



Report

Focus Group Study on California Standards for Healthcare Interpreters: Proposed Ethical Principles, Protocols and Guidance on Interpreter Interventions & Roles

**Submitted to the California Health Care Interpreters Association
Standards & Certification Committee**

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March 2002

Goal

The purpose of this document is to report on the analysis of the data obtained from four focus groups organized to review the California Standards for Healthcare Interpreters: Proposed Ethical Principles, Protocols and Guidance on Interpreter Interventions & Roles (the Standards) produced by the California Health Care Interpreters Association (CHIA). Section A presents the background of the project. Section B addresses the methodology of the study. Section C reports on the analysis of the data and discusses results. Based on the results of the analysis, Section D makes recommendations for modifications to the Standards.

Section A

Project Background

CHIA was founded in 1996 by the Directors of Interpreter Services in hospitals and provider groups in the San Francisco Bay and Los Angeles areas. CHIA received funding from the California Endowment in 2000 to develop standards, a plan for certification and develop its infrastructure. CHIA's mission is to support and promote the healthcare interpreting profession by setting standards of excellence that ensure equal access to quality medical care for all people. CHIA promotes the profession of health care interpreters through various objectives. Two of the main ones are the establishment of Standards of Practice and the adoption of a Code of Ethics.

In January 2000 CHIA appointed a group of members to form a Standard and Certification Committee (S&C). Committee members work in the health-care sector as

health-care providers, administrators, managers, interpreters, professors and researchers. S&C members are volunteers who meet regularly (either face-to-face or on the telephone) and represent the various regions of California (e.g. the Bay Area, the Central Valley and Southern California). The Standards document was a key responsibility of S&C to create a standardized set of protocols for all healthcare interpreters in the state of California.

The S&C met regularly for approximately 12 months. CHIA presented the drafts of the Standards for feedback at meetings of the three CHIA Chapters in spring and summer of 2001, before publicly releasing the draft Standards in parallel, at the CHIA conference at Valley Children's Hospital September 29 and on the CHIA website, <http://www.CHIA.ws>. It also released a draft of the Standards to experts in the field; including members of the National Council of Health care Interpreters and the Massachusetts Medical Interpreters Association (MMIA). After receiving feedback from readers and viewers the S&C, the Executive Director and the co-chairs made modifications or minor changes when the suggestions contributed to a clearer understanding of the Standards. The Standards 12th draft, approved unanimously by the S&C was used by the focus-group project, to which this report now turns. The project sought to answer the following research question:

What are health-care interpreters' opinions/reactions/thoughts on CHIA Ethical Principles and Standards of Practice?

This reports now turns to the methodology used to answer the research question.

Section B.

Methodology

This section explains the method used for the collection and analysis of the data. It also discusses the organization of the focus groups, selection of sites and participants and focus group protocol.

B.1 Focus Groups

In order to gather feedback from medical interpreters whose work would be directly impacted by the new Standards of practice, CHIA organized four focus groups to discuss the contents of the Standards. Within the tradition of qualitative research, focus groups are used to obtain a broadly representative theoretical/thematical overview of a given issue. Focus groups, by nature, are where a story unfolds, a hypothesis develops, and an explanation emerges. Focus groups, however, do not allow for generalizability of findings. Contrary to quantitative methods such as surveys, which allow for generalizability if randomly sampling is done, focus groups results only represent the view of the informants who participated¹.

The rationale behind the number and location of the focus groups was based on the number of existing and potential CHIA chapters at the time of the study. In October/November 2001, CHIA had three local chapters, namely: Bay Area, Central Valley, and Los Angeles. At that time, CHIA was also on the process of starting a new chapter in San Diego.

¹ For more information on Focus Groups the reader is directed to the works cited in the bibliography.

This resulted in the organization of four focus groups to be hosted in Los Angeles (11-10-01), Central Valley (11-13-01), Bay Area (11-14-01), and San Diego (11-28-02)

Each of the local chapters collaborated with CHIA in the organization of the sites, the identification and recruitment of qualified interpreters to participate in focus groups, and the mailing of materials.

B. 2 Materials

Approximately 7 days before the focus group session was held, each of the interpreters selected to participate received a package. It contained a letter of invitation to participate in the project (Appendix 1), two copies of the consent form (Appendix 2), and the Standards, draft 12 (Appendix 3). Participants were asked to sign and return a copy of the consent form to CHIA and to keep the other copy for their files.

B.3 Focus Groups Participants

Healthcare interpreters were invited to participate in this study. There was no requirement that Focus Group participants in any of the areas be CHIA members. The four regional coordinators approached the local/regional managers of interpreter services departments in regional/local health organizations and interpreter agencies to request participation of interpreters from their organizations. The requests followed the criteria established for this focus group initiative: i.e. interpreters were to have been interpreting for at least 3 years in a health or health-related setting; and the interpreters were to represent a wide range of languages, not just Spanish. Interpreter Services managers

interpreted the request and nominated those interpreters they felt matched CHIA's criteria.

CHIA Executive Director acted as the facilitator for the four focus groups. CHIA Administrative Assistant was present at all meeting and took notes.

B.4 Procedure

Focus group sessions were scheduled from 6:00 to 8:00 pm on weekdays. There was a sign-up sheet at the entrance of the room. Participants were asked to arrive a few minutes earlier. At the entrance, members of the local chapter and the CHIA Executive Director and Administrative Assistant greeted them. Participants had to sign their name and print their social security number on a form. Additionally, participants were required to have returned their signed consent form prior to the start of the session.

