



# Healthcare Interpreting and Informed Consent: What is the Interpreter's Role in Treatment Decision-Making?

Andrew Clifford

Volume 18, Number 2, 2e semestre 2005

Traduction engagée  
Translation and Social Activism

URI: <https://id.erudit.org/iderudit/015772ar>

DOI: <https://doi.org/10.7202/015772ar>

[See table of contents](#)

Publisher(s)

Association canadienne de traductologie

ISSN

0835-8443 (print)

1708-2188 (digital)

[Explore this journal](#)

Cite this article

Clifford, A. (2005). Healthcare Interpreting and Informed Consent: What is the Interpreter's Role in Treatment Decision-Making? *TTR*, 18(2), 225–247.  
<https://doi.org/10.7202/015772ar>

Article abstract

This article examines the part that healthcare interpreters play in cross-cultural medical ethics, and it argues that there are instances when the interpreter needs to assume an interventionist role. However, the interpreter cannot take on this role without developing expertise in the tendencies that distinguish general communication from culture to culture, in the ethical principles that govern medical communication in different communities, and in the development of professional relationships in healthcare. The article describes each of these three variables with reference to a case scenario, and it outlines a number of interventionist strategies that could be potentially open to the interpreter. It concludes with a note about the importance of the three variables for community interpreter training.

**Keywords:** community interpreting, informed consent, role of the interpreter, healthcare.

# **Healthcare Interpreting and Informed Consent: What is the Interpreter's Role in Treatment Decision-Making?**

**Andrew Clifford**

## **I. Introduction**

There is a meeting taking place in an oncologist's office, and several people are gathered around a table. The first of these is the oncologist, a physician and native English-speaker who was born and raised in Canada. Next is an elderly but competent male patient, a man who spent almost his entire life in Hong Kong and who speaks only Cantonese. Accompanying the patient are his adult children, who were born in Hong Kong and spent most of their formative years there. They are most comfortable speaking Cantonese, but they have few difficulties expressing themselves in English. Finally, there is also an interpreter present whose working languages are Cantonese and English.

In the course of the meeting, the physician explains the patient's diagnosis. The patient has hepatocellular carcinoma (HCC), a form of liver cancer. It is one of the most common types of cancer in Asia (Yeung *et al.*, 2005), and it is a serious health concern in Asian communities in North America (Nguyen *et al.*, 2004; McGlynn *et al.*, 2001). Patients with HCC have a low survival rate. In most cases, tumours are not amenable to curative treatments, and the median time between diagnosis and death can be as short as three months (Yeung *et al.*, 2005). The physician then goes on to say that there are two treatment options for the patient: curative therapies, which will be invasive, painful, and likely ineffective; and palliative therapies, which will seek to make the patient comfortable and increase his quality of life in the advanced

stages of a life-threatening disease. Now, the physician explains, he needs to obtain informed consent from the patient before pursuing one of these treatment options.

After relaying this information in English, the physician turns to the interpreter, and he nods to indicate that she should translate for the elderly patient. However, before she can begin, the patient's adult children interrupt with a frantic request: "Please don't tell our father he has cancer! We don't want him to know."

This kind of scenario places the interpreter at the heart of an intense and emotional dilemma. Somehow, a decision about treatment needs to come out of the meeting in the oncologist's office, but there is disagreement about how that decision will come about. The physician believes that sharing information with the patient is a necessary condition for decision-making. To withhold information from the patient would be unethical. The adult children believe that their father must be protected from the pain and harm of traumatic news. To expose him to such trauma would be to neglect their duty as loving children. The danger in this situation lies in the very real possibility that each side will become entrenched in its respective interpretation. The physician may retreat to a position consistent with his view of the events, concluding that "the patient's children are being unreasonable, and they want me to be unethical!" The patient's children may strike a similarly uncompromising stance by telling themselves that "the doctor wants to hurt our father, and he expects us to be disloyal!" If no one makes a move to bridge the distance between the two sides, it is likely that the situation will end badly. The physician may be prevented from giving quality care, the patient's children may experience a great deal of distress, frustration, and grief, and the patient may suffer unnecessarily.

Someone in this situation needs to find a way to break through this potential impasse, and this article argues that the person best suited to do so is the interpreter. In making this argument, we are parting company with those who feel that the interpreter's role should be more limited, that she should restrict herself to acting like a simple language conduit. Instead, we suggest that there are circumstances under which it is justifiable and even desirable for the interpreter to take on a more interventionist role and to participate in the encounter in a more active way.

Of all the people present in the oncologist's office, the

interpreter is arguably the most able to mediate between the parties and to point the way towards an acceptable resolution. Her role already requires her to navigate between the two language-cultures represented in the room, and her expertise navigating in this way also provides her with the necessary foundation for a more developed sense of cross-cultural communication. For example, even in something as simple as translating a typical greeting—the standard Cantonese phrase *nei hou* literally means “you good,” but it would be strange to render it by anything other than an equivalent English greeting like “hello”—the interpreter is on some level aware that people from different language groups behave differently even when faced with the same situation.

