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Conflicts in how interpreters manage their roles in provider–patient interactions

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Abstract

Interpreters face challenges because of the various role expectations that others have placed on them and then adopt specific strategies to manage these conflicts. This study examines the conflicts in medical interpreters' role performances, the sources of these conflicts, and interpreters' strategies for resolving conflicts. It is based on in-depth interviews with 26 medical interpreters from 17 languages in the Midwestern area of the USA. The results showed that interpreters experienced four sources of conflicts in their role performances: (a) others' communicative practices, (b) changes in participant dynamics, (c) institutional constraints, and (d) unrealistic role expectations. To resolve conflicts, interpreters justified their roles by identifying the source and location of an assignment, (re)defining the relationships and identities of the provider and the patient, and adopting specific communicative strategies. This study highlights the importance of speaker and contextual factors on interpreters' communicative strategies and management of role conflicts.

Keywords: Medical interpreting; Interpreters' roles; Patient–provider interactions; Language; USA

Introduction

The inequality of health services faced by patients with limited-English-proficiency (LEP) in the United States highlights the urgent need to develop effective interventions, one of which is to provide interpreters in health care settings (Department of Health and Human Services, 2001; Doty, 2003). Dysart-Gale (2005) argued that the interpreter traditionally has been conceptualized as "a 'conduit' transmitting messages between parties reliably and without distortion" (p. 92), an oversimplified role to describe the interpreter's practice. Nevertheless, after reviewing codes of ethics developed for medical interpreters from more than 20 institutions, Kaufert and Putsch (1997) concluded that many of those codes emphasize an objective and neutral role. The conduit role also is advocated by health care providers (Flores et al., 2003; Hatton & Webb, 1993).

A conduit, in essence, is an interpreting model that requires the interpreter to perform in a neutral, faithful, and machine-like manner. The Cross Cultural Health Care Program (CCHCP) proposed that a conduit is the *default* role and involves rendering in one language literally what has been said in the other without any additions, omissions, editing, or polishing (Roat, Putsch, & Lucero, 1997). In addition, the interpreter is trained to use the *first-person singular* (i.e., speaking as if he or she were the original speaker), creating the illusion of dyadic physician–patient communication and minimizing their presence.

Empirical studies on the practice of medical interpreters, however, have suggested that interpreters often are not neutral. For example, interpreters often side with providers rather than patients when faced with physician–patient conflicts (Bolden, 2000; Cambridge, 1999).

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Researchers have consistently found that interpreters enact roles that are not allowed in a conduit model (Angelelli, 2004; Davidson, 2000). Many studies have focused on the errors (e.g., editing information) made by interpreters, arguing that a lack of training was the cause of interpreters deviating from the conduit role (Cambridge, 1999; Elderkin-Thompson, Silver, & Waitzkin, 2001).

Interpreters, however, have argued that a successful medical encounter requires them to assume roles other than a conduit (Dysart-Gale, 2005; Hatton & Webb, 1993). Although no research systematically investigates the causes of the interpreter's non-conduit like behaviors, I propose that some of the non-neutral performances may be caused by interpreters' efforts to resolve conflicts in their role performances and others' role expectations. This is a new approach to conceptualize bilingual medical encounters: Whereas past research has focused on examining the interpreter as the person who is solely responsible for the quality of bilingual interactions, this approach highlights the interdependence of all individuals' (i.e., the provider's, the patient's, and the interpreter's) communicative behaviors as well as the larger communicative contexts (e.g., social settings and institutional policies).

This approach has great importance and potential for several reasons. First, researchers have noted that the interpreter may be motivated to deviate from the conduit role to facilitate provider–patient interactions. In a medical encounter, especially between individuals using different languages, the provider and the patient may have diverse goals, cultural differences, and expectations. In these situations, interpreters have been observed to actively assess the communicative contexts and adopt non-conduit roles to resolve conflicts (Davidson, 2000; Kaufert, Putsch, & Lavallée, 1998). Second, the interpreter is not solely responsible for the quality of interpreter-mediated interactions. The ability of other speakers to coordinate with the interpreter may also affect the quality of provider–patient communication (Roy, 2000). From this perspective, individuals' communicative behaviors in a medical encounter are interdependent (Elderkin-Thompson et al., 2001). Finally, contextual factors (e.g., institutional culture and policies) may have significant influence on how interpreters mediate the provider–patient relationship in areas of power, treatment choices, and cultural conflicts (Kaufert & Putsch, 1997). In short, this new approach allows researchers to investigate and improve bilingual health communication through the perspectives (e.g., contextual factors and other speakers' behaviors) that have not been explored in prior studies.

