

Understanding the Power of a Medical Interpreter

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Interpreters live in a dichotomous world. On one end, they are struggling to be viewed as professionals by healthcare providers and institutions. On the opposite end, the communities they serve often perceive them as medical providers. In this article, we aim to help interpreters come to terms with the responsibilities and ambiguities associated with the interpreting profession by exploring key concepts, such as impartiality and transparency in the triadic encounter.

Through a series of true-to-life examples, we will coach interpreters on how to handle complex ethical issues, including: Is it ever possible to be completely impartial in the triadic encounter?

Impartiality Versus Transparency in Cultural Coaching

"The medical interpreter will maintain impartiality"

(Massachusetts Medical Interpreters Association *Standards of Practice*, 1996)

Since the beginning, a precept of the interpreter movement towards professionalization has been that interpreters must be impartial. The intent of this rule was for interpreters to realize they cannot take sides or impose their own ideas in a session, even if they personally believe that they are helping a patient or a provider.

But the concept of impartiality has often been taken to extremes. Many interpreters would argue that the very act of cultural brokering is a violation of impartiality, since the cultural broker, by necessity, imposes a personal perception on the triadic encounter. Thus, some interpreters have refrained from acting as cultural brokers for the sake of maintaining the mainstream concept of impartiality.

So the question remains: Is it possible to act as a cultural broker while remaining truly impartial?

Cultural brokering is an accepted part of the interpreter's function. While some interpreters might resist the concept of informing a provider of the possibility of a culture clash before a session begins, such action is supported by section B-2 of the Massachusetts Medical Interpreters

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Association (MMIA) *Standards of Practice*, which states, as an indicator of mastery, that the professional interpreter's duty is to share cultural information that may be relevant and help clarify a problem. However, the interpreter should be sure to preface any cultural coaching with a tactful comment such as, “It may not be the case in this particular situation, but in my experience this ... (type of reaction, belief, value, practice, etc.) is common among members of (a certain) community, and you may want to check in with the patient on this issue.”

Just how far can an interpreter go as a cultural broker? While the answer varies with each case, the MMIA *Standards of Practice* states that the interpreter, in order to fully accomplish his or her work, must “pick up on verbal and nonverbal

cues that may indicate the listener is confused or does not understand,” and intervene accordingly. Hence, we see the need for some action, and perhaps a certain measure of assertiveness, on the part of the interpreter. Thus, impartiality is not synonymous with inaction, and the interpreter who sticks to the role of conduit to maintain impartiality will hinder, and not help, a session.

Yes, impartiality is a difficult concept for a human being to grasp. Even professionals with many years of experience in the triadic encounter struggle with living up to this standard of practice. It can be especially difficult when the interpreter knows there are high stakes involved, such as the patient's mental and physical well being, as well as a possibly adverse community reaction to an interpreter who does not follow “proper” cultural etiquette or religious norms.

The act of acknowledging the struggle with impartiality, paired with the ability to manage personal discomfort in the triadic encounter, is called transparency. In transparency, it is understood that the interpreter may not impose personal feelings on a session. In mental health, the imposition of personal feelings on a session can be referred to as *transference*, and can sometimes be defined as unconscious feelings that are related to the ways in which relationships with family and connection to culture influence one's behavior as a cultural broker. A transparent interpreter, rather than omitting information, would acknowledge a perceived cultural conflict in a private conversation with the provider and collaborate in the provider's search for healthy alternatives.

For example, abortion is one of various treatment choices offered by providers in cases of high-risk ➤

pregnancy. An interpreter may strongly believe that a patient from a certain ethnic or religious group will walk away from a session as soon as the word "abortion" is mentioned. Or the interpreter may predict an adverse reaction to clinical suggestions and a subsequent failure to return for follow-up treatment. The interpreter, under pressure, might make the deliberate decision not to interpret the provider's comments on abortion. Clearly, this would be the wrong professional choice and an abuse of power. And yet the number of interpreter service coordinators who get calls from medical providers and support staffs that suspect an interpreter has deliberately omitted vital information is astounding.