However, cultural knowledge gleaned purely through language will not be enough to allow the interpreter to actively intervene in the oncologist’s office. Indeed, despite the languages she shares with the other people in the room, there may be some important cultural differences that separate her from her clients. If the interpreter has only recently arrived in Canada, for instance, her exposure to English in other parts of the world may not have been enough to allow her to understand the physician’s attitudes and actions. Similarly, if she learned her Cantonese somewhere other than Hong Kong, she may not be able to put herself in the shoes of the adult children. To develop her cross-cultural communicative competence to the level required by this situation, the interpreter must become consciously aware of three key variables:

1. Culture-based communication preferences,
2. Ethical principles in cross-cultural healthcare, and
3. Levels of trust between practitioners and interpreters.

The goal of this article is to explore the interpreter’s interventionist role in ethically delicate situations. We will do this first by examining each of the three variables listed above as they apply to healthcare interpreting and informed consent. With this examination in place, we will then proceed to describe the strategies that interpreters can use to become active interveners. Finally, as a concluding thought, we will consider the implications that these strategies have for interpreter training.

## **II. Culture-Based Communication Preferences**

Just what is the source of the disagreement between the physician and the patient’s children? At first glance, the positions adopted by the two

parties may seem to be little more than a difference of personal opinion. The physician, being who he is, feels one way, and the children, being who they are, feel another way. The whole situation may appear to be individual, and random. The interpreter may initially think that it is difficult to predict each party's responses, and that it is therefore also difficult to prepare to mediate between them.

Indeed, it is important to recognize that there is an idiosyncratic element in communication, that people have personal communication preferences. The doctor's preference is to share information openly and freely with everyone involved. The children's preference is to restrict information sharing in a way that respects the roles of individuals within the family—as children, their duty is to protect their respected parent. However, upon closer examination, it is possible to see that personal preferences are expressed within a wider cultural frame.

When people are raised in a particular culture, they are exposed to a model of communication behaviour. It constitutes a norm, or a yardstick, that they use to make decisions about their own courses of action. Those decisions may lead them to subscribe to or rebel against, to varying degrees, the model they see around them. But they will nevertheless be influenced by the model. Their sense of a norm, and their own personal decisions, will be different from those of other people, who have grown up in a different culture.

To categorize the differences in models from culture to culture, the literature on cross-cultural communication has described a wide variety of cultural tendencies. Here, we limit our discussion to three specific tendencies that are at play in the oncologist's office. The three in question are derived from the work of Hofstede (2001) and Hall (1976), and are outlined briefly below.

### **1. Individualism vs. Collectivism**

This first tendency describes the strength of an individual's integration into a larger group. In individualist cultures, the individual is seen as the base unit in society. A great deal of value is placed on being independent, speaking one's mind, and offering personal opinions.

In collectivist cultures, the base unit is the group, and individuals build their identities around membership in a family, in a clan, or even in society as a whole. In terms of values,

collectivism stresses being dependent on other group members, demonstrating loyalty to them, and harmonizing with them.

## **2. Small Power Distance vs. Large Power Distance**

The second tendency relates to the way in which a culture views inequality. A culture that prefers a small power distance is a culture that believes power should be distributed equally. People generally try to downplay obvious signs of power, and they subscribe to the belief that all people are the same. It is acceptable to question or criticize those in positions of authority, and everyone is entitled to the “truth” or the “facts.”

In contrast, a culture that prefers a large power distance believes in unequal power distribution. In general, people take notice of the signs of authority, and all people play a role within an established vertical hierarchy. Public contradiction or criticism of an authority figure is not tolerated (instead a great deal of importance is placed on saving face), and there is a high degree of deference towards the authority figure’s personal wisdom.

## **3. Low-Context Orientation vs. High-Context Orientation**

The third and final tendency has to do with the preference for transmitting meaning explicitly or implicitly. In a culture that is marked by a low-context orientation, meaning is predominantly contained within the actual content of an utterance. People say things directly, and they go “straight to the point.” They make few assumptions about the background knowledge of their interlocutors, and they offer a great deal of explanation.

In a culture that is marked by a high-context orientation, a great deal of meaning may be within the receiver of a message or within the setting where it is transmitted. Producers of an utterance will often talk around an idea, setting all the pieces in place, with the exception of the main point. It is the role of the receiver to use gestures, space, and even silence to reconstitute information missing from the utterance. (Indeed, if the producer were to provide all the information, receivers might feel that they were being talked down to or that their intelligence was being insulted.) Little overt explanation is offered, and there is an assumption that producer and receiver have a great deal of shared knowledge.

There are two important points that the interpreter must bear in mind when she tries to apply these tendencies in her work. The first is that, although we have explained each of the tendencies here in terms of extremes, each one is, in reality, a continuum. No one culture is purely high-context oriented or entirely collectivist; instead, a culture may be described as being more high-context oriented or more collectivist as compared to another. Within each tendency, there is a wide variety of possibilities. If the interpreter works with people from a variety of backgrounds—that is, if she interprets for people from different English-speaking countries or for people from different places where Cantonese is spoken—she should expect to see the tendencies manifested to different degrees. She may find, for example, that there is a widespread preference for a small power distance among those clients who were born and raised in Canada, but that this preference is even stronger among clients who were born and raised in Australia (on this point, see Hofstede, 2001).

