

Inherent Tensions and Challenges of Oncologist–Patient Communication: Implications for Interpreter Training in Health-care Settings

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By examining actual medical encounters, we identify specific communicative characteristics inherent in gynecologic oncologist–patient interactions in the USA that may lead to challenges and barriers to successful bilingual health care. By using monolingual medical encounters, we aim to address the research design challenges in the field of bilingual health care and to generate new approaches to the research and training of health-care interpreting. In total, 44 segments (553.25 minutes) of the first medical visits to a gynecologic oncology clinic were included in the study. Using discourse analysis and a grounded hermeneutic approach, we found that oncologist–patient communication poses challenges for interpreters’ management of medical encounters in the following ways: (1) speakers’ inconsistent, ambiguous talk, (2) incompatible sociolinguistic norms, and (3) providers’ multilayered identity performances. Our findings highlight the importance of educating interpreters to be not only responsive but also proactive in managing the various intended and unintended meanings emerged in the discursive process.

Keywords: Provider–Patient Communication; Medical Interpreting; Interpreter Training; Language Barriers

I saw no visible signs that [the mother] was ready to cry from what was on her face. But her voice started quavering a bit and I knew she was on the edge of tears. I signed, “SHE’S READY TO CRY.” He looked at me and then looked at her and then looked at me again, and I nodded, “YES.” He then reached around to his desk to get a box of Kleenex and sure enough, when he made that gesture, she started bawling. (B. Nicodemus, American Sign Language (ASL)-English interpreter, personal communication, March 23, 2014)

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Studies about interpreting traditionally have been dominated by researchers from linguistics and interpreting studies (Nicodemus & Swabey, 2011), who have scrutinized numerous aspects of interpreters' linguistic performances to derive meaningful and practical guidelines for interpreter training. The focus on interpreter performances, however, can be misleading in health contexts as researchers have argued that the success of an interpreter-mediated medical encounter is assessed by (1) the quality of provider–patient communication, (2) the quality of care and health outcomes, and (3) cost–benefit analysis (Tsuruta, Karim, Sawada, & Mori, 2013). In other words, health-care interpreting is auxiliary to a larger communicative activity (i.e., provider–patient communication), which entails specific goals (e.g., providing quality care and ensuring optimal health outcomes).

Health-care interpreting as a field of research has been situated in a complex intersection of language, culture, and medicine (Hsieh, 2010, 2014). Because health-care interpreting is inevitably situated in intercultural health care, participants in interpreter-mediated medical encounters often need to manage the differences in language practices, cultural norms, and illness ideologies. By recognizing interpreter-mediated medical encounters as a goal-oriented, collaborative activity among multiple parties, researchers have noted that successful bilingual health care is dependent on provider–patient–interpreter collaboration to facilitate the quality of care (Hsieh, Ju, & Kong, 2010; Hsieh & Kramer, 2012). Since 2000, there has been a steady increase in evidence-based research in bilingual health care (Brisset, Leanza, & Laforest, 2013), often conducted by physician researchers. These studies have highlighted the complexity of bilingual health care by incorporating providers' perspectives, clinical consequences, and therapeutic objectives in their analyses (Brisset et al., 2013; Karliner, Jacobs, Chen, & Mutha, 2007).

A challenge faced by researchers in the field of bilingual health care is the difficulties in obtaining sufficient data for meaningful analysis. A review of 61 qualitative studies found that 75.4% of the studies ($n = 46$) used interviews/focus groups as primary data and only 19.6% ($n = 12$) used audio/video recordings of the actual encounters (Brisset et al., 2013). Many publications also share the same set of data derived from a parent study (Karliner et al., 2007).

Compared to collecting data through interviews/focus groups, examining actual medical encounters represents a more complicated and difficult research design due to complexities in recruitment, equipment preparation, and concerns about potential litigation and privacy violations. It is not surprising to have fewer studies based on actual medical encounters. However, researchers have found that participants' perceptions do not correlate with their or other participants' behaviors in the actual encounters (Cegala, Gade, Broz, & McClure, 2004). As a result, researchers have emphasized the importance of examining actual medical encounters, arguing that “connecting communication characteristics to difficulties and/or roles in future studies would give us better understanding of the communication process and help formulate relevant recommendations for different interpreting situations” (Brisset et al., 2013, p. 138).

Identifying communication characteristics of an emergent, dynamic medical encounter can be difficult due to the limited number of interpreter-mediated interactions. Individuals with limited English proficiency (LEP) account for 9% of the total US population (Whatley & Batalova, 2013). Thus, compared to the English-speaking population in the USA, the LEP population represents a considerably smaller pool of participants. The number of interpreter-mediated encounters is further reduced by several other factors. First, LEP patients often prefer to visit language-concordant providers in their local communities (Simon et al., 2013). Second, providers often underutilize professional interpreters and communicate with LEP patients directly despite their limited proficiency in patients' language (Diamond, Tuot, & Karliner, 2012). Two studies found that less than 20% of LEP patient received services from professional interpreters (Ginde, Sullivan, Corel, Caceres, & Camargo, 2010; Schenker, Pérez-Stable, Nickleach, & Karliner, 2011). Finally, researchers often need to limit the specific clinical contexts and language combination to ensure analytical rigor, which significantly reduce the number of eligible observations.

This paper is a response to these challenges by presenting a new approach to “connecting communicative characteristics to difficulties and/or roles” in interpreter-mediated medical encounters. We aim to examine actual provider–patient interactions to explore the challenges faced by interpreters in managing the communicative content and process of bilingual health care. Rather than using data of interpreter-mediated medical encounters, we used video-recordings of actual monolingual, English-speaking oncologist–patient interactions to formulate the basis of our arguments and analysis. This approach addresses the difficulties in obtaining quality and meaningful data for evidence-based studies in bilingual health care.

