CHAPTER 13

Bilingual Health Communication Model

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The bilingual health communication (BHC) model is a communicative model that explains how interpersonal dynamics can shape the process and content of interpreter-mediated interactions in cross-cultural care (Hsieh, 2016). The BHC model views interpreter-mediated interactions as a socially constructed, goal-driven communicative activity that requires multiparty coordination on the meanings and processes of healthcare delivery. I use the term *multiparty* (as opposed to *triadic*) to highlight that interpreter-mediated medical encounters may include other participants (e.g., nurses and family members) in addition to providers, patients, and interpreters. By adopting heuristic and ecological approaches to communication, the BHC model recognizes that when patients and their providers do not share the same language, their communicative challenges are not limited to language barriers but also include differences in social norms, cultural knowledge, and system-level infrastructures. The BHC model argues that individuals' ability to negotiate, coordinate, and collaborate with one another to achieve mutually agreeable solutions presents the best opportunities to achieve quality and equality of care.

Intellectual Tradition of the Bilingual Health Communication Model

When providers and patients do not share the same language, language brokers often are viewed as the standard solution to address communicative challenges. Although translators and interpreters are both language brokers, they work in different domains. Translators primarily work with texts; in contrast, interpreters

transfer oral or signed information from one language to another (e.g., from Chinese or American Sign Language to English). The BHC model centers on interpreter-mediated interactions in health contexts.

The literature, however, suggests two puzzles. First, healthcare interpreters often deviate from the interpreter-as-conduit model, a default role prescribed by interpreters' codes of ethics (Hsieh, 2016). By requiring interpreters to adopt a neutral, faithful, and passive presence in provider-patient interactions, the conduit model casts interpreters as invisible linguistic machines that transfer information from one language to another. However, despite their training, professional interpreters are found to regularly deviate from the prescribed passive role and actively intervene in the content and process of provider-patient interactions. Second, despite state mandates for and availability of professional interpreters, providers consistently underutilize professional interpreters (e.g., on-site interpreters and telephone interpreters) and rely on a wide variety of non-professional interpreters (e.g., family interpreters and bilingual staff) and their limited language proficiency in cross-cultural care (Hsieh, 2016).

The BHC model addresses these two puzzles by adopting a normative approach to theory development. Goldsmith (2001, p. 530) explained,

> A normative theory poses questions such as the following: When a social actor wishes to accomplish some purpose in a particular kind of social context, what are the constraints to accomplishing that purpose, what are the discursive resources that are available for addressing those constraints, and what are the evaluative criteria by which the effectiveness and appropriateness of the actor's efforts may be judged?

The BHC model is a theoretical account designed to predict and explain the meanings and evaluations of communicative responses during interpreter-mediated medical encounters. Rather than focusing on the accuracy and fidelity of interpreted texts or interpreter behaviors, the BHC model asks, "How do different participants coordinate with each other during the communicative event of provider-patient interactions?" By assuming individuals coordinate their competing goals through communicative practices, the BHC model argues that certain practices can be more effective and appropriate than others due to the unique values and preferences within specific contexts, including clinical contexts (e.g., end-of-life care), sociocultural contexts (e.g., organizational hierarchy and cultural preferences), and sociopolitical environments (e.g., attitudes toward noncitizens in the host society).

Following the traditions of dialectic theorists (e.g., Bakhtin, 1981), the BHC model conceptualizes interpreter-mediated medical encounters within the contexts of potentially conflicting goals and the dilemmas these goals can create. By recognizing that each participant in an interpreter-mediated encounter may have distinct goals regarding tasks, identity, and relationships and that these goals are often (a) implicitly coordinated between participants and (b) mediated by an interpreter, the BHC model explores

situations in which the tensions between individuals' management of these goals are high to understand how communication serves as a way to manage these competing goals.