The current study aims to examine the conflicts in medical interpreters' role performances, the sources of these conflicts, and interpreters' strategies for resolving conflicts. By understanding these issues from the interpreter's perspective, researchers will have a deeper understanding of the dynamics of bilingual health communication.

Methods

This study is a part of a larger study that examines the roles of medical interpreters, which includes an ethnographic study of shadowing Mandarin Chinese interpreters' daily assignments (i.e., participant observation) and in-depth interviews with interpreters from various cultures. This study is based on the interview data. I recruited medical interpreters from two interpreting agencies in the Midwestern area in the United States. Both agencies view medical interpreting as their primary task and have contractual relationships with local hospitals. A total of 26 participants from 17 languages (i.e., Arabic, Armenian, Assyrian, Mandarin Chinese, Cantonese, French, German, Hindi, Kurdish, Polish, Russian, Spanish, Turkish, Ukrainian, Urdu, Vietnamese, and Yoruba) were recruited, of whom 21 were practicing medical interpreters and 5 held management positions in interpreting offices. Interpreters included in this study are all considered *professional* interpreters and work as freelance interpreters in local hospitals. The majority of interpreters ($n = 17$) have participated a 40-hour training course developed by the CCHCP, which has been viewed as an industry-recognized training for professional interpreters. Those who had not attended the course either had passed certification programs offered by individual hospitals or had acted as trainers in education programs for medical interpreters.

Three months after the beginning of the ethnographic study, I conducted 14 individual and 6 dyadic interviews (each lasted 1 to $1\frac{1}{2}$ h). All dyadic interviews consisted of two interpreters from different languages (except one that included two Spanish interpreters). I asked all interpreters not to share their actual names with each other and made sure that all discussions were done in a productive and friendly manner. In these interviews, I relied on my experience as a medical interpreter and my prior data collected through the participant observation to navigate through the design, preparation, and interview process. I used grounded theory for the data analysis for both the earlier ethnographic study and this study (Strauss & Corbin, 1998). I coded the data from the earlier ethnographic study for dominant themes and categories, which led to a set of research themes that was later used in the interviews for this study. The focus of the research questions was to explore interpreters' understanding of their roles and to generate rich and diverse views, opinions, and experiences from participants of various cultures.

The limited number of interpreters does not allow me to make generalizations about cultural-specific patterns

or cultural differences of the interpreters. However, I included cultural information when the interpreter explicitly referenced it to explain his or her behaviors. The transcripts include two primary types of notation. The texts are CAPITALIZED when they were the speakers' emphasis and *italicized* when they were my emphasis. Each interpreter is assigned a pseudonym.

Results

Interpreters' sense of conflict

Contrary to an earlier study (Angelelli, 2002), which concluded that interpreters perceived their role as visible, most interpreters in the study said they strive to be invisible in provider–patient interactions (i.e., 21 of 26 participants claimed various forms of a conduit role). For example, Selena, an interpreter with 32 years of experience stated, "I am sort of in the background, I am the voice, I try to be faceless." Colin described his role, "I try not to exist in a sense. […] I just interpret." Sara explained, "The goal [of medical interpreting] would be to perform such a job that it seems that you were never there."

The effort to maintain "invisibility" creates challenges and dilemmas for the interpreters (Dysart-Gale, 2005). Several interpreters in the study were conflicted about the roles that they perform. On one hand, they are bound by the code of ethics and institutional policies to be a conduit; on the other, they witness the problematic consequences of their conduit performances. Silvia explained, "*Something is not right*. I keep thinking about this interpreting. This interpreting is very robotic. You know, you are a human being. You are a person. And you are not supposed to show emotions?" The emotionless aspects of the conduit role troubled many interpreters as they faced their emotions and compassion and realized that they are expected to assume the role of an emotionless professional. Shirley, director of the interpreter services in a major hospital, described an incident that she told a trainee that interpreters should not have any physical or emotional interactions with the patient (i.e., they are only the voice of others); however, when she and the trainee entered the exam room, the mother immediately gave Shirley a hug. Later, she told the trainee, "I was the interpreter the night her baby died. To not to let her hug me or not hug her back would have been unfeeling." Despite Shirley's desire to maintain a professional image, she felt the need to balance it with a compassionate persona.

Another aspect that the interpreters struggled with is their desire to, at times, advocate for their clients. Sometimes, although the interpreter may be aware of the questions that the patient should ask, if the patient does not advocate for himself/herself, a conduit role does not allow the interpreter to initiate any comments. Several interpreters talked about incidents in which they witnessed inadequate care but felt constrained to rectify the situation. For example, Stella said,

> There was one situation that the doctor could have explained things a little bit better and they just chose not to. […] The patient went home so confused. And I said to myself, "This is not my place. I cannot do this [i.e., advocate for the patient]." I could have resolved it. *I was in such turmoil because I didn't know what to do*.

