Smith, R. C., Gardiner, J. C., Lyles, J. S., Sirbu, C., Dwamena, F. C., Hodges, A., et al. (2005). Exploration of the DSM-IV criteria in primary care patients with medically unexplained symptoms. *Psychosomatic Medicine, 67,* 123–129.

Waitzkin, H. (1991). *The politics of medical encounters: How patients and doctors deal with social problems.* New Haven, CT: Yale University Press.

Waitzkin, H., & Britt, T. (1989). Changing the structure of medical discourse: Implications of cross-national comparisons. *Journal of Health and Social Behavior, 30,* 436–449.

Waitzkin, H., Britt, T., & Williams, C. (1994). Narratives of aging and social problems in medical encounters with older persons. *Journal of Health and Social Behavior, 35,* 322–348.

Waitzkin, H., Iriart, C., Buchanan, H. S., Mercado, F., Tregar, J., & Eldredge, J. (2008). The Latin American Social Medicine Database: A resource for epidemiology. *International Journal of Epidemiology, 37,* 724–728.

Waitzkin, H., & Magana, H. (1997). The black box in somatization: Narrative, culture, and unexplained physical symptoms. *Social Science & Medicine, 45,* 811–825.

Whitley, R., Kirmayer, L. J., & Groleau, D. (2006). Public pressure, private protest: Illness narratives of West Indian immigrants in Montreal with medically unexplained symptoms. *Anthropology & Medicine, 13,* 193–205.

Willging, C. E., Waitzkin, H., & Nicdao, E. (2008). Medicaid managed care for mental health services: The survival of safety net institutions in rural settings. *Qualitative Health Research, 18,* 1231–1246.

Chapter 6

Bilingual Health Communication

Medical Interpreters' Construction of a Mediator Role

Elaine Hsieh

Patients with limited-English-proficiency (LEP) often experience inequality in health services and poor health outcomes. Researchers have noted that when language barriers exist in provider-patient communication (i.e., when compared to English-speaking patients), a patient is likely to receive more diagnostic testing (Hampers, Cha, Gutglass, Binns, & Krug, 1999; Waxman & Levitt, 2000); 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; Gerrish, 2001); and is less satisfied with the quality of care (David & Rhee, 1998). Their findings suggest the urgent need to develop effective interventions to improve the quality of health care services received by patients with LEP, one of which is to provide interpreters in health care settings (Allen, 2000; Jones & Gill, 1998).

Interpreters often are viewed as the standard solution to language barriers between physicians and patients (Department of Health and Human Services, 2001; Flores, 2005; Flores et al., 2002; Woloshin et al., 1997). Interpreters traditionally have been conceptualized as conduits, invisible non-thinking language modems that allow providers and patients who do not share a common language to communicate with each other. *Interpreters-as-conduits* remains the prevalent ideology of translation models and training programs in many different areas. For example, the Cross-Cultural Health Care Program (1999), one of the leading programs in medical interpreter training, views the conduit role as the default role for interpreters. In an analysis of code of ethics documents from more than 20 institutions, Kaufert and Putsch (1997) concluded that many of the codes emphasize a mode of interpretation that calls for an objective and neutral role for medical interpreters. The National Standards of Practice for Interpreters in Health Care recognizes the various responsibilities of interpreters (e.g., advocacy and cultural awareness) but still emphasizes the importance of accuracy and impartiality in interpreters' practice (National Council on Interpreting in Health Care [NCIHC], 2005). Recently, NCIHC has proposed a national code of ethics for interpreters (for a complete discussion on the code of ethics, see NCIHC, 2004), which are based on three core

values: beneficence, fidelity, and respect for the importance of culture and cultural differences. In regards to fidelity, NCIHC (2004, p. 13) noted,

> The ethical responsibility of the interpreter, therefore, is to convert messages rendered in one language into another without losing the essence of the meaning that is being conveyed and including all aspects of the message without making judgments as to what is relevant, important, or acceptable. [...] The principle of fidelity requires that interpreters have the ability to detach themselves from the content of information.

The conduit model has been a prominent feature of the transmission models of communication, viewing communication as the transfer of information from a sender to a receiver (for a discussion of Shannon & Weaver's [1963/1949] conduit and noise models, see Dysart-Gale, 2005). The model adopts a monological and linear view of communication, assuming that meanings are created by the speakers (as opposed to co-created by all participants, including the interpreter, involved in the conversation; e.g., Bakhtin, 1981). The model also presupposes linear communication, in which the interactions between the speakers are only possible via the accurate, faithful, and neutral relay of the interpreter.

There are several reasons that a conduit model remains popular. First, interpreters traditionally have been expected to claim an invisible role (i.e., minimizing their presence and influence in the communicative process) so that they can claim authority and credibility for their services (Hsieh, 2002). A conduit model allows interpreters to deny any personal interference with their work. Second, a conduit model appears to be a straightforward way of interpretation and requires minimal training (i.e., an interpreter just needs to relay everything and not make any judgment). When talking about the complexity of interpreters' functions and roles in health care settings, Sara, a participant in our study who is also a practicing interpreter and trainer for medical interpreters, explained that the industry-standard 40-hour training is insufficient to educate the interpreters to be proficient in the variety of roles; however, she concluded, "You had better say, 'Everybody has to be robot.' That way, you don't have to deal with all the other issues. [...] It's easier." Finally, a conduit model suggests that the speakers are the only persons who have control over the process and content of communication. In other words, the speakers (e.g., provider and patient) can confidently assume that the interpreter says *exactly* what they said and that they still have full control over the information exchanged

The ideology of interpreters-as-conduits has been challenged in the past few years. Language and social interaction researchers have argued that human communication exchanges are always dialogical and the meanings and contents of communication are co-constructed by *all* participants of the communicative activity (Georgakopoulou, 2002; Miller, Hengst, Alexander, &

Sperry, 2000). Through both qualitative and quantitative analyses, researchers recently have argued that interpreters are not neutral or impartial participants in medical encounters but actively participate the communicative process (Angelelli, 2002, 2004; Davidson, 2000, 2001; Hale, 1999; Hale & Gibbons, 1999; Metzger, 1999; Rosenberg, 2001). Angelelli (2002, 2004) concluded that interpreters perceive their role as visible regardless of their work settings (e.g., conferences, courts, or hospitals), which also is evident in their role performances in the communicative process (i.e., actively intervening in the interpreter-mediated interactions). Interpreters often need to reconcile between the ideology and the practice of medical interpreting (Hsieh, 2001, 2006a, 2006b). In fact, interpreters may assume a variety of roles (e.g., conduit, co-diagnostician, institutional gatekeeper, patient advocate, and professional) to manage the complexity of bilingual provider-patient interactions (Hsieh, 2004a, 2006a, 2007). These studies successfully challenged the idea of interpreter neutrality and inspired researchers to develop more complex theories of interpreter-mediated activities.

These studies, however, suggest a missing link in researchers' efforts to deconstruct interpreters' claim of neutrality (i.e., a conduit role): If the conduit model remains the dominant ideology in the training programs and code of ethics for medical interpreters (Dysart-Gale, 2005), how do interpreters legitimize their practice? Do they still claim a conduit role? If yes, why and how do they enact the role?

To answer this question, I undertook a study to examine the roles of medical interpreters. Results reported here are part of a larger study, which included ethnographic shadowing of Mandarin Chinese interpreters' daily assignments (i.e., participant observation) and in-depth interviews with interpreters from various cultures. I recruited medical interpreters from two interpreting agencies in the midwestern area in the United States. Both agencies view medical interpreting as their primary task and have contractual relationships with local hospitals. A total of 26 participants from 17 languages (i.e., Arabic, Armenian, Assyrian, Mandarin Chinese, Cantonese, French, German, Hindi, Kurdish, Polish, Russian, Spanish, Turkish, Ukrainian, Urdu, Vietnamese, and Yoruba), of whom 21 were practicing medical interpreters and 5 held management positions in interpreting offices. Interpreters included in this study are all considered *professional* interpreters and work as freelance interpreters in local hospitals. The majority of interpreters ($n = 17$) had participated in a 40-hour training course developed by the Cross Cultural Health Care Program (CCHCP), which has been viewed as an industry-recognized standard for training professional interpreters. Those who had not attended the course either had passed certification programs offered by individual hospitals or had acted as trainers in education programs for medical interpreters.

