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INTERPRETER ADVOCACY IN HEALTHCARE ENCOUNTERS: A CLOSER LOOK

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Interpreter Advocacy in Healthcare Encounters: A Closer Look

Introduction

Advocacy is one of the nine ethical principles established by the National Council on Interpreting in Health Care (NCIHC) in its 2004 document *A National Code of Ethics for Interpreters in Health Care (NCIHC Code of Ethics)*. The *NCIHC Code of Ethics* sets the aspirational values and foundational beliefs about what is important and right in the healthcare interpreter profession. It serves as guidance for healthcare interpreters in making ethical judgments about what is acceptable and desirable behavior in the practice of their role (NCIHC, 2004, p. 6).

The NCIHC's 2005 document *National Standards of Practice for Interpreters in Health Care (NCIHC Standards of Practice)* sets the expectations for the performance of the healthcare interpreter role based on the ethical principles in the *NCIHC Code of Ethics*. The *NCIHC Standards of Practice* provides the "how to" of the healthcare interpreter profession by describing the actions or interventions that a healthcare interpreter can take to meet the objective of the corresponding ethical principle (NCIHC, 2005).

Our discussion of advocacy in the interpreted healthcare encounter will draw on both the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice*. Understanding the connection between the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice* is critical to the professional performance of the healthcare interpreter role. To underscore this connection, the

standards in the *NCIHC Standards of Practice* are organized by the ethical principle to which they correspond. The title of each set of standards applies to both the ethical principle and the corresponding standards. A summary of the ethical principle is presented on the left side of the standards that pertain to it (see NCIHC, 2004, page 3, for the complete listing of the nine ethical principles). In addition, the objective of each ethical principle and the corresponding standards of practice are stated immediately under the title. We will draw on this important connection between the ethical principles and the standards of practice throughout the paper.

Focus and Purpose

This paper focuses on the ethical principle of Advocacy and specifically on Standard 31, one of the corresponding standards under it. The ethical principle of Advocacy states:

When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if less intrusive actions have not resolved the problem (NCIHC, 2004, p. 3).

Standard 31 states: "The interpreter may speak out to protect an individual from serious harm" (NCIHC, 2005, p. 10). Both the ethical principle of Advocacy and Standard 31 speak to the justification for advocacy when someone's safety, health, well-being, or dignity is at risk. While standard 31 does not specify who is at risk, we usually focus on the patient, but we acknowledge that it could be someone else in the encounter.

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Our goal is to clarify the place of advocacy as an appropriate intervention during an interpreted encounter when a patient is at risk of harm. We further specify the use of advocacy for those situations in which the risk of harm is imminent, that is, when the potential risk needs to be addressed during the encounter in order to prevent serious harm.

We recognize that advocacy is still seen by many in the profession as an intervention that goes beyond the expectations of what healthcare interpreters can do, given their primary function of facilitating communication and understanding between a patient and a healthcare provider. To achieve our stated goal, we will dispel some misconceptions about advocacy in healthcare interpreting, clarify what advocacy is and is not, and describe in detail when it is appropriate and how it is best carried out within the interpreted healthcare encounter. Our hopes are that:

- 1) healthcare interpreter trainers, supervisors, and managers will use this document to deepen their understanding of advocacy in the interpreted healthcare encounter and use it as a guide in trainings and supervisory interactions, as well as to inform institutional policies;
- 2) healthcare interpreters will use this document to enhance their practice as they address difficult situations in which the health, well-being, or dignity of a patient is at risk; and
- 3) language service companies or organizations will use this document to review their policies and align them with the goals of patient safety and positive health outcomes in the healthcare setting.

We acknowledge that there are other codes of ethics and standards of practice that govern interpreter performance in different sectors such as the legal and the education sectors, in addition to health care. We also acknowledge that signed language interpreters who work with

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Deaf and hard of hearing individuals across a range of sectors are guided by the RID code of professional conduct (2005). We expect interpreters to abide by the appropriate code of ethics and standards of practice for each sector in which they interpret. The NCIHC Code of Ethics and NCIHC Standards of Practice were developed to guide interpreters in the field of health care.

We hope that everyone involved in the interpreting profession will benefit from the ideas presented in this paper.

We also acknowledge that advocacy during an interpreted healthcare encounter is not an easy task and should never be considered a routine intervention. We understand that experienced interpreters will be more likely to be able to recognize when there is a risk of imminent danger to a patient because of what the interpreters may have learned from past experiences or because they have interpreted for that patient on previous occasions. Experienced interpreters may also have a better understanding of the urgency and gravity of a potential risk and, as a result, may be able to determine whether their concern for the patient needs to be addressed immediately or can be brought up at a later time.

We want to reassure interpreters new to the field of healthcare interpreting that they are not responsible for something they do not know or have not experienced, or that is beyond their control. But we do want to stress that all healthcare interpreters are responsible for developing critical thinking skills to help them make connections between what they have learned from previous experiences and what is happening in the current situation. Such critical thinking skills will also help healthcare interpreters make well-reasoned and intentional decisions when faced with ethical choices.

In order to accomplish our goal of demonstrating that advocacy is an appropriate (if rarely used) intervention for healthcare interpreters, we will do the following:

1. Provide background information to set the context for the focus of this paper.
2. Present a definition of role that includes all aspects of a healthcare interpreter's practice, including advocacy. We offer this clarification of the concept of role to make clear that advocacy is an integral part of the healthcare interpreter role under specific conditions.
3. Define what advocacy is by identifying the central characteristics that make an intervention an act of advocacy. We offer this clarification to distinguish an act of advocacy from interventions that facilitate communication.
4. Examine key interventions that have been mistakenly labeled advocacy. We will show that these interventions, although not strictly message conversion, support the healthcare interpreter's primary function of facilitating communication and understanding between parties who do not speak the same language.
5. Explain the appropriate place of advocacy as an intervention of last resort within the interpreted healthcare encounter when a patient's health and well-being is at imminent risk of harm. We will present key questions to consider when determining whether advocacy is necessary and provide guidance on how to advocate in a positive and professional manner if needed.

History and Rationale for this Discussion

Interpreter Advocacy in Healthcare Encounters: A Closer Look

In 2001, the Standards, Training, and Certification Committee¹ (STC) laid out a series of steps to move the profession of healthcare interpreting towards certification. The first of these steps was the development of a code of ethics followed by the development of standards of practice based on the code.

From the beginning of its work, the Standards, Training, and Certification Committee was fully aware that advocacy was a controversial issue among healthcare interpreters, with some strongly maintaining that advocacy had no place within the healthcare interpreter profession. However, in a series of national focus groups and by means of a national survey to obtain feedback from working interpreters on the most relevant ethical issues to their professional practice, a significant majority of respondents strongly endorsed the inclusion of advocacy as an ethical principle. Nevertheless, healthcare interpreters, interpreter trainers, and other stakeholders continue to discuss a range of perspectives on whether or not advocacy is appropriate in the healthcare interpreting profession, and specifically within the interpreted encounter.

Focus group discussions at NCIHC's Annual Membership Meetings and other professional conferences held in 2015 and 2016 illustrated these ongoing debates and highlighted the need for additional explanation of all the ethical principles and their corresponding standards

¹ The Standards, Training, and Certification Committee was formed shortly after the NCIHC was formally organized as an incorporated entity in 1999. The Standards, Training, and Certification Committee was charged with the following tasks: 1) create a code of ethics to guide the practice of healthcare interpreting; 2) develop a unified set of standards of practice based on the code of ethics that would define competent practice in the field; 3) develop standards for training programs; and 4) create a national certification process. In 2007–2008, the decision was made to move the development of healthcare interpreter certification out of the NCIHC. A group of stakeholders came together to create a separate entity, which eventually incorporated as the Certification Commission for Healthcare Interpreters (CCHI). The NCIHC decided to drop certification development from the committee's purpose and name and became the Standards and Training Committee.

of practice. This paper focuses on the unresolved confusion and debate around the legitimacy of advocacy and its implementation in the healthcare interpreting profession.

The following are two common types of confusion:

- 1) *Calling any intervention that is not message conversion advocacy.* Most commonly, interventions such as asking for clarification, cultural brokering, or managing the flow of communication have, at times, been mistakenly called advocacy. These interventions, as we will explain later, are not acts of advocacy because they support the healthcare interpreter's primary function of facilitating accurate and complete communication and understanding within the encounter.
- 2) *Believing mistakenly that healthcare interpreters are responsible for protecting the patient and fixing anything that could go wrong before it goes wrong.* This belief results in healthcare interpreters inappropriately speaking for the patient even to the point of ignoring the patients' right to speak and act for themselves. Examples of such inappropriate actions include taking over the communication between the patient and the healthcare provider, giving medical advice to patients, or telling healthcare providers what to do based on the interpreter's opinion. While often done with good intentions, such interventions are not supported by the *NCIHC Standards of Practice*, they violate the ethical principles of Accuracy and Respect, and they interfere with the goal of direct communication between patient and healthcare provider.