This line of questioning presents two major shifts in research focus, moving away from the text-oriented, interpreter-centered analysis to an investigation of multiparty interactions in cross-cultural care. The first shift is to focus attention not simply on the frequency of individual communicative behaviors (e.g., interpreter alterations and mistakes) but also on the meanings of such practices. The end goal of a normative approach is to account for judgments that some communicative practices in interpreter-mediated medical encounters are "better" than others. The second shift in research focus is to move from a linear, positivistic view in prescribing appropriate behaviors in interpreter-mediated medical encounters to an interpretive, heuristic approach to predict and explain evaluations of behaviors as more or less appropriate and effective.

The BHC model does not aim to define, identify, or regulate the behavior that is deemed appropriate or effective in a given provider-patient interaction in a top-down manner. Rather, the BHC model explains why certain behaviors are evaluated more favorably than others by examining how well these practices adapt to the potentially conflicting values emerged in provider-patient interactions.

Main Goals and Features of the Bilingual Health Communication Model

By adopting a heuristic approach, the BHC model conceptualizes interpreter-mediated interactions as an interactive, goal-oriented communicative activity that is situated in the larger communicative event of cross-cultural care (for more details, see Hsieh, 2016). The next sections elaborate on the individual-level and interpersonal-level constructs of the BHC model, followed by the propositions of the model.

The Individual-Level Constructs

Individual-level constructs are factors that shape individual behaviors and evaluations of the interpreter-mediated medical encounter. The four individual-level constructs under the BHC model are: communicative goals, individual agency, system norms, and quality and equality of care (QEC; see Figure 13.1). All four constructs are applicable to all participants.

COMMUNICATIVE GOALS

All participants in interpreter-mediated interactions, including the interpreter, have communicative goals. The communicative goals may be inherent in the communicative activity but can also emerge during the dynamic discursive process. Although individuals in interpreter-mediated interactions may share some goals (e.g., improving a patient's health), they also have unique individual goals. For example, providers may hold specific interpersonal goals (e.g., developing trust and rapport) in addition

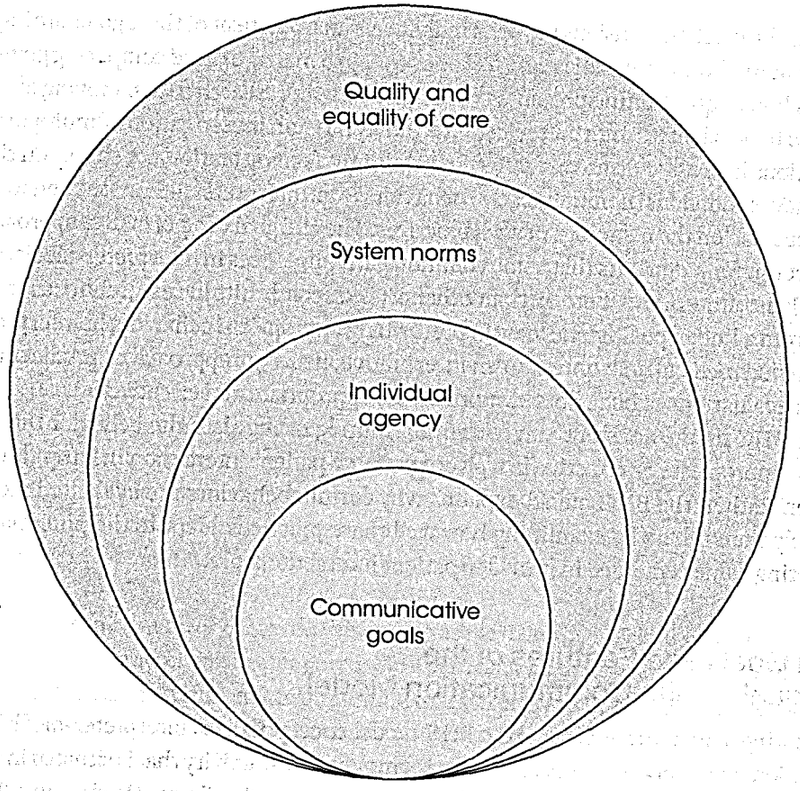

FIGURE 13.1 Individual-Level Constructs Within the Bilingual Health Communication Model

to their therapeutic goals. Individuals' multiple goals may not be compatible with each other or with others' goals. For example, patients may wish to receive Western biomedical care without giving up their cultural health practices (e.g., taking herbal medicine). Alternatively, providers may prefer interpreters who adopt an invisible role to facilitate provider-patient bonding, but interpreters may recognize that they can significantly improve the quality of care if they interject their knowledge and experience to facilitate provider-patient communication (Hassan & Blackwood, 2021).