I shadowed two Mandarin Chinese interpreters for the ethnographic study, following their daily routines, audio-recording the interpreter-mediated medical encounters, and taking fieldnotes to include nonverbal and contextual

information. Three months after the beginning of the ethnographic study, I conducted 14 individual and 6 dyadic interviews (each lasted 1 to 1½ hours). All dyadic interviews consisted of two interpreters from different languages (except one that included two Spanish interpreters). In these interviews, I relied on my experience as a medical interpreter and my prior data collected through the participant observation to navigate through the design, preparation, and interview process. Two research assistants and I used grounded theory for the data analysis for both the ethnographic and interview data (Strauss & Corbin, 1998). The focus of the research questions was to explore interpreters' understanding of their roles and to generate rich and diverse views, opinions, and experiences from participants of various cultures. The transcription includes two primary types of notation. The texts are CAPITALIZED when they were the speakers' emphasis and *italicized* when they were my emphasis. Each interpreter is assigned a pseudonym. In the transcript, health care providers are denoted as H, interpreters as I, and patients as P. I also have assigned pseudonyms for all participants so that readers have a better understanding of the interactions and relationships between providers, interpreters, and patients. A total of 11 health care providers, four patients, one patients' family member, and two mandarin Chinese interpreters were included in the participant observation data. All providers' pseudonyms begin with H (e.g., Helen and Henry) and the four patients' pseudonyms begin with P (e.g., Pam and Paula), and the Chinese interpreters are Christie and Claire.

The Construction of an Invisible Role

Conduit was, by far, the role that is identified most explicitly and frequently by the interpreters in this study (i.e., 21 of 26 participants claimed various forms of a conduit role). By examining interpreters' narratives and the metaphors with which they explicitly identified, I will demonstrate that interpreters' conceptualization of the conduit role extends beyond an information or linguistic transferring role. Contrary to an earlier study (Angelelli, 2002), which concluded that interpreters perceived their role as visible across various settings, the interpreters of this study strived to be invisible (i.e., to minimize their presence) in provider-patient interactions. For example, Selena, an interpreter with 32-years experience, stated, "I am sort of in the background, I am the voice, I try to be faceless. That way, I don't interfere with their communication or their rapport between the patient and the provider." Colin described his role, "I try not to exist in a sense. I just sort of let the patient and the provider talk, and I just interpret." Sara explained, "The goal [of medical interpreting] would be to perform such a job that it seems that you were never there."

Interpreters who identify with a conduit role often claimed that all that they do is "just interpret everything" and they are "just interpreters." The constant use of "just" in their narratives reflect their effort to claim a limited role (i.e., they are nothing more than a conduit). Claire explained,

Because when I went through the training, we have to interpret everything exactly as what the doctor said, even have to interpret exactly the same tone, and same expression, and the same use of words. So, I just did the same. I would always try to follow what I learned in the class. So, I did the same thing. I just interpreted in Chinese, just equivalent what he said in English.

The pursuit for neutrality challenges interpreters to justify their performances. Their physical presence in the medical encounters and their functions in eliminating language and cultural barriers between providers and patients make it difficult for interpreters to claim that they are truly faceless or nonexistent. Some interpreters claim a *non-thinking* status to justify their interpreting strategy. In other words, if their performances do not require them to think in the communicative process, they cannot interfere with the process or the content of provider-patient communication. Peter explained, "No matter what my judgment or my opinion, or my feelings [are], in a health care provider setting, I interpreted everything." Roger shared a similar attitude, "You cannot adjust [information] the way you like it or how you think. *You are here to work, not to think.* Remember."

Metaphors for the Conduit Role

In addition to the claims about a non-thinking role, interpreters developed many metaphors that are indicative of a conduit role. For example, interpreters often claimed that they are just the *voice*. The voice metaphor often is associated with the interpreters' desire to establish direct communication between the providers and the patients. Scott explained, "We are like the voice, we are not a person. [...] We become the voice of the professional, but we also become the voice of the patient. We are not a person in terms of being addressed to us directly." Interpreters in this study talked about how they actively incorporate this concept in their practice. For example, Silvia said, "I am only the voice and I keep reminding the doctor and the patient to talk to each other." Sophia said that at the beginning of a medical encounter, she would explain to her clients, "I am just a voice of you. Whatever you said is what I am going to say without adding or removing or anything. I'd rather if you talk directly to [each other]."

Robot (or machine) is another metaphor that interpreters used to describe their roles. The mechanical nature (i.e., non-thinking, non-feeling, and yet highly-skilled characteristics) of a robot corresponds to the values of a conduit model. A few interpreters talked about their roles as robots or machines. For example, Steve explained, "I mean I'd rather be considered more like a machine. They know that I am there, and then, I am doing my job, but I'd rather not be there as another person controlling the situation at all." Sara even argued, "If you want to keep your job, you want to become, really, a kind

of robot in order to keep your job." A mechanical view of interpreting is valued because human beings make mistakes and machines are thought to be more reliable, performing with great consistency. Shirley, a manager of interpreter services, recognized the human nature of interpreters, which may become unreliable as pressure mounts:

> We are human, and we have feelings, it's just like everybody else. However, in that moment, you are the person that the staff is depending on to provide that communication, to convey the same spirit that it is being given. So, the last thing that the team needs is for that *instrument to crumble.*

Alternatively, interpreters used the robot metaphor to describe their struggles to adhere to a conduit role. A robot metaphor often was used to contrast interpreters' emotional reaction in medical encounters. As a result, robot becomes a metaphor that is situated against interpreters' awareness of the challenge (i.e., their human nature) to live up to a conduit role (also see Hsieh, 2006a). Although a robot metaphor often highlights the interpreters' sense of conflict, it, nevertheless, reflects interpreters' understanding of the expected roles that others have placed on them. Rachel talked about such internal conflicts:

> We learned that we don't have to talk to patients. We learned that. We are not allowed, right? I don't like that. I can tell you, 'It's not right.' We are not robots. We have training; I know why we are here. But I say that because it's not true, I am not a robot.

Bridge is another metaphor that often is adopted by interpreters to describe their functions. A bridge, in a sense, is much like a conduit, providing a neutral channel for communication without adding personal interpretation or opinions. Steve explained, "I would just say that I'm there to provide some of the language bridge, to be a conduit." Rachel echoed, "My role is just to be a bridge, a bridge between the doctor and the patient." Although the bridge metaphor seems to be similar to a conduit in the sense that it provides a neutral channel for successful communication, interpreters' comment often reflected their awareness of the educational, socioeconomic, and cultural gaps between providers and patients. Rachel explained,

> [The goal of medical interpreting is] to help other people to bridge the gap, that's pretty much the theme of all the [training] classes. To help other people from our own country who do not speak English, who don't know the system and who don't know the culture, just to help them, guide them along, and help them as much as you can, to get through it.

Interpreters talk about how they adjust speakers' register, interject their own explanations, describe terms that have no linguistic equivalent, check for

understanding when necessary, or provide a necessary cultural framework for understanding. It is important to note that although these behaviors do not belong to the conduit role proposed by Cross Cultural Health Care Program (CCHCP, 1999), a major training program for medical interpreters in the United States, interpreters talked about these behaviors *without seeming to be aware that these behaviors require them to become an active participant in the communication*, evaluating the communicative process and interfering as necessary, which in fact makes them more than a conduit. In other words, although interpreters use bridge as a metaphor to describe the conduit role, the metaphor actually encompasses communicative behaviors that do not belong to a conduit role.

