

HEALTH LITERACY AND PATIENT EMPOWERMENT: THE ROLE OF MEDICAL INTERPRETERS IN BILINGUAL HEALTH COMMUNICATION

Elaine Hsieh

In 2000, 4.4 million households were linguistically isolated, meaning that no one in the household aged 14 or over spoke English at least “very well”; up from 2.9 million in 1990 (Shin, 2003). In 2007, nearly 55.4 million Americans spoke a language other than English at home, among which 24.5 million (8.7% of the population) have limited English proficiency (LEP); in 1990, the numbers were 31.8 and 13.9 million (6.6% of the population) respectively (Shin & Kominski, 2010). These demographic changes of the United States present unique challenges to the delivery of quality health care to individuals with LEP.

Researchers have noted that when language barriers exist in provider-patient communication, a patient is likely to receive more diagnostic testing (Hampers, Cha, Gutglass, Binns, & Krug, 1999); is less likely to receive preventive care (Woloshin, Schwartz, Katz, & Welch, 1997) and follow-up appointments after an emergency department visit (Sarver & Baker, 2000); is less likely to understand health-care providers’ instructions (Doty, 2003); and is less satisfied with the quality of care (Ngo-Metzger, Sorkin, & Phillips, 2009). Compared to their English-speaking counterparts, patients with LEP often make fewer comments and receive less information, responses, and social support from their provider (Rivadeneira, Elderkin-Thompson, Silver, & Waitzkin, 2000; Thornton, Pham, Engelberg, Jackson, & Curtis, 2009). As a result, patients with LEP are significantly disadvantaged when interacting with providers.

Low health literacy (e.g., lacking the skills to effectively communicate with providers) is a prevalent problem in the United States, with more than one-third of the English-speaking population and half of the Spanish-speaking population struggling with health literacy (Gazmararian, Curran, Parker, Bernhardt, & DeBuono, 2005). Challenges faced by populations with LEP are not limited to

their lack of literacy skills (e.g., inability to read the English materials). Even when education materials are translated into the patients' native language, they may still experience difficulties in understanding health information (Leyva, Sharif, & Ozuah, 2005). Populations with LEP often experience multilevel challenges that may lead to experiences of health disparities. In addition to the common factors that lead to low health literacy (e.g., education, socioeconomic status, and language proficiency), they also face challenges in seeking and providing information in health-care settings due to differences in their social norms and cultural expectations (Hsieh, 2006a, 2007). For example, they are likely to have different cultural expectations and normative beliefs for providers, patients, and patients' family members as they coordinate the management of an illness event. Researchers have argued that low health literacy contributes to health disparities experienced by racial and ethnic minorities (Paasche-Orlow & Wolf, 2010).

Interpreters are in a critical position to assist the patients with LEP to navigate the complex health-care system, which may require them to negotiate provider-patient differences in cultural expectations, social norms, and illness ideology. Two recent reviews found that providing professional interpreter services can improve patients' quality of care, treatment processes, health outcomes, satisfaction, and adherence (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007). In some studies, researchers have found that patients who receive interpreting services perform the same, if not better, than their English-speaking counterparts (e.g., Andrulis, Goodman, & Pryor, 2002; Tocher & Larson, 1996). Researchers have found interpreters to be active participants who systematically adopt purposeful strategies to improve a patient's health literacy (e.g., ability to seek, provide, and process information when communicating with providers), to protect institutional resources (Davidson, 2000), to reduce the cultural gap between the provider and the patient, to reconcile provider-patient conflicts, and to ensure the quality of provider-patient interactions (Hsieh, 2006a). However, as researchers noticed interpreters' active involvement in the communicative process, they also have questioned interpreters' ethics, and raised concerns about how some of their communicative strategies may infringe on providers' authority or patients' autonomy (Hsieh, 2010; Leanza, 2008; Rosenberg, Seller, & Leanza, 2008).

In this chapter, I will critically examine interpreters' communicative strategies, focusing on how they facilitate provider-patient interactions and influence patients' information-seeking and help-seeking skills with providers. Extending from past literature that recognizes interpreters' active involvement in medical encounters (Dysart-Gale, 2005), I will further explore whether the interpreters' strategies may improve or hinder patients' health literacy and autonomy in their illness events, which may have significant implications for the health disparities experienced by the populations with LEP.

Background

The findings presented here are part of a larger study that examines the roles of medical interpreters. Three data sets were presented here. The first data set include a one-year ethnographic study. I recruited two Mandarin Chinese interpreters, four patients, and 12 providers. I shadowed the interpreters in their daily routines and audio-recorded their interactions with the patients and the providers. In total, 12 medical encounters (each lasting 1–1.5 hours) were observed, audiotaped, and transcribed. The other two data sets are in-depth interviews and focus groups with health-care providers and interpreters. I recruited 26 interpreters (from 17 languages), and conducted 14 individual and six dyadic interviews (each lasting 1–1.5 hours). Interpreters included in this study are all considered professional, on-site interpreters. The interviews focused on exploring interpreters' understanding and practice of their roles.

After the initial analysis of the interpreters' interview data, my research team recruited 39 health-care providers from a major health-care facility in the southern United States as a part of NIH-funded research to examine the providers' views on the roles of medical interpreters. We recruited 39 providers from five specialty areas: OB/GYN ($n = 8$), emergency medicine ($n = 7$), oncology ($n = 11$), mental health ($n = 7$), and nursing ($n = 6$). In total, the research team conducted 8 specialty-specific focus groups (each lasting 1–1.5 hours) and 14 individual interviews (each lasting 1–1.5 hours). The research questions were designed to examine providers' perceptions, expectations, and evaluations of interpreters' roles and practices. All procedures of the study have been approved by the Institutional Review Boards involved.

Based on these data sets, I have examined interpreters' communicative strategies through their performances of specific roles (Hsieh, 2006a, 2007, 2008) and their corresponding challenges to provider-interpreter collaboration (Hsieh, 2010; Hsieh, Ju, & Kong, 2010). Some discussions here are similar to a study that involved discussions of interpreters' advocate role (cf. Hsieh, 2008); however, instead of focusing on role performance, the discussion here centers on interpreters' influence on patient health literacy and patient empowerment and its corresponding consequences.

