Healthcare interpreting ethics
A critical review

Robyn K. Dean

1 Introduction

This chapter addresses ethics in medical or healthcare interpreting and specifically focuses on interpreting situations where the patient does not share, or have a sufficient proficiency in, the language of their healthcare providers. Interpreters working in healthcare settings can seek out ethical guidance from multiple sources. All professions have various types of ethical content material (Hill 2004: 131), which both compels practitioners to take action and constrains action. The most obvious source of such ethical guidance is a formal code of ethics or code of professional conduct. There are, however, many other types of ethical content material. Normative ethical material can be found in sanctioned ethical documents (e.g. standards of care), prominent textbooks or other written sources, and even the ethical standards set by prominent educators or scholars in a field (Dean 2015: 96). All of these sources collectively have a normative effect (Hill 2004: 140); that is, they provide some guidance on what is effective or ineffective or what is right and wrong in professional practice.

This chapter reviews these sanctioned materials – ethical codes and standards of practice in healthcare settings. Some attention is given to practice norms outlined in research studies, and other discursive items that might have ethical weight for healthcare interpreters. The chapter concludes with suggestions for further movement toward improving healthcare ethics for practicing interpreters.

2 Ethical content material: ethical codes

An ethics review of any profession begins with the normative ethical material that is sanctioned by professional organisations and other such authoritative bodies that oversee the work of its practitioners. The same would be true for the field of translation and interpreting.

Most interpreters (and translators) are trained to work as generalists. That is, they tend to focus on improving their linguistic and translation skills without a significant emphasis on any particular domain, such as law or medicine. As such, it is important to
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consider generalist ethical codes within translation and interpreting as equally intended for healthcare interpreting contexts.

The generalist ethical codes in the field of translation can offer healthcare translators and interpreters some ethical guidance. Codes of professional conduct or codes of ethics (CoE) have been authored by an array of stakeholders. Most commonly, CoE are created for members in a professional organisation. They can also be created by private agencies or by governmental entities. Some CoE have been written for setting-specific purposes such as legal, educational, and medical settings (Mikkelson 2000: 50).

General translation and interpreting CoE tend to cite a broad range of ethical ideals; there does not appear to be too much variability in guidance across various subfields. In their international study, Leneham and Napier (2003: 79) found several key elements emphasised in CoE: professionalism, confidentiality, competence, impartiality, accuracy, employment, professional development, and professional solidarity. McDonough Dolmaya (2011) found similar tenets in her investigation of 16 ethical codes: accuracy, fidelity, professionalism, competence, and broader issues of employment (see also Kalina 2015: 68).

The overlap between these codes is significant. It has been argued that the subfields of written translation and interpreting (both conference and community interpreting) share the same set of ethical principles (Kalina 2015: 67). Yet, others have suggested that the generalist CoE limit the ethical options for community interpreters and result in insufficient guidance for ethical practice (Angelelli 2004; Dean and Pollard 2018; Leneham and Napier 2003; McDonough Dolmaya 2011). Some have further proposed that setting-specific ethical codes are therefore warranted (Angelelli 2004; Leneham and Napier 2003). Whether or not an ethical code specific to healthcare interpreting would provide significantly greater ethical guidance for interpreters in healthcare is explored next.

The International Medical Interpreters Association (IMIA) is an international organisation with chapters in 15 countries, including Brazil, Canada, China, Costa Rica, Egypt, India, Italy, Japan, Mexico, Russia, South Africa, South Korea, and Spain. The IMIA is based in the United States as is the National Council on Interpreting in Health Care (NCIHC). The IMIA published its ethical code in 20102 and the NCIHC in 2004.3 The Japanese Association of Medical Interpreters (JAMI) established its Code of Ethics for professional medical interpreters in 2011.4 Table 12.1 compares the ethical tenets of generalist codes with healthcare-specific codes gleaned from these associations’ documents.

As is evident in Table 12.1, most ethical tenets specific to healthcare overlap with the tenets from generalist’s codes. Ethical tenets that are unique to the healthcare-specific ethics documents include: advocacy, cultural interface/awareness, education and collaboration, interpreter privacy and health, societal contributions, and professional relationships. Further review of these tenets shows that while they use terms associated with healthcare-specific settings and professionals, there is not much offered that would be distinguishable from another setting. In other words, the healthcare terms that are used in these tenets (e.g. healthcare professionals or biomedical culture) could be readily replaced with their counterparts from another setting and still read as true and applicable. For the healthcare-specific codes to have a substantive application to healthcare, there would need to be additional content on the impact to those service-users in healthcare settings, such as providers’ effectiveness and patients’ health.

Furthermore, the same tenet may be used differently in different codes. In the NCIHC Code (2004), for instance, the tenet of advocacy is specifically identified as possibly needed for the sake of good health outcomes, whereas in the IMIA (2010) advocacy is only noted
as potentially necessary for good communication. Good health outcomes are unique to medicine whereas good communication is arguably important in any setting.