The *NCIHC Standards of Practice* affirms the concept of advocacy under two ethical principles, Professionalism and Advocacy. The use of advocacy under the ethical principle of Professionalism is called for when the quality of the interpretation is in danger of being

jeopardized by unfavorable working conditions. Standard 24, under Professionalism, states “The interpreter advocates for working conditions that support quality interpreting” (NCIHC, 2005, p. 9). Advocating for the profession usually occurs outside the interpreted encounter. For example, remote interpreters could advocate for high-quality equipment and connections in order for them to be able to hear and/or see clearly enough to ensure accuracy and completeness. However, there also are times when advocacy may be necessary within an interpreted encounter, such as when the conditions under which the interpreter is working are negatively affecting the quality of the interpretation. For example, assigning a single interpreter to a four-hour organ transplant orientation is a demanding situation both cognitively and physically that can lead to interpreter fatigue, increasing the likelihood that the quality of the interpretation will be negatively affected. This form of advocacy, while important, is not the focus of this paper.

Two additional standards under the ethical principle of Advocacy also affirm the use of advocacy. Standards 31 and 32 describe two different situations in which advocacy may be needed.

Standard 31 addresses situations in which there is the potential for serious imminent harm to the health, well-being, or dignity of a party, usually of a patient, during an interpreted encounter. Standard 31 states, “The interpreter may speak out to protect an individual from serious harm” (NCIHC, 2005, p. 10). This standard is intended to specifically address those extremely rare instances within an interpreted healthcare encounter in which the healthcare interpreter observes a potential for serious imminent harm to a party if the situation is not recognized and addressed in a timely manner. Usually, the subject of the potential for harm is the

patient, although it may also be a healthcare provider, or a member of the patient's support system present in the encounter.

Standard 32 addresses a second type of situation. It states, "The interpreter may advocate on behalf of a party or a group to correct mistreatment or abuse" (NCIHC 2005, p. 10). This standard focuses on observed patterns of mistreatment or abuse best addressed systemically by bringing them to the attention of appropriate personnel within the healthcare system. It allows a healthcare interpreter to alert the healthcare institution to persistent behaviors, policies, or practices that demean the dignity of an individual or a specific group of patients, or that deprive an individual or a group of patients from receiving the same quality and breadth of services as other patients. For example, if healthcare providers do not request interpreters because they think that their own rudimentary knowledge of a patient's language is enough to fully communicate with the patient, an interpreter could bring this to the attention of their supervisor or the institution's patient safety officer.

While Standard 32 has an institutional focus, the effect of "mistreatment or abuse" may put a patient in an interpreted encounter at risk for harm, thus creating a fluid boundary between Standards 31 and 32. In such a case, the healthcare interpreter will have to assess whether the provider's behavior puts the patient at risk for serious, imminent harm while in the encounter (Standard 31) or whether the provider's behavior can be addressed after the encounter either in a private meeting or through an institutional response if the behavior indicates a repeated pattern (Standard 32). The healthcare interpreter will have to assess what the best course of action is, keeping in mind the safety and well-being of the patient during the encounter.

Standard 31 has a clear focus on an individual, usually a patient, who may be at risk for serious imminent harm. This standard has generated significant discussion and confusion because an act of advocacy changes the stance of the healthcare interpreter from being a facilitator of the communication process to being a proponent of a specific course of action. An act of advocacy interrupts the normal flow of a healthcare encounter. Furthermore, because it involves the possibility of serious imminent harm to a patient, it requires the ability to think critically in making a quick assessment of the seriousness and urgency of the situation. The purpose of this paper is to clarify the appropriate use and practice of advocacy by a healthcare interpreter in this type of difficult situation.

In the next section, we will clarify the term “role” to show how advocacy is an integral part of the healthcare interpreter role as described in the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice*.

Definition of Role

A common practice in the field of healthcare interpreting has been to refer to certain interventions used by healthcare interpreters as separate roles. Thus, we hear references to the message-converter role, the clarifier role, the cultural-broker role, and the advocacy role. In fact, the phrase “advocacy role” is used in the *NCIHC Code of Ethics* (NCIHC, 2004, p. 19).

However, since the publication of the *NCIHC Code of Ethics*, we have come to realize that our use of the term “role” in the above instances was a substitute for the terms “task,” “act,” “duty,” or “intervention.” This imprecise use of the term “role” led many to state that when healthcare interpreters intervene with an act of advocacy, they are stepping out of the healthcare interpreter role and assuming a different role, such as that of an advocate. Such a viewpoint

misrepresents the scope of the healthcare interpreter role as described in the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice*.

To affirm the scope of the healthcare interpreter role, we now propose that our understanding of the concept of role follow the accepted sociological definition of role as a *set of interconnected and socially expected duties, rights, beliefs, values, and behaviors associated with specific positions in society*. Such societal roles occur in role sets, that is, in relationship to other roles that mutually share assumptions and expectations for each other's behaviors and responsibilities (Merton, 1957, p. 110). A familiar example of a role set is that of teacher and student. In the field of healthcare interpreting, the primary role set consists of the patient, the healthcare provider, and the healthcare interpreter.

Given the above definition, we now assert that *the healthcare interpreter role encompasses all the values, ethical principles duties, tasks, and behaviors established in the NCIHC Code of Ethics and the NCIHC Standards of Practice*. Therefore, when healthcare interpreters appropriately engage in an act of advocacy, they are not stepping outside the healthcare interpreter role. Rather, they are acting within the accepted range of behaviors and expectations for their role as they interact with the roles of patient and healthcare provider. In effect, the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice* describe the holistic healthcare interpreter role.

However, it is important to note that not all behaviors included in a role occur with the same frequency or are appropriate in all situations. Some occur routinely and frequently while others are reserved for very specific situations and are infrequently used. Within the role of the

healthcare interpreter, asking for clarification is a routine behavior, while advocacy is called for only in extremely rare and highly specific situations, as will be discussed later in the paper.

In the next section, we will examine what advocacy is in order to understand what it means to advocate within the healthcare interpreting profession.

Advocacy Defined

Advocacy is defined as “the act or process of supporting a cause or a proposal” (*Definition of ADVOCACY*, 2019). It is “the act of speaking on behalf of or in support of another person, place, or thing” (Your Dictionary, 2020). Advocacy, therefore, is the act of coming to the aid of another by supporting their cause or issue to arrive at a desired resolution. Although one may advocate for oneself, in which case it is called self-advocacy, advocacy often is undertaken to ensure that others have their voices heard and their rights respected, especially those who are most vulnerable and least able to speak for themselves.

In the United States, advocacy has become formalized and professionalized as a distinct role in fields such as health care, special education, and victim support, to name a few. Such professionals, known as advocates, are expected to understand the specific field in which they advocate and be prepared to navigate that field’s related systems to achieve the desired outcome or resolution for their clients. Advocates, however, although speaking and acting on behalf of someone else, do so with the consent and participation of the person they are representing.

In the healthcare setting, there are now formalized advocacy roles, such as that of Patient Advocate (NIH National Cancer Institute, 2020) or Nurse Advocate (registerednursing.org, 2020). Although the responsibilities of healthcare advocates vary by institution or organization, in general, their primary functions are to actively speak for, assist, and advise patients as they

negotiate their care within the healthcare system, and to act on their behalf to ensure that they receive the best care and services.

In short, an act of advocacy must meet two conditions:

- 1) Speaking for, acting on behalf of, or representing an individual, group, issue, or cause. A person who advocates supports the interests of the person, group, or issue.
- 2) Seeking to persuade or influence those with the authority to come to a resolution in line with the (best) interests of the person(s), issue, or cause they represent. Such persuasion goes beyond simply informing those in authority that a problem exists.

Historically, the role of advocate has been defined by an adversarial stance in which a third party enters a conflict or disagreement to support, promote, or defend the interests of one party against the interests of another. We propose, however, another approach to advocacy, one that is collaborative rather than adversarial. In collaborative advocacy, the advocate still speaks and acts on behalf of another to ensure that their interests are heard and their needs resolved, but they do so by engaging both parties in collaborative problem solving. In this approach, the advocate listens for what is important for each party and engages both parties in identifying the issue in contention as a shared one for which a mutually beneficial resolution is best (*Guiding Principles of Collaborative Advocacy / CADRE*, n.d.; *How Is Collaborative Advocacy Different?* 2011).

In this paper, we strongly encourage healthcare interpreters to take a collaborative problem solving approach even in the rare instances when circumstances present them with the need to advocate.

Interventions That Have Been Mistakenly Called Advocacy

In this section we will look at two main categories of interventions that have mistakenly been identified as advocacy: interventions which support good communication and understanding in the interpreted encounter, and the sharing of relevant information.