As they entered the room there was a side table set up with refreshments. Participants arrived promptly and helped themselves to some food. Starting time was slightly after 6:00 pm., in some cases 6:15 to 6:30. There was a tape recorder set at the center of the table.

Each of the sessions started with greetings from CHIA facilitator and the local chapter representative. The facilitator thanked participants for their time and commitment to CHIA and asked participants to introduce themselves by stating name, language combination, place of work and previous training in health care interpreting.

Afterwards, the facilitator asked interpreters to have the Standards in front of them for the discussion. He then laid down the rules by saying:

“We’ll go over these one by one on this, for health care interpreters to uphold? Would you, personally, be willing to uphold these? Why or why not. Could you describe an experience, maybe” (Los Angeles, p.2,)?²

The facilitator also asked interpreters to only speak once and wait until others had spoken before speaking a second time. He also asked for only one person to speak at the same time. After setting the rules, the conversation started, first going around the table with introductions, and this was then followed by comments from the participants on the Standards. Each ethical principle was read aloud by the facilitator. Then discussion followed on that point. Before moving on to the following principle, the facilitator tried to capture the opinions of the whole group, allowing the more silent participants time to express their opinions.

Time limitations did not allow for the inclusion of all the sections on protocol and intervention (Sections B and C of the Standards) in the discussion. Participants were asked to send their notes and suggestions to the CHIA office for any sections of the document they wished to provide more comments on or that were not covered in the discussion. Each of the sessions produced two tapes and much discussion even after the audio recorder was turned off.

B.5 The Data

A total of two tapes were produced for each of the focus groups. The resulting eight tapes were labeled with the following information: tape number, site’s name and date. The eight tapes were fully transcribed for content. At the time the study was performed, time limitations did not allow for an extensive reliability check. When

² Throughout the report, data from participants is presented in its original form.

omissions were found in the transcripts, the tapes were used. The bulk of the analysis was performed from the transcripts. Several copies of the transcripts were made.

Annotations were made in pencil by the margin to allow for correction, based on category fluctuation or solidification. These annotations (codes) constituted the basis of subsequent emerging categories and patterns (LeCompte & Schensul, 1999). The pattern of the nature of the interaction generated two categories: elicitation and reply. This category was objective and there was no need for corroboration.

Another copy was used for the communicative function/content of the reply. Four categories emerged from patterns of the function of the reply: Beliefs, Areas of Tension, Concerns and Suggestions. After analyzing the interactions according to their nature and attempting a first classification according to function/content of the interaction, I offered my categories to several members of local chapters who were present at the focus group sessions and to the facilitator and got their feedback (At the time of the analysis, interpreters who participated in the study were not available to go through the same process of category corroboration). In this way I made sure the perspective I had initially gained by approaching the data coincided with the informants' perspective. It also served as corroboration for categories. In order to assure that the categories were stable, I looked at the frequency and the stability across groups (Krueger, 1988).

Other documents used to complement the transcripts were: package of materials sent to participants, CHIA's records of meetings (e.g. lists of attending participants), notes taken by CHIA Administrative Assistant and Executive Director, and a number of telephone interviews with focus group facilitator.

The analysis of the categories identified for each group was carried out three separate times using unmarked transcript copies, in order to insure consistency in the identification procedure. In the paper copies color post-it markers were used for the different subcategories. Subcategories were considered temporary until they stabilized. The whole corpus was used for this procedure.

B.6 Summary of categories/subcategories emerging from responses

The main categories emerging from the transcripts are the following:

Beliefs: interpreters state what they believe certain facts are, and ought to be (e.g. interpreters are patients' advocates; interpreters should know cultural differences)

Areas of tension: interpreters identify dilemmas that they find difficult to reconcile (e.g. be neutral and be a member of the same small community as the patient; observe confidentiality but tell the provider when the patient does not disclose all the information provided earlier to the interpreter)

Concerns: interpreters state their preoccupations when implementing the Standards (e.g. the responsibility of the interpreter may be unlimited; culture is very broad)

Suggestions: interpreters suggest to CHIA alternatives either to terms (interpreting instead of interpretation) or wording of the Standards. They also suggest roles that CHIA could play to serve their interests better.

Section C

Results/Discussion

C.1 Demographics

Fifty-three interpreters participated in this study. Thirty-nine (73%) were female and fourteen (27%) were male. Of 53 participants, 43% were CHIA members. (Table 1 shows the breakdown of participants and percentage of CHIA members per site).

Table 1: Number of participants per site

Sites	Number of Interpreters	% CHIA members
Central Valley	13	.46
Los Angeles	13	.38
Bay Area	14	.79
San Diego	13	.08

Participants represented various language combinations. Table 2 (page 11) shows the breakdown of language combinations per site. In the four sites, Spanish/English was the most frequently used language combination. The minimum number of languages in a participant's combination was two (e.g. English/Hmong) and the maximum was six (English/ Farsi, Hindi, Pashto, Urdu, Dari).

