VOICES

PERSONAL STORIES FROM THE PAGES OF NIB

Stories from Those Who Interpret for Others in Healthcare

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Introduction
Stories from Those Who Interpret for Others in Healthcare

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Abstract. This symposium includes twelve personal narratives from healthcare interpreters who have navigated challenges while interpreting for patients and healthcare providers who do not share a common language. These stories are from trained professionals who speak a variety of spoken and sign languages. They describe what it is like to be a communication tool for a Patient-Physician relationship and the many ways this service takes a toll on their own physical and emotional health. They share the systemic dysfunction they have witnessed first-hand, as well as the gratification they feel when patients and their physicians successfully communicate the nuances of the health situation. Four commentaries on these narratives are also included, authored by experts and scholars in the fields of medicine and bioethics, with particular interests in the moral distress of healthcare providers, medical communication, the intersection of policy and ethics, and the education of future interpreters. The goal of this symposium is to call attention to the experiences of healthcare interpreters and to enrich discussions of the ethical ramifications of communication between people who do not share a common language.

Key Words. Medical Ethics, Narratives, Communication, Quality of Care, Moral Distress, Non-English Speakers, Interpretation, Translation

Introduction

Effective communication is the cornerstone of high-quality healthcare, significantly affecting patient outcomes, satisfaction, and overall experience (Wiles et al., 2023). In multicultural societies, language barriers between physicians and patients pose substantial challenges to delivering the best care. These barriers, which include both spoken and sign languages, can lead to misunderstandings, misdiagnoses, and inappropriate treatments, ultimately compromising patient safety and the efficiency of healthcare services (Brandl et al., 2020).

Professional interpreters facilitate accurate exchange of information, ensuring that both the physician's and the patient's voices are clearly heard and understood. Ad-hoc interpreters, such as family members or bilingual staff, may be well-intentioned but not equipped to fulfill this role. Informal interpreters lack impartiality, training, medical experience (usually), and can be distressed by the responsibility of the situation (Basu et al., 2017). Professional interpreters are trained to navigate the complexities of the interpersonal scenario, the medical terminology, cultural nuances, and ethical considerations. Sign language interpreters, in particular, are essential for bridging communication gaps with Deaf patients, who rely on visual language to understand and convey critical health information.

The presence of professional interpreters supports legal and ethical standards in healthcare. Regulatory bodies and accreditation organizations emphasize linguistic and cultural competence, mandating that healthcare providers accommodate patients' language needs, including the needs of Deaf patients (U.S. Department of Justice, Civil Rights Division, 2020). Professional interpreters, both for spoken and sign languages, are instrumental in fulfilling these mandates, thus safeguarding patients' rights to informed consent and equitable care (Beilfuss et al., 2023). The significance of professional interpreters extends beyond immediate clinical interactions. By facilitating better understanding and compliance with medical advice, interpreters contribute to improved health outcomes and reduced healthcare disparities.

The Call for Stories

The editors disseminated a call for personal narratives from people who have served as interpreters in healthcare situations. We sought stories from professional interpreters who have served patients and healthcare providers when they did not share a common language. Authors were asked to consider the following questions:

- What surprises you about interpreting in healthcare?
- Is there advice you would give those who want an interpreter? Is there advice for those who do not want an interpreter?
- What do healthcare providers need to know about working with interpreters?
- What training did you receive? How has the quality of your training impacted your ability to provide service?
- Do you have suggestions for people interested in becoming professional interpreters?
- What have you found challenging in your role? How has the experience affected you physically, emotionally, or economically?
- What would you like people who develop policies and laws to know about the role of interpreters in medical practice?

The editors of *Narrative Inquiry in Bioethics* published the call for stories in the *NIB* newsletter and on the *NIB* website. Additionally, the call was posted on several social media platforms, including LinkedIn, Facebook, and X (Twitter). It was distributed through the American Society for Bioethics (ASBH) and Medical College of Wisconsin (MCW) listservs. Marcela Testai, a physician, medical interpreter instructor, and one of the symposium commentary authors, shared the call on her LinkedIn page, where she has hundreds of followers interested and involved with medical interpreting. She also shared the call with the supervisor of interpreting services at Phoenix Children's Hospital. The National Council on Interpreting in Health Care distributed this invitation to their membership. The call was also shared with *NIB* colleagues and experts in medicine, clinical ethics, and patient advocacy. Thank you to everyone who helped us share the call.

The Narratives

The stories in this issue reflect on the importance of including interpreters as integrated members of care teams and the danger when institutions do not properly address the need for interpreter services. The authors describe instances where literal word-to-word translation does not work and when interpersonal connection and cultural awareness are crucial for true understanding. Nearly all of the stories were written by professional interpreters—one story written by Leo Almazan, a student in training at the time of his story, highlights the limitations of ad-hoc translators. We read about the personal distress felt when bearing the emotional weight of a patient's words when speaking in first-person and the many ways that each author's lived experience becomes part of the way they listen, process, and become a conduit for communication. The descriptions of the psychological toll of this profession triggered our desire for a fourth commentary that focused on moral distress. The narratives also speak of lessons learned from patients and the deep satisfaction that comes from facilitating meaningful interactions between humans during stressful health situations.

The Commentaries

This symposium includes four expert commentaries on the narratives. The commentary authors—Beth Epstein, Evan Goler & Jennifer W. Mack, Jennifer Mara Gumer, and Marcela Testai—provide unique perspectives informed and enriched by their expertise in medicine, bioethics, education of interpreters, communication, and improving healthcare for vulnerable populations.

Beth Epstein is a professor at the University of Virginia (UVA) School of Nursing and the UVA Center for Health Humanities and Ethics, where she teaches pharmacology and ethics. She studies moral distress among healthcare professionals and is an experienced clinical ethics and moral distress consultant.

Evan Goler is a research assistant who is involved in research with English-speaking participants, and who facilitates research with Spanish-speaking participants. Jennifer W. Mack is a pediatric oncologist who conducts research on medical communication, including for patients with limited English proficiency.

Jennifer Mara Gumer is an attorney and Senior Lecturer in Bioethics at Loyola Marymount University. She has experience practicing law in healthcare and life sciences. Her interest lies at the intersection of policy and ethics.

Marcela Testai is a physician anesthesiologist and pain and palliative care specialist with a background in Public Health. Dr. Testai's career trajectory was unexpectedly shaped by her immigration journey. Limited by H-1B visa restrictions, she worked as a court Spanish interpreter, and later as a medical translator. This experience, coupled with her medical training, led her to teach medical interpreting and translation.

Conclusion

This symposium offers an inside look at what happens between a patient and their healthcare provider when there is no shared language. The skilled professionals who step in to bridge this gap are more than word-to-word translation tools; they are living, breathing, *feeling* participants in a very intimate dance of conversation, diagnosis, and treatment. They often witness bad behavior or inferior interventions and are forced to decide if they should "stick to the script" or become an advocate for the patient. Sometimes, they are not acknowledged as a crucial member of the care team; other times they enjoy a rich professional life, one that sometimes stems from key childhood experiences that have evolved into a welcomed vocation. In all cases, they must deal with the emotional burden that comes from wearing a sometimes-heavy hat, speaking in first-person when a physician shares a complicated treatment plan or bad news—or when a patient articulates fears, confusion, or grief. These narratives illustrate the skill, experience, and artistry needed to listen, process, and interpret language—preserving the meaning of the words while applying culturally and situationally appropriate connotations to the communication. This accurate and nuanced communication is at the core of ethical interaction between patient and physician.

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Personal Narratives

A Day in the Life of a Spanish Interpreter

Giannina O'Leary

The good thing about Mondays is they almost guarantee I'll be able to sleep at least until 8 am. If I have a double shift, my supervisor will try to "un-zombie me" for the night as much as possible.

I get out of my car and head to the three small offices that are the interpreter's dominion. It takes me about ten minutes because the hospital is huge, and our offices are located on the other side of the building. One office is my supervisor's, the other is the sign language supervisor's, and the third is for all of us Spanish interpreters working today.

My first hour is all about phones. I sit at the desk and open EPIC, the hospital software where doctors, nurses, therapists, and yes, interpreters, work with the rest of the staff. I listen to the first voicemail; it's nothing unusual. It's from a mom who needs a follow-up appointment with Neurology. I call Mom back (at Children's, all our clients' parents are "Mom" and "Dad," they seem to like it, and I never heard a complaint about it). Her daughter has a seizure disorder, and she's due for a follow-up. They need to do it because the girl is growing, and she is outgrowing her Keppra medication; the doctor will probably increase the dose. They will also do an EEG to make sure her seizure activity is under control.

I continue picking up the phone, listening to messages, calling people back, and documenting the messages that were not answered. Other interpreters will take them later and try to call them again. In the meantime, when nobody answers, I translate a few of the forms for the Autism clinic. Their patients are usually two to three years old, and moms are usually worried they have not talked yet. Usually, when asked what they want for their child, their answer is for them to talk and act like normal children. If you work at a children's hospital, it's a very common goal.

My first appointment of the day is with the ENT (ears, nose, and throat) clinic. I go to the clinic's virtual space and see the patient has not arrived. Five minutes later, there is no sign of him, so I call them. Mom forgot about the appointment, and she is very apologetic. We reschedule it and I let ENT know. Then, I send a message to the hospital interpreter to ask if they need help. "Yes, please!" Someone just asked them to go help with rounds. Can I go?

"Sure! Send me the name and number of the room."

I am glad to have this little app on my phone, and that we text more than anything when we need help. It helps me keep everything on track. I have an anxiety disorder so severe that when I get anxious (and work always makes me anxious), my brain imitates symptoms of ADHD. I do not have ADHD *per se*, but if I think I am making a mistake, that I am not learning fast enough, or, that lives could be in danger (like, for example, in a hospital), my thoughts race, and it is very hard for me to focus on anything. For functionality purposes, I suffer from ADHD about 70% of the time I'm at work.

This little app can be my personal hell. If I am interpreting for a doctor and the pager goes off, my mind will not rest. My anxiety takes over. What if it's *urgent*? What if someone—not only someone—but a child, is dying? If I haven't checked my messages and the pager is going off, my mind is, too. It has been almost two years since I started this job, and so far, nobody has died during my service, so my brain understands it may be ok to relax a little. In the end, anxiety is anxiety, and it will get you. It will find something to worry about. Anxiety shines with creativity and thrives in a high-paced environment.

I make it to the Med Center and see a group of caregivers outside the patient's room. I blend in and listen. Rounds with the doctors are always fun because the whole team gets together and talks about them, so I get a full explanation of what is about to happen; I also learn new things almost every time. The patient we see this time has appendicitis and his appendix burst. All the contents of his colon were spread in his abdominal area, which is, of course, a culprit for infection. The patient will stay for a few days, receiving IV antibiotics. He will need oral antibiotics for a few more days when he goes home. That way, the risk of infection will be at its minimum. Mom understands, but she is a little frustrated. They were hoping to go home today.

My next appointment is at the NICU. I arrive at the NICU in five minutes because, by now, I know how to navigate the hospital (it took me a while to learn because anxiety distracted me every time I took a wrong turn and slowed down my learning skills). The nurse informs me that the baby was premature, and she doesn't know how to drink formula by herself. She needs a pump that gives her formula through a G-button—a hole made in the baby's stomach by a surgical procedure, through which the formula goes directly to her stomach.

The baby is tiny, pink, and incredibly sleepy. Mom's first language is Quiche, a native language from Guatemala—Spanish is her second language. She is not at all fluent. Quiche interpreters are incredibly rare, so we have a challenge here. Mom needs me to lower the register quite a bit, not because she is not smart, but because she doesn't have the vocabulary to understand what I say. I must repeat myself several times and simplify my words to make sure Mom understands well what is going on.

I am so immersed in this appointment that I haven't realized my next one has started already. They page me, and of course, I get anxious. Luckily, Mom is happy and understands everything, so we wrap up. Off I go. I arrive to the Cardiology clinic ten minutes late, but this is a caregiver's field, and they could not be nicer to my sorry ass. I explain an appointment ran long and they understand; it's not like their own doctors don't have the same problems all the time. My heart slows down and I take a few breaths, so I can focus on the patient.

This is a teenager born with a tiny hole in his heart—VSD (Ventricular Septal Defect). It is common; I see it often in this clinic. The patient had surgery when he was a toddler and now needs to follow up with the Cardiologist every five years to make sure things are ok. The EKG shows normal heart activity. I sit with Mom and interpret simultaneously in whispers while her son speaks in perfect English with the doctor; this is the norm with teenage patients born on US soil. Mom is there for consent, information, and support, but her son takes charge. This appointment is brief—taking only two minutes. I sit in the workroom, and when they tell me the AVS (After Visit Summary) is ready, I quickly translate it, print it, and go with the nurse to discharge them.

After lunch, I have an appointment at Endocrinology. This clinic is among the most interesting to me. Most of the cases here are for diabetes, but also thyroid problems (many due to autoimmune conditions that cause the body to attack the thyroid) and hormone problems (here we encounter children who hit puberty but are not growing well; they get shots of growth hormone).

The patient has type 1 diabetes, and as are many Kanjobal/Spanish speakers, they are undocumented, so they don't have health insurance. Mom doesn't know how to say "needle" in Spanish and doesn't know how to describe it, so it takes me about twenty minutes to figure out that word and what they need. This does not look good. I need to harden my heart today.

The doctor keeps asking questions. They do not have insulin (either long- or short-acting, both very necessary) or needles. They do not know how to read well, even in Kanjobal, and they do not know how to do math. The doctor can only give them some sample supplies of needles and insulin and schedule another appointment for a diabetes teaching session. They have had three so far, but it's a real challenge if you don't read more than basic words and don't do math. I would dare to say managing diabetes without basic literacy and basic math is nearly impossible.

When they look at her blood test results, they are not surprised. Her sugar level is 300 (normal range is 80–120), and her A1c shows it has been high for a while. Luckily, there is no trace of ketones in her urine this time, and she can go home. If they can't find a way to afford the child's medications, the only resource they will have from now on will be the ER when she becomes critical. Multiple admissions to the hospital are also in her future. It will be a temporary fix, and they will have to use it multiple times throughout her life. She will often pop up in my mind, and I will wonder what happened to her. Certain people just stay with you.

I go home and try to sleep a little before my night shift. Usually, I only get one or two hours, if any, of rest. Anxiety keeps me up if there is anything I must do later. Around 9 pm, I text the interpreter in charge of the hospital and he tells me they will need me. They have four people in their rooms and two more in the waiting room; it's a busy night. I get dressed, make coffee, and off I go again.

It's RSV season. The ER is full of germs, as only an ER from a children's hospital can be. Before I go into a room, I read the patients' charts, but I know I will need a mask for most of them. Most interpreters have had RSV at some point. I know I had it a couple of months ago because one of the doctors heard me coughing one night while I was on call and told me it sounded like RSV. I appreciated the fast-food drive-up free diagnosis—it would usually take hours in the ER and a few thousand dollars if you don't have insurance.

