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CULTURES OF INTERPRETING: DESCRIBING THE ROLE CULTURES PLAY IN MEDICAL INTERPRETING

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Abstract

U.S. populations are diversifying. Although immersed in an English-speaking population, immigrants are retaining their cultural identities. This understanding prompted a federal mandate for the services of bilingual interpreters to mediate healthcare delivery to non-English speaking clients. Although, the interpreter’s role has been defined, the specific impact of bilingual interpreters on healthcare outcomes has not been fully demonstrated. The consensus suggests that interpreters improve health care by facilitating communications. However, the fact that bilingual/cultural competency bears directly on client comfort and autonomy has gone unnoticed. Research has produced guidelines suggesting that interpreters act as neutral information conduits, but no research has examined the role that cultures play throughout these multicultural events. This mini-ethnographic study explores how Hispanic cultures ‘present themselves’ through the medium of interpreting. This study found that institutionalized concepts regarding culture are not ideal. The cultural complexity found within Spanish-speaking populations is beyond most healthcare professionals understand.
Acknowledgments

This thesis was prompted by the advent of ‘Cultural and Linguistic Competence’ within healthcare. Why did cultural and linguistic concerns develop and how were they being addressed? Over the course of a year’s review, my views changed: Instead of examining ‘cultural and linguistic competence’ as a generalized concept within healthcare, I decided to do qualitative research among specialized professionals who were expressly involved in cultural and linguistic practices. This resolve led me to study three bilingual interpreters who provide ‘communication services’ in a hospital setting to clients not fluent in English. These persons are the heart of my research and deserve my sincere thanks.

I would like to extend thanks to members of the staff at University General for their cooperation in this study.

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Introduction

The United States is becoming more geographically and culturally diverse. Among minority groups, Hispanics are the fastest growing demographic in the United States.¹ One study found that the Hispanic minorities increased 58% between 1990 and 2000 (Ramirez & de la Cruz, 2003). By 2030, according to current projections, 25% of U.S. residents will be of Hispanic origin/heritage (Tienda and Mitchell 2005, p. 3).

Spanish-speaking immigrants are no longer largely locating in areas historically associated with Hispanic/Latino cultures such as those found in Texas, Florida, and California (Suro 2002). Many are locating to the Midwest and Southeast, so-called “new settlement” areas (Pew Hispanic Center 2005). In contrast to old settlements, these new sites have witnessed rapid increases in their Hispanic/ Latino populations; being on the order of 300% to 400% since 1990 (Pew Hispanic Center 2005).² Importantly, Hispanics choosing these destinations represent only a small percentage of the population and tend to remain culturally and linguistically isolated, (Suro 2002). This new pattern of immigration is straining the older infrastructures of established urban areas; researchers point out that public health services need to provide more options for minority patrons (Pew Hispanic Center 2005). The Midwestern metropolitan area chosen for this research is a new settlement site; its Latino population has more than doubled since 1990 while its total population has decreased by more than nine percent (See Illustration no. 1) (THFOGC 2005, US Census Bureau 2001).

A major focus of health care research has been to examine ways in which the United States health care system will address special immigrant needs. Not surprisingly, language differences limit communications and are a major barrier to the delivery of health care services (Brach and Frazer 2005, Ferguson and Candib 2002, Ulrey and Amason 2001). There are proposals to
improve communications with Spanish-speaking minorities (CLAS 2001). National policy now mandates that interpreting services be employed to mitigate “communication barriers” (Department of Health and Human Services 2006). Some researchers conclude that it sufficient for interpreters to act strictly as language facilitators or “senders” (Hymes 1972, Beltran-Avery 2001). Others argue the need for skilled Medical Interpreters, and caution that even these may be unable to resolve complex communications issues, (Angelelli 2004, Davidson 2000). There is, in fact, no consensus as to how any language differences are to be resolved in medical settings. For one thing, it is difficult to comprehend how interpreters can function “neutrally” within the medical institutional setting. As Davidson and others have pointed out, there are cultural components exhibited linguistically in every human interaction (Bourdieu 1977b, Foucault 1963). Also, cultural components take many forms; be they personified, projected, or a constellated of sex, status, education, temperament or national origin. All can be displayed, and not just by dialect or word choice. We accept that “words are socially situated by, not created by, individuals”, (Mannheim and Tedlock 1995, p. 5). Hence, culture emerges through these situated actions. Furthermore, “The true locus of culture is in the interactions of specific individuals, and on the subjective side, in the world of meanings which each one of these individuals may unconsciously abstract for himself from his participation in these interactions.” (Sapir 1964, p. 151). Culture is constantly produced, reproduced and modified during dialogical events. “Once culture is seen as arising from a dialogical grounding, its emergent nature is revealed” (Ahearn 2001, p. 130).

Interpreting events are activities involving socially situated participants, who are agents in the construction of knowledge. Furthermore they exhibit agency when they act on what they have come to believe, know or suspect (ibid. 2001).
By framing language as a medium for cultural expression and exchange, interpreters effectively moderate information flow and serve as bilingual/bicultural filters between monolingual participants. In hospitals, interpreters function as cultural brokers in assessing patient needs and managing care. This study describes how “culture” is conceived, created, negotiated, stereotyped, etc. by medical interpreters. And by allowing the medical interpreters to express their ‘role’ in doctor/patient communications, I can describe Spanish-language interpreter strategies in practice as they are influenced their cultural beliefs or behaviors.