In other instances, in all three healthcare-specific ethical codes, unique healthcare content (e.g. concerns for the welfare of the patient) is noted. Only those tenets that specifically identify consequences to patients and providers are noted in italics in Table 12.2.

This review of relevant ethical codes raises the question of whether or not healthcare-specific ethical codes offer greater ethical guidance for practitioners or at least, do so in their current form. Standards of practice documents are explored later for their contribution to ethical guidance in interpreting practice. However, before additional ethical content material is explored, it is important to review some terms from the broader field of ethics. These definitions will both clarify and help to frame an examination of other types of ethical material in healthcare interpreting.

### 3 Common ethical terms defined

The question, ‘What is the role of the interpreter?’ is often used to begin discussions on the expected behaviours of interpreters. In response, practitioners, researchers, and educators typically respond with behavioural ideals conveyed through the use of metaphor. They might say: ‘Think of an interpreter as a bridge, a co-participant, or an advocate.’ Conversations in healthcare interpreting have also relied on the use of metaphors (Davidson 2000; Hsieh 2008).

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**Table 12.1 Comparison of ethical tenets of generalist codes with healthcare-specific codes**

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In past publications, my co-author and I have critiqued the use of rhetorical devices such as ‘role’ and ‘metaphor’ as a means of discussing ethics; these terms and constructs fall under the category of descriptive ethics and therefore, differ from how other professionals engage in discussions of normative ethical behaviour (Dean and Pollard 2018). As such, the question about the role of the interpreter as it is related to ethics is more accurately conveyed through the construct of responsibility. In other words, to make the question normative is to instead ask, ‘What is the interpreter responsible for?’ The construct of responsibility is more readily recognised as a normative ethical term (Dean and Pollard 2011). We have further argued that answers to questions of responsibility should be reframed through a catalogue of values and not through a series of metaphors (Dean and Pollard 2018: 57–60). Regarding healthcare interpreting, the question should instead be framed as, ‘What are the responsibilities of the healthcare interpreter?’

This shift from the use of metaphors to the use of values is necessary when interpreters engage with other professionals. The latter, e.g. doctors, lawyers, teachers, social workers, to name a few, are taught to evaluate ethical actions through a normative lens and would likely be confused by some of the terms the interpreting field uses to talk about the interpreting role. The use of metaphors leads interpreters to think of themselves like something else (a conduit, a participant, an advocate). It is more effective to assume the responsibility of a particular set of values, as is typical for service-based professions such as doctors and nurses (Dean and Pollard 2018).

Normative ethics are those values, rules, or principles used to evaluate the ethics of a decision. The term descriptive ethics is used in the ethics field to describe actions without any type of evaluative element. The statement, the interpreter did not interpret

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<th>Table 12.2 Unique healthcare ethical material stated in ethical codes</th>
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the conversation she could hear about another patient is stated in a descriptive manner. It is also descriptive to say that the interpreter in this case was behaving like a filter, a gatekeeper, or a judge. However, to be normative and to have an element of evaluation within the realm of healthcare, the behaviour should be linked to a value in healthcare. Therefore, the action could also be stated as, the interpreter respected the privacy of another patient when she chose not to interpret overheard conversations. Respecting patient privacy is an established healthcare norm. As such, this type of statement would be more recognisable to healthcare professionals.

In professional ethics, the term normative should not be confused with the term prescriptive. Prescriptive is often used in a negative way to describe pre-determined actions or a type of behavioural rigidity. While it is true that normative ethics can be prescriptive, normative ethics can also allow for behavioural flexibility – a flexibility within the parameters set by a catalogue of normative material like values and principles.

Often the deontological or rule-based approach to decisions is perceived of as the prescriptive brand of normative ethics. Teleological or goal-based decisions, while still normative, allow for behavioural flexibility. A deontological approach is characterised by its list of rules whereas a teleological approach is characterised by a list of values. Unlike rules which guide the practitioner to a right and wrong choice, values identify multiple effective and ethical choices (Dean and Pollard 2005: 270). In professional ethics, the consequences of a practitioner’s decisions are assessed in terms of which professional values are prioritised by the decision or whether they are prioritised at all. For example, imagine the decision that needs to be made by mental healthcare providers when they are faced with a patient who has suicidal thoughts and intentions but who makes assurances about their safety and asks to be discharged to go home. That provider is facing the choice between two valid but conflicting principles. The first is to maintain the safety of the patient and the other is to respect the individual’s autonomy (free from controlling and constraining behaviours). The provider has to uphold one value while forfeiting the other. These are the very same teleological decisions that healthcare interpreters must make about their own practice (Dean and Pollard 2018).

Normative ethics establishes the shoulds – how a person should act in a given situation. Whether that should is best conveyed through rules (deontology) or values (teleology) is determined by many factors. Ethical codes of service professions (such as those professionals who work in healthcare) almost exclusively come to be articulated through values. However, the ethical codes found in community interpreting have traditionally been articulated through rules (Cokely 2000; Dean and Pollard 2011). Many have found rules unhelpful because, like other service professionals, community interpreters encounter highly nuanced contexts. Instead of a list of dos and don’ts, interpreters should instead be taught to apply values to each situation referred to in the ethics field as specified principlism (Beauchamp and Childress 2012: 17–24; Dean and Pollard 2011: 157–158). It has yet to be determined or at least stated in overt terms which values interpreters should be responsible for. There are however, established theories that offer possible guidance in how these values might be determined.