In this study, we focus on the physician–patient interactions in gynecologic oncology settings. We choose this clinical context because the content and process of oncologist–patient communication are often sensitive and emotionally charged, requiring providers to manage the intricate balance of truth-telling, patient autonomy, and benevolence. In addition, these discussions are situated in social norms and infused with cultural values, resulting in diverging practices in different communities (Tuckett, 2004). Disclosure about poor prognosis is not a simple binary decision (e.g., to tell or not to tell) but a series of culturally situated social coordination about how, when, and to whom the disclosure should be made (Surbone, 2013). The nuanced and complex nature of cancer-related talk provides rich data to examine challenges faced by interpreters in intercultural health care.

We recognize the experimental nature of this approach as our data do not involve an interpreter or a bilingual component. Nevertheless, because providers generally have little training about working with interpreters (Brisset et al., 2014) and oncologists often maintain the same communicative script irrespective of patient differences (Gao, Burke, Somkin, & Pasick, 2009), physicians in our study are likely to adopt similar behaviors in both monolingual and bilingual medical encounters. By examining monolingual medical encounters, researchers can still identify the inherent challenges and barriers to interpreters' management of oncologist–patient

interactions. These challenges are not a result of interpreters' problematic performances or lack of competence. Rather, these challenges are inherent to *all* (gynecologic) oncologist–patient interactions as they reflect the complex nature of human interactions in cancer care in the USA.

These challenges were often silently faced by monolingual patients and providers as they struggle to understand and interpret each other's meanings and intentions (Manganello & Clayman, 2011). Meanings in everyday interactions often are inferred rather than explicitly expressed. People derive meanings through normative rules (Grice, 1996), which are often culturally situated and socially constructed. Because meanings are emergently constructed and dynamically negotiated in social interactions, it may be difficult to pinpoint a definitive meaning intended by the speaker at a given time during the conversation. This is particularly true in an oncological clinical encounter as all participants negotiate various shades of meanings in relation to optimism and survivorship. Nevertheless, interpreters are stuck in the communicative process. They do not have the luxury to participate in the conversation, only to reflectively contemplate the intention and meanings of other speakers. In turn-by-turn talk, they are obligated to provide an (official) “interpretation” of others' talk as soon as the other speaker's turn ends, allowing them to define and control the meanings of others' narratives.

Due to concerns about interpreters' power and control over the content and process of provider–patient communication, the health care industry has traditionally imposed the interpreter-as-conduit model in health care settings, which also is reflected in interpreters' codes of ethics (Leanza, 2008). Interpreters are taught that they are not responsible for problematic provider–patient interactions as long as they faithfully, neutrally, and accurately convey the information from one language to another (Hsieh, 2008). It is the providers' and patients' responsibilities to communicate with each other and interpreters are just the voices of others. This attitude is best reflected by the following statement from an interpreter:

Who are you to tell the doctor what to do? Because you have patients who are very submissive, very afraid, depending on what they went through. So, the interpreter thinks that he or she has a right to advocate. But were you asked to do so? (Hsieh & Kramer, 2012, p. 159)

Such an approach to interpreter-mediated medical encounters often leads to interpreters' experiences of powerlessness and frustration (Brisset et al., 2013; Hsieh, 2006). More important, it fails to recognize that the complexity and cultural differences in provider–patient communication. Recognizing the limitations of the conduit model, many researchers have urged to reconceptualize and expand interpreters' roles and functions in health-care settings (Hsieh, 2013; MacPhail, 2014).

By using monolingual medical encounters as data, we propose an innovative approach to the study of bilingual health care. Rather than examining interpreters' behaviors, we ask in what ways the characteristics of oncologist–patient interactions in our data could present challenges to interpreters' performances. By identifying the

specific communicative characteristics of medical encounters that may present difficulties, we aim to facilitate interpreter training by (1) examining the underlying causes of these difficulties, (2) exploring solutions to potential problems, and (3) identifying specific recommendation for providers and interpreters.

Methods

Participants and Procedures

This study is a part of a larger study conducted from January to October 2012, examining the illness experiences of patients who were newly diagnosed with gynecologic cancer. The larger study includes ethnographic observations, video-recorded medical encounters, and interviews. All video-recorded provider–patient interactions took place in counsel rooms and/or exam rooms in the gynecological oncology clinic. The patients received a \$10 Wal-Mart gift card for the video-recorded medical encounters. All research procedures have been approved by the appropriate institutional review boards.

In total, 29 patients and 3 oncologists (i.e., MDs with gynecologic oncology specialty) from a teaching hospital are included in this study. All participants are female and are native English speakers living in a large Midwestern city in the USA. The average age of the oncologists was 43.7 (standard deviation [*SD*] = 11.6). The age range of the patients was 42–89 (mean = 61.9; *SD* = 10.9). We have assigned pseudonyms to all participants. Patients' pseudonyms start with C (e.g., Cara) and oncologists' start with P (i.e., Pam, Pearl, and Piper).

For this study, we examined data collected during the patients' *first* medical visit, including only interactions between the patients and the oncologists. In these first encounters, the patients and the oncologists often have multiple interactions. We treated each patient–oncologist interaction as a data segment. In total, 44 segments (553.25 minutes) of the first medical visits were included in the study. The average time per segment is 12.6 minutes (*SD* = 8.5), averaging 1.5 segments per patient. Of the 44 segments, 9 were with Pam, 33 were with Pearl, 1 was with Piper, and 1 was with Pearl and Piper together. The first author assigned pseudonyms to all participants, archived all segments, and de-identified the data. A professional transcription agency transcribed all medical encounters. All transcripts were then reviewed and edited by the first author to ensure accuracy prior to data analysis.