It is important to note that the interpreters who used a bridge metaphor still saw themselves as conduits. They also talked about their non-thinking status and neutrality. For example, after identifying his role as a bridge, Peter explained his interpreting strategy, "No matter how I feel, what is my private opinion, I interpreted everything that was said in the room." Colin talked about how interpreters are bridges between two languages, providing cultural frameworks to other conversational partners; however, when one of his patients was asked to leave the clinic because of the lack of funds, Colin decided to not get involved because "It's not my battle. Being an interpreter, that's not our battle." In other words, although interpreters were aware of their functions in bridging the gaps between the provider and the patient in various aspects (e.g., linguistic, cultural, educational, and socioeconomic aspects), they still strived to be and saw themselves as conduits. Nevertheless, the interpreters' use of the bridge metaphor highlighted the fact that their understanding of the "conduit" role has extended beyond the conduit model envisioned in their training programs and the ideology of translation and interpretation.

The Communicative Goals of an Invisible Role

Conduit roles require interpreters to refrain from evaluating the process and the content of communication and interpret all information during the medical encounter. Interpreters talk about conduit roles as a way to accomplish two major communicative goals: (a) transferring complete information, and (b) reinforcing the provider-patient relationship.

Transferring Complete Information

The first goal is consistent with the ideology of conduit as it focuses on the neutral and faithful transfer of information. In Extract 001, the interpreter (Claire) performed a straightforward conduit role, helping the provider (Hillary) to investigate the patient's (Paul) treatment history for his diabetes.

Extract 001

> H: Does he see a diabetic doctor here?
> I: 那你在這裡有沒有見過糖尿的醫生？
> (Have you seen a diabetic doctor here?)
> P: 沒有
> (No)
> → I: No
> P: 以前沒有，是才發現的
> (I didn't before. I just discovered it.)
> → I: I just discovered it. Before, I didn't see a diabetes doctor.
> H: But now he does?
> I: 你現在看過醫生嗎？關於糖尿病的醫生？
> (Now you've seen a doctor? A diabetic doctor?)
> P: 沒有
> (No)
> → I: No
> H: Okay. Who gave you the medication for the diabetes?
> → I: 那你糖尿病的藥是誰給你的？
> (who gave you the medication for the diabetes?)
> P: 是醫生開的
> (A doctor gave me).
> → I: It's from a doctor.

In this interaction, the interpreter followed the speakers' utterances very closely in the highlighted interpretation. A conduit role requires interpreters to interpret not only the verbal messages but also the nonverbal messages. For example, if a speaker demonstrates specific emotions or attitudes, interpreters are expected to re-enact those nonverbal messages. Claire also talked about an incident in which she thought the patient was mistreated and she explained her choice of strategies:

> [The provider was] kind of rude and disrespectful. I just personally think that he is not respectful. [...] So, what can I do? I just interpret exactly in the same tone, in the same expression. *Because when I went through the training, we have to interpret everything exactly as what the doctor said, even have to interpret exactly the same tone, and same expression, and the same use of words.*

In other words, when assuming a conduit role, interpreters transfer *all* information indiscriminately. The interpreter not only includes all verbal information but also emulates *nonverbal information* (e.g., tone of voice and emotion). In Extract 002, during a prenatal examination, the interpreter (Claire) provided verbal interpretation of the provider's (Heather) and the patient's (Pam) nonverbal behaviors:

Extract 002

> P: 就我的牙齦出血。
> (I have bleeding in my gum.)
> I: I have bleeding in my teeth gum.
> → H: Only in her gum but not from below? [pointing at her crotch]
> → I: 下面有沒有流血？陰部有沒有流血？
> (Any bleeding from below? Bleeding from the vagina?)
> → P: [shakes her head]
> → I: Only in the teeth gum. But no vagina bleeding.

Claire explicitly interpreted Heather's nonverbal gesture (line 204), which as used to clarify the meaning of the word "below," as *vagina.* Claire also interpreted Pam's nonverbal gesture (i.e., headshakes, meaning "no") by providing a confirmation to the provider's statement (i.e., "Only in the teeth gum") and an answer to the provider's question (i.e., "But no vagina bleeding"). By replacing nonverbal gestures with verbal messages, Claire ensured the information was relayed with minimal ambiguity. In Extract 003, the ultrasound technician's (Helen) turned the computer screen toward the Patient (Paula) so that she can see the fetus:

Extract 003

> H: Baby's heart. [pointing at the screen]
> → I: 小孩子心臟的位置，她手指的位置。
> (The position of the baby's heart. Where she's pointing)
> [H' clicks the machine a couple of times]
> H: Baby's waist line. [creating a circle on the computer screen]
> → I: 小孩子的腰圍。他的腰，她現在用白色曲線慢慢圈出來是小孩子的腰圍
> (The baby's waist line. His waist. She is using the white line to circle it, that's the baby's waistline.)

During this medical encounter, the interpreter (Christie) and Helen were at the different sides of the patient's bed and it was inconvenient for Christie to physically point at the computer screen at Helen's side. However, Christie still tried to transfer complete information. Christie verbalized Helen's nonverbal gesture. In addition, Christie verbalized the information that was provided on the computer screen but not verbalized or gestured by Helen. In Extracts 002 and 003, although the interpreters tried to convey "complete" information, their choice of the communicative channels (i.e., nonverbal vs. verbal) was not the same as the speaker's choice. There were also situations that the interpreter chose the same communicative channel as the speaker. For example,

Extract 004 took place when the patient (Paula) brought her newborn back to the hospital for the first time after the delivery:

Extract 004

> H: Can you say congratulations in China- Chinese. A BEAUTIFUL BABY, SHE MUST BE VERY HAPPY, VERY PROUD, EVERYBODY IN THE BLOCK MUST BE JEALOUS OF HER!! [in a dramatic tone and loud volume]
>
> I: 他說喔，恭喜你有這麼漂亮的小孩子，你們街頭上面的人一定都會對你很羨慕的！！
> (He said, CONGRATULATION FOR SUCH A BEAUTIFUL BABY. People in your neighborhood must be very jealous of you!![in a dramatic tone and loud volume].)
>
> P: Thank you!

Some readers may notice that the literal message of interpreter's (Christie) interpretation is somewhat different from what the provider (Hank) said. Nevertheless, the communicative goal of the provider was to create a congratulatory message with a dramatic flair, which was successfully emulated by the interpreter.

Finally, the complete transfer of information may also include *information that is not directed or relevant to the other speaker* (e.g., conversations between providers). Although a couple of interpreters talked about their indiscriminate treatment of information, the two interpreters I observed did not interpret utterances that were not directed or relevant to the speakers. This may be due to the limited numbers of observed medical encounters ($N = 12$) and interpreters ($N = 2$). Nevertheless, this strategy may be significant for building the provider-patient relationship. For example, at times, a provider may consult with another provider in the presence of the patient (or a family member may speak directly to a patient), and a conduit role would expect an interpreter to interpret that information as well. Interpreters become not only the speakers' voice but also their *ears*. Yetta explained,

> Because everything I hear, when I am there, is like the patient should hear whatever I hear. So, whatever is there, I would say, "This has nothing to do with you, but this is what they are talking about." I would explain to the patient. To make him or her feel comfortable that they are just not there to say something about him. Because that scared a couple of my clients away, so, I would make sure that whatever I hear, [they'd hear too].

A speaker (e.g., a provider or a patient) may not be aware that the messages are not directed or relevant to him or her. Without the knowledge of the information exchanged between other parties, a speaker may grow suspicious about the relationship and interactions between the interpreter and other speakers (e.g., providers or family members). By interpreting all information indiscriminately, an interpreter allows a speaker to become not only a participant in provider-patient interactions but also a competent bystander to other interactions in a medical encounter.