Vermeer’s (1989/2000) Skopos theory guides the practitioner towards considering the aims, goals, and objectives of the client and/or the expectations of the target audience. In healthcare interpreting, the audience or the clients are providers and patients. The aims and goals of a healthcare provider, and arguably those individuals seeking their services, are governed by the values inherent in biomedical ethics. While biomedical ethics can be
traced back to the ancient times of Hippocrates, it was still in its nascent stages throughout most of the 20th century (Raupich and Vollman 2011).

The *Principles of Biomedical Ethics* by Thomas Beauchamp and James Childress (2012/1985), now in its 7th edition, is credited with creating a systematic and standardised analysis of healthcare principles. Beauchamp and Childress (2012) derived the four core principles of biomedical ethics from a series of universal moral ideals (e.g. nurture the young and dependent). While it was originally written in regard to biomedical ethics, others have proposed that these principles undergird all service-based professions (Dean and Pollard 2018: 59; Jonsen 1995: 248). The four core principles are: *respect for autonomy, non-maleficence, beneficence, and justice*, and are defined as follows.

*Respect for autonomy:* Most know the term autonomy to mean allowing individuals to make decisions for themselves – to have the freedom to direct their own destiny by the choices they make. However, in healthcare this principle is operationalised by two types of *obligation*: positive obligation and negative obligation. In this case, the terms positive and negative refer to the presence of something (positive) or the absence of something (negative). These terms are used the same way in medicine (e.g. a positive test result means the presence of something, such as cancerous cells). Therefore, respecting someone’s autonomy in a negative obligation manner would be to, for example, allow an individual to make decisions for themselves (i.e. self-determinacy) in the absence of controlling or constraining behaviours (Beauchamp and Childress 2012: 107).

*Non-maleficence and beneficence:* While these two principles share commonalities and are often identified and discussed in tandem (as in NCIHC 2004: 8), they are not ethically the same. Non-maleficence dictates that practitioners should not inflict harm, where harm is defined as, ‘the thwarting, defeating, or setting back of some party’s interest’ (Beauchamp and Childress 2012: 153). It is the value first articulated by Hippocrates in his ‘First, do no harm’. Beneficence carries a greater ethical obligation than non-maleficence. Beneficence is not just avoiding the direct act of inflicting harm, but protecting and removing other potential harms (as cited in Dean 2015: 55–56). It is also characterised by those actions which contribute to the welfare of another (Beauchamp and Childress 2012: 202).

*Justice:* The final core principle is justice which can be further defined by a particular justice theory. There are many theories of justice: distributive, libertarian, egalitarian, to name a few (Beauchamp and Childress 2012: 253–264). Not in every situation, but certainly in most professional service settings, the conceptualisation of justice is utilitarian in nature. Utilitarian is often described as the greatest good for the greatest number of people.

Seeking ethical guidance from established ethical norms in healthcare and working in accordance with these values is to firmly root healthcare interpreters in a time-honoured ethical foundation. The four core principles are not to supplant ethical norms established by either generalist or setting-specific ethical codes, as discussed above, but to enhance them. These four core principles and the values that grow out of them can be added to the values that healthcare interpreters are responsible for. That is, instead of asking, what is the role of the interpreter in healthcare settings, the normative question could be framed as, ‘What values established by the healthcare setting should similarly compel or contain the actions of the interpreter?’

The following illustration demonstrates how the values of the setting dictate patient, provider, and interpreter behaviour: in a psychiatric inpatient unit, the purpose is to
keep patients and staff safe. Safety is the main purpose of the setting and this purpose dictates decisions at every level. It dictates the very decision about admitting (or not) suitable patients to the unit – only those who are an imminent harm to themselves or others are admitted (i.e. to keep them and others safe). The unit is almost always locked and patients are not permitted to leave without the supervision or the permission of the staff. Safety also drives the behaviours of individual clinicians. As an example, no jewellery or ties should be worn in the presence of patients who might seek to use them to cause harm. Clinicians are often discouraged from meeting with patients alone in the patient’s room and are instructed to never let the patient move between the clinician and the door. Therefore, in this shared values-based approach to interpreting ethics, the interpreter’s behaviours should reflect a similar concern for patient safety. That is, interpreters should work in collaboration with (or at least not against) the purpose and values of the setting (Dean and Pollard 2013: 56; Pym 2000: 182).

