I would not wish on anyone, and I know firsthand that anyone going through it needs all the help they can get.

More Than Words: Communicating for the Quality of Care

Elaine Hsieh

My first experience as a healthcare interpreter was in the summer of 1998. I just completed the first year of a two-year graduate program in one of the top MA programs for conference interpreters—many of the graduates ended up working at the United Nations and international agencies. Many of my classmates chose to work in top business or government agencies for their summer internships. I wanted to do something different. Something that I may never cross paths with again if I miss the opportunity. So, I chose to work as a healthcare interpreter intern at a large healthcare system. The summer internship was supposed to be a refreshing break from the drudgery of rigorous training to be a conference interpreter at an international level.

As a graduate student who has received one year of intensive practicum training, I was proud of my "overqualification." At that time and to this day, the norm for most training programs for professional healthcare interpreters is a 40-hour short course (e.g., Bridging the Gap). With my advanced training and language proficiency, I thought this would be a fun, easy detour in my career development. I was excited to work with real people, no longer trapped in the isolating interpreting booths with headphones in conference rooms.

Little did I know that the summer internship would change my life and career trajectory. The first big jolt that challenged my confidence as an interpreter was also one of the first assignments I received. I was taking an elderly man to his first physical therapy session. The man had such severe scoliosis that he was essentially looking backward as he walked forward. As we walked into the clinic, a medical resident saw my patient and jumped up in excitement. With a great smile on his face, he exclaimed, "Wow! This is the worst case I have ever seen." I felt startled. I could see that the patient was unsure about the resident's excitement. Normally, I would just go ahead and interpret what the physician said. I would then introduce the patient to the physician, explain my role as an interpreter (e.g., "I will interpret everything you and the patient say so you understand each other"), and proceed to interpret what other speakers said.

However, all my training as an interpreter failed me at that moment. It's not because I was unsure about the linguistic equivalences of the resident's comment in Chinese. Rather, I was unsure how to best convey the information in a faithful, neutral, and accurate way without risking the provider-patient relationship and the quality of care. I explained to the physician, "Hi, my name is Elaine, and I am the healthcare interpreter. I am responsible for helping the patient understand what others are saying." Then, I asked, "How would you like me to interpret what you just said? You appeared very excited." The resident was taken aback, paused for a moment, and said, "Please tell him that I'm very happy to meet him." I interpreted that and proceeded to my regular routines.

Another memorable moment took place at the end of a long shift near the end of my summer internship. I was already packing up to head home when I received a call to assist a 90-year-old patient who had just been admitted to a mental health ward after a failed suicide attempt a few hours ago. As an interpreter, I was required to interpret everything in the first-person style. For example, instead of saying, "The patient is sad," I say, "I am sad." Whenever possible, I also embody the speaker's nonverbals, including attitudes and emotions, through my interpretation. During the intake, the physician asked, "From 1 to 10, 1 being the least happy day in your life and 10 being the happiest, what number do you feel right now?" With the emptiest stare and the most soulless voice, the patient said, "If I have never experienced happiness in my life, how

do I know which number to give?" Throughout the hour-long session, I spoke in the most despairing voice and expressed the most hopeless thoughts I could ever imagine. I did not even remember how I got to the parking lot afterward. However, as soon as I started the engine, I realized my arms shook so uncontrollably that I could not have been a safe driver. I sat in my car for another hour before I felt safe enough to drive home.

To this day, I think about these two events when thinking about my experiences as a healthcare interpreter. When conceptualizing the role of interpreters, we often imagine a human-form Google Translate that relays information from one language to another. We do not take sides—the code of ethics for an interpreter-as-conduit was clear. We do not speak unless others speak. We don't have a voice—we are the voice of others. We should be invisible. We have no agenda. Our feelings do not count. We protect other speakers' agency and autonomy by relaying information without censoring or modifying anything—by allowing other speakers to have full access and control over the interactions.

The two incidents challenged my understanding of the roles of interpreters. My uncertainty was not because of my lack of training but because all my training was to be a faithful, neutral, passive conduit of linguistic equivalences. However, the challenges I faced as an interpreter during these events were much more than linguistic equivalence.

In the first incident, I wondered if I had failed the patient. To honor patient autonomy and informed decision-making, shouldn't the patient have the right to know that their physician was not respectful so that they can evaluate their providers and the quality of care accurately? I interfered with the process and content of provider-patient interaction when I prompted the resident to revise what he said so that the patient would not hear what could be perceived as offensive. Would it be better if I interpreted what the resident said and let the chips fall? Was I wrong to use the event to educate providers to be more mindful? Did I overstep my role as an interpreter?