In the transcript, health-care providers are denoted as H, interpreters as I, and patients as P. In the following discussion, I also denote interpreters with a superscript I (i.e., ^I) and health-care providers with a superscript H (i.e., ^H) after their pseudonyms. I *italicize* some texts to highlight my emphases.

Interpreters' Influence on Patient Health Literacy and Patient Empowerment

We found that interpreters adopt a variety of strategies aiming to improve patient's health literacy. Researchers have found that patients' active participation (e.g., asking questions, providing information) in provider-patient interactions can lead to increase in providers' patient-centered communication (Cegala & Post, 2009) and better coordination between providers' and patients' goals (Cegala, Street, & Clinch, 2007). In this chapter, I will highlight two distinctive strategies employed by interpreters to facilitate provider-patient communication: (a) making inexplicit information explicit, and (b) providing the patient with the means of self-advocacy.

Making Inexplicit Information Explicit

Individuals rely on conventional norms and other relevant contexts to understand the speakers' intended meaning (Grice, 1975). Because providers and patients do not share the same conventional norms or contexts in bilingual and/or intercultural health care, providers and patients are likely to experience miscommunication or confusion if an interpreter provides little assistance in helping them to be aware of the relevant contexts.

Interpreters can elaborate on a speaker's comment to improve a patient's ability to request services, to understand medical procedures, and to engage in effective provider-patient interactions.

In Extract 001, Claire¹ elaborated the provider's comment to improve the patient's understanding.

Extract 001

H: Has she ever heard of Equal?

I: 你有沒有聽過 Equal? 英文叫 Equal 的這個糖, 代糖, 他們叫代糖, 不是真正自然生產的糖, 他們叫代糖, 老美叫代糖。名牌叫 Equal。(Have you heard of Equal? The English term for this sugar, Equal, they call it substitute sugar, it's not a naturally produced sugar. They call it substitute sugar. Americans call it substitute sugar; the brand name is Equal.)

P: 不知道 (No.)

I: No.

Claire's elaboration of the term, *Equal*, helps the patient to better understand the providers' information by providing background information about what substitute sugar is and that Equal is just a brand name. When communicating with one another, people often make cultural-specific inferences and assumptions that are embedded in their language practices. These inferences and assumptions, however, may not be transferable to another language and culture (see also Lee, 2009). Interpreters' familiarity with the social norms and cultural knowledge can be valuable in ensuring providers' and patients' accurate and effective exchange of information.

It is important to note that these cultural differences are not always transparent; as a result, interpreters' ability to detect and clarify the divergent understanding between the provider and the patient can be critical to ensuring the quality of care. The following interaction took place during an education session in which a dietician is educating a patient with gestational diabetes about portion size.

Extract 002

H: One-third of a cup of rice is a serving.

I: 三分之一杯的煮熟的米飯就是, 一個分量。(One-third of a cup of cooked rice is a serving.)

Does she have measuring cups at home?

I: 家裡有沒有量杯? (Do you have a measuring cup at home?)

P: 就是米飯的那個杯子。(Just the cup for rice.)

I: Is it the same measuring cup for rice?

H: Hmhm, yes.

P: 都是一樣的。(It's the same.)

I: Is it the same?

H: The—

I: Are they?

H: I don't know what she is referring to. I'll show her what I have.

I: 她有一個。(She has one.)

(H took out a glass measuring cup from the drawer.)

P: 這麼大阿！(That's big!)

Claire^I adopted several strategies here that are critical to the patient's health literacy. First, she used "cooked rice" (line 102) rather than the term "rice" (line 101) used by the provider. Recognizing that there are significant portion size differences between cooked versus uncooked rice (i.e., one cup of uncooked rice makes about three cups of cooked rice), Claire^I preemptively changed the provider's term, while keeping the provider's comment accurate, to ensure that the patient does not misunderstand the providers' comments.

Second, when the patient made statements (i.e., "just the cup for rice" [line 107] and "it's the same" [line 111]), Claire^I modified the statements into direct information-seeking questions. Previous studies in provider-patient communication have found that due to the power differences between providers and patients, patients often (a) do not seek questions even when they desire more information, and (b) when they do, they avoid using direct questions when seeking information from their providers (Cegala, 1997). Instead of treating the patients' assertion (which can be a form of an embedded question) as a statement, Claire^I changed it to a direct question to seek and clarify information ("Is it the same measuring cup for rice?" [line 109]). Similarly, when the patient acknowledged the provider's confirmation (line 110) by reinstating the implications ("It's the same." [line 111]), Claire^I treated the patient's utterance as an active information-seeking question (line 113). In fact, Claire^I's persistence in seeking and verifying the information exposed a miscommunication that would have been originally ignored by the provider. Claire^I's direct question ("Is it the same?"

[line 113]) and its reinstatement (“Are they?” [line 115]) forced the provider to admit potential misunderstanding (“I don’t know what she is referring to.”), and to resolve the problem (“I’ll show her what I have.”). The patient’s comment on line 121 (“That’s big!”) showed that there was a real difference in the size of measuring cups that the provider and the patient had in mind, and that there could have been significant clinical consequences had Claire¹ not insisted on pursuing accurate information.

Third, an important feature in this interaction is how closely Claire¹ followed the patient’s narrative, but at the same time, changed the nature of the narrative. Claire¹’s strategies could not be categorized as neutral or faithful; yet, these strategies are essential in facilitating provider-patient communication. By explicitly stating the inexplicit information (e.g., “cooked rice” as opposed to “rice”), Claire¹ also improved the patient’s ability to understand the information accurately and effectively. Because of the power differences, a patient may not feel comfortable asking the provider a direct question (Cegala, Post, & McClure, 2001). By reformulating the patient’s narratives into active, information-seeking strategies, Claire¹ significantly increased the patient’s ability to seek information.

Providing Means of Self-Advocacy

In addition to modifying others’ utterances to enhance patients’ health literacy, interpreters may enhance a patient’s quality of care through *providing means of self-advocacy to the patient*. This is different from the advocate role which requires patients to accept other-advocacy to rectify problematic situations (e.g., inequality or injustice of health-care services) (Roat, Putsch, & Lucero, 1997). In contrast, by providing means of self-advocacy, interpreters provide patients access to resources available in various areas (e.g., medical knowledge and relevant information), and empower patients to act as self-advocates.