The challenge is that most interpreters are not taught what the setting-specific values are nor how to operationalise them (i.e. how these values might be reflected in their decisions). If an interpreter did not fully appreciate the value of patient safety in the example of a psychiatric unit, they could inadvertently make decisions that compromised patient safety. Not only should interpreters follow the safety lead of the service professionals in the setting (e.g. similar placement in a room with a patient), but should actively apply the safety value in interpreting-specific decisions. As an example, an interpreter may intentionally choose not to interpret something overheard by a patient in another room if they determine that it is likely to cause additional stress and therefore, instigate possible unsafe behaviour. In other words, the decisions that interpreters make in a given setting need to be evaluated based on the values of the setting and not only evidenced in interpreting (such as, accuracy, impartiality, etc.). If they were only evaluated based on the values included in a generalist code of interpreting, then the interpreter might be compelled by the value of fidelity or completeness (e.g. everything is interpreted) and therefore, interpret all material heard, regardless of concerns for safety. Just like the mental healthcare provider in the above example who had to choose between the value of safety and respect for autonomy of a suicidal patient, the interpreter in this example must choose between safety and fidelity.

The preambles to both the International Medical Interpreters Association (IMIA) and the American National Council on Interpreting in Health Care (NCIHC) do include a series of core values. Both the NCIHC (2004: 8–9) and the IMIA (2010: 1–2) directly identify beneficence as one of its core values but not the other three (i.e. respect for autonomy, non-maleficence, and justice), at least not in those terms. Instead, they identify: fidelity, respect for the importance of culture and cultural differences (NCIHC 2004), transparency, right to equal treatment, confidentiality, and informed consent (IMIA 2010). The four principles put forward by Beauchamp and Childress are deemed core or foundational in healthcare because they are intended to generate other related ethical tenets. For example, right to equal treatment is arguably an outgrowth of justice and informed consent, or the intention that all patients understand and choose freely from available treatment options, is an outgrowth of respect for autonomy.

This contribution has thus far focused on ethical content material in biomedical ethics, generalist ethical codes in interpreting, and those ethical codes specific to healthcare interpreting. The next section returns to a review of available ethical content material for healthcare interpreters. This includes other ethical documents such as standards of practice and norms established by practice and discussions about practice.
4 Other ethical content material

4.1 Standards of practice

Standards of care or standards of practice (SoP) documents are another source of sanctioned ethical content that are designed to be more situationally-specific than broad ethical codes. Both the IMIA and the NCIHC have standards of practice documents. The IMIA (2007) and NCIHC (2005) SoP documents are different in length and structure. The NCIHC (2005) SoP document is 12 pages and devotes the majority of the document to listing each ethical tenet and its corresponding standards, with each standard illustrated with an example from healthcare. The IMIA SoP is almost 50 pages. The majority of the document (about 30 pages) serves as an assessment tool for each of the ethical tenets and the accompanying 27 standards using a Likert scale from 5 to 1 to indicate the degree to which an individual demonstrates behaviours that indicate mastery.

In the NCIHC (2005) national standards document, the original nine tenets listed above are illustrated with 32 standards. The nine tenets each have between two to eight separate standards. These standards further illustrate what is meant by each ethical tenet, including an example of such from healthcare. Also included for each tenet is an objective and a related ethical principle. Those interested in investigating these standards in greater detail are encouraged to download these documents from the NCIHC website (also see the Further Reading section).

The IMIA’s (2007) SoP breaks their 27 standards down into categories of three duties: Duty A: Interpretation; Duty B: Cultural Interface; Duty C: Ethical Behaviour. The duty of interpretation is recognised as the primary task of the interpreter and is defined as, ‘convert a message uttered in one source language into an equivalent message in the target language so that the intended recipient of the message responds to it as if he or she heard it in the original’ (2007: 13). To fully engage in the duty of cultural interface (duty B), interpreters must understand the inextricable nature of language and culture and therefore, ‘Interpreting in the health care arena requires the interpreter to understand the ways in which culturally based beliefs affect the presentation, course, and outcomes of illness as well as perceptions of wellness and treatment’ (2007: 15). Lastly, under ethical behaviour (duty C), interpreters are discouraged from abusing the power that they have as the only person in the room who understands both languages. They are also encouraged to keep information about the encounter confidential. Each one of these duties is further explained with 27 standards of best practice examples (Duty A = 18 standards; Duty B = 2 standards; and Duty C = 7 standards; a full list of these standards can be found in Appendix A).

After a review of the IMIA’s 27 listed standards, it appears that a majority of these ethical items are already identified in generalist ethics. However, new and distinguishable ethical directives relevant to healthcare interpreting are noted in A-4, A-15, A-16, B-2 and C-7. As a reminder, these items are not explained in written text, but instead offered as a series of behaviours that indicate (or not) mastery of this standard – as if this document is intended for assessment use. The behaviours that demonstrate mastery of the standards that identify new ethical material (A-4, A-15, A-16, B-2, and C-7) is included in the appendix for additional review.

These standards, when further defined by the illustrative behaviours, do seem to indicate that healthcare interpreters need to be concerned about values such as patient welfare
(non-maleficence, beneficence), continuity of care (perhaps an outgrowth of justice), and discrimination (non-maleficence and justice).