Second, as was pointed out earlier, individuals may subscribe in varying degrees to the tendencies in the cultures around them. For instance, the interpreter may encounter a client who has been raised in a culture that is, relative to another, marked by low power distance. Yet her client may nevertheless have a personal preference for high power distance. For this reason, she should not make unquestioned assumptions about a client based on their place of origin. Instead, she should examine her client's behaviour for evidence that suggests the degree to which his or her personal manner of communicating is consistent with wider tendencies in the client's culture. In other words, the people the interpreter will encounter in her work have all been exposed to broad culture-based tendencies in their lives, but they ultimately make personal decisions about their own communication preferences.

To understand how the interpreter might use her familiarity with communication preferences to better understand an interpreted encounter, we need only reconsider the situation in the oncologist's office in the light of the cultural tendencies outlined above. The physician, it would appear, prefers communication that is individualist, marked by small power distance, and low-context oriented. His concern lies primarily with the patient as an individual, and he is likely to maintain that the patient is entitled to the "facts" of the situation as a matter of *individual right*. He would like to transmit these facts in an open and direct manner to the patient. He may see his own input as "just" his personal, albeit informed, opinion, and he expects the patient to

speak his own mind as they work together, as two people who are more or less equal, to make a treatment decision. He may expect the patient to ask questions of him, to disagree with him, or even to criticize him (the physician is, after all, delivering some very bad news).

By comparison, the adult children's preferences lean in the direction of collectivism, large power distance, and high-context orientation. Their concern also lies with the patient, but they clearly perceive him in terms of his group membership—he is their father, the senior member of the family, and someone to whom they owe respect and loyalty. They see their relationship with their father from the perspective of interdependence. They have relied on him for many things in the past, and he now relies on them, this time for protection. The physician wants to present their father with information (perhaps a terminal diagnosis) that is extremely threatening to his honour and that may cause him to lose face. What is more, the physician wants to present this information in a way that is insulting to their father's intelligence. If the children were to have their way, they might eventually choose to share the bad news with their father, but in a way that is subtle and requires their father to make inferences. For example, if their father asks about his own prognosis, they may simply respond with silence to indicate the worst of all possible answers. They may feel that there is no need to convey this information bluntly. In addition, they may be very surprised by the doctor's consultative manner. They regard the doctor as an authority whose personal wisdom they should respect, and they expect him to make a decision. To see the doctor invite questions, disagreement and potential criticism may be disconcerting.

For the interpreter, the connection between the two parties' responses and larger notion of culture-based communication has an important ramification. Initially, the situation in the oncologist's office seemed like a random event. When she considered it at the discrete level of the actors involved, the disagreement between the physician and the adult children seemed to be the result of the interplay between individual personalities, something that would have been difficult to predict beforehand. However, when she stops to take into account larger cultural considerations, she may begin to see a pattern. Experience may have taught her that certain kinds of communicative preferences are common among her English-speaking clients, while others are widespread among the Cantonese-speakers that she serves. In fact, if she had known some of the details of this particular interpreting assignment before she walked in the office door—Western physician, frightening prognosis, Eastern



patient, and Eastern family—she may have been able to predict important behaviours to watch for in the encounter. In turn, her predictions may have allowed her to better prepare for the encounter.

### **III. Ethical Principles in Cross-Cultural Healthcare**

In the previous section, our discussion focused on culture-based communication preferences. As we have seen, individual actions are subject to the broad influence of culture as a variable, and this variable provides us with a helpful lens through which to understand and, to a certain extent, predict individual actions. However, culture is a very general variable that is at work in a variety of settings. The encounter in the oncologist's office takes place within one very specific setting—a medical one—and this too has an influence on the turn of events.

All the actors assembled in the oncologist's office are there because they are trying to make a decision about medical treatment. This decision is ultimately a moral one—the people in the room are trying to distinguish the right way of handling the situation from the wrong way of handling it. Indeed, one of the features of communication in healthcare that distinguishes it from communication in other areas is that healthcare frequently involves making moral judgments about human welfare (Beauchamp & Childress, 1983; Veatch & Flack, 1997).

For a judgment to be moral, it must typically have three characteristics. First, it must try to minimize ego-driven concerns by ensuring that concern for the other is taken into account. Second, it must be universal, that is, it must determine whether all relevantly similar cases are treated in a like manner. Finally, it must be ultimate, verifying that a primary commitment is made to the issue at hand and not to some other competing value (Beauchamp & Childress, 1983; Veatch & Flack, 1997).

It's easy to see how the characteristics of moral judgments shape the encounter in the oncologist's office. For example, the patient's children may eye the physician suspiciously. They may wonder whether the doctor is only concerned with his own interests. After all, it is likely easier for him to spit out a diagnosis than it is to think about the traumatic impact that diagnosis will have on the patient. Similarly, they may question whether the doctor would be so disrespectful and direct with other patients. Or has their father been singled out in some way? Finally, the children may worry that their father is not getting the best care. The

doctor may be allowing his value for another issue—like treatment costs or recruiting patients for a clinical trial—to outweigh his concern for their father.

For his part, the physician is likely to have parallel concerns. He may wonder whether the children are operating out of concern for themselves. To be sure, it is probably easier for them to deny their father's prognosis than to transmit the information he needs to make a decision about it. Likewise, he may question whether the children, in discussing someone else's treatment, would agree that the truth should be kept hidden from that person too. Or have they singled out their father for some reason? Finally, he may wonder whether the children are allowing their father to receive the best care. They may instead be allowing the value they place on other considerations—such as their respect for their father's status as head of the household—to take priority over their concern for him as an individual.

