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THE ROLE OF THE HEALTH CARE INTERPRETER
An evolving dialogue

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Background

As a distinct profession in the modern world, oral language interpretation has a well-established place in the fields of diplomacy, international justice and international conferencing. More recently, in the United States, court interpreting has developed as a specialized niche. In this context, health care interpreting is a newcomer in the field.

While the function of interpreting in order to allow communication between a patient and a health care provider who do not speak the same language has been going on for a long time, in the past this function was performed mostly on an ad hoc basis. Calling on whoever was immediately available — family members (including children), non-medical hospital staff, and even other patients — it was a practice that ran a high risk of inadequate communication resulting in misdiagnosis and inappropriate treatment that could, in a worst case scenario, result in the death of the patient. Such untrained individuals, often had little or no understanding of medical concepts or terminology and much less understanding of the importance of accuracy and completeness in the messages they conveyed. As a result, erroneous messages were often transmitted, new information added, or critical information omitted, drastically changing the nature of the original message.

Over the past ten to fifteen years, the changing face of immigration in the United States has had an unprecedented impact on the health care system. Today, over 300 languages are spoken in the U.S. Political, economic and social changes worldwide continue to feed a constant stream of immigrants into the country. Their immediate and frequently urgent health care needs do not wait for linguistic adjustment or cultural assimilation.

In 1994, as a response to the growing demand for oral language health care interpreting, a two-day working conference was held in Seattle, Washington. Initiated by the Cross Cultural Health Care Program of PacMed Clinics with funding from the Kellogg Foundation, and co-sponsored by the Society of Medical Interpreters in Seattle, this initial conference brought together health care interpreters, program planners, trainers and educators, and health care providers from the U.S. and Canada to form a working group.

Concerned with improving the quality of services for cultural-linguistic groups, for whom English as the medium of communication presented a formidable barrier, the working group addressed a number of issues that were emerging in this fledgling profession. Among these issues were the need to establish competencies and standards of practice for the profession; the preparation and training of health care interpreters; the preparation and training of providers working with interpreters; the implications of legislation and litigation on the field; and the need to promote research in the field.

Notwithstanding this array of important issues, the central theme that sparked the greatest discussion and controversy was the role of the health care interpreter. A number of key questions dominated this discussion.

- *What is the nature of the role?* Although there was agreement that the basic function of the oral language interpreter is to provide a linguistic conversion of a message spoken in one language into another, what did it mean in practice to do so accurately and

completely? If meaning rather than literal conversion was the goal, was the interpreter also expected to convey the emotional tone and affective content of the message?

- *What was the scope of the role?* Was the interpreter expected to adhere rigidly to the performance of a single task — oral language interpreting — much like a machine that performs a specific function? Or, were there other functions that interpreters could be expected to perform depending on the demands of the situation? For example, could the interpreter offer referrals or advocate for the patient's rights when these needs are not being met?

- *What kind of relationship was permissible for the interpreter to establish with the patient?* Did establishing a relationship of any kind interfere with the interpreter's ability to function effectively in her[1] role? If this were the case, what would it mean for interpreters who come from small communities in which they already have relationships with other community members, or who work with communities for whom personal relationships are important? Would a professionally personal relationship with the patient create a useful therapeutic relationship that would further the goals of the clinical encounter?

- *What kind of relationship was permissible for the interpreter to establish with the provider?* Should the interpreter be considered a legitimate member of the health care team? Or, was the interpreter's presence simply that of a tool to aid the provider in carrying out his function?

An outcome of the initial conference was a determination to continue the dialogue, certainly on the many issues in the field, but especially on the conceptualization and practice of the role of the health care interpreter.

Since 1994, six working group meetings have been held, with a formal group, the National Council on Interpretation in Health Care (NCIHC), established in 1998. This paper traces the evolution of thinking on the role of the health care interpreter over the past six years. It starts by describing the early polarization of thinking on the role, moves into clarifying a range of perspectives that are currently represented in the field, and finally offers a way of incorporating these perspectives while acknowledging a "creative tension" that exists among them. In keeping with the nature of the working group discussions, this paper focuses only on oral language interpreting in the face-to-face interpreter-mediated clinical encounter.[2]

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[1] References to the health care interpreter will use the feminine pronoun throughout the text. Although women and men both serve in the role of interpreter, the majority are women. References to the patient and provider, however, will use the masculine pronoun. This will be done to avoid the cumbersome use of phrases such as she/he and her/him.