There are a few mental healthcare-specific standards of practice, published by The Association of Sign Language Interpreters in the UK, the Registry of Interpreters for the Deaf in the US, and the Mental Health Interpreting Guidelines for Interpreters in Australia. Of these three standards of practice documents, the Australian document – developed in partnership with Monash University and Language Loop, and endorsed by the Australian Institute of Interpreters and Translators and the Australian Sign Language Interpreters Association – is the most extensive (over 50 pages). Mental Health Interpreting has arguably enjoyed a longer and more extensive discussion on ethical practice. This is due in part to the more pronounced role of communication in the delivery of mental health services. While communication is important in all aspects of healthcare, in mental healthcare, it is the main avenue for both diagnosis and treatment. Therefore, mental health interpreting ethical documents are more likely to reveal an advanced level of ethical expectations than what would be typical in healthcare.

4.2 Practice and professional norms

Beyond sanctioned ethical documents, healthcare interpreters can seek guidance in their colleagues’ practice – the patterns of action that seem to convey a practice norm. Toury defined norms as ‘values or ideals shared by a certain community as to what is right and wrong, adequate and inadequate’ (1980: 57) and proposed that they are deliberately variable in nature (Toury 1998: 12).

Sanctioned ethical documents can be, or at least can be perceived as prescriptive. The emergence of descriptive translation studies or DTS (Chesterman 1993; Marzocchi 2005) was driven by this perception and the desire to understand translators’ practices irrespective of prescriptive standards (Pym 2001: 129). Like translation, there was evidence of a prescriptive nature in interpreting that was later countered with data that found that interpreters’ practice decisions deviated from these rigid expectations. Interpreters were expected to behave in the least intrusive ways possible and to merely transfer the message between interlocutors, and were discouraged from concerning themselves with other aspects of the communication event (e.g. whether or not the patient understands the treatment plan). With DTS, there was a shift in interpreting studies away from prescription and toward description (see, e.g. the seminal study of Wadensjö 1998).

Studies into the actual behaviours (or norms) of interpreters have been one of the main sources of research in community interpreting, and especially in the healthcare setting. As mentioned above, interpreting scholarship tends to use roles and metaphors for discussing interpreters’ behaviours. These role metaphors are distinguishable from one another by the degree of involvement of the interpreter, from the least active/involved (e.g. conduit) to the more active/involved (e.g. advocate).

In a recent and extensive review of the research involving healthcare interpreters, Brisset, Leanza and Laforest (2013) reported principal findings centred on three themes: interpreters’ roles and behaviours (e.g. Hsieh 2008); problems associated with working with interpreters (e.g. Davidson 2001); and typical communication characteristics when working with interpreters (e.g. Fatahi et al. 2008). The first theme, interpreters’ roles is the one most applicable to this discussion since the term role is the apparent mechanism through which the field discusses behaviour and right-action. Below is a list of some of
the ways in which the authors of the reviewed studies described interpreters’ roles using metaphors or other descriptors:

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<tr>
<td>Hsieh (2008)</td>
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<td>Kaufert and Koolage (1984)</td>
<td>Language interpreter, informant, cultural broker, advocate</td>
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<td>Hasselkus (1992)</td>
<td>Facilitator, intermediary and direct source</td>
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<td>Hatton and Webb (1993)</td>
<td>Voice box, collaborator, excluder</td>
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<td>Drennan (1999)</td>
<td>Language and culture specialist, patient advocate, and institutional therapist</td>
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<td>Davidson (2001)</td>
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Similar to many other studies, Brisset and her colleagues (2013) concluded their review to suggest that interpreters’ behaviours fell along a continuum. The use of a continuum or a spectrum to describe the behaviours of interpreters is not unique (see Dean and Pollard 2005; Llewellyn-Jones and Lee 2013). Major and Napier (2019) conducted a case study where healthcare interpreters’ actions and decisions were plotted along a series of continua. Regardless of whether a series of metaphors or continuum are used, all of these studies conclude in the same way – interpreters behave in flexible ways and that flexibility is based on contextual factors. This is further evidence for what has been repeatedly emphasised in the field of interpreting studies since the 1980s (e.g. Angelelli 2004; Wadensjö 1998).

Research into interpreters’ practice decisions is vital to the development of the field – as it was in translation studies with the application of DTS. Investigations into practitioners’ actual behaviours is where a profession can identify the norms of behaviour and possibly gain ethical guidance to benefit the field at large. Yet, often times the interpreters’ behaviours that researchers have identified are abstracted into metaphor or conventions of role. In other words, research studies usually conclude with evidence that interpreters are not behaving according to prescriptive codes. Instead researchers find practitioners engaging in behaviours that reveal a more action-oriented and context-driven manner. These behaviours, instead of being evaluated by how they advance the values of the setting, are left in their descriptive form by reinforcing or inventing a series of new metaphors (as in the above examples). While those metaphors act as descriptions of behaviours, they are not designed to evaluate behaviours.

