Medical Interpreters as Tools: Dangers and Challenges in the Utilitarian Approach to Interpreters' Roles and Functions

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Abstract

Objective—This study explores the tensions, challenges, and dangers when a utilitarian view of interpreter is constructed, imposed, and/or reinforced in health care settings.

Methods—We conducted in-depth interviews and focus groups with 26 medical interpreters from 17 different languages and cultures and 39 providers of five specialties. Grounded theory was used for data analysis.

Results—The utilitarian view to interpreters' roles and functions influences providers in the following areas: (a) hierarchical structure and unidirectional communication, (b) the interpreter seen as information gatekeeper, (c) the interpreter seen as provider proxy, and (d) interpreter's emotional support perceived as tools.

Conclusion—When interpreters are viewed as passive instruments, a utilitarian approach may compromise the quality of care by silencing patients' and interpreters' voice, objectifying interpreters' emotional work, and exploiting patients' needs.

Practice Implications—Providers need to recognize that a utilitarian approach to the interpreter's role and functions may create interpersonal and ethical dilemmas that compromise the quality of care. By viewing interpreters as smart technology (rather than passive instruments), both providers and interpreters can learn from and co-evolve with each other, allowing them to maintain control over their expertise and to work as collaborators in providing quality care.

1. Introduction

Interpreter-as-conduit has been a prevalent ideology that sets the ethical standard for medical interpreters [1]. Interpreters are expected to serve a neutral, faithful, and passive role in provider-patient interactions [2, 3]. Interpretation is perceived as a simple one-to-one machinelike process [4], which reflects a utilitarian view of the interpreter's role. By this we mean that interpreters are conceptualized as instruments in the process, providing utility without influencing the content or dynamics of provider-patient communication. Tension may result if a provider suspects an interpreter did not provide word-for-word interpretation

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[5]. Ironically, given the complexity of provider-patient interactions, the best utility an interpreter can provide is far more complex.

Recent studies have found that interpreters actively and systematically intervene in provider-patient interactions to achieve effective, ethical, and culturally-sensitive care [6, 7]. Researchers also have highlighted provider-patient communication as goal-oriented activities in which the participants constantly negotiate multiple (and at times, conflicting) objectives in ongoing interactions [3, 4, 8, 9]. Although researchers have argued that optimal care, rather than neutrality, should be the basis for evaluating interpreters' performances [10], little is known about interpreters' actual role in achieving such an objective. If interpreters are viewed as the instruments of providers and can be influential in various aspects of care, how do they facilitate providers to achieve quality care?

In this paper, we explore the tensions, challenges, and dangers when a utilitarian view of an interpreter is constructed, imposed, and/or reinforced in health care settings. More specifically, in what ways does a utilitarian view of interpreters' roles and functions influence providers' expectations of and collaboration with interpreters? We advance the literature by exploring interpreters' diverse functions that are consistent with (but often neglected by) the conduit model of interpreting and identifying the areas of tensions between providers' and interpreters' views.

2. Method

2.1. Participants and Procedure

This study is part of a larger study that examines the roles of medical interpreters. The data included in this study are in-depth interviews and focus groups with providers and interpreters. The first author recruited 26 professional interpreters (from 17 languages) and conducted 14 individual and 6 dyadic interviews (each lasting 1–1.5 hours). The interpreters are from two agencies that specialize in medical interpreting in the Midwestern United States. The research questions focused on exploring interpreters' understanding and practice of their roles.

After the initial analysis of the interpreters' interview data, the first author and her research team recruited 39 health care providers from a major health care facility in the southern United States. The providers are from five specialty areas: OB/GYN (n=8), emergency medicine (n=7), oncology (n=11), nursing (n=6), and mental health (n=7). Because providers often have busy and variable schedules, the first author offered individual interviews to providers who were unable to attend the focus groups. In total, the first author and her research team conducted 8 specialty-specific focus groups (each lasting 1–1.5 hour, with 2–6 participants) and 14 individual interviews (each lasting 1–1.5 hours). Details of the interview questions for both providers and interpreters have been published in a previous study [5].