As both the physician and the patient's children bring their concerns to the encounter, they may have established notions of what ethical medical behaviour should look like. Indeed, it is likely in both cases that they will have been to some extent exposed, through their previous experiences in healthcare, to some form of disciplined reflection on the moral choices that people traditionally make. In other words, they will have had some exposure to principles of medical ethics. However, it is likely that the principles that motivate each will be different.

The physician will likely be swayed by two particular principles (Veatch, 1997a; Veatch & Flack, 1997).

### **1. Autonomy**

This principle holds that the patient has a right to make his own decisions, and that no treatments can go ahead without the patient's consent. The importance of autonomy as a principle of medical ethics can be traced back to the development of Protestantism, which gave the lay person more say in theological, and therefore ethical, concerns (Veatch, 1997b), and from the advent of liberal thought following the Enlightenment (Veatch, 1997a). Since these are the forces that likely also gave rise to the physician's communicative preferences, it may be useful to think of autonomy as representing in medical ethics what individualism, small power

distance and low-context orientation represent in communication more generally.

## **2. Veracity**

In order for the patient's consent to be meaningful, the patient has to have enough information to make a reasonable decision. Clearly, the patient will have difficulty acquiring this information if healthcare practitioners do not disclose it, and so honesty between practitioner and patient is paramount. As an ethical principle, veracity can be understood as the fallout from the Nuremberg trials. Evidence was presented at the trials that detailed the horrific experiments carried out by the Nazis, ostensibly in the name of science. The trials drove home the importance of obtaining voluntary and meaningful consent from patients (Beauchamp, 1997; Veatch, 1997b).

For the physician, behaving ethically is largely a question of respecting the principles of autonomy and veracity, something that also explains the importance placed on obtaining informed consent from patients. However, the principles were spawned by historical events in the West—the Protestant Reformation, the Enlightenment, and the Nuremberg Trials—which in turn suggests that we cannot expect these particular principles to have universal currency.

Indeed, the understanding that the patient's children have of ethical behaviour is likely shaped by two alternative principles.

## **1. Filial Piety**

This principle dictates that medical choices should be based on an understanding of the roles and responsibilities that exist within the family. Parents have an obligation to safeguard children, and children owe respect to their parents. In the case of an elderly patient, this means that there will be an expectation that the patient will be cared for by the rest of the family and relieved of many responsibilities, including the responsibility of making treatment decisions (Hui, 1999). Under filial piety, individual autonomy is replaced by familial autonomy. One-on-one encounters between patients and healthcare practitioners alone will be rare, and broader consultations involving practitioners, patients, and their families will be the norm (Fan & Li, 2004; Hui, 1999). As an ethical principle, filial piety can be traced back to notions of

communitarianism, which stress the individual's role in the wider community (Veatch, 1997a) or perhaps even to the Confucian principle of humaneness (often Romanized as *jen* according to the Wade-Giles system or as *rén* in Pinyin) and its modelling of interactions in society on relationships in the family (Tsai, 2005; Fan & Li, 2004; Hui, 1999).

## **2. Paternalism**

If filial piety removes the burden of decision-making from the patient, then paternalism places it on someone else. It suggests that patients are not always able to make decisions that are in their own interests, and that someone else may be better placed to do so. For example, the paternalist principle holds that revealing fateful news to the patient can at times be harmful, and it can advocate withholding information from the patient or even lying about the patient's condition (Fan & Li, 2004; Hui, 1999; Veatch, 1997a). Paternalism, of course, is not only found in Eastern ethical traditions; it was widely advocated in Western traditions before the advent of informed consent in the post-War era, and its presence can still be felt in the West today. However, Fan & Li (2004) argue that in Western paternalism the physician alone decides whether to withhold information from the patient, whereas in Eastern paternalism that decision is most often made in consultation with the family. (On this point, see also Tai & Tsai, 2003).

What is apparent at this point is that the positions adopted by the physician and the patient's children are consistent with two opposing ethical traditions. On the one hand, the physician maintains that behaving ethically in this instance requires him to focus on the right that the patient has, as an individual, to self-determination, and on his obligation to disclose as much information as possible so that the patient is truly able to exercise that self-determination. On the other, the patient's children believe strongly that doing right is a matter of showing respect to their father by making decisions for him when he is in pain and of safeguarding him from frightening news that would only cause him further harm.

The important point here is that the interpreter needs to recognize the power that ethical principles have in shaping the encounter in the oncologist's office. In the same way understanding cultural tendencies helped her to analyze communication generally, so too will a

familiarity with ethical principles help her analyze communication specifically within the medical realm. If the interpreter is going to work in healthcare, she needs to know the particularities of communication in this setting. This knowledge will serve her in good stead, helping her to once again predict wider patterns in her clients' behaviour, to recognize them when they are manifested in front of her, and to prepare her own responses.

#### **IV. Levels of Trust between Practitioners and Interpreters**

As we argued above, the danger in the conversation between the doctor and the adult children is that neither side will soften their position. For the physician, suggesting that he not obtain informed consent from the patient may be akin to "taking away his moral compass" (Solomon, 1997) and to casting him adrift without ethical guidance. For the patient's children, the idea of leaving their father unsupported and alone to receive devastating news and make what are potentially end-of-life decisions at a time when he is already suffering seems cruel and inhumane (Fan & Li, 2004). With so much at stake and such strong feelings at play, it may take a third party to mediate between the two sides.