Reinforcing Provider-Patient Relationships

A conduit role creates the illusion of dyadic physician-patient communication, which, in turn, reinforces the provider-patient relationship. In their training, interpreters are taught to strive for an invisible presence in provider-patient interaction by adopting a first-person singular interpreting style (i.e., speaking as if the interpreter were the original speaker) and interpreting indiscriminately. Roat, Putsch, and Lucero argued (1997) that the advantages of first-person interpretation include shortening the communication, avoiding confusion as to who is speaking, and reinforcing the primary relationship between the provider and the patient. In addition, by using first-person singular, the interpreter simplifies the interpreting context by presenting himself or herself as a non-person (cf. Goffman, 1959), creating the *illusion* of dyadic physician-patient communication. For example, in Extract 001, the interpreter stated, "*I* just discovered it. Before, *I* didn't see a diabetes doctor" (line 109), when the patient was actual referent.

At times, ironically, interpreters violate this rule and "interfere" with the content and process of provider-patient communication to reinforce provider-patient relationship. For example, Roger explained, "The only influence on the interaction when it comes to 'say her,' 'tell him,' [...] if she says, 'tell him I feel bad.' I go like, 'I feel bad.'" In Extract 005, the interpreter (Claire) used several different strategies to reinforce the relationship between the provider (Hilda) and the patient (Pam).

Extract 005

> H: Does she have any family history of diabetes?
> → I: 你家庭裡面有沒有成員是有糖尿病的？
> (Do any of your family members have diabetes?)
> → P: 沒有，(No)
> H: Is this her first pregnancy?
> → I: 第一胎？
> (First pregnancy?)
> P: 對
> (Yes)
> I: Yes
> H: Is she on any medication?

→　I: 你有沒有吃什麼藥，現在？
　　　(Are you taking any medicine now?)
→　P: No

The first-person interpreting style of the provider's comment should be "Does *she* have any family history of diabetes?" After all, this was what the provider exactly said. The interpreter, however, changed the actual comment and interpreted, "Do any of *your* family members have diabetes?", which changed it from second-person to first-person. Whereas the provider's comment implicitly recognized the presence of an interpreter, the interpreter's utterance directed the comment to the patient and thus, created the illusion of direct interaction between the provider and the patient. Although changing pronouns may appear to contradict a conduit style, the communicative goal (i.e., reinforcing the provider-patient relationship) was consistent with the ideology of a conduit role.

In addition, the interpreter did not interpret when the patient communicated directly with the provider. Although a conduit role includes the expectation that interpreters will interpret everything, in this example, the interpreter recognized that the provider was able to understand the patient's comment and did not require any interpretation (i.e., the patient answered in English). By *not* interpreting (or repeating) the patient's comment, the interpreter further minimized her presence in the encounter and reinforced the provider-patient relationship. This strategy suggests that the interpreter actively evaluates the speakers' utterances, deciding whether those comments should be interpreted (i.e., they are not assuming a non-thinking role). Shirley, a trainer in interpreting programs, explained how a silent interpreter allows patients to empower themselves by establishing direct communication with providers:

> [The patients] want to empower themselves, they want to use a little bit of English or whatever language that they do know. [...] The family wants to be able to say as much as they can, who are we to say, "You know what? Your English here is just not good enough!" It's the issue of empowering, and knowing that this person wants to take the initiative, because that goes to a lot more later on that [patient's] diagnosis.

Some interpreters in this study, in fact, believed that a conduit role facilitates patient empowerment by assuming that patients are competent individuals to act on their own behalf. In other words, patient empowerment is accomplished through respecting patients' autonomy (i.e., *not* to intervene on a patient's behalf or assume that the interpreter knows better) and acting as a conduit (i.e., not to provide personal opinions).

Interpreters in this study talked about adopting specific communicative strategies to minimize their presence and reinforce provider-patient relationships. For example, the interpreter (Christie) has assisted a patient (Paula) in

several prenatal appointments and was familiar with Paula's concern about her infant having the same genetic disorder as her oldest child. In Extract 006, Paula met a new physician (Heather) for the first time after her delivery:

Extract 006

> P: 我這個兒子這個病，要不要告訴她？
> 　　(My son's disease. Tell her or not?)
> I: Oh, she said that her first son has a disease. If you need to know the name of the disease?
> H: If it's an inherited disease, yeah.
> I: 它那是遺傳性的嗎？
> 　　(Is it inherited?)

This interaction is significant because of Christie's strategies to reinforce the provider-patient relationship. In line 601, Paula's comment was directed to Christie, asking for her opinion about whether disclosing the information was appropriate in this encounter. Christie's interpretation, however, differed from the patient's original question and treated the provider as the targeted audience. Christie also deferred Paula's concern (i.e., the appropriateness of the information) to the provider. Finally, when Heather provided an answer to Christie's question ("If you need to know the name of the disease?" in the form of a *conditional statement* ("If it's an inherited disease, yeah."), Christie interpreted it as *question* (i.e., "Is it inherited?"). By interpreting the provider's statement as a question, Christie projected Paula as the next turn speaker, directing the question to Paula. In Extract 006, from the speakers' perspective, the conversation was logical and orderly. Christie's communicative strategies effectively minimized her presence (i.e., the provider and the patient seemed to be talking directly to each other) while accomplishing the speakers' communicative goals (e.g., checking the appropriateness of information and obtaining details of a child's disease).

A similar example was also present in Extract 004. When the provider (Hank) asked Christie to congratulate the new mom, he first asked Christie, "Can you say congratulations in Chinese." This was not a question to check if Christie was a competent interpreter (because Hank did not pause for Christie to answer); rather, Hank was informing Christie about his communicative goal (i.e., to congratulate the new mom). In her interpretation, Christie eliminated Hank's comment that was directed to her (i.e., "Can you say congratulations in Chinese."). But she kept Hank's dramatic flair in the interpretation and *reformulated* the message to minimize her presence and to focus on Hank's communicative goal. In Extracts 004 and 006, the interpreters modified the message to create the illusion of a dyadic provider-patient interaction.

In addition to the verbal strategies, interpreters may also adopt specific nonverbal behaviors (e.g., positioning in medical encounter and eye contact)

to reinforce the provider-patient relationship. In the participant observation data, the two interpreters I observed often positioned themselves in a way that the provider and the patient are closer to each other than to the interpreter. In addition, in all occasions that a provider pulled the curtain to perform a physical exam, the interpreters always stood outside of the curtain and provided interpretation to the speakers' verbal messages (i.e., becoming "the voice"). By managing their physical positioning, the interpreters highlighted the provider and the patient as the primary participants in the medical encounter. Several interpreters in the interviews explained how they use nonverbal behaviors to facilitate the provider-patient relationship:

SHERRY: What happens is when you stand here, the patient is going to look at you and you have to be doing this [looking down at the floor], "I'm the voice, just look at each other." So, if you stand behind the patient, then the patient can't [turn their head backward], and they look at the physician, and then they are looking at each other.

STELLA: Once I step into the examination room, the interpretation begins, I detach myself emotionally from many things that are going on there, and I look at the floor, and I look at the ceiling or something. And I make sure that they talk to each other. [...] I have to detach myself from it and make sure that I don't get involved in it. And I am just the voice. Without my opinion.

Interpreters' narratives of their conduit role suggest that a conduit role actually requires an interpreter to adopt specific communicative strategies that are more than a neutral transfer of information. Interpreters in this study utilize both verbal and nonverbal strategies to reinforce the provider-patient relationship. By manipulating linguistic features, the interpreters create the illusion of a dyadic interaction. By being silent when the primary speakers communicate directly with each other, the interpreter empowers the speakers to establish rapport and trust with each other. By avoiding eye contact or standing behind a speaker, the interpreters not only become less visible but also influence others' communicative behaviors, making them to communicate with each other directly (e.g., having eye contact). From this perspective, interpreters' understanding of the conduit role is not a non-thinking, robotic way of interpreting but includes specific strategies to accomplish the communicative goal of reinforcing the provider-patient relationship.