As explained earlier, in the field of ethics, effective and ethical behaviour are not measured by descriptors but through a normative lens – those values, principles, and rules that measure the rightness of an action. Using descriptors to evaluate actions is similar to the analogy of trying to measure a room by a colour instead of through established metrics, like feet or metres. Research into the behaviours of practitioners need not only be descriptive. It can and should make substantive contributions to normative ethical material. Pym argues that this step of evaluation is necessary, stating: ‘Translators, teachers, students, critics, policy-makers rightly expect our research to have something to say on the matter [of ethics]’ (2000: 181). In other words, there needs to be an additional step beyond merely describing the interpreters’ behaviours. That step requires the use of normative ethical material (i.e. values, principles, and rules) to evaluate those behaviours. In the case of healthcare interpreters, this is reasonably done through normative ethical material already existing in healthcare, such as the four core principles discussed above (respect for autonomy, non-maleficence, beneficence, and justice).
One way in which descriptive terms have been wrongly used as a normative device is the use of the term ‘advocate’ in healthcare interpreting. It is not uncommon for the term advocacy to be used for and by healthcare interpreters (sign language interpreters might use the term ‘ally’ instead). Certainly, there are appropriate times when the terms ‘advocacy’ or ‘advocate’ are being used – such as in instances of intentional discrimination based on race, ethnicity, gender, etc. It is out of the concern for patients’ just treatment that likely drives the interpreter to deliberate on whether or not they should intervene. Arguably, such interventions could be seen as a derivative of Beauchamp and Childress’s core principle of justice.

What is arguably controversial about interpreters claiming to be advocates is not the calling out of unjust treatment; it is merely the poor word choice of ‘advocate’. At least in the United States, the term ‘patient advocates’ is reserved for those hospital employees who are hired to ensure quality care. It is important to note that patient advocates are almost exclusively called in when a provider has done something wrong. Therefore, when it is stated that an interpreter is acting as or should act as an advocate, it is likely to put healthcare providers on the defence. That is, stating there is a need for an advocate implicates wrong doing by a healthcare provider. In the mind of providers, it is reasonable to ask how interpreters who are not often trained in healthcare have the expertise to determine whether there was a wrong doing in the first place (unless, as noted above, it is intentional discrimination). This is in part why there is such controversy over the idea that interpreters should in some cases consider themselves as advocates.

Certainly, overt discrimination in healthcare settings is possible and it might be true that interpreters can identify when it has happened. However, this is less typical than the more frequent occurrence when an interpreter speaks up on a patient’s behalf (which is not accurately called ‘to advocate for’, at least not as it is used by healthcare systems). More often than not, what interpreters are responding to when they feel compelled to speak up on the patient’s behalf is when they witness a value inadvertently compromised by the provider – a value that provider already holds. For example, imagine that a provider hands a document which explains a treatment procedure to a patient who relies on interpreters for access and is told to review it in time for the provider to return for any questions. While this action may well be just and effective for a patient who shares the provider’s language, it may not be for a patient who does not. The provider is not likely to catch these types of missteps because, in their mind, it works well in most instances. For the interpreter to bring this possible misstep to the attention of the provider is not to be a patient advocate. It is merely an example of a physician being alerted to a compromised value that they already hold which may be beyond their awareness. The interpreter might instead say, ‘I understand that you’re aiming for informed consent with the use of this document, but given the patient’s lack of familiarity with the language and the healthcare system [or other such reasons that are specific to that patient], I am concerned that this document will not help in providing informed consent’. If the provider were then to respond by saying ‘I don’t care about informed consent’ (which is not likely to happen), then this would be an example of discrimination and the interpreter might be compelled toward advocacy. However, merely speaking up on behalf of the patient to alert the provider of a compromised, already held value should not be deemed advocacy. The implicit meaning and implication of the term advocate is not shared between provider and interpreter, and therefore appears to cause conflict. Specificity with terms and their meanings between descriptive ethics terms and normative terms would greatly reduce perceived
conflict between provider, patient, and interpreter. The field could find forward traction if it did not use descriptors (e.g., advocate) and instead, learnt to speak the same language of values used by healthcare professionals.

This is just one example of steps that need to be taken on a larger scale within the field of interpreting ethics. Instead of instituting rules for healthcare interpreters or relying on sociological constructs (metaphors and role conventions), the field should attempt to take its existing ethical ideals and compare them to those of the four core principles prevalent in healthcare. Further, newer ethical ideals can also emerge as a result of contemplating the implications of the four core principles in the profession. This is not a task to be undertaken by one individual, nor in the context of a single publication; it is outside of the scope of this chapter. Hopefully, this chapter will serve as a prompt for serious consideration of how the profession thinks and talks about healthcare ethics in healthcare interpreting (and translation and interpreting ethics more broadly) and how using the setting-specific values might advance practice and improve collaborative efforts with service providers.