Not all interpreters in this study felt a sense of conflict. Some interpreters were up front about their decisions to *violate* the training they had and, thus, they do not necessarily experience role conflicts. Nevertheless, the ones that do experience the discrepancies between their expected and desired behaviors highlighted the problematic pursuit of a conduit role.

Sources of conflict

Four sources of conflicts in role performances were reported by the interpreters of the current study: (a) others' communicative practices, (b) changes in participant dynamics, (c) institutional constraints, and (d) unrealistic expectations.

Others' communicative practices. The success of a conduit model relies on the speaker's ability to recognize and affirm the interpreter's performances (i.e., the speaker's behavior needs to be consistent with the interpreter's definition of the communicative contexts), without which the interpreter may feel compelled to deviate from a conduit role. For example, in a conduit model, the basic assumption is that *all* utterances are directed to the other participants and would be relayed by the interpreter. However, at times, a provider may make comments that are directed to the interpreter or other providers without expecting the patient to hear or be told those comments. Sandra explained, "[I think providers] feel more freedom and they speak more. And they say things in front of the patient because they know that [the patients] are not aware of what they are saying." Sandra talked about an incident that she was concerned about the legal consequences:

> [The patients] were Jehovah's Witnesses, and I know for instance, that they are not allowed to get blood transfusion. […However, the doctor said,] "When the time comes, if the patient will die if he does not receive the transfusion, *we are not going to allow it and we are going to do it anyway. But you tell them that's okay*."

In this incident, the provider's utterances were no longer directed to the patients but the interpreter and

projected a role expectation that was different from a conduit role. The conflict arose because the provider viewed the interpreter as a confidant, who was able to take sides and receive information without relaying it. If Sandra actually relayed *everything* the provider said, she would have violated the provider's role expectation for her.

Another situation that may lead to conflict in adopting a conduit role is when speakers do not act as competent participants (e.g., not knowing the norms of provider–patient interactions or not being able to provide information expected by others). Sometimes, cultural differences can make a speaker less-than-competent. Yetta explained that in Nigerian culture, even a common illness (e.g., high blood pressure) can be used as a personal attack against an individual. As a result, Nigerian people go to a great extent to hide their symptoms. She explained,

> The secrecy of not exposing what they have. […] I have to let the patients know that they are here to be treated, "TELL THEM, what's wrong with you. How you are going to get help." […] They are not used to revealing what's wrong with them.

A patient who is unwilling to disclose his or her problem certainly cannot have meaningful provider–patient communication. An interpreter who is confined to a conduit role would not be able to inform the provider about culturally sensitive ways to retrieve information necessary to treat the illness.

Interpreters also need to manage the cross-cultural differences in information management (Brashers, Goldsmith, & Hsieh, 2002). Telling bad news to a patient often requires great cultural sensitivity. Several participants discussed the challenges to manage the differences between the provider's and patient's preferences about how information should be managed. Roland explained,

> I remember [in] one situation, the intern insisted on telling the patient that he has cancer. And I said, "Well, this is really not the way it's done there. Because he would collapse by talking about it. He would just die in front of your eyes and his relatives would be suing you." The doctor said, "No, this is how it's done here. We think that the patient has a right to know." Yeah, I don't know the answer to that question. The patient has a right here to know. But in that case, the patient maybe doesn't want to know this. Who is right here?

An interpreter is in a position to understand the problematic coordination of information. Although both speakers may be competent participants in provider–patient interactions in their own cultures, the differences in information management strategies can lead to significant conflicts, in which interpreters play a central role in how the conflicts are resolved.

In other situations, interpreters may work for speakers who simply do not have the communicative skills to manage provider–patient interactions. For example, several interpreters talked about incidents in which a patient was not familiar with the information-seeking patterns of American providers and thus, was unable to provide the appropriate answer. Sara explained, "[Sometimes a patient's answer] sounds kind of like, 'What?' And the doctor would say, 'What is she saying?' And you have to repeat the same thing, but you know that the problem is *the provider is not asking the right question*." Stella talked about how the speakers' communicative skills may have significant influence on the patient's satisfaction:

> [The patient could not decide whether to receive an amniocentesis, and the doctor said], "I cannot make this decision for you. You have to make it for yourself." And the patient went home confused. And that's where it stood. […] And a week later, I had the very same situation with another doctor and the doctor simply said, "You know what, this is what I tell my patients. My wife never had the amnio, because she said whatever the baby is I'm still having it. So, she never had the amnio." So, the patient went home so happy. […] You want me to say something? I can't say anything. I'm not supposed to be saying anything. I know what to say. I have to tie up my tongue so that I didn't say anything.