Data Analysis

We adopted discourse analysis (Blum-Kulka & Hamo, 2011; Boxer, 2002) and a grounded hermeneutic approach (Addison, 1999) for data analysis and used NVivo 10 to organize and code all data (i.e., ethnographic notes, video data, transcripts, and analytic memos). By adopting discourse analysis, we assume that individuals' speech practices are both the product and the resources of their identity management in everyday life (Tracy, 2002). By adopting grounded hermeneutic approach, we assume

that “meanings are expressed in action and practices” and are “being negotiated constantly in ongoing interactions” (Addison, 1999, p. 150). Individuals strategically employ linguistic resources to frame, construct, and negotiate their understandings and management of task, identity, and relationships (Bazerman, 1990). In addition, because individuals’ speech practices are intertwined with their worldviews and social norms, individuals’ interpretation of the meanings of discourse is culturally situated and socially constructed. We believe that meanings constructed in discourse are both multilayered (Kramer, 2013) and multivocal (Bakhtin, 1981), which can also present specific problems in intercultural interactions (Blum-Kulka & Hamo, 2011; Suszczynska, 1999).

As we review the video recordings and transcripts, we focus on identifying narratives that may present difficulties and challenges to cross-cultural pragmatics (Boxer, 2002) and/to interpreters’ performances (Blum-Kulka, 1981). The first author is a native speaker of Mandarin Chinese and the second author is a native speaker of Japanese. Both completed college-level education in their home country before coming to the USA. The first author holds BA degrees in Chinese and English literatures and an MA degree in translation and interpreting studies. She also has worked as a professional interpreter internationally and as a faculty member in a graduate program for health-care interpreters. The second author holds a BA degree in British and American Studies. She has worked as an interpreter for Chunichi Shimbun (中日新聞), a major news organization in Japan. She also has over six years of experiences as an instructor for undergraduate Japanese courses at two state universities in the USA. We relied on our cultural knowledge about sociolinguistic norms in Mandarin Chinese, Japanese, and English to identify narratives that involve potential difficulties and challenges for cross-cultural pragmatics. This approach is within the traditions of discourse analysis in which ethnomethodologists rely on their cultural knowledge to examine speech practices. We also have included relevant literature whenever possible. Throughout the study, we held weekly meetings to review our individual memos and the lists of themes together to check for inconsistencies or missing themes.

Finally, following Creswell and Miller’s (2000) procedure to ensure the validity of our analysis, we invited faculty members in graduate programs for health-care interpreters to conduct audits and peer reviews. As auditors, they were asked to examine the narrative account of the manuscript and verify the credibility of our analytical procedure and findings. As peer reviewers, we asked them to provide feedback on the complexity of our analysis, including additional insights into cultural/linguistic variations based on the sample narratives. The faculty members are all professional interpreters. They are from different universities and train health-care interpreters in various language combinations, including American Sign Language (ASL)-English, Greek-English, and French-English.

It is important to note that our methodological approaches do not provide a comprehensive or exhaustive list of challenges nor frequency counts of these practices. Rather, the focus is on identifying distinctive categories of communication characteristics. Finally, due to the nature of our data, we included discussions about

implications for interpreter *behaviors* in the results section and elaborated on implications for interpreter *training* in the discussion section.

Results

Compared to a routine visit with a primary care physician, patients in our study are likely to experience anxiety and are motivated to address concerns on multiple fronts (e.g., prognosis, quality of care, and social relationships). Although the communicative characteristics identified can be found in other clinical contexts, our findings highlight the unique nature of gynecologic cancer care. Oncologist–patient communication poses challenges for interpreters’ performance in the following ways: (1) oncologists’ inconsistent, ambiguous talk, (2) incompatible sociolinguistic norms, and (3) physicians’ multilayered identity performances. The *italicized* portions of the transcript highlight the authors’ emphasis.

Oncologists’ Inconsistent, Ambiguous Talk

When a speaker’s narratives are incoherent or ambiguous, an interpreter may experience challenges in interpreting the talk. We found that inconsistent, ambiguous talk can be caused by two categories of talk: structural and informational inconsistency, and physicians’ management of multiple task goals.

Structural and informational inconsistency. In medical encounters, providers can provide information that can be perceived to be inconsistent or confusing. For example, Pam explained to Cailey:

The report doesn’t see anything big, spread, *which is good. They don’t even see that cancer that’s there.* [...] CAT scans are a little bit- I mean *they’re helpful, and then they’re not helpful* because we know you have a cancer and they don’t even comment on it.

In another example, when discussing Candie’s prognosis, Pearl said:

So I think what my examination says is that you’re better than average in terms of the way, you know, your exam is. And *I’m not seeing anything scary.* Okay? So *the only thing scary is the biopsy result,* not anything about your physical exam at all, so *that’s awesome,* okay?

These narratives provide conflicting information. In addition, because these conflicting statements appear to follow one another, the inconsistency embedded in the structure of narratives can present unique challenges for an interpreter to effectively identify and accurately convey the true meanings of these conflicting remarks. What does it mean to say something is “helpful but not helpful?” How about “Not seeing anything scary, except one scary thing. So that’s awesome!” Relaying information in the exact sequential structure may create confusion as not all languages and/or cultures share the same semantic structure and pragmatic

implications. In addition, such information is pragmatically incoherent, presenting multiple interpretations/meanings at the same time. Although a patient may choose to hear one meaning but not others or be able to understand the multiple meanings concurrently, it can be difficult for an interpreter to retain the multilayered and multivocal meanings at the same time.

