



# California Healthcare Interpreters Association

*Committed to setting standards of excellence that ensures equal access to quality medical care for all people by supporting and promoting the healthcare interpreting profession.*

## Focus Group Feedback Notes (Niels & Venus notes only) On the Components of the California Healthcare Interpreters Association (CHIA)

### CALIFORNIA STANDARDS FOR HEALTHCARE INTERPRETERS:

Proposed Ethical Principles, Protocols,  
and Guidance on Intervention  
for Health Care Interpreters

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Based on Focus Groups in  
Los Angeles (November 10, 2001);  
Fresno (November 13, 2001);  
Oakland (November 14) and  
**San Diego (November 28)**

# DRAFT CHIA Standards

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Please refer to the following codes to determine where the response came from:

**L = Los Angeles, F = Fresno/Central Valley, O = Oakland/Bay Area,  
S = San Diego**

Section A: Healthcare Interpreter Ethical Principles

Principle 1: Confidentiality

Draft Standard:	Comments:
<p><b><u>1. Confidentiality</u></b></p> <p>The interpreter treats all information learned during the interpretation as confidential.</p> <p>Performance Measures: The interpreter maintains confidentiality by:</p>	<p>Agree L, C, O, S</p>
<p>a) Advising all parties that the interpreter will respect the confidentiality of the patient/provider interaction outside of the healthcare setting;</p> <p><b>L, F, O, S: Sometimes the interpreter enters in the middle of Patient/provider conversation and can't say the introductory statement protocol because of lack of time. (a/b/c)</b></p> <p><b>O: Remove "outside of the healthcare setting"</b></p> <p><b>F: The interpreter has the freedom to reassure the patient in the target language that what is being said in the session will stay there and will not be repeated to anyone else.</b></p> <p><b>F: The interpreter advising the patient about the cultural principal that the interpreter respects the confidentiality of the patient/provider, reassuring the patient that the interaction will not be carried outside of the session. Culturally explaining the interpreter values and respect and keeps confidentiality.</b></p> <p><b>F: Example: when the husband is not the father of the child and both parents are with the doctor, how does the interpreter keep the patient/wife's secret when the patient does not want her husband to know that he not the biological father?</b></p>	
<p>b) Interpreting everything communicated within the session to all parties;</p> <p><b>S: sometimes the interpreter has to let the provider/patient know in the middle of the session that if something is said that is rude. The interpreter will interpret it right away.</b></p>	
<p>c) Advising all parties in the interpretation session to refrain from saying anything they do not wish to be interpreted;</p> <p>d) Refraining from disclosing any information without the full approval of the Limited English Proficient (LEP) person and his/her provider.</p> <p><b>S: Why is the word "LEP" used for the patient only while the doctor might be from another country. The doctor may be the individual with the language problem.</b></p> <p><b>S: "Full approval" is not part of the Mental Health Patient Protocol. Mentally ill patients are not able to give their consent or "full approval."</b></p>	

Draft Standard:	Comments:
<p>e) Refusing to convey to providers any information about the patient gained in a community context without the patient's full approval. (This may happen in linguistic communities that are demographically small.)</p> <p><b>S: Just because the doctor is in a hurry does not relieve the interpreter of his/her responsibilities. (?)</b></p> <p><b>S: This appears redundant - we should stick to the confidentiality principal.</b></p> <p><b>S: "Full approval" is not part of the Mental Health Patient Protocol. Mentally ill patients are not able to give their consent or "full approval."</b></p> <p><b>S, All charitable organizations are suppose to inform the authorities about any child or elder abuse, the only time confidentiality may be broken, to protect the individual.</b></p> <p><b>S, Breaking confidentiality should be done <u>during</u> the session not after the session. Most of the information may be passed on to the interpreter in the pre-session. Therefore the interpreter should encourage the patient at the beginning of the session to repeat to the provider the same information already passed on to the interpreter – so this may be interpreted while the patient is present and without breaking confidentiality.</b></p> <p><b>S: Have the confidentiality ethic part of everyone's consciousness and written language. Let the patient sign the confidentiality form. This way the confidentiality form stays in the patient's file. (what confidentiality form?)</b></p>	
<p>Note: In cases where the interpreter is privy to information regarding suicidal/homicidal intent, child abuse, or domestic violence, the interpreter acts on the moral, if not legal, obligation to transmit such information to the provider, in keeping with institutional policies, interpreting standards of practice and proposed ethical principles, and the law.</p> <p><b>S: Patients who have made suicidal statements should be warned the interpreter is required by law to pass this information on to the provider.</b></p> <p><b>F: Add an additional clause: Refusing to convey to patient any personal information about the provider</b></p>	