They call me to the front desk. A mom is carrying a toddler with a distinctive cough, like a big dog's bark coming out of a little girl's mouth. It's undeniably funny. Croup. Nurses can diagnose Croup from the other room without seeing the patient. It is that easy. The treatment is usually a one-dose steroid pill that will open their airway and help with the hardest part—nighttime. The steroid is long-acting, lasting two days, enough for the worst part of the disease to run its course. Patients with Croup stay in the ER until medications kick in and then can go home.

I return to my desk and see a patient being discharged. Their AVS is ready for translation. They have RSV. They only need sleep, plenty of fluids, and ibuprofen and Tylenol to manage the pain. It will last about seven days, and in the meantime, they cannot go to school. This is the most common disease we see in the ER, along with COVID and stomach viruses. I assist with another three cases of RSV and give them the same instructions about sleep, fluids, and medications. By now, I can interpret these cases in my sleep.

Things slow down, and we discharge the last patient at 3 am, which is normal. I get my stuff and clock out, knowing they could call me again later. I head to the interpreter's sleep room. Many parents wake up around 6 am to start their day, and that is when they realize their children are sick and head to the ER. I am on call until 7 am, and if I go home, anxiety will not let me sleep anyway.

In the sleep room, I watch TV to decompress, but it does not take long for sleep to set in; I'm exhausted. Even then, anxiety wakes me up every hour or so to make sure I am not missing a page. The first time I was on call, I forgot to raise the volume on my phone, and I slept through the pager for half an hour before I woke up and realized someone needed help. I never made that mistake again, but anxiety doesn't trust me now and keeps waking me up—just in case, several times a night, every time I'm on call. Anxiety adds an extra layer of tiredness to your life.

At 7 am, I hear the pager go off, but I know it means the morning interpreter has taken over. I have the day off today. I get up and head over to my car. I'm not worried about driving while sleep-deprived. I know anxiety will keep me up.

* * *

Deaf Interpreter

Paul Hostovsky

Her tiny hands, flitting, darting, happily signing as we wait for the audiologist to call her name, are a joy to behold. And it makes me want to take her by the hand and just walk right out of there, me holding her left hand, the Deaf interpreter holding her right hand, the three of us skipping through the waiting room and out the door of the audiology department, away from her parents who don't know how to sign—who want to "cure" her of being Deaf—away from the hospital and all the doctors with their pathological views of Deaf people.

But we can't do that. We must wait here in the waiting room until her name is called. And then we'll go inside for the meeting to discuss the elective cochlear implant surgery that she has not elected to have—her parents are electing it, because, understandably, they want her to be able to hear. And yet she's Deaf. But they didn't sign up for having a Deaf child. In fact, they were probably devastated when the audiologist told them: Your child is profoundly deaf.

Lower case d *deaf*: people who have a hearing loss. Upper case D *Deaf*: people who have a hearing loss and for whom sign language—and its attendant culture—represents their primary experience and allegiance; people who mostly attend Deaf schools, mostly marry other Deaf people, mostly hang out with Deaf friends and Deaf family, attend Deaf events and Deaf sporting competitions and Deaf theater and Deaf parties and barbeques and Deaf conferences and conventions, and are active in Deaf civic organizations and Deaf politics.

Ninety percent of Deaf people are born to parents who hear, who, for the most part, don't know any Deaf people, don't know how to sign, and want nothing more than for their child to be "normal," to be hearing, like them. So when the audiologist tells them about the option of an invasive surgery whereby they can implant an electrode in the cochlea of the inner ear and give the child a possibility of greater access to sound, the parents jump at the chance, the hope, of somehow making their Deaf child hearing.

But what about the other ten percent, the Deaf children who are born to Deaf parents? Well, that's an entirely different story: When the audiologist tells a Deaf couple that their child is profoundly deaf, those parents will often celebrate the news, smile a big knowing Deaf smile and give each other a big Deaf hug and high-five, and maybe even give the benighted audiologist a hug and a high-five too, for being the bearer of great tidings. Because healthy Deaf babies are good, the more, the better.

As for the ninety percent of Deaf children who are born to hearing parents, growing up to be a happy, healthy, linguistically, and culturally Deaf adult is not something they are able to learn from their parents. It's something that takes place horizontally instead of vertically (i.e., from other Deaf people). It's not unlike the experience of gay children, trans children, or transracially adopted children (e.g., children of color with white adoptive parents) who often don't learn to embrace their identities until they reach adulthood and meet others who are like them. But if there were a way to implant gay children to make them straight, or to implant trans children to make them cis, or to implant children of color to make them white, there would rightly be a public outcry condemning the practice as unethical and immoral. And yet the vast majority of Deaf infants and Deaf children worldwide are being implanted in the name of medicine, in an attempt to make them hearing, an attempt to eradicate Deaf people for their own good because some people don't value the way they are different. And the silence is deafening.

While the Deaf interpreter and I are chatting with the little Deaf girl in the waiting room and she is animatedly telling us about her favorite things, her parents are checking their phones and talking to each other in low voices and they do not look at us. She has not learned to sign from her parents; she has learned it from her Deaf friends and Deaf teachers at the school for the Deaf where she is in the 2nd grade, and her favorite subjects are science, art, and gym class, which are all taught in ASL. Her favorite animals are dogs and horses. Blue is her favorite color, and basketball and swimming are her favorite sports. She tells us all this and more with her beautiful, nimble little hands, and the grammar of her face is perfectly grammatical.

And I'm in the waiting room because I'm the ASL interpreter assigned to interpret this audiology appointment for the little Deaf girl. And the Deaf interpreter, my colleague, is also assigned because he is better able to understand her—and make himself understood to her—than I am, because she's still very young. Most people don't realize that there are Deaf sign language interpreters—sign language interpreters who are Deaf themselves.

Deaf interpreters often work in tandem with us hearing sign language interpreters, not unlike a surgeon working in tandem with another surgeon, an architect with a civil engineer, or a pilot with a copilot. You've probably seen Deaf interpreters on TV interpreting for the mayor, governor, or FEMA director, and you didn't realize the interpreters were Deaf. As for me, I can almost always tell the difference between a Deaf interpreter and a hearing interpreter on TV because the Deaf interpreter's signing is always so, well, *Deaf*. Which is to say, virtuosic. If it's a Deaf interpreter, there's a hearing interpreter off-camera, across from the Deaf interpreter, "feeding" them the spoken message, which the Deaf interpreter then re-interprets in a more elegant, more accurate, and more understandable way. The Deaf interpreters are the rock stars of the sign language interpreting profession. They do it better than we hearing interpreters because ASL belongs to them. Because they grew up with it, live it, love it, eat it, breathe it, and they own it collectively with other Deaf people.

But not all Deaf interpreters do the high-profile work of press conferences with the cameras rolling. Most of them work in the community like us hearing interpreters, where they're assigned to interpret for Deaf people who benefit from their expertise: Young Deaf children, for example, whose language is still developing; Deaf adults from other countries who do not know ASL (there is a different sign language in every country where there are Deaf people); Deaf people with cognitive or developmental challenges; DeafBlind people; Deaf people who are so-called language deprived because they were never exposed to sign language and they didn't acquire any formal language, spoken or signed. Also, sometimes, everyday normal Deaf people will request the services of a Deaf interpreter simply because they prefer the linguistic and cultural fluency of a Deaf interpreter as opposed to a hearing interpreter like myself who learned ASL as a second language and will never be able to achieve the easeful, native fluency of a Deaf interpreter.

So the little Deaf girl in the waiting room is signing a mile a minute while her parents look away and we wait for the audiologist. And her language is downright musical. It may sound oxymoronic, but there is indeed music in sign language. ASL isn't linear the way spoken languages are linear—one discrete word following on the heels of the next. Rather, ASL is—there's no other word for it—*symphonic.* It creates meaning simultaneously with the hands, face, eyebrows, eye-gaze, lips, tongue, head-tilt, shoulder-turn--all the various sections of the body's orchestra creating meaning at the same time. A visual-gestural symphony rising up all at once, like a controlled explosion.

ASL has its own rhythms, assonances, crescendos and decrescendos, riffs, and repetitions, most of which have grammatical functions. For example, one beat versus two can indicate the difference between a verb and a noun; a single movement versus a repeated movement can be the difference between simple present and present continuous, or between modified and unmodified verbs. Additionally, much of the grammar of ASL occurs on the face, such as negation, imperatives, interrogatives, adjectives, and adverbs. Of course, this little Deaf girl doesn't have a meta understanding of ASL's grammar yet, but she's using it in her sentences.

And the thing is, it feels good to sign. The physical pleasure one derives from signing and watching other people signing is perhaps not unlike the physical pleasure one derives from making music and listening to music being made. Interestingly, *sign* and *sing,* but for two inverted letters, are the same word. A happy accident? Maybe. And yet, signing and singing are just two different (or maybe not so different) ways that the body expresses energy, shaping meaning and emotion out of thin air, putting it out there for the world to take in.

But silence, to Deaf people, who are intensely visual people, isn't lack of sound; it's lack of movement. Sound *is* movement, in fact. It's energy moving in waves, which is what music is, after all. And when Deaf people look into the faces of hearing people, they usually see silence. They see silence because hearing people, for the most part, do not use their faces to express meaning or emotion. Compared to Deaf people, they have very little facial expression when they talk. Hearing people are pretty poker-faced if you ask Deaf people. And that's because their intonation is all in the voice, which is invisible to Deaf people.

And yet, when Deaf people look into the faces of other Deaf people, what do you think they see? They see music! Movement, beauty, energy, meaning. They see intonation. They see gymnastic eyebrows, eloquent eyes, adverbial tongues, and all the risible muscles being put to good, resounding use. They see their language, a visually stunning and musical language, full of inflection, *anima*, and soul.

Back in the waiting room, a nurse finally calls the little Deaf girl's name, and all six of us—the girl, her parents, the nurse, the Deaf interpreter, and me—squeeze into the little examining room and wait for the doctor to come. When he finally arrives, he doesn't address the little Deaf girl directly; he speaks to the parents. He tells them about the surgery, its anatomical details, efficacy, risks, and possible outcomes. I sign what the doctor is saying, and the Deaf interpreter signs it again for the little Deaf girl, trying to make sure she understands what is being said, even though much of it is technical and over her head. She interrupts and tells her parents and the doctor that she does not want to have the surgery. I translate this into spoken English for the doctor and the parents. The little Deaf girl is crying now. The mother, embarrassed, smiles indulgently, pats her daughter's head and lies to her: It won't hurt, she says. And you'll be happy when you can hear. Because you want to be able to hear, don't you? The little Deaf girl shakes her head no and continues crying, and the Deaf interpreter gives me a pained look from across the room, and his look speaks volumes.

* * *

"Call me Dr. XXX!"

Yilu Ma

Disclaimers. Names have been changed to protect the privacy of those mentioned.

Scheduled to interpret for a Mandarin-speaking woman, I entered the examination room and introduced myself to the neurologist and the patient, who was accompanied by her husband, brimming with smiles and sitting on the edge of the chair.

"How are you, Katie?" the husband greeted the doctor, using his accented English.

"Call me Doctor XXX!", the physician returned, her eyebrows knotted with gravity. Immediately, the friendly and light-hearted air in the room froze.

This occurred many years ago at a small clinic where I usually went to interpret as a per-diem interpreter. It happened so quickly that I was totally unprepared, and honestly, shocked at the way the physician reacted to the husband. I felt bad for the patient who sat next to her husband without saying anything, being quiet throughout the interactions. She suffered from dementia and was so dependent on her husband. I also felt slightly angry at the doctor's insensitive response to a mere friendly gesture, though seemingly improper, given the conventional power dynamics between the patient and the physician and the way doctors are esteemed in the American medical culture. But the doctor could have reacted to this perceived slight and disrespect with a mere laugh or simply pretended not to have heard it.

Even more distinct was the fact the doctor showed her irritation in front of a third party—me, the medical interpreter. I felt she almost directed that to me and right in my face, and yet I felt powerless, helpless, and even embarrassed. I wondered if the doctor would do the same in front of her other colleagues—physicians and nurses. She might have been more diplomatic. Was her rebuke an impulsive reaction or a deliberate projection of her power, putting the husband back into his place? Should I intervene to ameliorate the impact and explain it? What if the doctor became angry with me if I ventured, and would it worsen things despite my good intentions? All these questions were stirring around in my head. Eventually, I decided to mind my own business and stayed in my role. But this episode of her open reprimand and implicit power projection stuck in my mind then and many years after.

Over the years, I moved up from a medical interpreter to the Director of the Interpreter Services Department of a major teaching hospital in Boston and worked deliberately to elevate the status of medical interpreters by educating clinicians about who we are, what we do, what qualifications and trainings we have and the unique roles we play in cross-cultural communication and care delivery. We demythologized medical interpreters' traditionally reductive role of mouthpiece and advocated their full-fledged member role on the care team. Through our regular conversations and dialogues (instead of top-down teaching sessions by clinicians), medical interpreters partner and team up with physicians, nurses, social workers, chaplains, ethicists, residents, and fellows. We learn from one another to foster a culture of collaboration and mutual respect, gradually bringing about a transformation of power dynamics; medical interpreters are valued for their unique roles of language conduit, clarifier, cultural broker and patient advocate. Interpreters now are empowered to ask questions, seek clarification, and advise on care approaches before, during, and after medical encounters with confidence and teamwork spirit.

One of the tangible changes that we collectively implemented is that for each patient appointment, we will allocate time for a short meeting between the interpreter and the provider in what we call a "pre-huddle"; the purpose of the quick meeting is for the provider to brief the interpreter about the patient's medical condition and the goal of treatment. The provider will use the opportunity to solicit any input from the interpreter around language and cultural challenges.

The interpreter, possibly having worked with the patient before, will provide some background and context if proper and necessary. This simple process change has boosted the interpreter's morale and engagement. Both parties feel comfortable and familiar with each other's roles and moves. By working in such an environment of collaboration and mutual respect, both the interpreter and provider are energized and enthused to deliver the most compassionate and highest quality patient care. We quantified this enhanced confidence level in our research and training and published the findings in an article, "What's Lost in Translation: A Dialogue-based Intervention that Improves Interpreter Confidence in Palliative Care Conversations," published in the Journal of Pain and Symptoms Management.

While celebrating all the notable progress and the advocacy work we accomplished, I still remember that day and experience. I can hardly hold back from sharing it with my co-workers and colleagues. One of the reasons I keep bringing this up is that I learned over the years sharing one's vicarious trauma is an effective way for self-care. Though an unwholesome experience, it has turned me into a stronger person as I relate it to others. More importantly, learning from my lesson and being able to self-reflect upon it allows other interpreters to deal with their own strained encounters due to cultural differences, power dynamics, role mismatches, and self-perceived statuses. As a result of our group discussions about various frustrations in our daily work as medical interpreters and sharing them with the medical team, I'm now personally feeling encouraged and empowered more than ever to speak up and speak out if I have something helpful to offer to the medical team. As a leader, I'm also immensely gratified to see that my co-workers have become more open and outspoken about linguistic and cultural differences, and they tackle challenges as proud members of the entire medical team.