Due to the naturalistic nature of our data, we were not able to identify the speakers' "true" or intended meaning in these self-conflicting remarks. Interpreters face similar challenges. To clarify the meaning, an interpreter may attempt to seek clarification (e.g., "Doctor, can you clarify? What does it mean to be helpful but not helpful?"), which inevitably disrupts the flow of provider-patient interaction.

It is also important to note that these self-conflicting remarks may not be the speakers' failure or mistake in providing a coherent meaning. In fact, it is not uncommon for providers to provide both optimistic and pessimistic statements in a single medical encounter (Robinson et al., 2008). Strategic ambiguity has been identified as a communicative behavior utilized by many to manage conflicting goals (Bavelas, Black, Chovil, & Mullett, 1990). In other words, these structural and informational inconsistencies may be intended structure to "cover all grounds." Nevertheless, not all cultures appreciate ambiguous talk. For example, a Greek female patient would find an oncologist's ambiguous attitude problematic as a visit to a specialist entails expectations of obtaining definitive answers from a knowledgeable expert (E. Fragkou, personal communication, March 11, 2014).

Ambiguity can result from intended or unintended speech. While seeking clarification is an effective strategy to resolve unintended ambiguity by the speaker, an interpreter who wishes to clarify the meaning by asking the speaker to commit to a single meaning fails to recognize the speakers' complex strategies in navigating the semantic and pragmatic fields of speech.

Management of multiple task goals. A provider may have competing, if not conflicting, task goals that need to be managed during the discursive process. For example, when Cadence expressed concerns about hormone deficiency if her healthy ovary was removed, Pam responded:

Well, *your hormones probably are pretty not working* so much anymore because you're after 50. [...] So after menopause, these ovaries, they're not dead, *so you're right, they still do make some hormones.* It shifts, and so they make different hormones, more androgen type hormones.

On the surface, it would appear that Pam was inconsistent in the information provided. However, a closer look at the surrounding talk suggests that Pam's agenda was to encourage Cadence to remove both ovaries. Pam's strategic omission of information (i.e., ovary's hormone production) was initially used as a strategy for persuasion. However, as she tried to balance her goals in pursuing her agenda while being accurate (or truthful) about medical facts, Pam may appear being deceptive (i.e., not informing the patient about the truths) or incompetent (i.e., not knowing the facts). In this particular interaction, Pam's goals include: (1) providing accurate

medical information, (2) suggesting Cadence to remove both ovaries, and (3) respecting Cadence’s autonomy and decision-making. These are not compatible goals, especially when Cadence was reluctant to remove her healthy ovary.

Similarly, when Piper explained to Candie about removing her omentum, she said, “We’ll take that out and basically *you don’t use it for much. It walls off infections and kind of is considered the watchdog of the abdomen*, trying to protect your intra-abdominal organs but is not super important for your life.” Piper’s description about omentum was contradictory. However, such a contradiction reflects the inherent tensions between a provider’s treatment agenda and the patient’s right to autonomous, informed decision-making.

The providers’ conflicting narratives may be a result of their desire to honor competing (and potentially conflicting) goals. However, these narratives can present particular challenges to interpreters. For example, the conflicting information may raise concerns about the speaker’s communicative competence. If the speaker is knowledgeable about the topic discussed, why would drastically different (and at times, opposing) information be provided? Following Grice’s cooperative principle and conversational maxims (e.g., a speaker should give as much details as possible without being overly redundant; Levinson, 1983), a patient in a dyadic interaction can derive the implicatures (i.e., the presumptive or preferred meaning that is implied but not explicitly stated; Levinson, 2000) of the providers’ conflicting narratives (e.g., the ovaries should still be removed even if they produce hormone; omentum is valuable but not important when you are fighting for your survival). However, in an interpreter-mediated, triadic interaction, a patient may find such conflicting information troubling because it is unclear whether the interpreted, self-conflicting remark is a result of a purposeful talk from the provider to generate implicatures or an incoherent talk due to lack of interpreter competence (i.e., the interpreter was confused and thus unable to provide a coherent meaning). In other words, others may question the interpreters’ competence when ambiguous or self-contradictory remarks are provided.

Incompatible Sociolinguistic Norms

Whereas oncologists’ inconsistent, ambiguous talk focuses on message content and pragmatic inconsistency, the second pattern, incompatible sociolinguistic norms, highlights the cultural differences in linguistic resources used to generate meanings. Language users derive meanings through conventions, contexts, and socio/cultural norms (Tracy, 2002). Differences in these areas may lead to challenges to individuals’ understanding and interpretation of the meanings.

Differences in shared knowledge and implicatures. Providers often used analogies, humor, and other linguistic resources to facilitate patients’ understanding and to reinforce provider–patient relationships. For example, when explaining the way to determine Caroline’s optimal treatment, Pearl noted:

We don't want to do too much and hurt you if it doesn't seem necessary. We don't want to do too little and not be informed of what we really need to be doing. We'll try to find the just right. Sort of like *the papa bear, mama bear, baby bear*, I guess.

