The Communicative Perspective of Medical Interpreting

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Abstract

This paper used medical interpreting as an example to examine the recent attention to the communicative nature of translation and interpretation. In presenting the historical development of community interpreting, I examined the reasons why the communicative aspect of translation and interpretation has been ignored in the traditional translation studies. The recent research on community interpreting highlighted the fact that the neutrality envisioned in traditional ideology (i.e., translators as conduits) is not practiced even among professionals. I provided a brief overview of efforts from various disciplines (i.e., anthropology, sociology, applied linguistics, psychology, and communication) to resolve such discrepancies, which led to the recent attention to the communicative perspective of translation and interpretation. I argued that interpreters' choice of interpreting strategies is not solely dependent on their linguistic ability or interpreting competence. Various factors (e.g., communicative goals, social identities, institutional contexts, contextual factors) may influence interpreters' performances. Communication as a discipline provides well-grounded theories on how these factors may influence interpersonal interactions. Using the constructs and concepts developed in communication research, I presented a theory of medical interpreting that incorporates an interdisciplinary understanding of the communicative perspective of interpreting.

Translation studies, which include research on translating and interpreting, is a young academic discipline (Wadensjö, 1998). Despite the proliferation of translation models and translation theories, few theorists have presented a comprehensive or universal theory. For hundreds of years, translation theorists have been struggling with conceptual issues (e.g., free vs. literal translation) without reaching a clear agreement or conclusion. As a result, the theoretical development of translation studies is relatively stagnant (Hsieh, 2002b).

The recent development in translation studies, however, may have provided a new direction to break the deadlock. The focus of this paper is to discuss the recent attention to the communicative perspective of interpretation. Medical interpreting, a particular type of community interpreting, is used as an example because this is an area that provides vivid examples of the communicative perspective of interpreting.

I will first provide a brief overview of the theoretical development of consecutive interpreting with a focus on community interpreting. I will explore the development of interpretation theories across various disciplines, highlighting the recent shifts to the communicative nature of translation and interpretation and researchers' approaches to interpretation as a communicative activity. I will then discuss the contributions of community interpreting to translation studies. I will examine the particular constructs and factors that are highlighted by communication and interdisciplinary approaches. Finally, I will use medical interpreting as an example to discuss
how these constructs and factors can be applied in reality.

I. Historical Development of Community Interpreting

In contrast to translators and simultaneous interpreters’ concerns to the theoretical development of translation as a discipline (for a detailed review, see Hsieh, 2002b), consecutive interpreters have made relatively few contributions to the development of translation studies. From a professional point of view, consecutive interpreting has grown up somewhat independently of, but in the shadow of, simultaneous interpreting (Gentile, Ozolins, & Vsilakakos, 1996). This can be partly attributed to the history of consecutive interpreters.

Before 1950, consecutive interpreting was the dominant mode of interpreting; however, unlike simultaneous interpreters, consecutive interpreters have much more diverse backgrounds and identities. More importantly, unlike simultaneous interpreters, who entered the arena of politics, judicial systems, and other high-profile areas as established professionals, historically, consecutive interpreters were seldom regarded as “professionals.” Often they were treated as non-professionals, such as bilingual aids, bilingual guides, go-betweens, or bilingual helpers (Gentile et al., 1996). Despite their importance in cross-cultural interactions (e.g., missionary, commerce, and power and territorial expansion), before the seventeenth century, these “non-professional” interpreters often were slaves, kidnapped natives of the newly explored or conquered regions who were forced to learn the language of the abductors (Bowen, Bowen, Kaufmann, & Kurz, 1995; Gentile et al., 1996; Karttunen, 1994). To reduce the likelihood of the escape of interpreters, Columbus even brought his captives’ wives abroad so that the men would not leave (Kurz, 1990). The low social status of these interpreters provided them few opportunities to contribute to the theoretical development of translation studies.

Professional consecutive interpreters did emerge from the various fields in the early twentieth century. Starting from the late nineteenth and early twentieth centuries, many consecutive interpreters performed their tasks so successfully that they became high-ranking military officers, government officials, diplomats, and ambassadors (Bowen et al., 1995). Unfortunately, unlike professional translators or simultaneous interpreters who have generated specific theoretical concerns related to their practice, these professional consecutive interpreters provided little input to the development of translation theories.