The erstwhile scene, still vivid and surreal, has evolved into an effective self-nurturing, benevolent, and educational tool in my toolbox.

* * *

Translating Care for the Voiceless Patient

Leo Almazan

Undocumented immigrants do not have the luxury of having a professional interpreter by their bedside to help them navigate the complexities of their often-dire situation. Most of the time, they have to rely on the kindness of volunteers or untrained medical personnel to help them. In 2001, I was a non-clinical student in training at a level 1 trauma hospital in the Midwest. The night in question, one of the residents asked me to go to the infectious diseases unit to translate for a newly admitted undocumented patient.

The patient was in his early twenties. This was the second time he had arrived in the US after walking through the desert. His diagnosis was dire—he drank stagnant water during his journey, and he had acquired an aggressive type of infection whose origin (viral? bacterial?) the specialists could not as yet determine. After initial testing, the doctors discovered that he was also suffering from full-blown AIDS.

When I entered the room where the young man was lying, shaking violently due to a high fever, I felt deep anger and profound sadness. People looked at the young man with a mixture of disdain and anger. He was, after all, "wasting" the hospital's precious resources. At the same time, his immediate reaction after hearing me speak to him in his native language and sensing that I understood him, that is, that I could empathize with his fears, made me decide that I would do whatever I could to help him.

After a brief initial conversation, it became painfully clear that he neither had any formal education nor did he understand the gravity of his medical condition, aggravated by AIDS. Besides that, he did not comprehend what was being done to him, which included the use of experimental drugs that he had not consented to take.

My task then morphed from an untrained translator trying to help someone understand a foreign language to a new ally trying to help someone navigate the short-, mid-, and long-term life-altering decisions he would have to make without full knowledge or understanding of his actual circumstances. In short, I quickly transition from interpreter to advocate.

It was probably the result of the stress and pressure I suddenly found myself experiencing, but I remember thinking back to my high school etymologies class and realizing that the verb "to advocate," from *ad-vocare*, means to support, defend, or protect someone. "When did I commit to any of those things?" I thought to myself. And then I immediately remember thinking, "Not at all! I did not commit to any of those things! All I said "yes" to was to lend my voice for a couple of minutes so that a doctor and a patient could understand each other. I surely did not intend to lend my voice to someone who has no voice!"

A second and even bigger surprise for me, however, was that, in the process of translating, I could hear what the young man and the physician were truly saying to each other. In other words, as my mouth moved to speak, now in Spanish and now in English, I was able to capture and translate not only the words being said but also the feelings and emotions and the deeper meaning of what was being communicated. For example, when the young man asked, "¿Voy a estar bien?" ["Am I going to be OK?"] I could "hear" his real question, "Am I dying?" When the doctor said, "Your CD4+ cell count is less than 200," I heard him say, "Couldn't you have chosen another place to die?" Conscious of my role, however, I limited myself to performing my duties as professionally and precisely as possible.

The following day, I consulted with a professional interpreter who worked at the same hospital, and I asked her how I could be more helpful to the young man. As she advised me how to proceed, I could tell she was truly torn.

On the one hand, she wanted me to proceed with the outmost professionalism, to remain "neutral," "objective," and to avoid, at all costs, "antagonizing" the medical personnel. On the other hand, however, she agreed with me that there was a real need for advocacy in favor of the young man. "After all," she said, "how could you not feel personally and emotionally involved when it is clear that the young man is so desperately vulnerable?"

I do not remember much of the content of our conversation, but I do remember her parting words very clearly. She said, "We must be professional in what we do, but we can never cease to be human. I guess the best piece of advice I can give you is this: treat him as you would like to be treated in similar circumstances."

I returned to the young man's room every day for the next couple of weeks. At times, I went there because my presence had been requested by yet another clinician who needed to communicate something to the young man. Most times, however, I just went to sit with him and talk to him about his life, his dreams, his fears, and his plans for the future. I realize now that it was always after the last kind of visits, the personal ones, that I left the young man's room feeling the most exhausted mentally and emotionally, while at the same time feeling the most rewarded and reinvigorated to keep up helping him in whichever way I could.

The last time I saw the young man, he had been stabilized enough for him to be able to leave the hospital. It was serendipitous that I walked by when he was literally leaving his room. Our last conversation has stuck with me, even after all these many years.

"You are leaving already," I said in a surprised voice.

"Yes," he responded in his usual quiet and shy way. "They say it is time for me to go."

"And where are you going?" I replied. "I mean . . ."

"I'll go live with some friends," he said, reading my meaning.

After an uncomfortable silence, he added: "I will never forget your voice." After another awkward pause, he added, "I mean, not the actual tone of your voice or the words you used to help me understand the doctors, but the warmth and the care I felt every time you tried to help me."

Without another word, we embraced each other and then went our separate ways.

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Are We There Yet? A Narrative of Firsthand Interpreter Experiences in the Medical Field and Insights to Aid Language Access Compliance

Hilda Sanchez-Herrera

My Spanish interpreting journey began in 2008. In those days, very little training was available, and online studies were very new and rare. Early trainings involved out-of-town interpreter and translation conferences, reading the recently released Culturally and Linguistically Appropriate Services (CLAS) standards documents, and participating in the diversity events at the hospital and in the community. Eventually, I did three different medical interpreter training programs, each teaching me something new and improving my skills. The first few years opened my eyes to what it meant for one to be trained, qualified, and certified. It has been a marvelous learning experience.

Now, with sixteen years of experience and the vastness and richness of being an interpreter in various settings, I continue to learn to be flexible, patient, and courageous. I've also learned to be a teacher because clinical staff have one perspective of what interpreting is, and we have another. I've learned to be courageous because the field of Language Access is very demanding and involves encountering a lot of biases and judgmental perspectives. Language Access champions advocate throughout the nation so that those who are working in this field will have better working conditions. Collaborations started in the community, extending into social services, legal, and beyond.

Interpreting sessions that had the most impact are many, but a few stand out, including a patient I assisted who had presumed Locked-In Syndrome and a domestic abuse female at a maternal-fetal appointment. I have had to explain to a family what it means to be brain dead and have interpreted for numerous palliative care sessions.

The presumed Locked-In syndrome patient was quite the experience. I had recently started working on the floor at the hospital and was making my rounds to Spanish-speaking inpatients. One morning, I arrived just as the physician team was making their rounds. I listened to the briefing: a 42-year-old female had suffered a stroke. She could not speak and could not use her extremities. The team had done what they could and reached the conclusion that she was "locked-in" because she was aware but their neurological exams were inconclusive. I asked if they had used the video or phone interpreting services and they said yes but it was not fruitful. I offered to rule out a language barrier. They agreed.

It was then that the patient began making great progress in her recovery. The team was amazed at the patient's reaction. She cried when she heard her language spoken. We established communication via a board and eye signals. Speech therapy came and they were able to assess her ability to speak and swallow. While she remained approximately 6 months in the hospital, it was not until the last two months that she made great strides, and it was all due to language access. Eventually, she was transferred to another healthcare facility closer to home. I was overjoyed and wondered why they had not had this success earlier. It was later determined that the connections were not good, and the interpreter could not "see" what the patient was doing.

The domestic violence female was an emotional one for me. I was scheduled to assist at two of her appointments that morning: one at maternal fetal and the other at ENT. Upon arrival, I greeted her and noticed her eyes were watery and her face seemed a little swollen, but I did not want to make her feel embarrassed, so I remained quiet. I accompanied her to the ENT appointment first. The doctor asked her questions, and she seemed nervous. Still no intervention. We finished and went to the maternal-fetal appointment. On the way to the office, I asked if she was ok. She began to cry and said in a soft tone, looking around, that her partner had hit her on the way to the clinic.

I was shocked! I knew that permission was needed to share this information with the providers and that her safety was critical. She thought about it and though a little frightened, she agreed. I spoke with the nurses and the doctor, to which they called the social worker to come and assist. The doctor began the appointment. The staff was very good at making sure everyone was safe: the patient, the unborn baby, other staff, and the interpreter. We made her feel safe and respected her privacy. Her partner dropped her off and went to park the car, so he did not know where she was having the appointment. I had stepped outside to get a drink of water when he asked me (unbeknownst to him, I was her interpreter) where to find the clinic and the patient. As privacy practices dictate, permission is needed to share patient information with anyone who is not with the patient. I denied knowing her and directed him to the other maternity clinic he kept asking about, which was on another floor. I was new at interpreting. This exposure to real-life trauma caused many questions to surface regarding privacy, safety, sharing information, and interventions.

After everything was said and done, the patient decided to go back home with her abuser. This broke my heart, and tears flowed. I sat with the social worker, who gently explained that I had experienced second-hand trauma, and the tears were my reaction to it. She also stated that abuse victims usually take seven attempts before having the courage to leave their abuser. I was pensive and thought about all of this. We had transportation and lodging ready for her. All she had to do was say, "OK, I will stay." Instead, she left. I learned a valuable lesson from this assignment—free will is fragile, and outside circumstances can overrule and constrain anyone in any circumstance. I decided to learn more about family abuse and how best to prepare as an interpreter.

There are times when family cannot be present, for instance, in emergency room procedures or post-anesthesia recovery. My skills and me being present brings solace and comfort to those who do not speak English. They are more relaxed and open about what ails them. Working in a healthcare setting has its many challenges. One has to navigate a culture that is not always open to new ideas or experiences. Life is a precious gift that healthcare providers have chosen to protect. Yet, in many instances, these very coworkers do not allow one to do their job properly or efficiently. Some do not know how to work with interpreters, nor do they understand what our role entails. Some are rushed. Some prefer to use their unrefined skills instead of us interpreters.

I have to say that in recent years, it is getting better, although collaborations are still few and rare, and standards of practice between bilingual staff, travelers, and interpreters vary. This opens up another set of challenges and liabilities. The CLAS Standards were developed in a national effort to provide language access to all limited English clients in their language of national origin. It identifies 15 areas for improving access to limited English clients. These, along with Title VI of the Civil Rights Act of 1964, President Clinton's Executive Order 13166 in 2000, and now Section 1557 of the Affordable Care Act of 2010, along with many interpreter/translator associations advocating for professionalization, are forming the backbone for a foundation in Language Access opportunities. Interpreters in either the medical field, courts, conference, or educational settings have a code of ethics to follow. Our standards of practice are also a guiding factor in providing culturally competent care alongside the clinicians. All should read these so that clinicians know why interpreters do and do not do certain things.

Medical schools are beginning to include interpreter training for their first and second-year students, though this is still slow and few in coming. Foreign residents and physicians are encouraged to inquire at their facilities about providing one-on-one care for their patients in their native language. Taking either a language assessment test or presenting higher education degrees in their native language are ways to comply with the Joint Commission standards and other federal regulations. Hospitals, providers, and health plans can be held liable when language access is not taken into consideration. There are many documented legal cases showing negligence in not providing the services. Clinicians are respected in the communities they serve because of their ability to make them whole again. If we take into account the cultural aspect of medicine, we have to consider the traditions that some communities hold near and dear that form their identity. There is still much work to be done. The good thing is that it is slowly coming to fruition. What legacy will educators, clinicians, and interpreters leave for the next generation?

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One Interpreter's Journey of Interpreting for Pregnancy Loss

Marisa Rueda Will

"Interpreters have to know everything." This is what I thought as I watched and shadowed a seasoned interpreter at a world-renowned medical center, during my J-term internship. The fact that I had gotten this opportunity was still hard to believe. There I was, shadowing medical interpreters at one of the best hospitals in the world during my senior year of college after abruptly dropping my secondary education minor to pursue a career in medical interpreting. I felt fortunate for the opportunity and seized the chance to learn from the best of the best.

When that same institution hired me after I graduated college in 2006, my training consisted of shadowing other interpreters and having them shadow me. There was no strict process, just one-on-one on-the-job training. The training I received was the best it could be at the time, but not even close to what it takes for an interpreter to become confident and prepared to interpret for most appointments.

Growing up I hadn't been interested in the medical profession. When I started working as an interpreter, I soon learned that in addition to my A and B languages, I also needed to learn a C language—the language of medicine. Just as I learned Spanish, I had to learn that a CAT scan was a type of imaging study, and a creatinine level was a measure of kidney function. I was fascinated by the language of medicine. The acronyms, medications, diseases, body parts, hormones, markers, genes, everything.

As fascinating as medicine was, it wasn't the reason I considered medical interpreting my calling. As soon as I started working as a volunteer healthcare interpreter at a local free clinic, I knew it was the way I wanted to make a difference in the world. The Spanish speakers I was helping were low-income, underprivileged people with serious medical conditions and a host of other socioeconomic problems. These were people who needed help. These were people who needed to be heard. These were people who needed to be seen. As an interpreter, I would be able to give them a voice. Fast forward 18 years and I am still making a difference in the lives of patients with Limited English Proficient (LEP) by giving them the gift of communicative autonomy, or the right to be in control of and responsible for their own communication.

Communicative autonomy is one of the founding principles of the medical interpreting profession. It differentiates the professionals from ad-hoc interpreters and bilingual family and friends. This is because upholding communicative autonomy means that regardless of my personal beliefs, I must remain impartial in all situations. I must interpret what is said and allow all parties involved to guide the conversation as they see fit. Ideally, I only intervene to mediate for cultural or linguistic reasons when needed.

Some of the most ethically conflicting cases I have had to interpret have centered around pregnancy loss and abortion. When I started interpreting, I was a young single woman with a relatively liberal view on reproductive rights. However, one stillbirth and three healthy pregnancies later, my personal beliefs on the subject have become more complicated. Each time I interpret for a loss or induced abortion, I must dig deep and ask myself if I can remain impartial. I can still remember the first time I faced this dilemma.

One evening, I was called to interpret for a labor and delivery case. When I arrived, I was informed that it was an induction of an 18-week-gestation fetus that had tested positive for Down syndrome on genetic testing. At the time, I didn't have strong beliefs about abortion. I had never been pregnant and really wasn't sure where I stood on the spectrum of a woman's body, a woman's choice, and abortion is murder. However, there I was, smack dab in the middle of an elective abortion on a weeknight.

The bereavement nurse was seasoned and experienced. If it hadn't been for her guidance and poise, the ordeal would have been much more overwhelming. She took the reins of the situation with that calming healthcare provider aura that tried-and-true providers learn to adopt. I followed her lead and interpreted with that same calm, experienced tone, while inside, my heart was racing, and I was morally conflicted.

The parents, who were in their mid-20s, were heartbroken throughout the entire process. The information I had to relay was horrifying. "Your baby might be breathing when he is born, or he might have already passed. If he is alive, he might live for a few minutes or longer, and it is hard to predict exactly how long that will be. Would you like to hold or see your baby after he is born?" By this point, I had succumbed to my default coping mechanism for traumatic interpreting events—dissociation. I was there, and I was interpreting in the first person as if I were the healthcare providers and as if I were the family, but at the same time, I was disconnected from my own body, thoughts, feelings, and the environment around me.