I was certain that it was an unintentional blunder by the resident. The elderly patient was not the intended audience for the resident's comment. Providers often discuss things in front of non-English speaking patients rather than going to a separate room, believing the patients could not understand what they said. We all have done the same—we say things out loud in foreign countries because we believe that overhearers do not know English. As an interpreter, am I responsible for ensuring that the patient not only understands what the resident said to him but also "overhears" others' speech? As an interpreter, should I exercise my power to "remove" others' unintentional mistakes? If a provider sounds absent-minded or impatient, would it be appropriate for me to interpret in a tone that is attentive and engaged? Is it wrong to make a provider sound more caring than they appear in English?

In the second incident, I was unprepared for the emotions that rushed through my body. I did not realize nor anticipate my vulnerability when interpreting for a patient with suicidal thoughts after a long day, speaking in her voice and experiencing her despair. None of my training mentioned interpreters' experiences of vicarious trauma when working in situations where they may develop strong identification and intense emotions. I was shocked to realize there were few self-care resources and scarce training to help interpreters in these situations.

Throughout the summer, I shared my stories with other professional healthcare interpreters and my professors, asking what they would have done and scrutinizing if I had acted properly. What I learned was that the answers are very different depending on how we conceptualize and situate the roles and functions of an interpreter. If we follow the interpreter-as-conduit model, which is rooted in the code of ethics that arises from court interpreting, interpreters should adopt a passive, instrumental function in provider-patient interactions. It is not the interpreters' responsibility to manage other speakers' identities or relationships, let alone the quality of care. If a patient or a provider acts poorly, interpreters should act the same and, thus, empower other speakers to assess the quality of care and address the problematic interactions. My uncontrolled emotions resulted from a lack of professionalism—an artifact of my novice status.

However, if we view interpreters as members of the healthcare team, the answers become very different. People started to contemplate the strategies and interventions I could adopt to minimize the potential harm to the providers' face, the overall healthcare delivery, and even myself. When weighing different options, I was encouraged to consider the impact on the immediate interaction and the long-term consequences of my strategies, including quality of care, patient empowerment, provider education, and my self-efficacy and well-being.

I learned that these two events highlighted that communication—not interpretation—was the challenge I faced. My problem was not that I could not provide the equivalences of meanings but that I was ill-equipped to manage the tasks, identities, and relationships in provider-patient interactions. How can healthcare interpreters support effective and appropriate bilingual health communication that promotes patient autonomy and empowerment while supporting quality care, including providers' therapeutic objectives and provider-patient relationship? Interpreters' visibility and vulnerability should not be ignored or treated like an amateur mistake.

After receiving my MA degree, I pursued a doctoral degree in health communication and became a researcher of cross-cultural and bilingual health communication. I became one of the first researchers to adopt a communicative approach (rather than a linguistic approach) to analyze interpreter-mediated medical encounters. I have also received funding from the National Institutes of Health to examine providers' needs and expectations for healthcare interpreting. By focusing on the communicative goals and interpersonal dynamics of interpreter-mediated provider-patient interactions, I explore how providers, patients, and interpreters can coordinate and collaborate with one another to achieve quality and equality of care.

With over two decades of research, I have a much deeper understanding and appreciation of the complexity of interpreter-mediated medical encounters. Now, I recognize that interpreters' inherent desire to encourage positive, supportive interactions may not be consistent with providers' therapeutic goals. For example, a mental health provider may intentionally confront and agitate a patient as part of the therapeutic process to prompt self-reflection. Trying to make the provider sound nicer than they are would essentially compromise the provider's treatment plan. On the other hand, lending an attentive, caring tone to an overworked physician at the end of their 12-hour shift at the emergency department to help a patient with limited English proficiency feel less anxious after a traumatic incident should be welcomed.

To ensure quality care in interpreter-mediated interactions, interpreters should not be limited to the role of a passive instrument with no agency to facilitate quality care. The boundaries of language, culture, and medicine are emergent and shifting in cross-cultural care. Interpreters are essential partners who can assist providers and patients in navigating patient-centered care, supporting patient autonomy, and protecting provider-patient trust. I learned that good healthcare interpreting does not result from the interpreter providing a perfect relay of information. Rather, as I wrote in my 2016 book *Bilingual Health Communications: Working With Interpreters in Cross-Cultural Care*, "A successful interpreter-mediated medical encounter is a coordinated achievement between all participants involved."

From Linguistic Bridge Builder to Aspiring Physician

Manuel Patiño

I have been formally working as a medical interpreter for 2.5 years, but I have been closing linguistic bridges for as long as I can remember. My parents are from Colombia, and they immigrated to Boston in the late nineties, where I was born some years later. As the oldest son born in the US, I grew up as the only fluent English speaker at home. This meant that I was the first person my