Interventions to Support Communication and Understanding

The *NCIHC Code of Ethics* and the *NCIHC Standards of Practice* recognize that to achieve the accurate transmission of messages spoken in different languages and to support shared understanding of meaning across cultures, healthcare interpreters may have to speak autonomously. That is, they may need to speak in their own voice, such as when asking for clarification or alerting parties to possible misunderstandings due to linguistic or cultural differences. However, when doing so, healthcare interpreters are expected to “maintain transparency” by indicating that they are speaking for themselves (see Standard 6 under the ethical principle of Accuracy in NCIHC, 2005, p. 5). Accuracy and Cultural Awareness are routinely used to support communication and understanding and show why these interventions are not acts of advocacy. Other interventions under different standards are also sometimes mistaken for advocacy but we have limited the discussion to these examples.

Ethical Principle: Accuracy

The ethical principle of Accuracy and the standards of practice that support it are central to the function of facilitating communication and shared understanding. The ethical principle of Accuracy states: “Interpreters strive to render the message accurately, conveying the content of the original message, taking into consideration the cultural context” (NCIHC, 2004, p. 3). As stated in the *NCIHC Standards of Practice*, the objective of this principle is “to enable other

parties to know, as precisely as possible, what each speaker has said” (NCIHC, 2005, p. 5). The following three standards listed under the ethical principle of Accuracy are the most pertinent to the function of facilitating communication and understanding:

- 1: The interpreter renders all messages accurately and completely without adding, omitting, or substituting.
- 2: The interpreter replicates the register, style, and tone of the speaker.
- 4: The interpreter manages the flow of communication. (NCIHC, 2005, p. 5).

Rendering the message accurately and completely. Standards 1 and 2 require interpreters to convey the entire message expressed by the speaker as closely as possible, including meaning that is conveyed not only by the words used but also by the register, style, or tone of the speaker. Standard 1 also clearly states that an interpreter does not add to, omit, or substitute any aspect of the message based on their own ideas of what they think the message is or should be. All these requirements are necessary so that the listener receives the message as if they were hearing it directly in a language they understood.

There may be times, however, when the interpreter does not understand what the speaker said, is unsure of the speaker’s meaning, or simply could not hear the speaker. In such cases, the interpreter may speak autonomously, that is, in their own voice, to ask for clarification or repetition.

Managing the flow of communication. Standard 4 allows the interpreter to manage the flow of communication in order to ensure that both the patient and the healthcare provider have the opportunity to speak and be heard and that the interpreter is able to make the linguistic conversions and convey the messages accurately and completely in a timely manner. For

example, Standard 4 allows the interpreter to intervene when two or more people are speaking at the same time, when the interpreter is unable to interpret accurately because of the length or complexity of the utterances, or when the speaker does not allow the listener a chance to ask a question or comment.

There are also times when linguistic misunderstandings can arise between the patient and the healthcare provider, just as they do between people who speak the same language. For example, the healthcare interpreter may observe that the patient and the provider are speaking at cross-purposes; that is, they are talking about different things and not realizing it. If this goes on for several exchanges and neither party has realized that they are not talking about the same thing, the healthcare interpreter may consider stopping the flow of the conversation and alerting the parties to the misunderstanding, especially if the consequences of the misunderstanding may be detrimental. By stopping the flow of communication, the healthcare interpreter creates a conversational space in which the patient and provider have the opportunity to restate what each one was talking about and address the issue of each party.

Ethical Principle: Cultural Awareness

The ethical principle of Cultural Awareness addresses a common source of misunderstanding between patients and healthcare providers who do not speak the same language and, even more critically, who often do not share similar cultural values, beliefs, and assumptions about health and health care. The ethical principle of Cultural Awareness in the *NCIHC Code of Ethics* states: “The interpreter continuously strives to develop awareness of his/her own and other (including biomedical) cultures encountered in the performance of their professional duties” (NCIHC, 2004, p. 3). This ethical principle places a responsibility on the

healthcare interpreter to learn as much as they can about all the cultures for which they interpret in order to be able to detect when a cultural belief or value may give rise to a misunderstanding. The objective of the ethical principle of Cultural Awareness is “To facilitate communication across cultural differences” (NCIHC, 2005, p. 7). The corresponding standard, Standard 15 states, “The interpreter alerts all parties to any significant cultural misunderstanding that arises” (NCIHC, 2005, p. 7).

Alerting parties to cultural misunderstandings. Cultural differences often are reflected in the meaning attached to words, as well as in the underlying assumptions or beliefs embedded in the message. Standard 15 allows healthcare interpreters to intervene by alerting both parties to the possibility of a misunderstanding due to differing cultural perspectives. Healthcare interpreters are often in the unique position of having a general understanding of both a patient’s cultural framework and the culture of health care in the United States. Healthcare interpreters are often aware of healthcare provider’s medical training or cultural framework may influence how they make sense of a patient’s message, as well as how a patient’s cultural values and beliefs may be shaping their thinking. Neither patient nor healthcare provider, however, may realize that they are receiving each other’s messages from an unshared perspective.

However, as much as interpreters may know about these cultural frameworks, such knowledge does not make the interpreter an expert on how each individual person integrates their culture of origin into their lives or how much they may have acculturated to their new environment and to the norms and practices of medicine in the United States. Therefore, while Standard 15 allows interpreters to share relevant cultural information, such information should be provided not as a fact but simply as a theory or hypothesis of why a misunderstanding may be

occurring. This intervention, called cultural brokering or cultural mediation, is done with the goal of arriving at a shared understanding between the patient and healthcare provider of what is being said and how it might affect diagnosis and treatment. The healthcare interpreter then returns to interpreting while the parties explore whether there is a culturally based misunderstanding, determine what the nature of the misunderstanding is, and negotiate how to resolve it.

Reasons Why These Interventions are not Advocacy.

In all the interventions described above (clarification, management of flow of communication, and cultural brokering), the actions taken by the healthcare interpreter fall within the parameters of the ethical principles and standards of practice. The ethical principles and standards we have discussed support the primary function of facilitating communication and understanding between two parties who do not speak the same language and often do not share the same culture in order to meet the mutual goal of positive health outcomes.

When healthcare interpreters intervene in the ways described above, they move from converting messages spoken by others to briefly speaking in their own voice, that is, speaking autonomously. They pause the communication process to ensure that the speaker's message is being conveyed as accurately and completely as possible. Thus, when interpreters ask for clarification, they are checking with the speaker to be sure they understood the speaker's message. They do not tell the speaker what the message should be. When healthcare interpreters engage in cultural brokering or cultural mediation, they do so to raise the possibility of a misunderstanding but leave it to both the patient and the healthcare provider to uncover for

themselves whether cultural assumptions may be acting as barriers to shared understanding and what the nature of the misunderstanding might be.

These interventions are not acts of advocacy because the healthcare interpreter is neither speaking on behalf of one party nor attempting to persuade the other party to take a specific action. The ownership of the message remains with the speaker and the choice of how to respond remains with the listener. In all these cases, the healthcare interpreter is acting in accordance with their primary function, to facilitate communication and shared understanding. In addition, interpreters are bound by Standard 6 (NCIHC, 2005, p. 5) under the ethical principle of Accuracy to be transparent, that is, to let the patient and the health care provider know when they are briefly speaking autonomously in support of facilitating accurate and complete communication.

Interventions to Provide Relevant Information

Before moving to the discussion of advocacy within the interpreted healthcare encounter, we will examine an additional type of intervention that is often questioned as to its appropriateness and/or mistakenly labeled as advocacy. This intervention is that of providing relevant, objective information to the patient and/or provider—information that is directly connected to the needs and well-being of the patient. In this section, we will present the rationale for sharing relevant information by citing the support for such interventions in the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice*. We will then discuss the implementation of this intervention in relation to two specific types of information: 1) relevant institutional information, and 2) relevant medical information. Finally, we will show why such interventions are not acts of advocacy.

Rationale for the Provision of Relevant Information

The rationale for the provision of relevant information as an acceptable intervention within the scope of a healthcare interpreter's practice is based on two key aspects of the *NCIHC Code of Ethics*: the value of beneficence and the ethical principle of Respect.

Beneficence is one of the three core values that underpin the *NCIHC Code of Ethics*. The value of beneficence is described as an “essential obligation and duty to support the health and well-being of the patient and her/his family system of supports (e.g., family and community) and to do no harm” (NCIHC, 2004, p. 8). This is a value that is shared with all other healthcare professionals. Therefore, in keeping with this mutual goal, interpreters may provide relevant, objective information to the patient and/or the healthcare provider that may be of benefit to the patient or that may, in some rare cases, prevent harm to the patient.