After hours of Cytotec, Pitocin, contractions, conversations about what-ifs, and my own brief moments of internal dialogue, it was time for delivery. When baby boy came into the world, his silence was deafening—it was a silence that was soon replaced by the guttural sobs of a mother and father who had just lost their child.

At some point, the delivery room was filled with medical personnel. There were nurses, trainees, doctors, anesthesia providers, and me. I started to feel hot and dizzy. I hadn't eaten anything for hours, and my body had been in high-alert mode to keep it together during this tragic situation. One of the nurses saw I was fading and brought me some juice and crackers to keep me from passing out.

After delivery, we came back to the discussions about burial versus cremation and coping with pregnancy loss. I learned that the hospital had a burial plot for babies that were born under these circumstances. It was a physical place where parents could go and pay their respects to their child. Once a year, the parents would receive a card in the mail inviting them to a memorial service. Little did I know that I would be on the receiving end of one of those cards a few years later.

I was 27 weeks along with my first child. My husband, Adam, and I knew we were having a girl and decided we would name her Maya. I was starting to show a little, and my Spanish-speaking patients would ask me about my bump as we walked down the clinic hallway to make follow-up appointments or before we said our official goodbyes at the end of the visit. All my interpreting colleagues and many of the healthcare providers I worked with also knew I was expecting.

One weekend, I wasn't sure if I could feel her moving anymore. Counting fetal movements doesn't start until 28 weeks, and I still wasn't sure how to distinguish between baby movements and other sensations that are common in the first and second trimesters.

I tried to push the thought that something was wrong out of my head. After all, it was a Friday, and we had plans over the weekend to see *The Phantom* *of the Opera* with my parents. I wanted Maya to feel the joy I felt when witnessing an enthralling musical performance.

On Sunday night, I told Adam we should go to the hospital for peace of mind. I still believed I was overreacting, but I knew I would be anxious if I didn't get examined.

The resident entered the room with the portable ultrasound and did an exam. I remember her rubbing the transducer slowly back and forth over my abdomen many times. Finally, she looked at us and said the dreaded words, "Your baby doesn't have a heartbeat; I'm so sorry."

Suddenly, Adam and I were faced with decisions we never imagined we would have to make. The physicians explained that a vaginal delivery was the healthiest option for me and the most likely to prevent complications in future pregnancies. I reluctantly opted to start the induction process. It was surreal. I had gone to the hospital for reassurance, and now I was staying to deliver my stillborn daughter.

There I was, back in that labor and delivery room where I had interpreted for the parents of the baby with Down syndrome. Only this time, it wasn't her in the bed—it was me. The guttural sobs weren't hers, but mine. How could this be happening to me?

After Maya was born, I was on leave from work for the allotted six weeks. During that time, I started to get therapy for my post-partum depression, connected with other women who had lost babies, and even helped form a pregnancy loss support group in our local community. When it was finally time for me to return to work, I started back part-time and slowly worked up to full-time.

I'm glad I did because it was suffocating to walk alone down all the halls where I used to walk with my baby. It was excruciating to evade or reluctantly answer the questions of coworkers and patients inquiring about the little one they thought was waiting for me at home. I can still feel the sting of well-intentioned comments from family and friends after Maya died. "At least you didn't lose a child." "Your loss isn't as bad as other losses." "Everything happens for a reason." "When are you going to start having kids?"

Losing Maya is the worst thing I have ever experienced. I can only imagine how difficult it would have been if I didn't speak English, have a solid financial situation, or a dependable support system. Even though Maya never got to live the life I imagined for her, I make a point to share the lessons her existence has taught me with others.

On March 17, 2012, when I was pregnant with Maya, I took the Certification Commission for Healthcare Interpreters (CCHI) exam to become a nationally certified healthcare interpreter and passed. I treasure that she was part of that moment with me because since then, I have continued to grow professionally and use our story to teach others. I became a licensed interpreter trainer in 2017 and built an educational program for interpreters. Now, when new interpreters join our team, they have courses and resources to supplement their on-the-job training and are better equipped to serve LEP patients and healthcare providers.

What I strive to teach medical interpreters and healthcare providers alike is that pregnancy loss is common, and you never know what someone else is going through. Even if a person appears to be having a normal pregnancy, you may not know the full story. I had three "normal" pregnancies after Maya, but there was never a day I felt confident that everything was going to turn out alright.

The reality is that many LEP patients in the United States have limited access to healthcare. Conversations had with a professional medical interpreter and healthcare provider before, during, or after a pregnancy loss are likely some of the few opportunities that LEP patients will have to receive proper counseling.

When it comes to pregnancy, I tell interpreters to expect the unexpected and evaluate their own conscious and unconscious biases around pregnancy loss and reproductive health. A professional medical interpreter knows when they will be able to remain impartial in a situation and when they should recuse themselves.

Immediately after I lost Maya, I had to recuse myself from abortion and fetal demise cases. Almost 12 years later, however, I feel specially qualified to interpret for these situations. It is a situation

I would not wish on anyone, and I know firsthand that anyone going through it needs all the help they can get.

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More Than Words: Communicating for the Quality of Care

Elaine Hsieh

My first experience as a healthcare interpreter was in the summer of 1998. I just completed the first year of a two-year graduate program in one of the top MA programs for conference interpreters—many of the graduates ended up working at the United Nations and international agencies. Many of my classmates chose to work in top business or government agencies for their summer internships. I wanted to do something different. Something that I may never cross paths with again if I miss the opportunity. So, I chose to work as a healthcare interpreter intern at a large healthcare system. The summer internship was supposed to be a refreshing break from the drudgery of rigorous training to be a conference interpreter at an international level.

As a graduate student who has received one year of intensive practicum training, I was proud of my "overqualification." At that time and to this day, the norm for most training programs for professional healthcare interpreters is a 40-hour short course (e.g., Bridging the Gap). With my advanced training and language proficiency, I thought this would be a fun, easy detour in my career development. I was excited to work with real people, no longer trapped in the isolating interpreting booths with headphones in conference rooms.

Little did I know that the summer internship would change my life and career trajectory. The first big jolt that challenged my confidence as an interpreter was also one of the first assignments I received. I was taking an elderly man to his first physical therapy session. The man had such severe scoliosis that he was essentially looking backward as he walked forward. As we walked into the clinic, a medical resident saw my patient and jumped up in excitement. With a great smile on his face, he exclaimed, "Wow! This is the worst case I have ever seen." I felt startled. I could see that the patient was unsure about the resident's excitement. Normally, I would just go ahead and interpret what the physician said. I would then introduce the patient to the physician, explain my role as an interpreter (e.g., "I will interpret everything you and the patient say so you understand each other"), and proceed to interpret what other speakers said.

However, all my training as an interpreter failed me at that moment. It's not because I was unsure about the linguistic equivalences of the resident's comment in Chinese. Rather, I was unsure how to best convey the information in a faithful, neutral, and accurate way without risking the provider-patient relationship and the quality of care. I explained to the physician, "Hi, my name is Elaine, and I am the healthcare interpreter. I am responsible for helping the patient understand what others are saying." Then, I asked, "How would you like me to interpret what you just said? You appeared very excited." The resident was taken aback, paused for a moment, and said, "Please tell him that I'm very happy to meet him." I interpreted that and proceeded to my regular routines.

Another memorable moment took place at the end of a long shift near the end of my summer internship. I was already packing up to head home when I received a call to assist a 90-year-old patient who had just been admitted to a mental health ward after a failed suicide attempt a few hours ago. As an interpreter, I was required to interpret everything in the first-person style. For example, instead of saying, "The patient is sad," I say, "I am sad." Whenever possible, I also embody the speaker's nonverbals, including attitudes and emotions, through my interpretation. During the intake, the physician asked, "From 1 to 10, 1 being the least happy day in your life and 10 being the happiest, what number do you feel right now?" With the emptiest stare and the most soulless voice, the patient said, "If I have never experienced happiness in my life, how do I know which number to give?" Throughout the hour-long session, I spoke in the most despairing voice and expressed the most hopeless thoughts I could ever imagine. I did not even remember how I got to the parking lot afterward. However, as soon as I started the engine, I realized my arms shook so uncontrollably that I could not have been a safe driver. I sat in my car for another hour before I felt safe enough to drive home.

To this day, I think about these two events when thinking about my experiences as a healthcare interpreter. When conceptualizing the role of interpreters, we often imagine a human-form Google Translate that relays information from one language to another. We do not take sides—the code of ethics for an interpreter-as-conduit was clear. We do not speak unless others speak. We don't have a voice—we are the voice of others. We should be invisible. We have no agenda. Our feelings do not count. We protect other speakers' agency and autonomy by relaying information without censoring or modifying anything—by allowing other speakers to have full access and control over the interactions.

The two incidents challenged my understanding of the roles of interpreters. My uncertainty was not because of my lack of training but because all my training was to be a faithful, neutral, passive conduit of linguistic equivalences. However, the challenges I faced as an interpreter during these events were much more than linguistic equivalence.

In the first incident, I wondered if I had failed the patient. To honor patient autonomy and informed decision-making, shouldn't the patient have the right to know that their physician was not respectful so that they can evaluate their providers and the quality of care accurately? I interfered with the process and content of provider-patient interaction when I prompted the resident to revise what he said so that the patient would not hear what could be perceived as offensive. Would it be better if I interpreted what the resident said and let the chips fall? Was I wrong to use the event to educate providers to be more mindful? Did I overstep my role as an interpreter?

I was certain that it was an unintentional blunder by the resident. The elderly patient was not the intended audience for the resident's comment. Providers often discuss things in front of non-English speaking patients rather than going to a separate room, believing the patients could not understand what they said. We all have done the same—we say things out loud in foreign countries because we believe that overhearers do not know English. As an interpreter, am I responsible for ensuring that the patient not only understands what the resident said to him but also "overhears" others' speech? As an interpreter, should I exercise my power to "remove" others' unintentional mistakes? If a provider sounds absent-minded or impatient, would it be appropriate for me to interpret in a tone that is attentive and engaged? Is it wrong to make a provider sound more caring than they appear in English?

In the second incident, I was unprepared for the emotions that rushed through my body. I did not realize nor anticipate my vulnerability when interpreting for a patient with suicidal thoughts after a long day, speaking in her voice and experiencing her despair. None of my training mentioned interpreters' experiences of vicarious trauma when working in situations where they may develop strong identification and intense emotions. I was shocked to realize there were few self-care resources and scarce training to help interpreters in these situations.

Throughout the summer, I shared my stories with other professional healthcare interpreters and my professors, asking what they would have done and scrutinizing if I had acted properly. What I learned was that the answers are very different depending on how we conceptualize and situate the roles and functions of an interpreter. If we follow the interpreter-as-conduit model, which is rooted in the code of ethics that arises from court interpreting, interpreters should adopt a passive, instrumental function in provider-patient interactions. It is not the interpreters' responsibility to manage other speakers' identities or relationships, let alone the quality of care. If a patient or a provider acts poorly, interpreters should act the same and, thus, empower other speakers to assess the quality of care and address the problematic interactions. My uncontrolled emotions resulted from a lack of professionalism—an artifact of my novice status.

However, if we view interpreters as members of the healthcare team, the answers become very different. People started to contemplate the strategies and interventions I could adopt to minimize the potential harm to the providers' face, the overall healthcare delivery, and even myself. When weighing different options, I was encouraged to consider the impact on the immediate interaction and the long-term consequences of my strategies, including quality of care, patient empowerment, provider education, and my self-efficacy and well-being.

I learned that these two events highlighted that communication—not interpretation—was the challenge I faced. My problem was not that I could not provide the equivalences of meanings but that I was ill-equipped to manage the tasks, identities, and relationships in provider-patient interactions. How can healthcare interpreters support effective and appropriate bilingual health communication that promotes patient autonomy and empowerment while supporting quality care, including providers' therapeutic objectives and provider-patient relationship? Interpreters' visibility and vulnerability should not be ignored or treated like an amateur mistake.

After receiving my MA degree, I pursued a doctoral degree in health communication and became a researcher of cross-cultural and bilingual health communication. I became one of the first researchers to adopt a communicative approach (rather than a linguistic approach) to analyze interpreter-mediated medical encounters. I have also received funding from the National Institutes of Health to examine providers' needs and expectations for healthcare interpreting. By focusing on the communicative goals and interpersonal dynamics of interpreter-mediated provider-patient interactions, I explore how providers, patients, and interpreters can coordinate and collaborate with one another to achieve quality and equality of care.

With over two decades of research, I have a much deeper understanding and appreciation of the complexity of interpreter-mediated medical encounters. Now, I recognize that interpreters' inherent desire to encourage positive, supportive interactions may not be consistent with providers' therapeutic goals. For example, a mental health provider may intentionally confront and agitate a patient as part of the therapeutic process to prompt self-reflection. Trying to make the provider sound nicer than they are would essentially compromise the provider's treatment plan. On the other hand, lending an attentive, caring tone to an overworked physician at the end of their 12-hour shift at the emergency department to help a patient with limited English proficiency feel less anxious after a traumatic incident should be welcomed.

To ensure quality care in interpreter-mediated interactions, interpreters should not be limited to the role of a passive instrument with no agency to facilitate quality care. The boundaries of language, culture, and medicine are emergent and shifting in cross-cultural care. Interpreters are essential partners who can assist providers and patients in navigating patient-centered care, supporting patient autonomy, and protecting provider-patient trust. I learned that good healthcare interpreting does not result from the interpreter providing a perfect relay of information. Rather, as I wrote in my 2016 book *Bilingual Health Communications: Working With Interpreters in Cross-Cultural Care*, "A successful interpreter-mediated medical encounter is a coordinated achievement between all participants involved."

* * *

From Linguistic Bridge Builder to Aspiring Physician

Manuel Patiño

I have been formally working as a medical interpreter for 2.5 years, but I have been closing linguistic bridges for as long as I can remember. My parents are from Colombia, and they immigrated to Boston in the late nineties, where I was born some years later. As the oldest son born in the US, I grew up as the only fluent English speaker at home. This meant that I was the first person my parents would turn to for any help with the language—doing taxes, filling out legal paperwork, or emailing their bosses. They would also turn to me to learn more about and understand their chronic medical conditions outside of the hospital.

I remember coming home from school one day in 8th grade to my dad asking me: "¿Manu, me ayudas a traducir estos resultados?" He was pondering his recent lumbar spine MRI report and asked me to help him translate and interpret the medical jargon, and I gladly agreed. However, my fourteen-year-old brain drew a blank when thinking about how to translate "herniated discs" and "pinched nerve." I turned and gave my dad a fragmented Spanish translation of the MRI report, to which he nodded for some portions, stared blankly for others, and finally thanked me with a warmness that could not mask his confusion. It pained me to know that I wasn't able to help my dad understand what had been causing him severe pain in the previous months.