[2] More recent discussions have expanded to include distance-interpreting methodologies, in particular telephone interpreting. While many of the issues are the same, there are unique characteristics that differentiate face-to-face and telephone interpreting. These differences will not be addressed in this paper.

The Early Dichotomy

The early dichotomy in conceptualizing the role of the health care interpreter centered on the limits of what interpreters could do as part of their role and the nature of the relationship of the interpreter with both the patient and the provider. During the first meeting of the working group, the dichotomy was identified as the "interpreter in a historically traditional neutral interpretation role" perspective versus the "interpreter with varied responsibilities in health care and in her community" perspective.[3]

According to the neutral[4] interpreter perspective, the sole function of the medical interpreter is "message passing." The interpreter's only responsibility in the encounter is to provide accurate and complete transmissions of messages conveyed in one language into another language, allowing the patient and provider to interact, as nearly as possible, as if they are engaged in a same language exchange. From this perspective, the interpreter is not an active player in the social encounter occurring between patient and provider. The ideal interpreter presence is unobtrusive and non-relational. There is no recognition that the interpreter could already have connections with the patient community or with the medical institution in which the encounter was occurring. Establishing a relationship with the patient is discouraged. Neutral interpreters do not initiate any interventions of their own accord and maintain a disengaged presence. The interpreter is there simply as an "instrument," that is, a "black box" in which messages entered in one language come out in another.

In contrast is the active interpreter perspective, in which the interpreter is someone who is likely to hold a variety of responsibilities, beyond that of "message passing." This perspective is championed by interpreters who come from small, closely-knit cultural communities and by those who interpret for communities in which relational ties form the foundation of trust and credibility. The fact that they are bilingual and can negotiate both cultures — theirs and the mainstream culture — often casts them into a position of assuming many other tasks and functions that their community needs to survive.

This perspective incorporates the likelihood that the interpreter often is a part of or has knowledge of the patient's cultural context that the provider might not and knowledge of the culture of medicine that the patient might not. It recognizes that such knowledge is central to the ability to understand the "intended meaning" of the messages that are being conveyed and make the appropriate equivalent conversions. Because of this the interpreter is sometimes required to assume an active role in the clinical encounter. For example, if a cultural factor such as a belief, assumption or value is creating a misunderstanding that affects the goals of the encounter, the interpreter would be expected to intervene. In such situations, the interpreter has the legitimate option of alerting both parties to the miscommunication, offering suggestions as to what could be impeding mutual understanding, and assisting both parties to explore and negotiate these impediments to understanding.

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3 Phrases that are taken directly from meeting notes and lengthy comments made by participants appear throughout the paper. Comments attributed to participants, however, are not direct quotes but rather paraphrases of what was said. Although some of the sessions were audiotaped, they were not clear enough for accurate and complete transcriptions to be made.

4 Throughout the paper, the reader will come across words like neutral and advocacy. I have tried to define these terms in the context in which they are being used rather than providing a single definition that applies in all cases. Over the many discussions of the working group, attempts were made to arrive at common definitions but no consensus was reached.

This perspective also acknowledges that the interpreter is a social presence that cannot be ignored. Factors such as gender, age, and the social status of both the patient and the interpreter enter into the social dynamics of the encounter and can require adjustments in behavior, including linguistic behavior, to meet cultural norms and expectations that could impact the nature of the communication if left unaddressed.