Table 2: Participants' Language Combination

Los Angeles 11-10-2001 7 languages; 13 participants	Central Valley 11-13-2001 7 Languages; 13 participants	Bay Area 11-14-2001 8 languages; 14 participants	San Diego 11-28-02 16 languages; 13 participants
Cambodian	Cambodian	Chinese – Vietnamese – Mandarin	Arabic
Chinese	Punjabi- Indi	Farsi – Arabic	Arabic, Farsi
Japanese	Russian-Ukrainian -	Mandarin – Lao	Farsi, Hindi, Pashto, Urdu, Dari
Korean	Spanish	Spanish	French, Kinyarwanda, Kirundi,
Spanish	Spanish	Spanish	Mnong
Spanish	Spanish	Spanish	Polish
Thai	Spanish	Spanish	Somali
Thai	Spanish-Arabic	Spanish	Spanish
		Spanish- Portuguese	Spanish
			Spanish
			Spanish
			Spanish
			Vietnamese
			Vietnamese, Cantonese

C.2 Opinions

During the sessions, interpreters stated their opinions on the Standards. Their statements are divided into the following categories: Beliefs, Areas of Tension, Concerns and Suggestions. These categories were stable within and among groups.

C.2.1 Beliefs

During the discussions, interpreters shared deep beliefs about different aspects of interpreting. Their beliefs can be classified into the following 3 categories:

- Beliefs about role

There was a broad range of opinions as to what the role of the interpreter is or should be. For some participants, interpreters are called to interpret and their duty is to interpret everything that is said. For others, their role is broader and goes from being a

confidant or friend to being an advocate. Given the broad range of possible roles, some participants turn to the CHIA protocol as the solution to avoid being caught in a situation where patients' expectations are not met. The following quote illustrates this:

“We either had formal or informal training, but no one ever set the protocols down. So it is long overdue. Whatever your role is, it's very clear that we need to maintain a certain level of confidentiality and make sure that the non-English speaker understands why we're there and so it's, I agree with you. It's, it's very difficult when you go into that area. You're caught in a situation where they want you to be the confidant, but you're not.” (Los Angeles, p.6)

For some participants, interpreters are neutral and transparent parties and the question of role presents no problem. They even go so far as to suggest that when they are present, the non-English speaker and the native speaker have the same communicative possibilities. As this Fresno participant comments:

“Say that the doctor speaks Cambodian, why should I deny the care provider that same right. I will not. I interpret everything including “hey do not translate that”. Because our job is to make this person, this non-English speaking person, an English speaking person. I even interpret background noise if I have to, just to make them well aware of everything” (Fresno, p.10)

Others do not see the issue of transparency so clearly. Rather, they see themselves as friends and counselors of one of the parties. And for some the issue is not so simple.

The following statement is an honest illustration of their perception of the complexity of the role of the interpreter:

*“Yes, I think that we are not counselor, we are not mediator, we are not a friend. You know, to say that in a sense that we don't want them to be confidant, so I think that we have to keep distance and know our boundary. But, you know, I was reading the whole thing and then we talked about advocacy in the winter time and you know we have to change sometimes our role from mediator, you know, whatever... whatever, just message transmitter to sometimes you have to help them something, then patient is confused because I'm not just transmitting information. I'm not just conveying what they're saying. **Sometimes I do take sides, you know.** (emphasis on original)” (Los Angeles, p.19)*

While some participants wrestle with their role (invisible and neutral, or friend and counselor), others believe that interpreters are patients' advocates. In fact, for some, that is the norm at their workplace. The following statement illustrates the belief that interpreters are patients' advocates:

“Well, I have one problem, and see where I work we're told that we're patient advocates. I mean, I don't know how other people work and that's the rule where I work and one thing that the document has, it can't write policy for hospitals, okay, because each hospital has to write its own policy. I don't mind, I can be impartial with my cousin, you know, if they came in, I mean, I don't know what difference that would make, but I'm not going to be impartial towards any patient, in other words, if there is something that is going wrong, I'm told at my institution, I am told that my job is to be a patient advocate. That's not being impartial, that's being partial, and that's the rules where I work, so, I mean...” (Bay Area, p.15)

Some participants even state that interpreters are responsible for watching out for patient's rights. On the other hand, participants also believe that interpreters are vehicles to obtain information for both parties. In this sense, interpreters are not seen as powerful participants but as mere conduits to accomplish communication. This seems to contradict the view of interpreters as cultural brokers, as capable of explaining differences and educating parties.

“One of the comments I wanted to say was on item three. To add this addition someplace in there, that “the interpreter should be aware when a misunderstanding is caused by a cultural difference and intervene at that point and do culture brokering.” I don't think that is stated clearly in there and it should be in there at some point somewhere. That it is the responsibility of the interpreter to intervene and either prevent a misunderstanding from happening or correct a misunderstanding that has already happened” (San Diego, p.27).

Furthermore, in some cases, interpreters believe themselves to be prepared to educate providers on culturally based beliefs and practices, for example, the use of folk medicine and home remedies.

“Because we are knowledgeable about the culture and most of our clients would try home remedies first and if that doesn’t work then go to the doctor. But they may continue to be doing that. And it is an issue that most providers need to be aware of and they just don’t ask that. And I think it would be prudent for a good interpreter to bring that up” (San Diego, p.19)

Even when interpreters believe that they may be capable of brokering culture, they are also aware of their own limitations. They turn to the Standards for guidance and help. For example, many want to understand the impact of their body language. They believe that they can convey opposite messages with their body language and their oral language. In this sense, they see that the protocol could raise their awareness about what they should and should not do. As one participant states:

“I would just add, going back to the nonverbal stuff, the interpreter observes nonverbal language as well. Because many times nonverbally the interpreter could convey dislike, disagreement, disgust, and I think that needs to be included, that the interpreter needs to observe his or her own nonverbal language and should refrain from doing things such as nodding or rolling their eyes or getting frustrated or discussed. Because I think that is another angle for showing impartiality. But I am saying you roll your eyes because you think that the patient is lying for instance. You are conveying everything accurately and completely but with your demeanor and your own nonverbal language you are altering that communication. Interpreters do that. So I think that it needs to be said. Because we do that unconsciously. So maybe if it is written and we become aware of it we will be less likely to do it” (Fresno, p.17)

Another area where participants turn to the Standards for guidance and differ in their opinions is “common sense” or judgement calls. While some participants were eager to resort to common sense when guidelines were insufficient or not clear, others pointed out that common sense could be dangerous. The following quotes illustrate this dilemma.