| Illustration #1 | Source: US Census Bureau, Census 2000 |

Illustration #1 Source: US Census Bureau, Census 2000
Literature Review

Geertz defined culture as, “the webs of significances that man spins for himself” (1973, p. 4). Culture is represented here as networks of human interactions together with all the inferences and implications that can be drawn from these associations. Kleinman specifically elaborates Geertz’s definition to include the practice of medicine. He found that medicine, health, and illness took on new meanings in cultures not confined by Western medical practices. Each culture develops concepts about acceptable behaviors for the ‘sick’. Kleinman writes, “Language, illness beliefs, personal significance of pain and suffering, and the socially learned ways of behaving when ill are …always… culturally shaped phenomena” (1991, p. 7). He notes that patients, family and friends, as well as various healthcare professionals/nonprofessionals, are involved in communicating relevance and negotiating power within the medical services setting; each one impacts how illness is translated, interpreted, or communicated. The inescapable element of individual subjectivity fascinated Kleinman. In order to rationalize this element of subjectivity in medicine, Kleinman followed, (as I have,) another’s definition of culture, namely, Sapir’s. Sapir suggested that the significance of culture could be found in the meanings that individuals abstract for themselves through their participation in some event or action, (Sapir 1964). More important, according to Sapir, were unconscious aspects of these events, communicated through relevance and negotiations of power. Individual understanding was bound to unconscious thought processes, which subjectively influenced and marked the participant (ibid. 1964). This implied that personal understanding, created and recreated during each encounter, was only superficially conditioned by extrinsic or environmental factors. By accepting this, we acknowledge that participants in interpreter mediated medical encounters exhibit knowledge and behaviors, which are culturally reflective. Still, medical interpreters are
expected to exchange information as objectively and unambiguously as possible. In fact, the entire dynamic of triadic interaction is modulated by language differences, differences of culture and contextual tensions; it is subject at all times to the skills and novelty of the interpreter. Western medicine can be studied as a cultural system, dependently tied to perceptions of institutional hierarchies, language use and professional-patient interactions as means of identifying illness. Research has indicated that health outcomes are affected not only by patient’s beliefs and expectations but also by doctors’ subjective understandings (Brown 1998, Kleinman 1982). It is the subjectivity of each individual that contextualizes practice. This placement of understanding within individuals does not obviate the role that environment or objective context plays in the creation of a reality. Rather, it attempts to explain how individuals might view the same action differently and contribute to misunderstanding and miscommunication, often observed when participants do not share a common language, i.e., the Rashomon effect.³

Ardener, in his work examining Whorf’s claim, “Language determines experience and therefore produces separate cultural worlds,” agreed that, “…those misunderstandings, which occur at the level of close interactions between individuals where language looms very large…” constitute an undeniable reality (1982, p. 3-4). Byron Good tells us, “Physicians and their patients categorize signs and symptoms differently, ascribing significance based on personal experience,” (1994, p. 90-91). Misunderstandings and conflicts compound when health care providers and patients do not share a common language. Medical interpreting, the conversion of medical information from a source language into a target language, has been proposed as, “a communications bridge that extends across languages and cultures,” (Brach and Fraser 2000, CLAS 2001, Hatim 1997, Parish 2003, Snell-Hornsby 1988). Medical interpreters communicate symptoms, clinical diagnoses and treatment options between patients and clinicians (Gilbert
2001, NCCC 2005). But this statement fails to acknowledge the complexity of interpreting events. Interpreters introduce their own understanding of events and thus mediate the process of designation. Communications convey more than mere words; feelings, attitudes, preferences, intentions, etc. are all communicated semantically or syntactically. There is no consensus as to how communications bridges are to be constructed.

Most recent research focuses on the development of three interpreting styles: Line-by-line, Summary and Remote-Simultaneous (Ide 2005, Gerrish et al. 2004). Each approach has advantages and disadvantages. Line-by-line is the literal interpretation, which attempts to include all words spoken during an interpreting session, accomplished through turn-taking (Gerrish et al. 2004) This technique requires the interpreter to remember complete uninterrupted statements from the source language which the interpreter then interprets word-for-word into the target language. Research suggests that the level of concentration required for this type of interpreting is difficult to maintain; also, source and target may become inattentive. Interpreters interviewed for the Gerrish, et al., study explained that line-by-line is impractical in situations for which specific medical terms cannot be directly translated and creates circumstances for error (2004). The summary style limits interpreting to only that information strictly conveying a message during a communication event (Ide 2005). Davidson’s investigating this technique found that although it saves time; it may not be best for patient care (2000). He concluded that interpreters made judgment calls about the information to be conveyed. In some situations, pertinent information was not transmitted between the parties involved and interpreter judgments were not always appropriate (ibid. 2000). A recent study suggests that a style of interpreting involving audio headsets for patient, clinician and an off-site interpreter, termed, ‘Remote-simultaneous’ may be more congenial to doctor/patient interactions (Flores et al. 2003). This research found
that patients and clinicians made eye contact more often than during triadic sessions in which
interpreters actively participated. Patients asked more questions regarding health related topics
and these generated further clinical discussions. Fewer diagnostic errors were observed during
these sessions, contrasting with studies of sessions in which the interpreter was physically
present. However, remote-simultaneous was considered inferior as compared to situations in
which patients and clinicians shared a common language and communicated directly. The
inability to directly translate specific medical terms in some situations remained a problem.

In addition to discussions of interpreting styles are the choices of appropriate roles for
interpreters during triadic interactions. Some studies suggest that interpreters should act with
neutrality, and thus provide a strict mechanical translation (Hatim 1997, Snell-Hornsby 1988).
This is considered the standard or ideal style of practice. Others contend that this draconian
approach places unreasonable demands upon individuals who choose to provide this public
service (Angelelli 2004, Dysart-Gale 2005, Gerrish et al 2004). They advocate a more active
approach by interpreters. For example, Brooks, et al., demonstrated that verbal communications
could be enhanced using strategies that include key word emphasis, gesturing and posturing
(2000). Interestingly, several studies found that most clinicians lack a basic understanding of
rudimentary interpersonal and cross-cultural communication strategies such as shared time
utilization, posturing, signing, and others, (Gerrish et al. 2004, Napoles-Springer 2005, Ulrey
2001). These same studies indicated that those individuals who advocate for a neutral or passive
interpreter are the same ones in need of elementary communications training. Interpreting is
interactional. It involves multiple settings, strategies and a variety of characters, all contributing
to the communication process. The idea that an interpreter’s role can be standardized is merely
beguiling. These cultural interactions are events that provide a rich and varied source of information.