An individual's ability to fulfill their communicative goals may be dependent on their and others' communicative competence as well as other contextual factors during the communicative event. For example, an interpreter who believes that the quality of interpreter-mediated communication is dependent on a passive, neutral conduit interpreting style may feel frustrated when a provider lacks sufficient intercultural competence to "ask the right question" (Hsieh, 2006, p. 724). When a provider responds to a Jehovah's Witness's refusal of blood transfusion by saying, "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,*" an interpreter is put in an impossible position to honor provider-interpreter trust without compromising patient autonomy and informed decision-making (Hsieh, 2006, p. 723). Alternatively, interpreters may alter others' narratives to provide culturally appropriate empathic communication, offer topics for information-seeking, and facilitate understanding (Hsieh, 2016). From these perspectives, interpreters' alterations to others' narratives are not mistakes but purposeful activities to achieve specific goals.

INDIVIDUAL AGENCY

Individual agency is a necessary condition for individuals involved in a medical encounter to pursue their communicative goals. From an institutional perspective, individual agency can be shaped by power structures, institutional hierarchy, access to resources, and professionalism. For example, physicians are likely to have more individual agency than nurses because they are the head of a healthcare team, imbued with higher institutional power. In contrast, compared to nurses, interpreters may have even less individual agency as they do not always have an institutionalized office (e.g., interpreter services), can be outsourced to external agencies, or are considered to be low-priority workers. As a result, physicians are likely to exert their own communicative goals over those of an interpreter when their goals conflict with one another. On the other hand, because interpreters are often trained to assume a neutral, passive presence in provider-patient interactions, an interpreter may actively refrain from intervening in the medical discourse even when they have observed problematic interactions (Hsieh, 2008).

At an individual level, individual agency can also be derived through individuals' educational background, self-efficacy skills, communicative competence, emotional status, and motivational relevance. For example, a family interpreter who also serves as the primary caregiver is motivated to ensure the patient gets quality care and may be more likely to intervene in the provider-patient communication and exert their communicative goals than a telephone interpreter at a remote location. At an interpersonal level, individual agency can be shaped through interpersonal relationships, social obligations, and interactional dynamics. For example, a provider may feel reluctant to rely on a family interpreter when working with a new patient with advanced cancer due to concerns about the quality of interpreting. However, the same provider may feel comfortable relying on a family interpreter in a simple follow-up visit with a long-time patient with arthritis. Or a provider may feel pressured to use a family interpreter because the patient shows extreme anxiety in a new environment and resists sharing his/her medical information with a professional interpreter who belongs to the same small immigrant community as the patient. Finally, at a system level, individual agency can be influenced by cultural norms and social expectations. For example, in cultures that adopt the family-centered model (i.e., medical decisions are jointly determined by the patient and her support network) rather than the patient autonomy model (i.e., medical decisions are made solely by the patient), a patient may purposefully rely on supportive others "for information-seeking and health decision-making as these actions are essential to their

understanding, performance, and fulfillment of their social roles" (Hsieh & Kramer, 2021, p. 178). In short, individual agency is not just an inherent or fixed ability that a human agent holds but is also a quality that can be interactively negotiated and socially enacted.