## Principle 2: Accuracy and Completeness

Draft Standard:	Comments:
<p><b>2: Accuracy and Completeness:</b>            Interpreter transmits the content, spirit and cultural context of the original message into the target language, making it possible for patient and provider to interact as if they were communicating directly with one another.</p> <p><i>Performance Measures:</i>            The interpreter strives for accuracy and completeness by            :</p>	<p><b>All: Yes, we agree these are important.</b></p> <p><b>S, CHIA's standards should be extensive enough to include sections on interpreting for the following specialty areas: Mental health, disability, and speech impairment. Currently these are missing from the standards of practice.</b></p>
<p>a) Converting verbal and non-verbal messages from source language into a target language in terms that the listener can understand without omitting, modifying, condensing or adding to the original message;</p> <p><b>F, item "a" and "f" are contradictory.</b></p> <p><b>O, It is better to make item b and c part of item a.</b></p>	
<p>b) Conveying the meaning of gestures, body language, and tone of voice;</p> <p><b>L,S,F,O, If the interpreter is behind the patient, the interpreter cannot see the body languages to interpret the motions.</b></p> <p><b>L,O,S,F, Sometimes the culture does not allow you to translate the rudeness.</b></p> <p><b>F, I interpret everything even the background voice.</b></p> <p><b>S, In Asia, Middle East, Near East, people do not look at each other in the eye when they talk. So when one is interpreting, it is not right to look at the person eyes or face. The person's head should be looking down. As such the interpreter will not be able to describe the body or facial language.</b></p> <p><b>S, Sometimes we have to interpret the word accurately otherwise the provider/patient does not understand what is going on.</b></p> <p><b>F, O, S: "tone" used with 2 different meanings in b) and c). Here it seems to mean "the vocal pitch and loudness" while in c) it means "emotional level and intent," as in sarcastic, jovial, serious, concerned, etc.</b></p>	

- c) Maintaining the tone and the message of the speaker, even when it includes rudeness and obscenities;

**S: If rudeness is not interpreted, how else is the physician to know whether it is potentially the medication causing the aggravation and frustration for patient? If it is not interpreted then the provider will not know.**

**F: this item needs more clarification**

**O: A phrase or word that is rude/profanity in one language may be just a strong word in another. Example, some African American man use profanity which is part of their everyday language and it becomes difficult/challenging to interpret those words into a language where the use of the word would imply extreme disrespect.**

**O: [about register] In cases were there are a lot of derogatory words used, or one of the parties becomes upset, some interpreters will switch to reported speech. For instance when there is a lot of anger, the interpreter should not imitate the anger, but changes to a reporting tone.**

- d) Revealing and correcting interpreting errors as soon as recognized.

**L,S,O, F: yes**

- e) Clarifying meaning and verifying understanding, particularly when there are differences in accent, dialect, register and culture.

**S: When it comes to rudeness that is part of the dialect, the interpreter should know not to interpret literally, but rather to say the expression in the linguistic equivalent.**

**Example: If someone says “oh shit” translate it as “ie caramba” in Spanish.**

- f) Maintaining the same level of language register used, allowing for linguistic and cultural adjustments to facilitate understanding when necessary.

**S: In Asia, Middle East, Near East, people do not look each other in the eye when they talk. So when one is interpreting, it is not right to look at the person, and one’s head should be looking down, as such the interpreter will not be able to describe the body or facial language.**

**F: Cultural adjustments includes adding the necessary “honorifics” (for example in SE Asian languages) in order for the interpreter to maintain the intent and register of the provider.**

g) Stating untranslatable medical terms in English, and then alerting provider about the problem, and allowing the provider to give a simplified explanation of the term.

**L, F, S, O: What does “untranslatable medical terms” mean? This has to be clarified.**

**O: Ask the doctor for an explanation of the “untranslatable medical terms” or when a medication is not known, the interpreter should ask the doctor for an explanation**

**O: Training is needed to bring everyone in healthcare interpreting world to the same level. There is a need for universal training.**

**S: Expand on item g, it is not clear.**

**S: Interpreters in San Diego spend much of their interpreting time in psychiatric settings and CHIA does not address psychiatric/ mental health interpreting at all.**

**L: Positioning is sometimes an issue: we should allow eye contact with the patient. This means encouraging a human factor between patient and interpreter. Interpreter is not just a disembodied voice.**

**F: When Doctor or nurse conference in front of the patient and ask the interpreter not to interpret, then the interpreter should not interpret.**

**F: [major disagreement – this issue went back and forth for a while. From an interpreter with court interpreting training/background/certification:] The interpreter should interpret everything that an English speaker would hear – If medical staff wish to conference they should leave the room.**

**F: In the case of a conversation not directed at patient, its OK to use reported speech.**

**S, In psychiatric cases it is very important to maintain the same level of language but another interpreter says distasteful words would not be translated and the interpreter should not interpret derogatory words or profanity.**