The dichotomy between these two perspectives was vividly highlighted in an exchange between two participants at the first meeting of the working group. Their comments are paraphrased below:

> *When I arrive and find that the family is waiting and the doctor is not yet ready, I visit with them in the waiting room. This way I can learn many things about them, whether they are a rural family, what news they've had from [our country]. It helps me do a better job when we meet with the doctor.* (Community Interpreter)[5]

> *No, no, you should never meet separately with the client . . . you enter the room when the doctor arrives and you leave when he or she leaves. You don't visit with the patients!* (Program Director)[6]

Clear lines were drawn between the two perspectives — "the interpreter as neutral and uninvolved" versus "the interpreter as active and engaged in a variety of functions and behaviors".

A Continuum: From Conduit To Community Embeddedness

In the ensuing meetings of the working group, the polar extremes of "neutral interpreter" and "active interpreter" continued to tug at each other. However, as the dialogue progressed and the field evolved in different parts of the country, a range of role conceptualizations emerged often informed by the specifics of the cultural linguistic communities that were most salient in that setting. The "neutral interpreter" softened into "the interpreter as conduit" — someone who provides a linguistic bridge and, at times, even a cultural bridge between a provider and a patient who do not speak the same language and do not share a common worldview. The "active interpreter" perspective became differentiated into several conceptualizations. Two of these address the variety of functions and distinct roles that an interpreter could play while in the interpreter-mediated encounter. The third addresses the unique circumstances of non-Western cultures, small language communities, and First Nation cultures.

In the 1997 and 1998 meetings of the national working group, these four conceptualizations were examined at length. The four are:

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5 Meeting notes, Seattle, Washington, 1994.
6 Meeting notes, Seattle, Washington, 1994.

1. The interpreter as conduit
2. The interpreter as manager of the cross-cultural/cross language mediated clinical encounter
3. The incremental intervention model
4. The interpreter as embedded in her cultural-linguistic community

These conceptualizations continue to inform practice in the field today. The following sections summarize each perspective, including key assumptions in each. Critical issues in the enactment of each role will be examined.

The interpreter as conduit

The interpreter as conduit offers an approach to the role that is most compatible with conceptualizations of the interpreter role in other venues, such as the courtroom or diplomatic settings. The role is defined solely by the core function of "message transmission," [7] performed by a third party, whose presence, ideally, is as "invisible" as possible. However, unlike the previous conceptualization of the "neutral interpreter," this approach now acknowledges that message transmission requires more than literal or word-for-word conversions. It recognizes that accurate message transmission has to be based on equivalencies of concepts and this requires knowledge of the cultural context and background of the patient as well as the medical culture. It also recognizes that finding culturally appropriate equivalencies is not an easy matter.

This approach limits the responsibility of the interpreter to the linguistic aspects of communication between patient and provider. That is, providing the linguistic conversion of a message spoken in one language into its equivalent in another. *Effective* message transmission, however, rests with the provider not the interpreter. In other words, responsibility for understanding the message rests with the provider much like it does when the provider and the patient speak the same language. The interpreter simply provides the conversion so that the provider is able to respond to the original message as if he were communicating directly with the patient. If information needs to be clarified or if additional information needs to be elicited in order to arrive at an understanding of culturally based beliefs and assumptions, it is the provider who does so not the interpreter. "The interpreter is there as a 'bridge' [but] what is brought across the bridge is not up to [the interpreter]. It is not up to the interpreter to provide cultural explanations or to serve as a cultural broker." [8]

Clearly, this perspective restricts the addition of other responsibilities especially those of "cultural brokering." Cultural brokering, that is, the shared exchange of cultural information on the part of the interpreter, is perceived as dangerous on at least two levels.

First, it is considered difficult enough to ensure quality in interpretation when the only criterion is "pure" interpretation. Expecting an interpreter to be able to perform other functions and maintain quality in all these functions is considered a difficult requirement to fulfill. If health care interpreters function as cultural brokers, there is the danger that they could inadvertently offer cultural information as they view it and not as the patient views it. Cultural views, after all, are

7 Meeting Notes. Seattle, Washington. 1998.
8 Meeting Notes. Seattle, Washington. 1998.

personal and unique to each individual; each person lives her culture in her own way even when she lives "within the culture." And while many interpreters are themselves blended into two or more cultures, this does not guarantee skill in understanding the nuances of culture and culture conflict. Furthermore, even when interpreter and patient speak the same language, they do not necessarily share identical cultural background because of differences in regional origins, social status, education, gender, and other such factors. Because of these complexities, this perspective deems it safer to circumscribe the interpreter role within the boundaries of linguistic conversion.

