Interpreter-mediated Communication

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Diversity of healthcare interpreters

Interpreter-mediated medical encounters represent an interdisciplinary area of research that highlights the intersection of languages, cultures, and medicine. The literature has provided conclusive evidence that when patients do not share the same language with their clinicians, they experience significant health disparities. Although researchers are uncertain about the exact processes and pathways in which language barriers create health disparities, interpreters have been viewed as the standard solution to improve language-discordant patients' access to and quality of care.

Several reviews have concluded the positive impacts of professional interpreters (Karliner et al., 2007). The professionalization of healthcare interpreters involves developing formal training and an official certification process, upholding standards of practice through codes of ethics and specific qualifications, and forming professional organizations that make exclusive claims on expertise. Nevertheless, clinicians consistently underutilize professional interpreters even when professional interpreters are readily available, when they perceive the benefits of professional interpreters, and when there are long-running state regulations requiring access to professional interpreters (Gutman et al., 2020). In fact, nonprofessional interpreters are often the norm, rather than the exception, in interpreter-mediated medical encounters.

Clinicians have complex understandings of interpreter-mediated communication (Hsieh, 2015). Clinicians' concerns are not limited to interpreters' professionalism or their risks to litigations. Different types of interpreters are not interchangeable and may hold diverging strengths and weaknesses. For example, family interpreters may not have sophisticated medical knowledge but can provide unique insights when soliciting a patient's medical history; in contrast, bilingual nurses can be particularly helpful when explaining complicated medical procedures. Although telephone interpreters are professional interpreters, clinicians can become concerned about the lack of immediacy and emotional connection with their patients when using telephone interpreters. The geographic location, hours of service, patient language, clinical complexity, and clinical urgency can influence clinicians' preferences and interpreter availability.

Researchers consistently have found that clinicians often expect professional interpreters to assume a neutral conduit role. Because nonprofessional interpreters often assume other social roles (e.g., patients' family members or bilingual nurses), clinicians generally are not preoccupied with nonprofessional interpreters' credibility or trustworthiness as there is little expectation of impartiality or neutrality. In addition, nonprofessional interpreters' credibility and trustworthiness may already be

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established through their other social roles. In contrast, professional interpreters are the unfamiliar others (to both the patient and the clinician) and need to gain their legitimacy through their "professional" conducts, which often entail converting their identities into a fixed set of expert skills in an increasingly dehumanizing, specializing, and impersonal system (e.g., healthcare settings). This attitude is further reinforced through healthcare interpreters' codes of ethics and training, emphasizing a neutral, objective role. Professional interpreters, thus, were often conceptualized as neutral, objective, passive tools, rather than as active agents, in facilitating clinician–patient interaction.

The interdependent nature of interpreter-mediated communication

Clinicians', patients', and interpreters' choices of communicative styles serve specific functions and are interdependent with each other (Leanza, Boivin, & Rosenberg, 2010). Many researchers have examined clinicians' impact on interpreter-mediated encounters through their choice of interpreter utilization, including potential barriers and facilitators that may influence their choices (Hsieh, 2015). However, clinicians' influences over the quality of interpreter-mediated encounters extend far beyond these pre-encounter decisions. For example, "A nurse [interpreter] could do an excellent job with one physician only to have difficulties with the next one. … Every physician … had an individual style for relating to the patient, and the nurse [interpreter] had to accommodate that style" (Elderkin-Thompson, Silver, & Waitzkin, 2001, p. 1355). Interpreters are more likely to misinterpret or to ignore a physician's questions when they are structurally more complicated. These findings underline the importance of the physicians' role and communicative strategies in achieving successful interpreter-mediated interactions. Successful interpreter-mediated medical encounters also rely on clinicians' abilities to monitor the communicative process, communicate their priorities, negotiate their therapeutic goals with others' communicative needs, and be responsive and adaptive to emergent shifts in the changing boundaries of language, culture, and medicine.

Patient communicative competence (e.g., the ability to seek and provide information) is positively correlated with the quality of information provided by the clinician. In bilingual healthcare, interpreters can play a significant role in this process by overtly and covertly enhancing others' communicative competence. For example, to ensure effective and appropriate clinician–interpreter interactions, interpreters may conceal the clinicians' stigmatizing attitudes or ask questions on behalf of the patient. Interpreters actively provide emotional support by noting the need to bridge cultural differences and to ensure quality care (Theys et al., 2019). Conversely, interpreters' behaviors may compromise other speakers' communicative competence (Roter et al., 2020). For example, when interpreters focus on medical information and ignore clinicians' rapport-building talk, clinicians may appear emotionally detached.

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Interpreter emotion work and self-care

The literature on interpreters' occupational hazards and self-care first emerged in the late 1980s in the literature for signed language interpreters, focusing on interpreters' upper extremity cumulative trauma disorders as a result of repeated movement of arms, hands, and wrists. The analytical focus is reinforced by the interpreter-as-conduit model and the utilitarian approach to healthcare interpreters, treating interpreters' bodies as a tool to be protected and maintained. Although the research community has been aware of the negative consequences (e.g., emotional exhaustion and burnout) of clinicians' emotion work since the early 1980s, few had paid attention to interpreters' experiences until the early 2000s (Theys et al., 2019). Because interpreters adopt a first-person speech style during interpreter-mediated interactions, they can be particularly vulnerable to emotion contagion and vicarious trauma, both of which have been identified as important predictors of burnout for health professionals. Studies have found that interpreters who work with war refugees, asylum seekers, and torture survivors may experience heightened risks of post-traumatic stress disorders (Splevins et al., 2010). At the time of this writing, there are few structured resources in organizational settings, the industry, or interpreter training for interpreters to cope with their experiences of emotional exhaustion or vicarious trauma.