Several studies have attempted to describe the roles that interpreters actually play. Davidson suggests that interpreters function as institutional gatekeepers; they are regulators, timekeepers who control the flow of information and improve bureaucratic efficiency (2000). He suggests that they grant privileges to those who warrant them. He further suggests that all interpreters will act alike, ‘irrespective of their sociocultural background.’ Davidson’s research contrasts sharply with Angelelli’s. Her interpreters assigned themselves roles, such as ‘patient advocate’, ‘cultural broker’ (someone who brokers culture between two different ethnic parties) or ‘teacher’ (someone who teaches a patient about Western Medicine), based on their own experiences (2004, p. 153). This self-labeling suggested that individual interpreters see themselves playing an active role in contrast to others in similar circumstances. However, if interpreters view their roles as invariant, they fail to acknowledge the commonality of a larger social reality and minimize alternate social realities. Without accommodation, such a state of affairs leads to confusion and potential conflict. The authors of both of these important studies on interpreter roles fail to grasp the impact that the interpreter’s cultural makeup plays in the interpreting process. Davidson and Angelelli argue that the institutional *habitus* is the primary influencing force (2000, 2004). But once again, the institution negates the habitus of each individual. During these events, culture is continuously produced, reproduced and modified as individuals interact. Culture is created during dialogical events and its evolving nature is visible. The act of interpreting involves socially situated participants, who are agents in the construction of knowledge. Furthermore they exhibit agency when they act on what they have come to believe, know or suspect, (Ahearn 2001, p. 130).
While the studies focused on Spanish-speaking interpreters, neither assessed the role that acculturation played in defining the actions of the interpreters. Nor did the research examine the impact of inter- and intra-cultural distinctions that exists within the Latino communities (Davidson 2000, Angelelli 2005, Napoles-Springer 2005, Gerrish et al. 2004). Nothing in the literature describes the role the interpreter’s culture plays in triadic interactions. Of particular interest should be the contributing cultural markers, such as ethnicity, gender, age, social position, education level and bilingualism, which are exhibited and influence the interactions of communication events.

Significant to the study of Spanish language medical interpreting should be the labels: ‘Hispanic’ and ‘Latino,’ insofar as they fail to account for the multiplicity of ethnic and cultural distinctions that exist within these populations (Antshell 2002; Bedolla 2003). Furthermore, these terms fail to recognize processes of acculturation (Uhlmann et. al 2002). Hispanic individuals will familiarize themselves with American culture based on their life experiences. This suggests that those populations labeled as Hispanic will exhibit cultural heterogeneity, not homogeneity, as the terms Latino or Hispanic suggest. Heterogeneity may be exhibited in a number of ways. Research indicates that language skills, socioeconomic status, race, and ethnicity are used within Latino communities to define an individual’s place inter-culturally and intra-culturally (Aguirre and Turner 1998, Bedolla 2003, Comas-Diaz et al. 1998, Graham 1990, Tienda and Mitchell 2006, Wade 1997). These inter- /intra-cultural displays and distinctions have been thus far ignored in literature addressing aspects of medical interpreting. Furthermore, it is highly unlikely that interpreters avoid exhibiting cultural nuances during interpreting situations. Sapir’s approach to culture supports this argument (1964). Unconsciously or
consciously, interpreters exhibit behaviors that for them are ‘natural’ but which may be ‘foreign’ to their clients, thus creating barriers to care.
Research Setting

Hope General, one of eight hospitals in this Midwestern “new settlement”, was established early in the 19th century and served the populations of an expanding mid-western metropolitan area. True to its stated aims, this public hospital has maintained a priority to provide quality services to underserved, underrepresented populations (AUH 2005). In 2002, Hope General created the new Spoken Language Department within Patient Services by hiring an on-site Spanish language interpreter. Two more interpreters were added a year later. Currently, HG employs eleven Spanish-speaking interpreters, a more than a three-fold increase in as many years. Hope General appears to have created a haven for many Hispanics in the area; it is obvious that an option to communicate in native tongues appeals to its patients.

Much of the data collected during the research period was recorded in the Spoken Language office. For the most part, the interpreting office looked like any other. There was little that could be associated with the interpreters’ country of origin. The only obvious indicators were mailboxes, constant reminders that this was a multi-ethnic and culturally diverse location. At some point, the Spoken Language supervisor ‘Elaina’ taped miniature flags to everyone’s mailbox. Interpreter origins include Central and South America, Spain, the United States, the Caribbean, Palestine and the African continent. The international flavor of this office was revealed in the language switching that took place while I was collecting data. Interpreters conversing among themselves switched back and forth between English, Spanish, and French. This situation is unique to Hope General; no other facility in the area has more than a single bilingual individual personally available for assisting patients with limited English proficiency (Personal contact 2007). The uniqueness of this setting provided this researcher an opportunity to explore how culture is contextualized by Medical Interpreters working in a new settlement site.
**Methods**

This exploratory qualitative ethnography attempts to describe instances of cultural brokering exhibited by Hispanic/Latino Medical Interpreters in a new settlement’s clinical setting. A number of data collecting methods were utilized in this qualitative ethnography: shadowing, field notes, semi-structured interviews and a literature review. Each data-collection tool played an important role in addressing the following aims:

1. Describe how cultural differences are contextualized by health care providers, patients and interpreters during dialogical interactions.

2. Describe and analyze interpreter ‘roles’ which emerge through situated actions. These roles take various guises, including ‘cultural broker’, ‘patient advocate’, ‘institutional informant’, ‘neutral observer’, ‘guide’, etc.

Shadowing, a form of participant observation, allowed the researcher to observe the day-to-day activities of Medical Interpreters in the institutional setting. Field notes summarized real-time impressions for the researcher and aided in the reconstruction of a daily narrative of interpreter activities. Semi-structured interviews provided insights as to what interpreters and staff members thought about interpreter’s personal/professional responsibilities vis-à-vis patients/institution.

The goal of this qualitative exploratory research was to describe how culture informed interpreter roles and was displayed during interpreting interactions. The three studies were chosen, “to maximize what we can learn” (Stake 1995, p. 4). Each vignette describes, elaborates and rationalizes the subjectivity and individuation exhibited by a medical interpreter during data collection.

*Participant Selection*

In order to collect data for this ethnography, I shadowed and interviewed three interpreters who were volunteered by the institution. Each interpreter was a full-time employee who worked
primarily with Spanish-language patients. There were additional institutional criteria. The health care facility was concerned with the intrusiveness that a lengthy study might create. The institution and researcher adopted a one-month period as an appropriate time frame during which the data was to be collected. It was agreed that each interpreter be shadowed for five days, (totaling thirty to thirty-five working hours.) The equal distribution of time was presumed to add a measure of coherence to the various data collected. In addition to the three interpreters, ten hospital staff members were interviewed to obtain their perspectives on Spoken Language services. Fifteen hospital staff members were approached during the data collection phase and asked if they would consent to be interviewed for this study. The ten consenting staff members comprised one physician, three nurses, one nurse anesthetist, one MRI technologist, one social worker, one financial officer and two clericals. These interviews helped to contextualize interpreting events from a clinical perspective.