“I think you have to use your understanding and common sense. You have to use common sense. Because it is important that if the child is going there or that person is going there for health care, I think the most important thing is to convey the information that is important. You know, using your common sense. Because sometimes you create big problems” (Fresno, p.10)

“If you do that then you are giving interpreters all kinds of options to pick and choose what is important and what is not. And then we open a great big can of worms” (Fresno, p.10)

“As I hear everybody talk I am also thinking that we share responsibility with everybody in the encounter and many times the interpreter has to exercise a little common sense because the providers know that this is a non-English speaker and many times they hold conversations that maybe they shouldn't hold in front of that patient because they are used to telling the interpreter when and what to interpret. So in that respect I agree we have to have a standard or a rule so this does not happen, so that we can also work in better harmony with the providers” (Fresno, p.11)

- Beliefs about behaviors of self and others

Participants not only have beliefs about the role they, themselves, play in an interpreted encounter, but also about the role of the other interlocutors and about their behaviors. Some of these beliefs are related to the health care provider. For example, some stated that the provider is the party that holds power, to the point of even deciding the course of the interpreting. Providers sometimes decide whether or not there is time for a confidentiality statement. The following comment illustrates this.

“But if you work in house, most of the time you just walk in there when the doctor is already there and they have a started the interviews, you really have no time to ask the doctor what this is going to be about or to say anything, because they've been waiting for you and they just, they have so many patients waiting that they just want to get out of there as soon as possible ...” (Los Angeles, p.37)

Participants perceive patients to be less powerful parties than providers.

Interestingly, participants consider patients to be “their clients”. Participants also think patients entrust their care to them and are in greatest need of their protection.

“I think that actually the client's is the patient and you have a different trust, you have fiduciary trust, then you have a <unintelligible> or information of your clients. You have to treat with higher than the provider, but you have to be honest with your provider. Some information that the clients entrust you and reveal to you and is not appropriate to go ahead and tell the provider you are not supposed to tell. Let's say that, you know, the, the patient tell you about their immigration problems, but actually not have nothing to do with that, with, with the treatment, or have nothing to do with the doctor visit, and if you go ahead and leave you that, that information, that might jeopardize some of the

eligibility of that patient that <unintelligible> be turned down for that treatment” (Los Angeles, p.7)

The notion of trust is especially prevalent in small communities in which the interpreter is a member and as such, is likely to experience a conflict of roles.

“For example, we have many patient’s are Mental Health patients with mental health problems. Community problem that you know, everybody asks so and so and you know it is a problem that you don’t discuss in public, but you know that this problem is there. The individual who is in a situation where an interpreter needs to interpret for him or her... the (inaudible) to what you are supposed to interpret, but the reality may be that it is not the issue. People tend to use it as a, maybe I do not want to interpret for him or her because such a thing is not true. Their mentality is there. The stereotype is there. So that interpreter may not be the most effect individual to really deliver that message or interpret that. Some may not understand what I say, but this is much hard to describe, in Spanish or some other language interpreter in black and white and with the Hmong or (inaudible) Cambodian or some others it may not be the case. You are to select wording that is not existing in the English language and go around that. It may be too much or maybe not enough. That seems to be the dilemma of (inaudible) interpreter faces today. We still have problems today. So I am not quite sure of this, to me I would like, at least one or two examples where this occurs where you should do it and maybe it would not take too much time” (Fresno, p.5)

Participants were willing to share their views on how they deal with face-threatening messages, especially those that contain either insulting tone or insulting terms. While some participants saw the need to ensure that the tone of the original message was preserved in the rendering, others stated that there is no need to do this since the tone is evident to the listener. Interestingly, for the latter the underlying assumption is that tone can be interpreted in the same way cross-culturally. The following statements illustrate positive and negative perceptions of preserving the tone of the original statement.

“The tone I don’t think is what we are talking about right now. In any language if we talk you will be hearing my tone and you can interpret my tone. But the words out of my mouth you cannot interpret because you don’t know the language. So if the client is shouting I don’t need to shout, “HEY WHAT ARE YOU DOING?” I mean we are not in a

jungle. You can hear him and you can tell about his tone. I don't need to have the same tone just the words. That is my comment. In a case where I tell the doctor or the provider that the client used a bad word and he wanted to know exactly what the word was, I would tell him. But if one of them is upset because the other one acted improperly and said a bad word I do not need to say the bad word to alert the other person exactly what the word was to give him the impression of what was said. I can say, "He said a bad word because he was upset about what you said." (San Diego, p.8)

"I think, the tone of the voice, I guess we were mostly emphasizing the bad part of it, but the other part where the tone of voice is definitely necessary is also for a more positive situation. I do interpretation also for social workers as well as for the Chaplain, and for many times with the Chaplain, it is praying or saying words of comfort, and in those cases, it is so essential to really mimic as closely as possible the comforting and soothing tone that the provider is giving. So, like, just thinking about that part, definitely here it is so important to apply the tone of voice and gestures and, you know, just trying to convey the soothing or comforting that the provider is trying to give." (Bay Area, p.12)

Opinions varied widely regarding what to omit and what not to omit, especially in terms of insults and side conversations. Some participants subscribe to the idea of transparency in their behavior. They received that idea from their training and they do not question it. As this participant states:

"I think that, like you said, training, you know, me and Rosa have trained, we have all been trained differently, but where Rosa and I were trained, we were trained to say it exactly the way the doctor says it, no omissions, no, you know, what they say, that's what we say. You know, we're just an invisible voice there, just repeating everything no matter what it is, you have to repeat it. And I think, you know, with universal training, then we all could go by these rules and really be one unit, instead of having different ways of interpreting." (Bay Area, p.11)

On the other hand, others believe that omissions are necessary sometimes, either because they judge the information as irrelevant or problematic to one of the parties, or because it would only make matters worse. The following comments illustrate this issue.