Interpreter Roles in Health Care Settings

It is important to note that interpreters play a variety of roles in health care settings. For example, researchers have observed interpreters acting as institutional gatekeeper (Davidson, 2000), co-diagnostician (Davidson, 2001; Hsieh, 2007), physician assistant (Bolden, 2000; Elderkin-Thompson, Silver, & Waitz-

kin, 2001), patient advocate (Haffner, 1992), and some variations of these roles (Hsieh, 2004b, 2006a, 2008). Cross Cultural Health Care Program (1999) proposed four roles (i.e., conduit, clarifier, cultural broker, and advocate) of medical interpreters (for a detailed review of roles, see Roat et al., 1997). CCHCP explained, "the 'appropriate' role for the interpreter is the least invasive role that will assure effective communication and care" (Roat et al., 1997, p. 18). In other words, all roles are legitimate and different situations may call for different roles. It is then interesting to find that the conduit role remains the most predominant role in the code of ethics for medical interpreters (Kaufert & Putsch, 1997; for a detailed discussion of the code of ethics, see Dysart-Gale, 2005) and the most explicitly and frequently claimed role by the interpreters of this study. The objective of this chapter is to examine how interpreters understand and enact the conduit role.

Interpreters as Active Participants

The current study supports earlier studies in finding that interpreters are actively involved in the process and content of provider and patient interactions. Past studies have used interpreters' non-conduit behaviors (e.g., acting as patient advocate or screening for illness-related information) as examples of their active involvement in provider-patient interactions (e.g., Davidson, 2000, 2002; Roy, 2000). In contrast, this study demonstrated that even when interpreters believed that they were assuming the neutral, faithful, and impartial role of a conduit, they still were active participants in the medical encounters. From this perspective, it is important not to simply categorize all deviations from the source texts as interpreters' errors because some of them may be motivated by specific communicative goals (e.g., reinforcing provider-patient relationship).

Interpreters in this study claimed the conduit role by utilizing metaphors (e.g., voices of others, robot, and bridge) that minimize their role in influencing the content and process of provider-patient interactions. However, an analysis of the strategies they employed to enact the role, it was evident that they were calculated and purposeful performances for specific goals. The conduit role enacted by the interpreters in this study is not the conduit proposed or prescribed in the code of ethics and the trainings for interpreters (i.e., a role that does not interfere with the process or content of communication). This is, in fact, an unexpected finding. The current study challenges the legitimacy of using this term to describe interpreters' performances for this role. Because interpreters' communicative strategies for this role have extended beyond a conduit model, it is necessary for researchers to use a new model to describe the role performances that reflects the communicative goals of (a) transferring complete information and (b) reinforcing provider-patient relationship. In other words, although interpreters in this study demonstrated their desire

to accomplish the communicative *goals* of a conduit role, these goals were not accomplished through a conduit *role*.

Interpreters' performance of the two communicative goals emerged in this study reflects an institutional view of the values and norms of provider-patient interaction. Interpreters' communicative strategies reinforce the institutional objective to create the illusion of a dyadic interaction, promoting direct interactions between the provider and the patient (Roat et al., 1997; Hsieh, 2001) and empowering them to control the content and process of interactions. This institutional objective is embedded in interpreter training as well as the health care system's focus on the provider-patient relationship. In other words, the interpreters enact an invisible role that is motivated to enforce specific institutional objectives. For example, interpreters talked about verbal and nonverbal strategies used to empower their clients and reinforce the provider-patient relationship. They provide interpretation for both verbal and nonverbal information. They metacommunicate to encourage providers and patients to direct comments to each other and to look at each other. They stand behind a patient and look at the floor to avoid eye contact, both of which encourage primary speakers to interact directly with each other. Finally, interpreters even actively change the verbal messages to create direct conversations between the provider and patient. Despite the changes in translated utterances, interpreters utilizing these strategies should be considered to be assuming a conduit role because the changes were made for the purpose of reinforcing the provider-patient relationship. Researchers have noted that providers' verbal and nonverbal behaviors may influence patients' disclosure patterns (Duggan & Parrott, 2000; Robinson, 1998), treatment choices (Roter & Hall, 1992), and perception of providers' attention (Ruusuvuori, 2001). By forcing providers and patients to modify their verbal and nonverbal behaviors and creating the illusion of a dyadic interaction, interpreters may effectively influence speakers' communicative behaviors, perceptions about quality of care, and health outcomes.

Interpreters' manipulation of (or influence over) other speakers' communicative behaviors is a topic that rarely has been examined in past literature. Most studies have focused on interpreters' communicative interpreting strategies, examining whether their interpretation was problematic (e.g., Elderkin-Thompson et al., 2001) or how their interpretation has influenced the contexts or dynamics of the interpreter-mediated interaction (Roy, 2000). No studies, however, discussed how interpreters adopt specific strategies to *influence* other speakers' behaviors. The interpreters in this study have explicitly talked about their intention and strategies to change others speakers' behavior as a way to manage interpreter-mediated interaction. Influencing other speakers' communicative behaviors is not consistent with the interpreting style of a conduit model. Nevertheless, the interpreters still see themselves as conduits because these strategies focus on maximizing the speakers' role in the communicative process.

If a model that is the traditional model for training of interpreters fails to

describe the practice of professional interpreters, we should no longer attribute the deviations from the conduit role as interpreters' mistakes or incompetence. Rather, we need to recognize the complex responsibilities and functions of interpreters and consider if the conduit model is realistic or even acceptable. In essence, the fundamental problem of putting emphasis on the conduit model forces researchers as well as interpreters to oversimplify their roles and the complexity of interpreting as a communicative activity.

From this perspective, it is important to reconsider the definition of interpreters' neutrality. In the conduit model, interpreters are taught to achieve neutrality by remaining passive, allowing the speakers to do the talking, thinking, negotiating, and even arguing. This approach aims to minimize an interpreter's presence in and influence over provider-patient interactions. Interpreters' neutrality is enacted through their impartiality (e.g., "I interpret everything."), invisibility (e.g., "I try to be faceless." or "I am the voice."), and the lack of personal opinions or judgment (e.g., "I don't think."). The conduit model assumes that an interpreter does not have any communicative goals or personal agenda. The interpreters in this study, however, suggested that they *do* have specific communicative goals (i.e., transferring complete information and reinforcing provider-patient relationship), which may motivate them to not only deviate from the speakers' original utterances but also to influence other speakers' communicative behaviors. For these interpreters, their neutrality is not maintained though the lack of (personal) agenda; rather, it is enacted through maximizing the speakers' access to all information, ensuring the speakers' control of the information exchanged, and reinforcing the primary relationship. All these strategies reflect the institutional views of provider-patient communication and interpreter-mediated interactions. In other words, although the interpreters remain neutral to the speakers during the communicative process, their strategies are not "neutral" in the sense that they carry specific agenda to accomplish an institutional view of interpreter-mediated medical encounters that is appropriate and effective.

Moving Beyond a Conduit Model: Interpreters as Bilingual Mediators

By recognizing interpreters as active participants, researchers have opportunities to move beyond a conduit model and explore the complexity of interpreting as a communicative activity coordinated between multiple parties. I am not suggesting that medical interpreters no longer need to pursue accuracy, neutrality, or faithfulness to the source text and other traditional criteria that have been valued in a conduit model. However, I believe that by conceptualizing interpreters as mediators (as opposed to conduits), researchers and interpreters can have a more solid and comprehensive foundation to further the theoretical development and practical guidelines for interpreter-mediated interactions.