On the other hand, the vast majority of consecutive interpreters work in less visible and, often, less formal environments (e.g., hospitals, judicial courts, or immigration services). To differentiate these interpreters from other translators and interpreters, they generally are called community interpreters. Community interpreting (which is also called liaison, ad hoc, public service, contact, three-cornered, or dialogue interpreting) is a genre that is performed in two language directions by the same person (Gentile et al., 1996). Community interpreting generally is carried out in face-to-face encounters between officials and laypeople who are meeting for a particular purpose at a public institution, such as legal or health care settings (Gentile et al., 1996; Wadensjö, 1998). Community interpreters often are untrained bilinguals who see “community interpreting as a temporary occupation, practiced while awaiting an opportunity to start a ‘real’ job” (Wadensjö, 1998, p. 53). Community interpreters sometimes even refrain from putting effort and time into developing professional skills due to the instability of the labor market for community interpreting (Wadensjö, 1998).

Because the development of translation and interpretation theories traditionally was driven by practicing translators and interpreters and because few community interpreters have viewed community interpreting as a lifelong career, community interpreters have provided little theoretical input to translation studies. Instead, the professionalism, ethics of conduct, and ideology of community interpreting are strongly influenced by the theories and concepts (e.g., neutrality, detachment, conduits, and fidelity) developed from translations and simultaneous interpretation (Hsieh, 2001a). For example, in examining the roles of court interpreters, Fenton (1997) stated:

The interpreter was here [in an Australian legal case] declared a conduit pipe, a mere machine, transmitting the message in one direction in one language and in the other direction in the other language, like an electrical instrument overcoming a long distance. Thus, the interpreter as a human being between the two parties was eliminated.

The Australian case had followed an English precedent from the 1950s
models for translation studies (Hatim, 1997). Psychology have provided crucial momentum to interpretation. Linguistics, especially contrastive the recent development in the studies of translated texts rather than the translators (or translation theories, which emerged from literary traditionally ignored in the early development of (Niranjana, 1992; Rafael, 1988; Woolard & Schiefflin, 1994). These two perspectives were active roles of interpreters (DiGiacomo, 1994) and their efforts in contextualizing translation as a dynamic activity (as opposed to a static text) (Niranjana, 1992; Rafael, 1988; Woolard & Schiefflin, 1994). These two perspectives were traditionally ignored in the early development of translation theories, which emerged from literary criticism and focused on the examination of the translated texts rather than the translators (or interpreters).

Applied linguistics, discourse analysis, and psychology have provided crucial momentum to the recent development in the studies of interpretation. Linguistics, especially contrastive linguistics, provided the basic explanatory models for translation studies (Hatim, 1997).

However, as translation schools began to develop in the 1950s and 1960s, researchers soon discovered the limitations of a pure linguistic approach and proposed that an interdisciplinary approach was necessary (Shreve & Koby, 1997). The various sub-fields of linguistics and psychology (e.g., sociolinguistics, pragmatics, discourse linguistics, neurolinguistics, psycholinguistics, neuropsychology, and cognitive psychology) have brought new perspectives and approaches to the investigation of interpretation. One of the strengths of these areas is that they have already established valid research methods in examining human discourse. The themes and concepts that have been explored in these fields include (a) cognitive processes of interpretation, (b) equivalences of translation, and (c) neutrality of interpreters (Hsieh, 2003).

The latest findings in these areas suggest that the neutrality envisioned in traditional ideology (i.e., translators as conduits) is not practiced even among professionals (Berk-Seligson 1987, 1988, 1989, 1999; Hale, 1999; Hale & Gibbons, 1999). These phenomena raise important questions. For example, if professional medical interpreters are not neutral or impartial participants in the medical encounters but are actively involved in the communicative process through specific communicative strategies, it is important for researchers to ask why and how interpreters choose one specific strategy rather than another. It is important to recognize that interpreters' choice of interpreting strategies is not solely dependent on their linguistic ability or interpreting competence. Various factors may influence interpreters' performances. For example, medical interpreters are forced into a very difficult position. Their roles in health care settings are not without challenges. A patient's family member may not want an interpreter to interpret the physician's comments about the patient's poor prognosis; however, a physician may insist on telling the patient about his or her terminal illness even if such information giving goes against the norms of the patient's culture. In addition, an interpreter may feel it is ethically wrong to inform the patient but may face the risk of being fired if he or she refuses to interpret the information. A medical interpreter must resolve these issues and conflicts during the communicative process. Therefore, medical interpreters' performances are not only dependent on other speakers' utterances but also on their understanding of the communicative goals of the interpreting events, the role expectations that others (e.g., physicians,
patients, hospitals, and even interpreting agencies) have placed on them, and the contextual factors (e.g., emergency vs. routine follow-up) that are relevant to the interpreting events. Interpreters may adopt a specific communicative goal (e.g., to obtain correct medical history) or a specific role (e.g., physician aide or patient advocate) and choose their interpreting strategies accordingly. These are issues that rarely are examined in research on translation, interpretation, or bilingual health communication.