**S, There may be a need for the interpreter to intervene to ensure the provider understands the culturally appropriateness issues**

## Principle 3: Impartiality

Draft Standard:	Comments:
<p><b><u>3. Impartiality</u></b></p> <p>The interpreter refrains from accepting assignments or withdraws at any point where personal ties, beliefs or biases, including conflict of interest, may affect impartiality, unless there is no alternative interpreter.</p> <p><i>Performance Measures:</i></p> <p style="padding-left: 40px;">Interpreter maintains impartiality by:</p>	<p><b>L,F,O,S: Highly agree with this section. However, the descriptor is ONE strategy of a larger principle (relating to revealing potential or actual conflict of interest or biases toward or against one or the other party)that should appear here.</b></p> <p><b>L, F: Sometimes you are not given the choice to refrain from accepting assignments or withdrawing. Example: when there is no one else to interpret, when you are in the middle of the session and then realize you don't want to partake in the interpretation, like abortion or abuse. Although there was an interpreter who refused to interpret for a cancer patient because of emotional reasons.</b></p> <p><b>S: The interpreter should remain impartial at all times. When she/he cannot interpret because of moral and religious reasons she/he should withdraw.</b></p> <p><b>S: Withdrawal should only happen if that is acceptable to all parties. It has to be discussed in detail with both parties.</b></p>
<p>a) Demonstrating no preferential behavior or bias towards either party involved in the interpretation</p>	
<p><b>F: Change “interpretation” to “interpreting”</b></p>	
<p>b) Allowing the parties to speak for themselves by not giving advice or counsel, or taking sides;</p>	

- c) Respecting the right of the parties in a conversation to disagree with each other. While interpreters hope that all interactions will go smoothly, in no case is the interpreter, having done his/her best to accurately present each side of the conversation, to blame or responsible when interactions result in disagreements between patients and providers;

**O: Participant from San Francisco General hospital reported that his training at the hospital was that interpreters were supposed to be patient advocates.**

**O: Another hospital's interpreter said that interpreters were trained to have the role of pleasing and advocating and at the same time being impartial**

- d) Refraining from allowing any personal judgments to influence their interpreting duties, even when the interpreter disagrees with the message, or perceives it as wrong, untruthful, and/or immoral, and refraining from interjecting personal opinions, beliefs or biases into the exchange;

**L, F: If you are "Refraining..." then you are allowing personal judgment to influence the duties. If you ask the doctor/patient "do you want me to interpret" then you are giving the provider/patient the right to choose whether they still think you should interpret or not, despite the now explicit possible conflict. Only then are you being impartial.**

- e) Disclosing any personal ties with the patient to the healthcare professional;

**F,O: When we take an assignment we should look at all the angles before accepting the assignment.**

- f) Declining to interpret when there is a perceived conflict of interest, or a belief that may influence objective interpretation.

**F: Change "interpretation" to "interpreting"**

**F: Central Valley interpreter disagrees with item "f" – The issues should be brought out on the table but not necessarily requiring turning down the interpreting – what happens when no other interpreter?**

**O: The interpreter should decline to interpret if the patient is known to her/him.**

**S: An interpreter said some interpreters choose not to interpret because of religious beliefs. Example: an interpreting session about abortion.**

**S: there needs to be an explanation of "conflict of interest"**

**S: Add item "g" Refraining from exhibiting body language or facial expressions, such as rolling the eyes, which would demonstrate lack of impartiality.**

## Principle 4: Professional Distance

Draft Standard:	Comments:
<p><b>4. Professional Distance</b></p> <p>The interpreter understands the boundaries of the professional role; monitors his/her own behavior and needs; and refrains from personal involvement.</p> <p><i>Performance Measures:</i> Interpreter maintains professional distance by:</p>	
Protecting his/her own privacy and safety;	
Refraining from becoming personally involved to the extent of compromising the provider-patient therapeutic relationship;	
Avoiding personal, political, religious, or other potentially controversial topics with all parties.	
<b>S: [add:]...during waiting and other non-interpreting time.</b>	
g) Refraining from creating expectations in either party that the interpreter role cannot fulfill.	

## Principle 5: Professionalism and Integrity

Draft Standard:	Comments:
<p><b>5. Professionalism and Integrity</b></p> <p>The interpreter demonstrates professionalism in a manner consistent with the professional standards and ethical principles of ethics of the healthcare interpreting profession.</p> <p><i>Performance Measures:</i> The Interpreter demonstrates professionalism and integrity by:</p>	<b>All: Yes!</b>
a) Understanding his/her responsibilities and accountability as a healthcare interpreter; <b>L: What accountability?</b>	
b) Ensuring level of language proficiency and interpreting skills through appropriate assessment; <b>F: Who does assessment?</b>	
c) Informing both parties about limitations in skills and experience when necessary. Considers declining assignments requiring skills beyond one's level of language proficiency and interpreting skill;	
d) Declining bribes, gratuities, or favors from any party involved in the interpretation; <b>L, F, O, S: Cultural factor involved – no \$, of course, but food gifts may be disrespectful to turn down.</b>	

e) Participating in basic training and ongoing professional development through related continuing education activities, such as community college classes, interpreter’s organization workshops, or health seminars; <b>All: Yes</b>
f) Dressing in appropriate attire; <b>F, O: What is appropriate attire? Uniform whites? Street clothes? Tie? This may be situational...</b>
g) Refraining from fulfilling any functions or services that are not part of the healthcare interpreter’s role or soliciting any other business; <b>All: Yes</b>