Second, if interpreters serve as "cultural brokers," they run the risk of being used as "quick fixes"[9] for the health care institution. According to this perspective, interpreters are hired to show that the system has solved the problem of providing culturally competent care for patients who speak languages other than English. But it does not make the system itself more culturally sensitive and diverse, nor does it provide an incentive for providers to develop culturally competent practices. An interpreter role that endorses the involvement of the interpreter in other functions can result in "[enabling] the provider not to have to learn to do better, thereby impeding the development of a bond between provider and patient."[10]

This approach to health care interpreting works best when providers are culturally competent in conducting their practice, an expectation that is not often borne out. As a result, this approach reluctantly acknowledges that there are times when an interpreter may have to intervene in her own voice to alert patient and provider when the cultural gap makes message conversion extremely difficult if not almost impossible. In such cases, it recognizes that the interpreter may have to stop the communication process and alert both parties to the fact that a word or concept in one culture has no equivalent word or referent in the other (untranslatable words). Such an intervention, however, would be done cautiously and only in the interest of keeping the lines of communication open between patient and provider.

The interpreter as manager of the cross-cultural/cross-language mediated clinical encounter.[11]

The conceptualization of the "interpreter as manager of the cross-cultural/cross-language mediated clinical encounter" defines the primary function of the role as the facilitation of the communication process between two people who do not speak the same language in order to make possible the goal of the encounter — the patient's well being. Since the goal of the clinical encounter hinges on the development of shared meaning between what the patient presents and how the provider interprets this, facilitation of the communication process requires more than linguistic conversions especially when the cultural framework of meaning for patient and provider are very disparate. The interpreter accomplishes this not only by providing the appropriate linguistic conversion from one language into another but also by actively assisting, when necessary, to overcome barriers to communication embedded in cultural, class, religious and other social differences.

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9 Meeting Notes. Andover, Massachusetts, 1997

10 Meeting Notes. Andover, Massachusetts, 1997

11 This conceptualization is most closely tied to that described in the *Medical Interpreter Standards of Practice* developed by the Massachusetts Medical Interpreters Association and Education Development Center, Inc.

This conceptualization defines the context of the interpreter-mediated clinical encounter as a social relationship in which the traditionally dyadic relationship between patient and provider is transformed into a triadic relationship with the interpreter as a legitimate and potentially active social presence. It recognizes that the simple addition of a third party inevitably shifts the dynamics of power between patient and provider, acknowledges that it is only the interpreter who has full access to what is going on at any given point in time. This knowledge invests the interpreter with the power of information. In enacting the role, therefore, it is the responsibility of the interpreter to use her power in the interest of the health care goal. Thus, the interpreter manages the encounter to accomplish the following:

- keep the focus of communication between the provider and the patient, consciously striving to make sure that she does not get drawn into the natural tendency of the provider and the patient to form an alliance with the interpreter and direct their messages (literally and relationally) at the person who understands them;
- maintain the flow of communication for both parties engaged in the interaction;
- pace the communication to meet her own level of language comprehension and fluency in both languages in order to maintain accuracy and completeness without indiscriminately interfering with the flow of communication between patient and provider; and
- intervene, when necessary, to "flag" cultural barriers to communication or assist in exploring information that will diminish cultural barriers to understanding.