Providing relevant information is also supported by the ethical principle of Respect, which states “Interpreters treat all parties with respect” (NCIHC, 2004, p. 3). We often think of respect in the simple meaning of the word, that is, as acts of politeness and civility. We often forget that the definition of respect also includes acts that exhibit care, concern, or consideration for the needs and feelings of others (*Respect / Definition of Respect in English by Lexico Dictionaries*, 2019). In addition, Standard 13 under the ethical principle of Respect states, “The interpreter promotes patient autonomy” (NCIHC, 2005, p. 6). Providing relevant information that enhances a patients' ability to navigate the healthcare system on their own and to manage their own health concerns and outcomes supports patient autonomy while responding in a caring manner to the needs of the patient. It is a way of acknowledging and respecting the patient's dignity as a competent individual.

In addition, providing relevant information, whether it is related to institutional and community resources or to medical information pertinent to the patient's well-being, is also a sign of respect towards the provider. By sharing timely or meaningful access to information that may not be readily available to the provider, the interpreter supports the provider's goal of assuring the safety and well-being of the patient. Providing relevant information can promote mutual respect and understanding by allowing important institutional or medical information to be communicated in the hearing of all parties.

For example, if in the give and take of a medical interview the interpreter notices that a topic mentioned for discussion has not been addressed, the interpreter may remind the parties of that topic to facilitate the provider presenting all information and the patient asking all their questions and weighing all possibilities before making a decision.

In today's complex and multilayered healthcare system, the need for timely and relevant information to be able to effectively navigate the healthcare system, and, more importantly, to ensure that all relevant medical information is available in a timely manner, has grown exponentially. It has become clear that communicating or sharing relevant information is essential within the treating team, to which the interpreter belongs (Braunack-Mayer & Mulligan, 2019).

Relevant Institutional Information.

Institutional information refers to information about the availability and location of services and departments within a healthcare facility and how to access such services. It also includes information about resources in the community to support the well-being of the patient and the goals of the medical encounter. For example, either a patient or provider, or both, may

want to know about health insurance coverage, transportation programs, how to request a prescription refill, the availability of culturally and linguistically appropriate community resources, and more.

One way to think about providing institutional information is to consider what any person would do if they were in a medical facility and someone asked them how to locate a specific department or service (e.g., radiology, blood lab, pharmacy). In most cases, that person would willingly respond if they had the information. The person with the information is simply responding in a caring, respectful manner to a request for information and is obviously not advocating when doing so.

In fact, today, many healthcare facilities expect staff to help patients with wayfinding (White, 2019). Many have a “take, don’t tell” policy which encourages staff, including healthcare interpreters, to accompany the person to the appropriate location rather than giving them spoken directions or a facility map. This is not advocacy.

During an interpreted healthcare encounter, any request for institutional information is interpreted, whether it comes from the patient or the healthcare provider, and whether it is made to the patient, the healthcare provider, or the healthcare interpreter. All responses to the request are also interpreted, whether the response comes from the healthcare provider, the patient, or the healthcare interpreter. In doing so, interpreters maintain transparency to ensure that all parties are aware of what is being said.

If the request for information is made to the healthcare provider and the provider does not know the answer, it is reasonable for the healthcare interpreter to share the information if they know it with both the patient and the provider. This holds for remote interpreters too, although it

may be less likely that they would receive such requests for institutional information. However, if a remote interpreter has information relevant to the request, it is reasonable for them to share that information.

Occasionally, the healthcare interpreter may become aware that they have information that could assist the parties to meet the shared goal they are discussing but which no one else has mentioned (e.g., a transportation program that will bring the patient to appointments). In such a case, the healthcare interpreter may consider sharing that information, taking into consideration the best time and manner to do so. Healthcare interpreters should always be careful to avoid taking over the conversation or sharing information that is not necessary.

When a request is made before or after the interpreted encounter, healthcare interpreters may respond in several ways depending on the type of information and the interpreter's available time. If the healthcare interpreter knows the answer and it is relatively simple, it is reasonable for the interpreter to respond to the request, as long as the interpreter is imparting only objective information. Examples of such requests might include how to schedule the healthcare provider's recommended follow-up appointments, or which office handles billing. When the interpreter does not have the information or when the question is more complex and involves specialized expertise, such as how to access a range of healthcare-related services, the interpreter's response should be to connect the patient with someone who can provide the information or assist in identifying the appropriate person or office.

Why Providing Relevant Institutional Information is not Advocacy.

Providing relevant institutional information is not an act of advocacy because the healthcare interpreter simply offers objective information that could assist the patient and/or

healthcare provider achieve their respective goals in the encounter. The information supports a patient's ability to navigate the healthcare system and make informed decisions for themselves. The provision of information respects the healthcare provider's limited time by saving the provider from having to research additional services and resources to benefit their patients. In providing such information, healthcare interpreters do not speak on behalf of anyone, nor do they advise or persuade anyone to take any specific action. The interpreter simply offers objective information. It is for the patient and/or the healthcare provider to decide what to do with that information.

Relevant medical information.

Because this is a topic that has not been widely discussed, we want to clearly present the background parameters and considerations for using this intervention.

First, by medical information, we mean information that the interpreter has learned from having interpreted for the patient in the current or previous encounters, or in similar contexts with other patients. The interpreter may also have learned information that is relevant to the current situation from professional development workshops or their own studies. This information must be directly relevant to the situation at hand and verifiable. We do not mean in any way that healthcare interpreters give medical opinions or advice.

Second, we recognize that less experienced interpreters or interpreters working in situations new to them will not always recognize when medical information they know is relevant in the current situation. They cannot be held responsible for something of which they are unaware.

Third, in considering whether to share relevant medical information, interpreters must carefully weigh their obligations under the ethical principles of confidentiality, respect for the patient's wishes, and interpreter role boundaries, as well as the core value of beneficence (NCIHC, 2004). This is why developing critical thinking skills is of paramount importance for healthcare interpreters.

The need to consider sharing relevant medical information during an interpreted healthcare encounter occurs when the healthcare interpreter becomes aware that they may have medical information about the patient that has not been mentioned in the current encounter, or in the current phase of the encounter, but which may have relevance to the goals of the session. Healthcare interpreters who interpret for the same patient during a whole appointment or over a series of encounters may remember medically relevant information that the patient has not shared, or that the provider may have forgotten or missed in the patient's record, and/or which is not immediately accessible because the patient was seen in a different health system on previous appointments. The healthcare interpreter may see the relevance of the information they have to the purpose of the current encounter.

In such a situation, the healthcare interpreter may comment that there may be medical information relevant to the current encounter which may need to be considered by both the patient and the healthcare provider. Making such a comment creates an opportunity for the healthcare interpreter to check with the patient while at the same time informing the healthcare provider that there may be some relevant information that has not been shared.

Confidentiality, however, is an issue the healthcare interpreter needs to consider. If the information is already in the patient's record and is available to the treating team, sharing such

information with members of the treating team during an encounter is not a breach of confidentiality. The healthcare interpreter is simply reminding both the patient and provider that the information exists and may have relevance in the current session. On the other hand, if the healthcare interpreter is aware of information that comes from an unaffiliated healthcare system or through another outside source, the healthcare interpreter should first check to see if the patient wants to share the information or wants the interpreter to share the information to avoid breaching confidentiality (NCIHC, 2004). In most cases, when medical information that is relevant to the goals of the current session is shared, both parties are pleased to consider it to ensure positive outcomes in the encounter.

Note, however, that we are describing a situation in which the relevant information is verifiable. Verifiable information is information that can be objectively checked for accuracy and is not simply based on the healthcare interpreter's opinions or feelings.

Why Providing Relevant Medical Information is not Advocacy.

To understand why sharing relevant information is not an act of advocacy, let us look at the following example. In the exam room, a patient asks the nurse about an antibiotic he had stopped taking before finishing all the prescribed pills. The nurse is concerned and lets him know that she will not be coming back with the doctor but will mention it to the doctor before s/he comes into the examination room. The doctor enters, talks with the patient, and gets ready to end the visit and leave the room. The healthcare interpreter realizes that no mention has been made of the antibiotic. The healthcare interpreter knows that stopping the use of an antibiotic can be problematic and that the patient has not received an answer to his question. Before the doctor leaves the room, the interpreter informs the doctor that the patient had a question that had not

been answered about the antibiotic he had stopped taking. The interpreter informs the patient what the interpreter just said to the doctor, which allows the patient the opportunity either to ask the question or to say that it is no longer a concern.

In the above case, the interpreter shared relevant medical information about the patient's medication with the provider and explained that the patient's question about the medication was still unanswered. The interpreter was transparent with both the provider and the patient. This gave the patient and the provider the opportunity to discuss the importance of taking the full dosage of the antibiotic.