### Principle 6: Cultural Competency

Draft Standard:	Comments:
<p><b><u>6. Cultural Competency</u></b></p> <p>The interpreter strives to bridge the cultural differences between all parties to facilitate communication and mutual respect.</p> <p><i>Performance Measures:</i> The Interpreter demonstrates cultural competency by:</p>	<b>All: Yes!</b>
<p>a) Understanding the impact that diversity and cultural differences could have on the healthcare encounter;</p>	
<p>b) Continually updating their knowledge of the dynamic cultures of patients, their communities in the US, and in their home countries, as well as the culture of the US healthcare system;</p>	
<p>c) Using intervention strategies to clarify terms or issues in language usage or culture , as suggested in the <i>cultural liaison</i> role (see Section C: Guidance on interpreter interventions).</p> <p><b>F: Is this the right title for the role?</b> <b>F: Interpreter should be aware of when misunderstanding is because of a cultural factor. It is responsibility of the interpreter to intervene to prevent misunderstanding.</b></p>	

## Principle 7: Respect for Individuals and Community Beliefs

Draft Standard:	Comments:
<p><b>7. Respect for Individuals and Community Beliefs</b></p> <p>The interpreter strives to support mutually respectful relationships between all three parties in the interaction: the patient, provider and interpreter, while supporting the health and well being of the patient, as the highest priority of all healthcare professionals.</p> <p><i>Performance Measures:</i> Interpreter demonstrates and promotes respect for individuals by:</p>	Yes
<p>a) Treating all parties, equally, with dignity and respect regardless of ethnicity, race, age, color, gender, sexual orientation, religion, nationality, political viewpoint, socio-economic status, or cultural health beliefs;</p>	
<p>b) Recognizing the expertise that all parties bring into the interaction, by refraining from assuming control of the communication, and providing a full and complete interpretation of all voices in the interaction;</p>	
<p>c) Allowing for physical privacy, and maintaining spatial/visual privacy of patient as necessary, while positioning themselves in the interaction;</p>	
<p>d) Advising the provider of potential communication barriers due to gender differences between the patient and the interpreter, when this occurs;</p> <p><b>S: correction: gender differences between the patient and the provider, or the patient and the interpreter, when this occurs..</b></p>	
<p>e) Refraining from influencing patient decisions and healthcare choices (e.g. informed consent, medical procedures, or treatment options).</p>	
<p>f) Responding to disrespectful remarks by reminding all the parties in the interaction of the ethical principle requiring accurate interpretation for everything that is spoken, including rudeness, and discriminatory remarks and behaviors.</p>	

**Additional:**

**S: Missing 8<sup>th</sup> ethic on respecting patient health and well-being.**

## Section B: Standardized Interpreting Protocol

This standardized interpreting protocol is the procedural framework that guides the interaction between Interpreters, patients and providers. Interpreters facilitate communication between patients and their families and providers who do not speak the same language or have the same cultural background. Flexibly addressing the many issues that arise is an art form. This is a complex and demanding profession where the interpreter must use his/her training, experience, knowledge and judgment. As discussed in Section C, Guidance on Interpreter Roles and Interventions, the interpreter may face circumstances where the ethics in Section A are challenged by the healthcare professional's goal of achieving positive health outcomes. Please see Section C for further guidance on this issue.

While the actual context and urgency of any specific interpreting session may require making some modifications, the interpreter strives to use the following protocols taking place in the three stages of an interpretation session/ interaction/encounter: before the encounter, during the encounter, and following the encounter:

### Protocol 1: Pre-Session, or Pre-Encounter

Draft Standard:	Comments:
At the beginning of the session, the interpreter establishes the basic guidelines to the interpreting encounter, by:	
a) Providing his/her name, the language of interpretation, and organizational affiliation;	
b) Stating he/she will maintain the confidentiality of the encounter to both provider and patient;	
c) Informing the parties about how the flow of communication in the interpreted encounter will take place. This includes the following:	
d) Interpreting everything spoken by either party;	
e) Requesting that the patient and provider should address each other directly (first person)	
f) Requesting that the parties pause after each idea that they speak to allow interpreting;	
g) Warning that the interpreter may potentially need to intervene for clarification;	
h) Inquiring about any special needs, concerns or questions either participant may have with respect to the interpreting task or the interpreter's responsibilities, or any special terminology which may be discussed in the session about to take place	