In the case of the first patient, the provider's inability to provide appropriate information and the patient's lack of self-advocacy skills created problems. Stella was aware of what needed to be asked and what information should be given; however, for her to *initiate* information-seeking or information-giving behaviors would require her to depart from a conduit role.

Finally, there are logistical reasons for why a conduit role may become impractical. For example, several interpreters talked about the challenges to interpret heated or confrontational conversations when overlapping is common because of the difficulties to track all the information and provide an exact interpretation.

Others' communicative practices, as a source of conflict, focus on how the speaker's individual behaviors present challenges to interpreters. The next category, changes in participant dynamics, highlights the interactive and dynamic process of provider–patient interactions.

Changes in participant dynamics. A change in the participant dynamics may require an interpreter to adapt to a different role, causing conflicts in interpreters' role performances. For example, an additional participant (e.g., a nurse or a family member) in a provider–patient

interaction may challenge the assumptions of dyadic provider–patient communication (e.g., all conversations are between the provider and the patient and center on the patient's illness). It is not uncommon for two providers to discuss issues irrelevant to the current case or for the family members to have a private discussion with the patient during a medical encounter. In these situations, the spoken utterances may not be directed to the primary speakers (i.e., the provider or the patient); however, if the interpreter does not relay the information, the primary speakers would be excluded from understanding the ancillary interactions. On the other hand, the speakers may decide to have those conversations exactly because they know that the bystanders would not understand their comments. For an interpreter, interpreting those comments would violate the speakers' assumption about the privacy of the conversation. I asked interpreters how they would respond when a resident and a supervisor argue about the diagnosis in front of a patient (an actual event experienced by one of my interviewees). An interpreter must decide how much he or she is going to include the clients in a conversation that (a) is not directed to them and (b) may or may not concern them. Several participants explained their responses:

> Albert: I would stop the interpreting and tell both providers that they don't have to argue in front of the patient, especially if the patient KNOWS a little bit English. So, "Can you stop it or take your time, or go some other places and discuss this." I'd want the main provider to speak to the patient.
>
> Rachel: What are you going to do? Are you going to confuse the patient? And the patient should know that even doctors didn't know what's going on, right? I don't know.
>
> Ulysses: In this type of situation, it is best tell the physicians politely that they should not talk in front of the patient about their diagnosis. […] They should not fight in front of the patient. Otherwise, my job is to interpret everything and I have to tell the patient that they are talking about diagnosis, they have not come to the conclusion. I will inform the patient when the doctors have come to the conclusion, it's a different thing. Otherwise, if they are just talking between themselves, I would never disclose the diagnosis. Or at the end of the session, I may ask the doctor, "Doctor, you were talking about the diagnosis. Should I tell?"

These three interpreters adopted very different strategies to manage the role conflict. Albert took control of the provider–patient interaction and asked the speakers to follow his definition of the interactional context. Albert's focus was to manage the inappropriate performances of the individuals who are involved in the medical encounter. On the other hand, Rachel's and Ulysses' comments reflected their uncertainty about the change in participant dynamics. Rachel's comment suggested that she is aware of how changes in participant dynamics can create role conflicts for the interpreters. By interpreting the conversation between two providers, the patient may become more confused and even distrust the providers. Rachel was unsure about the role interpreters should play in this scenario (e.g., being a conduit vs. a facilitator who promotes a positive provider–patient relationship). Ulysses first talked about an interpreter's role in controlling the conversational context ("It is best tell the physicians politely that they should not talk in front of the patient about their diagnosis"), highlighting his role as a conduit ("My job is to interpret everything"). However, his later solution appeared to accept the providers' expectation of privacy ("If they are just talking between themselves, I would never disclose the diagnosis.") and relegated the management responsibilities to the providers (i.e., asking providers whether he should interpret or not). The shift in his response reflected a change in his role (i.e., from a conduit to a physician aide). In short, it was evident that the interpreters in the study were aware of the private nature of the providers' conversation and recognized that the changes in participant dynamics (i.e., from the interaction between a provider and a patient to a private conversation between providers) may require them to assume roles other than a conduit.

Another situation that could lead to role conflicts for interpreters is the direct communication between a provider and a patient, which challenges the interpreter's control over the provider–patient communication and the legitimacy of the interpreter's presence. This situation is not uncommon in provider–patient interactions because the speakers often have some or limited understanding of each other's language. Several interpreters said that they welcome the patient and the provider to communicate directly with each other, seeing such behaviors as self-empowerment strategies. Interpreters in this study explained that they would assume the role of "invisible" participants who continuously monitor the quality of communication and intervene as they see fit (e.g., provider–patient miscommunication). The difficulties to balance the speakers' desire to empower themselves and the quality of provider–patient interactions present great challenges to interpreters' management of their roles.