Shadowing

According to McDonald, shadowing describes a research technique that places the observer in close association with the observed for an extended period (2005, p. 456). The technique is particularly useful for studies in which the research is focused on relationships within an institutional/bureaucratic setting. My use of shadowing allowed access to most routine activities associated with the three working interpreters. Throughout the shadowing, my questions elicited a stream of information from each interpreter. Some questions were asked in order to clarify earlier interpreter statements. Other questions attempted to elucidate interpreter points of view regarding events witnessed by the researcher.

Shadowing as a qualitative analysis tool allowed me the opportunity to observe the interpreters in an organizational/institutional setting. By observing daily events and developing a
detailed description of the inconsequential and commonplace, as well as acknowledging the vague and the ineffable, shadowing furnished a more or less holistic view of each interpreter. It sufficed by providing a contextual framework based on constraints within the institutional environment with which to describe individual working interpreters and their interpreting roles. The shadowing is in the context of a running dialogue/commentary.

My data collecting was limited to interpreter interactions with patients or staff. I was not allowed to participate in any triadic clinician/patient/interpreter interactions. I shadowed each medical interpreter for one working week but the total hours for each interpreter varied from 30 to 35 hours. Researcher observations involving patients were confined to common areas open to the public, such as waiting areas, hallways, the interpreter’s office, and in a few instances, areas, such as EMD, where the interactions could be witnessed by anyone moving through the department. In these situations, observations were made at a ‘social distance’ (completely out of hearing range; some 30 or so feet away, based on the setting) from interpreter-mediated interactions to be certain that patient rights, according to HIPPA regulations, were not violated.

Field Notes

Much of the collected data are in the form of field notes, which were hand written in small spiral notebooks. To minimize disruptions, I jotted short notes using key words and phrases, as is recommended by Crabtree & Miller, filling in the details after I left University General each day (1999, p. 61-62). These ethnographic note-taking strategies allowed me to focus on the context in which activities occurred. Field notes were utilized in the construction of narratives which explore, describe, and rationalize the subjectivity and individuation exhibited by each medical interpreter during data collection.
Semi-structured interviews

Semi-structured interviews were audio recorded with each of the three medical interpreters and ten clinical staff who agreed to participate. This interviewing technique collected qualitative data by allowing participants the time and scope to air their opinions on any subjects thought relevant to this research. Furthermore, it encouraged them to go off on personal tangents if even remotely pertinent to the topic being discussed and thus evoked more diversified ranges of responses. The researcher’s objective was to utilize respondent's views and experience to furnish a variety of contexts in which to describe interpreter interactions.

Questions were designed to elicit interpreter and clinician motivations, feelings, and expectations, regarding appropriate or optimal forms of cultural brokerage exhibited during interpreting interactions. As we will see, the meanings or significance of “culturally appropriate” or culturally competent forms of interpreting are contingent and often responsive to forms of class-ism within and across different Hispanic subcultures (rather than to formal guidelines or ideals of medical interpreting). Questions not limited to the objectives above elaborated the processes by exploring the role that culture plays during interpreting and/or how it is expressed/suppressed (Crabtree and Miller 1999, Miles and Huberman 1994).

All interviews were transcribed verbatim. Transcript data (with personal identifiers removed) were organized during the analysis phase so that interpreter and staff statements could provide context for the interpreters who were my units for analysis. Each vignette provides insights into interpreter roles. These roles variously reflect the institutional setting, the working environment, and reveal the influences individual interpreter’s culture and perceived status play in interpreter mediated interactions.
Presentation of Vignettes

The units of analysis are the interpreters, three of whom I shadowed. I will present each interpreter in a vignette reviewing some of that interpreter’s interactions. However, I will begin by describing each of the interpreters, in order that the readers may develop some sense of who they are. I will then move to a discussion of themes that are represented in the three vignettes.

The interpreters have varied national origins. Mary was born in the United States; Alicia and Jeff moved here more than twenty years ago and have dual citizenship. They range in age from forty-five to fifty-five years. Each is married and has children. Jeff has earned a Bachelors of Arts degree and completed an eighteen-month university study course, which certifies him to interpret in the Federal Courts system. Alicia has an Associate degree in Business. Mary has attended a number of medical terminology conferences and classes and has worked as an interpreter with the local courts. All three are considered fluent in Spanish and English. Alicia’s and Jeff’s English speech is slightly accented. Mary speaks without the slightest accent; colleagues describe her Spanish as colloquial. All have worked as Spanish-English interpreters for several years.

During my interviews, I learned that the interpreters are all very committed in their work, but their opinions differed markedly as to what their proper roles might be. Only one offered a definition that is ‘ideal’, i.e., consistent with the standard consensus that interpreters act as neutral information conduits, strict translators, adding or subtracting nothing from a dialogue, and simply convert words from a source language into a target language. The following interpreter opinions were expressed during the interviews.

1. “Interpreting is a great help for the patient who becomes sometimes very lost and confused; it is a great help for them”. This interpreter later states during the interview
that one must sometimes, “act as a teacher” to ensure that the patient “understands what is going on”, (Source 1).

2. “Medical interpreting is when you have to use medical terms to help someone that does not speak English”. A later comment gives insight into interpreting roles. This interpreter suggested that one “may question a doctor about an issue they feel the patient did not understand”, (Source 3).

3. “Facilitating conversation between a patient and a provider ….my voice is neutral.” He went on to state that, “The interpreter is not a communicator…people who filter are doing bad interpreting.” This interpreter is very earnest; he does not mean to be ironic. (Source 2)

These expressions imply that medical interpreters do more than, “provide interpreting, transliterating and translation services” (UHISL 2006). In fact, culture is displayed and emerges throughout the process of interpreting. Culture is acknowledged and reinforced during interpreter-mediated interactions. Interpreters create or assume ‘roles’ for themselves in order to broker linguistic and cultural interactions for immigrant patients and medical providers.

How are the cultural differences best negotiated and what is the personal/social/professional role of the interpreter and who defines these roles? Within University General, medical interpreting had been described in a general, idealized fashion by supervisory staff and management. They suggested that medical interpreters function best when they conform to objective standards of ‘neutrality’. In their actual practice neutral objectivity has little to do with interpreters mediating cultural differences. Of course, the institutional role of medical interpreters may be closely defined and their status fixed within a structured hierarchy. But within even the strictest discourse of triadic interactions where institutional power is exercised
and other professional relationships are being established, there is an added dimension of flexibility for expression reserved to the interpreter. Let us describe how interpreters display their roles within routine interpreting practices so we can demonstrate how cultural specifics of class, gender, status, etc., emerge and affect such practices.