"My only other comment, and it has already been talked about, like in a school class that the interpreter has to go through. My only concern is that in many cultures if a person is crying and you repeat it you are insulting the person. Particularly Hmong. If you have an elderly gentleman there and you repeat it you are insulting him. So that would not be a good practice to do that, especially if a younger interpreter is interpreting for an elder and you continue to do those things you really " (Fresno, p.14)

“For some Asian and Chinese, they are not that really bad about tempers, or use very bad words, and if, once in awhile, maybe ten, fifteen years I have only one or two patients, but when they get upset or mad, and they say something rude and the provider already have sensed that the patient is mad, and to me it matters what they said. It not really affecting the content of the doctor’s treatment, so the doctor or patient is upset and why he is upset, and for myself, I am not used to say those like obscenity words or bad words, and I don’t have any patients that say anything bad, but their tone of voice, I cannot yell at other people, but I explain patient is upset and the provider already know what’s going on and sense that the patient is upset. It doesn’t matter in that case. But I cannot say cover the tone and then yell like, say the rudeness. I cannot follow them” (Bay Area, p.10).

However, making a decision on whether to interpret or omit is not easy, as this participant says.

“...so I would have to culturally be sensitive when I translate that area, but, so again this is another judgement call. You have to realize that when the patient is being rude to the provider, or the provider being rude to the patients, how do you define that. How do you decide that culturally this is, you know, this is a cultural sensitivity issue or is this really the person that you're trying to interpret is really being rude? So this is a very difficult issue right here” (Los Angeles, p.11)

Regardless of the reason for omitting, not all participants share an idea of transparency and neutrality. The following comments illustrate this problem.

“Let’s say you are a good interpreter, right? And you are interpreting everything that is going on. All of a sudden, I am a nurse, I come in the room and I tell the doctor, “you are giving the patient erythromycin and he is allergic to it. Do you still want to give him that or change it?” Now there is no need for you to interpret that. It has nothing to do with the patient” (Fresno, p.10)

Even if they do not believe transparency is completely plausible, participants think that it is important to alert the parties to everything that was said during the interpreted encounter, in order to give parties more options to make informed decisions.

The following comments illustrate this.

“What about the idea of being true and being accurate as possible so that both parties, let’s say the provider is being very rude and saying these things to the patient, be

true to that so that the patient is aware that the provider is not being nice to them, and that the patient could choose another provider if they wanted, or in the same sense, that the patient is really angry and to also let the provider know that the patient is upset about something and you need to be able to have a very true, sort of accurate interpretation of what's going on" (Bay Area, p. 10)

"Yeah, we have that. But I do see in the hospital in the psychiatric patients, they lost their temper and they raise up their tone and say that F-you word and I just want to have, just trying my, just act like actor, I just think, 'oh, I'm just an actor right now, so I raise up my voice and F-you. I just did that. Things the doctor and psych patient, it's very important to the provider to know what to work from the psych patient because they can tell they mix signs a lot. So, I just pretend I am the patient" (Bay Area, p.12)

As to side conversations, some participants stated that they should be left out of the interpreted message because they were not originally intended to be shared (e.g. classes, ground rounds).

"Usually when it is physicians talking among themselves, especially since I work at a teaching hospital, this goes on a lot, professor to residents, so then, and obviously it is a totally different register from the way we work, otherwise I am communicating with a patient, then I just explain again, remind, usually they know that it is a teaching hospital, but sometimes, you know, during that conversation, I just remind them that it is a teaching hospital and that the professor is checking different points, or I say what is the general subject they are reviewing based on what we have just covered together, then I say what they are reviewing. And, that, you know, I don't translate everything at that point, when they are not addressing to the patient, but I do tell the patient what they are talking about in general" (Bay Area, p. 14)

Sometimes side conversations would only make one or both parties uncomfortable and some participants felt it is best to omit them.

"I understand what you are saying. It is right. But sometimes when you have English-speaking people the doctor and the nurse do not discuss it in front of the patient. They go outside. But when the patient is foreign, I have been in that situation. I had someone, an older person, come in and he was dying and the two doctors were standing in front of the patient saying, "he is going to keep coming here until he dies, until he gets pneumonia and finally..." I can't translate that for the patient. And I ask the doctors, "Would you like me to translate that?" And they say, "oh, no. This is among ourselves." "Then please step outside." That is what I am saying. But if you understood what they were saying you wouldn't have said that." (Fresno, p.11)

Other participants thought that all parties to the interpreting encounter should be informed that everything said during the encounter would be interpreted, and side conversations should therefore not be an exception to the rule. Participants trust that training would be necessary to make this fact explicit. As one Los Angeles participant stated:

“I think even sometimes the physician or the social worker, they tend to speak among themselves, whether they should let this information to go to the patient or sometime in front of patient they talk, they discuss among themselves and if we want to have this to be involved in a standard, this is a big training issue to let them know in advance that physician don't discuss in front of the patient if we want to have this then maybe we need some time to have this training for that” (Los Angeles, p.4)

Participants also expressed their views about their behavior about confidentiality. They explained that understandings of confidentiality may vary from culture to culture and therefore may differ from what is stated in the Standards.