Rather than claiming neutrality through passivity, I propose to use the

mediator model to reconceptualize interpreters' role performances that aim to achieve neutrality, faithfulness, and impartiality. The mediator model adopts the values (i.e., impartiality and faithfulness) embodied in a conduit model and extends its theoretical basis to phenomena that cannot be explained by a conduit model (Payne, Kohler, Cangemi, & Fugua, 2000). The conceptualization of the roles of mediator emerged from the field of conflict resolution (McCorkle, 2005). Folberg and Taylor (1984) argued that mediators allow the participating parties to be self-empowered by taking the responsibility for the decision-making process. Mediators accomplish neutrality and impartiality through active and careful management of verbal and nonverbal strategies to manage the dynamics of participants as well as the content and process of interactions (Cobb & Rifkin, 1991; Jacobs, 2002; Payne et al., 2000). Although researchers still debate about the appropriate enactment of neutrality and impartiality for mediators, the mediator model highlights the human agents in the communicative process and situates the mediators as the skilled expert in facilitating the multi-party communication in which individuals may share competing or conflicting goals (McCorkle, 2005). Jacobs and Aakhus (2002, p. 200) concluded that a competent dispute mediator should have: "(1) the ability to choose which model to apply to any particular session and to any particular moment in the session and (2) the skills with which a mediator implements any particular model." A competent interpreter should also follow the same standards and practices of mediators.

Unlike dispute mediators, however, medical interpreters do not presume that the participating parties have conflicting goals. Nevertheless, it is not uncommon for providers and patients to have competing or conflicting objectives due to cultural differences and treatment preferences (Brashers, Goldsmith, & Hsieh, 2002). The challenge faced by interpreters is not resolving conflict for parties that are often at odds with each other, but rather they are being vigilant in identifying potential or hidden differences and needs of participating parties, which often emerge in the dynamic process of provider-patient interaction and are inferred rather than explicitly communicated (Tracy, 2004). As mediators, interpreters focus on facilitating the providers' and patients' common and collaborative goals of ensuring the quality and delivery of care. Once they identify the competing or conflicting goals of the participating parties, however, they need to actively manage the interaction through communicative strategies to ensure appropriate and effective communication.

The mediator model in medical interpreting has several key characteristics. First, it recognizes the values (e.g., faithfulness, neutrality, and accuracy) that are inherent in a conduit model (McCorkle, 2005). Second, it centers on the speakers' equal voice and presence in an interpreter-mediated activity (i.e., a focus on the human agent, as opposed to the text, in the communicative process). A mediator is an active but neutral participant (Jacobs, 2002). Although they actively intervene in the communicative process, their primary objective is to allow the speakers to be equally represented in the communicative pro-

cess. Third, it provides an interpreter leverage to intervene in the communicative process (i.e., as an active but neutral co-participant in the provider-patient interaction; Payne et al., 2000). A mediator does not take sides but serves only to facilitate a conversation between the speakers. Although interpreters may adopt specific communicative strategies to influence the communicative process, their strategies are acceptable and appropriate provided that they do not side with the speakers and the speakers have equal access to and control over the information exchanged. Finally, it assumes that interpreters are skilled professionals who can make online and fair judgment to manage the communicative process (Jacobs & Aakhus, 2002). With the mediator model, interpreters find legitimate grounds to exercise their expertise as linguistic, cultural, and communicative experts. They are expected to shift between various role performances and adopt different strategies to ensure the appropriateness and effectiveness of provider-patient interactions.

A mediator model is consistent with the values and communicative goals of a conduit model, but also provides practical solutions to dilemmas faced by interpreters who wish to be neutral facilitators in medical encounters. For example, a conduit model does not expect an interpreter to interfere with the communicative process. An interpreter speaks after a speaker presented a comment; however, in everyday life, overlapping talk is not uncommon (e.g., arguments) and interpreters may feel frustrated because they are unable to listen to multiple individuals and interpret different comments at the same time. Nevertheless, a strict adherence to a conduit model does not provide them leeway to intervene the problematic situation. On the other hand, a mediator model allows an interpreter to intervene the communicative process so that the provider and the patient can effectively and equally voice their opinions. In these situations, a mediator model expects an interpreter to interrupt the interaction, providing suggestions of an effective process (e.g., an interpreter may say, "Please let me interpret the doctor's comment first and then I will tell the doctor about your concerns."). In a mediator model, interpreters' primary concern is to intervene the communicative process in a way that ensures the speakers' equal access to and control over information.

Another predicament faced by a conduit model is the conversations that take place in front of but do not include the primary speakers. For example, an additional participant in provider-patient interaction (e.g., a nurse or a family member) may challenge the assumptions of dyadic provider-patient communication (e.g., all conversations are between the provider and the patient and center on the patient's illness; Hsieh, 2006a). In these situations, the spoken utterances may not be directed to the primary speakers (i.e., the provider or the patient) who the interpreter serves or be relevant to the medical encounter. In addition, because an interpreter's service is not needed for these conversations to take place, the speakers usually talk to each other at a faster pace and do not leave time for the interpreter to interpret. These conversations, at times, may include private information (e.g., two providers discussing another

patient's diagnosis or family members talking about issues unrelated to the illness) that the speakers may not want others to know. A conduit model requires an interpreter to relay everything, regardless the relevance of the information. An interpreter may feel awkward or unethical to interpret verbatim when he or she believes that it is privileged information (Hsieh, 2006a); nevertheless, a conduit model expects an interpreter to relay all information without making any personal judgment about the appropriateness or effectiveness of the information.

A mediator model, in contrast, allows an interpreter to actively evaluate the emergent interactions and take interventions to ensure that the communicative process is fair and unbiased. Interpreters do not need to try to squeeze in their interpretation when their services are not relevant or needed in the interaction. When an interpreter believes that the conversation took place is not relevant to the provider-patient interaction (i.e., the interaction is still fair and unbiased), he or she can just inform the speakers that the conversation is unrelated to the medical encounter, provide a brief summary of the context (e.g., "The doctors are talking about another patient."), and allow privileged information to remain private. These behaviors do not violate the faithfulness, impartiality, or neutrality the public expects from an interpreter; at the same time, they still ensure that both speakers are not marginalized and their voices and rights are protected in the communicative process. Whereas in a conduit model, transferring complete information means interpreting without evaluating whether the information is relevant to the speakers, in a mediator model, transferring complete information means that an interpreter make judgments about the best way to relay information so that the both speakers' control over the provider-patient interaction is secured and equitable.

Finally, a mediator model does not presume that other speakers are familiar with the communicative process of interpreter-mediated activities. For example, most speakers are layperson who may not be aware of or have problems to understand the code of ethics or the specific communicative styles that interpreters are required to follow. As a result, unlike interpreters who are trained to adopt specific frames (e.g., interpreters as nonpersons), a layperson may not know that they should address another speaker directly and should not interact with the interpreter. A strict adherence to a conduit model, however, requires an interpreter to provide a verbatim relay of a provider's third-person comment (e.g., "Ask him if it hurts;" a communicative norm in multiple-party interactions), which would simply confuse the patient (i.e., because in this case "him" is the patient; Hsieh, 2006a). A mediator model allows an interpreter to actively evaluate the speakers' communicative goals and to modify their strategies accordingly. In other words, in a mediator model, an interpreter can modify their verbal and nonverbal messages without feeling conflicted about violating their expected role.