In summary, the changes in participant dynamics require interpreters to adapt. In certain cases, a conduit role would actually violate other speakers' expectation of privacy or empowerment strategies. Interpreters need to decide how to control the participant dynamics to obtain quality care for the patients and to maintain an optimal provider–patient relationship.

Institutional constraints. There are several institutional constraints that may interfere with the interpreter's choice of role performances. Institutional constraints come from several sources: Institutional culture, hierarchy, policies, regulations, and environment may all present challenges to an interpreter's choice of roles. Several interpreters stated that they would not do the simplest tasks (e.g., reading the instructions on the prescription, helping a patient to complete a questionnaire, or writing down a provider's instruction) outside the presence of providers because of their concerns about liability. The institutional hierarchy also may make it difficult for interpreters to adopt certain roles (e.g., to challenge providers' behaviors). For example, the institutional culture often treats the provider's time as a scarce resource and pressures the interpreter to conserve the provider's time. Several interpreters explicitly talked about possible conflicts. Rachel explained, "You are between the doctor who is in a hurry, who wants to leave, and the patient who wants to talk, who needs time. You know, that's a really difficult situation." In these situations, the provider and the patient may have very different expectations for the interpreter, which created challenges to the interpreter's choice of role performances.

Interpreters in the study also talked about how environmental constraints limit their choice of roles. For example, a conduit role does not allow an interpreter to have direct communication with the speakers; therefore, the interpreter is instructed not to be alone with a patient at any time. However, this expectation may not be feasible or realistic. Claire explained,

> You cannot remain in the same room with the patient alone. [...but any interpreter will tell you that after the initial check-up, the nurses] just leave you alone in the [exam] room! Where else can you go? I tried. I tried to not to stay in the same room, and then, I stepped out of the room and stayed in the hallway, and the nurse would tell me, "Don't stay in the hallway, you are not allowed here. Stay in the room!" I said, "Can I sit out in the waiting area?" They said, "NO! You have wait with the patient. The doctor is coming." I think this is not possible, you know, in all situations.

Space is a scarce resource in medical facilities. The power-hierarchy within the health care system, the interpreter's outsider status, the limited numbers of patients with LEP, and the pressure to conserve the provider's time all present difficulties in establishing a space dedicated to interpreters. The discrepancies between training for interpreters and the reality of medical encounters lead to interpreters' awareness of their lower status in the health care system and their inability to correct the situation.

Problematic role expectations. An interpreter needs to make judgments about how a message should be relayed, a process that is directly linked to the interpreter's choice of roles; however, an interpreter's decision may be incongruent with others' expectations. For example, an interpreter may decide to elaborate on clinical information because the patient may not have the medical knowledge to understand the physician's comment (Angelelli, 2004); however, such behaviors may violate the provider's expectation of a conduit role. Sandra talked about an incident in which the physician was upset and questioned her why she used the term "pressure in the eye" to replace his term "glaucoma." She realized that she has violated the provider's role expectation but felt that it was important for the patient "to know more what he was going to be tested than the terminology for the procedure." In other situations, speakers may expect an interpreter to keep their secrets. Patients, at times, may choose to reveal certain information to the interpreters but not to the providers, interpreters then would struggle between telling the truth (i.e., violating the patient's confidence) versus interpreting what was said by the speaker.

Interpreters experience problematic, if not unrealistic, role expectations. In their training, interpreters are told to adopt a conduit role that emphasizes a robotic view of interpreting; however, it is unrealistic to expect an interpreter to be distant and invisible in an environment that often is emotionally charged. Selena explained, "The code of ethics says that you cannot establish an emotional rapport with the patient. But it's very hard to do, when you know if you hold a patient's hand, that's going to convey, 'I sympathize with you.'"

In addition, interpreters' communicative styles may not be familiar to laypersons. In typical training, interpreters learn specific strategies to create the illusion of a dyadic communication, reinforcing the provider–patient relationship. For example, interpreters often are trained to avoid direct eye contact with the speakers so that the provider and the patient will pay attention to each other (rather than to the interpreter). Stella explained, "[When interpreting,] I detach myself emotionally from many things that are going on there, and I look at the floor, and I look at the ceiling or something. And I make sure that [the provider and the patient] talk to each other." To a layperson, this behavior may seem strange. Several interpreters noted incidents in which the speakers believed that they were shy, indifferent, incompetent, or deceptive because they avoided eye contact during the interpreter-mediated interactions. In other situations, a speaker may be confused by the interpreter's first-person interpreting style because he or she did not know whether the comment came from the interpreter or other speakers.