We can see from this example that sharing relevant medical information is not an act of advocacy because the interpreter is not acting on behalf of one party and is not attempting to persuade either party to take a specific course of action. The healthcare interpreter is simply creating an opportunity for the patient and the provider to verify the medical information and determine its relevance. In doing so, the interpreter's allegiance is to the shared goal of positive health outcomes for the patient and to the provider's commitment to quality care.

There are times, however, when the relevant medical information may be directly related to the potential for serious imminent harm to the patient and the information is not addressed. We will come back to this scenario in the next section when we discuss in detail the use of advocacy in the interpreted encounter.

We have now seen that healthcare interpreters have several interventions that they can use to support their primary function of facilitating communication and understanding without the need for advocacy. We have also discussed how sharing relevant information is supportive of good health care and is not advocacy. However, although they are rare, there are situations in

which advocacy may be needed to prevent serious imminent harm. In the next section, we explore in detail the appropriate use of advocacy during an interpreted healthcare encounter.

Advocacy in the Interpreted Healthcare Encounter

We now return to the main focus of this paper—advocacy in the interpreted healthcare encounter and its justification in the ethical principle of Advocacy as stated in the *NCIHC Code of Ethics*:

When the patient’s health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if less intrusive actions have not resolved the problem. (p. 3)

The ethical principle of Advocacy has four points:

- 1) to provide the justification for advocacy in the interpreted healthcare encounter;
- 2) to address the two conditions of advocacy—speaking on behalf of someone else and persuading others to take specific actions;
- 3) to direct the healthcare interpreter to think critically; and
- 4) to direct the healthcare interpreter to first use other interventions to resolve the issue and to use advocacy only as a last resort.

The ethical principle of Advocacy is supported by the value of beneficence, one of the three foundational core values in the *NCIHC Code of Ethics* (NCIHC, 2004, p. 8). Beneficence is defined in the Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing and Allied Health (*beneficence*, n.d.) as “a moral obligation to act for the benefit of others.” It goes on to

include four components of beneficence: “(1) one ought not to inflict evil or harm ...; (2) one ought to prevent evil or harm; (3) one ought to remove evil or harm; and (4) one ought to do or promote good” (*beneficence*, n.d.). As stated in the *NCIHC Code of Ethics*, upholding the value of beneficence means that healthcare interpreters, like all other healthcare professionals, “...have as their essential obligation and duty to support the health and well-being of the patient and her/his family system of supports ... and to do no harm.” (NCIHC, 2004, p. 8)

We have acknowledged that the potential for imminent harm in an interpreted encounter can affect not only the patient but also the healthcare provider(s), or a member of the patient’s family system of support present in the encounter. While our focus in this paper is on the patient, the discussion we present here is applicable to any situation in which any individual in the encounter may be at risk of imminent harm.

Two Types of Harm

Let us consider the two types of harm that justify an act of advocacy: 1) health or physical harm, and 2) harm to the well-being or dignity of the patient, in other words, emotional harm.

In the case of physical harm, deciding whether to advocate is triggered by the possibility of risk to the patient’s physical health and well-being if the potential for serious harm is not addressed during the encounter—in other words when the potential for harm is urgent and critical. Such a concern expressed by the healthcare interpreter should be based on verifiable, medical information and not on the healthcare interpreter’s opinions, beliefs, feelings, or biases. Healthcare interpreters must also keep in mind that most of us are not medically trained, and, even when we are, we are not acting in the capacity of a clinician. Therefore, interpreters cannot

assume that their assessment of the potential for serious imminent harm is accurate, or that the healthcare provider is unaware of the situation and is not taking steps to address it. Unless the potential for harm is imminent, the healthcare interpreter should wait and see if anyone else addresses the issue.

However, if no one else addresses the issue and the risk of harm appears imminent, the interpreter's first choice of intervention should be to alert the parties to this potential for serious imminent harm and if the healthcare provider is unaware of the information, suggest that it be verified. The need for advocacy arises only after the interpreter has shared the concern and its medical basis, but the information is not addressed and the potential for serious imminent harm remains.

In the case of emotional harm or harm to the emotional well-being or dignity of the patient, deciding whether to advocate is more challenging. Evaluating a person's emotional state is difficult in any circumstance and even more so in a cross-cultural, cross-linguistic situation. While some signs of emotional distress, such as crying, may be similar across different cultures, there are also cultural signs that are unique. Furthermore, it is difficult not to project our own feelings into an emotionally charged situation. For these reasons, healthcare interpreters must be especially aware of their own feelings and be able to differentiate their feelings from those of the patient when seeking to gauge whether the patient is experiencing emotional harm or whether the patient's dignity is being jeopardized.

For example, healthcare interpreters sometimes describe healthcare provider behaviors that appear to them as disrespectful, abrupt, badgering, brusque, or discourteous, and feel a need to protect the patient from such behaviors. But patients may have coping mechanisms that allow

them to continue to engage productively in the encounter. Some patients, in fact, may not want the interpreter intervening for them, seeing this as an infringement on their autonomy.

It is, therefore, the patient's emotional state during a healthcare encounter that should drive the need to consider whether an act of advocacy is necessary. It is not the place of the healthcare interpreter to decide how the patient should respond. The need for advocacy to prevent harm to the emotional well-being and dignity of a patient during a physical health encounter should only arise when the healthcare interpreter observes that the patient is becoming increasingly distressed and struggling to stay productively engaged in the encounter, and that the healthcare provider is not responding in a constructive way to the patient's emotional state. However, before the healthcare interpreter assumes that there is a need to advocate on behalf of the patient, they should consider, as we mentioned earlier, whether there is a cultural disconnect resulting in the healthcare provider not recognizing different cultural signs of distress and disorientation. In this case, the healthcare interpreter would want to consider cultural brokering as the initial intervention.

So far, we have been describing the potential for serious harm to the emotional well-being or dignity of the patient during an encounter focusing on the physical health of the patient. We will now consider advocacy by healthcare interpreters in mental health encounters.

Identifying the potential for serious emotional harm to a mental health patient, however, is much more difficult, especially for interpreters with little experience or background in this area. The symptoms presented by a mental health patient are by their nature emotional or psychological and sometimes both. Such symptoms as emotional distress and incoherent speech

patterns can occur both when the patient is being emotionally affected by their interactions with the provider and when these symptoms are due to their mental health status.

Therefore, in the mental health setting, the primary function of the interpreter is to provide an accurate and complete rendition of what the patient says, including tone and affect, no matter how inappropriate or nonsensical it may seem to the interpreter. This is critical information that the mental health provider needs in order to fully understand what the patient is experiencing and how best to treat the patient. It is also the interpreter's function to provide an accurate and complete rendition of what the provider says, including tone and affect, even though at times it may appear inappropriate too. What the provider says and the tone and affect with which it is said often carries a therapeutic intent that the patient needs to experience as part of their treatment. Intervening during these difficult moments in the mistaken belief that the patient is experiencing emotional harm due to the encounter and therefore needs to be protected from emotional harm may, in fact, interfere with the therapeutic relationship that the provider is working to establish. However, there are two circumstances in which the potential for harm to the patient can be of concern to interpreters working in a mental health setting.

The first circumstance for potential harm may arise because of cultural and linguistic disconnects between the patient and the mental health provider that can result in the provider overlooking, misinterpreting, stereotyping, or generally mishandling presenting symptoms with potentially serious consequences in diagnosis and treatment (Gopalkrishnan, 2018). As mentioned previously, cultural disconnects also happen in other settings and the interpreter's first step should be to use their cultural brokering skills to draw attention to the possibility of a cultural misunderstanding.

The second circumstance is based on provider behavior. The majority of mental health providers are very professional and well-intentioned. While it is not common, some mental health providers have abused their position by shaming, blaming, humiliating, or showing a consistent lack of empathy towards the patient (Seunagal, 2020). Such behaviors on the part of the mental health provider could result in the potential for harm to the emotional well-being and dignity of the patient. In such cases, the interpreter may consider intervening with an act of advocacy, as will be outlined in the next section.

Whether the intervention is for cultural brokering or advocacy, the interpreter should evaluate if it would be best to address any concerns outside of the interpreted encounter during a post-session debrief. Except in the rare cases where the potential for harm is imminent or where the cultural disconnect may result in serious misdiagnosis, it is best for the interpreter not to interject themselves in the delicate interaction between patient and provider.

Because of the complexities of the mental health encounter, we strongly encourage interpreters to seek additional training in mental health interpreting and ongoing professional development. This could include requesting pre- and/or post-conferencing with the mental health provider whenever possible to anticipate what might happen in the encounter, learn from what happened, and analyze how their interpretation helped or hindered the process. This is in keeping with two other standards of practice. Standard 21, under the ethical principle of Professionalism states: “The interpreter discloses skill limitations with respect to particular assignments” (NCIHC, 2005, p. 9). Standard 28, under the ethical principle of Professional Development, states: “The interpreter seeks feedback to improve his or her performance” (NCIHC, 2005, p. 10).