This definition of the role works best when the interpreter is accepted as a member of the triadic relationship that has the well being of the patient as its common goal, and in which each party is accepted for his or her respective source of power or expertise. The provider offers both technical and therapeutic expertise providing the knowledge and skills that the patient needs to meet his or her health-related goals. The patient brings into the encounter expertise about his or her own symptoms, beliefs, needs and expectations, and the ultimate right to make decisions for himself. The interpreter's expertise resides in her linguistic skills and understanding of the interpreter-assisted communication process. Her commitment is to support the two parties as they negotiate their respective domains of expertise. The interpreter does this not by taking control of the substance of the messages, but by being mindful that shared meaning does not automatically occur even when speakers use the same language. When, in addition to language, different cultural frameworks enter into the picture, the likelihood that shared meaning will develop is even more tenuous. In the interest of the clinical goal, then, the interpreter can intervene to make sure that both parties understand the messages that are being transmitted. In this sense, the interpreter may be said to function as a "communication advocate." [12]

At times, the interpreter may also engage in "referral advocacy,"[13] which refers to the provision of information about other services — both within or outside the health care setting — that the patient may need as a result of or in conjunction with the clinical visit. In some cases, this may entail the accompaniment of the patient by the interpreter to the appropriate department or

12 Meeting Notes. Andover, Massachusetts. 1997
13 Meeting Notes. Andover, Massachusetts. 1997

unit within the health care setting, and the subsequent provision of interpreter services in that department or unit. At no time, however, does the interpreter engage in the kind of advocacy in which she speaks directly either for the patient or the provider during the clinical encounter.

Incremental Intervention[14]

Like the previous conceptualization, the incremental intervention approach defines the role of the health care interpreter as follows: "the role of the health care interpreter is to facilitate understanding and communication between people in the health care setting who speak different languages. The primary focus is on communication clarity. To achieve such clarity, it may be necessary to provide linguistic clarification, cultural brokering, and limited advocacy while respecting the goals of the individual participants and the community. In doing so, the interpreter must also keep in mind the programmatic and institutional context in which she is interpreting as well as the cultural and political context of the patient's community."[15] Thus, from this perspective, the primary role of interpreter as linguistic facilitator is accompanied by a repertoire of communication-oriented and other interventions that the competent interpreter could call upon as needed.

In this model, the role of the interpreter is seen as flexible, ranging from the least intrusive role of conduit, to clarifier, to culture broker and finally, to the most intrusive role of advocate. The model recognizes the need for the interpreter to stay in the background and to support communication and relationship-building directly between patient and provider, while at the same time allowing the interpreter a legitimate way to intervene if she perceives that a misunderstanding is occurring. The level of intrusion that is least invasive yet will adequately facilitate understanding between patient and provider dictates the choice of role. Movement across the boundaries of different roles is determined by the demands of the situation. Examples of these contextual variables are the provider's skill in working with an interpreter and his overall cultural competence, the degree of cultural distance between patient and provider, and the experience of the patient in a western medical environment. The interpreter role expands incrementally to bridge the gaps between patient and provider, so for different patients, different providers and in different interactions, the interpreter may assume different roles. In doing so, however, it is extremely important for the interpreter to be *transparent* as she moves from one function to another. If the interpreter has to speak at all with her own ideas, whether to ask for clarification, to check for understanding, or to act as a cultural broker, she has the obligation to make each participant aware of what she said to the other. The specific interpreter program, the community, or the profession may also set the parameters of which level of incremental interventions are considered appropriate under what conditions.

Proponents of this perspective see the kind of neutrality that is totally disengaged even in the face of obviously ineffective communication "as unacceptable and as morally and legally irresponsible." Since the power dynamics between the patient and provider naturally favor the provider, neutrality is perceived as "detrimental to advancing the goal of the encounter" and, therefore, "not serving anyone's interests." An interpreter who understands both the provider

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14 This conceptualization was originated by Cynthia E. Roat, MPH and is the basis of the "Bridging the Gap" interpreter training model.

15 Meeting Notes. Andover, Massachusetts. 1997

and the patient viewpoints is in a unique position to enhance the achievement of the goals of the interaction by encouraging the exchange of cultural information to achieve a deeper level of meaning. Fidelity to the message is thus enhanced. Not to make use of this unique position is "to waste a valuable opportunity to serve as a 'healing connection' between the patient and the provider." Furthermore, experience shows that despite training in the "neutral" model, most interpreters "guiltily incorporate other approaches" as needed.[16]

Like the manager role, this approach works best when the interpreter is seen as a legitimate member of the triadic relationship. It assumes that each party, but especially the interpreter and the provider, has a clear understanding of their respective boundaries and that differences in their sources of power are acknowledged. Thus, while the interpreter is responsible for clear communication, the provider and the patient are responsible for the ultimate resolution of the encounter. It acknowledges that many providers do not possess the cultural competence to always understand when there are cultural barriers to communication and understanding. This relationship works in the best interest of the patient when the provider is trained to work with an interpreter and values the interpreter as an ally in providing quality health care.