Interpreters’ familiarity with the topic transitions and information flow allows the patients to communicate in a way that is consistent with providers’ expectations and management of the medical encounter. In Extract 003, the patient indicated her concerns in an earlier conversation with the interpreter that her baby was losing weight. After the provider asked the mother about her

feeding pattern, Christine¹ initiated the following information exchange sequence.

Extract 003

I: 你是不是要問醫生她今天量的體重比出生的時候還要少？(Didn't you want to ask the doctor why she is weighing less today than when she was born?)

P: 對啊 (Yes.)

I: Another question, before, the nurse weighed her, and she was born 7 pounds 11 oz., then today, the weight is only—It lost about 6 oz.

H: 6 oz. It's normal.

I: 她說這是正常的 (She said it's normal.)

The interaction between Christine¹ and the providers in lines 306–309 is consistent with the earlier discussion in which the interpreter issued direct questions while making explicit statements on inexplicit information. Christine¹ not only provided the baby's original birth weight, but also highlighted the amount of weight loss. The information was obtained in a previous conversation with a nurse, but not with the current provider. Christine¹'s use of meta-communication (i.e., “another question”), and inclusion of the exact amount of weight loss (i.e., 6 oz.), allow the provider to respond to and evaluate the patient's concerns more effectively.

What is particularly interesting in this interaction, however, is that when Christine¹ first initiated the question (line 301), the question was directed to the patient. Christine¹ might feel that the patient's concern was appropriate to be the next topic after the information exchanged about the baby's feeding patterns. Such a judgment requires a speaker's ability to understand the norm of information exchange patterns in provider-patient interactions, which an interpreter may have more experience with than the patient. In the interviews, several interpreters noted that they often remind and prompt patients about topics to discuss with the providers. By directing the question to the patient first (as opposed to directing the question to the provider), the patient is empowered to have control over the provider-patient interactions, and is socialized into the norms of topic transitions. In the future, the patient may be able to initiate the questions without the interpreter's assistance. In other words, the interpreter's strategies in Extract 003

not only allow the patient to have control over the topics discussed in the current interaction, but also educate the patient about the norms of future provider-patient interactions.

An interpreter may also coach a patient about *how* to request proper services or information. In Extract 004, the patient complained that the hospital provided water with ice for her to drink after her delivery, a practice that contradicts a Chinese custom which specifies that women after delivery should only drink hot water.

Extract 004

P: Yeah, 我這天-我兩天在醫院都是喝冰水 (Yeah, these days—I drank chilled water in the hospital.)

I: 其實醫院它有熱開水, 你跟護士講, 她就會給你熱開水 (Actually, they have hot water in the hospital. If you tell the nurse, she'd give you hot water.)

P: 我說-我說給她聽, 我不要 ice, 它都不是凍的, 她就沒有放 ice (I said—I told her that I don't want ice. So, it's not icy. She didn't put ice in it.)

I: 沒有放冰, 對對。你應該跟她說 hot water (No ice. Right. Right. You should tell her, "hot water.")

P: Hot water.

This interaction happened when the patient and Christine¹ were alone in the exam room, waiting for the provider. Christine¹ informed the patient about services available in the hospital (line 404) and the proper way to ask for the services (line 410). Christine¹ used the English term, "hot water" (line 410), instead of saying its equivalent Chinese term, showing that Christine¹ was providing the patient with the tool to obtain the services. The patient's verification of the information and repetition of the English term in line 413 shows that she understood Christine¹'s communicative goal of empowering the patient.

For patients who are from a different culture and/or society, it is possible that they are not familiar with the kinds of services available, their rights as patients, or the appropriate norms of provider-patient interaction. Because interpreters are familiar with the typical exchanges in medical encounters, and have observed successful and problematic provider-patient interactions, they can be extremely helpful and valuable in assisting patients in navigating the health-care systems. Stacy¹ explained,

Because [patients] might be worried, but they don't know what they are worried about. So, I ask them, "Would you like to ask if taking that medication has side effects?" So, I help them to understand some of the procedures and foresee something so that they would not worry about it later on.

Sara¹, another interpreter, talked about a situation in which a Spanish-speaking father explicitly told her that he did not know what questions to ask; in response, she coached him to ask the physician to provide clarification of the diagnosis, to discuss alternative treatments, and to explain long-term consequences of the disease. In another case, after witnessing a provider's prejudicial attitude, Colin¹ informed the patient that if he wished to file a complaint, he would be able to take him to the complaint office and interpret for him. In such situations, by providing access to illness-related information and health-care facilities, interpreters significantly enhance the patients' abilities to obtain quality care.

Balancing Benevolence and Social Justice With Patient Autonomy

In the last section, we provided examples of how interpreters' strategies may empower patients and enhance patients' health literacy, not only for the current medical encounter, but also for future provider-patient interactions. It is important, however, to take a critical view on the interpreters' strategies, exploring potential concerns about and consequences of interpreters' efforts in empowering patients.

Patient Empowerment and Patient Autonomy

Recent studies have increasingly emphasized the importance of interpreters' active role in bilingual health care (Fatahi, Hellstrom, Skott, & Mattsson, 2008; Messias, McDowell, & Estrada, 2009); however, it is important to recognize that interpreters' involvement and intervention is not without limits (Hsieh, 2010). Although acting as direct advocates (e.g., acting on behalf of the patient without the patients' or providers' explicit consent) may be efficient in meeting the patients' needs (Hsieh, 2008; Messias et al., 2009; Rosenberg et al., 2008), such strategies may blur the lines between the patients' and the interpreters' agenda and communicative goals (Leanza, Boivin, & Rosenberg, 2010; Rosenberg et al., 2008).