When to Consider Advocacy as an Intervention.

Healthcare interpreters should only consider the need for advocacy after they have tried all other interventions to alert the parties to the potential for serious imminent harm to the patient, whether physical or emotional, and the attempts have failed to address the concern. It is extremely rare for a situation to reach this point because all healthcare professionals have as their first consideration the health and well-being of their patients (Parsa-Parsi, 2017). In today's complex healthcare system, the safety of the patient is paramount and there are laws (Rights (OCR), O. for C, 2008), protocols, and accreditation standards (*National Patient Safety Goals*, 2020) in place to ensure that the goal of patient safety is achieved. However, there may still be occasions when relevant medical information is not readily accessible or is missing. For example, several providers from different institutions may be involved in the treatment of the same patient and as a result patient records may be stored in separate systems that may be difficult to access quickly or may need proper authorization. There also are times when healthcare providers may be overwhelmed by high patient load and unexpectedly complicated conditions which could lead to lapses in memory due to fatigue and the pressure of time. Shift changeovers also may result in key information being unintentionally dropped during the transition.

As mentioned previously, healthcare interpreters who interpret for the same patient across appointments may occasionally be the only ones in the encounter aware of relevant information that could directly impact actions being taken. In other words, the information they have may lead them to be concerned about a potential for serious imminent harm if that information is not made known and addressed in a timely manner. For example, the interpreter knows from

previous experiences with the patient that there is a restriction on taking blood pressure in a specific arm because the patient has a port there. The provider has already put a cuff on that arm and is about to start pumping. If the patient does not immediately speak up, the interpreter may quickly share information by saying “the interpreter believes there is a port in that arm.” The vast majority of providers would pause to verify such information, or just change arms immediately. In the very unlikely event that the provider begins pumping the cuff instead, the interpreter would pivot to advocacy, saying “Stop. There is a port on this side. The patient was told to never let anyone take blood pressure in that arm.”

Healthcare providers usually welcome such information because it helps them remain true to their oath to promote the health and well-being of their patients and ensure patient safety. Furthermore, it protects the healthcare facility from possible liability. Such an intervention—the provision of relevant medical information—often is enough for appropriate action to be taken and, as a result, avoid the need for advocacy.

It would be highly unusual if the relevant medical information shared by the interpreter were not addressed and the potential for serious imminent harm remained unacknowledged. However, if such an occasion were to arise, advocacy on the part of the healthcare interpreter is justified according to the ethical principle of Advocacy (NCIHC, 2004). Nevertheless, the shift from facilitating communication to advocacy is a weighty decision and one that should not be taken lightly. It is an act of last resort when all other interventions have failed to address the potential for serious imminent harm to the patient.

We recognize that on such rare occasions an interpreter may face a dilemma between conflicting perspectives on whether to advocate or not. Clearly, the *NCIHC Code of Ethics*

justifies the use of advocacy to prevent harm to a patient. But what if the interpreter’s language service company or organization prohibits advocacy as part of their practice? Does the healthcare interpreter risk the possibility of getting fired if they advocate? How does the interpreter’s decision align with their personal ethical or moral values? Rare as the need for advocacy in an interpreted healthcare encounter may be, we encourage all healthcare interpreters to consider these questions and to be clear in their own minds as to how they would react if faced with a situation in which the potential for serious harm is not addressed.

The Appropriate Use of Advocacy in the Interpreted Healthcare Encounter

The *NCIHC Code of Ethics* and the *NCIHC Standards of Practice* support the use of advocacy by healthcare interpreters during an interpreted encounter for a very specific purpose: to prevent serious imminent physical and/or emotional harm to a patient. Such an intervention is in accordance with the value of beneficence—to do good and prevent harm. This value aligns with the healthcare industry in general, which now affirms that it is the duty of all personnel in the healthcare arena—from doctors and nurses to receptionists and maintenance staff—to speak up when they perceive that a person’s safety and well-being is at risk (*National Patient Safety Goals*, 2020). For healthcare interpreters, intervening with an act of advocacy in an interpreted encounter should be taken only as a last resort after other less-intrusive interventions have failed.

Questions to Consider When Deciding Whether Advocacy is Needed

In this section, we describe the thinking process in which healthcare interpreters should engage when faced with a situation in which there is a potential for serious imminent harm to a patient. The process we describe is applicable whether the potential for serious harm is physical or emotional.

Interpreter Advocacy in Healthcare Encounters: A Closer Look

Below are questions healthcare interpreters need to ask themselves when they are concerned that there is the potential for serious imminent harm to the patient. While the questions are arranged in what appears to be a sequential order, healthcare interpreters may find that they need to go back to a previous question in order to move forward or that the order in which they think through the questions may vary depending on the situation. Thinking through these questions, however, should become second nature for healthcare interpreters, a process they can engage in quickly to make a timely decision on whether there is a need to advocate.

Is the information that alerted you to the potential for serious imminent harm to the patient objective and verifiable? Your first step is to clearly identify the verifiable medical information or observations in the case of emotional harm that could result in serious imminent harm. Such information, as indicated previously, should be verifiable so that it can be checked for accuracy or confirmed through objective observations in the case of emotional harm. The information you provide should not be based simply on your personal opinions, values, or vague feelings that something is not right.

Is your assessment unbiased by your own feelings and opinions? Take the time to evaluate your reactions to the situation. Are you assessing the situation based on objective information or is your response being influenced by your own emotions, values, beliefs, biases or vague feelings that something is not right? You want to make sure that you are not projecting your emotional reactions onto the patient. This is especially important to remember when addressing harm to the emotional well-being of the patient.

Are you reasonably certain no one else will recognize and correct the potential for serious harm before harm occurs? If there is a time delay in the implementation of the action

that may cause harm, it is advisable to wait to see how things develop before intervening. In doing so, you are respecting both the autonomy of the patient to speak for themselves and the expertise of the provider.

Have you confirmed the information with the patient as well as their understanding of the implications for their health and well-being? There are a number of concepts underlying this question. The first is related to the ethical principle of Respect. The interpreter's primary function is to facilitate communication, not to take over the communication. Overstepping by the interpreter could result in less active participation by the patient. Second, Standard 6 under Accuracy states that "The interpreter maintains transparency" (NCIHC, 2005, p. 5). The interpreter should never become involved in discussion with either of the parties without filling in the other side in a timely manner. Third, it is easy to confuse which information applies to which patient. If the interpreter has worked with many patients with the same condition in similar appointments, they may have an incorrect recollection about which patient has which issues. Checking with the patient avoids wasting time on a non-issue, thus eliminating the possibility of advocacy. Practical steps include the following:

- confirming your memory (if your memory was incorrect, no further action is necessary other than bringing the provider up to speed about the exchange with the patient)
- informing the patient that you have a concern for their safety if this information is not shared with the healthcare provider and is not verified for accuracy.
- asking the patient if they want to share the information themselves or if they want you to speak on their behalf.

If the patient is reluctant to have this information shared because they do not want to be seen as complaining, making trouble, or questioning the authority of the provider, you can assure the patient that you will make it clear to the provider that you are speaking autonomously and not interpreting. We will discuss the issue of reluctant patients in more detail below.

If the patient is sedated, unconscious, or in an altered mental state, you may want to involve any family members that may be present, following the guidelines above.

Have you exhausted all the interventions you have at your disposal to transparently alert the parties to the potential for imminent harm without having to advocate? Consider the interventions you have at your disposal to transparently alert both parties to the potential for harm without having to advocate. The following are examples:

- Have you tried to pause the action by alerting both the patient and the healthcare provider to the possibility that there is information that may be relevant?
- Have you shared the relevant information with both the patient and the healthcare provider so it can be verified?
- Have you created a collaborative space in which the information you shared can be discussed by both the patient and the healthcare provider?

Sharing information gives patients the opportunity to speak for themselves. It allows the patient to share their experience related to the information provided and allows the healthcare provider to explain if, how, and why the action they are taking is worth the risk if that is the case. Or, if the healthcare provider was not aware of the information, it allows the healthcare provider the opportunity to verify the information and take appropriate action before proceeding. Sharing relevant medical information, as described previously, is a less-intrusive, non-advocacy type of

intervention. If both parties acknowledge the concern and move to address it, YOU HAVE JUST AVOIDED THE NEED FOR ADVOCACY, and can resume interpreting.

Is the potential for serious harm still there? If no attempt is made to address the concern by verifying the information, and the potential for imminent harm remains, then you are justified, according to the *NCIHC Code of Ethics* and the *NCIHC Standards of Practice*, in advocating on behalf of the patient. Such a scenario, however, is extremely rare in today's healthcare environment, in which the safety of the patient is paramount, and protocols have been instituted to ensure it. However, if it does happen, you are justified to engage in an act of advocacy to prevent harm.