SYSTEM NORMS

According to the BHC model, the system includes social systems and cultures in which there are specific norms, values, and worldviews that are imposed upon individuals. Individuals interpret meaning through the system to which they subscribe. For example, providers' understanding of illness is based on the culture of medicine, which may conflict with a patient's cultural illness ideology (e.g., an illness caused by spirits stealing one's souls). Because system norms guide the behaviors of individuals within the system, individuals' behaviors are always coherent and consistent within the meaning structure of the system. However, because individuals in cross-cultural care are not necessarily regulated by the same systems and the systems involved may not be compatible with each other, individuals may struggle to (a) identify the systems at play during a medical encounter and (b) prioritize and negotiate the systems that give meaning to the current interaction. For example, patients may choose to ignore a provider's treatment recommendation if they believe the provider has failed to provide an accurate diagnosis. Just as a U.S. patient may scoff at a shaman's effort to dispel an evil spirit, a Hmong parent who believes that his child's epilepsy is caused by a lost soul is unlikely to accept a U.S. physician's explanation that the illness is caused by an electrical storm in the brain (Fadiman, 1997). However, in the United States, providers can contact child protective services and remove a pediatric patient if they suspect that the parent has endangered the child by providing substandard care (Fadiman, 1997). In other words, not all systems are of equal footing.

The identification and prioritization of systems may prompt individuals to ignore or overrule other participants' needs and preferences. An interpreter may choose to editorialize other participants' narratives if they feel obligated to act as institutional gatekeepers to conserve limited resources, moral mediators to ensure the quality of care, or patients' health literacy guardians to avoid ill-informed decision making (Hsieh, 2016). By aligning themselves with a system of higher power/value (e.g., moral values and ethical standards), those with a lower institutional ranking (e.g., nurses and interpreter) may feel legitimized to adopt behaviors that override the values of other systems (e.g., organizational guidelines) or attitudes of superior others (e.g., physicians). Miscommunication due to incompatibilities between systems can result in problematic outcomes, including intense conflicts.

QUALITY AND EQUALITY OF CARE (QEC)

QEC is the overarching value of the BHC model—an all-encompassing value that integrates differences between systems, providing an ultimate value that guides the interpretation of competing systems in cross-cultural care. Even though QEC cannot escape the influences of (cultural) systems, individuals within different systems can learn to recognize and acknowledge its transcending values. For example, a provider can recognize and respect a parent's desire to provide the best care for a child patient, despite their disagreement on the treatment procedures. Similarly, interpreters can educate providers, patients, and their family members about the cultural differences in the meanings and functions of truth-telling in end-of-life care, allowing all participants to become aware of other participants' legal and social obligations.

The BHC model argues that individuals from different (cultural) systems can generate an integrated value of QEC. As such, the BHC model adopts the integral fusion approach delineated by Hsieh and Kramer (2021) as parties of a communicative event resolve potential differences and conflicts through developing mutually agreeable consensus and solutions. Within the integrated value meta-system, values within different systems (from the participants) are not always consistent or compatible with each other. Thus, QEC is neither a fixed nor universal value. Rather, QEC is always contextually situated, interactionally managed, and locally defined in the communicative process. It allows individuals with competing system norms to acknowledge others' perspectives and forces all participants to subject themselves to the meta-value of quality of care that is co-constructed by all involved in the medical encounter. Such an approach also echoes the argument that interpreters' and providers' practices should be guided by valued principles situated in interactional contexts, rather than a set of predetermined, context-free rules.

All participants collaborate to develop a prioritized list of diverse values, accessing resources to strengthen their claim and control over the definition of QEC. For example, a U.S. physician may adopt different disclosure strategies for a poor prognosis with a German patient versus a Japanese patient in response to differences in the patient's cultural norms. In addition, a U.S. physician may have different communicative patterns when talking to a Japanese patient who has lived in the United States for decades, a German exchange student on a summer program, or a Syrian refugee who recently arrived in the United States out of fear of genocidal threats. Differences in providers' communicative behaviors are not causes for inequality in healthcare delivery (i.e., treating everyone the same does not equate to quality care). Rather, a physician's ability to understand, empathize, adapt, and respond to a patient's unique needs and expectations can give the provider more resources to provide QEC. This requires a provider to be mindful of the specific criteria and contexts that shape a patient's understanding of QEC.

The Interpersonal-Level Constructs

While individual-level constructs shape individual behaviors and evaluations of interpreter-mediated medical encounters, interpersonal-level constructs delineate the dimensions through which these individual-level constructs operate.