“Confidentiality means that when I meet you in a community setting you do not need to worry about me disclosing your personal information. I have had this experience also with Spanish speaking patients, that even though they have a word for confidentiality, culturally it is unacceptable to keep information confidential when we are talking about our own family members. That rule does not apply for them either, in their minds. That is when I step out of that interpreting role and I become more of an advocate and I educate about how the system works. Because without that it is very difficult to convey the full meaning of what we mean and why this is important” (Fresno, p. 6)

C.2.2. Areas of Tension/Dilemmas

Participants identified various areas of tension or dilemmas. When they turn to the Standards for help in those areas, they find CHIA's position to be vague and unhelpful. One of these areas of tension involves the acceptance of gifts. Gifts mean different things in different cultures and participants think that declining a gift may not be as simple as it

sounds. Gifts are signs of appreciation and not necessarily bribes. Obtaining a balance between professionalism and affect is not easy. The following comment illustrates the tension.

“ Could I make a small comment on D? At the clinic where I work the clients are migrant workers and they tend to come over and bring you a basket of fruit, this or that, which they have just picked from the field, and for us to decline is an insult. It is out of gratitude. It is not a bribe. They are not asking for a favor. They are just thankful for the help we gave them ” (Fresno, p.26)

Another dilemma that participants face is the balance between being neutral, respecting confidentiality and advocating. Some participants do not think these approaches can be reconciled. The following comments illustrate the tension that participants face in their jobs.

“Would it make sense for all of those interpreters then if we hear a comment that is just perceived or discriminatory or rude or whatsoever to say, step out and say, "Excuse me, the interpreter would like to remind the doctor that I am obliged because of ethical principle to be accurate and complete, to interpret everything that is being said. Do you wish me to interpret what you just said?" Would that make sense if we say that and we go back to our ethical principle number 2 which is accuracy and completeness. Would that make sense?” (Los Angeles, p.33)

For some a neutral approach is always an implausibility in the context of patients and health care providers, and for others it is contextually bound within the specific interaction.

“One of my fears is that what we are doing is not being impartial. Do we do the same for the care providers? Let’s say that the care provider is not being treated fairly. Some patients would come in and demand narcotic drugs. Are we advocating, “oh doctor, please do not listen to this patient?” Are we doing that? What happened to the neutral position? When we say something like this and we contradict ourselves then the code is not working. And I think, if it is not working then we have to remove it. And that is why we have to work together to come up with some sort of solution. And I don’t know what it is.” (Fresno, p.36)

“I think a doctor has a lot of knowledge about the patient that the decision to tell him or not to tell him is his decision, so if he asks me not to tell the patient this, I won't. But I would say it's not right for him to tell me that the sentence and then stops me to tell, that's, that's correct. But if he asks me not to tell him, that's my duty not to. “But don't

tell this to the doctor." So what do you do? You know, this is really the gray area that Sandra was talking about. It's really difficult to decide what to do and it's really based, depends on what the situation is. What the circumstances are. What the subjects are and it's really difficult for me, I've been working for a long time as an interpreter, but difficult issue. So I don't know if we can come up with any conclusion today, but this is something really have to think, we have to think about." (Los Angeles, p.9)

There is no clear right or wrong answer for many issues. This constitutes a source of anxiety for some participants, especially in instances when observing or not observing confidentiality could have fatal consequences. The following remarks about an HIV positive patient illustrate this point.

"... partners who were HIV positive. The person could not print it. The doctor could not tell the other partner, "hey, your partner is HIV positive." In this (inaudible) if you are not telling, it is just like suicide and homicide, which is basically applying the same position. If you are not telling the partner that your partner is HIV positive you are basically looking at homicide to (inaudible) in a very slow manner." (San Diego, p.25)

"But that is (inaudible) not trying... what I am trying to say. That is not trying. I do offer but by the time this offering is accepted the person is going to get infected. Unwittingly you have killed a person. (inaudible)... killing of a person, for God's sake?" (San Diego, p 27.)

"But one of the aspects too, culturally would you like to hear it from somebody else or would you have wanted...? If I was positive, I would want the opportunity to be told that I need to tell my partner. I don't want somebody else to tell them. And if I don't want to then... okay they call my culture. My husband would probably have a very difficult (inaudible) but I would expect, I want him to at least know, think about it, (inaudible) it. Don't go and say I give you five minutes, five hours. Who is anyone to decide that for me? Maybe I will decide tonight at 10 o'clock at night. And then my wife or my husband already knew at 8 o'clock because somebody else called them? They didn't even give me the opportunity. I deserve that. And that is one thing you have to look at from the aspect of the patient. This is hypothetical but still." (San Diego, p.27)

C.2.3. Concerns

As participants shared their views and opinions on the Standards, they expressed genuine concerns about implementing them. Some concerns are related to the pressure of their workplace and the lack of time. Others are about ethics and others are about their role as interpreters.

- Concerns about time

Most participants expressed concern about time being limited and out of their control. Even when they understood the importance and need of holding a pre and post session, they said that in practice they seldom have the time to do them.