2.2. Data Analysis

We used constant comparative analysis for the data analysis [11, 12], coding the data for dominant themes and categories. The utilitarian view of interpreters emerged as a dominant theme in our open coding process. We independently reviewed all transcripts and identified the utilitarian view of interpreters' role, functions, and performances when the participants explicitly discussed (a) their expectations or performance of the conduit model of communication, (b) interpreters' role as a duplication or an extension of other speakers' roles and functions, and/or (c) interpreters as tools/instruments of others. We then adopted selective coding to identify the areas of tension in interpreters' and providers'

conceptualization of the utilitarian view of interpreters' roles and functions in health care settings.

The various forms of interviews may lead to variations in the participant dynamics and discussions [13]. Each data set was analyzed independently. The combination of data collection methods allows us to obtain richer data by including more perspectives from participants with diverse expertise and communicative needs. The transcripts are CAPITALIZED when they are the speakers' emphasis and *italicized* when they are the authors' emphasis. Each participant is assigned a pseudonym, with a superscript I for interpreters and H for health care providers.

3. Results

The utilitarian view of interpreters' roles and functions influences providers in the following areas: (a) hierarchical structure and unidirectional communication, (b) the interpreter seen as information gatekeeper, (c) the interpreter seen as provider proxy, and (d) interpreter's emotional support perceived as tools.

3.1. Hierarchical structure and unidirectional communication

We recognize the fact that health care team is, by nature, hierarchical. A utilitarian view of interpreters, however, suggests unidirectional communication (i.e., provider to interpreter). For example, Mindy[H] said,

> I would prefer the interpreter give me *literally* what they understand the words are. And then, afterwards, I can ask the interpreter when the patient is gone, "Is that a code for so and so?" if I did not understand that.

In other words, she does not expect interpreters to interrupt the interaction but will ask the interpreter for clarification if she deems necessary. This expectation can be problematic because her comments suggest that she believes that only one meaning can be present in the appropriation of meanings in words. In addition, for an outsider, the literal meaning may still make sense and be meaningful albeit the fact that that was not what the speaker meant. If the interpreter, as an insider, does not proactively provide the insider, culturally-coded meaning, it may never come to the providers' mind to question the "literal meaning of the words."

Interpreters were trained to provide information about their roles, functions, and preferred communication styles for providers and interpreters (e.g., providers and patients should address each other directly and ignore the presence of interpreters) at the beginning of each medical encounter. However, many interpreters complained about being under pressured to skip that introduction because providers do not have time to listen to them. For example, Cristie[I] explained, "There's no time for you to have the introduction, they just want to hurry up and finish all the interpreting job. […] They don't have that patience to listen to you."

Because interpreters are viewed as tools, their opinions or perspectives are not expected, needed, or desired. Stella[I] noted that when she suggested providers to adopt communicative styles that are consistent with the conduit model (e.g., addressing the patient directly by using first person), "Some of [the providers] just refuse to do it. They get mad at you, because they think you are telling them what to do. […] They don't want to be told." Some interpreters silenced their own opinions even when they recognize that a provider-patient interaction is problematic. For example, Vicky[I] 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 though. So, the interpreter thinks that he or she has a right to advocate. *But were you asked to do so*?

Stella[I] talked about an incident that a provider was not communicating with the patient effectively, "I know what to say. I have to tie up my tongue so that I didn't say anything. [...] You are just the voice. You don't have an opinion there." In a conduit role, interpreters are only the voices of others. Interpreters-as-tools are not expected to function if others are not there to utilize the tools. For example, Sherry[I] explained,

> I know what the prescription is. I'd [ask the provider]. I do, and it's REALLY hard when you are an interpreter to do that. Because you can just pick up the prescription and say, "Oh, well, it says blah, blah, blah."

As a result, even when interpreter know what the needed information is, they are not supposed to offer the information. Some providers noted that they find such practices inefficient. For example, Gemma[H] commented, "[A] patient would ask you a question, and I'd say [to the interpreter], 'Well, you know the answer.' So, and the interpreter would just give information like where the labor and delivery is located."

In contrast to interpreters' sense of self-restraint in providing their opinions, knowledge, or suggestions to providers or patients, providers' narratives suggest a sense of hierarchy (and ownership, at times) when discussing provider-interpreter relationships. For example, several providers noted that they prefer professional interpreters (as opposed to family interpreter) because they work for them. Gloria[H] noted,

> I rely on the fact that the PROFESSIONAL interpreter is supposed to be working for ME, as a go-between with the patient. [...] The interpreter's ROLE is to be neutral and to communicate both sides. [...] Professional interpreter should not have a hidden agenda.