A few interpreters in our study raised concerns about how interpreters' active involvement may infringe on patient autonomy (i.e., patients' right to make decisions without the influences of providers and/or other health-care professionals). Shirley¹, manager of the interpreter office of a major hospital and a trainer of an interpreting program, explained, "By NOT empowering, by giving your opinion, going immediately into an advocacy role as a medical interpreter, I feel that you keep [that patient], that parent or that guardian, or primary caretaker, from becoming empowered." Sharon¹, the director of an interpreting agency, echoed, "They do more harm than good when you try to be more than an interpreter, when you try to be an advocate for the patient." Although patient empowerment is often perceived as the communicative goal of the advocate role (Hsieh, 2008), some interpreters argued that advocating for patients or acting on a patient's behalf can be problematic because it compromises patient empowerment. From this perspective, the best form of patient empowerment is to allow patients to have full control over the medical encounter without the influence of the interpreter (see Hsieh, 2008). Several interpreters discussed their decisions of *not* being an advocate. For example, Vicky¹ explained,

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

The emphasis on patient autonomy echoes the traditional emphasis on the conduit role, in which interpreters are only the voices of others (Hsieh, 2009; Kaufert & Putsch, 1997; Messias et al., 2009). In the United States, patient autonomy emerged in the 1960s in the overall atmosphere of antipaternalism and redefined beneficence as medical paternalism (Rothman, 2001). As a result, an ideal patient is an informed patient who is capable and willing to assume all responsibilities in their illness events (Kapp, 2007).

Conceptualizing interpreters' noninterference as respect for patient autonomy, however, is based on problematic presumptions. The interpreter-as-conduit model assumes that: (a) all participants are competent speakers who can communicate effectively and appropriately, (b) it is desirable to maintain the existing structure of relationships and patterns of communication, and (c) there are

minimal differences between speakers' cultural knowledge and social practices. However, medical interpreters do not operate on an equal playing field, in which providers and patients are equal participants (Kaufert & Putsch, 1997). Literature on provider-patient communication has long documented that the differences in power and medical knowledge often compromise patients' full participation in provider-patient interactions (Elderkin-Thompson, Silver, & Waitzkin, 2001). Providers do not spend more time interacting with patients with LEP (Thornton et al., 2009), even though they often believe that they do (Tocher & Larson, 1999). Patients with LEP often experienced prejudicial attitudes and cultural differences, which can lead to reduced patient satisfaction and compromised care (Dohan & Levintova, 2007; Hicks, Tovar, Orav, & Johnson, 2008). In addition, patients from different cultures may desire different degrees of patient autonomy in their illness events (Back & Huak, 2005; Blackhall, Murphy, Frank, Michel, & Azen, 1995).

In bilingual health communication, patients and providers are not on equal footing, nor do they share similar cultural, social, or communicative norms. A patient may not know how to voice their concerns. Stacey¹ said that she often asks her patients to "give [her] a word or something that they don't understand" so she could "ask different questions to the doctor on their behalf." In other cultures, it may not be appropriate to disclose one's illness. For example, Yetta¹ explained that in Nigerian culture, even a common illness (e.g., high blood pressure) can be used as a personal attack against an individual. As a result, Nigerian people go to a great extent to hide their symptoms. She explained,

The secrecy of not exposing what they have...I have to let the patients know that they are here to be treated, "TELL THEM, what's wrong with you. How you are going to get help."...They are not used to revealing what's wrong with them.

A patient who is unwilling to disclose his or her problem certainly cannot have meaningful provider-patient communication. In these situations, if interpreters maintain neutrality by avoiding active intervention (e.g., encouraging patients to voice their concerns, to seek information, or to assert their rights), they ignore their important functions in addressing the social inequality embedded in bilingual health communication (Messias et al., 2009).

Benevolence, Social Justice, and Health Literacy

Patient autonomy is not simply allowing the patient to make their own decisions; rather, providers are obligated to create the conditions necessary for autonomous choice in others (Pantilat, 2008). If the patients do not know what information to seek, what services are available, or what rights they have, they are not in a position to make autonomous decisions. To ensure patient autonomy in bilingual health care, it is essential that medical interpreters (and other providers) actively respond to the situational and contextual demands to ensure that a patient is informed and empowered to make autonomous decisions.

Providers rely on interpreters to offer culturally sensitive care (Kaufert & Putsch, 1997; Schapira et al., 2008). Interpreters are extremely valuable to providers in understanding a patient's distress. Gemma^H noted, "If [interpreters] can be more than just the verbal communication, if they can help bridge the culture, it's HUGE." Celia^H commented on a case in which she thought that the patient's mother was overly emotional,

[Once I noticed] the mother was so horrified about the child losing hair. [The interpreter] explained to me, in this particular culture, hair is regarded as a wedding veil, and you don't cut your hair. That was very helpful to me to understand that reaction.

Because of the cultural, power, and socioeconomic differences between the providers and the patients with LEP, it is likely that patients may not actively express all of their concerns. Providers also may face challenges in interpreting patients' subtle nonverbal cues, which are often cultural-specific. As a result, an interpreter who not only relays all information but also actively monitors (and intervenes in) the communicative process is essential in protecting patient autonomy. For example, an interpreter may choose to explicitly express the emotional tone (e.g., "I'm very nervous because...") or address the patients' concerns (e.g., "The patient looks puzzled, can I ask the patient if he has any questions?"). As interpreters actively incorporate patients' nonverbal behaviors (that are neglected or misunderstood by the providers) into the communicative process, they empower patients to have a full range of expressions and control over the provider-patient interactions.

It is important to note that some of the interpreters' communicative strategies may appear to facilitate provider-patient commu-

nication to seek or give “accurate” information, but do not necessarily empower patients or enhance other speakers’ communicative competence. For example, Ulysses^I talked about modifying providers’ utterances when they may be considered problematic in his culture (i.e., Muslim). He explained,

[The doctors] ask about sexual contacts outside of the marriage, which is a really really very bad question. It is very offensive. For Muslim ladies in particular.... I said, “Does *your husband* go to other women?”... Even though they might be practicing [adultery], they do not talk. But there is a way to make it soft, just ask another way.

Ulysses^I intervened into the diagnostic process by changing the provider’s actual question (e.g., “Do *you* have other sexual partners?”) to what he considered a more culturally appropriate one. He argued that Muslim women would recognize the doctor’s intention in evaluating sex-related health risk, and would provide accurate answers to their situation (e.g., “Yes, my husband goes to other women”), even if the husband is faithful. Although Ulysses^I was able to avoid a potential provider-patient conflict, his intervention denied the opportunity for the provider to become more culturally sensitive, or for the patient to become familiar with the medical dialogue in the United States.