In summary, the recent development of translation studies has shifted to the communicative nature of translations. Although applied linguistics (e.g., sociolinguistics and psycholinguistics) has included the contexts of translation in its conceptualization and have broadened the scope of translation studies, the discipline itself does not provide established theories that offer theoretical foundations for the roles, social identities, communicative goals, interactive patterns, or organizational roles of the individuals involved in interpreter-mediated conversations. To incorporate these various perspectives, researchers have now notice the tremendous value of community interpreting in the future development of translation studies.

III. Contributions of Community Interpreting to Translation Studies

Translation and simultaneous interpreting have been intensively investigated, yet the development translation theories in general has been relatively stagnant (Hsieh, 2002a, 2002b). One of the reasons is that researchers of translation have been trapped in theoretical and conceptual debates (i.e., whether a translation should incline towards the source or the target language, and the consequent faithful vs. beautiful, literal vs. free, form vs. content disputes) without have empirical research to support their arguments. In these debates, the contexts in which translations were understood and used as a tool, a resource, and a product of communication were made invisible. As a result, the theorists often treated translations (and interpretations) as isolated and independent texts and believed that a "perfect" or "ideal" translation can be achieved and valued across the boundaries of time, space, and people.

On the other hand, in the area of simultaneous interpreting, although researchers have made significant contributions to the understanding of cognitive process and information processing models of interpreting, some studies (e.g., neurolinguistics) have been criticized for being "purely scientific" and do not have practical use (e.g., training programs) (Dodds et al., 1997). Even when examining simultaneous interpreting as a communicative activity, researchers often failed to observe the interactive and dynamic perspectives of interpreting because simultaneous interpreters generally work in isolated booths, interpret unidirectionally from one language to another, and are not seen by speakers and audiences. To a large extent, simultaneous interpreters are similar to translators in terms of their working conditions. As a result, research on simultaneous interpreting has paid little attention to the interactive perspectives of interpreting.

As researchers have now recognized the importance of the communicative process of interpreting (Tommola et al., 1997), community interpreting will be the field that marks the watershed of the development of translation studies. First, its salient context of interactive exchanges between participants allows researchers to examine interpreting from a communicative perspective. By investigating individuals' construction and management of their identities and communicative goals through these exchanges, researchers can expand the traditional scope of translation studies (i.e., examination of translated text) to include a more dynamic view of interpreting as a communicative activity. Second, the accessibility of participants in community interpreting allows researchers to investigate the differences between the participants' understanding and evaluation of interpretation. By understanding the factors that influence individuals' understanding and evaluation of interpretation, researchers and theorists can bypass an endless philosophical debate in translation studies (i.e., what constitutes a good translation?) and start to explain and predict the appropriateness and effectiveness of a particular translation or interpretation (Hsieh, 2001c, 2002a). Finally, the salience of institutional contexts (e.g., interpreting in courts, hospitals, emergency departments, police stations, and immigration offices) in community interpreting allows researchers to examine the influences of institutional contexts on interpreters' choice of styles and strategies. This is an aspect that is often muted or neglected in research on translation and simultaneous interpretation, partly due to the abstractness or the seeming sterilities of institutional contexts in these two genres. The examination of institutional contexts will provide researchers with rich resources to
explore the various factors that influence translators and interpreters' performances.

In summary, the characteristics of community interpreting provide researchers great opportunities to explore interpreting as a communicative activity. Examining interpretation from a communicative perspective is about exploring the interactive and dynamic component of an interpreting event, an aspect that has been long neglected in traditional translation studies. Although almost all community interpreters are intuitively aware of the dynamic interactions between participants and the social, cultural, and organizational contexts, few have attempted to generate theories that account for the influences of these factors. Fortunately, researchers have now begun to examine reasons for the lack of theoretical development in the communicative process of translation and interpretation.

IV. Interpretation as a Communicative Activity

In a high-level conference on interpreting, researchers identified the need to investigate the communicative process of translation (Tommola et al., 1997). In the same conference, participants noted the lack of qualified researchers as a major obstacle to future development of translation studies (Tommola et al., 1997). Although the contributions of the "outsiders" (i.e., researchers who are not interpreters but have disciplinary interests in interpreting, such as cognitive psychologists and neurolinguistics) have been fruitful, few practicing interpreters have investigated interpreting from their perspectives.

Reasons for interpreters' lack of research interest include (a) insufficient research training, (b) insufficient financial and social motivation, (c) the lack of institutional support, and (d) the lack of interactions with the academic community (Tommola et al., 1997). As a result, while other disciplines (e.g., linguistics) have devoted themselves to the more apparent features of interpretation (e.g., types of mistakes made by interpreters), interpreters were into personal interpretations (which was mostly based on personal experience rather than empirical data), assertions, and counter-assertions (Dodds et al., 1997). Nevertheless, in contrast to the seemingly subjective topics investigated by the outsiders, interpreters were much more interested to the objective, active, and dynamic nature of interpreting (e.g., Haffner, 1992; Loutan, Farinelli, & Pampallona, 1999).