Using a well-known English fairy tale, *The Three Bears*, to describe a complicated and potentially dangerous procedure can be very helpful. English-speaking patients in the USA probably first heard the story as a child and later shared the story with their children. The reference provides emotional memories that are comforting and reassuring. However, for patients who are not familiar with the story, the reference can lead to additional anxiety as it highlights that they are in an unfamiliar cultural territory. It also may be awkward for the interpreter to tell the whole story as the storytelling will take up significant time for a simple reference. In addition, LEP patients are unlikely to find the story they heard the first time comforting. For some cultures, the reference also may be considered inappropriate as the patient is involved in a life-threatening situation involving complex medical procedure. For example, French physicians are unlikely to reference stories or use jokes when communicating with adult patients as such speech practices are reserved for child patients only (E. Fragkou, personal communication, March 11, 2014).

In fact, it is not uncommon for providers in our study to create a comfortable environment through teasing or joking. For example, when Pearl commented about an earlier procedure to Cadence's husband, she said, "We *tortured* your wife a little bit, I'm sorry to say (smile and chuckle)." In another appointment, upon entering the room, Pearl teased Caimile about participating in this video-recorded study, "Okay. We've got to be on our best behavior." In both incidents, the patients and their family members reacted positively by laughing, acknowledging the physician's attempt to lighten the mood. In the USA, providers' use of humor is positively correlated to patient compliance (Baile & Aaron, 2005). In contrast, although Japanese providers also try to create a friendly environment, these narratives would be considered socially inappropriate (if not unimaginable; see also Ishikawa, Takayama, Yamazaki, Seki, & Katsumata, 2002). Pearl's chuckle would not be recognized as an effort to acknowledge the patient's suffering but an insensitive gesture to a patient's life-threatening illness. Similar to French culture, Japanese would also consider joking inappropriate when working with an older patient as the speech act implies that the patient is treated as a child.

Differences in sociolinguistic norms and their corresponding implicatures can have significant clinical consequences. For example, because ASL uses facial expression, body posture, and space around the signer to communicate meanings, hearing physicians have been reported to misdiagnose "an expressive Deaf person as having tics, inappropriate affection, and personality and mood disorder" (Barnett, 1999, p. 19).

In addition to differences in interpreting the meanings of a speech act, different languages/cultures may have unique expectations for appropriate speech style (e.g., direct versus indirect speech) in a given situation. Providers in our study often employed direct communication style when discussing patients' conditions. For

example, when discussing her hesitance to remove an enlarged cyst in Carol, an 89-year-old patient who also had an elevated tumor marker, Pearl commented, “I don’t think it’s cancer and if it’s cancer, *I wouldn’t want to know anyway*. [...] *It’s not like you need to live 10 or 20 years*.” When discussing the treatment options with Cara, a patient who was in a wheelchair and required a breathing machine, Pam suggested not to pursue chemotherapy in case of noncurable cancer and concluded, “*You’re not the healthiest egg*. So I can give you a lot more toxicity—sometimes the treatment is worse than the disease sort of thing.” In these examples, the direct speech was inconceivable in Japanese or Chinese social contexts (Yum, 1988).

In the USA, oncologists often stress the importance of open communication (Rogg, Aasland, Graugaard, & Loge, 2010) and believe that providing complete information is necessary for patient empowerment and informed decision-making (Parsons et al., 2007). However, other cultures are likely to question the provider’s assertion on “facts” that are based on probability (as opposed to reality). In Asian cultures, being blunt about a patient’s physical condition or chances of survival would be considered presumptuous, arrogant, insensitive, and even malicious, rather than being objective and professional (Blackhall, Frank, Murphy, & Michel, 2001; Yum, 1988). In contrast, because the Deaf community adopts a communicative style that is more direct than the norms in American English, a hearing physician who delivers a poor prognosis in a gentle way may be considered offensive as a Deaf person may feel that the physician is withholding information (Barnett, 1999; Mindess, 2006). If an interpreter interpreted these narratives as is, the provider is likely to assume unintended identities (e.g., being insensitive, malicious, or deceptive).

In summary, when providers’ narratives involve: (1) a potential mismatch of the shared knowledge and speech genres, and/or (2) the differences in (cross-cultural) illocutionary forces (Wierzbicka, 1985), an interpreter faces challenges in managing the providers’ meanings. Even when the same story, talk, and/or speech were interpreted, one culture may interpret the speech to be comforting while another may interpret it to be callous.

Differences in public vs. private spaces. Different cultures may impose different expectations about the types of information that is considered private versus public. For example, “America is a place where strangers suddenly share information with you about their ‘private activities’ in a way that is ‘difficult to imagine’ for northern Europeans or Asians” (Whitman, 2004, p. 1155). Failure in observing the cultural boundaries of privacy may result in problematic attribution to the speakers’ identity or intention.

For example, when Celine asked about when her surgery will be performed, Pam responded, “All right, if [a nurse] can’t get it done, then we’ll have to delay and I think Dr Phillips might be on *vacation* that following week so, um, might result in *a couple of weeks’ delay*.” The comment stood out because Pam disclosed a personal reason (i.e., Dr Phillips’ personal vacation) for a potential delay in the treatment procedure. In the USA, most would consider that Dr Phillips is entitled to vacation

and that patients do not have the right to intrude on the physician's personal time. Thus, taking a personal vacation is just as good and legitimate as any other reasons. In contrast, vacation would be considered a private activity that would not be appropriate to be disclosed to patients in Japan. In addition, such a reason would further intensify the contrast between a patient's suffering and the provider's worry-free state, with the provider's personal time taking the priority. In short, the disclosure is likely to lead to patients' problematic assessment about the quality of care and provider-patient relationship. In Japanese contexts, a provider is more likely to use the excuses of "going to a conference," "being fully booked," or other business-related reasons to maintain a positive identity and provider-patient relationship (see also Barnlund, 1975).