Growing up, experiences like these lit a fire under me and fueled my desire to pursue a career in medicine so I could one day give my parents the care they deserved. In college, I took my pre-medical coursework with the intention of taking a couple of years before medical school to work and save up money. I wasn't sure what I would do for my gap years until my mom took an online medical interpreting course during my junior year. At the time, she worked as a patient transporter, and decided to take this course to improve her English. Since I was doing remote schooling during the pandemic, I spent many hours at home helping her prepare for her weekly assessments. By learning about the medical and sociocultural skills that interpreters must have to effectively serve patients, I became interested in diving into the interpreting world myself. In particular, I was drawn to how crucial it is for interpreters to not only overcome linguistic barriers, but also to navigate social and cultural disconnects between Western medical practices and those of Latin America.

Motivated to learn more, I took the same online course in Spring of 2021 and absolutely loved it. At several points, I thought to myself: "Why hadn't I thought about medical interpreting sooner?" For me, it was the perfect combination of all my interests: using my bilingualism on a daily basis, learning in a medical setting, and serving my local Hispanic communities. After finishing the course, I cold-emailed the Head of Interpreting at my university's local hospital to see if they had any per-diem positions available. Luckily, they did! After two months of interpreting exams, paperwork, and onboarding, I was given a shiny new badge that read: "Manuel Patiño, Interpreter I."

I still remember my first appointment as an official interpreter. It was for a young man— let's call him Juan—looking to freeze his sperm in anticipation of radioactive treatment for thyroid cancer. I had arrived a couple of minutes late to the waiting room since it was my first time going to the radiology-oncology department. When I introduced myself to Juan, his face lit up as if we'd known each other for years. He expressed how uneasy he was feeling at the prospect of going through this appointment with his limited English, and thanked me many times for my presence. Though I don't remember the specifics of the appointment, I often think back to Juan's beaming face upon seeing me and the faith and trust he had in me to be his linguistic bridge. The most impactful and important aspect of medical interpreting for me has been this: the ability to form emotional connections with patients going through arguably the most difficult moments of their lives.

One aspect of medical interpreting that surprised me is the amount of time that interpreters spend in the Operating Room (OR) for procedures where patients are not completely asleep. My first time interpreting in the OR—and first time in the OR in general—was to assist a kind older lady—let's call her Doris—who was receiving left cataract surgery. Doris had already received right cataract surgery some months prior, so in retrospect, I was probably more on edge than she was going into the procedure. I remember being confused and almost tripping in the pre-operative area as I put on what the nurses called a "bunny suit," a blue one-piece to keep the germs from our regular clothes tucked away in the OR. After we filled out the surgery consent form, we rolled the patient into the OR. Once there, I was surrounded by eye surgeons, anesthesia technicians, and nurses.

I had become comfortable interpreting in the outpatient clinics, but I felt out of place as I stood alongside all these medical providers in the OR. However, once the surgeon began speaking to the patient, I put on my interpreting hat, and my insecurities melted away. I was feeling a sort of imposter syndrome because I felt that a college student like myself couldn't possibly be qualified to work alongside medically-trained professionals during a procedure. However, I knew that my experience as a linguistic bridge builder for my family, coupled with my course preparation, had prepared me very well for this moment. I also knew that my role as an interpreter was just as meaningful and important as everyone else's in the OR, so I reminded myself of this and leaned into a fascinating new experience. At the end, I received praise from the surgeons and a "God bless you and your family always" from Doris, which warmed my heart.

While working per diem and doing my senior year of university, I began preparing for the national certification exams. Interpreters can work in a hospital setting with a 60-hour course under their belt, but it is becoming more and more common for hospitals to require national certification for part- and full-time positions. This ensures that patients receive the highest quality interpretation possible while at the hospital. These exams are demanding because they cover a range of medical terminology, covering medical specialties that I seldom would see in my per-diem work. I spent months reviewing online resources and getting accustomed to the style of the written and oral exams. Thankfully, I passed both exams on my first try and became nationally certified in May of 2022, right before my college graduation. Shortly after graduation, I applied to and received a full-time medical interpreter position back home in Boston. I spent the summer studying for and taking the medical school entrance exam, and shortly after, I began working.

The transition from per-diem to full-time interpreting brought new challenges and learning experiences. I went from interpreting for a couple of appointments a week to doing 15-20 in a single day. My hospital has a hybrid interpreting model, meaning that ~70% of the appointments we do are either over the phone or through video, and the rest are in-person. This model, which was solidified mainly due to the COVID-19 pandemic, has allowed us interpreters to maximize the number of patients we can assist in a given day. For me, this means that every day is an incredible learning experience. I can go from an outpatient physical therapy appointment, to a 26-week pregnancy visit, to an in-person ENT procedure. This job has truly allowed me to learn about the ins and outs of the healthcare system in ways I never imagined. I am able to see how healthcare professionals of all specialties provide care to patients and work together to ensure that patients get the best care possible.

Another important and rewarding aspect of interpreting full-time is that I have the opportunity to follow a patient's trajectory over time. There is one patient—let's call her Luz— whom I have had the greatest pleasure of working with many times since I began working full-time. My first encounter with Luz was during an interventional radiology procedure. She had been recently diagnosed with metastatic ovarian cancer, and in anticipation of chemotherapy, she needed to have a port placement surgery. Having a port means that providers have easy access to her blood for routine lab work and administering treatment; this is much preferred over having to place an IV every time she comes to the hospital.

I remember meeting Luz in person and immediately feeling her warm energy. In subsequent appointments, I learned about the specifics of her diagnosis and her difficult living situation. As I learned about the various challenges she was enduring, I wondered how she was still able to maintain such a warm energy. What struck me the most was that her demeanor reminded me of an aunt who passed away in 2020 from metastatic stomach cancer. Even during her last months of life, when treatment gave her debilitating symptoms, my aunt continued to give love to everyone around her. Working with Luz touched an emotional aspect of my life that I was not expecting to encounter in my interpreting. I feel honored and lucky that through my work, I can meet and support incredible human beings going through incredible life circumstances.

Needless to say that, every day, I keep finding more and more confirmation that medical school is the best path for me. I often daydream during work, imagining myself being on the provider's side and providing care to these patients in a language they feel truly comfortable with. I expressed these emotions and motivations in my medical school application when I applied in the Summer of 2023. Despite my insecurities with my academic performance and standardized test scores, I am lucky to have received twelve interviews from incredible medical schools all across the country. This reaffirmed to me that medical school admissions look not only at the applicants' "numbers" but also value the personal life experiences that have carried us to this moment.

All my interviewers have been fascinated with my professional experience as an interpreter and are curious to learn more about how I got into interpreting. I have eagerly shared what I have written in this piece. My upbringing in an immigrant Colombian household and seeing my parents struggle with language barriers in healthcare have largely fueled my passion for serving Spanish-speaking communities. I am ecstatic to begin medical school in August of 2024 and get one step closer to my dream of becoming a bilingual physician. I am eternally grateful for the patients I have served and the personal growth I've had as an interpreter. I know that I will carry with me the experiences I've had with patients like Juan, Doris, Luz, and many others, as I continue advancing in this profession.

* * *

Towards Language Justice: A Call to Identify and Overcome Structural Barriers

Felicity Ratway

The patient I am interpreting for praises my interpretation. I've done nothing particularly noteworthy to merit her praise; I followed basic ethical tenets, nothing more. Hearing everything the provider says rather than a brief synopsis exceeds her expectations after many experiences working with untrained interpreters, or being refused interpreting services altogether. The bar shouldn't be this low.

I am exhausted. Like most interpreters, I am an independent contractor. I must work 5 am–9 pm to get paid for 8 hours of work. With some language companies, I earn less than minimum wage. To many new interpreters, $35 per hour sounds great—then they realize that driving to and from a one-hour appointment involves two hours of unpaid drive time. In rural areas, this really takes a toll. I spend hours checking pay stubs; I find errors nearly every pay period, but I wouldn't have a court case for the repeated underpayments because when I reach out to ask for the errors to be fixed, they are eventually corrected. Despite my state and national certifications and Master's degree in Interpreting and Translation Studies, medical interpreting doesn't pay the bills. I supplement my income through multiple other jobs.

Laws intended to protect the patients we work with as interpreters are seldom enforced. Title VI Guidance defines a competent interpreter as one who has been trained, demonstrated proficiency, demonstrated interpreting skills, and agrees to abide by ethical standards. Patients fare better when competent interpreters are available, but when most patient and provider experiences are with interpreters who haven't met competency standards, patients and providers (understandably) lose trust in the profession. The profession has few opportunities for advancement and struggles to attract interpreters to go through rigorous training or build a long-term career. Skilled interpreters soon leave for greener pastures: the Oregon Health Authority (OHA) houses a registry of interpreters who meet minimum state training and proficiency requirements, and a 2019-2021 study found that roughly 92% of interpreters due to renew dropped off of the registry instead.

When I began interpreting, I was shocked by how infrequently laws protecting patients' rights to interpreting services were followed in practice. At primary care appointments, patients often cannot answer questions about specialist visits because interpretation was not provided at the specialist's office. I knew recipients of federal funds couldn't legally bill patients for interpreting services, yet I was asked to sight-translate paperwork that stated patients would be billed for interpreting services if they were late to an appointment. I reported the issue; years later, the same paperwork would still appear on their public-facing website. I discovered that though state law required credentialed interpreters to be made available, no agency had been tasked with enforcing that law; all that could be done with my complaint was to refer it to the patient's insurance company.

In Oregon, Coordinated Care Organizations (CCOs) manage Medicaid plans, and are required to pay for interpreting services for their members. Instead of hiring interpreters directly, many contract with language companies that, in turn, hire us. Providers must book interpreters through the specific language companies contracted with the patient's CCO to avoid paying for the interpreter themselves. I am often called to interpret for speakers of indigenous languages even though I am not able to meet their needs as a Spanish interpreter. I offer contact information for organizations that could provide interpretation in the appropriate language, but the receptionist tells me that she can only go through specific vendors because the clinic doesn't want to have to pay out-of-pocket. Indigenous-led organizations that pay indigenous interpreters a living wage are not contracted with the CCOs in my region. In some cases, when interpreters are not available for a particular language through the CCO's preferred vendor, providers instead ask that an appointment be rescheduled, hoping that an interpreter will be available later. I have seen speakers of rare languages seeking primary care end up in the hospital after being rescheduled several times.

Providers I work with often don't know the minimum requirements to become an interpreter in my state, assuming that language companies will make sure that the interpreters they send to medical appointments meet the minimum standards. Phrases like "[company name]-qualified interpreter" on invoices and name badges and company names with "Certified" or "Qualified" in the title reinforce this erroneous belief. Training is required by state and federal law, but some of the language companies I have applied to don't require training, using nothing more than a 10-question multiple-choice translation questionnaire or a recitation of the pledge of allegiance to verify proficiency and interpreting skills.

Recognizing that the complex system through which interpreters are paid contributes to limited access to interpreters for patients and low pay and poor working conditions for interpreters, I reached out in 2017 to the American Federation of State, County and Municipal Employees (AFSCME)about forming a union so that we could bargain rates directly with the state of Oregon. That same year, I became involved in the Oregon Council on Health Care Interpreters (OCHCI), which advises OHA on matters related to interpreting in healthcare. I initially participated as a public commenter, though I would later become Chair of the Advocacy and Legislative Committee.

We began meeting with AFSCME in 2018. I heard from other interpreters who had reached out in previous years to try to unionize, some of whom were blacklisted from language companies as a result.

In 2019, new CCO contracts were negotiated. Along with other members of OCHCI, I advocated for provisions that CCOs report on access to interpreters among their members. OHA, striving to reach an ambitious goal of health equity by 2030, included this provision. We passed legislation allowing us to unionize as independent contractors, which was signed into law in January 2020.

In February 2020, we began door-knocking, collecting signatures from interpreters in support of forming a union. In March, we paused door knocks, and our focus became responding to the pandemic. As contract workers, we were often refused Personal Protective Equipment (PPE); it was available only to employees. Contract interpreters travel between different hospitals and clinics—one interpreter without PPE could potentially spread COVID-19 to many different locations, exacerbating risk among the patients we serve. OHA directed me to county emergency managers to request PPE. I created a Google form for interpreters to request PPE and wrangled together a group of interpreters willing to volunteer to pick up and distribute it. Exposures were also an issue—I worked in the same room for hours with a fellow interpreter who later informed our interpreting company that she had tested positive for COVID-19. The company that sent us to the job site never informed me that I was exposed. It was well after the fact that the interpreter herself let me know.

When the new CCO contracts took effect, I began requesting the quarterly reports through public records requests. The figures were staggeringly low: access to interpreters on the OHA registry was recorded in only about 5% of encounters where we were needed. Along with other members of OCHCI, I advocated for language access to be adopted as an incentive metric.

In 2021, a language access incentive metric was adopted. Unsure how to approach statistical analysis of the data I was requesting, I decided to pursue a PhD. We were officially recognized as a union and held elections for our bargaining team. We went to the bargaining table, but there was no system in place to schedule and pay interpreters directly. The state could not simply use the money allocated to CCOs to pay for interpreting services—those services come out of CCO's global budgets, and the state does not know how much is actually spent on interpreting services, especially given that language companies often require CCOs to sign NDAs. We passed legislation promoting accountability for the existing law that obligated providers to work with credentialed interpreters, requiring OHA to study scheduling and payment mechanisms so the agency could pay interpreters directly and ensuring interpreters had the right to PPE.

In 2022, OHA completed its study on scheduling and payment mechanisms, but still would not bargain rates with the union. We agreed to "bridge payments" of an equal amount to go out to each interpreter instead while a scheduling mechanism was developed. As our 2021 bill went into effect, clinics and hospitals began to prompt us for our OHA registry numbers upon check-in. Some language companies issue company ID numbers and encourage interpreters to provide these numbers instead if they don't have a state credential number; I started to see these company-issued numbers on interpreter sign-in sheets at clinics, and the state started to see them on language access reports submitted to OHA by CCOs.

In 2023, we secured $2 million to bargain over and advocated for the state to use a portion of it to set up a scheduling and payment system so that we could bargain rates. The state asserted that they don't have the legislative authority to do so. The state also informed us that, even after a scheduling and payment system is set up, they will not be willing to bargain CCO appointments with us until 2025 or 2026 because that would require a change in the CCO contracts. Finally, the state acknowledged that they do have the ability to require CCOs to disclose contracts with language companies showing their spending on interpreters, but hesitate to use such a heavy-handed approach to find out how much is currently being spent on interpreting services. This makes it difficult to know how much money needs to be allocated by the legislature to pay interpreters directly and how much of what is spent makes it to interpreters' pockets.

In 2024, we passed a bill giving the state legislative authority to purchase access to or develop a scheduling and payment system so that we can bargain over fee-for-service Medicaid appointments. These appointments do not go through CCOs, so a system will be set up when it becomes possible to bargain over CCO appointments. I am continuing my doctoral research—I am working with OHA on a data use agreement to research the topic of access to interpreters in Oregon. I am hopeful that my research will help advance health equity by identifying factors that affect access to interpreters and whether certain groups of patients are at greater risk of not having access to needed interpreting services.