What do you do if the patient asks you, the healthcare interpreter, not to advocate on their behalf? As we mentioned previously, some patients may be reluctant to bring up relevant medical information that the provider has not requested directly and may ask the interpreter not to speak on their behalf. Some patients may be responding to the idea of advocacy from cultural values that place great respect on authority figures, such as healthcare professionals. Some may fear that if the provider is offended, it may result in less attention or services for them.

If you have clearly indicated to the patient the reasons for your concern that they are at risk of serious harm if the information is not shared with the provider and they still ask that you not share the information, you may need to inform the patient that you have a professional obligation to speak up to prevent harm (NCIHC, 2004). In a way, you are advocating to the patient for their own safety, in accordance with the value of beneficence. Again, you can assure the patient that in doing so you will make it clear to the healthcare provider that you are speaking autonomously as a member of the treating team and not interpreting.

If the patient still insists that they do not want you to advocate, then you are faced with an ethical dilemma. Do you act according to the ethical principle of Respect for the autonomy of the patient or do you act according to the ethical principle of Advocacy and the value of Beneficence to prevent and do no harm?

Ethical dilemmas can occur between the principles within any single code of ethics. This is the nature of ethical decision-making. It is therefore extremely important for you as a healthcare interpreter to anticipate, as much as you can, those areas in which you may face ethical dilemmas in your practice and to be prepared to make ethical choices in the moment. The ability to make informed ethical choices requires developing and sharpening critical thinking skills as well as thinking ahead of time what your personal hierarchy of values is, that is, which ethical values are most important to you.

Additional Considerations When the Potential for Harm is Emotional

While the above questions are applicable in situations in which the potential for harm is to the emotional well-being of the patient, there are a few additional things to consider. In our description of emotional harm, we noted that it may take some time to observe that the patient is beginning to show signs of emotional distress. Some of the signs to look for are:

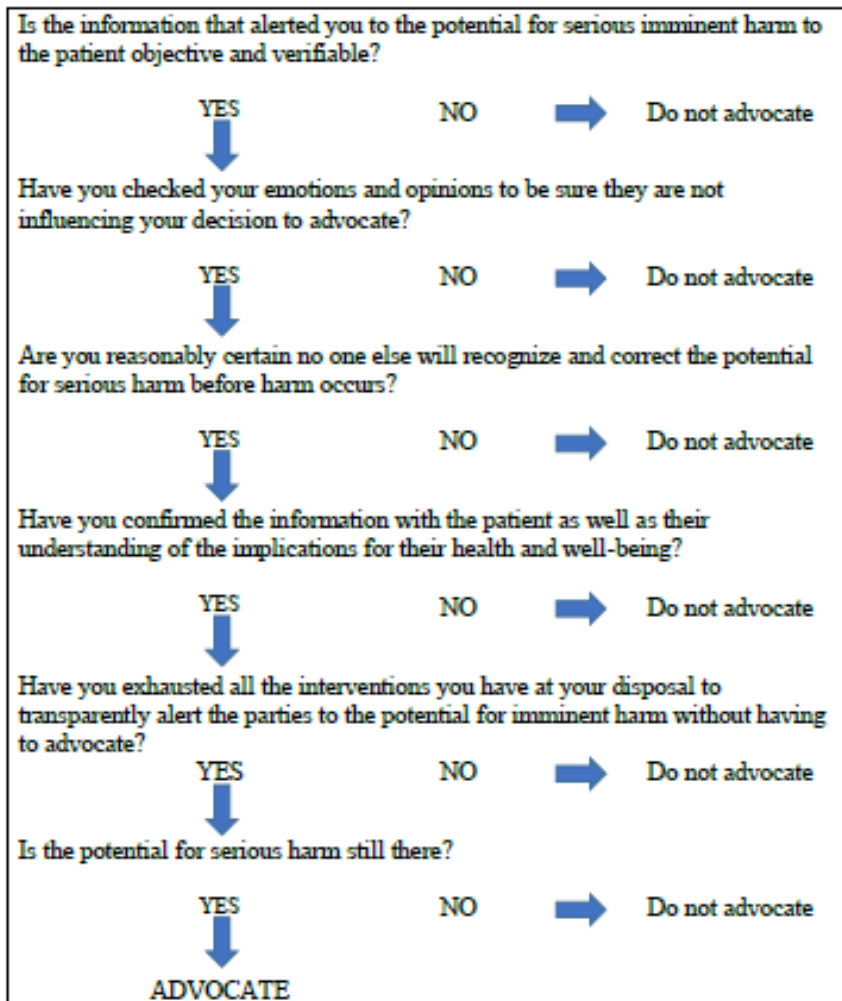
- disorientation, when the patient is beginning to have a hard time focusing on what is going on;
- incoherence, when the patient is beginning to have difficulties responding to the healthcare provider in a coherent way;
- withdrawal, when the patient is distancing themselves from the situation.

Signs of emotional distress, however, may be tricky to recognize because the expression of affect can differ across cultures. For example, crying tends to be a somewhat universal sign that most people recognize as indicating that something is not going well for the person. Other signs, however, such as changes in speech or intonational patterns, tend to vary across cultures. These cultural differences may prevent a provider from recognizing when a patient is in distress. In such cases, the healthcare interpreter may want to intervene by using cultural brokering to bring the patient's behavior to the attention of the provider.

When the healthcare interpreter begins to notice such signs of distress and the provider has not addressed them, they can check with the patient to see if the patient can describe what they are experiencing, making sure that they indicate to the healthcare provider what they are doing and why. If the patient can express what they are experiencing and feeling, the healthcare interpreter goes back to interpreting so that both can work to resolve the cause of the distress. If the patient has reached the point where they are no longer able to engage coherently with the provider, then the healthcare interpreter may consider sharing with the provider what the interpreter is observing. This offers the healthcare provider the opportunity to examine the patient's behavior in a different light and to consider what they can do to support the patient until the patient can again engage productively in the encounter. If the healthcare provider does nothing to acknowledge and address the patient's emotional state, the interpreter may consider asking to speak with the provider in private to advocate for the patient and the goal of the encounter. This action allows the patient the space and time to recover from the stress and allows the provider time to reflect on the situation without pressure. Such a simple "time out" might be enough for both the patient and provider to engage once again in achieving their shared goal.

Below is a diagram (Figure 1) that illustrates a process for deciding whether to advocate. It is intended to serve as a concise visualization of all the questions that need to be considered by the healthcare interpreter when deciding whether advocacy is needed.

Figure 1 Advocacy Decision Making Process



How to Advocate Positively and Professionally

When healthcare interpreters establish that advocacy is justified because of the continuing potential for serious imminent harm to the patient, they should keep in mind the

importance of maintaining a positive and professional relationship with both the patient and the provider. In the healthcare encounter, everyone present has the same goal —the health and well-being of the patient. Because of this, best practice for healthcare interpreters is to take a collaborative problem-solving approach when advocating to generate a mutual understanding of the potential for harm, verify the risk, and arrive at a shared resolution in support of the patient’s health and well-being.

The suggestions below describe behaviors that support acting in a positive and professional manner when advocating. We offer these in the spirit of ensuring that even when advocating, a healthcare interpreter strives to maintain a positive, collaborative relationship with the provider as well to support a positive relationship between the patient and the provider.

These suggestions hold whether or not the healthcare interpreter has the patient’s consent to advocate. Again, these are not necessarily sequential steps. They are reminders of how to advocate in a way that respects all parties and supports the shared goal of preventing harm.

- *Maintain transparency.* When advocating, it is imperative that you keep the patient (if conscious and mentally coherent) as well as the healthcare provider informed every step of the way. At the same time, you also need to make sure that the medical staff is aware that you are no longer interpreting but are speaking on behalf of the patient to protect their safety. Make sure that all parties know that everything is being interpreted, including all suggested resolutions. Any resolution must have the agreement of both the medical staff and the patient.

- *Identify who has the responsibility and authority to address your concern and resolve it.* Usually, the appropriate person or persons to address your concern are the medical staff present. But if none of them have addressed the potential for harm, or do not have the authority

and/or the knowledge to do so, try to enlist them in identifying who the appropriate person is. If they are unwilling to collaborate, you may need to become persistent in finding the right person. As a professional, you may want to familiarize yourself with the general authority structures of institutions for which you interpret to be prepared for the rare occasions in which you may need to advocate.