## Protocol 2: During the Session, or Encounter

<b>Draft Standard:</b>	<b>Comments:</b>
During the session, the Interpreter facilitates cross-cultural communication to support the patient-provider relationship by:	
a) Positioning her/himself to maximize and encourage direct communication between patient and provider;	
b) Reminding the patient and provider verbally or with gestures to address each other directly, as needed;	
c) Using the first person (“I”) as the standard form of interpreting, to enhance direct provider/patient communication <sup>1</sup> . Exercises discretion in switching to the “third person” when the first person form causes confusion or is culturally inappropriate for either or both parties;	
d) Indicating clearly when the Interpreter is speaking on his/her own behalf, instead of interpreting the words of either patient or provider; (when intervening for clarification purposes)	
e) Attending to the verbal and nonverbal cues that may indicate the listeners are confused or do not understand and checking whether clarification is needed;	
f) Managing the smooth flow of communication by, for example, pacing the amount of information presented, or avoiding side conversations with either party;	
g) Intervening for clarification when the interpreter does not understand the terminology or message;	
h) Considering interrupting the communication process in extreme circumstances to privately discuss with the provider or patient issues of concern to the interpreter that may not be openly discussed within the session. For example, sensitive matters requiring privacy may arise when there are multiple members of the patient’s family in the room, when a patient’s safety is in jeopardy, or there could be harm to others (See Section C);	

## Protocol 3: Post-Session, or Post-Encounter

<b>Draft Standard:</b>	<b>Comments:</b>
At the end of the session, the Interpreter provides closure to the interpreted session by:	
a) Facilitating the scheduling of follow-up	

<sup>1</sup> The Interpreter avoids using third person references, such as “the patient said,” or “the doctor asked.”

appointments, and reminding the patient or the receptionist to request an interpreter;	
b) Directing the patient to their next appointment;	
c) Filling out all required documentation on the interpreted session;	
d) Considering reporting and documenting issues that have arisen in the session and may impact the quality of patient care (for example, incident reports);	
e) Handling confidential written information about the patient in an appropriate manner under the Health Information Portability and Protection Act (HIPPA, 2000);	
f) Recording interpretation session in the patient chart, as required;	
g) Debriefing with the provider, and/or the supervisor, within the boundaries of confidentiality, about the concerns of the Interpreter arising from the session, and giving feedback on the interaction, if possible or appropriate;	
h) Addressing the needs to recover from highly emotional and stressful encounters by taking a brief time out or finding resources for emotional support within the boundaries of patient confidentiality.	

## Section C: Guidance On Interpreter Roles & Interventions

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### Introduction to Breadth of Healthcare Interpreter Responsibilities

CHIA recognizes that interpreters in healthcare settings face situations unknown to court, business, conference and administrative interpreters. As such, they are often expected to deal with those situations in ways that might seem to conflict with some of the ethical principles outlined earlier. We hope that this section will offer some helpful guidelines and insights as to what those situations and expectations are and some strategies for interpreters to handle these situations. We know that not all interpreters will feel comfortable taking on all of the roles described here. Professional training is essential to helping the interpreter understand and be able to reliably and effectively work in these different roles.

### The Shifting Understanding of Healthcare Interpreter Roles

The concept of the interpreter as a “conduit” or “black box” translating machine, as well as the concept of cultural brokering and advocacy on behalf of patients were first discussed by Kaufert (Kaufert & Koolage, 1984), and discussed further by Putsch (Putsch, 1985). These roles, as well as the concept of an incremental intervention model, are referred to in Maria-Paz Beltran Avery’s review of interpreter roles for the National Council on Interpreting in Health Care (Avery, 2001), and in the training manual for the Bridging the Gap Interpreter Training program as delivered by the Cross Cultural Health Care Program., Seattle, WA (Roat & others, 1999, 1996)

The healthcare interpreter’s purpose is to make possible communication, which is accurate and complete, between two parties who do not speak the same language and may not share the same culture. Guided by this purpose, the healthcare interpreter is expected to take on and **fluidly move between various roles** in the course of an interpreting session. While in these roles, the interpreter may see the need to perform different types of interventions, which may range from a basic interruption for clarification to highly delicate types of interventions, both inside as well as outside of the interpreting session. In all interventions, the interpreter needs to make sure that all messages that originate from the interpreter are clearly understood by all parties, in addition to ensuring that all parties understand that the interpreter has generated the content of the message itself. This concept is known as “transparency.” The interpreter should be aware, at all times, that the most appropriate role

is the least invasive role that will assure effective communication and care (Roat & others, 1999, 1996, pp. 17-21)

The following will illustrate the different types of intervention requesting the interpreter to take increasingly complex roles other than “message converter” or “conduit”.