Future directions

Healthcare delivery and interpreter diversity

An argument that is pervasive in journal articles and among practitioners is the necessity for professional interpreters. Indeed, professional interpreters are extremely valuable in healthcare settings, as several reviews also have found valid support for the benefits for professional interpreters (Karliner et al., 2007). However, this is different from promoting the exclusive use of professional interpreters in healthcare settings.

The challenge of studying nonprofessional interpreters is that there have been a plethora of commentaries, case studies, and anecdotal observations that highlight the problems of working with nonprofessional interpreters. However, many other studies also have demonstrated that professional interpreters also make plenty of (similar) interpreting errors. In other words, without comparative studies, identifying the problems with nonprofessional interpreters is an inadequate claim for the exclusive use or superiority of professional interpreters. The lack of comparative studies and the limited number of larger-scale, evidence-based studies on nonprofessional interpreters make it difficult to make any conclusive arguments about the positive or negative impacts of nonprofessional interpreters.

We need to understand why clinicians underutilize professional interpreters. Identifying the facilitators and barriers to the use of professional interpreters, instituting organizational guidelines on the appropriate use of interpreters, and empowering clinicians to make strategic, meaningful, and appropriate use of interpreters are essential in ensuring the quality of bilingual healthcare. Portraying nonprofessional

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interpreters as substandard and inappropriate simply prohibits a healthy discussion on interpreter utilization. Recent evidence-based studies have demonstrated that clinicians adopt different communicative behaviors when working with patients who are immigrants and marginalized populations. By examining and comparing monolingual and bilingual clinician–patient interactions, researchers can explore the best practices for clinicians to communicate and negotiate their communicative goals during the emergent interactions, to maintain control over the quality of care, and to develop strategies and skills to work with different types of interpreters.

Interpreter-mediated communication as goal-oriented activities

Healthcare interpreting is a unique form of interpreting because it is ancillary to a larger communicative event, cross-cultural care, which often entails specific goals (e.g., achieving optimal care). Various studies have consistently demonstrated that interpreters often adopt a physician-centered approach in managing clinician–patient interactions, favoring clinicians' biomedical perspectives and ignoring patients' nonmedical talk (Roter et al., 2020). In addition, some early evidence suggests that interpreters are likely to reinforce physicians' authoritative role/voice with minimal regard to the emergent dynamics of clinician–patient interactions or the clinicians' intended performance (Roter et al., 2020). This is likely due to interpreters' (i) assumption of clinicians' authoritative expert identity and (ii) failure to recognize and/or respond to the emergent shifts in clinicians' multilayered identities and multiple goals. If we continue to develop prescriptive behavioral guidelines (e.g., specific behavioral strategies) to train interpreters and clinicians, we are likely to encourage and foster a rigid understanding of interpreter-mediated interactions.

From this perspective, processual guidelines (i.e., the underlying principles/values to guide the practices), which recognize the complexity and multivocality of human interactions, are much more meaningful and beneficial to interpreter and clinician training. In other words, by recognizing interpreter-mediated medical encounters as goal-oriented communicative activities, researchers have begun to explore the effective strategies that can facilitate interpreters' and clinicians' collaboration to achieve the quality and equality of care (Hsieh, 2010).

Conceptualizing a multiparty model of interpreting

Healthcare interpreters do not simply transfer information from one language to another. As they provide their linguistic services, they are also in a position to inform, educate, and empower other speakers for future interactions. Some recent studies have highlighted that clinicians continue to emphasize interpreters' conduit role. Such attitudes, however, put pressure on interpreters (i) to avoid intervening in the clinician–patient communication even when they perceive problematic interactions or (ii) to conceal or disguise their intervention to avoid others' scrutiny (Leanza et al., 2010). As researchers highlight that successful interpreter-mediated interaction requires clinicians, patients, and interpreters to coordinate and negotiate their communicative goals, it is important to incorporate these aspects of interpreters' functions

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into the communicative practices and organizational cultures in healthcare settings. For example, developing organizational cultures that support and value interpreters' clarification and/or elaboration on cultural issues (as opposed to viewing these behaviors as intrusions to clinicians' authority or time) will allow both clinicians and patients to have better communicative competence in future interactions. Providing training for interpreters to develop interpreting styles that are adaptive and responsive to emergent challenges during medical encounters will improve interpreters' agency in managing problematic encounters.

By taking a multiparty view of interpreting, researchers can expand our investigation beyond the linguistic transformation in interpreter-mediated interactions. When all parties are viewed as active participants in the medical encounter, a new world is opened to researchers of bilingual healthcare. A wide variety of contextual factors (e.g., communicative goals, interpersonal trust, ongoing relationships, and identity management) become relevant to the process of interpreter-mediated communication. By recognizing the variety of interpreters (e.g., on-site vs. telephone vs. family interpreters) available in healthcare settings, researchers have explored the impacts of different types of interpreters on patient satisfaction, clinician expectations, patient–interpreter relationships, institutional costs, discursive processes, and clinical consequences (Price et al., 2012). Interpreters, along with their interpersonal relationships, diverse functions, emotions, and job-related hazards, become legitimate issues to be explored (Theys et al., 2019). This not only marks a new milestone in the investigation of interpreter-mediated communication but also expands the field of investigation by recognizing the true complexity of the multilingual, multicultural healthcare process.

SEE ALSO: Clinician–Patient Communication: Intercultural; Culturally and Linguistically Appropriate Services; Language Brokering.

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