The Interpreter As Embedded In Her Cultural-Linguistic Community

The conceptualization of the interpreter as embedded in her cultural-linguistic community takes a qualitative leap that uniquely differentiates it from the previous approaches. While it recognizes that the core function of the interpreter is the transmission of messages from one language into another, it assumes that the person performing the function is there as a whole person embedded in the social fabric of her community. It assumes that roles and functions, while they can be intellectually and structurally compartmentalized, are enacted in a web of social relationships. The role of the interpreter, therefore, cannot be separated from who the interpreter is, who the patient is, how the interpreter relates to the patient, what the nature of her relationship is to the provider and the institution of medicine, and what the historical and political context of their community is in the United States.

This perspective recognizes that for many cultural-linguistic groups, language is more than a tool for communication. Language is a part of the life essence. It defines who the people are. It establishes relationships. It has the power to shape reality. It is the perspective that is generally espoused by non-Western cultures, small language communities, and First Nation cultures. A Navajo participant at the 1998 meeting in Seattle, Washington best captured this perspective when she said:

> *We have to think of ourselves as being part of the community. We have to think about the people that we are talking to (and our relationship to them). There is a clan system. There are certain things I can't interpret if it's for my husband's clan . . . or for my father's clan, especially if it is about certain sensitive things, like the male parts of the body. There are certain things that I, as an interpreter, cannot interpret if the person I am interpreting for is older than me. I can't say certain things to a*

16 Meeting Notes. Andover, Massachusetts. 1997

male that I can say to a female. There are certain things a young female interpreter can't say to a young man. There are certain things a male interpreter can't say to a woman.

And, then there is spirituality. There are certain things I can't interpret to anybody because of the spiritual part of it. In our culture, there are some things you don't say. So, I have two worlds that I have to take the patient through — Western medicine that is separate from our lives and the Indian way of life where we're at all the time. By knowing both sides, I bring those two forces together. I show the patient - this is what is over there. I show the provider - that is what is over there.

So, it's a lot more than just saying what the doctor and patient say. You have to consider all these things.[17]

For these cultural-linguistic groups, community oversight is critical. The interpreter has to have credibility as a member of the community in order to have credibility as an interpreter. The community has expectations of interpreters that go beyond the fact that they were hired as interpreters. Interpreters are seen as important intermediaries between a powerful system — the institution of medicine — and the community. So, the community puts pressure on the interpreter to stay true to the norms and beliefs of the culture and not jeopardize the survival of that culture, while at the same time asking the interpreter to make possible access to the desired benefits of that powerful system.

These cultural-linguistic communities face multiple needs yet resources are scarce. People who possess the skills to bridge the cultural and linguistic gaps are few and in great demand. Those who possess these skills often have training in more than one job role. Thus, it is the nurse, the social worker or the case manager who also serves as the interpreter. In these situations, as in the incremental intervention approach, transparency is again of utmost importance in order to maintain trust among the members of the triad. Each party in the triad needs to be aware of the responsibilities the interpreter is prepared to assume through training and experience. The interpreter has to be clear with both patient and providers when she crosses the boundaries of different roles. The provider has to be clear when he designates the interpreter to assume a role other than that of interpreter (i.e., to take a clinical history, to follow-up after the encounter, etc.), always considering the interpreter's skills and respecting her limitations when making such assignments.

The Current Status of the Health Care Interpreter Role Definition

As evidenced throughout this paper, the health care interpreter role involves a complex set of skills and expectations practiced within a setting that is socially, culturally and politically complex at both an interpersonal and institutional level.