When interviewing providers, I used the Ulysses^I scenario to solicit their reflection on his strategies. While recognizing the potential cultural differences and conflicts, providers often emphasize their desire to be informed about the cultural differences. Gloria^H explained,

If we don’t understand the cultural aspect, then we need to know: That’s offensive. Well, you can preface it with “I understand that this might be something that would not be asked in your home country. This is why I need to ask this question.”... I absolutely want to know. Because we want the patient to understand, in order to have choices, in order to feel right about it, because it’s what her decision is. We want her to feel good about it.

From this perspective, Gloria^H viewed it as her responsibility to know the cultural differences, as it empowers her to honor patient autonomy. Several providers also voiced concerns about interpreters’ strategies in modifying their narratives without consulting with them first, believing that such strategies infringe on their control over the medical dialogue (see Hsieh, 2010). In addi-

tion, they argued that cultural knowledge is essential in helping them to interact with future patients appropriately and effectively.

Interpreters in Bilingual Health Care

It is important to note that both researchers and practitioners have long recognized interpreters' tremendous power in influencing provider-patient communication and relationships (Hsieh, 2010; Rosenberg, Leanza, & Seller, 2007; Rosenberg et al., 2008). The traditional response, however, is to limit interpreters' control and influence over bilingual health care by restricting their performance in a limited role and minimizing their presence in health-care settings (Leanza, 2008). This attitude also is reflected in the responses of some interpreters in our study, as they equated advocating for patients with infringing on patient autonomy. It is not uncommon for interpreters to explicitly claim a limited role (Bot, 2005; Hsieh, 2009). However, interpreters' beneficent actions (i.e., behaviors to help prevent or remove harms or to simply improve the situation of others) (Pantilat, 2008) should not be viewed as medical paternalism. They may serve as interventions aiming to ensure patient autonomy and communicative competence in bilingual health care.

Examining interpreters' performance and its *long-term* influence on health literacy and patient empowerment is critical in advancing the theoretical development and practice implications for bilingual health communication. Most studies in bilingual health care do not consider prior interactions between participants. This is consistent with the traditional emphasis on the conduit model, in which interpreters are viewed as language machines (Leanza, 2005). If interpreters perform properly, like good machines do, they would transfer information from one language to another neutrally and faithfully. There should be minimal differences from one interpreter to another or from one session to another. After all, a machine either works or does not. One would expect the computer in the library to behave in exactly the same way as the computer at home. There is no history or prior relationship between the user and the computer that may influence their future interactions. In other words, if interpreters were treated simply as a functional tool to facilitate communication, the interpreters' performance and impact are limited to the specific interaction. As a result, the examination of interpreter-mediated interactions traditionally

has been limited to the immediate, turn-by-turn talk. Few studies explore how interpreters' strategies may influence the quality of communication or the interpersonal relationship over time.

However, researchers have argued that the temporal aspect of illness management requires individuals to learn to coordinate with others efficiently and appropriately (Brashers, Goldsmith, & Hsieh, 2002). As participants learn about each other's communicative needs and styles, there may be important changes in their communicative behaviors. For example, a family interpreter may act on behalf of the patient because they also are caregivers and are aware of the patient's concerns (Rosenberg et al., 2008). Professional interpreters have reported that prior relationship with a patient makes the interpreting task less challenging (Hsieh, 2006a). Providers also noted that familiarity with an interpreter's communicative styles allows them to work more efficiently with the interpreter (Fatahi et al., 2008; Hsieh et al., 2010). The history within the provider-patient-interpreter triad influences how they interact with each other.

Interpreting agencies and providers are aware of such possibilities. However, traditionally, their strategies are to limit the interactions between the interpreter and the patient (e.g., avoiding assigning the same interpreter to the patient repeatedly, and prohibiting interpreter-patient interaction in waiting rooms), and to limit interpreters to the conduit role (Hsieh, 2006a; Leanza, 2008). Several recent studies, however, have challenged the usefulness and practicality of such practices (Hsieh, 2010; Hsieh et al., 2010; Leanza et al., 2010). Rather than prescribing a limited role or fixed functions to interpreters, researchers have recommended that health-care institutions and providers recognize the diversity of medical interpreters (Hsieh, 2006b; MacFarlane et al., 2009), be adaptive to the communicative needs and contexts (Hsieh & Hong, 2010; Leanza et al., 2010), and nurture institutional cultures and practices that promote interpreters' involvement in the delivery of care (Schapira et al., 2008).

Medical interpreters also need to be mindful about the complexity of their roles and functions in health-care settings. Their performance in bilingual health care and its corresponding influences entail both immediate and long-term consequences. Interpreters adopt various strategies to meet the multiple, emergent, and often conflicting demands in provider-patient interactions

(Hsieh, 2006a, 2009; White & Laws, 2009). During provider-patient interactions, interpreters need to anticipate providers' and patients' communicative needs and actively address potential issues of social inequality and cultural differences (Hsieh, 2010). For example, when interpreters made a speaker's inexplicit information explicitly expressed in their interpreted text, they drew little attention to the nuances of the potential misunderstanding, while ensuring that the communication continued smoothly. When an interpreter changed an indirect information-seeking statement into a direct information-seeking question, they improved the provider's ability to hear and to respond to the patient's information needs. The success of these strategies, however, relies on the interpreters' ability to anticipate and understand the speakers' communicative goals. If the interpreters misunderstand the speakers' intended meaning, the misinterpreted texts may lead to confusion, if not conflict, or even constitute unethical intervention (Lee, 2009). From this perspective, developing effective communication practices (e.g., meta-communication about the speakers' objectives prior to the medical encounter) to help interpreters anticipate the speakers' intended meaning is critical in ensuring the quality of interpreter-mediated interactions.

On the other hand, interpreters need to recognize that their communicative strategies can influence how patients and providers interact with each other in the future (e.g., their health literacy, cultural sensitivity, and communication competence). When interpreters take the time to provide means of self-efficacy to the patients, the patients are not only empowered to participate in the immediate interaction, but also have the opportunity to extend their new skills and knowledge with other providers in future interactions. In contrast, when interpreters actively change a speaker's utterances without informing the speaker about the changes, they deprive the speaker of the opportunity to develop communicative competence (e.g., to learn about the social norms of the medical discourse and the cultural expectations of the provider or patient role). It is from this perspective that interpreters need to further evaluate the appropriateness of their involvement and intervention in provider-patient interactions. Some strategies may be efficient in the immediate contexts, but do not empower the speakers for future interactions.