In summary, whereas a conduit model focuses on the equivalence between the source and target texts, a mediator model emphasizes the interpreters'

responsibility to maintain an equitable process of communication between the speakers. In a mediator model, interpreters are viewed as expert communicators who are capable of making effective judgment and active interventions to accomplish specific goals: (a) both speakers have equal access and control over information exchanged, (b) their roles and interpretations are neutral and faithful, and (c) the relationship between primary speakers is the focus of the interpreter-mediated interaction. A mediator model presents specific limits for interpreters' communicative strategies in the sense that it expects interpreters to be neutral and faithful throughout the communicative process. Interpreters' intervention or modification of information is acceptable only when these behaviors reinforces provider-patient relationships and ensures the equal voices and presentation of both speakers. A mediator model does not allow an interpreter to advocate for a speaker, to suppress a speaker's problematic behavior, or to interpret information selectively. In short, a mediator model does not give an interpreter unlimited freedom in intervening in provider-patient interactions; rather, it provides specific role expectations and communicative goals for interpreters to conduct bilingual provider-patient interactions that maximize the speakers' roles in the communicative process.

A mediator model is superior to the conduit model in prescribing and regulating interpreters' performances. A conduit model allows interpreters to claim authority and credibility for the services they provide by renouncing the active roles of interpreters in the communicative process; in contrast, a mediator model does so by recognizing interpreters' expertise. Whereas a conduit model treats deviation from the source texts as errors or exceptions, a mediator model provide researchers to examine the effectiveness and appropriateness of those deviations. In doing so, the research and health care community can explore the necessary trainings and guidelines that are critical for interpreters to accomplish the various role performances in health care settings. In addition, rather than demanding the blind trust from other speakers, a mediator model encourages the participants to be vigilant about the interpreters' communicative strategies, questioning and challenging the interpreters' performances as they see fit.

Conclusion

As trained experts, interpreters adopt and move between various roles to facilitate provider-patient interactions (Bolden, 2000; Davidson, 2001; Hsieh, 2004a). I want to emphasize that this chapter does not argue that bilingual mediator should be the only role that an interpreter can play; in fact, by being versatile in various roles (or role models), interpreters may best ensure the appropriateness and effectiveness of provider-patient interactions. The main objective of this chapter is to propose a new model (i.e., the mediator model) to replace the conduit model, a default role of medical interpreters. My goal is not to drastically modify the conduit model, but rather to provide a different way

to conceptualize a specific role that often is placed on medical interpreters. As researchers have noticed the problems of a conduit model, the discrepancies of interpreters' practice and ideology, and the values of interpreters' active involvement in the communicative process, it is important to develop a model that not only explains interpreters' practices but also provides theoretical basis to guide their code of ethics, training programs, and everyday practice.

A mediator model views interpreters as neutral but active participants in provider-patient interactions. It allows interpreters to intervene in the communicative process, but also requires them to assume specific communicative goals (e.g., reinforcing provider-patient relationships and maximizing the speakers' role), which already are embedded in interpreters' training programs. Whereas a conduit model envisions a type of neutrality (i.e., an exact duplication of information and interactive contexts) that is impractical (if not impossible; see Hsieh, 2001), a mediator model challenges an interpreter to maintain a neutral position (or at least appearance) in the communicative process. Interpreters' ability to effectively, appropriately, and smoothly accomplish the communicative goals of a mediator role and to maintain a neutral position will significantly influence the quality of provider-patient communication and relationship.

Finally, researchers need to investigate the complexity of medical interpreters' practices and its corresponding consequences. In recent studies, researchers have explored possible factors for interpreters' non-conduit behaviors. Interpreters' non-conduit behaviors may reflect their effort to improve a patient's health literacy (Angelelli, 2004), to protect institutional resources (e.g., providers' time; Davidson, 2002), to reduce the cultural gap between the provider and the patient (Angelelli, 2004), to reconcile provider-patient conflicts (Hsieh, 2006a), and to ensure the quality of provider-patient interactions (Dysart-Gale, 2005, Metzger, 1999). As interpreters become active participants, however, they inevitably infringe on others' control over the medical encounter (Hsieh, 2006a, 2006b). Health care providers have gone through rigorous education and certification to validate their ability to solicit, screen, and evaluate medical-related information; in contrast, interpreters generally have minimum training in those skills. In fact, Flores and colleagues (2003) found that 63% of interpreting errors had potential clinical consequences. As researchers notice interpreters' active involvement in the communicative process, it is important to examine interpreters' ethics (e.g., Davidson, 2001) and explore the impacts of their communicative strategies (Hsieh, 2006a). In other words, although the recent findings of bilingual health communication highlight the importance of interpreters' role in provider-patient interactions, they also highlight the significance of developing ethical boundaries for interpreters to function effectively without compromising providers' authority and patients' autonomy.

References

Allen, J. E. (2000, November 6). Worlds and words apart: Inadequate interpreter services for non-English-speaking patients has medical experts and civil rights advocates concerned. *Los Angeles Times*, p. S1.

Angelelli, C. V. (2002). *Deconstructing the invisible interpreter: A critical study of the interpersonal role of the interpreter in a cross-cultural linguistic communicative event.* Doctoral dissertation, Stanford University, Stanford, CA. (ProQuest Digital Dissertation, AAT 3026766)

Angelelli, C. V. (2004). *Medical interpreting and cross-cultural communication.* Cambridge, England: Cambridge University Press.

Bakhtin, M. M. (1981). *The dialogic imagination: Four essays by M. M. Bakhtin* (M. Holquist & C. Emerson, Trans.). Austin: University of Texas Press.

Bolden, G. B. (2000). Toward understanding practices of medical interpreting: Interpreters' involvement in history taking. *Discourse Studies, 2,* 387–419.

Brashers, D. E., Goldsmith, D. J., & Hsieh, E. (2002). Information seeking and avoiding in health contexts. *Human Communication Research, 28,* 258–271.

Cobb, S., & Rifkin, J. (1991). Practice and paradox: Deconstructing neutrality in mediation. *Law and Social Inquiry, 16,* 35–62.

Cross Cultural Health Care Program. (1999). *Bridging the gap interpreter handbook* (Rev. ed.). Seattle, WA: Author.

David, R. A., & Rhee, M. (1998). The impact of language as a barrier to effective health care in an underserved urban Hispanic community. *Mount Sinai Journal of Medicine, 65,* 393–397.

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics, 4,* 379–405.

Davidson, B. (2001). Questions in cross-linguistic medical encounters: The role of the hospital interpreter. *Anthropological Quarterly, 74,* 170–178.

Davidson, B. (2002). A model for the construction of conversational common ground in interpreted discourse. *Journal of Pragmatics, 34,* 1273–1300.

Department of Health and Human Services. (2001, January 30). *Limited English Proficiency (LEP).* Washington, DC: Author. Retrieved November 7, 2005, from http://www.hhs.gov/ocr/lep/

Doty, M. M. (2003). *Hispanic patients' double burden: Lack of health insurance and limited English.* The Commonwealth Fund. Retrieved August 22, 2005, from http://www.cmwf.org/usr_doc/doty_hispanicdoubleburden_592.pdf

Duggan, A. P., & Parrott, R. L. (2000). Research note: Physicians' nonverbal rapport building and patients' talk about the subjective component of illness. *Human Communication Research, 27,* 299–311.

Dysart-Gale, D. (2005). Communication models, professionalization, and the work of medical interpreters. *Health Communication, 17,* 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,* 1343–1358.

Flores, G. (2005). The impact of medical interpreter services on the quality of health care: a systematic review. *Medical Care Research & Review, 62,* 255–299.

Flores, G., Fuentes-Afflick, E., Barbot, O., Carter-Pokras, O., Claudio, L., Lara, M., et

al. (2002). The health of Latino children: Urgent priorities, unanswered questions, and a research agenda. *Journal of American Medical Association, 288,* 82–90.

Flores, G., Laws, M. B., Mayo, S. J., Zuckerman, B., Abreu, M., Medina, L., et al. (2003). Errors in medical interpretation and their potential clinical consequences in pediatric encounters. *Pediatrics, 111,* 6–14.

Folberg, J., & Taylor, A. (1984). *Mediation: A comprehensive guide to resolving conflicts without litigation.* San Francisco: Jossey-Bass.