**Vignette 1**

Requests for interpreting services come throughout the day from almost every Hope General department; they come in the form of notes, emails or phone messages and are posted, optimally, one day in advance of the service ordered. The Spoken Language Office supervisor compiles the language service requests and assigns the interpreters. These schedules detail patient names, ordered services and required languages.

Although the interpreters are usually meeting their clients for the first time, they occasionally recognize a patient’s name and may recall details about the person from a previous appointment. Most interpreters suggest that at most they might recognize a face, from time to time, but make no further associations; they rarely remember names.

On this particular day, Alicia recognizes the name of her first patient. She acknowledges that the client has a real need for her interpreting services; she has seen this patient before. This time, as it happens, Alicia will personalize the interpreting encounter in such a way as to affect the services outcome.

**Shadowing Alicia: Who is she working for?**

It is 9:07am when I follow Alicia into the Perinatal Department (PD) for her first appointment scheduled for 9:00 am. The patient and her partner are seated in the waiting area. Alicia describes them as an “indigenous couple.” Both individuals are quite short with dark skin, dark eyes and dark hair. The patient is very pregnant. The couple rises when Alicia enters the waiting
room. The interpreter’s surprise is evident. A few minutes earlier she had remarked that they might not show up. She stated, “A lot of them are missing appointments right now.” In the spring of 2006, the United States was opting for stricter enforcement of immigration laws and interpreter caseloads had been affected.

Alicia crosses the room and introduces herself in English, “I am the Hospital’s Spanish Language Interpreter.” Getting no response, she announces herself again, in Spanish. A short conversation ensues and papers are transferred to the interpreter. Alicia excuses herself and takes these documents into the Office of the Financial Counselor. After about ten minutes, the couple is invited in. They sit on a sofa. The interpreter stands between them and the Financial Counselor who is seated at her computer with her back to them. After twenty minutes, the couple exits the office; they both are visibly upset. Alicia follows and explains to me that the patient’s ultrasound appointment will have to be rescheduled because the couple has not brought the correct paperwork with which to apply for Financial Assistance. Also, the patient’s partner is unwilling to pay the Up-Front Fee required to keep today’s appointment. There is more discussion while the interpreter attempts to schedule a new appointment. The patient’s partner wants to bring the patient back on Friday because he is not scheduled to work that day. If he cannot bring her then, he will have to miss work again. The interpreter gives him an appointment card with a new date, (not Friday.) The couple leaves.

Viewed in a limited context, this episode appears mundane. It is only after the couple departs and the interpreter describes what happened, that the burden of the exchange is unpacked. The interpreter expresses frustration and repeats several times: “I told him what I wanted, but he never brings the right papers.” She adds, “He would not answer my questions to my satisfaction.” Alicia believes the patient’s partner ignored her instructions and was deliberately
evasive about the couple’s financial situation. In light of the current repressive situation regarding immigrants, this individual may have felt a need to be imprecise. Or, he may have felt uncomfortable discussing financial matters with someone who would not acknowledge his social status, due in part to the ambiguous marital situation. Such statements as, “If he doesn’t behave himself…”, and, “They’re not married; I don’t have to let him stay.” indicate that a cross-cultural conflict exists for the interpreter which might limit the patient’s access to care.

Cross-cultural issues aside, Alicia appears to act primarily as an agent for the institution. Alicia mediated the conversation regarding monies, and protected a financial interest for the hospital. I conclude this based on records of financial counseling conducted by other interpreters. Of the thirty-plus interpreting sessions for which I collected data involving other interpreters, not one ended with the patient being rescheduled. Furthermore, the financial counselor indicated that the Perinatal Department prefers Alicia because, “She’s more stringent about financial matters” and, “She is more formal concerning financial matters” (Source 4, 2006). This person indicated that Alicia would question a patient until she and the financial counselor, “were satisfied.” During my observation of Alicia, four of twelve appointments were cancelled and rescheduled, “due to financial issues.”(Source 1, 2006). Davidson would argue that Alicia’s activities are dictated by the institutional habitus (2000). However, the habitus argument does not allow for Alicia’s individuation, her freedom to choose to act otherwise. It can also be argued that she is acting as an instrument of the foucaultian system, controlling and disciplining those who do not make the effort to abide within society (1977). Statements, such as “I told him what I want”, and, “not to my satisfaction” reaffirm her station within the medical hierarchy. However, these expressions would not be articulated in a foucaultian setting, where power is latent. Alicia expresses frustration that an interpreting session that did not go as scheduled due to the lack of
requisite financial documents. The statement, “These documents use to be good enough…,” confirms this dissatisfaction. The expressions suggest that she feels a responsibility for the patient and is thus expressing a frustration with a system that does not allow for exceptions. This connection nullifies the foucaultian role of domination (1977). Alicia’s display is subjective, rather than objective. It argues that this interpreter’s activity fall within the Sapirian concept of culture (1964). Alicia negotiates power and maintains her social position within the institution by being stringent; at the same time, she displays feelings of empathy and exercises responsibility for her patients when they are turned away due, in part, to her actions.

But, some might ask, “Did she do her job?” The answer is, “Yes.” Despite conflicting factors affecting the interpreter-mediated interactions, she completed the task assigned her by hospital policy. She created a linguistic bridge, which enabled communications. That she maintained CLAS standards is difficult to say. But we can say with certainty that these interactions were heavily influenced by the contextualization of culture exhibited by each participant.

**Vignette 2**

While interviewing the interpreters, I learned that each perceives interpreting work differently. Some considered their work as an opportunity to simply help people in need and others suggested that they were educating immigrant patients about Western medicine. Jeff informed that he bridges the communication gap, ‘excluding and including nothing’. His description implies that he acts mechanically, converting words from English into Spanish and vise-versa, neither omitting nor adding anything that is not spoken. Many consider this approach ideal. However, interpreters don’t work in a sociocultural vacuum; they constantly contribute in culturally specific ways to the triadic interaction, though sometimes unaware of their influences.
Culture is exhibited in every interpreter action and often speaks louder than words. The following describes data collected while shadowing ‘Jess.’

**Jeff in the MRI Center: Is neutrality always best?**

It is a late afternoon appointment at the MRI Center. Jeff arrives to find the patient waiting with her young son. Jess approaches, stops in front of them, leans over with hand out-stretched and introduces himself to both the patient and her young son. They smile brightly when he shakes the child’s hand.