In summary, the discursive structure, linguistic resources, and sociocultural norms all generate (implied) meanings that go beyond the literal meanings of the words. When providers' narratives are interpreted in another culture, they may carry additional illocutionary forces that are nonexistent in the original culture (Suszczyńska, 1999). Different cultures also may have a preferred style for performing a speech act that is unique to its cultural and social norms. While individuals from other cultures can derive meanings for these speech acts, it is possible that they would consider these acts to be awkward, unusual, and problematic (Suszczyńska, 1999; Wierzbicka, 1985). In short, it is not about *what* was said but *how* it was said.

Providers' Multilayered Identity Performances

Individuals often manage multiple identities at the same time, while making some identities more salient than others (Tracy, 2002). Providers in our study displayed multilayered identities. Whereas providers' management of multiple task goals highlights challenges for interpreters to anticipate and recognize the competing *instrumental tasks* (i.e., what are we doing?), providers' multilayered identity performances center on the complex and emergent meanings of providers' identities. By using the term multilayered, we highlight that these identities often coexist within a single medical encounter, with different identities being enacted and emphasized depending on the topic discussed or the dynamics emerged. For example, when Candie noted that she had found an article in which Pearl discussed a surgical procedure, Pearl responded, "We've proved [that we do a good job]. It was a very exciting outcome because everybody loves the minimal invasive surgery. We call it [...] *our standard of care* now rather than being a research thing." Pearl was able to claim the expert identity by highlighting how the procedure that she published is now a standard of care practice. Providers in our study frequently displayed identities as experts and authority as they provided medical knowledge, gave details about medical procedures, and offered expert opinions about recommended treatment plans. This is to be expected. These identities often are enacted and emphasized by interpreters (Butow et al., 2011; Hsieh, 2007). However, providers in our studies also enacted other identities.

For example, providers often explicitly acknowledged their lack of knowledge, confusion for diagnosis, or potentials of making mistakes. When reviewing Charlene’s records, Pearl concluded, “*It’s a little bit confusing. I’m going to try to make sense of this.*” In other occasions, Pearl explained to Charlene why biopsy results during the surgery may not offer a definitive diagnosis, “*The pathologist can be wrong at the time of the surgery, and we could miss it, because you can’t do 100 slides [of biopsy], you can only do 1 or 2.*” In another appointment, Pearl explained to Charity, “The pathologist looks at it and calls us back and says it’s cancer, it’s not cancer, or they don’t know, and *sometimes they don’t know.*” These narratives highlight the limitations of medicine and providers. At times, they just do not have the answers.

On the surface, this identity would appear contradictory to their identity as clinical experts. However, effective communication about uncertainties is essential to facilitate informed decision making (Epstein, Alper, & Quill, 2004) and critical to patient satisfaction (Politi, Clark, Ombao, & Legare, 2011). In the USA, providers’ willingness to communicate uncertainties and risk would likely to be perceived positively (e.g., honest and trustworthy). From this perspective, providers’ multi-layered identities involve assuming the role of honest and trustworthy expert who would not overstate his or her claims.

Another common tension within providers’ multilayered identities reflects the struggles in providing expert opinion and respecting patient autonomy. As clinical experts, the providers can offer opinions that are not open for negotiation. When Cadence questioned the necessity of removing her noncancerous uterus, Pam replied, “You had this history of adenocarcinoma in site two of the cervix [...], the standard of care is removal of the uterus for that diagnosis. [...] *You don’t want to mess around with that.*” At the same time, a provider may wish to honor patient autonomy and avoid manipulating patients’ decision-making. For example, Pearl started a consultation with Charlotte by saying, “Well, *you are in charge. You are the one that has to live with all of this.* [...] So you have to kind of, as I said, decide who you are, what kind of risk you’re willing to live with.” Such an approach also highlights patient empowerment.

As patient-centered care and shared decision-making become values central to health care delivery in the USA, providers are cautioned against manipulating patients’ decision making process by offering incomplete or inaccurate information (Karnieli-Miller & Eisikovits, 2009). Nevertheless, pursuing providers’ therapeutic agenda and respecting patient autonomy are not only two competing task goals. These task goals also have identity implications. As providers enact these two valued identities (i.e., an expert who respect patient autonomy), an interpreter inevitably needs to face the tensions embedded in these identities. More important, at times it may be difficult to assess what is the providers’ desired identity and what is the one that is “for show” only.

For example, when meeting Charmaine, a 76-year-old patient, Pearl explained, “We’re trying to figure out who you are, what your daily life is like, what you’re able to do, what you’re able to function, *whether you’re willing to be disabled, you know,*

by surgery and everything else in order to live for three years.” This appeared to be an effort to portray an objective, patient-centered, expert identity. However, although patient preference is noted here, Pearl’s description about the potential negative complications and the minimal gain suggest that she discouraged the surgical option. Later, when Charmaine expressed her desire to have the surgery, Pearl commented, “I wasn’t expecting that answer. So, that’s interesting.” In fact, Pearl later resorted to other persuasion tactics (i.e., providing extensive details about the surgery and the anticipated long recovery). However, once Charmaine agreed to opt for chemotherapy instead, Pearl responded, “I thought *if we got real specific with you, you might understand*. So, I think at your age-then we usually try to be gentler.”

This example further illustrates the dilemma faced by interpreters. The challenge of the multilayered identities is that although each identity may be equally genuine and sincere (Goffman, 1959), the provider’s enacted identity is dependent on the emergent, dynamic communicative process. If the patient had agreed with the physician’s assessment, the physician identity that honors patient autonomy would be the prioritized performance. However, as soon as the patient disagreed with the physician, the physician quickly shifted into an authoritative expert identity, emphasizing her medical expertise, providing technical details, and persuading Charmaine to abandon her original decision. Once the persuasion was successful, Pearl quickly shifted back to the identity that values patient autonomy. As interpreters manage the various communicative goals and identities of providers, they will have to be responsive to the emergent changes in providers’ performance of multilayered identities.