Previous studies have suggested that due to the pressure to maintain a neutral performance, interpreters often “hide” their intervention (a) outside of the medical encounter (e.g., coaching patients about their rights or questions to ask when providers are not around) (Hsieh, 2006a), or (b) in the voices of others (e.g., imposing their own agenda while appearing to be interpreting for others) (Leanza et al., 2010; Rosenberg et al., 2008). These strategies allow the interpreters to appear neutral, while manipulating the process and content of provider-patient communication. Although these strategies may be well-intended, they also limit other speakers’ abilities to understand the complexity of bilingual health care, as the interpreters’ manipulation of the communicative process is hidden from others. As indicated by the providers in our study, they are interested in learning more about the cultural expectations and social norms of their patients (Fatahi et al., 2008; Rosenberg et al., 2007). These knowledge and communicative skills will allow them to be better providers in the future.

As interpreters provide their linguistic services, they are also in a position to inform, educate, and empower other speakers for future interactions. It is important for the providers and health-care organizations to recognize this central aspect of interpreters’ functions. Some recent studies have highlighted that health-care providers continue to emphasize interpreters’ conduit role (Fatahi et al., 2008; Leanza, 2005). Such attitudes, however, put pressure on interpreters to (a) avoid intervening in the provider-patient communication even when they perceive problematic interactions (Hsieh, 2006a, 2009), or (b) conceal or disguise their intervention to avoid others’ scrutiny (Keselman, Cederborg, & Linell, 2010; Leanza et al., 2010). As researchers highlighted that successful interpreter-mediated interaction requires providers, patients, and interpreters to coordinate and negotiate their communicative goals (Hsieh, 2010; Leanza et al., 2010), it is important to incorporate these aspects of interpreters’ functions into the communicative practices and organizational cultures in health-care 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 on providers’ time) will allow both providers and patients to have better communicative competence in future interactions.

While research on health disparities traditionally has focused on system-level factors, interpreters are in a unique position to reduce health disparities at both the system and interpersonal levels. Although at a system level, starting from the late 1970s, there have been federal and state legislative efforts to require clinicians to provide interpreters for the populations with LEP in the United States (Youdelman, 2008), recent studies have found that providers still underuse interpreters (Ginde, Sullivan, Corel, Caceres, & Camargo, 2010; Schenker, Pérez-Stable, Nickleach, & Karliner, 2011). In addition, few providers receive training on working with interpreters (Flores et al., 2008) despite significant differences in the communicative practices between providers, interpreters, and patients (Hsieh, 2010). To address the problematic utilization of medical interpreters, researchers have recommended (a) incorporating bilingual health communication and cultural sensitivity training for providers (Tribe & Lane, 2009; Wu, Leventhal, Ortiz, Gonzalez, & Forsyth, 2006); (b) taking advantage of the cultural diversity within the health-care team (e.g., bilingual nurses) while providing clear boundaries of role responsibilities and expectations (Moreno, Otero-Sabogal, & Newman, 2007; Wros, 2009); and (c) developing organizational cultures and practices that encourage equality between members of the health-care team, rather than allowing physicians to have unchallenged authority (Hsieh, 2010; Tribe & Lane, 2009).

When interpreters are reconceptualized as having an active role, providers and interpreters are empowered to address health disparities at an interpersonal level. A recent study indicated that on-site interpreters allow other speakers to effectively address cultural nuances in ways that other types of interpreters (e.g., video-conference and telephone interpreters) do not (Nápoles et al., 2010), which highlights the interpersonal aspects of bilingual health care. Interpreters can serve as an important resource to educate providers about relevant cultural and linguistic issues (Wu et al., 2006), and to address potential discrimination and social inequality (Messias et al., 2009). As interpreters contemplate the variety of strategies available in managing the effectiveness and appropriateness of provider-patient interactions, they also should consider the long-term impact of those strategies. For example, as interpreters educate providers about cultural differences, the providers also develop the needed skills for future inter-

actions. By anticipating patients' communicative needs, they provide the necessary conditions (e.g., health literacy) that enable patients to make autonomous decisions. As researchers highlight the importance of integrating research in health literacy and health disparities (Baur, 2010; Paasche-Orlow & Wolf, 2010), bilingual health communication represents an important field of study. While requiring providers to provide interpreters can be viewed as a legislative intervention to address health disparities at the system and/or organizational level (Bonet, 2009; Hsieh, 2012), interpreters can have a much more profound effect in improving the quality of care. Interpreters' interventions not only facilitate the immediate provider-patient interactions, but also can have long-lasting impacts on providers' and patients' communicative competence, empowering them to address and negotiate their communicative needs and therapeutic objectives in future interactions (with or without the interpreters). It is from this perspective that interpreters are particularly valuable in improving health disparities faced by populations with LEP.

Acknowledgments

This study was partially supported by Grant #1R03MH76205-01-A1, funded by the National Institutes of Health/National Institute of Mental Health. Part of the data has been published in previous studies that examined the roles of medical interpreters.

Bibliography

- Andrulis, D., Goodman, N., & Pryor, C. (2002). What a difference an interpreter can make: Health care experiences of uninsured with limited English proficiency. Retrieved from http://www.accessproject.org/downloads/c_LEP_reportENG.pdf.
- Back, M. F., & Huak, C. Y. (2005). Family centred decision making and non-disclosure of diagnosis in a South East Asian oncology practice. *Psycho-Oncology*, *14*(12), 1052-1059.
- Baur, C. (2010). New directions in research on public health and health literacy. *Journal of Health Communication*, *15*(2), 42-50.
- Blackhall, L. J., Murphy, S. T., Frank, G., Michel, V., & Azen, S. (1995). Ethnicity and attitudes toward patient autonomy. *Journal of the American Medical Association*, *274*(10), 820-825.
- Bonet, J. E. (2009). Full circle: The qualified medical interpreter in the culturally competent healthcare system. In S. Kosoko-Lasaki, C. T. Cook, & R. L. O'Brien (Ed.), *Cultural proficiency in addressing health disparities* (pp. 103-115). Boston, MA: Jones and Bartlett.