For this reason, we argue that it may be appropriate for the interpreter to adopt a more interventionist strategy in her work. However, before we can explore what such a strategy might look like, it is necessary to first understand the variables that place constraints upon her. One of the most important variables to consider is the degree of trust that has been built up between the interpreter and the physician. This is a topic that has been addressed at length elsewhere (Clifford, 2006), so our discussion here will be brief.

There is a widely held belief in the realm of community interpreting that the only defensible and ethical strategy for the interpreter to use is to repeat in the target language everything that is said in the source language as exactly as possible. This belief maintains that the role of the interpreter is simply to act as a neutral and invisible conduit, transferring information from patient to healthcare provider and back again. However, as popular as this "conduit model" of interpreting may be in some quarters, observation of interpreters at work has demonstrated repeatedly that interpreters engage in a variety of behaviours that go beyond simple linguistic transfer (Angelelli, 2004; Metzger, 1999; Wadensjö, 1998), and an examination of ethical models

in translation studies has suggested that a wider role for the interpreter is ethically defensible (Clifford, 2006).

Nevertheless, advocates of the conduit model stress that it is oftentimes difficult to get an interpreter into the doctor's office in the first place. In the scenario outlined at the beginning of this article, it was simply taken for granted that an interpreter was present in the oncologist's office, but it frequently takes a lot of lobbying to convince healthcare practitioners that it is necessary to work with a professional, trained interpreter when treating patients who have limited proficiency in the practitioner's working language. For this reason, advocates of the conduit model argue that, once in a practitioner's presence, interpreters should allow the practitioner to have maximum control over the encounter with the patient. Doing so increases the likelihood that the interpreter will be called into the practitioner's office the next time around, and that patients will therefore have access to the kind of communication needed to benefit fully from the healthcare they are receiving.

However, consultations with healthcare providers have provided some indication that the dynamics of the relationship between interpreter and practitioner may be more complex, and that there may be occasions in which the interpreter can exercise more latitude. One way to help interpreters choose appropriate strategies is to associate these strategies with varying levels of trust that are established as the interpreter and the practitioner become accustomed to working together.

### **1. Cede Control over the Situation**

When a practitioner and interpreter collaborate for the first time, the practitioner is unfamiliar with the interpreter's professional competence. As a result, there will likely be only a limited sense of trust. In an instance like this, it is probably best for the interpreter to work according to the conduit model, that is, to make an effort to provide exact translations of all that is said. In other words, the interpreter should cede control of the situation to the practitioner, in the interests of building a professional relationship on trust.

### **2. Provide Additional Information**

As the provider and interpreter continue to work together, their sense of comfort and familiarity may grow. Consequently, the provider may call upon the interpreter for isolated bits of

cultural information that help provide a better level of care for the patient (e.g., the interpreter may warn the provider about dietary restrictions that are common in the language community, or about religious/cultural holidays that may interfere with treatment, etc.).

### **3. Offer Assistance to a Team Member**

As the provider places evermore trust in the interpreter, the interpreter may increasingly be viewed as a member of a treatment team. The provider may therefore approach the interpreter before an encounter with a patient in order to learn about cultural variables that have to be considered when mapping out a treatment plan. Alternatively, during the encounter with the patient, the interpreter may be asked to help mediate knowledge gaps (e.g., the interpreter may explain the way the healthcare system functions to the patient, or she may explain some of the patient's health-related expectations to the provider).

In short, this quick summary of trust-building suggests two things about community interpreting. First, interpreting is a complex activity. It will frequently require the interpreter to move beyond the confines of the conduit model and take on roles that involve more than simply transferring information from the source to the target language. Second, the roles that the interpreter is able to adopt will be governed to a large extent by the amount of trust that has built up between the interpreter and the healthcare provider. At the beginning of a professional relationship, the interpreter will likely take on a more limited role, but as that relationship grows, the interpreter may be given more latitude to intervene in the medical encounter. In this sense, there is an element of predictability to the interpreter's interventions. They will be in part directed by trust, just as the interventions made by the physician and the patient's children were directed by communicative preferences and ethical principles.

## **V. Implications for Interpreting**

In the preceding section, we examined how interpreters may use cues from their collaboration with healthcare providers to judge the type of role that they may justifiably assume. However, this examination has not yet explained the specific behaviours that might be associated with the interpreter's different roles. In other words, once an interpreter has

determined the role that would be appropriate in a given setting, what does the interpreter actually do? To answer this question, we now revisit each of the three levels of trust and describe what the interpreter in the oncologist's office might do to intervene in each case.

### **1. Cede Control over the Situation**

If the interpreter is working with the physician for the first time, it is not likely that she will have the opportunity to intervene actively in the encounter. Instead, it is more likely that her behaviour will follow the dictates of the conduit model. However, just because she will not be asked to explain the cultural and institutional factors at work in this situation to anyone does not mean that she can be ignorant of them herself. Indeed, she has an obligation to understand the differences in communicative preferences and in ethical principles that are at play in the oncologist's office. The conduit model indicates that she should remain as neutral as possible, something she cannot do if she does not understand the variables that have led both the physician and the patient's children to take up their respective positions.