Hopes For the Future

I hope that legislators and policymakers within government agencies, healthcare facilities, and coordinated care organizations will consider taking a closer look at interpreting services; providers and CCOs will review their contracts with language companies, begin asking interpreters they work with about their training, and take a second look at language access policies; legislators will pay close attention to how the language access bills they pass are implemented after they pass; and legislators and government agencies will consider how they might begin to track access to interpreters at a statewide level and formulate a plan to address any gaps they may identify.

There are many systemic issues facing interpreters and the communities we serve:

- inconsistent access to interpreting services;
- lack of enforcement of existing laws,
- community uncertainty about where to raise concerns about poor-quality interpreting or lack of access to interpreting services, and whether such concerns will be addressed if reported;
- uncertainty about roles and responsibilities in providing interpreting services;
- lack of data collection on access to interpreters and on the interpreter workforce;
- lack of an accessible reporting mechanism for language access issues;
- low pay and poor working conditions for interpreters and few avenues for reporting issues like short paychecks, contributing to high turnover among interpreters;
- a complicated, inefficient payment structure;
- poor quality of interpretation;
- lack of trust in the interpreting profession

There are real, significant impacts on patients' lives when we don't get interpreting services right. Making systemic changes is a frustratingly slow process and requires active participation from all groups involved, from patients to interpreters to providers. Whatever your role in healthcare, I hope you, too, will get involved, dear reader.

* * *

Voices in the Shadows: The Hidden Complexities of Being a Medical Interpreter

Liliana Crane

As a Spanish interpreter at a Hospital for 16 years, I continue to be surprised at the lack of knowledge regarding the role of a Spanish Interpreter. Often the Spanish interpreter cannot interpret word for word; the interpreter's primary role is to find the best way to culturally convey messages between the provider and the patient so they can understand each other's intended meaning. I have noted a significant change in our patients' literacy and the providers' level of experience. Because of our patients' low literacy level, the providers need to lower the complexity to obtain the answers to many of their questions; however, lowering the complexity may be more challenging than it sounds for some providers.

The first question a provider asks when the patient arrives at the Emergency Department (ED) is, "Why you are here?" or "What brought you here to the Emergency Department?" It seems a simple question. However, often I hear these answers: "I am here because my wife/husband brought me in the car" or "Because in 1980, my cousin had similar symptoms and died."

As interpreters, we have to repeat the question differently to obtain the answer sought by the provider. If we repeat the question word by word, the answer won't change. That is when experience as an interpreter and cultural knowledge of our patients play a crucial part.

The interpreter's experience and familiarity with the target population are as vital to the communication as being proficient in both languages. Our patients often use words made up from a combination of English and Spanish, such as *nursa*, referring to a nurse, or *friza*, referring to a blanket, and derived from freezing. Our patients often refer to the leg as the foot, so when the provider asks what is hurting, the patient will sometimes say, "My foot."

As an interpreter working extensively with this population, I know that body part clarification is necessary. Pinpointing the body part the patient is referring to through visual confirmation is essential to treating the appropriate ailment. It is similar to doing a dual identifiers; instead of asking for name and date of birth, we ask for location (right or left) and visualization by pinpointing, with one finger, the body part being referenced. The role of clarifier is one of the interpreter's roles, and it has become the main practice for me to make communication accurate.

The provider should know that what the patient verbally expresses may not be what they mean to say based on their literacy levels, mental health, cultural background, and upbringing. Words may have different meanings in different languages despite being spelled the same. For example," Take this medication *once* daily" may be in discharge instructions, prescriptions, or medication labels. In English, "once" means "one time," but in Spanish, it means "eleven."

Communicating using the limited Spanish that a provider may have, or using Google to translate words for a patient with limited English language ability is highly discouraged but often done. The problems with these methods are often overlooked. One cardiologist told an adult male patient, "Te amo," with the patient's mom in the room. I was the interpreter on-call that night. The provider called me because he thought the patient's mother gave him a weird look after telling the patient, "Te amo," which is how Google translated the words "I like you." The provider's intended message was to say that he liked working with the patient. Google does not put the words in context, so the provider told the patient he was in love with him by saying, "Te amo." After a good laugh and an education on why using Google is inappropriate, I clarified with the patient and his mother what the provider intended to say. The provider quickly learned that Googling phrases or using a little Spanish may get you in trouble.

I currently work full-time as a physical therapist assistant and Spanish medical interpreter. I have a Master of Business Administration, am certified by the American College of Sports Medicine as a Certified Exercise Physiologists® (ACSM-EP®), and am a certified Medical Interpreter (CMI). All of my education has been in the medical field, and while my education played an important part, the best training I have received continues to come from experience. I have learned to listen, clarify, and ask questions without offending the parties involved. I use repeat-back, in which I repeat the information to the patient before interpreting it to the provider to ensure the message is correct. I follow this by teach-back to ensure the patient understands the provider.

One patient with whom I have been familiar for the last 10 years has Parkinson's disease. As the disease progressed, his speech became increasingly difficult to understand. Because of my familiarity with this patient, we communicate using repeat back; however, my familiarity with his body language also helps. If the patient turns his head away from me, he is frustrated because I am not understanding, and I have to find another way to ask the questions. If I interpreted for him on his last visit, I could use the information as a base. It took time and patience on my part, but it was the minimum I could do for someone with a progressive disorder that affected his nervous system, body control, and speech. Some providers tried to use CyraCom—or video interpretation—with the above patient; because of his progressive speech challenges caused by Parkinson's, the remote interpreters believed and said that the patient did not speak Spanish, which was hurtful for the patient to hear.

The medical interpretation profession requires proficiency in both languages; a deep understanding of medical terminology to lower the register as seamlessly as possible, communicate accurately, and obtain the care necessary; and a good understanding of various medical conditions to understand what the patient is experiencing.

Over the past few years, we have been getting an influx of Ecuadorians whose language is presumed to be Spanish. However, their primary language is Quechua. Most Ecuadorians know only a few Spanish words. There are many Quechua dialects, but there are no medical interpreters who are adept in each dialect, and Spanish interpreters are typically called to perform interpretations for these patients. One challenging interpretation in which I was involved was with the family of a 4-month-old baby born with heart and lung defects. Despite being on multiple medications, the baby's condition deteriorated to the point that the parents needed to make a tough decision. The provider initiated a conference call with the patient's mother to explain that the medications at their highest doses were not working as well as expected. The patient's mother kept repeating the words in her limited Spanish: "Disconnect . . . no more medication." As an interpreter with an understanding of Latino culture, it was hard to believe that this patient's mother wanted to discontinue the medications and "disconnect" the baby via conference call. After 10 -15 minutes of repeat-back, asking questions, and explaining the provider's message at the lowest complexity, I understood what the patient's mother was trying to convey; she wanted to disconnect the baby from medical equipment. Still, she wanted to continue just one medication that would keep her baby alive. Over time, she understood that each medication was helping the baby differently.

An interpreter's job is to understand and convey each message as intended. During this previous interpretation for the infant's parents, I felt very uneasy in the encounter because of the parents' limited Spanish, their low healthcare literacy, and their poor understanding of body function. I recommended that the provider encourage the parents to arrive at the hospital as soon as possible to continue the conversation in person. I was the interpreter in-house when the parents of the patient arrived at the unit; after trying to explain the condition of the child with words, my suggestion was to try drawing the heart and the lungs for the parents to understand the close interaction with the heart and the lungs and how one affects the other.

An area that becomes challenging to interpret is the end of life, full-code, or when people are on a ventilator. The vast majority of the population that we serve have low literacy and minimum knowledge of the human body. Our population needs different explanations of the meaning of being "brain dead" when on a ventilator, and loved ones can see the patient's chest rising up and down. Often, in their minds, this means the patient is breathing and the heart is working.

It requires proficiency to explain hospice versus palliative care as well as to explain CPR and intubation to our Latino community. One young woman was dying of cancer after multiple rounds of chemo and radiation; she weighed 90 pounds, had terminal cancer, and was full code. The provider explained that CPR offered a chance of survival by restarting her heart, and intubation would assist her with breathing temporarily. The significant other and the patient said yes to the minimum possibility of staying alive with that explanation. As the interpreter, I clarified with the provider and explained that it was essential to explain that even if by any chance her heart restarted, all her ribs would be broken, and the cancer would remain. With a young and inexperienced provider, explaining this concept becomes more challenging. An interpreter could help the provider deliver the information tactfully and truthfully.

Being an interpreter is a gratifying and fascinating profession, but not everyone who is bilingual is qualified to be an interpreter. Interpreting requires additional layers besides being bilingual, such as extensive knowledge of medical terminology, a love for the profession, patience, and a solid vocation to help others. It can be mentally exhausting and emotionally draining. I was once called to interpret for a mother to let her know her eight-year-old daughter needed to be intubated. For me, interpreting for the family during the death of their child was extremely emotionally draining. My role at that point was to put all my emotions aside and make sure the family could express their feelings and ask questions. When interpreting, I usually left a patient's room after interpreting the messages, but on that day, I stayed with the mom since I was familiar with her. With mom and me in the room, the providers started the intubation process. Suddenly, all of the clinical alarms sounded, and the mother of the child launched herself on top of the child, screaming, "You are killing my child!" I tried to get the mom to leave the room so the providers could assist the patient, and I stayed with mom in the hallway for 45 minutes while the medical team worked to save her daughter's life. I maintained a stoic disposition to the end while helping mom in this horrible situation and while providers kept coming to update her. After 45 minutes, my emotions started to get to me, so I called a co-worker at home and asked her to come immediately to replace me. The child passed away, and my co-worker arrived when the mom was entering the room to see the deceased child. My co-worker finished the interpretation, and I left to deal with my emotions and compose myself.

In conclusion, I want providers and people to understand that being an interpreter requires more than being bilingual. I hope that my experiences illustrate the complexities of being a medical interpreter.

* * *

The Voice of Patients: The Exclusive Work of a Human Who Can Advocate

Laisson DeSouza

There is much conversation in the medical interpreter community about the effects of artificial intelligence in the work we do, and how we may or may not be out of a job in the coming years. Back in the day, I used to think about the future of interpreting and dread the day machines would do something intrinsically of human nature: communication and interpretation.

As time goes on, I am much more assured that all medical interpreters have their place solid, as technology progresses. I started as a medical interpreter in 2015, newly arrived from Brazil and having left a promising career in education there, as there were some pressing family needs that obligated me to move to the United States. Medical interpreting was the way to get closer to a field I loved and learn something new. The classes had all the elements that attracted me to the profession, including extensive medical terminology, in-depth discussion of human anatomy and physiology, intense discussions about culture and the role of medical interpreters, and the practice of medical interpreting in several role-play sessions with knowledgeable and experienced instructors in the field.

When I first started, there were many questions and not as many answers. Because of the nature of what we do, each patient and each encounter is unique. Sometimes, you may have prepared your vocabulary list for a topic, and the encounter goes somewhere else, wasting the effort you put into that specific appointment. And now you better be ready for several new words and expressions that both the patient and provider may use. The interpreter can always ask for clarification; however, it is important to develop your language wealth so that interruptions on our part do not affect the flow of communication.

Sometimes, you get to work with lovely providers who respect you as a professional and a human being, and sometimes, you have to work with rude providers who see you as an intruder or a disposable piece of human equipment. We are witnesses of how much providers go through as they face a broken system to care for their patients, and we share their frustration when they have to say that the insurance has not approved a procedure, a course of treatment, and so forth, and that there is nothing they can do to ameliorate the situation. We are witnesses, we are there, we are part of it.

The line that separates an interpreter and other important healthcare professionals can be blurred. There is an expectation that interpreters act as case managers, doing screening calls or surveys, or that they will contact patients to deliver pharmacy instructions, and other requests. We are used to advocating for our patients, but we seldom advocate for ourselves to ensure that we have better working conditions and are seen as an important part of the care team. We are part of the medical encounter to collaborate and should be seen as a resource to promote communicative autonomy—at times, medical providers such as nurses and clinicians see interpreting as a burden, and, understandably, a 15-minute routine appointment will take at least double that time, but again, is it not the ultimate goal to provide optimal care for a patient? How would that be possible without hearing the voice of the most important element of an encounter, the patient?

So many touching moments have warmed my heart over the past few years. The first time that joyful expecting parents could hear the heartbeat of their baby who would be born in a few months—and all the questions that followed in the pre-natal care appointment—were moments that reached deep into my heart, reminding me of how privileged I am as an interpreter to be the voice and ears of people in a process that makes us human. Another heartwarming moment came when, after months of speech therapy, a child with a developmental delay was able to say a few words for the first time. I can still remember how all involved—the care team, the mother, and myself—clapped our hands in excitement at this milestone. Medical interpreters are bound in their actions by standards of practice such as role boundaries and impartiality, and they feel joy and excitement when positive things happen to their patients. I know, as I have felt that multiple times despite being unable to demonstrate it on different occasions.

On the other hand, nothing could have prepared me for the heart-wrenching moments that are part of this job. When you go through school to become a medical interpreter, depending on the program you take, there will be a few comments on self-care and mental health, but nothing that deeply describes the emotional burden that may envelop an interpreter in several specialties, including interpreting life-changing diagnoses or losing a patient.

Although I am not expected to develop a friendship with my patient, there is rapport and the chance that you will interpret several times for the same patient during the course of a treatment. I vividly remember a very enthusiastic cancer patient whom I had the privilege to serve for several chemotherapy sessions. This caring person used to tell the care team funny stories about her children and was very hopeful about the treatment.

Because of role boundaries, I never expressed my opinion, but deep inside, I was also hopeful that all would go well and that this young mother would be able to care for her family. Given the nature of the treatment, that patient was transferred to a new hospital, and I lost contact. I thought that everything went well, and often, when interpreting for other patients in oncology, I would wonder what happened to this patient. One night, while dealing with the loss of my own sister because of COVID, I was browsing social media when I saw a fund-raising post to provide funds to a family in need and also to send the body of the deceased mother back to a foreign country. After a few seconds of staring at the picture of that person, I came to terms with the fact that that deceased mother, so loved by all, was *my enthusiastic and hopeful cancer patient*. There was no hope and no enthusiasm left. She was gone. Nothing had prepared me for this reality.

In summary, advocacy is one of the roles of a medical interpreter. It is essential to speak up for those who are in such desperate need of resources and to fight inequality and discrimination in healthcare for all patients who have communication access needs. However, I do believe that the best form of advocacy comes from doing the best we can to interpret to our patients, to make sure that their message comes across as close as possible to what they intend to say, and that they can hear what is said as accurately as possible.

In my experience, powerful and heroic acts of advocacy are part of the life of a medical interpreter, but not often. The extraordinary acts of advocacy are part of our daily routine, when as *real* advocates, we preserve and promote communicative autonomy and lend our voices or hands to our patients so that their voices can be heard.