An interpreter's conduit role, at times, may be inappropriate for some cultures, which assign negative implications to communicative styles that are valued in a conduit model. Interpreters from these cultures experience social pressures that lead to role conflicts. For example, a conduit role does not allow an interpreter to interact directly with a speaker. Several interpreters talked about their struggles to reconcile the various role expectations. For example, Claire explained, "For Chinese culture, it is very rude if you don't talk to people, if you just sit at a separate place. Patients would find you rude if you don't talk to them." Although a conduit role may carry the image of an emotionless professional that is valued in the Western biomedical culture, it may be problematic to people who do not share the same appreciation for that role expectation. Interpreters must decide how they are going to reconcile the various roles that might be expected from them.

Communication is an activity that requires the participants to coordinate behaviors, understanding the implicit and explicit meanings of their behaviors. Interpreters constantly are required to evaluate the process of coordination, to monitor miscommunication, and to ensure that successful interactions are achieved. This task is made difficult by the various sources of role conflicts that interpreters encounter. Nevertheless, interpreters have developed specific strategies to resolve these conflicts.

Resolutions to conflicts

Some of the strategies presented here may be considered "errors" in the traditional literature (e.g., Flores et al., 2003); however, interpreters in our study viewed them as strategies to reconcile the various role conflicts they encounter in provider–patient communication.

Creating boundaries. Some interpreters talked about creating boundaries for their role performances. There are several ways that interpreters create boundaries for their role performances. First, because several interpreters have other jobs (e.g., case manager and patient representative) in health care settings, they choose their roles based on which job title assigned them the interpreting task. Stella explained that because she was given different instructions, she acted as an advocate when she serves as the staff interpreter for a hospital and as a conduit when she takes the freelance assignments from the interpreter agencies. Because interpreters may have several "official" roles, they may face conflicts between these roles. Sharon, director of a major interpreting agency, mentioned an incident in which she found that a case manager, who also acted as the interpreter for his clients, had the attitude of "I am going to go with my client to every appointment and I'm going to be the interpreter. *I am going to lie if I had to, to get my clients their benefits*." The advocate role was chosen because the case manager felt that his responsibility to obtain the client's benefits superseded the need to provide neutral interpretation.

The second way that interpreters in this study created boundaries is to narrow the definition of medical encounters. In other words, although they feel obligated to act as a conduit *during* medical encounters (i.e., appointments), they are not constrained to the conduit role outside of the medical encounters. Sophia explained,

> I am going to be an advocate when that family finishes [the appointment]. I would take them to the clinic and I am not going to interpret. I ask for the bill statement and I can go and make the claim for them. […]. [I am an interpreter] when I am in the room, but when I am outside and they come to see me, then I'm an advocate.

Creating boundaries for role performances allows interpreters to justify their choices of roles, reducing role conflicts. Whereas creating boundaries seems to define roles through static factors (e.g., the source and location of an assignment), the next strategy (i.e., redefining relationships and identities) is to define roles through dynamic interactions.

(Re)defining relationships and identities. At times, interpreters encounter conflicts in role expectations during a medical encounter (e.g., a speaker makes an inappropriate comment), motivating an interpreter to shift into a different role. It is also important for an interpreter to let other speakers know that the dynamics of the interpreter-mediated interaction have changed, so that others can respond accordingly. Some interpreters *claim* specific roles as they change their communicative behavior. To a certain degree, the interpreter strategically claims specific roles to navigate through the role conflicts. Stacey noted,

> When I assume the role of advocate, I let the doctor know that I am assuming the role. I am not just interpreting. I am advocating for the patient. So, he knows where I am coming from. I said, "*I am a friend of the family*. And I know the situation. Let me explain to you the issues around this." So, they understand.

When I asked Stacey if she was truly a friend of the family, it was clear that it was only a claim for the role because she does not have any social interactions with her clients outside of health care settings. Interpreters claim roles to justify their behaviors. Sophia explained that when she interpreted for her mother, she assumed the role of a daughter (rather than a professional interpreter) and thus, was justified to take care of her mother by modifying the provider's disclosure of poor

prognosis. Christie explained that when she provided assistance that was not permitted in a conduit model, she did not do it as an interpreter but as a "volunteer for a charity organization." In short, by claiming certain roles, interpreters in the study redefined their relationships with others and, thus, justified their behaviors.

Some interpreters also talked about (re)defining their relationships and roles *with* others. For example, they talked about incidents in which they made sure that the patient was aware of their roles and identities. Yetta noted,

> I would explain to the patient that "I am here just to make sure that you understand what the doctor's saying and the doctor understands what you are saying. *I am not interested in your case at all*." Because in my community, [… people do not want others to know about their illness.] So, I give them the confidence that I'm here to interpret and once we get out of here, there's no discussion.