If it becomes evident that the patient might harbor a deep distrust of the American medical system, perhaps due to a perceived cultural or religious lapse on the part of the provider, the transparent interpreter should address this possibility privately with the provider. Instead of making generalizations to promote stereotypes, the interpreter might preface the cultural coaching with the clarifying phrases "it seems to me" or "it is my understanding." The interpreter must take care not to lump entire ethnic or religious groups together, as such rigidity is detrimental to the triadic relationship and can steer a provider in the wrong direction.

The challenge in cultural coaching is that an interpreter must determine whether the perceived conflict stems from the patient, or if it is, in reality, a personal issue for the interpreter. Even professionals of the highest caliber sometimes experience countertransference issues in the triadic encounter. Countertransference is the interpreter's conscious or unconscious emotional response to the patient or provider. In countertransference, the

conflict perceived by the interpreter may not initially have been an issue for the patient, but could easily be carried by the interpreter to the point of becoming an impediment to successful triadic communication.

Interpreters who have not been coached on how to approach controversial issues such as abortion often attempt to manage difficult sessions by "shutting down" or repressing feelings of discomfort, rather than working them out. When personal conflict is ignored, the result is often impulsive behavior, such as the failure to interpret information shared in a session.

Hence, as interpreter trainers and program coordinators reexamine the concept of impartiality, they begin to look closely at how other healthcare professions deal with similar issues, and it becomes clear that interpreters must be trained in transparency, rather than in cold impartiality. In transparency, the fact remains that interpreters cannot impose their own ideas or take sides in a session, but there is a deeper understanding, namely: *interpreters are human beings and, as such, cannot be entirely impartial when dealing with certain situations, events, and beliefs.*

Transparent interpreters are encouraged to identify, explore, and work through personal biases that could potentially affect their performance in the triadic encounter. Simultaneously, they are trained to discern the potential for cultural misunderstanding in a session. When they sense a breakdown in intercultural communication, they control the impulse to "fix" or to "explain," and, instead of imposing doubt and acting as providers, they wait for the right moment to provide the necessary coaching.

The transparent interpreter chooses to inform the provider of the possibility of the existence of cultural or religious beliefs that may affect

the patient's reaction to a specific treatment plan, and may suggest to the provider culturally appropriate ways of approaching controversial issues. This brief intervention should be done in a non-imposing way, and the interpreter should suggest that the provider explain to the patient that a potentially sensitive topic is about to be discussed. In the above-mentioned example, the interpreter might have suggested to the provider, in a private discussion outside the exam room, the use of a synonym for the term "abortion," such as "terminating the pregnancy" or "ending the pregnancy." If the provider were to agree, the interpreter would simply interpret, and both parties would wait to see the patient's reaction to the clinical recommendations.

In an abortion case, standard close-ended questioning may prove useless to the provider. For example, the provider may inform the patient of her choices and the patient may answer "yes" without really meaning it, which could lead the provider to believe that the patient had indeed agreed to the abortion. Close-ended questions often do not work well for patients who do not feel comfortable challenging authority, and the interpreter, familiar with this aspect of the patient's culture, may suspect that the patient's answer was just a formality. Rather than asking the patient about her choice of whether or not to have an abortion, the interpreter could first ask the provider to step outside. Privately, the interpreter could suggest that the provider use the explanatory model, in which he or she begins to "explain" the reason for a consideration of "the termination" or "the ending" of the pregnancy, perhaps in a story form.

To summarize, there are extreme cases in which a provider may believe that a mother's survival depends on her decision to go ahead with an abortion.