- *Speak in a calm and respectful manner.* How you advocate may be the single most important aspect of the advocacy process. Avoid placing blame on anyone, remembering that you are part of the treatment team working together for the benefit of the patient. Professional and respectful behavior should always be the norm.
- *Explain your concern concisely, providing the medical information or observations that led you to this concern.* It is important to describe your concern clearly and objectively to the person with the authority and knowledge to address the issue. State the medical information or observations that led you to conclude that there might be a potential for imminent harm that needs to be investigated. To the extent possible, describe your concern by using the terminology and medical concepts that healthcare providers use. Insist that the information that led you to this concern is verified, such as checking the patient's record or consulting with others, prior to taking action. In the case of emotional harm, objectively describe your observations of the patient's behavior or responses in the situation and promote a different approach.
- *Share your concern in terms of the shared goal of the encounter—the health and well-being of the patient.* This reminds everyone present that you are all there to support the health and well-being of the patient and ensure their safety, as well as to support the integrity of

the institution in delivering high quality health care and protecting it from possible legal consequences.

- *Return to the task of message conversion as soon as possible.* Once the concern is acknowledged and steps are being taken to resolve the issue, go back to interpreting between the patient and the medical staff involved.
- *After the encounter, it is advisable to report the situation to your supervisor and to use the experience as an opportunity for professional development.* Because of the seriousness of situations in which you need to advocate, it is a good practice to report it to your supervisor. Your supervisor will appreciate having heard your account of the situation in case someone else brings it up to them. This is also an opportunity for you to confidentially review and debrief your experience with a senior interpreter, or other knowledgeable resource person, on how you handled the situation and what you might have done differently and more effectively. Reviewing such experiences with others is an opportunity for professional growth.

The Challenge of Advocacy for Remote Interpreting

In 2004, when the NCIHC published *A National NCIHC Code of Ethics for Interpreters in Health Care*, interpreting in healthcare settings usually was provided onsite. Since then, the modalities of interpreter service provision have expanded swiftly to meet the demands of languages not frequently spoken, the urgency of care, the lack of onsite interpreting services in rural areas, and other newly emerging needs. These modalities include telephonic and video interpreting. Although there are many benefits to their usage, remote interpreters face some difficult challenges when the need to engage in acts of advocacy arises.

There is widespread agreement among healthcare interpreters that it is more difficult to know whether advocacy is warranted when interpreting remotely than when physically present in the interpreted encounter. Non-staff remote interpreters for languages that are widely spoken may be less likely to interpret for the same patient or provider on a consistent basis. This limits their access to information that onsite, and particularly staff interpreters, may have learned from previous encounters with the same patient and/or providers. Remote interpreters may be less likely to know the context of the visit and also have less access to useful visual cues. Telephonic or even video modalities restrict easy access to information that comes through body language, information that may indicate a lack of understanding, distress, or disorientation.

Many non-staff remote interpreters are generalists and may have limited knowledge of the normal routines of a healthcare facility or of standard medical procedures. Consequently, they may be less aware of the possibility of potential for harm and even when they are aware, the limitations of the technology may make it more difficult to advocate effectively when ongoing relationships have not been established with providers or patients.

Although it may be more difficult for interpreters working remotely to recognize a potential for serious imminent harm to a patient, when they do, they have the same ethical responsibility as all other healthcare interpreters to alert all parties to this possibility. Healthcare interpreters working remotely should follow the same thinking process outlined previously, using less-intrusive interventions first and only resorting to advocacy when all else has failed. At the same time, we recognize that it may be more difficult to advocate when one is not physically present and unable to identify the person with the authority to resolve the issue or to follow-up after the encounter. Remote interpreters are also hampered by the ease with which they can be

disconnected (intentionally or not), the reality that most calls are initiated by the providers, and the rarity of post-session debriefings.

Unfortunately, there is also still a tendency on the part of many patients and providers to think of remote interpreting as the technology being used rather than the person behind the technology. This results in remote interpreters being perceived simply as a voice that comes out of a machine. There is less opportunity for the interpreter to establish the most basic of relationships with either the patient or the provider through the simple verbal or non-verbal cues of welcome and empathy during an in-person encounter that help build trust and confidence in the interpreter. This is true even when the interpreter is well trained and trying to utilize all the techniques available for building rapport and managing conversation flow. In a recent study by Showstack (2019), the Spanish-speaking patients she interviewed often spoke of “la maquina” (the machine) when referring to the remote interpreting service. In anecdotal information from interpreters, providers have also been known to refer to remote interpreting by the instrument used to provide the interpreting service.

While this perception may be changing, it is still more difficult for remote interpreters, especially for non-staff remote interpreters, to be seen as part of the treating team because they are tied to technology and not physically present. This lack of human connection makes it easier for the remote interpreter to be ignored and disconnected by the provider. Some language service companies or organizations, however, have instituted an important structure through which a connection can be established when needed, that is, they have designated a company representative as a contact or liaison to the contracting institutions. In situations where the potential for harm cannot be brought up or is not addressed during the interpreted encounter, this

structure provides an avenue through which a serious concern could be conveyed to the parties involved after the remote interpreter has been disconnected.

Interpreters for languages of limited diffusion (LLD) may have more continuity with certain patients. Because of the small numbers of interpreters available for any specific LLD, they tend to interpret remotely for the same set of patients even when they are located in different parts of the country. Thus, they may get to know these patients, their providers, and become more familiar with the healthcare facilities. As a result, LLD interpreters are more likely than other remote interpreters to be able to establish relationships with patients and providers alike and may become accepted as part of the treating team. Although they still face limitations that result from the use of remote technologies, their ability to address a potential for serious imminent harm and to advocate, if needed, may be closer to those of onsite interpreters.

Conclusion

The *NCIHC Code of Ethics* (2004) includes advocacy as one of the nine ethical principles that guide the profession of healthcare interpreting. The *NCIHC Standards of Practice* (2005) describes how advocacy can and should be used to apply the objective of the ethical principle of advocacy. In this paper, we have focused on the use of advocacy specifically during the interpreted encounter, an area in which there continues to be considerable misunderstanding and in which the consequences to the health and well-being of the patient are serious.

Advocacy during an interpreted encounter is done in accordance with the value of *beneficence*, one of the three core values in the *NCIHC Code of Ethics*—a value that is shared with all other healthcare professionals. It is an intervention that allows the healthcare interpreter

to speak up autonomously to prevent serious imminent physical or emotional harm to a patient during an interpreted encounter.

The key aspects to remember about advocacy in the interpreted encounter are the following:

- Advocacy is an intervention within the accepted scope of practice of a healthcare interpreter; therefore, when an interpreter engages in an appropriate act of advocacy, they are not stepping out of the healthcare interpreter role.
- Advocacy during the interpreted encounter is reserved for a very specific purpose—to address a situation in which the potential for serious imminent physical or emotional harm to the patient persists even after it is brought to the attention of the healthcare providers.
- Advocacy is an intervention that should be based on verifiable information. The decision to advocate should not be based on the interpreter’s personal opinions, values, beliefs, biases, or feelings.
- Advocacy is an intervention of last resort and should be used only when other less-intrusive interventions have failed. The aim of these less-intrusive interventions is to prevent the need for advocacy.
- Advocacy is best implemented as a collaborative problem-solving process and not as an adversarial process.
- Advocacy is an intervention that supports the shared goal of both the patient and the provider—the health and well-being of the patient.

To understand the place of advocacy in the interpreted encounter, we have reinforced several key ideas throughout the paper. These are:

- *The healthcare interpreter's primary function is that of facilitating communication and understanding between two parties—patient and healthcare provider—who do not speak the same language and most likely do not share the same cultural framework. This function often requires that the interpreter use a variety of interventions that are not strictly linguistic message conversion but support the shared goal of good health care for the patient. Interventions that contribute to this function are not acts of advocacy.*

- *Self-reflection is an important attribute that healthcare interpreters need to continue to develop. It is especially essential when engaging in acts of advocacy to avoid the influence of personal opinions, values, beliefs, biases, or feelings in deciding when and how to intervene. Self-reflection also supports the development of critical thinking skills, that is, the ability to think clearly and rationally by observing, analyzing, and evaluating information before applying it to what you do and what you believe.*

- *Healthcare interpreters sometimes speak autonomously. They do so for two primary reasons: (1) to support communication and understanding in pursuit of good health care provision; and 2) to prevent serious physical or emotional harm to the patient, that is, to advocate. Of course, the interpreter must always be transparent.*

- *The aim in speaking autonomously is to create a “conversational space” in which the patient and the healthcare provider can collaboratively explore for themselves issues that may be interfering with the goals of the encounter and arrive at their own resolution.*

In Summary:

In accordance with Standard 31 of the *NCIHC Standards of Practice*, healthcare interpreters may intervene with an act of advocacy on the rare occasions when the potential for

serious imminent harm to a patient is not addressed and the danger of harm remains. In doing so, healthcare interpreters maintain the integrity of their role using an intervention that is within the holistic scope of that role. Their allegiance when advocating is to the value of beneficence — preventing harm in support of the health and well-being of the patient. In the words of the *NCIHC Code of Ethics*:

When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if less intrusive actions have not resolved the problem.

(NCIHC, 2004, p. 4)

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