TRUST-CONTROL-POWER

As a theoretical dimension, trust-control-power shapes how participants negotiate the various individual-level constructs with one another, reflecting individuals' efforts and competition in defining their interactional (and professional) boundaries. This can be particularly tricky in cross-cultural care, as the boundaries of medicine, language, and culture are often overlapping and blurred (Hsieh, 2010). In addition, the three components (i.e., trust, control, and power) are interdependent and intertwined with each other. For example, as an interpreter develops more trust with the provider, the interpreter will have more power to control the process and content of provider-patient interactions. On the other hand, a provider who insists on maintaining absolute control over the interpreter-mediated interaction can develop a utilitarian view of the interpreter's role and function in which even the interpreter's interpersonal care (e.g., emotional support) is viewed as a tool for the provider's therapeutic objectives (Hsieh & Kramer, 2021). In other words, even interpreters' communicative goals are subject to providers' control.

TEMPORAL DIMENSION

Time is an important dimension in any system. Most systems are open systems that develop adaptive changes in response to outside influences as well as internal tensions. Because interpreter-mediated provider-patient interactions involve several different systems, each of which entails its own unique values and norms, the participants are likely to face tensions, challenges, and conflicts due to their diverse systems, including practices and values. However, time as a dimension makes integration of diverging systems possible at individual, organizational, and even cultural levels.

The Propositions of the BHC Model

Based on the individual- and interpersonal-levels constructs proposed in the BHC model, I offer the following general propositions that guide the understanding and interpretation of interpreter-mediated medical encounters:

1. Successful BHC is dependent on individuals' ability and agency to negotiate and adapt to competing and/or emerging goals. Moving away from the focus on interpreter performances, this proposition views interpreter-mediated medical encounters as a collaborative achievement among all participants.
2. The desired interpreting style is dependent on contexts. Rather than adopting a positivist stance on pursuing the ideal interpretation through equivalences between two languages, the BHC model acknowledges that contexts are essential in participants' understanding and preference of interpreting performances. The contexts include but are not limited to clinical, interpersonal, and sociocultural contexts.
3. Evaluation of the appropriateness and effectiveness of interpreters' interpreting strategies requires consideration of the corresponding short-term and long-term impacts. One strategy may have desirable short-term impacts in clinical care but problematic consequences for long-term provider-patient trust.

Continuing the Conversation

As a normative model, the BHC model provides a basis for recommendations about how communicators can achieve desirable outcomes. Thus, the BHC model is applied with a focus on problem-solving in real healthcare settings. In language-concordant provider-patient interactions, desirable outcomes are not necessarily predetermined or universal for all patients. Rather, desirable outcomes are emergently negotiated and continually (re)evaluated during the evolving, dynamic, and emergent process of a patient's illness event. Similarly, in interpreter-mediated medical encounters, desirable outcomes are not fixed targets to be achieved but are socially constructed through meaningful interactions among all participants. By recognizing that the communicative process, the meaning of an illness event, and even the quality of care are socially constructed, the BHC model provides multiple opportunities and entry points for theory development and practice implications.

A challenge faced by a normative model is that it is often regulated by sociocultural norms. As such, it can be vulnerable to the social injustice and inequality that are embedded in the social norms of a particular community, time, or place. Nevertheless, a unique aspect of the BHC model is its recognition of interpreters' agency and responsibility in addressing social injustice and protecting patients' voices and perspectives. Such an attitude has been reflected in the current literature, which recognizes the needs and values for interpreters to serve as patient advocates and system agents. In other words, interpreters are expected not to blindly reinforce the existing unbalanced or unjust process of provider-patient communication. The BHC model expects a skillful interpreter to have high individual agency in providing all participants with equal access to and effectiveness of clinical and interpersonal care.

Some may argue that conceptualizing interpreters as social agents who are obligated to protect individuals' equal access to and effectiveness of bilingual health communication may appear to be a Western value because not all cultures believe that all individuals should have equal footing in a communicative event. In this regard, I view interpreters as being essential in ensuring freedom of expression, a fundamental human right delineated in the UN's Universal Declaration of Human Rights. This obligation to human rights transcends any cultural/system norms and is essential to the communicative process in healthcare settings. The common denominator is our shared humanity.