Type 1 Basic Intervention: Managing communication flow (within the interpreting session).

In the *message converter* role the interpreter is expected to monitor the flow of communication between all the parties present, throughout the entire interpreting session. Intervention may be needed when either party speaks too fast and/or does not stop to allow the interpreter time to interpret. Another reason may be to manage turn-taking, avoiding instances when several speakers may talk at the same time or not allow a party to finish expressing a sentence or thought.

Techniques and strategies to effectively carry out the different types of interventions mentioned in this section should be explored in detail and practiced in the context of a comprehensive and professional healthcare interpreting training.

## Type 2 Intervention: Message Clarification:

The interpreter is expected to monitor both speakers and, to the best of his/her ability, assist all parties to understand the terminology and language used in the interaction (as per Ethical Principles 2 and 4). When there is evidence that one, or both, of the parties, or the interpreter, does not understand the meaning of a word or phrase, the interpreter, in the *message clarifier* role, needs to intervene by:

- a) Interrupting the communication process, with a word, comment, or a gesture to the party currently speaking, as needed or as appropriate;
- b) Alerting the parties that the interpreter is seeing signs of confusion from one or more of the parties, by identifying the confusing word or concept that may have caused the confusion;
- c) Requesting or assisting the speaker of a word or concept unfamiliar to the listener or the interpreter to restate the unfamiliar word or concept in a simpler way; and when requested,
- d) Exploring ways to describe concepts to participants using analogies, or “word pictures” when there are no linguistic equivalents in either of the languages.

The interpreter should always keep in mind the importance of allowing the patient and provider the opportunity to communicate and clarify things for each other first, before undertaking any interpreter-directed clarification.

## Type 3 Intervention: Cultural Guiding

The *cultural liaison* role goes beyond clarification to include a range of intervention actions that typically relate to an interpreter’s ultimate purpose of making possible communication, that is

accurate and complete, between two parties in a healthcare setting who do not share the same language and may not share the same culture.

At times, a provider's interview strategy, questions, comments and remarks to a patient, when accurately and precisely interpreted, may be heard and received by the patient as culturally inappropriate, even though no disrespect was intended. This is particularly important when care providers approach patients or clients from cultures that do not share a western tradition of biomedical understandings.

"If a cultural factor, such as a belief, assumption or value, is creating a misunderstanding that affects the goals of the encounter, the interpreter [*in accordance with Ethical Principle 6*] would be expected to intervene [*in the cultural liaison role*] by:

- 1) Interrupting the communication process, again with a word, comment, or a gesture, as needed or as appropriate;
- 2) Alerting both parties to the potential for miscommunication or misunderstanding [*e.g.: "As an interpreter, I think that there may be potential danger for miscommunication/misunderstanding..."*]
- 3) Offering suggestions as to what cultural factor(s) could be impeding mutual understanding; and, when requested,
- 4) Assisting both parties to explore and negotiate these impediments to understanding." (Avery, 2001, page 4). In certain cases, when requested, the interpreter may also need to explain the cultural custom, health belief or practice of the patient to the provider, or educate the patient on the western healthcare concept.

This type of intervention has been previously called *cultural brokering*, *cultural mediating* or *cultural bridging*"(Avery, 2001; Roat & others, 1999, 1996)

## Type 4 Intervention: Advocacy:

Healthcare interpreters within a hospital or clinic setting have a responsibility as a part of the healthcare team that complicates their tasks as an interpreter. This responsibility, documented in health organizations with mature interpreter services in the United States and Canada by Agger-Gupta (2001), may require the health-care interpreters to consider a higher-order ethical principle that may seem to conflict with some of the ethical principles identified in Section A. As a part of the health-care team and in accordance with the Patient's Bill of Rights, health-care interpreters are required to place the well-being of the patient as one of their highest concerns in all that they do in the clinical setting. This obligation, an ethical obligation of all healthcare professionals, may occasionally lead the healthcare interpreter to take the role of patient advocate and perform a range of interventions, in addition to the message-converter, message clarifier, and cultural liaison tasks. The activities associated with this role, in many cases, take place before or after the interpreting session itself.

In so doing the healthcare interpreters may find a range of conflicts between their paramount concern for patient well-being, and their obligations to the seven healthcare interpreter ethical principles, including confidentiality and impartiality, in Section A.

Advocacy can be as simple as accompanying the patient to the pharmacy or to diagnostic test departments or it may involve helping the patient make follow-up care appointments. Advocacy may also involve educating patients about their rights, or about healthcare policy and culture, or it may be as controversial as assisting the patient in filling out a grievance form or seeking resolution for a systemic problem. Due to the wide variety of institutional policies and procedures that exist, not all interpreters may be allowed to intervene in all of these ways, or feel comfortable taking such action. Due to the complexity of this role and the controversy that it raises, CHIA suggests that advocacy interventions remain an option left to the judgment of the more experienced, seasoned, knowledgeable and well-trained interpreter. The advocacy role should also be discussed in interpreter training and orientation.