Discussion

A recent review concluded that seven elements are essential to successful provider–patient interactions, including provider competence, provider trustworthiness, cultural competence, communication with patient and families, information quality, patient/surrogate competence, roles, and involvement of patient/families (Dy & Purnell, 2012). Our findings highlight interpreters’ critical role in shaping all these elements, including provider competence and provider trustworthiness.

Researchers have found that individuals from diverse cultures share drastically different expectations for provider–patient interactions (Meeuwesen, van den Brink-Muinen, & Hofstede, 2009). Although some cultures may expect more rapport-building talk, others may prefer a more hierarchical, business-like relationship. A favorable identity performance in one culture may be interpreted negatively in another. Failures to anticipate and respond to the differences in cultural expectations and social norms are likely to result in frustration and problematic interactions, posing risks to the quality of care and health outcomes (Street, Makoul, Arora, & Epstein, 2009).

Interpreters are in a precarious position in these interactions. Providing accurate interpretation of the content while allowing the audiences to derive unintended, problematic, and even negative understanding about the physicians’ identities or

provider–patient relationships should not be an acceptable performance (Robb & Greenhalgh, 2006). Because health-care interpreting is auxiliary to the provider–patient communication, it is important that interpreters can facilitate and honor the primary speakers’ tasks, identities, and relationships.

Implications to Interpreter Training and Practices

Because prescriptive behavioral guidelines (e.g., specific behavioral strategies) do not recognize the complexity and multivocality of human interactions (Lee, Wang, Chung, & Hertel, 1995), we offer processual guidelines (i.e., the underlying principles/values to guide the practices) in the following section. It is important to note that we are not proposing that interpreters should completely abandon the neutral, faithful role envisioned in the codes of ethics. However, our findings suggest some necessary changes in interpreting ideologies and training emphasis.

First, interpreters should be responsive to providers’ complex and dynamic management of task goals and identity performances. Various studies have consistently demonstrated that interpreters often adopt a physician-centered approach in managing provider–patient interactions (Baraldi, 2009; Bolden, 2000), favoring providers’ biomedical perspectives and ignoring patients’ nonmedical talk. In addition, some early evidence suggests that interpreters are likely to reinforce physicians’ authoritative role/voice with minimal regards to the emergent dynamics of provider–patient interactions or the providers’ intended performance (Butow et al., 2011; Hsieh, 2007; Hsieh et al., 2010). This is likely due to interpreters’ (1) assumption of providers’ authoritative expert identity and (2) failure to recognize and/or respond to the emergent shifts in providers’ multilayered identities and multiple goals.

Our findings suggest that providers often shift between various voices and identities, strategically emphasizing one over the other depending on their communicative goals, therapeutic agenda, and patient responses. Even when they appear to provide inconsistent, self-conflicting narratives, many of those are employed to mark their ambivalence or uncertainties and/or to subtly promote specific agenda. When interpreters fail to recognize the complexity of providers’ strategic management of identities and manipulation of information, they are likely to compromise patients’ evaluation of provider competence and provider trustworthiness.

From this perspective, interpreter trainings should include developing abilities and strategies to recognize and anticipate the subtle shifts in providers’ narratives during the discursive process. A preconsultation meeting may help interpreters to anticipate the providers’ general objectives but cannot address the emergent and dynamic shifts in providers’ stance during the discursive process (Goffman, 1959). Interpreters need to know when to seek clarification when ambiguity arises and when to maintain providers’ strategic ambiguity. Because providers would not be able to anticipate the unanticipated meanings resulted from cross-cultural pragmatics, interpreters need to actively evaluate potentially unintended meanings and effectively communicate their

concerns to providers. As part of the training, interpreters should practice identifying the multilayered and multivocal meanings embedded in providers' narratives, developing sensitivity to changes in contextualization cues in verbal communication (e.g., speech genre, word choice, and register) and nonverbal communication (e.g., facial expressions, vocal behaviors, and body movements).

When interpreters become sophisticated thinkers and users of languages, they will be more apt to recognize the subtleties and complexities of others' talk and their corresponding impacts. Without such awareness, an interpreter would not be able to provide timely and appropriate interventions that best meet the needs of the specific contexts. A successful management of interpreter-mediated encounters requires interpreters to not only be responsive but also proactive in managing evaluating and anticipating the multivocal meanings that may emerge intentionally or unintentionally in the cross-cultural contexts.

Second, it is important to recognize that interpreters' alterations and interventions can enhance the quality of care and improve provider-patient communication. Rather than educating interpreters to view the communicative content and process exclusively as the providers' and patients' responsibilities (Hsieh & Kramer, 2012), our findings highlight the potential values of interpreter interventions. In the past, some physician researchers have conceptualized all alterations (e.g., omission, substitution, and editorialization) as interpreter errors. For example, Flores and his colleagues found that 12–73% of interpreter errors have clinical consequences (Flores, Abreu, Barone, Bachur, & Lin, 2012). Recent studies also have confirmed that interpreters frequently alter others' talk (Jackson, Nguyen, Hu, Harris, & Terasaki, 2011). Flores et al. implicitly suggested that all clinical consequences caused by interpreter alterations are bad. However, when researchers actually coded the positive and negative impacts of all interpreter alterations, they found something interesting. For example, Butow et al. (2011) found that 70% of all alterations are inconsequential or positive to the quality of care. Jackson et al. (2011) found that only 5% of alterations were clinically significant, with 1% having a positive effect and 4% having a negative effect. In other words, not all alterations are errors or mistakes. Some, in fact, improve the quality of care.