Summary

The BHC model demonstrates how communication theories and practices can accommodate an existing dominant system (e.g., Western biomedicine and bioethics) without compromising minority or marginalized perspectives (see also Hsieh & Kramer, 2021). Rather than seeking conformity to a predetermined value, individuals with different

perspectives negotiate, coordinate, and collaborate with one another to generate a mutually agreeable consensus (e.g., QEC). Through the process, the parties of a communicative activity are transformed into a team—a community with shared goals and values. The fairness and equity of the process can be safeguarded at both individual and system levels (e.g., institutional policies and human agents). Each team member is empowered to voice their perspectives *and* to respond to emerging challenges. Because all parties' perspectives are incorporated into the problem-solving process, the desirable outcomes are always responsive and inclusive to those involved. In addition, because communication is always ongoing and never-ending, the BHC model recognizes that the "perfect" solution is not achieved by a final result but rather is reflected in the *process*—all parties are committed to listen to others' differences and to generate an integrated value system that respects and accommodates all who are involved.

FOR FURTHER THOUGHT AND REFLECTION

1. To ensure the quality of interpreter-mediated interactions, healthcare institutions are typically focused on limiting interpreters' interference to provider-patient interactions. In what ways does the BHC model provide new opportunities and intervention points to improve the quality of care in interpreter-mediated medical encounters?
2. Although the BHC model appears to be specific to interpreter-mediated interactions, can you think of other communicative activities or research projects that can benefit from adopting a multiparty, goal-oriented approach to communication?
3. Does the BHC model provide more insights into communicative activities of interprofessional teams? Is it possible to develop transcending values to guide the conflicts of competing systems or communicative goals? How? Is it always possible to create an integrated value system?
4. The BHC model adopts a normative approach to predict and explain the meanings and evaluations of individuals' communicative behaviors. What are the strengths and weaknesses of a normative model?

CREDIT

Fig. 13.1: Adapted from Elaine Hsieh, *Bilingual Health Communication: Working with Interpreters in Cross-Cultural Care*, p. 137. Copyright © 2016 by Taylor & Francis Group.

STORIED REFLECTION

Grappling With My *Zonas Erróneas* as a Double Outsider

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Erroneous: Containing error; mistaken; incorrect; wrong; straying from what is moral, decent, proper, etc. ("Erroneous," 2021)

When I was a child in the Dominican Republic, I remember my parents' excitement about the book *Tus Zonas Erróneas*. The celebrated self-help book was about "bold, but simple techniques for taking charge of your unhealthy behavior patterns" (Dyer, 1976, front cover). It was around this time that I recall wanting to become a psychologist. Like my father, I wanted to help people communicate more effectively about their individual and relational struggles. Those days represent the beginning of my musings on human behavior's complexities and perhaps my complicated relationship with communication theory.

Tus Zonas Erróneas was about self-awareness, establishing a deeper appreciation for, and healthier relationships with, ourselves and others. These concepts later became central to my postsecondary education journey in the United States. It was in hindsight that I discerned a central theme was driving my academic aspirations: *self-understanding*. However, that was also a tumultuous time in my life. I was having challenges communicating with my mother. I thought, "Why do we struggle so much to communicate? *What is wrong with me?*"

My poor communication with my mother became a catalyst for my intellectual pursuits—and also an intense period of self-definition. One of the ways that I defined myself was as an *outsider*. During this time, I perceived myself to be not only an outsider but also a *double outsider*. I perceived my burden as an immigrant to be both linguistic and cultural, which manifested relationally. For example, when an acquaintance responded viciously to something I said (cultural), and *how* I said it (linguistic), it included criticism, *"What the hell is wrong with you?"*

Grappling with my perceived double burden as an immigrant fueled my desire to understand myself, and others, which led me to an undergraduate interpersonal communication course. We studied classic theories like social penetration theory and uncertainty reduction theory, but I felt distanced from them. Largely, during that time, when I reflect on my relationship with communication theory, *disengaged* is a word that comes to mind. I could not place my disconnect anywhere, and to aggravate things I remember seeing some of my colleagues revel in their "theoretical epiphanies." Once again, I found myself contemplating, *"What is wrong with me?"*