Yetta chose to highlight certain aspects of her roles in response to specific concerns that patients from her culture would have. On the other hand, an interpreter may rebuff others' request for certain performances by asserting their specific roles. Steve explained, "I have had one situation that the provider said, 'Well, you don't need to interpret that.' And I said, 'Actually, I do. It's my job.'" By asserting his responsibility as a conduit, Steve implicitly informed the provider that he is an independent professional (as opposed to a physician aide).

Some interpreters used various strategies to directly or indirectly define roles *for* others. For example, an interpreter may make speakers aware of their identities as a strategy to rectify problematic communication; in other situations, an interpreter may choose to use a third-person interpreting style to differentiate himself/herself from the actual speaker. Certain methods of information giving may be problematic in different cultures. Interpreters in the study talked about the ways that they made it clear that the message is not from them but from others:

> Vicky: If the patient is told to have cancer, I am not going to tell her, "You have cancer." […] I would tell the patient, "*The doctor says it MIGHT be*. So, in order to prevent the tumor from getting bigger, *he* would like you to undergo chemo."
>
> Ulysses: What I would do is I try to be polite and say, "The doctor is asking for HIS information, do you smoke?" "NO, Sir, how can you smoke, you know it's prohibited in our religion." "Yes, but even then, it is the *American* way."

In addition, other speakers may fail to recognize the interpreter's role, which may lead to miscommunication. For example, Sara talked about an incident in which two providers were startled by "her" comments about the providers' incompetence (e.g., "If you don't know what you are doing, why don't you look for someone else?") when they were debating about the appropriate treatment for a boy. She eventually resorted to nonverbal signals (i.e., shaking her head and pointing to the father of the patient while interpreting the father's utterances) to let the providers recognize the actual speaker of those comments.

Interpreters also may implicitly remind others about their roles and identities. Shirley noted that when a speaker makes an inappropriate comment (e.g., profanity), she would hint to the speaker that *he or she* is the person who makes the comment, not the interpreter; she explained, "What we have done is we will say something like, 'You sure you want me to interpret that?' DON'T USE ME as a camouflage." Interpreters also may choose to explicitly define roles and relationships for the speakers. For example, when Vicky felt that a staff member's comments were inappropriate, she defined the patient's identities, forcing the staff to back down:

> A staff was looking at the client, "ARE YOU SURE YOU WANT TO GO THROUGH THAT ROUTE? Are you sure you want to waste your time?" So, I told the lady, "You know, you are dealing with a person who is a refugee, who has been in the States for 3 days. He doesn't even have his own social security card. He is still fighting the jetlag. So, if you ask if he is sure or not, he doesn't know. So, please, understand his situation." So the lady said, "All right" and she backed off.

In summary, when interpreters (re)define their roles, they justify their communicative behaviors. On the other hand, when interpreters (re)define roles for *others*, they influence others' perception about the dynamics, contexts, and content of the medical encounter. The process of (re)defining relationships and identities, however, can be a constant negotiation and coordination between all participants.

Manipulating communicative strategies. Finally, interpreters may opt to manipulate linguistic and communicative strategies to resolve role conflicts. For example, interpreters talked about how they manipulate the message for specific communicative goals. As noted earlier, Vicky explained that she would disclose a poor prognosis on diagnosis by prefacing it with "*The doctor THINKS it MIGHT be…*" By doing so, Vicky not only differentiates herself from the doctor (i.e., using third-person interpreting style), but also softens the blow by using hedges. An interpreter may also intentionally choose a different corresponding term to avoid the negative implications that often are associated with the provider's term (e.g., cancer). For example, Roland said that he intentionally used the word leukemia to replace

the provider's use of the word cancer because the former may have less negative connotation to the patient.

Interpreters' manipulation of linguistic strategies in an ideal world (i.e., both speakers have no knowledge of the other's language) is always covert because they are the only ones who understand both languages. As a result, interpreters have tremendous power to influence the content and the process of communication. Through covert strategies, interpreters would be able to remain invisible, enacting the conduit role that is valued in provider–patient interaction while performing other types of roles. For example, some of the interpreters talked about how they *covertly* hinted to patients to discuss symptoms that they mentioned earlier with the interpreter but had not with the provider or coached the patient about appropriate information-seeking skills. These communicative strategies allowed patients to advocate for themselves, which presents a more competent and assertive patient identity, without compromising a provider's expectation of a neutral interpreter.