5 Issues and forward advancement

Ethical codes were never intended to be a sufficient source of ethical guidance for practitioners. In the NCIHC’s CoE, it states this explicitly (2004: 7). Instead, they are designed to protect service-users from untoward consequences at the hands of service professionals (Solow 1980). Hill (2004) proposed that ethical tenets were codified as a direct result of past practitioners’ unethical behaviour. It is understandable therefore, that ethical codes tend to contain a list of prohibitive tenets (interpreters shall not…) and are written in a rule-based or deontological manner. For example, interpreters are directed not to accept work that is outside their competency levels (discretion), not to disclose information about their work (confidentiality), not to advise or express opinions (neutrality/impartiality), and not to add or omit source material (fidelity). While the tenets might be stated deontologically, in more rigid terms such as ‘dos and don’ts’, other ethical material in these same documents frames things in a teleological manner (e.g. a patient’s welfare is at stake). Similarly, in the preamble to the IMIA code of ethics, it states that the code is designed to help interpreters with ethical dilemmas which is not the same thing as guiding interpreters in moment-to-moment decisions (2010: 3). In the field of translation, practice norms have attempted to guide translators and interpreters in their moment-to-moment decisions. DTS have aimed to identify regularities or norms in translation practice. For Chesterman the study of norms can add ‘an empirical account of actual translation behaviour’ (1993: 2) which he further suggested could lead to ‘general descriptive laws’ (1993: 2). Both Chesterman (1993) and Pym (2000: 5) affirmed that some normative element is necessary in DTS (see also Marzocchi 2005). Further, Pym asserted that ‘Translators, teachers, students, critics, policy-makers rightly expect our research to have something to say on the matter [of ethics]’ (2000: 181).

This is where descriptive interpreting studies appears to be struggling for forward movement – unable to translate the research identifying the actual actions of interpreters into saying something evaluative about those actions. Most of what is offered at the conclusion of such studies is new and different metaphors or other abstractions such as role space (Llewellyn-Jones and Lee 2013), role fluidity (Major and Napier 2019), or role transparency (Nicodemus, Swabey and Witter-Merithew 2011). In another publication (Dean 2015: 86–87), I noted that in nine separate qualitative studies, the authors offered a full 40
different metaphors to describe interpreters’ behaviours (Davidson 2000 and 2001; Hsieh 2007 and 2008; Leanza 2005; Angelelli 2004 and 2006; Hale 2007; Dysart-Gale 2005). This material can only be helpful if it is operationalised within the ethical framework of healthcare ethics (as demonstrated above in the example of ‘advocate’).

Roy (1993) proposed that new and different metaphors have not appeared to move interpreters out of the conduit norm. Instead, she concluded that the use of metaphors has, ‘limited the profession’s own ability to understand the interpreting event itself and the role of the interpreter within the event’ (1993: 127). She also suggested that the profession needed to adopt a different paradigm (1993). Perhaps this paradigm can be advanced by constructs from ethics. First, the field of ethics would make a distinction between normative and non-normative ethics (Beauchamp and Childress 2012: 1–2). Descriptive ethics are non-normative. Descriptive ethics describe actions taken, i.e. what healthcare interpreters actually do in practice (such research has been summarised by Brisset, Leanza and Laforest 2013). Normative ethics attempts to evaluate the ethical nature of those practices (Beauchamp and Childress 2012: 1).

Having a normative or evaluative element in translation and interpreting practice does not automatically lead to rigidity or prescription, as a deontological approach would (Dean and Pollard 2018: 55). Behavioural flexibility is normative in the ethical construct of teleology. However, regardless of the approach, deontological or teleological, there needs to be a series of ethical principles by which an action is assessed and measured. While there have been multiple studies on the actions of healthcare interpreters (summarised in Brisset, Leanza and Laforest 2013), very few actually comment on the ethical nature of the decisions made. In cases where evaluation of behaviours is offered as ethical or unethical behaviour, normative ethical material was not used (Davidson 2001; Major and Napier 2019: 198). Norms, or regularities of behaviour, ‘must be followed up by evaluation, compared to a set of standards, or substantiated with some ethical traction’ (Dean 2015: 15). After a decade or more of translation practice descriptions, Pym exhorted the field to make ‘a return to ethics’ (2001: 129). To take this advice would mean an overhaul in how the profession of healthcare interpreting conceives of and talks about ethics.

6 Conclusion

Healthcare interpreting has made significant strides towards documenting and codifying context-specific ethical material. Indeed, advancements in healthcare interpreting ethics are arguably greater than most speciality settings in community or public service interpreting. Not only do some countries have sanctioned ethical codes and documented practice standards, there are even efforts to codify healthcare interpreting standards at an international level.

Many of these ethical content documents illustrate an interest in the ideals already established by the medical field and by healthcare professionals. This effectively aligns the ethics and practice of interpreters with their healthcare colleagues – a justifiably ethical position. Not only does the codifying of shared healthcare values ground interpreters ethically, it can also serve as a practical guide for practitioners’ decisions.

What is less known is the degree to which interpreters have the skills necessary to apply these shared values to their practice decisions. Indeed, the use of practice values is not evident in interpreters’ discourse. Based on terms and phrases that have been documented in research, it is evident that both participants and researchers employ metaphorical (e.g. team member) or other figurative devices (e.g. role) to describe the actions taken
Healthcare interpreting ethics

by interpreters. In other words, the field has not fully demonstrated that it knows how to articulate decisions as a reflection of practice values even if there is evidence that standards and codes document some of these same values.