- Bot, H. (2005). *Dialogue interpreting in mental health*. New York, NY: Rodopi.
- Brashers, D. E., Goldsmith, D. J., & Hsieh, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research, 28*(2), 258–271.
- Cegala, D. J. (1997). A study of doctors' and patients' communication during a primary care consultation: Implications for communication training. *Journal of Health Communication, 2*(3), 169–194.
- Cegala, D. J., & Post, D. M. (2009). The impact of patients' participation on physicians' patient-centered communication. *Patient Education and Counseling, 77*(2), 202–208.
- Cegala, D. J., Post, D. M., & McClure, L. (2001). The effects of patient communication skills training on the discourse of older patients during a primary care interview. *Journal of the American Geriatrics Society, 49*(11), 1505–1511.
- Cegala, D. J., Street, R. L., Jr., & Clinch, C. R. (2007). The impact of patient participation on physicians' information provision during a primary care medical interview. *Health Communication, 21*(2), 177–185.
- Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics, 4*(3), 379–405.
- Dohan, D., & Levintova, M. (2007). Barriers beyond words: Cancer, culture, and translation in a community of Russian speakers. *Journal of General Internal Medicine, 22*(2), S300–S305.
- Doty, M. M. (2003, February 1). Hispanic patients' double burden: Lack of health insurance and limited English. The Commonwealth Fund. Retrieved from <http://www.commonwealthfund.org/Publications/Fund-Reports/2003/Feb/Hispanic-Patients-Double-Burden--Lack-of-Health-Insurance-and-Limited-English.aspx>.
- Dysart-Gale, D. (2005). Communication models, professionalization, and the work of medical interpreters. *Health Communication, 17*(1), 91–103.
- Elderkin-Thompson, V., Silver, R. C., & Waitzkin, H. (2001). When nurses double as interpreters: A study of Spanish-speaking patients in a US primary care setting. *Social Science & Medicine, 52*(9), 1343–1358.
- Fatahi, N., Hellstrom, M., Skott, C., & Mattsson, B. (2008). General practitioners' views on consultations with interpreters: A triad situation with complex issues. *Scandinavian Journal of Primary Health Care, 26*(1), 40–45.
- Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research & Review, 62*(3), 255–299.
- Flores, G., Torres, S., Holmes, L. J., Salas-Lopez, D., Youdelman, M. K., & Tomany-Korman, S. C. (2008). Access to hospital interpreter services for limited English proficient patients in New Jersey: A statewide evaluation. *Journal of Health Care for the Poor and Underserved, 19*(2), 391–415.
- Gazmararian, J. A., Curran, J. W., Parker, R. M., Bernhardt, J. M., & DeBuono, B. A. (2005). Public health literacy in America: An ethical imperative. *American Journal of Preventive Medicine, 28*(3), 317–322.
- Ginde, A. A., Sullivan, A. F., Corel, B., Caceres, J. A., & Camargo, C. A., Jr. (2010). Reevaluation of the effect of mandatory interpreter legislation on use of professional interpreters for ED patients with language barriers. *Patient Education and Counseling, 81*(2), 204–206.

- Grice, H. P. (1975). Logic and conversation. In P. Cole & J. L. Morgan (Eds.), *Syntax and semantics: Speech acts* (Vol. 3, pp. 41–58). Cambridge, MA: Harvard University Press.
- Hampers, L. C., Cha, S., Gutglass, D. J., Binns, H. J., & Krug, S. E. (1999). Language barriers and resource utilization in a pediatric emergency department. *Pediatrics*, *103*(6), 1253–1256.
- Hicks, L. S., Tovar, D. A., Orav, E., & Johnson, P. A. (2008). Experiences with hospital care: Perspectives of Black and Hispanic patients. *Journal of General Internal Medicine*, *23*(8), 1234–1240.
- Hsieh, E. (2006a). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science & Medicine*, *62*(3), 721–730.
- Hsieh, E. (2006b). Understanding medical interpreters: Reconceptualizing bilingual health communication. *Health Communication*, *20*(2), 177–186.
- Hsieh, E. (2007). Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science & Medicine*, *64*(4), 924–937.
- Hsieh, E. (2008). ‘I am not a robot!’ Interpreters’ views of their roles in health care settings. *Qualitative Health Research*, *18*(10), 1367–1383.
- Hsieh, E. (2009). Moving beyond a conduit model: Medical interpreters as mediators. In D. E. Brashers & D. J. Goldsmith (Eds.), *Communicating to manage health and illness* (pp. 121–146). New York, NY: Routledge.
- Hsieh, E. (2010). Provider-interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions. *Patient Education and Counseling*, *78*(2), 154–159.
- Hsieh, E. (2012). Interpreter services. In S. Loue & M. Sajatovic (Eds.), *Encyclopedia of immigrant health* (pp. 936–941). New York, NY: Springer.
- Hsieh, E., & Hong, S. J. (2010). Not all are desired: Providers’ views on interpreters’ emotional support to patients. *Patient Education and Counseling*, *81*(2), 192–197.
- Hsieh, E., Ju, H., & Kong, H. (2010). Dimensions of trust: The tensions and challenges in provider-interpreter trust. *Qualitative Health Research*, *20*(2), 170–181.
- Kapp, M. B. (2007). Patient autonomy in the age of consumer-driven health care: Informed consent and informed choice. *Journal of Legal Medicine*, *28*(1), 91–117.
- Karliner, L. S., Jacobs, E. A., Chen, A. H., & Mutha, S. (2007). Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. *Health Services Research*, *42*(2), 727–754.
- Kaufert, J. M., & Putsch, R. W. (1997). Communication through interpreters in healthcare: Ethical dilemmas arising from differences in class, culture, language, and power. *The Journal of Clinical Ethics*, *8*(1), 71–87.
- Keselman, O., Cederborg, A-C., & Linell, P. (2010). ‘That is not necessary for you to know!’ Negotiation of participation status of unaccompanied children in interpreter-mediated asylum hearings. *Interpreting*, *12*(1), 83–104.
- Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. *Interpreting*, *7*(2), 167–192.