Researchers across various disciplines have now, fortunately, recognized the complexity of translation as a communicative activity and have pushed for interdisciplinary efforts to investigate translations (Neubert, 1997; Tommola et al., 1997; Toury, 1980; for review, see Hsieh, 2003). Communication, as a field that is interdisciplinary in nature, provides an excellent foundation for the future development of translation studies. The various sub-fields of communication (e.g., interpersonal communication, group communication, organizational communication, and health communication) have provided valid grounding for the theoretical foundations for the roles, social identities, communicative goals, interactive patterns, and organizational roles of the individuals involved in interpreter-mediated events as well as the impact of institutional, organizational, and group dynamics on interpreting activities. The major contributions of interdisciplinary (mainly communicative) approaches are as follows.

I Communicative Goals & Social Identities

Communication researchers have long noted that communicative goals and social identities have significant impact on individuals' formulation, interpretation, and evaluation of messages (Brashers, Goldsmith, & Hsieh, 2002; Boydell, Goering, & Morell-Bellai, 2000; Goldsmith & Fitch, 1997; O'Keefe & McCormack, 1987). From this perspective, an interpreter may adopt a specific communicative goal (e.g., obtain correct medical history) or a specific role (e.g., physician aide or patient advocate) and exercise his or her power to control information and informational flow accordingly. In Bolden's (2000) analysis of a medical history taking session, the interpreter "only conveys information related to the medical contingencies and leaves out information presented by the patient if it is unrelated to that set of contingencies. Additionally, patients' narrative, experiential, subjective accounts are rejected and excluded from summary translations" (p. 414). Similar observations were made by Cambridge (1999).

The different communicative goals of the individuals involved in interpreter-mediated conversation may lead to frustration and miscommunication. For example, Metzger (1999) discussed a case in which a pediatric physician was frustrated and dissatisfied with an interpreter-mediated conversation because the interpreter was focusing on obtaining medical-related information rather than building
rapport between the physician and the patient, which was a major communicative goal for the physician. It is important in future research to examine how interpreters and other interlocutors choose and negotiate their communicative goals and social identities in order to identify relevant factors that can influence the evaluation and the quality of interpreter-mediated conversations.

2 Institutional Influences

Communication researchers have highlighted the influences of organizational environments and group dynamics on individuals’ communicative patterns (Keenan, Cooke, & Hillis, 1998; Marin, Sherblom, & Shipps, 1994). Because interpreters generally work where the contexts of institutions (e.g., United Nations, diplomatic occasions, hospitals, courts, and immigration services) are strong, it is crucial to examine how the institutional contexts have influenced interpreters’ performances.

There has been little research on this perspective; however, some researchers have hinted at institutional influences. For example, research on the practice of medical interpreters often showed that interpreters took up the role of physicians’ advocate more often than the role of patient advocate (Bolden, 2000; Davison, 2000; Elderkin-Thompson, Silver, & Waitzkin, 2001). Although many researchers have suggested that the results of their studies on interpreting could be attributed to an institutional influence (e.g., Elderkin-Thompson et al., 2001), none has conducted systematic research on the effects of institutional influences on the roles or performances of interpreters.

V. In Search of A Theory of Medical Interpreting

Research in bilingual health communication has come from two main camps: physicians who use interpreters (Baker, Parker, Williams, Coates, & Pitkin, 1996; Baker, Hayes, & Fortier, 1998; Buchwald et al., 1993; Woloshin, Bickell, Schwartz, Gany, & Welch, 1995) and interpreters themselves (Haffner, 1992). As Davidson (2000) stated:

The physicians generally lament the difficulties of diagnosing patients, establishing a clinical relationship, or providing adequate care to patients when using an interpreter; the interpreters tend to focus on their role as ‘linguistic ambassadors’ for the patient, a stance in favor of overt ‘advocacy’ interpretation. Neither group, however, rests their arguments on analyses that explore exactly how, in discourse, interpreters advocate or obfuscate the conversational process. (p. 384)

In these studies, interpreters also are viewed as a generic group, a common variable that can produce certain, presumably similar, impact on the outcomes of bilingual health communication. As more and more studies are conducted, researchers are confronted by conflicting information about interpreting services. The arguments about what interpreters have reached a deadlock.

Rather than seeing medical interpreters as a generic category or developing a particular type of communication strategies recommended for all situations, I see interpreter-mediated communication in health settings as a dynamic situation involving various interlocutors. Health care providers in particular should adjust their communication strategies accordingly to achieve quality care. To build a theory of medical interpreting, researchers need to be attentive to all relevant contextual issues that are involved and build the success of interpreter-mediated communication on the behaviors of all individuals, including health care providers, patients, and interpreters.

