presumed acute cholecystitis (an acute inflammatory process involving

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**Figure 2**

**Case 3 - Diagram showing elective interpretation and communication by family members, blocking message of dangerous illness and terminal prognosis to patient and to selected family members of an Ibo-speaking man with aggressive T-Cell Lymphoma.**

**KEY**

1. Monolingual, Ibo-speaking Nigerian cancer patient who was visiting his family in the U.S.
2. Patient’s wife, who resides in Nigeria, communicates with proxy decision makers in U.S. via phone.
3. Bilingual son who is employed in U.S. as an engineer, becomes co-decision maker with sister via control of language interpretation.
4. Bilingual daughter who works as a nurse in U.S. shares control of communication and decision making with her brother.
5. Monolingual daughter from Nigeria, accompanying her father, is frequently present in hospital room, but is excluded from communication because her family fears that bad news would harm her pregnancy and her fetus.
6. Members of the extended family in Nigeria who receive delayed messages, and were informed of the serious nature of the illness.
the gall bladder); during surgery he was placed on a respirator. The identification of aggressive T-cell lymphoma during the surgery was unanticipated. The physicians had difficulty weaning the patient from the ventilator post-operatively, and it became apparent that the patient had extensive lung involvement with the lymphoma. The patient spoke only Ibo, but was responsive and cognitively competent.

The patient's bilingual son and daughter were informed of the attending physician's request that a professional interpreter be involved in communicating with the patient. They responded that they would not allow another bilingual Ibo-speaking person from outside the family to provide interpretation. They also refused a proposal that the AT&T Language Line Service be used to provide objective, external interpretation. The family members insisted that they would provide all interpretation, and asked that information on the patient's diagnosis and terminal prognosis be withheld from both the patient and from his monolingual daughter who had travelled with him from Nigeria. They explained that their sister was pregnant and needed to be protected from the trauma of knowing her father's terminal prognosis. The patient's son and daughter who lived in the U.S. also explained that disclosure would abate hope, and might hasten the patient's death (see figure 2). The bilingual family members varied in how they gave information about the patient's prognosis to his family members in the U.S. and to his family members in Nigeria. The son and daughter contacted elders from their father's kin group in Nigeria, and informed them of the situation and sought their advice. During consultations with the healthcare providers, they expressed the fear that if their monolingual, Ibo-speaking sister, who was often in the room with her father, learned of the prognosis, this would place her unborn child "at risk." As the patient's illness progressed, the son and daughter who lived in the U.S. informed their mother, who lived in Nigeria, of their father's diagnosis.

The son and daughter's complete control over communication through their involvement as interpreters created a dilemma for the caregivers. After several days, the physicians informed the son and daughter that the patient's survival and chances of getting off the ventilator might be improved if he underwent chemotherapy. Given the son and daughter's opposition to direct communication with the patient, which would be required to obtain the patient's consent for therapy, the oncologist was initially unwilling to initiate chemotherapy. The oncologist firmly stated that the patient must know the diagnosis, as well as the risks and benefits of the proposed chemotherapy, so that treatment could be initiated in an ethical way. The son and daughter again refused to communicate either the terminal prognosis or the risks of proposed treatments to their father. Ultimately, the oncologist, after extended consultation with son and daughter and the healthcare team members, agreed that the son and daughter could act as proxy decision makers in signing the consent agreement for chemotherapy. Following the chemotherapy, the patient came off the ventilator, went into remission, and was able to return to his home in Nigeria.

The family's perspective in the third case study clearly prohibited communication of a terminal prognosis. This perspective appears to reflect cultural values that parallel those documented in recent research on the negotiation of advance directives and other consent agreements in cross-cultural situations. Based on this research, questions have been raised about whether principles of autonomy are "truly respectful of all people in all cultures." Carrese and Rhodes's ethnographic study that documented Navajo values about the communication of negative information during deliberations on end-of-life treatments reported a strong cultural prohibition against "the telling of bad news"; 86 percent of the subjects said that advance-care planning was a dangerous violation of traditional Navajo values. Carrese and Rhodes concluded, "Policies complying with the Patient Self-Determination Act, which are intended to expose all hospitalized Navajo patients to advance care planning are troublesome and warrant re-evaluation." It is
CONCLUSION

There are currently major gaps between ethical codes of conduct for interpreters in healthcare and the realities of medical interpretation. Issues such as poverty and class distinctions, the use of language, beliefs about health, and family process influence the positions and assumptions that patients and healthcare providers carry into, and through, the process of delivering healthcare. Interpreters are both witnesses and participants in this process. They often recognize the nature and consequence of medical discourse, and the risks when it breaks down. Conflict around issues such as truth-telling, obtaining informed consent, and the revelation of dangerous diagnoses may lead to dilemmas in which the institution or provider (as in cases two and three) must either accede to the interpreter’s view of cultural issues, accept the family’s request, or withdraw. Negotiation does not, and should not, always lead to acquiescence to Western views of informed consent, truth-telling, or patients’ autonomy.