For example, if the interpreter's own communication preferences are in line with those of the physician, she may have difficulty empathizing with the children and be tempted to view them as unreasonable people who are asking the doctor to behave unethically. Conversely, if her communication preferences are in line with those of the children, she may be tempted to conclude that the doctor is a heartless man who wants the children to be disloyal and disrespectful. In either case, she will have difficulty being a neutral and invisible conduit for information transfer, because the temptation will be great to pass judgement on one of the two parties. To counter this difficulty, she will need to actively call upon her knowledge of communication and ethics, suggesting that even within the confines of the conduit model, there is an element of activism to the work that she carries out.

### **2. Provide Additional Information**

If the interpreter is beginning to form a working relationship with the physician, she may occasionally have the opportunity to make her own, non-interpreted contributions to the conversation. She may want to consider using this opportunity



to add information that will help each side reach out to the other. To do so, she will have to take two quick actions. First, she will need to identify for herself the cultural and institutional variables that are shaping the misunderstanding. Second, she will need to find a concise way of describing those variables to the two parties in the encounter.

The interpreter may, for instance, point out to the physician that “in the East, it is very important for children to help their parents save face.” In a similar aside to the patient’s children, the interpreter might note that “in the West, it is very important for the practitioner to obtain informed consent.” Clearly, neither of these brief statements is going to resolve the disagreement entirely, but they will afford each party a glimpse into the world of the other. In addition, the interpreter will have to be careful to add this information in a way that is transparent (Solomon, 1997). She will have to distinguish the instances when she is contributing something of her own accord from those where she is interpreting something the physician or the children said. Usually, it is enough to consistently mark non-interpreted utterances (“I’d like to add something of my own here...”) and leave interpreted utterances consistently unmarked.

### **3. Offer Assistance to a Team Member**

If there is a well established working relationship between the interpreter and the physician, the interpreter may have the opportunity to offer more substantial assistance. This opportunity may come in the form of a briefing session that takes place before an encounter with actual patients. In these sessions, the interpreter’s duty is to raise issues that could potentially have a negative impact on cross-cultural healthcare communication, and also to explore the ways in which compromise can be used to prevent miscommunication.

For example, the interpreter should point out that family involvement will be a strong theme in the elderly patient’s treatment, and she should signal that the children may be very protective of their father. If necessary, she can very briefly describe why that is the case, by outlining some of the material presented in this article about communication preferences and ethical principles. However, the interpreter’s most valuable

contribution may potentially lie in her ability to help the physician construct strategies that can potentially avoid a disagreement with the children before it happens. One strategy, described in detail in Solomon (1997), may be to sit down with the elderly patient during his first visit and explain that the doctor would be willing to share information about the patient's condition in one of three ways: with the patient alone, with the patient's children alone, or with the patient in the presence of his family. The patient could then decide which of the three options would be his preference. This strategy helps the physician address the issue of autonomy by understanding whether autonomy in this situation will take the form of individual autonomy, family autonomy with paternalistic decision-making (i.e., the children make a decision without necessarily informing the patient), or family autonomy with family co-decision-making (i.e., all family members have a say in the decision) (Cong, 2004).

An alternative strategy would involve the physician sitting down to talk about communication with both the patient and his children. He could start by saying that he recognizes that families often build an important bridge between the doctors and the patients, but that he likes to encourage families to actually cross the bridge, that is, to share information with the patient (Cong, 2004). This approach has several advantages. First, it signals to the family that their role and their wishes will be valued and respected. Second, it allows the physician to broach the topic of his obligation to obtain informed consent. However, the physician should be aware that the children's method of "crossing the bridge" may not take the form he expects. Cong's (2004) interviews with healthcare stakeholders in one Eastern locality, Beijing, showed how information can be transmitted both indirectly and clearly. The stakeholders suggested that families tend to disclose information to patients when the outcome is positive. When it is negative, information tends not to be disclosed. Thus, it is likely possible for patients to recognize fateful news by the fact that their families are not forthcoming with it.

There is also a final possibility that might salvage the situation in the oncologist's office the way it actually played out. Culhane-Pera (2003) describes a case where she treated an elderly female patient who was

facing a terminal diagnosis. The patient was from a culture that might accurately be described as collectivist—decisions about her treatment were being made by her adult children in consultation with community leaders. Culhane-Pera attended a decision-making meeting where the patient was absent, and subsequently went to see the woman. She informed her patient that she had been talking with the patient's children about treatment, and she asked whether the patient wanted to know what they had talked about. Culhane-Pera then notes that she watched and listened carefully for the patient's high-context response (i.e., silence, changing the topic—both of which signalled the answer “no”). The interpreter might counsel the oncologist to use a similar approach in his dealings with the elderly man from Hong Kong.