Jeff asks the patient to accompany him to the registration area. There, for several minutes and with the interpreter’s help, the patient answers the registration clerk’s questions. Following this exchange, the clerk gives Jeff a clipboard, and asks him to explain to the patient the clinic’s need of a personal history for its records. The interpreter guides the patient to a seat. Jeff explains to the patient that she needs to provide a personal history, hands her the clipboard and moves away to take a seat. The patient spends several minutes looking at the clipboard, but does not answer any of the questions. The interpreter, seeing this, approaches her again. Jeff asks if the patient needs help. She tells him that she can read and write Spanish, but not English. The interpreter scans the questionnaire and asks the patient if she would mind moving to a different seat. The patient agrees and Jess guides her to a chair in a quiet corner. Taking a seat so that they face one another, Jeff translates questions using a hushed voice and writes down the patient’s responses. The questionnaire completed, the patient returns to her seat near her son; Jeff takes the clipboard back to the registration desk. Everyone now waits for the MRI technologist.

Later, alone with Jeff, I ask why he had the patient move to another seat before filling out the form. He explains, “There were questions on the form that some mothers might be hesitant to answer if their child were present, very personal questions. And since I had to read the form out
loud, there was no way to protect the mother from being uncomfortable if we stayed where the patient had been seated.” I ask for an example and Jeff states, “The date of her last menstrual cycle.”

Later that week, I follow Jeff back to the MRI Center for another appointment. Again, he has to assist a female patient fill out the patient history forms. This time Jeff’s actions are rather different. He does not ask this patient if she would like move away from her male companion. When I later ask why he did not ask the patient to move, he states, “A wife should not be embarrassed to answer these questions in front of their husband.”

Communications, in the context of interpreting, are interactional phenomena produced by the individuals involved. Bateson proposed that communication always implies a commitment, thus defining the relationships and behaviors of those involved (Ruesch et al. 1951). Interpreting requires an understanding of how relationships can define communication and behavior. A Bourdieuxian opinion of this vignette would argue that Jeff should exhibit consistent behavior throughout both interpreting sessions (Davidson 2000). The agency that Jeff demonstrated with the young mother directly conflicts with descriptions of institutional habitus. And though Jeff has emphatically expressed that he does not influence events; his conduct suggests an awareness of and sensitivity to cultural values and situations that create discomfort.

While the two interpreting session are in several ways similar, there are some major differences that result in changed behavior. In the second interpreting session, the interpreter does not ask his patient if she might want, need, or expect privacy under such questioning circumstances. Whether Jeff’s actions are generated by hospital policy or cultural awareness, he produced an environment that allowed one woman to speak freely while possibly confining the other. Applying the theory of practice suggests that Jeff’s actions were correct in the second
interpreting session because ‘agency’ is not directly observable. But, by exhibiting such a broad range of behaviors, the right to choose is implied. Habitus is defined as an internalization of culture, which dictates ones actions without thought; unconsciously displayed by the body (Bourdieu 1977). The idea of unconscious display stands in stark contrast to Jeff’s actions; it requires that we look elsewhere for answers. In one discussion of culture, Sapir argues, “The ‘so-called culture’ of a group of human beings is essentially a systematic list of all the socially inherited patterns of behavior which may be illustrated in the actual behavior of all or most of the individuals of the group” (Sapir 1964, 151). Sapir is pointing out that many social scientists have tried to develop understandings about cultural groups by systematically listing their exhibited characteristics. He admits that much has been learned this way. However, it should be remembered that the significance of an individual’s action is in the meanings he attaches to it.

Jeff exhibits a trait or list mentality when interacting with these two women by treating them differently in what appears to be similar situations. He treats them consistently according to his own understandings, i.e., as a carrier of Hispanic culture. But he acts inconsistently in his treatment of them as women. He recognizes the need for privacy and acts with empathy for a mother and child. On the other hand, he chooses to ignore the possibly identical need in the wife attended by her husband. It is in Jeff’s unconscious understandings of culture that his actions are formed and carried out.

**Vignette 3**

New situations and unforeseen problems challenge the interpreter daily. Some challenges are easily met while others create additional difficulties. Interpreters find ways to minimize their own emotional involvement while creating ostensibly objective communication links for their patients. But occasionally, communications fail despite the best efforts and through no fault of
the interpreter or the client. As we shall see, the interpreter is left questioning her work within
the system, wondering what role she played in the institution’s failure.

**Mary helping a couple: Is it empathy?**

One morning Mary is called to Perinatal for an interpreting session with a patient who had
been seen in the Department of Emergency Medicine (DEM). The interpreter meets the patient
and her husband in the waiting room. Mary introduces herself and explains she will be helping
them, “communicate today”; she then leads them into the Financial Counselor’s Office where
they all seat themselves on the couch. After twenty minutes of filling out paperwork, the
interpreter helps the couple to schedule an ultrasound. This takes about two minutes. The couple
takes seats in the waiting room; Mary sits nearby. After about thirty minutes, the patient is
called for her ultrasound. The threesome exits the waiting room, but after several minutes they
all return, confused. They will have to wait just a little longer; “We are waiting for the doctor to
arrive.” Mary explains, “The tech was told that the doctor overseeing the procedure had arrived,
but he is not actually here yet.” After waiting twenty minutes longer, the doctor arrives and the
patient is led away for the ultrasound. Following the procedure, the patient is advised to go to
Obstetrics for a blood test. When they arrive in Obstetrics, they are asked, “Why didn’t you
come to the lab first?” The laboratory work takes a little over an hour to process and the couple
will have to wait again. The interpreter asks them if they were told to come to OB first. They
answer “No.” After checking the time, Mary suggests they eat lunch while they are waiting.
Mary shows them the way to the cafeteria and promises to rejoin them in an hour, around 1 p.m.

Mary returns to Obstetrics at 12:55 p.m. to find the couple waiting. Mary checks with the
laboratory personnel and finds that the results are back. She asks if the results have been called in
to the doctor yet. “The doctor would like them to wait; he will be here shortly to explain the
results and what treatment needs to be pursued.” It is not a short wait, as it turns out; its a little over two hours. When the doctor arrives, he confirms that the patient has miscarried and will need to come back tomorrow for surgery. The interpreter explains all this to the couple; they cry quietly.