The vital role played by the interpreters in the second and third cases illustrates how power is asserted and how role conflict is inherent in cross-cultural communication that involves conflicting ethical value systems. In models of interpretation that acknowledge and legitimate the interpreter’s role as a mediator, a culture broker, an advocate, or a professional team member, there has been a move toward the formal specification of the obligations and rights of intermediaries. We believe that the premature development of these specifications, in the absence of more detailed study of the broad issues involved, is risky. Medical discourse within the boundaries of a “single” culture is problematic enough.

The process of specifying and establishing codes of practice is likely to play a significant part in defining the relationships between patients, healthcare professionals, and language intermediaries. The specification of work roles and the adoption of codes of conduct will also clarify the relationships between interpreters and healthcare institutions, and between interpreters and communities. We have found in our research on obtaining informed consent and truth-telling during deliberation on end-of-life treatment that the interaction between a patient and an interpreter often involves significant trust relationships, and may be bound by cultural constraints. Since a patient’s trust in an interpreter may not always be transferred to the healthcare professional, this relationship may need to be reflected in institutional process and recognition of the interpreter’s roles in relating to patients, families, healthcare providers, and institutions.

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NOTES


2. R.W. Putsch, “Cross-Cultural Communication: The Special Case of Interpreters in Health


6. Putsch and Joyce, "Dealing with Patients from Other Cultures," see note 2 above, pp. 1050-55.


12. Ibid.


29. R.W. Putsch, J.M. Kauert, and M. Lavallée, “Balancing the Expectations of Institutions and Cultural Communities in Urban Health Interpretation Programs” (Presentation at the First International Conference on Community Interpreters, 5 June 1995, Toronto, Ont.).


33. Cynthia E. Roat, personal communication with the second author, August 1996. Roat is the editor of Bridging the Gap (see note 32 above), and is Interpreter Training Coordinator at the Cross-Cultural Health Care Project at the Pacific Medical Center in Seattle, Wash. The vignettes and questions about the interpreters’ code come from use of the code in interpreter training over the past two years. The interpreters have often had years of experience interpreting in medical systems without formal training, and many have had extensive backgrounds and experience in health services.

34. Note on the use of language in text. In many systems, interpreters are asked to speak in the first person (as if they were the patient speaking), and healthcare providers are asked to address commentary to the patient: “You are anemic . . . , etc.” This construct of interpersonal exchange does not work well in languages that depend on formal identification of kinship or relationships (depending on one’s age or social position). In these linguistic frameworks, individuals are addressed by age-specific or family-structure-specific terms, and use of these terms often implies the speaker’s respect for the person addressed. For example, first-person interpretation is difficult to do in Cree; Cree interpreters frequently use third-person commentary when they interpret. A similar pattern has been reported by Vietnamese interpreters in Seattle.

35. The interpreter has used the term “no blood” because there is no term for anemia in Cree. The interpreters’ code addresses lack of linguistic equivalency under “accuracy” and
“conveying cultural frameworks.”

36. A comprehensive process of documenting the changes in messages was used in our research on Cree, Ojibway, and Inuit interpreters in Manitoba, Canada. It involved audiotaping or videotaping verbatim text, back- translating messages, and confirming interpretations with both clinicians and interpreters. We found little in the healthcare literature on validating comparisons that involve textual information and review of videotaped transcriptions by independent interpreters, clinicians, and patients' representatives. Additional research using more systematic linguistic analysis may be required to document the difference between the ideal and the real in interpreter-dependent healthcare interviews.

37. Carrese and Rhodes, “Western Bioethics on a Navajo Reservation,” see note 29 above; Beryene, “Medical Disclosure and Refugees,” see note 23 above; Kauftert and O’Neil, “Biomedical Rituals and Informed Consent,” see note 1 above.


40. Kauftert and Koolage, “Role Conflict Among Culture Brokers,” see note 1 above, pp. 50-63.


42. Cases from Washington State have been recorded using ethnographic techniques, conducted by participant interviews, with the goal of understanding the participants’ intents and meanings. The “trouble cases” found in this environment that we describe have involved extensive debriefing and record keeping. Although the nature of the circumstances were often viewed retrospectively, the second author’s position as an attending physician allowed him to be involved in the cases reported here from the outset. The statements attributed to the physicians and interpreters are paraphrased and are not quotes from audio recordings.


44. Kauftert and O’Neil, “Biomedical Rituals and Informed Consent,” see note 1 above, pp. 55-63; Carrese and Rhodes, “Western Bioethics on the Navajo Reservation,” see note 22 above, p. 826.


46. Carrese and Rhodes, “Western Bioethics on the Navajo Reservation,” see note 22 above, p. 826.

47. See note 23 above.