“No, I mean, I think it's very important, but it's not up to us. You know, we're there to, the, usually the doctor is the one who has control of the conversation and the situation and sometimes you're not given the chance to, to say anything. If something comes up during the conversation, yes. You can mention some of these things, but you were saying I remind you that I'm supposed to interpret everything you said. Uh, you know, you want me to interpret that and things like that but, at the beginning, you don't have time to start and, you know, usually, and here in Southern California, and depending on the language you work with, most people have worked with an interpreter or most people have been assisted by an interpreter before and they know what to expect” (Los Angeles, p.37)

- Concerns about ethics

Participants expressed their concern about what constitutes true ethical behavior. They found it difficult to understand how general rules can be applied to very specific and unique situations. For many, ethical considerations are like double-edge swords, resulting in a problem regardless of the participants' choice of action. The following comment is about excusing oneself in the case of a conflict of interest. What is ethical behavior in this instance? To leave the interview with no interpreter, or to continue even if aware of a potential conflict?

“I think that the call should lie on the patient or the provider, not for, you know, you, I don't think that you should excuse yourself because situation that, you know, when you are on an assignment and you just happen to find out that you have some conflict of interest, but in the eye of the doctor or, or the patient is probably not important, so they probably want you to go on and do your job and if you excuse yourself and they could not find someone else to replace you at this moment, I think that, that does not do, you know, serve that purpose” (Los Angeles, p.14)

For other participants, ethics would no longer be a problem if they would completely embrace the conduit model of interpreting.

“I feel there's a lot of sensitive issues, however, when you're interpreting, the word means the same whether you agree with it or not and we need to keep into consideration that we are interpreting. We're a vehicle to get the information from the patient and the member to the provider, whether we agree with it or not. There, like I said, there are sensitive issues where you may not agree with it. The bottom line is you still need to translate the information whether you agree with it or not, and there are, there have been instances where the pro life the pro life issue has come and you just can't get involved. You can't, you just can't get involved in their decision-making. You just need to interpret or translate” (Los Angeles, p.17)

- Concerns about boundaries

Participants expressed concern about the boundaries (or lack thereof) of their job and how they could become liable for a situation beyond their control and expertise. The following statements illustrate how many times interpreters are asked to perform roles that go beyond their responsibility and for which they have no expertise.

“The other thing is that when you go into, uh, depends on the pa-, uh, the doctor, but some doctor expects you to be their assistant. I was told and he took it for granted that I would help him put the patients on the bed or get him off the bed. What if the patients get injured? You know. I, I would not be responsible, but my agen-, probably, agency would probably be. So you have to be really, really careful when the doctor thinks that you know you are there to assist them other than <Unintelligible> interpreting. You have to make sure, and they kind of have the authority. They think that they, they have the authority to tell you what to do, but you have to let know. "I'm not here to assist you physically, you know, what the nurses would do. I'm here just to interpret," and I have done my, you know, I, I've made a mistake in the past” (Los Angeles, p.25)

“I am not against helping patients. I sound very cruel in what I said. But at the same time we need to put it in a container somewhere. We cannot just let it run. And once we do that we open ourselves to inviting lawsuits really. What happens if we forget to exercise our little side role and someone found out about this, the guideline, that we did not follow that guideline to the tee. So what happens next when we are being sued or being testified against? “Well, I didn't do that because the interpreter didn't take me to the pharmacy. Therefore I didn't get my medications. He didn't call me and remind me to come to the appointment. And that is why my child passed away.” Then what next? You see, so we have to protect ourselves. We have to design something that has to be written. You cannot allow loopholes” (Fresno, p.39)

“Some interpreters don’t want the responsibility of actually doing referrals and providing them with, you know, I mean, that would be sort of like what a social worker might do. That... that person, then the social worker might provide them with mental health services or, you know, other kind of services for this patient. Some interpreters might feel that actually is their responsibility.” (Bay Area, p.31)

For some participants the solution to boundaries should be in CHIA’s hands. By establishing another ethical principle CHIA could set boundaries for them and they would feel protected.

“I felt that there was something missing here and it’s kind of on the other principle, but it’s about respect and this is what I wrote. Respect professional boundaries by declining to take other roles that may be offered or assigned by health providers. So, one should have that ability to put those boundaries. And, even though I hear that we are trained in different ways, like the advocacy role that our friend here was talking about, that might be part of how they have been trained but on the other hand, you have to be careful because providers can easily put us in the position of doing other things which we are not entitled to do, we don’t have the training, we don’t have the capacity to do those things. So I definitely think that defining those boundaries should be part of this professional business” (Bay Area, p.18)

Other participants are concerned about their identity or other private information revealed during the course of the interview. They feel the need to establish boundaries with patients in their interactions beyond issues of role or professionalism. The following statement illustrates concern about interpreter’s privacy.

“Yes, private stuff about you. I think that is irrelevant with anything that has to do with interpreting. I think for your own safety and privacy you shouldn’t disclose any of that. If you refrain from answering their questions like what your name is, (inaudible)? Which part of Punjab are you from? If you don’t answer they feel like you are not being part of them. You are creating a distance there and they don’t want to open up. That really happens a lot. And many times I have to say, “You know, we have very limited time. That is why I can’t ...” (Fresno, p.21)

Participants are concerned not only about limiting their role in terms of their duties, but also in terms of the expectations that the parties may have for them. In the area

of cultural expertise, they believe CHIA is asking too much of them. The following statements illustrate this concern.