On the other hand, a mother's personal belief system may prohibit even the discussion of abortion as an option. But as a result of the transparent interpreter's cultural coaching, both provider and patient will have the opportunity to hear each other's views through unobstructed cross-cultural communication. The interpreter's intervention will result in the patient's awareness of her clinical options, and in the provider's greater understanding of that patient's beliefs. The patient will make the decision, and the transparent interpreter will leave the session with the freedom of a good conscience, knowing that he or she did not withhold any information from the patient or provider or influence the decision-making process through omission. Of course, if the interpreter does not feel that he or she can objectively interpret in cases involving abortion or other sensitive matters, it is permissible for the interpreter to reject the assignment. A future article will further address this issue.

However, if the interpreter had acted merely as a conduit, interpreting spoken words while ignoring their underlying cultural and religious implications, the patient might have left the session to never return for follow-up care, possibly suffering complications and even death. It is clear, then, that by explaining to the provider the possible harmful outcome of the use of the term "abortion," the interpreter may actually have contributed to a positive outcome in a triadic relationship where respect and trust are preserved.

Should an interpreter address the provider or the patient when performing the non-conduit aspects of medical interpretation?

Many interpreters have expressed a desire to coach patients in their understanding of the American medical

system. These individuals argue that to be a cultural broker with the provider is to be a "provider advocate," and, that being the case, that it is also part of their job to act as "patient advocates." The question raised is: Should an interpreter coach a patient without the involvement of the provider? Before you answer, consider the following cases.

A patient refuses to take his medication, so that he can keep drinking his daily glass of wine. The interpreter, familiar with this culturally influenced custom, fears that the patient will not tell the provider about neglecting the treatment, so she tells the patient that since he's not an alcoholic, it's all right to drink the one glass, as long as he is aware of the adverse reaction between alcohol and the medication. When the patient sees the doctor at a follow-up visit, it appears that alcohol is a major issue in the healing process. The patient has a history of alcoholism.

A young patient is pregnant. She insists on having a caesarian, a common practice in her country of origin. As both the interpreter and the patient leave the session to schedule a follow-up appointment, the patient complains to the interpreter that doctors in the U.S. are not as friendly as doctors in her country. The interpreter attempts to correct this perceived misunderstanding and tells the patient that in the U.S., caesarians are not recommended unless the delivery is considered high risk. At a subsequent visit, the provider, unaware of the patient's feelings and conversation with the interpreter, finds the patient resistant to treatment suggestions and that she voices

multiple complaints regarding her pregnancy. He begins to order more tests.

In all these cases, the interpreters stepped outside the boundaries of their profession and became, for just a moment, medical providers. By practicing cultural coaching with patients, without the presence and orientation of a provider, they run the risk of creating an unequal balance of power and subsequently breaking trust in the triadic relationship by promoting an environment in which the boundaries between interpreting and medical practice are blurred. And their advice could kill.

Do interpreters really have "power" over patients? Well, to the patient, the interpreter is the one who speaks the same language, often comes from the same country, and can even share the same physical traits. "The interpreter is like me," the patient reasons, "and the interpreter is my friend."

Understandably, patients may initially relish the thought of having a friend or ally in the triadic encounter. It is up to the interpreter, then, to balance the distribution of power in a medical session. In the above-mentioned cases, the interpreter would have done well to hold a pre-session and/or post-session with the provider, or at the very least, to pull the provider aside to discuss the cultural issues that could potentially influence the session. Once informed of the cultural issues involved, the provider could then take the initiative to address the subject with the patient. After all, the ultimate goal of an interpreting session is that the patient and provider develop a therapeutic alliance. And a large part of the healing process stems from a patient's trust in a provider. ➡

In conclusion, culture shapes meaning, and interpreters have the power to "save lives" when they accurately convey the meaning of the message. But interpreters can also "kill" patients through inaccurate interpretation due to a poor understanding of self (transference and countertransference). May we all strive to be transparent interpreters and to fully accomplish our work, thus securing the success of cross-cultural communication in the triadic encounter!

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