### **Why Advocacy?**

Because of cultural and linguistic barriers LEP patients often face incredible challenges when trying for example, to set up an appointment, comprehend diagnosis or prognosis, seek advice on medication, follow-up with treatment. LEP patients typically are unfamiliar with the American healthcare system's policies and procedures, and are ignorant of their own rights and responsibilities within the system. Interpreters may find themselves in situations where, for a variety of reasons, the patient for whom they are interpreting has difficulty receiving the same level of care provided to English-speaking patients. These situations are the basic reason why interpreters feel the need to shift into the advocacy role.

The following categories illustrate the circumstances in which a healthcare interpreter may need to make the critical judgment call to intervene in the "Advocate" role. The suggested interventions are identified in order from least invasive to greater interpreter involvement.

### **Advocacy A: Discovered Potential Threat of Injury or Harm to Patient or Others:**

In the course of rendering services to their clients in medical settings, healthcare interpreters often find themselves spending time alone with the patients. Because they are viewed by the patients as the only representatives of the healthcare sites with whom they can communicate, interpreters often become the recipients of significant health-related information. As discussed in both Sections A and B, professional healthcare interpreters establish guidelines for the patient and provider in the pre-session, stating their obligation to tell the other party what has been said in the other language, in part to avoid this kind of dilemma. However, when the interpreter is the direct recipient of information, often without anyone else present, the interpreter is faced with a dilemma unknown to interpreters in court, conference, business or administrative settings.

Only in circumstances when the interpreter estimates that the information may be critical due to potential threat of harm or injury to the patient or others, the interpreter may choose to:

- a) Advise the patient to share the same information with the healthcare provider because it may be important to the practitioner's understanding of the patient's problem and may be significant in any treatment plan;
- b) Offer to assist the patient in conveying the information to the health provider;

- c) During the subsequent interaction, if the information is not presented, the interpreter may request a post-session with the provider to alert them to the problem.

Some may feel that the interpreter in situation c) will be violating the ethic of confidentiality. However, sharing information that could prevent medical error or injury to the patient and may be viewed as a higher-order ethical and professional action in order to promote the best health outcome for the patient. Such an intervention should never be done lightly or routinely.

We recognize that some interpreters will not feel comfortable with taking the above-mentioned step, and may not choose to intervene as an advocate in these cases. Such a resolution cannot and should not be held against any interpreter because they are not trained health professionals, and therefore are not expected to understand the health significance or the full extent of any of the information revealed by the patients in the absence of a provider.

In most circumstances when they are made the recipients of information they do not seek, the interpreter will abide by the ethical principle of confidentiality (ethical principle 1). Interpreters also need to know that they are not legally responsible for the health outcome of the patient, particularly if the patient chooses to withhold information from their provider.

### **Advocacy B: Discovered Spousal or Family Abuse:**

A related situation comes about when an interpreter is told information, sometimes in the absence of a provider, about potentially harmful situations, including family or spousal abuse. In this situation, California interpreters are not currently specifically identified as legally obligated to report a potentially harmful situation to their supervisor. While there is no legal obligation, there may well be a moral conflict for the interpreter to report this information further to their supervisor or to the practitioner who originally met with the patient. The interpreter could request a post-session with the provider to discuss the situation. In all cases, but particularly where the interpreter also functions as the staff of the healthcare institution that services the patient, the interpreter needs to abide by that institution's policies and requirements and act accordingly.

### **Advocacy C: Individual and Systemic Discrimination:**

There are two types of discrimination:

Discrimination by an individual denying services, or giving inferior services to one or more individuals from a specific ethnic, racial, linguistic, religious, cultural, physical or mental disability, or socio-economic group, than services typically given to others; and

Systemic discrimination, where an organization, as part of its normal routine, policies or procedures, either denies services or provides a service which marginalizes or gives a sub-standard service to individuals from a specific ethnic, racial, linguistic, religious, cultural, physical or mental disability, or socio-economic group.

Both of these types of discrimination are illegal, and contrary to the Civil Rights Act of 1964 (U.S. Government, 1964). There may be different actions, possible interventions and consequences if the discrimination is an individual action or comes as the result of a systemic issue.

#### **C1: Individual Discrimination**

An interpreter may become aware of, or be a witness to, discriminatory treatment of a patient by a provider. For the interpreter to take any intervening action in these situations, such as reporting the

incident to their supervisor, is typically difficult and controversial, given the power differential between an interpreter and a practitioner. Interpreter intervention in such situations involves a conflict between the promotion of the well being and rights of the patient and the impartiality principle that is part of an interpreters' code of ethics. This is especially difficult given the need for the interpreter to work effectively with the provider, and the ability of the provider to adversely affect the interpreter's subsequent employment.