The lack of an articulated understanding of ethical values can be an indication that these values are not compelling practitioners’ behaviours. It is also true that the ability to articulate values does not necessarily predict associated behaviours. It is unclear whether or not the values expressed in the field’s ethical content material are similarly evident in the decisions of the average healthcare interpreter. This is where the field needs to focus its advancement efforts (for educational efforts in this direction see Marin 2020). The ethical content material of the field, from the ethical codes to the prominent discourse of practitioners, educators, and researchers, needs to be consistent. Practice values and how they are articulated and operationalised within healthcare settings need to be the priorities for practitioners’ professional development.

Notes

1 Searching in traditional databases for ethical content material does not often produce complete results. Ethical content material can be documented in ethical codes, standards of practice documents, government policies and protocols, and certainly also in academic articles. For this chapter, the searches were conducted mostly in English. However, several colleagues in other countries were able to conduct a basic search in their specific languages (German, Spanish, French, etc.) and indeed, an array of ethical content material in healthcare ethics was available in these languages. Only a few of those were sanctioned ethical codes specific to healthcare. One ethical code for interpreters offered by the International Organization for Standardization had a section devoted to healthcare interpreting ethics but was not publicly available. The search also produced several standards of practice documents in both medicine and mental health settings (addressed in detail later), a university sponsored report with limited uptake in medical facilities (Finland), a theoretical article on the need for mediators to work with interpreters in medicine (France), and policies and procedures regarding interpreting services designed for medical facilities and healthcare providers (the Netherlands, United Kingdom).


5 Specified principlism ‘is the process by which a person harmonises a broader principle to a given situation. It is a constant negotiation between what the principle aims for and how that comes to play out in the nuance of circumstance, seeking to maximise the positive outcome and mitigate the negative impact’ (Dean 2015: 52).


Further reading


This text is seminal to the field of medicine; the impact that this text has had on ethics in healthcare and professional ethics in general cannot be overstated. For healthcare interpreters, the first chapter would be a good introduction to medical ethics.
Robyn K. Dean


This chapter addresses the use of descriptive ethics and normative ethics in community interpreting and the associated concerns. It also proposes a list of values that could be used in community interpreting (including the four core principles). This list is derived from ethical codes as well as other ethical content material in the profession.


This review article examined 66 qualitative studies of interpreters in healthcare. It provides an overview of research into healthcare interpreting over the last 30 years. The authors reported three principal findings: interpreters’ roles and behaviours; problems associated with working with interpreters; and typical communication characteristics working with interpreters.

Related topics
Dialogue Interpreting in Mental Healthcare, Community/Liaison Interpreting in Healthcare Settings, Child Language Brokering in Healthcare Settings

References


Appendix A

Appendix A 27 Standards of Best Practice

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<th>Item</th>
<th>Standard</th>
<th>Demonstrated Behaviour</th>
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| A-4  | Address the ‘comfort needs’ of the patient... | • When the issue arises, assesses potential areas of discomfort for the patient (e.g. gender or age of the interpreter) and discusses them with the patient  
• Is cognisant of body language and/or specific verbalisation suggesting discomfort  
• Checks to identify the source of distress  
• Reassures the patient by providing information about credentials, professionalism, and the ethics of confidentiality  
• Explains the reality of the situation (e.g. perhaps only one interpreter is available) and tries to put the patient at ease  
• Offers options to address the discomfort, when available |
| A-15 | Assist the provider with interview closure activities | • Encourages the provider to give appropriate instructions, making sure the patient is clear about next steps and has asked any questions they may still have  
• Checks with the patient on the need for an interpreter at any of the follow-up appointments  
• Observes ‘closure etiquette’ by making closing remarks appropriate to each party |

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<th>Item</th>
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| A-16 | Ensure that concerns raised during or after the interview are addressed and referred to the appropriate resources | • Encourages the provider to make the appropriate referrals  
• Understands or asks about the institution’s system of service delivery  
• Makes sure patient gets appointment with the appropriate resources and with an interpreter if needed |
| B-2  | Recognise and address instances that require intercultural inquiry to ensure accurate and complete understanding | Pays attention to verbal and nonverbal cues that may indicate implicit cultural content or culturally based miscommunication (e.g. responses that do not fit the transmitted message; display of discomfort or distress when certain topics are brought up)  
Assesses the urgency/centrality of the issue, at that point in time in that particular exchange, to the goals and outcomes of the encounter:  
• Assesses the best time and method by which to raise the issue  
• Interjects and makes explicit to both parties what the problem might be  
• Prompts the provider and patient to search for clarity  
Shares cultural information with both parties that may be relevant and may help clarify the problem (e.g. says, ‘It’s possible this is what is happening, because often people from… believe that…’)  
In cases where ‘untranslatable’ terms are used, assists the speaker in developing an explanation that can be understood by the listener |
| C-7  | Deal with discrimination | On occasions where the interpreter feels strongly that either party’s behaviour is affecting access to or quality of service, or compromising either party’s dignity, uses effective strategies to address the situation  
If the problem persists, knows and uses institutional policies and procedures relevant to discrimination |