Nacia[H] commented, "I consider them colleagues, but ancillary services to mine. Ultimately [I am] in charge, so they're functioning underneath my umbrella."

3.2. The interpreter seen as information gatekeeper

Although the conduit role requires interpreters not to filter or modify information, many interpreters commented on receiving a provider's instructions on managing information and information flow. For example, Vicky[I] said, "Sometimes, doctors say, 'Okay, I am going to ask a question, you give me the answer. *If it doesn't deal with my question, I don't want to hear it.*' I have that kind of doctors before." Eli[H] noted, "The interpreter should at least to have a capacity to be able to redirect the patient and kind of filter what they say, if the response is completely unrelated to the question." Gloria[H], an OB/GYN physician explained,

> *The interpreter needs to get them stopped* because that's not why they are there about that day. [...] I had a patient walked in one day, who had 40 complaints and always want to tell me they are turning off the husband from the ventilator that night and that he's going to die. And we spent time on that. But- I got her into a psychiatrist after that too. Because *that's not a pap smear*.

Physician's focus on medical problems (and more specifically, medical problems related to their specialty) is different from a patient's understanding of their illness event, which is situated in their everyday life. In interpreter-mediated interactions, providers rely on interpreters to cut off interactions that they would not have had even with English-speaking patients.

The challenge in interpreter-mediated encounters is that providers may not be able to control the flow of conversation as effectively or efficiently as they would have had in English-speaking conversations. As a result, if a provider does not wish to address certain topics or does not have time for the interaction, they rely on the interpreter to act as gatekeepers to

control or limit the patients' narratives. Providers' expectations, however, contradicts with interpreters' training in following the conduit model as the default role. Interpreters are frustrated about these situations. Recognizing the providers may not be familiar with their training or the conduit model of interpreting, Ulyssess[I] explained, "You cannot dictate the doctors. But I feel that providers should know some of the rules that we follow by." Some interpreters noted that they do not change their communicative behaviors despite the providers' request. For example, Sara[I] noted, "I have doctors that go like, 'Please, tell him, I need the answer, I don't want all the other stuff. I am talking about this.' I have doctors like that. But I just said the same thing. Then, again, 'I'm interpreting exactly what they are saying.'" Other interpreters tried to accommodate the providers' expectations. For example, Rachel[I] explained,

> [I have a patient who] is a talker, you know. And every time, the doctor asked a question, he would ask yes or no question or just a short answer, and she answers it and then, after that, she tries to say different things. […] What do I do? *I just control it*. I mean, I said, "Excuse me, please just answer the question." […The doctor] was not interested in this, you know?

Interpreters' willingness and ability to redirect or control the patients' narratives allow the providers to save time. In fact, some providers noted that such ability is appreciated. Ed[H] noted, "We have several interpreters here, and the ones I work with for a long time, and I am very comfortable with them redirecting patient and stopping patient and things."

Interpreters are in a difficult situation. To refuse the providers' request is to challenge the providers' control over information exchanged; similarly, to restrict the patients' comments is to silence their narratives when they may not feel comfortable in assessing the medical value of the patients' comments. For example, Steve[I] explained,

> Sometimes, I get cut off when [the doctors] got the answers. I started interpreting what the patient says, and they would cut me off as soon as they hear their answers. Sometimes, the doctor or the provider would say, "Oh, yeah, yeah, I don't need to know all that." *I have to trust that the doctor has heard what they need to hear*. I think that's about it. *If I kept interpreting, they might not listen anyway*.

3.3. The interpreter seen as provider proxy

It is important to note that both interpreters and providers acknowledge the problems of interpreters bonding with patients or vice versa, arguing that such may interfere with the providers' treatment objectives. For example, Sharon[I] noted, "[The bonding] would allow the patient to control the interpreter, because they are going to expect certain things from you." Mindy[H] noted that interpreters may bond with a patient inappropriately by "stepping outside of their role, which is to be neutral." There can be a hidden tug-of-war between the providers and interpreters in competing for the patient's affection and trust. For example, Marcella[H] noted, "Cause we need to be the ones [as opposed to interpreters] that bond with them. [The patients] would have to be able to trust us." In short, there is a general concern about how interpreters' relationship with the patient may impact the providers' interpersonal, clinical, and therapeutic objectives. Both interpreters and providers cited incidents in which an interpreter was fired (or should be fired) because they acted as patient advocates.