The interpreter’s frustration is obvious. When I ask Mary, she states, “They made them sit here all day for nothing! They had the information in EMD earlier. EMD did an ultrasound. Why did he make them wait?” Mary goes on to explain that this was the first pregnancy for this 34-year-old woman, and calls it a “tough break.” As it happens, the EMD’s protocol required the radiologist to sign off on the morbid ultrasound… and…so…a duplication of services resulted (!) The interpreter’s frustration is compounded by the fact that the medical system failed to support the patient/couple during the late grief episode or treat them with sensitivity or timeliness at any time during their daylong trial.

One would assume that Mary is frustrated by the system and empathizes with her patients. “Why did the doctor make them wait?” But the interpreter is more than frustrated. In response to earlier questions about client involvement and professional distance, Mary states, “I don’t get emotionally involved; I have seen too much. Nothing really bothers me now.” It is suggested that the interpreter’s underlying frustration is with a system that forced her to spend all day dealing with a difficult case, (‘Why did the doctor make me stay with them all day?’) In such an instance, it would be difficult to remain emotionally detached. Mary’s actions constantly contradict what interpreters have been educated to say and do by an institution that assumes that treating the ‘body’ is sufficient. In this instance, the interpreter appears to be constrained within the ‘the medical system’ just as the patients are. Mary’s role in this event is difficult to understand. She did not act as a cultural broker or a patient advocate, because she limited her
attentions to interpreter-mediated interactions. In this instance, it can be argued that both the patient and the interpreter were disciplined by a system. The system failed this patient by not providing the patient or the interpreter with appropriate and timely instructions. If either had been informed, or had become informed, time would have been utilized efficiently the emotional distress lessened for all involved. The relevant question defining medical interpreting, here, is whether any neutral, professionally dispassionate, objective, indiscriminately unbiased, etc., ‘patient treatment’ could have improved this patient’s health outcomes, if it had not been so entirely empty of empathic content?
Discussion

The three accounts reflect a variety of behaviors, knowledge and attitudes displayed by medical interpreters working in a complex and professionally structured setting. The theory that connects these actions was that culture is emergent within institutionally situated interpreter mediated interactions. Within this model, three threads were discerned which connect these vignettes; social status, created environment (settings), and perceived social roles. Social status is a perceived quality associated with any human interaction. Interpreters display their perceived social status during interactions with both patients and clinicians. Social status also influences the setting that interpreters create when interacting with their patients and the roles that interpreters utilize. This study explored how these cultural influences translate into appropriate care as it is described by the Department of Health and Human Services in their standards regarding Linguistically Appropriate Services for individuals with Limited English Proficiency (OMHRC 2001). The influence of each of these threads will be discussed is such a way that their underlying or unobvious complexities will be revealed.

In any discussion of interactions, there are processes that are attributable to the culture of each participant. These cultural displays contribute to the perception and negotiation status within any interaction. This is an important idea to keep in mind when issues of health and illness are being discussed. Within the healthcare setting we find patients, their families and friends, as well as multiple clinical specialists, all with attributable hierarchical status. Interpreters, as new institutional actors have not fully established their place within the medical hierarchy. An interpreter’s status is assigned in large part by how their responsibilities are defined by the institution. Within Hope General, the interpreter role is defined as follows, “The Spoken Language Interpreter will provide interpreting, transliterating, and translation services, as needed
for Limited English Proficient (LEP) patients and staff throughout the Hope General”(AUH 2006). From this description, we can see that the interpreter’s position is broadly defined. In many instances I observed, the three interpreters exhibited behaviors that suggest Hope General grants them latitude within this definition. But it is the differing perceptions of their status as interpreters that they distinguish themselves from coworkers. Alicia believes that her responsibilities lie with the institution and primarily within the Perinatal Department to which she has been informally assigned. She has an ascribed status within this department. However, when Alicia attempts to assert her status outside of Perinatal, she becomes frustrated because other departments do not acknowledge the distinction. Jeff, on the other hand, cultivates relationships in a number of departments throughout his workday. His relative status within the institution allows him flexibility and broad access to services. He introduces himself as a “Spanish language interpreter who is here to help you communicate,” he is self-assured when interacting with patients (Source 2). Mary is described as one who doesn’t go out of her way to talk to staff. In contrast to Alicia, who is “more stringent” about hospital policies, Mary is described as “more casual” and, more of a “disinterested party” to the whole interpreting process (Source 4, Source 9). By adopting a neutral persona, Mary has affected other’s perceptions of her interpreting style. Likewise, she is a guarded patient advocate who usually restricts her client interactions to the triadic interpreting sessions; she may introduce herself, but she will not initiate any communications with her clients. Mary maintains a professional detachment while exchanging information or communicating services. She has relatively indifferent status within the institutional setting.

The interpreter’s perceptions of social status within the institutional setting affects how roles are assumed and responsibilities are exercised during communication events. All three
interpreters displayed variant perceptions of culture during triadic interactions. Roles are created and recreated, as interpreters deem appropriate to their cultural understanding of unfolding events. This is not meant to imply that the interpreter will assume the same role in similar situations. Why these variations are present is a matter of individuation based on changing cultural perceptions, abstracted by the participants. And though these three interpreters represent a sub-set of the interpreter sub-culture within the hospital community, each presents a unique cultural locus based on their national origins, educational background, socioeconomic status, etc., as do each of their clients. Interpreter roles fluctuate based on perceived relevance. I argue that Jeff represents a unique example of changing cultural perceptions based on what he understands to be relevant, confirming and appropriate in variable, (real-life, real-time) interpreting encounters. Jeff adopted one role during the interpreting sessions with the mother accompanied by her young son and a variant role with the adult couple just three days later. As a patient advocate Jess recognized and affirmed the status of the mother by excluding the child. He later acted as a cultural broker by mediating the husband’s status as a priority. This exclusion of the minor and inclusion of the adult male husband reflects Jess’ observance of Hispanic cultural norms; in this sense, the variant roles do not conflict. In each instance, Jeff needed to help the patient complete a health history; the apparent inconsistencies reveal something of his cultural identity. Similarly, I suggest that Alicia and Mary would assume roles appropriate to their understandings of Hispanic cultural norms in order to achieve similar goals. Every interpreting situation is unique and interpreters develop roles based on their varying cultural perceptions in order to communicate; it makes little difference how the interpreting event is structured otherwise.
A hospital is a sharply stratified social hierarchy, thoroughly systemized and standardized; it includes centralized clinics, concentrations of specialists and volumes of supporting services. Optimal use of time and space are crucial to its functioning. Time is described here as an institutional variable that has social and economic value. This institution is the medical interpreters working environment. Local dimensions of time and space are important to the interpreters for building and maintaining an environment in which information can be optimally shared. Watzlawick, et al. write, “communication implies a commitment and thereby defines the relationship” (1967, p. 51). This suggests that the behaviors of the individuals will be dictated by the relationships that are created. Communications space is a shared, social space and refers to the area in which interpreter mediated events occur. An interpreter’s commitment to providing an effective communication link is clearly a relationship building behavior and is an efficient utilization of time and space. How interpreters structure their unique local time & space depends on how they perceive their roles and responsibilities. Each interpreter’s perception of time and space may be different with different values assigned to each. But it is in how these dimensions are displayed that we learn about building relationships. Interpreters, proximal to a hospital employee, may be viewed as aligned with the institution, although alternate views can be argued. In the episode describing Alicia in the Financial Counselors office, the patient and her partner may have assumed the explicit power alignment to be both implicit and complicit! Furthermore, Mary tendency to sit or stand closer to the patient may appear as an alignment with her patients. Jess’ position is seen as more variable. He may stand or sit next to one patient, but in the next do neither. If privacy needed, he stands with his back to the patient and may even be behind a curtain, if one is available. What is being suggested here is the implicitness of behavior patterns;
a form of communication that does not require words. (These alignments are expressed in
Illustration no. 2)