* * *

Don’t Mute the Messenger

Nilsa Ricci

As a Spanish interpreter, I spend a lot of time talking with patients, family members, and other care team members. Like how an actor reciting from never-before-seen cue cards is talking or how a medium in a trance during a séance is talking. I *talk* without my voice. This leaves a lot left unsaid.

I am also a resident, and I communicate with patients, family members, and other care team members in my own words. Working as both a Spanish interpreter and resident has given me a unique perspective, particularly about the boundaries I am able to set with patients. Both Spanish interpreters and medical providers are expected to maintain a professional distance with patients, which can provide a certain level of emotional protection. However, the nature of interpreting compromises this distance and protection.

In first person I must speak,
Which makes my position unique.

I was taught to interpret everything in the first person. For example, instead of saying, "The patient's mother is asking if her baby is dead . . . ?" I ask, "Is my baby dead?!" The intent is to facilitate direct communication between patients and providers so they can build rapport. Unnoticed is that I hear a patient's traumatic experience, process it, and then deliver those vivid details in the first person of another language. My sense of self is breached because the first person is no longer innately reserved for my own self. The topic does not even have to be traumatic in the typical sense for it to cause harm. Speaking in the first person erodes the boundaries between self and non-self, exposing me to emotional trauma.

One day, I was paged to an intensive care unit to interpret for a doctor and mother in front of an unconscious person on a ventilator. I had to play the role of a doctor who desperately wants to convince a mother that her son has no chance of survival—I must directly challenge any hope for a miracle to spare her a long road of heartbreak and disappointment. I also had to play the role of a mother who strongly questions science—I know faith is essential to my son's recovery, and I will wait for a miracle.

In breaking bad news, there is that heavy moment when hopeful eyes beg for anything other than the painful message about to be delivered. The words may not be mine in origin, but the reaction is always to my interpretation. I watch the light of hope dull into despair and observe life leave the mother's essence.

Boundaries blur as I play each part:
I lend my voice but sacrifice my heart.

Suddenly, I am wearing the mother's shoes and we experience grief's abyss together. I am made to recount memories I had with my son and made to long for the ones we will never form. Tears obscure my vision, and I feel my heart break as I realize my son is dead. My world crumbles and my vocal cords quiver then halt. I know the next sound will be incomprehensible. Wailing, the mother's voice is only intermittently understandable. In Spanish, she exclaims, "How many years must I live without you?" The doctor looks at me, inquisitive of my new silence.

False memories flood my brain
As if possessed by pain.

I hear myself say, "I can't understand her exactly," and then summarize her words in the third person. Instantly, I feel some relief. But with the relief comes shame for showing my weakness—for needing to break the protocol to cling to my sense of self. My pager suddenly beeps, breaking through the confusion like an alarm clock interrupting a nightmare. In a daze, I remember I am the interpreter—not this doctor, not this mother. I do not have a patient with complete loss of brain function. I do not have a son to bury. The doctor says, "Let's give her some privacy," and we excuse ourselves from her grief.

Why then are your shadows still in sight
Even now that my own script I write?

I did not switch to the third person in time and instead experienced the mother's sorrowful words in the first person. Since I felt grief, my heart still ached. Unfortunately, there is rarely time or space to debrief after a traumatic encounter before the next urgent page. A sweet treat helps, the doctor tells me as I rush to the emergency room to submit to other roles.

But the ice cream melts before I can say
That I died today.

Simple measures, such as a short pre-session before interpreting, could help prevent trauma. In these sessions, the provider could directly relay the clinical context and reveal the agenda. For example, the interpreter could learn the bad news from a distance and advise the provider about cultural considerations that may resonate with the patient. Together, they could better anticipate patient reactions, which may soften the emotional impact for all. In practice, sometimes I do not even know the patient's name before interpreting.

A short post-session after interpreting could help ground the interpreter and mitigate trauma. In these sessions, the provider and interpreter could reflect and share insights with each other as they work together to provide culturally competent care for the patient. When working as a Spanish interpreter, I am lucky if I can scribble down the provider's name, needed for my documentation, before they run off. Until these pre-session and post-session measures are standardized, I think it is unethical to prevent Spanish interpreters from setting protective boundaries for themselves—including temporarily breaking out of the first person.

Empathy goes too deep,
If safe boundaries I do not keep.

A provider's objectivity can be compromised if they also interpret for their patient. I had a Spanish-speaking patient with a complex condition who presented with psychosis. As a resident, I communicated with her in Spanish before rounds. I asked her numerous questions, noticed her moments of silence and limited responses, performed a thorough physical exam, and tried my best to empathize with her situation. One morning, a consult team was ready to assess her but had not paged interpreter services. Per protocol, I quickly paged them to avoid a conflict of interest. We waited for what felt like an eternity. Finally, the team asked if I could interpret for them. My heart sank. I did not want to blur the boundaries between my patient and me, but I reluctantly agreed.

I keep wearing my white coat as a reminder that I am still her doctor and introduce myself now as the interpreter. This time, my patient's silence is prolonged. She takes a breath to elaborate on what is bothering her, and then . . . nothing. My lungs are full of air, but my voice is stuck in the middle of a phrase that just cannot cross the threshold of my lips. It is an agonizing feeling. *Say something!* I scream internally, but my patient does not, and so I do not. The scarce response, even if nonsensical, gives some relief.

Experiencing my patient's cycle of smothered sounds and stray words during the interpretation created a conflict within me. I wanted to assuage the symptoms I was made to feel and, as a resident, I could now either take immediate action or wait for the consult service's recommendations as initially intended. To maintain my objectivity, I needed to re-establish the boundaries I had with my patient. From then on, I arranged for a Spanish interpreter to work with us during team rounds and share their insight. Some interpreters had worked with my patient many times in the past and provided key information about her baseline.

Spanish interpreters experience and culturally preserve patients' communication styles and mannerisms. They have a wealth of insight regarding patients and, many times, this insight is a heavy burden to carry alone. Unfortunately, instead of *working with* interpreters, providers often *use* them. Interpreters are excluded from treatment team discussions and are often an afterthought at best.

Sometimes, especially when paged to the trauma bay, there is no interpretation. Instead, I am left alone to comfort frightened family members in my own words while providers perform emergency interventions. The assumption seems to be that I will automatically know what to say to family members since we speak the same language. Due to my medical education, I see meaning in the chaos around us and can focus on being a calming presence. Interpreters should be given basic education on various medical procedures. It is unfair to put them in situations where they do not understand the interventions taking place. Without background knowledge, interpreters are stuck experiencing traumatic cases through the eyes of the patient and their family.

Far too often, providers forget about the interpreter after their expertise is no longer needed or nonchalantly dismiss the interpreter as if they did not experience that traumatic event too. As if the interpreter is not a human being. As a resident, it is standard practice to be included in team debriefings. I have never been invited to a debriefing after one of the patients for whom I interpreted died. Ironically, the profession with the highest degree of emotional involvement receives the least consideration.

The injustices I witness as a Spanish interpreter are unsettling. There are times when I am paged to interpret a discharge session, but the patient begins to express the concerns that brought them to the hospital. It is clear they did not have appropriate interpretation before I arrived. It is also disturbing when providers copy and paste their English discharge instructions into an online translation service, which reduces the Spanish language to utter nonsense. I quickly intervene to address serious issues, but I cannot be there to correct every mistranslation. Even worse is when I check in on a patient only to find an empty room—the proud provider tries to reassure me that they discharged the patient with instructions they translated into Spanish. It is haunting to think about how these miscommunications impact health outcomes.

Years ago, I learned that my mother did not have access to a Spanish interpreter in order to provide informed consent for a procedure. Her doctor told her they could "fix" her uterus. She understood this to mean her doctor could repair it. Only after having a hysterectomy did she realize what her doctor meant. Although still shocking, this incident does not surprise me now.

Today, many consent forms are not available in any language other than English. Sometimes providers ask a bilingual staff or family member to interpret due to the misconception that the only prerequisite for medical interpretation is bilingualism. Sometimes providers think practicing their Spanish or miming with their patients is risk-free. Sometimes providers think they know what is best for their patients and communication is not necessary. It is unsurprising that Spanish-speaking patients still face significant disparities in health outcomes.

Because I know interpretation greatly impacts patient autonomy and treatment, I continue to work as a Spanish interpreter during residency. Through this process, I experience healthcare dysfunction from different perspectives and advocate for change.

Many millions of people in the United States speak Spanish, which is the second most spoken language here after English. If the healthcare system cannot get it right for Spanish-speaking patients, then how could it possibly get it right for patients who speak any other language? A good litmus test for how patients with limited English proficiency are treated is to observe how interpreters are integrated into their care. Interpreters do a lot of talking but are rarely heard. Don't mute us.

* * *

The Ramp and the Stop Sign

Linda Pollack-Johnson

When I first began working as a medical interpreter, my goal was simply to use my language skills to help people. I looked forward to learning more about the cultures of my two non-English languages (French and Italian). I did *not* anticipate that I would learn so much about the talents and culture of those who are differently-abled. I had *no clue* that I would learn to see the world differently—more fully—and that I would have the opportunity to be part of life-changing moments for those I serve.

Most of my interpreting assignments are at hospitals and doctors' offices, where I help Italian-speaking patients navigate through the maze of the U.S. healthcare system. I often get assigned to work at one of the best hospitals in the country, where a lot of research into new treatments takes place.

A new gene therapy drug was developed at that hospital to treat children suffering from a degenerative retinal disease. This disease gradually clouds the vision of the afflicted children. Without the one-time treatment, they eventually lose their vision completely. Six of the subjects who are part of the clinical trial for this drug are Italian. They live in Italy and fly back and forth to the US for their check-ups. They have been involved in this study for over 10 years, so all of them are young adults now. More recently, some of them are starting to come with their spouses.

This was the case for Matteo (not his real name) who came for his annual visit with his wife Paola (not her real name). Matteo was one of the first courageous volunteers to get the experimental treatment. At that early stage, the dosage considered to be safe was significantly lower than the safe dosage they are using now. As a result, Matteo did not experience as much improvement in his vision as might have been possible later in the game. He can see things that are close to him but not at a distance. He has learned to use and rely on his other senses to compensate for his visual impairment.

Matteo, Paola, and I were walking from the main hospital, where we had just finished a lunch break, and were heading to the building where Matteo was scheduled to meet with his ophthalmologist. I looked at my watch and realized we had time to kill before the doctor would be ready for us. I suggested we take a moment to tour a portion of the building that looked very inviting but that I had not had time to explore.

A large section of the first-floor lobby of the building has an extra-high ceiling. It creates a kind of atrium, from the lobby to the second floor. A graceful, winding ramp meanders in appealing, gentle curves through this open space. It resembles a vine where the stem is the ramp and where an occasional round "leaf" sticks out from the side of the ramp and serves as a kind of rest stop or balcony where one can pause and appreciate the view. I think it would be really fun to explore it in a wheelchair, but that was not necessary or appropriate for our little group—Matteo is able to walk and navigate on his own, sometimes with the help of a guide.

I opted to lead them downhill, so we took the elevator up one floor and started from the top of the ramp at the second floor. From there, the first "rest stop" was an empty balcony where I described to Matteo that the clear, plexiglass panels making up the protective railing were etched with the names of what I imagined were the donors who contributed to the hospital or to this artistic installation. It was nice but not particularly "accessible" to a person with a visual impairment.

We moved on down the ramp. The next rest stop was only slightly more interesting. It had a tall, clear glass display case in the center of the balcony. You could walk completely around it, but I was unsure what was inside it, if anything. With some disappointment in my voice, I suggested we could move onward down the ramp. Instead, Matteo approached the display case and touched it—something I would not have done, having been raised with strict orders to keep my hands to myself, especially in museums and hospitals. Activated by his touch, the inside of the display case lit up, showing a bright jumble of shiny, silver ribbons, mirrors, prisms, and rainbows. We moved around it, admiring the lights and enjoying seeing each other through the glass panels.

Having thus discovered the secret that there was an interactive component to the rest stops, we continued downhill in great anticipation of the next balcony. There, we found three child-sized, cylindrical tables rising from the floor. Each table had a clear glass surface showing, beneath the glass, another layer containing a glittery liquid. Each table had a different color of shiny liquid inside. Working together, like players in an escape room, we discovered that you could spin the tabletops. The centripetal force from our spinning efforts formed ocean-like waves in the glitter juice. Matteo, Paola, and I enjoyed experimenting with rotating the tabletops in different directions and speeds and then getting close enough to see the waves emanating outward from the center.

We continued downhill to the lobby level, where the ramp ended in a well-lit corner dominated by a large, colorful, fake tree. I had often seen this tree from a distance as I passed through the lobby, but I had never taken the time to examine it. Its branches are all very high and are out of reach of any visitor. They create a canopy of leaves, but this time I could see that the leaves were actually pinwheels painted in primary colors. As we explored this space, passing under the tree, we must have triggered a motion detector. It was as if a gentle breeze had started spinning all the pinwheels above our heads! Again, we were enchanted by the magic, so we stood awhile in awe!

Maybe these are the take-away messages from our trip down the ramp:

1. The world is enhanced when we experience it with all of our senses.
2. Added effort to explore and experiment will be rewarded.
3. Some things are best experienced up close.

Shortly after our visit to the tree, as we made our way to Matteo's appointment, I expressed the most important take-away lesson from my trip down the ramp—my gratitude to Matteo for showing me how to *see* and enjoy the world more fully. Without his presence, without his bold, exploratory approach to life, encouraging me to use all of my senses, I would have missed all that playful fun and beauty.

More recently, I find myself singing the praises of all these remarkable people—meaning *all* the subjects who have sacrificed so much to participate in the clinical trial. At each revisit, I make sure that they share with the Principal Investigator all the extraordinary accomplishments they have achieved in spite of their visual impairments (e.g., hiking in mountains; performing vocal concerts in the style of Edith Piaf; earning advanced degrees in law, philosophy, literature—these require huge amounts of reading— skydiving; scuba diving; zip lining through a jungle; downhill skiing; bareback horseback riding; and training and competing at the international level of Paralympic running). I am humbled and inspired by their zest for life, boldness, and courage to disregard confining cultural expectations.

I offer you one more example of their unique talents. A mobility test is one of the tests the subjects do each time they come for a check-up. They are filmed (from the waist down) as they navigate through a series of obstacle courses, first at a very low light level, then with medium light, then with bright light. At the very lowest light level, it is challenging for them to find their way using only their vision. One of the obstacles, placed at head height on the course, is a small cardboard STOP sign that they need to avoid. It dangles from a string tied to a pole that stands on a tripod. It is not dangerous. But if they bump into it, their score is "dinged" by one point. Several of these subjects can *hear* the STOP sign from a meter away! To be more precise, the normal airflow in the room moves differently as the STOP sign blocks it, and the subjects can perceive the sound of the air moving around that obstacle! They have shared this insight with me, and I have passed it on to the investigators so they can factor this superpower into the vision assessment.

I will end with another story. One of the subjects had just returned to the hospital for the first time since receiving the treatment to her eyes and was asked to share any observations from her daily life about changes in her vision. She was very excited to report that the treatment had increased the level of light that she perceived at nighttime so much that she could see the stars in the night sky for the first time in her life! My eyes teared up as I interpreted that statement to the team.