In contrast, providers and interpreters showed little concern about the impacts of interpreters siding with health care providers. Some providers explicitly stated their expectation for interpreters' alliance. Camila[H] argued, "The translators should work with [providers] in a way that best meet their needs. I don't think patients are really thinking about the translator.

I think they are thinking about their health care." Carmen[H] explained, "[Interpreters are] pursuing [my] agenda. Their bias is towards us."

Some of the behaviors in this category may coincide with the co-diagnostician behavior discussed by other researchers [14, 15]. However, the primary focus of this category is the providers' assumption of interpreters' tasks in executing their objectives *without* their input. For example, Cecil[H] noted that as a pathologist, he cannot do his job without a sample of the patient's biopsy. Rather than having the interpreter to interpret back and forth between him and the patient, he allows the interpreter to "push" the patient, convincing the patient independently, to give consent to the procedure. He concluded,

> Usually the interpreter understands that this is really necessary. […] *I don't know what they're saying. The interpreter doesn't really say what they're saying.* [..] The bottom line is […] interpreter does whatever on their side, and the patient put their name to the permission [for the biopsy].

Although Cecil[H] was comfortable with the interpreters' independent conversation with the patient, his expectation is that the interpreters operate as an automated tool that executes his objectives (without his supervision or input). Many interpreters also talked about incidents in which a provider handed them a written consent form and asked them to go over the consent process with the patient. From this perspective, providers' utilitarian approach to interpreters' role, in fact, supersedes their expectation of the conduit model, in which the interpreters are only the voices of others. One may argue that, the interpreter in this particular situation actually adopt the providers' therapeutic objectives and, thus, assume the (unspoken) voices of the provider.

3.4. Interpreter's emotional support perceived as tools

Interpreters often are conflicted about the appropriateness in providing emotional support in health care settings [16], as it is an expected behavior embedded in social/cultural norms but not an approved performance in the conduit model. However, interpreters also talked about providing support to patients so that they are more likely to accept the providers' suggestions. For example, Vicky[I] explained,

> Sometimes, to comfort the patient, you have to hold the patient's hand. […] "Okay, these are difficult times. I know you are frustrated with your health. But you know, *this is what the doctor thinks. So, why don't we try.*" "Well, this doctor is not good enough. I am not going to take it." "Well, it's up to you. But *give yourself a try first.*"

Interpreters' emotional support and bonding can be a valuable resource in provider-patient interactions because the natural tendency for patients to feel connection with someone who shares the same language. For example, Mandy[H] commented, "When [interpreters] get on one on one terms with the patient, with just the small talk, they can sometimes tell you WAY MORE than if you've had a formal communication with everybody in the room."

Providers' sense of effective communication, however, often centers on patients' willingness to accept their care. For example, Michael[H] noted, "If [the patients] are connecting with the interpreter and the language gives them comfort, I want to connect myself with the interpreter if that's going to give us some kind of benefit to that patient that will improve their outcome." Interpreters' emotional support allows them to enter into patients' private worlds, to which the providers may not be privy, which may provide additional treatment opportunities. Some providers also talked about how interpreters' emotional support allows the interpreters' to become a trusted agent to the patients.

This expectation of interpreters' emotional support views interpreters as active agents in pursuing providers' therapeutic objectives. Some non-conduit behaviors are considered acceptable and appropriate. For example, interpreters' casual interactions with the patient may provide valuable information that may be medically relevant. Interpreters can communicate with the patients directly and independently to pursue the providers' agenda. In other words, providers adopt a utilitarian view of interpreters' relationship with patients and see it as opportunities and/or resources to achieve their own objectives.

4. Discussion and Conclusion

4.1. Discussion

The conduit model limits interpreters' power by objectifying interpreters as language-transferring machines [17], a restricted role that silences interpreters' voice. In contrast, a utilitarian approach is far more complicated and extensive in shaping interpreters' roles and functions: Interpreters as a whole, including their emotions and interpersonal relationships, are viewed as instruments to accomplish the provider's goals.