Several interpreters also talked about how they purposefully employ specific strategies to influence others' communicative practices and role expectations. For example, interpreters in my study talked about explicitly informing others about the appropriate ways to communicate (e.g., using short sentences and establishing eye contact with the other speaker rather than the interpreter) at the beginning of a medical encounter. Interpreters also talked about employing nonverbal strategies (e.g., avoiding eye contact) to prompt others to modify their communicative behaviors. By forcing others to modify their behaviors in a way that is consistent with the conduit model, interpreters were able to change the communicative contexts and others' role expectations. For example, Roger explained, "You look down and you just [looking down]. I am not here. […] Sometimes, you go down [looking down], he looks at you and your ear, one time, two times, and he turns around and he looks at the patient."

In summary, interpreters' manipulation of communicative strategies functions in two ways to resolve conflicts of role expectations. Through a covert manipulation of their communicative strategies, interpreters are able to perform various roles while appearing to be a conduit (or in the roles that are expected by others). On the other hand, by using strategies that influence others' communicative behaviors, interpreters are able to reshape others' role expectations and thus, reduce possible conflicts.

Discussion

Successful bilingual health communication relies on more than an interpreter's linguistic skills. The interpreter's ability to coordinate and negotiate other speakers' communicative goals and identities is crucial to the effectiveness and appropriateness of provider–patient interactions. Despite the fact that the interpreters in the study were trained to adopt a conduit role, their interactions with others constantly reminded them of the various role expectations that others have placed on them and the need to shift between roles. They were aware of the conflicts of their role performances. More importantly, the sources of conflict were not necessarily under their control: They can only adapt.

This study highlights several issues that are rarely examined in bilingual health communication. First, to understand why interpreters fail to adhere to a conduit model, researchers must recognize how other speakers influence the interpreter's communicative strategies and management of roles. Although past literature has discussed how interpreters may actively mediate provider–patient interactions (e.g., Angelelli, 2004; Davidson, 2000), few researchers systematically explore how communicative behaviors of speakers and interpreters are interdependent. This study suggests that some of the provider's communicative behaviors (e.g., treating the interpreter as a confidant) project the interpreter in roles other than a conduit. In fact, if interpreters followed a conduit model in those situations, they would have violated the provider's trust and expectation. A conduit role does not allow an interpreter to take initiative; however, when a speaker cannot be a competent participant, an interpreter feels the pressure to depart from a conduit role in order to facilitate the provider–patient interaction. This perspective suggests that if providers can effectively manage the quality of provider–patient interactions, an interpreter may be more likely to adhere to the conduit model. In short, the interpreter's ability to adhere to a conduit role is dependent on other speakers' communicative skills and behaviors.

Second, it is important to reexamine the institutional policies and expectations that we place on medical interpreters. For example, it is unrealistic to expect interpreters not to have any direct interactions with their clients when they have to stay in the same exam room with a patient for a long period of time. It is unfeeling to expect interpreters not to comfort a patient when they may be the only persons that the patient can relate to or communicate with in health care settings. When interpreters refuse to provide simple services without the presence of the provider, the providers inevitably will face increased workload. Dysart-Gale (2005) argued, "The conduit model provides neither a complete description of interpreter work in clinical settings nor adequate grounding for ethical decision making in interpreter practice" (p. 98). By underscoring the absurdity of these expectations, it is not my argument to abandon all these role expectations for interpreters; rather, I believe it is necessary for institutions to present interpreters with realistic expectations and appropriate means to accomplish them. By developing realistic

expectations and policy guidelines, interpreters are less likely to depart from an appropriate role and are more likely to be held accountable for their inappropriate behaviors.

Third, we need to recognize that the interpreter's various job titles and identities may influence his or her approaches to the assignments and clients. Some researchers have argued that bilingual support staff and providers may be an invaluable resource in bilingual health communication (Mitchell, Malak, & Small, 1998). However, Johnson, Noble, Matthews, and Aguilar (1999) found that bilingual support staffs often are conflicted about their responsibilities and roles because they feel that their interpreting responsibilities may interfere with their other jobs, a finding supported by the current study. This study also suggests that interpreters may strategically claim their roles to justify their potentially problematic behaviors. As a result, although interpreters may recognize the need for their neutrality, their interpreting task may be intertwined with other obligations and identities, presenting challenges to their neutrality.

Finally, it is essential for researchers to examine interpreters' communicative strategies and the corresponding consequences. This study showed that some interpreters' strategies for resolving conflicts are problematic and inappropriate. Although these strategies reflect interpreters' effort to manage their roles and to reconcile various conflicts, they should not be accepted without challenges. Among the strategies discussed in this paper, some are more effective and appropriate than others. It is important for researchers to further examine the implications of these various strategies as well as their impacts on provider–patient communication and patients' quality of care. By doing so, researchers will be able to provide sound recommendations for interpreters to manage the conflicts of role performances without compromising the quality of health care services and provider–patient relationship.

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