“When you ask interpreters to strive to bridge the cultural differences and tell them to update their knowledge or cultural competency, aren't we now creating something that is contradicting the earlier principle D, professional distance. Because we try to refrain from creating expectations in either party that the interpreter cannot fulfill. To me, to obtain more knowledge of our culture, you are creating additional expectations. Like what if they come up with something that you do not know? Then what are we going to do then?” (Fresno, p.27)

“Well. I understand that we are going to be a bridge for parties to exchange information. We emphasize things such as being impartial, neutral, interpreting everything that he said, and allowing them to work out that relationship and with communication bridge their own cultural differences. It sounds here like we have a greater role to play in that interaction. And I believe that is what (inaudible) was talking about, that all of a sudden there is an expectation that we will know and we will bridge” (Fresno, p28).

“Because interpreters should not be perceived as cultural experts, and I think we are running into problems when we are sought out for expertise advice about culture. We need to learn techniques to elicit that information from the patient and then we interpret their words, their interpretation of cultural beliefs and practices. Because my concern is that we already seem like the experts many times just because we are bilingual or just because we look Asian or whatever.” (Fresno, p. 29)

In sum, participants willingly shared their views on the Standards. In general, participants see the Standards as a very important document that is long over due in the profession of health care interpreting. They did, however, identify a divorce between the ideal situation ruled by the Standards and the reality of their workplace. They hoped this tension would be reconciled once all parties involved in an interpreting encounter became aware of it. For most participants raising awareness will be possible only through education.

“When I read at this whole document, I found it really useful. The whole guideline is great. But, you know, just like even laws, regular civilian laws, we know that we all have to follow them, we don't always follow by the letter of the law. And, the same

way here too. Everything is covered, everything is very useful, but we already know that there will be exceptions. That's what I was thinking as I was going through them. But, nevertheless, we should not omit them, they should be there". (Bay Area, p. 23)

"When I was reading the document I wondered what CHIA is going to do to implement these in our agencies. Because we cannot implement them if, as in my case I am not at that level. And yes it is very useful but do we really do this? I don't do pre and post session through my agency. There is no time. Medical is one of the problems, because Medical doesn't pay for pre or post sessions. So is CHIA doing something at a higher level to implement this so we can do our part?" (Fresno, p.33)

Section D

Recommendations for CHIA

D.1 Methodological limitations

As mentioned before (methodology section), focus groups are a very specific tool for research. Their purpose is to open leads for further research, to obtain stories, not to provide definite answers. Focus groups are not a substitute for survey research (Krueger, 1988). Focus group results should be used according to the purpose for which they were intended. In this specific case, CHIA conducted focus groups to explore health care interpreters' opinions/reactions/thoughts on CHIA Ethical Principles and Standards of Practice.

The nature of the method used does not allow for generalization of the results or for implementing changes based on the findings. Focus group results are not intended to provide definite answers to questions (Greenbaum, 1993:59). They can be helpful, however, to provide input in decision-making processes. Given these limitations, this report now turns to various recommendations based on the findings.

D.2 Major Recommendations

From the discussions it became apparent that participants were uncertain as to the role of the Standards. Their comments posited a number of basic questions. Are the Standards meant to protect interpreters? Are they meant to inform/educate the reader/user in general? Related to these questions is the concept of target reader/audience. Who is the intended reader for this document?

Since interpreters may work as in house staff or as free-lancers, Standards need to contemplate both alternatives and need to be applicable to both case scenarios. Many times, participants referred to a tension arising from their institutional policy conflicting with CHIA's expectations. One example of this is the tension between neutrality and advocacy. Policy at the workplace may encourage advocacy among interpreters, while CHIA may prescribe neutrality. These tensions need to be reconciled.

Another issue that emerged from the discussion is the need for education on the guidelines. Participants expressed the need to educate providers and patients on the importance of the Standards. The Standards are important but may not be fully understood or appreciated by all parties to the interpreted encounter. Participants turn to CHIA to provide this education.

D.3 General Recommendations Based on Participants' Suggestions

- There was a consensus to include mental patients. CHIA Standards should encompass all health-care services; including mental health is a significant part of them. Participants would like to see mental health specifically addressed.

Including mental health will require re-conceptualizing the areas of informed consent and confidentiality.

- Participants believe that CHIA could benefit from researching how ASL interpreters established their Standards of practice.
- Participants would like to see the Standards address cases where interpreters play dual roles due to their background or position (e.g. social worker and interpreter).
- Participants need Standards to protect them, especially in those cases where providers or institutions do not provide for interpreters' debriefing.
- Participants would like CHIA to take a stand on issues regarding the role and responsibility of the interpreter (e.g. reporting behavior). Participants expressed that many times they feel uncomfortable with current ambiguities, and the position of the Standards is not explicit enough to be helpful.

D.4 Minor/Specific Recommendations Based on Participants' Suggestions

Minor linguistic changes:

- Refrain from using the phrase "creating expectations". Participants feel they are not *creating* expectations because expectations already exist. They suggest this part should be reworded to avoid implying that interpreters are responsible.
- Change "interpretation" to "interpreting" in the whole document
- Change "competency" to "awareness" in the whole document
- Every time the Standards make reference to one party (generally the provider), the same should be valid for the other party (generally the patient).

Minor content changes:

Principle 2

- A and F contradict each other
- A, B and C overlap
- Interpreters cannot always do B
- C: Tone is subtle/needs clarification
- G: Medical terminology needs clarification

Principle 3

- D add issues due to gender

Principle 5

- A: accountability is troublesome
- Remove F or replace with “dressing professionally”

Principle 6

- Replace “competency” by “awareness”
 - _ Protocol 3 B and G are not clear
- Advocacy A and B can be confused

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