VI. Findings of Interpretation in Medical Settings

With the recent development in health communication, researchers have noticed the importance of language and culture in bilingual health communication. Language is the means by which a physician accesses a patient’s belief about health and illness, creating an opportunity to address and reconcile different belief systems (Woloshin et al., 1995). When patient do not share the same language with health care staff, it is inevitable that they are more likely to experience more problems in the health care services they receive. Researchers have noted that when language barriers exist in physician-patient communication, a patient is likely to receive more diagnostic testing (Hampers, Cha, Gutglass, Binns, & Krug, 1999; Waxman & Levitt, 2000), less likely to receive follow-up appointments after an emergency department visit (Sarver & Baker, 2000), and less likely to understand health care staff’s instructions (Gerrish, 2001).
Researchers often view interpreters as the standard solution to language barriers between physicians and patients (Woloshin, et al., 1995). In the United States, starting from the late 1970s, there have been federal and state legislative efforts to require physicians to provide interpreters for patients with limited ability to speak English (Fortier, 1997). The most recent action at the U.S. federal level is an Executive Order on Improving Access to Services for Persons with Limited English Proficiency issued by the White House on August 11, 2000. This order resulted in written guidelines being provided by the Department of Health and Human Services to health care providers, to ensure language assistance for persons with limited English skills (Department of Health and Human Services, 2001).

This assumption that interpreters are the solution to bilingual health care communication is largely based on the concept that interpreters can act as cultural brokers and patient advocates in cross-cultural encounters (Cross Cultural Health Care Program, 1999; Haffner, 1992; Kaufert & Koolage, 1984). Empirical studies on the practice of medical interpreters, however, suggested some troubling findings because interpreters often act in a non-neutral manner (e.g., siding with health care providers rather than patients when faced with physician-patient conflicts) (Bolden, 2000; Cambridge, 1999). It is possible that interpreters may not be the panacea for bilingual health care communication.

Although researchers and the public often view interpreters as the standard solution to language barriers between physicians and patients (Department of Health and Human Services, 2001; Fortier, 1997; Woloshin et al., 1995), empirical studies of the practice of medical interpreters have produced some conflicting findings. Several studies have provided evidence of the benefits of providing interpreter services. For example, in Tocher and Larson's (1996) study, the treatment process and outcomes of diabetes care for interpreted patients were as good as, if not better than, English-speaking patients. In another study, Spanish-speaking patients who received interpreter services had less communication with their physicians, were less likely to receive facilitation from the physicians, and were more likely to have their comments ignored (Rivadeneyra, Elderkin-Thompson, Silver, & Waitzkin, 2000). Compared to patients who thought an interpreter was necessary but were not provided one, interpreted patients were not significantly different in their objective understanding of diagnosis and treatment (Baker et al., 1996). In another study, Spanish-speaking patients who communicated through an interpreter were significantly less likely to be given a referral for a follow-up appointment after an emergency department visit (Sarver & Baker, 2000). Finally, patients who communicated with their health care provider through an interpreter were less satisfied with provider-patient relationship even in areas unrelated to languages (Baker & Hayes, 1997).

Hsieh (2001a) argued that the reasons for the inconsistent findings include (a) failure to see medical interpreters as a diverse group that include professionals and nonprofessionals from different cultures; (b) neglect of contextual factors (e.g., physicians' communicative styles and the organizational environment) that influence interpreter-mediated conversations; and (c) research design flaws that cannot account for good or bad performances of medical interpreters. Conflicting findings about health outcomes and other variables (e.g., provider-patient relationship, satisfaction, treatment adherence, information management) are not indications of the insignificant or incoherent impacts of interpreter-mediated communication. Rather, these conflicting findings suggest new questions, such as "what are the complicated components, roles, process, and meanings of interpreter-mediated communication?"

The contribution of communication researchers to the study of provider-patient interactions is the identification and understanding of the many factors that are involved in provider-patient communication (Brashers et al., 2002; Goldsmith, 2001).

It is essential to examine interpreters' strategies for resolving provider-patient miscommunication and conflicts, responding to
different communicative goals and contexts, and accounting for cultural differences. These are questions that have rarely been raised before and are critical to the success of interpreter-mediated communication. By finding answers to these questions, researchers and health care providers can develop effective communication models to work with different types of interpreters (e.g., professional interpreters, telephone interpreters, bilingual health care staff, and patients’ family members) without compromising the quality of care, which may reduce the cost of care significantly.