- Leanza, Y. (2008). Community interpreter's power: The hazards of a disturbing attribute. *Journal of Medical Anthropology*, 31(2-3), 211-220.
- Leanza, Y., Boivin, I., & Rosenberg, E. (2010). Interruptions and resistance: A comparison of medical consultations with family and trained interpreters. *Social Science & Medicine*, 70(12), 1888-1895.
- Lee, J. (2009). Interpreting inexplicit language during courtroom examination. *Applied Linguistics*, 30(1), 93-114.
- Leyva, M., Sharif, I., & Ozuah, P. O. (2005). Health literacy among Spanish-speaking Latino parents with limited English proficiency. *Ambulatory Pediatrics*, 5(1), 56-59.
- MacFarlane, A., Dzebisova, Z., Karapish, D., Kovacevic, B., Ogbobor, F., & Okonkwo, E. (2009). Arranging and negotiating the use of informal interpreters in general practice consultations: Experiences of refugees and asylum seekers in the west of Ireland. *Social Science & Medicine*, 69(2), 210-214.
- Messias, D. K. H., McDowell, L., & Estrada, R. D. (2009). Language interpreting as social justice work: Perspectives of formal and informal healthcare interpreters. *Advances in Nursing Science*, 32(2), 128-143.
- Moreno, M. R., Otero-Sabogal, R., & Newman, J. (2007). Assessing dual-role staff-interpreter linguistic competency in an integrated healthcare system. *Journal of General Internal Medicine*, 22(2), S331-S335.
- Nápoles, A. M., Santoyo-Olsson, J., Karliner, L. S., O'Brien, H., Gregorich, S. E., & Pérez-Stable, E. J. (2010). Clinician ratings of interpreter mediated visits in underserved primary care settings with ad hoc, in-person professional, and video conferencing modes. *Journal of Health Care for the Poor and Underserved*, 21(1), 301-317.
- Ngo-Metzger, Q., Sorkin, D. H., & Phillips, R. S. (2009). Healthcare experiences of limited English-proficient Asian American patients: A cross-sectional mail survey. *The Patient: Patient-Centered Outcomes Research*, 2(2), 113-120.
- Paasche-Orlow, M. K., & Wolf, M. S. (2010). Promoting health literacy research to reduce health disparities. *Journal of Health Communication*, 15(2), 34-41.
- Pantilat, S. (2008). Ethics fast fact: Autonomy vs. beneficence. Retrieved from http://missinglink.ucsf.edu/lm/ethics/Content%20Pages/fast_fact_auton_bene.htm.
- Rivadeneyra, R., Elderkin-Thompson, V., Silver, R. C., & Waitzkin, H. (2000). Patient centeredness in medical encounters requiring an interpreter. *American Journal of Medicine*, 108(6), 470-474.
- Roat, C. E., Putsch, R. W., III, & Lucero, C. (1997). *Bridging the gap over the phone: A basic training for telephone interpreters serving medical settings*. Seattle, WA: Cross Cultural Health Care Program.
- Rosenberg, E., Leanza, Y., & Seller, R. (2007). Doctor-patient communication in primary care with an interpreter: Physician perceptions of professional and family interpreters. *Patient Education and Counseling*, 67(3), 286-292.
- Rosenberg, E., Seller, R., & Leanza, Y. (2008). Through interpreters' eyes: Comparing roles of professional and family interpreters. *Patient Education and Counseling*, 70(1), 87-93.
- Rothman, D. J. (2001). The origins and consequences of patient autonomy: A 25-year retrospective. *Health Care Analysis*, 9(3), 255-264.

- Sarver, J., & Baker, D. W. (2000). Effect of language barriers on follow-up appointments after an emergency department visit. *Journal of General Internal Medicine, 15*(4), 256–264.
- Schapira, L., Vargas, E., Hidalgo, R., Brier, M., Sanchez, L., Hobrecker, K., ... Chabner, B. (2008). Lost in translation: Integrating medical interpreters into the multidisciplinary team. *Oncologist, 13*(5), 586–592.
- Schenker, Y., Pérez-Stable, E., Nickleach, D., & Karliner, L. (2011). Patterns of interpreter use for hospitalized patients with limited English proficiency. *Journal of General Internal Medicine, 26*(7), 712–717.
- Shin, H. B. (2003). Language use and English-speaking ability: 2000. Retrieved from <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>.
- Shin, H. B., & Kominski, R. A. (2010). Language use in the United States. Retrieved from <http://www.census.gov/prod/2010pubs/acs-12.pdf>.
- Thornton, J. D., Pham, K., Engelberg, R. A., Jackson, J. C., & Curtis, J. R. (2009). Families with limited English proficiency receive less information and support in interpreted intensive care unit family conferences. *Critical Care Medicine, 37*(1), 89–95.
- Tocher, T. M., & Larson, E. B. (1996). Interpreter use and the impact of the process and outcome of care in type II diabetes. *Journal of General Internal Medicine, 11*(1), 150.
- Tocher, T. M., & Larson, E. B. (1999). Do physicians spend more time with non-English-speaking patients? *Journal of General Internal Medicine, 14*(5), 303–309.
- Tribe, R., & Lane, P. (2009). Working with interpreters across language and culture in mental health. *Journal of Mental Health, 18*(3), 233–241.
- White, K., & Laws, M. (2009). Role exchange in medical interpretation. *Journal of Immigrant and Minority Health, 11*(6), 482–493.
- Woloshin, S., Schwartz, L. M., Katz, S. J., & Welch, H. G. (1997). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine, 12*(8), 472–477.
- Wros, P. (2009). Giving voice: Incorporating the wisdom of Hispanic RNs into practice. *Journal of Cultural Diversity, 16*(4), 151–157.
- Wu, A. C., Leventhal, J. M., Ortiz, J., Gonzalez, E. E., & Forsyth, B. (2006). The interpreter as cultural educator of residents: Improving communication for Latino parents. *Archives of Pediatrics & Adolescent Medicine, 160*(11), 1145–1150.
- Youdelman, M. K. (2008). The medical tongue: U.S. laws and policies on language access. *Health Affairs, 27*(2), 424–433.