In any interaction, the individuals involved exchange information. But shaping how this
information is exchanged is one of the interpreter’s primary roles. Everything that I have
discussed thus far plays a key role in how information is conveyed and received by the
participants. Interpreters create environments for information exchanges based not only on their
perceived status but the roles they choose to employ and the relationships that they cultivate. In
many instances that I observed, they can act independently. They gather information, which is
later conveyed to hospital staff. Alicia did this several times while I was shadowing her. She
would collect financial information from a patient and then transmit the information to a
financial counselor without the patient being present. But similarly, Mary would ask a patient
questions while waiting for a clinician. When asked why, she said, “I was gathering background
information about the patient for future reference.” Jeff also participated in information
gathering, but for a different purpose. He acquired and conveyed information to a patient, so that
he could provide the patient, a young woman from El Salvador, with privacy. He stated “I told
her about the stitches, so that I could leave her with her baby.” In each instance, we find
elements of their perceived status, role creation and institutional alignments. Sapir proposed, “A
personality is carved out by the subtle interaction of those systems of ideas which are
characteristic of the whole, as well as of those systems of ideas which get established for the
individual through more special types of participation.” (Sapir, 1964, p. 157). By this argument, I
suggest that each interpreter exhibited ambiguous feelings of responsibility for both their patients
and for the institution. They created interpreting roles and cultivated alignments in an attempt to
maintain an appearance of balance. Furthermore, these alignments and interpreting roles may
have at times evoked feelings of alienation within the patient population or from hospital staff.
This phenomenological paradigm has gone unrecognized in the works of others (Angelelli 2005, Davidson 2000). While both these researchers readily agree that information is conveyed, neither has acknowledged the impact that an interpreter’s culture contributes to the process of institutionalized medical interpreting.

| Patients ⇔ Alicia/Institution |
| Patients ⇔ Jess ⇔ Institution |
| Patients/Mary ⇔ Institution |

Illustration 2: Interpreter Alignments
Final Thoughts

In three vignettes I have described instances in which interpreters created environments that helped or hindered patient access to health care. What may we learn from their stories? Interpreters are not neutral. They are individual culture bearers contributing to every interpreting exchange. The notion that, ‘they strictly translate,’ is a gross understatement and misapprehension of interpreting function. No two interpreting sessions are the same, ever; they continually change relative to the participants. It is through the interactions of individuals that these interactions are created and perceived. But more importantly it is in the thoughts, feelings and behaviors of these individuals that a cultural context is constructed.

This exploratory ethnography has barely scratched the surface in revealing social and cultural complexities associated with cross-cultural medical interpreting processes. Every participant exhibits singular aspects of culture throughout interpreter-mediated interactions. Moreover, culture emerges as an artifact from common understandings and provides bases for mutual action. More research is needed. One area that should be explored is the manner in which medical interpreters “broker” culture. What is the nature of the exchange associated with “cultural brokering” and how does the process affect health outcomes? Another area of interest is the culture of the interpreter. This study has demonstrated that interpreters are not neutral. How can their cultural displays be utilized or mitigated? We can educate interpreters about the influence their roles have on the interpreting process and design programs to explain how their displays impact interpreting events and are perceived by others.

This study is obviously limited. The ‘shadowing’ fieldwork research methodology is usually employed over a much longer period and maintains focus on a single individual. A future study
might observe this standard practice to yield more extensive data for comparison, control and prediction.
Footnotes

1. The term Hispanic, formulated by the US government in the 1970’s, is a pan-ethnic label denoting individuals of Spanish descent or immigrants of Spain, Central or South America and the Caribbean, regardless of race. The only other distinguishing marker for this consensus is the use of Spanish as the individual’s primary language. No allowance was made for individuals from these areas that may not recognize Spanish as their primary language. Currently, there are 19 distinct ‘Hispanic’ nationalities living in the U.S. (Teinda and Mitchell 2005; 16-18).

2. In many cases the terms Hispanic and Latino have been used to define the same ethnic minorities. In most instances, the term Latino signifies someone from Latin America or an individual living in the United States with Latin American heritage (Tienda and Mitchell 2005).

3. “The Rashomon Effect was first described in the 1950 Japanese film titled “Rashomon.” The film depicts a violent encounter as seen through the eyes of four witnesses, lending dramatic emphasis to the lesson that there is not one version of any event but as many as there are viewers.” Social scientists have in recent years begun to utilize this technique. (Wolcott 1994, p. 21-22).


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**Document**

About University Hospital (AUH)  


[www.OMHRC.gov/CLAS/finalculturalla.html](http://www.OMHRC.gov/CLAS/finalculturalla.html)


**Research Sources**

Source 1: Called Alicia for this research paper was interviewed in May-June 2006
Source 2: Called Jess for this research paper was interviewed in May-June 2006
Source 3: Called Mary for this research paper was interviewed in May-June 2006
Source 4: Referred to only as a financial counselor in this research paper was interviewed in May 2006.
Source 9: Referred to only as a physician in my research notes and interviewed in June 2006.