VII. Building a Theory of Medical Interpreting

Although there have been some studies on bilingual health communication, few researchers have attempted to generate a conceptual framework for medical interpreting. As a result, most research has focused on specific phenomena and the discussions have been limited to data analysis without theory-building; however, research on bilingual health communication and medical interpreting has come to a point that it needs to be guided by theories. Researchers need to conduct studies that are both theory-driven and data-driven so that the interactions between theories and data can bring the best out of each other and complement each other.

It would be difficult to list all relevant factors that need to be included in a theory of medical interpreting; however, a sound theory of medical interpreting should be attentive to the following variables: (a) types of interpreters, (b) communicative goals, (c) role expectations, and (d) contextual influences. A theory of medical interpreting is not a theory of medical interpreters. Rather, it is about how different individuals (i.e., health care providers, patients, and interpreters) involved in interpreted medical encounters can achieve effective and satisfying communication.

1. Types of Interpreters

Currently, there are five types of medical interpreters in practice, including chance interpreters (e.g., family members or friends), untrained interpreters (i.e., bilingual support staff), bilingual health care providers, on-site interpreters, and telephone interpreters. These five types of interpreters possess different degrees of professionalism (Hsieh, 2001b). Although in current health care settings, on-site interpreters and telephone interpreters are considered professional interpreters, most interpreters are not from these two sources. For example, in Baker et al.'s (1998) study at Harbor-UCLA Medical Center, CA, 88% of the interpreters used had no formal training in interpreting. The different types of interpreters often entail significant differences in their costs and problems (Flores, 2000). For example, a professional interpreter has high linguistic and cultural competency but is expensive; in contrast, a family member generally provides free services but has little medical knowledge to interpret sophisticated medical procedures.

In the field of bilingual health communication, many studies treat medical interpreters as a generic group without mentioning how the identities and backgrounds of the interpreters may bias their studies (e.g., Carrasquillo, Orav, Brennan, & Burstin, 1999; Rivadeneyra et al., 2000; Sarver & Baker, 2000). Even in the case that the characteristics of the interpreters are identified, researchers often attribute the outcomes of their studies to the professionalism (or non-professionalism) of their interpreters without having comparison (or control) groups to examine how different types of interpreters would have influenced the outcome variables. Although researchers have been confronted with conflicting outcomes, they have not examined whether the results were affected by the professionalism of medical interpreters or not.

In short, more studies of bilingual health communication should be dedicated to the impact of different types of interpreters. If nonprofessional interpreters do reduce patients’ satisfaction considerably, it may be important to educate health care providers to avoid the use of nonprofessional interpreters whenever possible, to endure the higher cost of professional interpreters, and to develop communication strategies to reduce problems resulting from the use of nonprofessional interpreters. It is also possible that in certain situations (e.g., interpreting for a patient with a cold), the professionalism of interpreters is not a salient issue and health care providers can save the cost of professional interpreters and focus on other issues. To develop a theory of medical interpreting, researchers must keep the varieties of medical interpreters in mind in conceptualizing their research and translation models. A medical interpreting theory that is exclusively designed for professional interpreters may have little practical value for health care providers.
2. Communicative Goals

It is important to note that an interpreter is not the only person who has communicative goals in bilingual health communication. All individuals involved in interpreter-mediated communication (e.g., health care providers, family members, and patients) have their own communicative goals. However, their communicative goals are mediated and communicated by interpreters. There are situations in which an interpreter has to actively adopt specific communicative goals to ensure the quality of communication and the effectiveness and quality of health care services. For example, in an emergency department, a physician and a gunshot victim may have very different communicative goals in mind and have very distinct communicative patterns. Whereas the victim may be frantically discussing the severity of his injury, requesting a painkiller, or moaning in pain, a physician has a specific order of questions that need to be answered so that the priority of the emergency treatments can be determined. If an interpreter adopts the conduit model, he or she is required to interpret whatever information is said by the victim to the physician, which could include screaming for pain, yelling at bystanders, or incoherent talk about his injury. By interpreting the victim’s speech indiscriminately, an interpreter not only hinders the effectiveness of the communication but also delays the necessary treatments urgently needed by the victim. In such situations, the effectiveness and the quality of communication may be best achieved by interpreters’ active identification as a proxy of the physician, adopting the communicative goals of the physician.

A theory of medical interpreting needs to account for not only the communicative goals of all participants but also the impact of the goals and goal conflicts on the interpreting strategies of interpreters (Hsieh, 2000). Past research on medical interpreting has not explored these issues directly, although researchers, at times, have pointed to the conflicts of communicative goals as a reason for miscommunication or failed communication between physicians and patients (e.g., Metzger, 1999).