The questions faced by practitioners and researchers are: (1) what makes an alteration good or bad? (e.g., what are the characteristics of alterations/interventions that improve the quality of care?) and (2) how to best maintain transparency for interpreters' alterations and interventions? The literature so far has provided limited answers to both questions because interpreter alterations have been viewed as taboo behaviors as they are often conceptualized as errors or mistakes (see Flores et al., 2012). However, recent studies have suggested that it is time to start thinking about these issues and consider potential ethical and/or organizational guidelines for these practices. Ignoring the values and importance of interpreter alterations fails to recognize the contributions interpreters can make to the quality of care.

For example, is it appropriate to tell the full story of three bears or just to provide an editorialized statement? Is it okay to downplay a provider's teasing or should the interpreter inform the provider about potential cultural mismatch? Should the

interpreter inform the physician during or after the encounter? What about the provider's problematic manipulation of information? Interpreters' strategies may have different short-term and long-term impacts (Hsieh, 2007, 2010). For example, covert strategies (e.g., providing an editorialized statement or downplaying a providers' teasing without interrupting provider–patient communicative sequences) ensure the flow of provider–patient interactions. These strategies, however, effectively remove others' control over the communicative process. In contrast, seeking clarification, informing providers about potential misunderstanding, and educating providers about cultural differences during the medical encounters inevitably disrupt the flow of communication and challenge the providers' authority and control over the medical encounters. However, these strategies not only provide immediate resolutions to interpreting challenges but also enhance the providers' communicative and cultural competence, which will be valuable for future health-care delivery (Hsieh & Kramer, 2012).

Previous studies have suggested that providers may be open to interpreters' intervention but expect transparency in the process (e.g., informing providers about their alternations; Hsieh, 2010). However, there may be situations in which an interpreter may find maintaining transparency difficult. For example, because interpreters are sensitive to others' communicative goals as they manage the discursive process, they may find providers' management of multiple goals problematic. A study about actual provider–patient interactions concluded that although providers often advocated for shared decision making as a central value of patient-centered care, treatment decisions “tended to be unilaterally made, using a variety of persuasive approaches to ensure agreement with the physician's recommendation” (Karnieli-Miller & Eisikovits, 2009, p. 6). As interpreters become aware of providers' competing values and goals, they may find the providers' manipulation of information giving and withholding (along with other persuasive approaches) problematic if not unethical. Although interpreters' trainings have provided them more active roles, such as patient advocate or system agent role (Brisset et al., 2013), interpreters may find it difficult to challenge providers' (deceptive) manipulation of information due to the organizational hierarchy, provider–patient relationship, clinical complexity, and even lack of job security.

We recognize that when and how interpreters can best provide their intervention, including pragmatic alterations and physician education, may be dependent on various contexts (e.g., clinical, interpersonal, organizational, sociocultural, and ethical contexts). In addition, many of the contextual issues are beyond what can be addressed through interpreter training. What works for a senior on-site hospital interpreter who has a supportive organizational culture and shares strong provider–interpreter trust may not work for a telephone interpreter who generally works with a nation-wide pool of professionals randomly. An interpreter for mental health care may need a different approach than an interpreter in an emergency department (see also Hsieh & Hong, 2010; Hsieh, Pitaloka, & Johnson, 2013). As a result, interpreter training cannot offer standardized solutions for interpreter interventions. Rather, we can only educate interpreters about the variety of issues they need to consider as they

contemplate *whether*, *when*, and *how* they should intervene in provider–patient interactions.

Finally, our study highlights the importance of provider training in intercultural health care (Jacobs, Diamond, & Stevak, 2010). Individuals' communicative competence is interdependent with each other in medical encounters (Cegala, Street, & Clinch, 2007). Our study shows that providers' communicative content, discursive structure, and multilayered identities can pose challenges to interpreters' understanding and interpretation of providers' narratives and influence the patient's evaluation about interpreter and provider competence (see also Hsieh, 2006). Researchers have argued that providers need to establish best practices when working with interpreters, which should include new routines (e.g., pre- and postconsultation meetings) and communicative skills (e.g., specialized communicative styles) for interpreter-mediated interactions (Leanza, Miklavcic, Boivin, & Rosenberg, 2014). This issue has been largely ignored in current provider training (Jacobs et al., 2010). Improving provider–interpreter collaboration requires providers to (1) recognize potential dilemma caused by their communicative practices and (2) modify their communicative behaviors for intercultural health care.

In summary, our goal is not to provide one-size-fits-all answers. The best interpreters are the ones who have multiple strategies and solutions to a given situation, allowing them to be flexible and adaptive to the corresponding contexts. This is what ultimately separates interpreters from machines. Interpreters see the fear of an angry father fighting for his child's life and hear the sorrow in a physician's assertive voice, noticing that meanings are being emergently negotiated. They respond to the subtle shifts with the resources available to them. Maybe it is a softer tone of voice. Maybe it is to downplay emotions when discussing end-of-life care. Maybe it is to ask the doctor to discuss the issue in a different way. There are no perfect answers.

Rather than presenting a formulaic solution of “if this, do that”; we argue that a better approach is, “If this, here are the options. Knowing that one should be concerned about these principles and values, pick one that best fits your situation.” This approach requires interpreters to be critical thinkers and problem-solvers, making judgments about what constitutes the best solution.

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