- a) A first response could be: Reminding the parties of the interpreter's ethical principle to 'accurately and completely' (Ethical Principle 2) interpret everything that is said in the interaction;
- b) A second response could be: Asking the provider to explain the intentions of their comments or actions, to eliminate the possibility that the perception of discrimination is not, in fact, a misunderstanding;
- c) If this is not effective in resolving the problem, the interpreter could consider documenting the incident and bringing the documented circumstances to the attention of the interpreter's supervisor or the department in charge of such matters, within the healthcare facility. The desirability, and even the ability of the interpreter to take such action may well be limited by the policies of the institution in which the interpreter works. At the least, a conversation, or de-briefing, of such incidents with the interpreter's supervisor, within the boundaries of the confidentiality ethic, are suggested to enable the supervisor to be aware that their staff have witnessed events which may require a future response or action.

## **C2: Systemic Discrimination**

A response to a health organization's policies and procedures that have the effect of screening out members of identifiable categories of people is much more complex for the individual interpreter to address. Addressing systemic discrimination is the subject of other training. It is not expected that interpreters would take any intervention in this situation on their own.

Systemic discrimination is very difficult to address because typically individuals within a given organization do not see or understand that the impact of their established policies are discriminatory. Interpreters need to be aware of their institutional policies and procedures, as well as patient civil rights. If the interpreter is able to identify and document a discriminatory policy or procedure, the first step in dealing with this would be:

- a) A debriefing with the interpreter's supervisor about the situation, again, within the boundaries of the confidentiality ethic, may be enough to bring the discriminatory policy or procedure to the attention of the hospital or clinic;
- b) If a discriminatory action or policy is not recognized by the hospital or healthcare organization as unjust and requiring change, there are certainly other avenues for addressing discrimination, including taking the concern to patient and community advocacy organizations, or the regional office of the US Department of Health & Human Services' Office for Civil Rights. A full discussion of advocacy intervention is beyond the scope of this document.

Advocacy interventions are a delicate undertaking, often requiring an interpreter to have substantial field experience, advocacy and mediation skills, knowledge of the healthcare system, knowledge of institutional policies and procedures, a high degree of maturity, and the ability to exercise good judgment and distinguish what's appropriate from what is not, in order to know how to act within their organizational constraints and expectations.

### **Criticism of the Advocacy Role:**

Critics of the interpreter's *advocacy* role see it as being in conflict with the interpreter's ethical principles of impartiality and professional distance. If the test of an interpreter is what would the interaction look like if both parties spoke the same language, then advocacy might be seen, by some, as patronizing because it may compromise the patient's autonomy and right to self-determination, but this presumes the non-English speaking patient is aware of and able to act on their rights as a patient. A last criticism is that the provider may see the advocacy role as a "pairing" alignment between the patient and interpreter, essentially compromising the independence of the interpreter and undermining the provider's trust in the interpreter.

### **Support for the Advocacy Role:**

Supporters of the *advocacy* role see the healthcare interpreter as the critical element in assisting the LEP patient to understand, navigate and/or negotiate the complex western healthcare system. "When interpreters choose to advocate for patients, they move beyond a concern with clarity of communication and adopt a concern for the quality of care the patient is receiving" (Roat & others, 1999, 1996). Understanding this critical distinction and acting upon it is what characterizes the Advocate role for interpreters.

Successful patient advocacy will remain an optional role for each individual healthcare interpreter, due to the high level of skill and personal qualifications required to be successful. However, there is no denying that issues relating to advocacy will continue to permeate many interpreting encounters, and will remain the subject of many debates in the healthcare interpreting profession. It is imperative for healthcare interpreters to know when it is appropriate and when it is not appropriate to advocate, and to develop the skills necessary for effective advocacy.

### **Advisory Bioethics Committee**

The California Healthcare Interpreters Association (CHIA) is establishing an Advisory Bioethics Committee, involving practitioners, legal assistance, as well as experienced interpreters, who can examine each case and determine a consistent and ethical course of action. The goal of this committee will be to help resolve ethical conflicts by providing the healthcare interpreters with assistance, and recommendation in taking a course of action concerning cases that may have important and conflicting moral or ethical meanings.

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#### **Written Comments:**

**Please add your comments from Section C to the [Survey page...](#)**

## References

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### **Thank you for your help!**

Please print out and mail or fax the completed form  
by **Friday, November 30, 2001** to:

**CHIA Standards Feedback  
16 West Mission St., Suite D  
Santa Barbara 93101  
Or Fax: 805-682-1276**

**Please call the CHIA office: 805-682-1215 if you have questions.**