Researchers also need to explore the mediating and interpreting strategies of interpreters. Researchers have identified interpreters’ active involvement in communicative processes (e.g., correcting informant’s statements, interpreting selectively, adding complementary information, or omitting details) (Cambridge, 1999; Elderkin-Thompson et al., 2001; Pochhacker & Kadric, 1999; Vasquez & Javier, 1991). Although many researchers tend to view these performances as “inappropriate” interpreting styles (e.g., Cambridge, 1999; Elderkin-Thompson et al., 2001), these may be active and conscious interpreting choices made by interpreters. Interpreters may consciously deviate from the original utterances in an attempt to produce effective, efficient, compressed, informative, supportive, or authoritative messages, whatever best fits their communicative goals at the moment. So far, this point is purely speculative. To examine this concept, ethnographic research is indispensable in exploring interpreters’ goals through the examination of their practices.

3. Role Expectations

The third important concept is role expectations. Interpreters may adopt specific communicative (or interpreting) strategies when they perceive their roles as similar to or different from a physician’s expectations (e.g., the interpreter as physician aide) or a patient’s expectations (e.g., the interpreter as patient advocate). Research on physician-nurse communication has indicated that nurses’ and physicians’ communication styles are strongly influenced by the institutional culture, organizational norm, perceived authority, communication style of the counterpart, and the prior relationships between the individuals (Katzman, 1989; Keenan et al., 1998; Marin et al., 1994). Researchers should examine how (a) institutional culture, (b) perceived authority, (c) perceived communicating styles, and (d) prior relationship between participants define the roles of the individuals who are involved in medical interpreting. Role expectations also can be explored from several perspectives. For example, physicians, family members, and patients may have different role expectations for interpreters. Questions can include (a) How are these different expectations conveyed and negotiated in medical encounters? (b) How do interpreters reconcile these different expectations? and (c) How do individuals employ various communicative strategies that reflect the role expectations for themselves and by others?

4. Contextual Features

Contexts in medical interpreting also can include a variety of themes, such as interpersonal contexts (e.g., prior interpersonal relationship), institutional contexts (e.g., hospitals), cultural contexts (e.g., different cultural beliefs and folk
beliefs), and communicative contexts (e.g., communicative channels). Research on provider-patient communication and physician-nurse communication has demonstrated that some variables (e.g., trust, prior interpersonal relationship, cultural values, organizational norms, and individuals' perceived conflict style) have important impacts on individuals' communicative strategies in medical settings (Cline & McKenzie, 1998; Katzman, 1989; Keenan, et al., 1998). There is no research yet that systematically and empirically examines these contextual influences on the communicative strategies or evaluations of medical interpreting.

In an earlier study, I (Hsieh, 2001b) examined the differences between interpreting styles of on-site interpreters and telephone interpreters that are caused by their contextual differences (e.g., communicative channels and access to non-verbal cues). Table 1 presents these characteristics.

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<tr>
<th>Characteristics</th>
<th>On-Site Interpreter</th>
<th>Telephone Interpreter</th>
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<tr>
<td>Style of interpretation</td>
<td>First Person</td>
<td>Third Person</td>
</tr>
<tr>
<td>Informing the presence of cultural elements</td>
<td>High</td>
<td>Moderate</td>
</tr>
<tr>
<td>Interpretation of nonverbal messages</td>
<td>Active</td>
<td>Avoid</td>
</tr>
<tr>
<td>Guiding the flow of communication</td>
<td>Moderate</td>
<td>Active</td>
</tr>
<tr>
<td></td>
<td>(Do not interfere unless (Use Verbal cues) necessary)</td>
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To build a theory of medical interpreting, researchers should explore the differences and influences of the specific contexts for different types and modes of interpreting. For example, nonprofessional interpreters may be more likely to be influenced by certain contexts than professional interpreters, and vice versa. From a more practical perspective, to formulate effective training programs for interpreters and for health care providers, researchers need to understand what are the salient contexts for a particular mode of interpreting (e.g., on-site vs. telephone interpreting), a particular type of interpreter (e.g., professional vs. nonprofessional interpreters), or individuals from a specific culture (e.g., Chinese vs. Hispanic). Understanding contextual influences will allow both researchers and health providers to generate bilingual health communication models that are both economically feasible and medically effective.

From the perspective of interpreting as a communicative process, a theory of medical interpreting should describe (a) types of interpreters, (b) communicative goals, (c) role expectations, and (d) contextual influences as theoretical constructs that explain and predict communicative behaviors of individuals involved in interpreter-mediated conversation. A theory of medical interpreting not only is important to individuals who are involved in interpreter-mediated conversations but also to researchers of translation studies. As research on medical interpretation broadens its scope and deepens its analysis, researchers from the areas of translation and interpretation, interpreter-mediated communication, mediation, information management, cross-cultural communication, and health communication will benefit significantly as well.