Georgakopoulou, A. (2002). Narrative and identity management: Discourse and social identities in a tale of tomorrow. *Research on Language and Social Interaction, 35,* 427–451.

Gerrish, K. (2001). The nature and effect of communication difficulties arising from interactions between district nurses and South Asian patients and their carers. *Journal of Advanced Nursing, 33,* 566–574.

Goffman, E. (1959). *The presentation of self in everyday life.* Garden City, NY: Doubleday.

Haffner, L. (1992). Translation is not enough: Interpreting in a medical setting. *Western Journal of Medicine, 157,* 255–259.

Hale, S. (1999). Interpreters' treatment of discourse markers in courtroom questions. *Forensic Linguistics, 6,* 57–82.

Hale, S., & Gibbons, J. (1999). Varying realities: Patterned changes in the interpreter's representation of courtroom and external realities. *Applied Linguistics, 20,* 203–220.

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,* 1253–1256.

Hsieh, E. (2001, November). *To be or not to be: Discrepancies between the ideology and the practice of interpreters.* Paper presented at the annual meeting of National Communication Association, Atlanta, GA.

Hsieh, E. (2002). Necessary changes in translation ideology. 翻譯學研究集刊 *Fan I Hsueh Yen Chiu Chi K'an* [Studies of Translation and Interpretation], *7,* 399–435.

Hsieh, E. (2004a). *Bilingual health communication and medical interpreters: Managing role performances and communicative goals.* Doctoral dissertation, University of Illinois at Urbana-Champaign. (ProQuest Digital Dissertation, AAT 3153318)

Hsieh, E. (2004b, November). *"I am not a robot!": Interpreters' Roles and Communicative Goals in Health Care Settings.* Paper presented at the annual meeting of National Communication Association, Chicago.

Hsieh, E. (2006a). Conflicts in how interpreters manage their roles in provider-patient interactions. *Social Science & Medicine, 62,* 721–730.

Hsieh, E. (2006b). Understanding medical interpreters: Reconceptualizing bilingual health communication. *Health Communication, 20,* 177–186.

Hsieh, E. (2007). Medical interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science & Medicine, 64,* 924–937.

Hsieh, E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Qualitative Health Research, 18,* 1367–1383.

Jacobs, S. (2002). Maintaining neutrality in dispute mediation: Managing disagreement while managing not to disagree. *Journal of Pragmatics, 34,* 1403–1426.

Jacobs, S., & Aakhus, M. (2002). What mediators do with words: Implementing three

models of rational discussion in dispute mediation. *Conflict Resolution Quarterly, 20,* 177–203.

Jones, D., & Gill, P. (1998). Breaking down language barriers. The NHS needs to provide accessible interpreting services for all. *British Medical Journal, 316,* 1476.

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,* 71–87.

McCorkle, S. (2005). The murky world of mediation ethics: Neutrality, impartiality, and conflict of interest in state codes of conduct. *Conflict Resolution Quarterly, 23,* 165–183.

Metzger, M. (1999). *Sign language interpreting: Deconstructing the myth of neutrality.* Washington, DC: Gallaudet University Press.

Miller, P. J., Hengst, J., Alexander, K., & Sperry, L. L. (2000). Versions of personal storytelling/versions of experience: Genres as tools for creating alternate realities. In K. S. Rosengren & C. N. Johnson (Eds.), *Imagining the impossible: Magical, scientific, and religious thinking in children* (pp. 212–246). New York: Cambridge University Press.

National Council on Interpreting in Health Care. (2004). A National Code of Ethics for Interpreters in Health Care. Retrieved March 28, 2007, from http://www.ncihc.org/NCIHC_PDF/NationalCodeofEthicsforInterpretersinHealthCare.pdf

National Council on Interpreting in Health Care. (2005). National Standards of Practices. Retrieved March 28, 2007, from http://www.ncihc.org/NCIHC_PDF/National_Standards_of_Practice_for_Interpreters_in_Health_Care.pdf

Payne, K., Kohler, P., Cangemi, J. P., & Fugua, H., Jr. (2000). Communication and strategies in the mediation of disputes. *Journal of Collective Negotiation, 29,* 29–47.

Roat, C. E., Putsch, R., & Lucero, C. (1997). *Bridging the gap over phone: A basic training for telephone interpreters serving medical settings.* Seattle, WA: Cross Cultural Health Care Program.

Robinson, J. D. (1998). Getting down to business: Talk, gaze and body orientation during openings of doctor-patient consultations. *Human Communication Research, 25,* 97–123.

Rosenberg, B. A. (2001). *Describing the nature of interpreter-mediated doctor-patient communication: A quantitative discourse analysis of community interpreting.* Doctoral dissertation, University of Texas at Austin. (ProQuest Digital Dissertations, AAT 3008433)

Roter, D. L., & Hall, J. A. (1992). *Doctors talking with patients/patients talking with doctors: Improving communication in medical visits.* Westport, CT: Auburn.

Roy, C. B. (2000). *Interpreting as a discourse process.* New York: Oxford University Press.

Ruusuvuori, J. (2001). Looking means listening: Coordinating displays of engagement in doctor-patient interaction. *Social Science & Medicine, 52,* 1093–1108.

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,* 256–264.

Shannon, C., & Weaver, W. (1963). *The mathematical theory of communication.* Urbana: University of Illinois Press. (Original work published 1949)

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (2nd ed.). Thousand Oaks, CA: Sage.

Tracy, K. (2004). *Everyday talk: Building and reflecting identities*. New York: Guilford.

Waxman, M. A., & Levitt, M. A. (2000). Are diagnostic testing and admission rates higher in non-English-speaking versus English-speaking patients in the emergency department? *Annals of Emergency Medicine, 36*, 456–461.

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*, 472–477.

Chapter 7

Negotiating the Legitimacy of Medical Problems

A Multiphase Concern for Patients and Physicians

John Heritage

In this chapter, I explore a theme that often emerges in the context of patient problem presentation, but that also surfaces elsewhere in the medical visit. This is the theme of legitimacy: Specifically, the idea that the patient's visit to seek medical care should be properly motivated by an appropriate medical problem. From the physician's perspective, this theme is summed up in a rather hard-nosed fashion by the New Zealand primary care physician who observed that "In order to have the privilege of talking to your doctor, you must fulfil the essential precondition of being sick. Then you may go to him and ask him if he will perform his professional services upon you" (Byrne & Long, 1976, p. 20). At the societal level, this theme is enshrined in everyday language that contains numerous terms for patients who inappropriately seek medical care: hypochondriac, malingerer, crock, and so on, and the pathological disposition to do so (as manifested in Munchausen's Syndrome) is itself treated as a medical condition. And it is also present in contemporary popular culture. A recent cartoon in the *New Yorker* magazine depicts a nurse entering a crowded waiting room and saying, "We're running a little behind, so I'd like each of you to ask yourself 'Am I really that sick, or would I just be wasting the doctor's valuable time.'" (*New Yorker*, May 14, 2001). And this concern helps to explain the peculiar conflict we sometimes experience when we go to the doctor: we want to be told that we are well, but we also would like to have had 'good reasons' for wrongly believing that we were not. As another *New Yorker* cartoon, depicting the delivery of a diagnosis, caricatures the concern: "You're not ill yet, Mr. Blendell, but you've got potential" (*New Yorker*, September 11, 1998).

These common sense normative orientations have been systematized by social scientists. In his classic formulation of the "sick role," Parsons (1951, pp. 436–439) observed that persons entering the sick role are entitled to some exemption from normal social tasks but that, correspondingly, they have the obligation to view being sick as undesirable and to resist any temptation to take advantage of the "secondary gains" of the sick role in the form of economic, social, and emotional support. It is this latter set of obligations, of course, that inform the morally loaded terminology and orientations sketched above.

By the very act of making the appointment and walking into the physician's