In each of the three cases outlined above, what is noteworthy is the interpreter's intervention. At the first level of trust, there is no overtly active intervention. In other words, the only activity the interpreter is outwardly engaged in is the matching of source-language forms with corresponding target-language ones. However, the interpreter does need to educate herself about issues that go beyond linguistic transfer if she is to carry out her work successfully. At the second level, the interpreter is able to intervene, that is, she breaks out of the constraints of the conduit model to make an independent contribution to the discussion in the oncologist's office. That intervention is limited in nature—she is only able to make a few quick observations, taking care to identify them as such—but the information she provides may allow the other actors in the conversation to bridge the distance that separates them. Finally, at the third level of trust, the interpreter intervenes in the proceedings in an overt and active way. She is a participant in the briefing sessions where treatment plans are explored, and she uses her expertise in cross-linguistic and cross-cultural communication to propose communication strategies to the physician.

## **VI. Conclusion**

In this article, we have outlined a number of important variables that affect the interpreter's work in the doctor's office. Interpreters must be aware of differences in culture-based communication preferences that affect community interpreting generally, and they must be conscious of the principles of medical ethics that will influence interpreting specifically in the area of healthcare. They must also understand the ways in which the relationships they have built with healthcare providers can remove constraints placed around their role.

The interpreter's knowledge of these three variables is key. In healthcare interpreting, there will be instances where communication between patients and providers is stalled by misunderstandings. To circumvent these misunderstandings, each side needs to open a window through which they can fairly and accurately view the other, yet it seems unlikely that in all cases they will be able to open this window for themselves. Healthcare practitioners have a heavy burden ensuring that their technical knowledge and ability to practice are kept at a level that is state-of-the-art. To be sure, they can take some responsibility for delivering healthcare in a way that is culturally sensitive, but it seems unreasonable to believe that they will be able to gather detailed knowledge about the cultural tendencies and ethical beliefs of all the cultural communities that they serve. It likewise seems unfair to expect patients who require interpreting to take responsibility for successful cross-cultural communication, particularly when patients have had limited access to formal education or when they are relative newcomers to the countries in which they find themselves. Instead, it makes better sense to place interpreters in charge of success in cross-cultural healthcare communication. Through their language knowledge, interpreters have a good foundation for this task, and it is reasonable to ask them to develop a comprehensive understanding of the peoples who are represented by their working languages. Of course, interpreters need to build on their foundation and cultivate their knowledge of communication preferences, ethical principles, and levels of trust. Only then can they effectively and responsibly take an interventionist approach to their work.

However, interpreters cannot put their knowledge of the three variables to good use if they do not possess that knowledge in the first place. And while there are obviously individual interpreters who will be able to reflect on their professional experiences and become overtly aware of the three variables, there are others who will not. For this reason, the kind of information presented here should be included in the training that community interpreters receive. Currently, community interpreting as a profession is in a state of flux—where once formal training for community interpreters was rare, an ever-increasing amount of attention is now being paid to the profession, and this attention will undoubtedly result in more formal training. The weight of the evidence presented in this article would seem to indicate that future training programs should focus squarely on the complexity of the role of the interpreter and on the information that interpreters need to navigate that complexity.

Ultimately, this training will help interpreters to be more successful in their work. This success will hopefully translate into the prevention of the types of disagreement that was mapped out in this article. Instead of retreating to their entrenched positions, what if—through the interpreter’s interventions—the physician and the patient’s children were each able to come to a better understanding of the other’s position?

The physician might reflect on the situation and note, “Before, I always obtained informed consent by dealing directly with my patient as an individual, but now I can see that sometimes it’s important to work with the patient as a member of a larger group.” Similarly, the patient’s children might consider the events at hand and remark, “We want to protect our father while he’s vulnerable, but we can see that it makes sense for the doctor to offer the information needed to offer our father the best care possible.” If these are the statements made in the oncologist’s office, then the interpreter will know that she has successfully taken on an active role in treatment decision-making and guided her clients to meaningful understanding. In so doing, she will have paved the way for a truly ethical decision about curative or palliative treatment, and she will have done her part to help ensure that the physician is able to offer quality care, that the patient’s children see their loved one treated with compassion and respect, and that the patient can hope for a more positive outcome.

**University of Toronto**

### **References**

ANGELELLI, Claudia (2004). *Medical Interpreting and Cross-Cultural Communication*. Cambridge, Cambridge University Press.

BEAUCHAMP, Tom L. (1997). “Informed Consent,” in Robert M. Veatch (ed.). *Medical Ethics* (2<sup>nd</sup> ed.). Sudbury, MA, Jones and Bartlett, pp. 185-208.

— & CHILDRESS, James F. (1983). *Principles of Biomedical Ethics* (2<sup>nd</sup> ed.). New York, Oxford University Press.

CLIFFORD, Andrew (2006). “Is Fidelity Ethical? The Social Role of the Healthcare Interpreter.” *TTR*, 17, 2, pp. 89-114.

CONG, Yali (2004). "Doctor-Family-Patient Relationships: The Chinese Paradigm of Informed Consent." *Journal of Medicine and Philosophy*, 29, 2, pp. 149-178.

CULHANE-PERA, Kathleen A. (2003). "'Please Help Me': A Physician Responds to a Hmong Woman's End-of-Life Struggles," in Kathleen A. Culhane-Pera, Dorothy E. Vawter, Phua Xiong, Barbara Babbitt & Mary M. Solberg (eds.). *Healing by Heart: Clinical and Ethical Case Stories of Hmong Families and Western Providers*. Nashville, Vanderbilt University Press, pp. 289-294.

FAN, Ruiping & LI, Benfu (2004). "Truth Telling in Medicine: The Confucian View." *Journal of Medicine and Philosophy*, 29, 2, pp. 179-193.