5. Summary

Research and theory are dependent on and complementary to each other. Without theories, research becomes isolated findings that provide limited meanings or significance. Without research, theories are simply hypotheses and speculations. As researchers and the public have become more aware the various issues of bilingual health communication, it is important that researchers begin to formulate theories of medical interpreting.

VIII. Conclusion

In this paper, I began with the historical development of community interpreting, a long-neglected sub-field in translation studies. By examining the recent development across various fields and the strengths of community interpreting in complementing the voids in translation studies, I argued that community interpreting will mark the watershed of the theoretical development in translation studies.

A communicative approach to the studies of interpretation emphasize the importance of the
interactive and dynamic nature of interpreting as a communicative activity. Recognizing that each type of community interpreting (e.g., medical interpreting or court interpreting) has its specific contexts and constructs that influence its communicative process, I used medical interpreting to illustrate how its communicative perspective can be applied through the examination of four constructs (i.e., types of interpreters, communicative goals, role expectations, and contextual factors).

This paper is a part of an ongoing process of developing a normative model of bilingual health communication (i.e., physician-patient communication that requires the assistance of medical interpreters). Recognizing the flaws in past research on medical interpreting, I argued that several variables (i.e., types of interpreters, communicative goals of individuals, role expectations of interpreters, and contextual features of the communicative events) should be included in the analysis of medical interpreters. A careful examination of these variables can further develop and test the nascent perspectives that I have generated through earlier research. It is important that the preliminary model of bilingual communication can be supported and modified through empirically collected data.

In the future, I will examine the communication strategies and beliefs (e.g., interpreting selectively, adding complementary information, omitting details, using common words instead of jargon, making the speakers' utterances more assertive or polite, or using gaze to coordinate the flow of conversation) of both professional and nonprofessional interpreters in health care settings. If interpreters are actively involved in the process through specific communicative strategies, it is important for researchers to ask why and how interpreters choose one specific strategy over another. This perspective poses two specific research questions: First, what are relevant categories of (a) types of interpreters, (b) types of communicative goals and goal conflicts, (c) role expectations for interpreters, and (d) types of contextual factors that affect interpreters' communicative performances? Second, what are the relationships between (a), (b), (c), and (d)? The answers to these questions will allow researchers and health care providers not only to manage the shortage of professional interpreters in medical settings but also to face the challenges of providing quality health care services in the real world.

Translation and interpretation are much more than transferring one language to another. They are communicative activities that are intertwined with individuals' everyday life. Researchers of translation and interpretation must recognize that the significance of their work extends far beyond the translated texts. For example, by studying the process of medical interpreting, researchers can provide effective interventions that improve the quality of services provided to patients who do not share the same languages with their health care providers. Similarly, by understanding the intricacies of court interpreting, researchers can establish procedures that improve the equality of the justice system. To sum up, I urge researchers of translation studies to cross their disciplinary boundaries and extend their academic and theoretical territories to other disciplines. By interacting and collaborating with researchers of other disciplines (e.g., public health and health communication in the case of medical interpreting; social work and judicatory in the case of court interpreting), we will not only expand our research territories but also acquire new perspectives on our theories.

Notes

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2. Simultaneous interpreting and consecutive interpreting are both modes of interpreting rather than types of interpreters. It is, therefore, inappropriate to categorize interpreters as simultaneous interpreters or consecutive interpreters; however, for the conciseness of the paper, I decided to abbreviate interpreters who work in simultaneous modes as "simultaneous interpreters" and interpreters who work in consecutive modes as "consecutive interpreters" or "community interpreters."

3. Simultaneous interpreters defined here is restricted to interpreters who work unidirectionally (i.e., interpreting from language A to language B) in simultaneous mode. Although sign interpreters often work at simultaneous mode, in the field of translation studies, they often are categorized into community interpreting because they generally work in face-to-face situations and interpret bi-directionally (i.e., translating for two parties back and forth between two languages).

References


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由傳播角度檢視醫療口譯

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摘要

本文以醫療口譯為例，檢視近來口筆譯研究所強調的溝通層面。對話口譯的研究顯示即便是專業口譯人員亦不完全遵循傳統翻譯理念（如：譯員中立、傳聲筒理論）所建立的譯員角色。作者綜合整理各領域（包括人類學、社會學、應用語言學、傳播學等）對口譯活動的研究，發現學者們近年來都強調由溝通層面檢視翻譯活動的重要性。口譯員會受許多因素（如：溝通目標、角色期待、情境因素等）影響改變其翻譯策略。作者以醫療口譯爲例，討論在考量醫療口譯的溝通層面時，應當納入醫療口譯理論的重要概念。

關鍵字：醫療口譯、對話口譯、醫療傳播、雙語醫療傳播。