The utilitarian approach highlights several issues that require further consideration. First, whereas the conduit model views all speakers' voices to be equal (except the interpreter's voice), the utilitarian approach identified in our study privileges the providers' voice. Interpreters have been found to be biased toward providers' (as opposed to patients') perspectives even when they are familiar with the conduit model [18–20]. We suspect that this is because the utilitarian approach has superseded the conduit model in guiding both providers' and interpreters' practices in bilingual health care. Despite health care communities' emphasis on a team approach and open communication [21], the utilitarian approach involves the presumption that the interpreter, while a part of the health care process and team, is also somewhat peripheral to the process, playing an auxiliary or supporting role. The interpreters' voice is silenced. More importantly, the patient's voice is marginalized as interpreters are expected to redirect patients and filter information when the discussion becomes irrelevant to the provider's agenda. In short, the utilitarian approach can lead to divergent understanding about the success of a medical encounter (e.g., a provider may feel that all communicative goals are met when the patient and/or the interpreter feel otherwise).

Second, the utilitarian approach may lead to compromised care by situating interpreters in positions that can be ethically problematic. One issue emerged was the interpreter's role in information management. Providers' willingness to allow interpreters to act independently on their behalf may blur their professional boundaries. Because interpreters may not have the skills to differentiate what is medically meaningful (to the specific illness or the specialty), they may feel uncomfortable to filter "irrelevant" information. However, the utilitarian approach renders them powerless to resist providers' expectations. In addition, as interpreters preemptively filter out information, providers miss the opportunity to evaluate the quality or the meaning of the information they never received.

Another issue is the objectification of interpreters' emotional work. A humanistic, patient-centered approach requires providers to be attentive to patients' emotional needs [22]. However, the utilitarian approach views interpreters' emotional work and relationships as resources to be exploited. Providers in our study recognized interpreters' substantial power in influencing patients' attitudes and treatment decisions. Patients often place tremendous trust on their interpreters making them " honorary family members" simply because their commonality in language, ethnicity and country of origin [23]. Our findings suggest that interpreters' emotional work can be strategic in serving providers' objectives (rather than patients' emotional needs). From this perspective, the utilitarian approach may fail to

provide patient-centered care because patients' emotional needs are not honored but manipulated (via interpreters) to serve a provider's agenda.

Finally, we propose that interpreters should be viewed as a form of smart technology rather than a passive instrument to be wielded by the users. Whereas a hammer does not have control over its use or develop new skills over time, an intelligent program accommodates and learns from its users' needs but also sets a clear parameter about its functionality. Because of the changing boundaries of medicine, culture, and language in bilingual medical encounters, providers and interpreters often need to negotiate their roles, responsibilities, and expertise [5]. Although our findings suggest providers have used interpreters mostly as passive instruments, expecting interpreters to "don't speak unless spoken to" fails to recognize the complex utility an interpreter can offer in culturally sensitive care [16, 24]. When interpreters are viewed as smart technology, there will be a mutual-learning process between the interpreter and the provider. For example, a provider may trust a particular interpreter to assume more responsibilities (e.g., filter information or obtain consent) over time when they are familiar with the interpreter's skills after long-term collaboration [25, 26]. In short, we believe that a utilitarian approach should involve both providers and interpreters to accommodate, negotiate, and co-evolve with each other, allowing them to develop effective strategies to achieve their collaborative goal of optimal care[27, 28].

4.2. Conclusion

When interpreters are viewed as passive instruments, a utilitarian approach may compromise the quality of care by silencing patients' and interpreters' voice, objectifying interpreters' emotional work, and exploiting patients' needs. However, when interpreters can be viewed as smart technology, a utilitarian approach allows providers to remain in control of medical encounters while taking advantage of interpreters' feedback and recommended parameters. All parties will need to learn from and co-evolve with each other as collaborators in achieving culturally sensitive care.

4.3. Practice Implications

Based on our findings, we propose the following recommendations. First, incorporating interpreters' voices into the dynamic and emergent provider-patient interaction in a way that enhances the quality of care and honors the voices of providers and patients. This should be an issue to be explored at multiple levels (e.g., practice guidelines, provider/interpreter trainings, and research programs). Second, while recognizing a team approach is necessary in delivering quality care, it is important for researchers and providers to be critical in making sure that the utilitarian approach does not silence patients' perspectives or exploit patients' needs. Finally, providers should view interpreters as smart technology with learning capacity rather than a passive, static instrument. In other words, interpreters and providers should co-evolve and co-develop the parameters and strategies to best collaborate with each other in achieving their shared goal of optimal care.

Acknowledgments

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