HALL, Edward T. (1976). *Beyond Culture*. Garden City, NY, Anchor Press/Doubleday.

HOFSTEDE, Geert. (2001). *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations* (2<sup>nd</sup> ed.). Thousand Oaks, CA, Sage Publications.

HUI, Edwin. (1999). "Chinese Health Care Ethics," in Harold Coward & Pinit Ratanakul (eds.). *A Cross-Cultural Dialogue on Health Care Ethics*. Waterloo, ON, Wilfred Laurier University Press, pp. 128-138.

McGLYNN, Katherine A., TSAO, Lilian, HSING, Ann W., DEVESA, Susan S. & FRAUMENI, Joseph F. (2001). "International Trends and Patterns of Primary Liver Cancer." *International Journal of Cancer*, 94, 2, pp. 290-296.

METZGER, Melanie (1999). *Sign Language Interpreting: Deconstructing the Myth of Neutrality*. Washington, Gallaudet University Press.

NGUYEN, Mindie H., WHITTEMORE, Alice S., GARCIA, Ruel T., TAWFEEK, Saraa A., NING, Jing, LAM, Suzanna, WRIGHT, Teresa L. & KEEFFE, Emmet B. (2004). "Role of Ethnicity in Risk for Hepatocellular Carcinoma in Patients with Chronic Hepatitis C and Cirrhosis." *Clinical Gastroenterology and Hepatology*, 2, 9, pp. 820-824.

SOLOMON, Mildred (1997). "From What's Neutral to What's Meaningful: Reflections on a Study of Medical Interpreters." *The Journal of Clinical Ethics*, 8, 1, pp. 88-93.

TAI, Michael Cheng-tek & TSAI, Tsung-po (2003). "Who Makes the Decision? Patient's Autonomy vs Paternalism in a Confucian Society." *Croatian Medical Journal*, 44, 5, pp. 558-561.

TSAI, D. F.-C. (2005). "The Bioethical Principles and Confucius' Moral Philosophy." *Journal of Medical Ethics*, 31, pp. 159-163.

VEATCH, Robert M. (1997a). "Autonomy and Communitarianism: The Ethics of Terminal Care in Cross-Cultural Perspective," in K. Hoshino, (ed.). *Japanese and Western Bioethics: Studies in Moral Diversity*. Dordrecht, Kluwer Academic Publishers, pp. 119-129.

— (1997b). "Medical Ethics: An Introduction," in Robert M. Veatch, (ed.). *Medical Ethics* (2<sup>nd</sup> ed.). Sudbury, MA, Jones and Bartlett, pp. 1-27.

— & FLACK, Harley E. (1997). *Case Studies in Allied Health Ethics*. Upper Saddle River, NJ, Prentice Hall.

WADENSJÖ, Cecilia (1998). *Interpreting as Interaction*. London, Longman.

YEUNG, Yuk Pang, LO, Chung Mau, LIU, Chi Leung & WONG, Benjamin C. (2005). "Natural History of Untreated Nonsurgical Hepatocellular Carcinoma." *American Journal of Gastroenterology*, 100, 9, 1999-2004.

**ABSTRACT: Healthcare Interpreting and Informed Consent: What is the Interpreter's Role in Treatment Decision-Making? —**

This article examines the part that healthcare interpreters play in cross-cultural medical ethics, and it argues that there are instances when the interpreter needs to assume an interventionist role. However, the interpreter cannot take on this role without developing expertise in the tendencies that distinguish general communication from culture to culture, in the ethical principles that govern medical communication in different communities, and in the development of professional relationships in healthcare. The article describes each of these three variables with reference to a case scenario, and it outlines a number of

interventionist strategies that could be potentially open to the interpreter. It concludes with a note about the importance of the three variables for community interpreter training.

**RÉSUMÉ : L'interprétation dans le domaine des soins de santé et le consentement éclairé: quel est le rôle de l'interprète dans le choix du traitement?** — Dans cet article, l'auteur fait le point sur le rôle de l'interprète communautaire face à des conflits d'éthique dans le domaine de la santé. Dans des circonstances bien définies, on propose à l'interprète un comportement plus interventionniste que de coutume. Mais avant d'intervenir plus activement, l'interprète doit développer ses compétences dans trois domaines : il doit se familiariser avec les facteurs servant à décrire la communication dans différentes cultures; il doit connaître les principes d'éthique médicale privilégiés par différentes collectivités; et il doit bien comprendre le fonctionnement de ses relations avec des professionnels de la santé. Après avoir décrit, à l'aide d'une étude de cas, chacune de ces trois compétences, l'auteur examine les stratégies interventionnistes disponibles à l'interprète et, en guise de conclusion, il souligne l'importance des idées présentées dans l'article pour la formation d'interprètes communautaires.

**Keywords:** community interpreting, informed consent, role of the interpreter, healthcare.

**Mots-clés :** interprétation communautaire, consentement éclairé, rôle de l'interprète, soins de santé.

**Andrew Clifford:** School of Graduate Studies, University of Toronto, 63 St. George Street,  
Toronto ON M5S 2Z9, Canada  
Email: [andrew.clifford@utoronto.ca](mailto:andrew.clifford@utoronto.ca)