17 Meeting Notes. Seattle, Washington. 1998.

At the interpersonal level, health care interpreting occurs in a setting that is dialogic. It involves two people interacting and talking to each other in order to achieve a shared, common goal — the health care of the patient. This goal is both interpersonal and institutional. In the health care setting, the dialogue itself is a critical tool that allows the patient and the provider to negotiate a diagnosis and subsequent treatment plan that will lead to the well being of the patient. If the meaning of the messages from each is not clear to both the patient and the provider, the likelihood that a mutually satisfactory outcome will be achieved is seriously compromised, with potentially significant implications for the institution. The interpreter, therefore, has to attend not only to the mechanics of message conversion, but also to the development of shared understanding across language and culture. [18]

We have seen from the discussion of the four role conceptualizations that the parameters of the interpreter role contract or expand depending on the institutional and community context in which the interpreting occurs, as well as on the characteristics and skills of the provider and the interpreter. Within cultural-linguistic groups, the degree to which individuals have been assimilated or aspire to assimilate into the mainstream culture often affect the degree to which they accept and understand western beliefs and methods of health care and treatment. Thus, the diversity of patients — even from the same cultural-linguistic group — also presents a challenge to creating a uniform definition and set of role expectations.

Notwithstanding all these complexities, the working group eventually arrived at some cautious agreements on basic aspects of the role of health care interpreter. These agreements are as follows.

- The basic function of the health care interpreter, as in other interpreter-mediated settings, is to provide a linguistic conversion from one language system into another in such a way that the original meaning is maintained.

- Accuracy and completeness are professional standards that underscore the practice of interpreting. In the health care setting, however, fidelity to meaning may require the use of metaphors as well as negotiated explanations of concepts that do not necessarily have matching referents in the other language.

- In providing this linguistic conversion, the interpreter also functions to facilitate understanding and communication between people who speak different languages. The interpreter acts in the interest of the shared goal of achieving the well being of the patient.

- In the health care setting, in which shared meaning is so critical to the successful achievement of the goal of the encounter, the interpreter cannot remain a passive, uninvolved party. There are times when, because of the cultural distance between the parties, the interpreter may have to serve as a cultural bridge.

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18 In other settings, such as conference and court interpreting, there is no assumption that the success of the encounter is dependent on mutual understanding. In fact, court interpreting occurs in a setting in which the major parties are in an adversarial relationship. The goal of communication is not to develop shared understanding but to make a point. In conference interpreting, the communication is uni-directional. Understanding is assumed but not addressed.

- Transparency in the actions of the interpreter is paramount whenever the interpreter steps out of the core function of providing a linguistic conversion. That is, the interpreter has an obligation, whenever she speaks in her own voice, to make sure that the both parties understand what she has said.

- Irrespective of where a role perspective draws the boundary for what is acceptable in the role, an interpreter is expected to perform only those functions for which they are qualified by training and experience.

- Interpreters do not speak for either the patient or provider during the interpreter-mediated encounter.

Disagreements among the conceptualizations of the role still arise on two points: 1) the boundaries of what are considered acceptable functions within the role, and 2) the nature of the relationship of the interpreter with the patient and the provider.

At one extreme, the interpreter as conduit assigns the most circumscribed function to the role — linguistic conversion — and ascribes the most minimal relationship that the interpreter can have with either the patient or the provider. At the other extreme is the interpreter as embedded in the patient community in which the interpreter may perform a variety of tasks in addition to interpreting, and is likely to have multiple levels of social relationships with the patient and the provider within and outside the interpreter assisted clinical encounter.

In between these extremes are the perspectives of managing the communication process and the incremental intervention model. In both these perspectives, the interpreter focuses on the task of facilitating the communication process between two parties who do not share a language or culture. But here, unlike the conduit model, the interpreter is present as a potentially active member of the triad with the option of choosing among different roles to support the goal of the clinical encounter as needed. Establishing a relationship with both the patient and the provider is seen as a valid human reaction and a potentially therapeutic tool. With the patient, the interpreter builds on the initial trust that comes from sharing a language and, in some instances, a cultural affinity. With the provider, the interpreter builds on their shared commitment to the well being of the patient and, in some situations, on their institutional affinity. However, the underlying focus of the relationships tends to be limited within the context of interactions related to the patient's health related needs.

In addition, debate continues over how points of agreement actually are enacted in practice. What, for example, does accuracy really mean? In the interest of accuracy, is it necessary for the interpreter to mimic the emotional tone and content of messages? If the emotional tone and content is not understood or is misunderstood, is it the responsibility of the interpreter to verbalize them? What about the concept of completeness? What are the ethical implications when the mandate for completeness conflicts with deeply held cultural values and beliefs of the patient? What does it mean to "interpret everything that is said" when doing so may have serious implications for the well being of the patient? Should there be "universal rules and expectations" for making such decisions?

As we will see in the next section, finding a single, all encompassing definition of the health care interpreter is no longer an overriding concern.

Creative Tension:[19] The Principle That Connects Different Perspectives

> *As interpreter, my heart is with the patient. I interpret what the patient feels and where he is coming from. But my mind is with the provider – where their knowledge, their wisdoms and their scientific values are. And that's how I interpret.*[20] (Navajo Interpreter)

At the end of six years, the value of the discussions held by the NCIHC lies in an acknowledgment and respect for the diversity of contexts, strengths, needs and demands in which oral language interpreters perform this essential service. More important than finding a single definition is the dedication and conscientiousness with which interpreters, providers, members of diverse linguistic and cultural communities, educators and trainers, policy makers, and researchers approach their work and their deliberations. Equally important is their commitment to providing access and quality of health care services to populations that experience enormous barriers to meeting their health needs. Participants in each of the working group conferences have come to the realization that the goal of the ongoing dialogue is not to agree upon a single, "universal" definition of the role, but to appreciate the different perspectives as interdependent aspects of a dynamic and continuous evolution of the field.

This continuing evolution is grounded on an important principle of growth and development and the creative tension between polar perspectives in the field. (See Figure 1.)[21] Both polarities are critical. The conduit perspective keeps the field grounded in the central function of the interpreter — the linguistic conversion that allows communication between a patient and provider who do not speak the same language. The embeddedness perspective challenges the profession to consider its place in a holistic view of the patient's well being — a wholeness of heart, mind, and spirit. One without the other is incomplete.

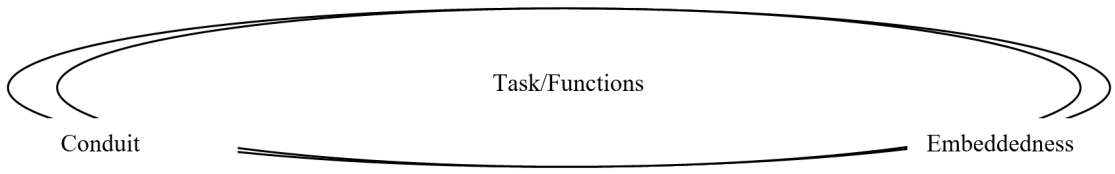

Figure 1: Creative Tension: the principle that connects the different perspectives

19 The term "creative tension" is borrowed from Peter Senge who uses it to describe the tension within organizations between the vision of where the organization wants to be and the current reality of where the organization is truthfully.

20 Meeting Notes. Seattle, Washington. 1998.

21 This representation was used by the author at the meeting held in 1999 in Monterey, California.

In the middle are the perspectives of the interpreter as manager of the communication process and of the incremental intervention model. These two perspectives focus primarily on the functions and tasks that the interpreter performs in the interest of making possible the communication between the two parties and the development of shared meaning. These two perspectives move in either direction— sometimes closer to the conduit approach and sometimes closer to the embeddedness approach — depending on the context of the interpreter-mediated encounter.

The evolution of the role will continue and the dialogue will be energized by the creative tension between the polar perspectives. Without the conduit perspective, the profession runs the danger of losing its focus. Without the embeddedness perspective, it runs the danger of losing the heart and spirit of those for whom the survival of their communities is paramount. All, however, are committed to bringing access and quality in health care to all patients.