This haiku summarizes the major kinds of satisfaction I have experienced as a medical interpreter:

Grateful
For the chance to help
For the time she saw the stars
For life lessons learned

* * *

How Policies and Practices in Medical Settings Impact Communication Access with Deaf Patients and Caregivers

Kelley Cooper, Maggie Russell, Debra Chaiken,
Michael W. Mazzaroppi & Gretchen Roman

Introduction

We are a group of Deaf community members, sign language interpreters, organizational leaders, and academic partners. We have a collective point of view about how policies and practices in medical settings impact communication access with Deaf patients and caregivers. Here, we account multiple stories from our respective experiences in an effort to improve healthcare institutions' awareness of the recommended modalities when communicating with Deaf patients accessing care. Our stories clarify any misunderstandings about communication with Deaf patients who expressively use spoken language and receptively use sign language. We convey that it is imperative to use visual language when explaining discharge paperwork and emphasize that it is critical for a Deaf caregiver to be fully aware of the plan of care when offering support to their loved one. We illustrate the importance of honoring the requests for in-person sign language interpreting versus video remote interpreting (VRI) as well as requests for Deaf-Hearing sign language interpreter teams. Deaf interpreters bring formative cultural, linguistic, and life experiences and work in partnership with a hearing interpreter to provide a more nuanced communication exchange across a wide range of visual languages.

Maggie Russell: Anecdote 1

The hospital recidivism rate for a Deaf Nepali male patient continues to increase. As the Interpreter Referral Service Director, I am aware of this patient because he receives care management services from our organization. He has several life-threatening conditions, attends dialysis, is on multiple medications, and is frequently in and out of the local hospital. The hospital considers him as someone who identifies as an oral Deaf person, as he has severe to profound hearing loss with little or no residual hearing and visually receives signed language but expressively uses spoken language. Three interpreters, a spoken Nepalese interpreter, a Deaf Nepali Sign Language (NSL) interpreter, and a hearing American Sign Language (ASL) interpreter, working together as a team are recommended for effective communication with this patient and the medical team of providers. However, interpreting services at the hospital provide only one interpreter, a spoken Nepalese interpreter, which does not satisfy the necessary accommodations for access. A plethora of prescriptions were added to his regimen to counter the condition that caused a recent inpatient stay. The patient's wife is his primary caregiver. She communicates receptively and expressively using NSL. A Deaf NSL and hearing ASL interpreter team creates effective communication with his wife and the medical team of providers. Since she is expected to follow the doctor's recommendations as explained in the discharge instructions, she also requires accommodations for communication access. Neither the patient nor his wife received a formal education, and they do not read or write English or the language of their country of origin. Therefore, information in English or Nepalese conveyed in the printed discharge paperwork is inaccessible. The new medications were not incorporated into his already established monthly "pill pack," and the couple was unable to read the information on the pill bottles that were delivered to their home. Subsequently, incorrect use of the newly prescribed medications significantly delayed the patient's course of recovery. This couple also had minimal exposure to medical information and medical processes prior to living in the United States; the medical services in the refugee camps in Nepal were typically non-existent. Utilizing a hearing ASL interpreter alone does not constitute barrier-free access for either of these individuals. Interpreting medical documents in a visual format is so critical for providing access, but it doesn't necessarily guarantee comprehension because of their limited health literacy. In addition to employing the recommended interpreting team, using teach-back methods during an encounter is a good way for medical providers to ensure the patient and caregiver's understanding of the plan of care.

Maggie Russell: Anecdote 2

As the Interpreter Referral Service Director at our organization, I served as the hearing interpreter on a Deaf-Hearing ASL interpreter team at a follow-up gastrointestinal appointment from a gall bladder biopsy for a Deaf male patient, along with his Deaf wife. Subsequently, he was referred to the cancer center at a hospital in a neighboring county. There, the couple requested a Deaf-Hearing ASL interpreter team because of concerns they would not understand the husband's pending diagnosis and anticipated complex medical treatment recommendations. Their request for a Deaf-Hearing ASL interpreter team was not honored, and instead, a non-certified hearing staff sign language interpreter was provided. After the initial appointment, the couple shared that they did not understand the staff interpreter. Upon scheduling a follow-up appointment at the cancer center, they asked again for a Deaf-Hearing ASL interpreter team, but for a second time, the request was not honored. The nature of the follow-up was to confirm the cancer diagnosis and proposed treatment plan. Another non-certified hearing staff sign language interpreter arrived to the follow-up appointment but had limited availability. Due to the urgency of the patient's condition, the medical team proceeded to write back and forth to communicate with the Deaf patient upon the interpreter's departure. A replacement interpreter was not secured. It's important to recognize that English is not the couple's primary language, and their reading ability is roughly at a second-grade level. They attended Deaf residential programming and the wife received support services for a learning disability. Ultimately, despite the Deaf patient's request to receive services at their facility's cancer center, the oncologist and nurse advised that the patient receive services at a cancer center closer to his home. The small-town hematology and oncology facility within the patient's county willingly secured a Deaf-Hearing ASL interpreter team for all his procedures and chemotherapy appointments. Again, I served as the hearing ASL interpreter on this team. The day of his port insertion procedure, the medical team learned that this patient, who was diagnosed with stage 4 gall bladder cancer, did not understand the reason for the port insertion or the port insertion procedure. The medical team was surprised about this patient's unawareness of his disease progression and proceeded to review all of the test results and treatment recommendations with him and his wife. Sadly, the Deaf patient, who was a father of two young hearing children, passed away only two months after his time of diagnosis.

Kelley Cooper

Many medical providers are shifting from in-person sign language interpreting to VRI when delivering services to Deaf or hard-of-hearing patients. VRI provides sign language interpretation remotely through the use of a laptop or tablet. When utilizing VRI, hearing and Deaf or hard-of-hearing individuals who are onsite together connect with a remote interpreter who is in a separate location and often in a different region of the United States with dialectical signing differences. As the Deaf Services Director at our organization, I am working with a Deaf New American client and offering him social work services. Two weeks prior to one of his medical appointments, I contacted the facility and requested an in-person Deaf-Hearing ASL interpreter team to ensure full access for this patient. I explained that VRI was not an effective accommodation because the patient was born in a different country, and although he was learning ASL, he had not yet achieved fluency. The medical facility had previously provided an in-person interpreter but had since contracted with a VRI vendor and is now offering only VRI services. VRI currently does not provide Deaf-Hearing ASL interpreter teams. Because of the inaccessibility of the accessibility services being provided, I accompanied this patient to his appointment. The VRI device was difficult to see because of how it was positioned and the glare from the plastic shielding the screen.

The intermittent streaming connection caused the picture to be poor and subsequently, delayed the interpretation. I recognized that because the VRI interpreter was not from the same region as the patient, they were struggling to understand each other. I stepped in to function as a Deaf Interpreter with the intention of matching the patient's linguistics and facilitated effective communication for all involved. Compared to a hearing patient with the same appointment, which might typically take about 45 minutes, the whole process from registration to completion of this patient's appointment took almost two and a half hours. The medical team was not educated in the set-up and use of the VRI device, but more importantly, they did not demonstrate cultural competency when providing services to the Deaf patient and his accompanying support. Healthcare providers need to know that VRI is not a one-size-fits-all model. It may work very well for some Deaf patients but not for others.

Michael W. Mazzaroppi

I am an advisory board member of our organization, academic partner, and Deaf community member. I have also been denied the necessary accommodations for communication access in a medical setting. I had been fighting pneumonia for a few weeks. After having tried a few rounds of antibiotics, I was not getting better, so I went to an emergency room. While waiting for a bed to become available, a medical team of physicians, nurses, and other specialists were busy examining me. Honestly, I had no idea what was happening and quite frankly, I was terrified. I could see by their faces that my health was not good, so I asked for an ASL interpreter. I immediately realized that I had made the mistake of making this request using spoken English. I identify as Deaf and as someone who expressively uses spoken English, but receptively, I will often need to receive ASL. At first, I sensed some confusion because the nurse thought I was asking for a Deaf family member; however, I made it clear that the request was for me even though I can speak. Unfortunately, historically, there is an assumption that ASL users do not speak and only use ASL. However, this is not true. Every Deaf person may have their preferred means of communication, such as speaking, signing, or a bit of both. Regardless, the nurse responded, stating that they would make sure I had my hearing aids and that the doctors and the medical staff would make sure that everyone would speak louder. When I explained that these efforts may not be enough to ensure my comprehension, I was told that I could ask for clarification on anything. Since I was very ill and had no energy to further assert my rights, I agreed. Looking back, I wish I had been more insistent and that the medical team would have honored my request to have an ASL interpreter present.

Conclusion

The Deaf community is very diverse. Medical facilities and practitioners only allowing for one interpreter or only providing VRI may not ensure a successful medical encounter. Some Deaf patients may have no previous exposure to medical care, and some Deaf patients may speak for themselves but receive information visually using a sign language interpreter. Denying the necessary accommodations can compound a patient's limited health literacy and escalate fear. The medical setting is often a high-stakes environment. Some Deaf patients may request a hearing ASL interpreter for one scenario, but a Deaf-Hearing ASL interpreter team for another. Deaf patients and caregivers know best about their unique linguistic needs. We hope sharing our narratives promotes awareness for greater inclusivity of all roles involved and fosters access to quality care delivered by the medical team. The policies and practices pertaining to the provision of sign language interpreters in medical settings need to be flexible and honor the requests of Deaf patients to ensure effective communication.

* * *

And When May I Cry? Juggling Emotions in Healthcare Interpreting

Mateo Rutherford-Rojas

Disclaimers. All names have been changed to protect the privacy of the patient and the patient's family.

Baby Oliver had been in the NICU almost since he was born. Oliver was born with a relatively simple congenital problem, which required him to have a routine corrective surgery.

Unfortunately, routine surgeries don't always deliver routine results. Due to unexpected complications during the operation and a prolonged lack of blood flow, several of Oliver's tiny organs suffered partial necrosis. It was just a matter of time until little Oliver's life could no longer be sustained with tubes, pumps, liquids, and pain medications. How much time Oliver's tiny body could hold out was unclear—he had days, maybe a week. The care team had already communicated to Oliver's parents, who were still teens themselves, the options that were available. The team provided sufficient medical detail for the parents to understand the logic of the situation. They faced the most difficult decision any parent—past, present, or future—would ever have to make. Before his birth, the parents expected to take little Oliver home, to love and nurture him, and witness him grow well into adulthood. Now, they had two choices. They could either choose to disconnect Oliver from the machines and let him die in their loving arms or watch him fade away, connected to his incubator and accompanying equipment, barely able to touch him through the multiple life-sustaining wires and tubes.

The message had been delivered in Oliver's parents' language many times. In fact, every Spanish interpreter on staff had worked with the care team and Oliver's family at some time during their stay. Their ears heard it, but their minds could not comprehend how a routine operation could end like this. It is in these moments that most people rely heavily on their faith, as did Oliver's parents; waiting for God's miracle to happen.

Perhaps it was the Chaplain's suggestion that God's miracles are not dependent on medical machines and life-sustaining equipment. Or that perhaps God needs Oliver and knows his family is strong enough to let him go. But at moments like these, religious philosophy and the nature of God do not provide a simple and clear answer. Still, someone has to decide , "Yes, it's time to hold him and say goodbye" or "No, we are not yet ready to let go of our hope."

I don't know what the final deciding factor was or when that moment came for these young parents so full of love and hope for their new family. All I know is that I had the tremendous honor and responsibility of interpreting for the parents and the care team when the gravity of the situation had penetrated all those human mechanisms of self-preservation. Oliver's parents chose to embrace their son, hold him in their arms one last time, and say, "Goodbye, we love you."

This situation is not unusual at our hospital. As one of the nation's primary academic children's hospitals, patients come to us for miracle cures or to die in comfort and peace. In this case, what was unusual and touched the hearts of everyone in the room—surgeons, specialists of every organ system, bedside nurses, chaplains, social workers, and yes, the interpreter—was the final message the parents had for the care team. "Please, please, our only wish is that no parent ever have to make a decision like this again, please." We were all shocked and humbled by these anciently wise teenage souls whose hearts were broken, and their primary concern was for every other parent in the world, whom they would never meet— "May they never feel our pain."

How I wish their desires had come true. However, soon after the situation with Baby Oliver, I would find myself again in the NICU interpreting the same messages to two other families, though their stories were distinctly different. Unlike little Oliver, the babies in the later cases were diagnosed with genetic disorders that presented little to no hope for recovery, though their deaths were no less painful for the parents and siblings.

As interpreters, we hold the emotional weight of our patients' and providers' messages until we can transmit them to the person for whom they are intended. If we break down emotionally, the message cannot be delivered. Indeed, communication stops and our responsibility of facilitating communicative autonomy cannot be met. So, with broken voices and weepy eyes, we do the best we can to say the words, to convey the meaning, and to hold our human empathy deep inside. And when patients and others on the care team let their tears flow, that's when we—the healthcare interpreters—may cry with them.

* * *

To Engage or Not to Engage: An Interpreter and a Mother's Need for Connection in the Cardiothoracic Unit

Rosa C. Moreno

Five minutes into my shift, I arrived at my assigned area for the day, the cardiothoracic intensive care unit. Soon after, I received a phone call from the charge nurse that my interpreting services were being requested—words that set the tone for what would be a busy day. I took my notepad, clipped my pen onto my lanyard, and off I went. As I turned the corner of the long hospital corridor, I saw a group of providers standing outside a room, and I knew it was going to be one of those "tough" conversations. I was escorted inside the hospital room. As is customary, I scanned the room and noticed the patient was a female in her teens and her mama of a humble demeanor.

> *Interpreters serve as vital conduits in bridging the linguistic and cultural gaps between individuals who speak different languages. Interpreters convey spoken messages faithfully and impartially, striving to maintain the integrity and tone of the original communication.*

I interpreted for the cardiologist and for Mama, whose look of worry was evident. Her daughter had gone into cardiac arrest during the night on the oncology unit and was unconscious, initially admitted for recently diagnosed leukemia. Between every piece of information, Mama invoked her faith and, with it, the hope of her daughter pulling through. The patient would get an MRI to find a plausible explanation. We all left the room except Mama. I waited outside in case other providers needed me. Mama walked out to the hallway and asked me to please not leave her side the rest of the day. "Of course," I replied.

> *To patients: Understand that interpreters are bound by professional ethics, including confidentiality and impartiality. Avoid engaging in side-conversations with interpreters, as their primary focus should be on facilitating communication between you and healthcare providers.*

Mama and I waited outside the MRI room. Wait time was filled with the telling of stories and anecdotes of Mama and her two daughters. They arrived in the US three years prior, leaving their home and family to escape inevitable violence. They journeyed on foot and ride-hopped through the country of Mexico and then endured the detention center experience. A woman they encountered was kind enough to rent the family of three a room in her home. Mama shared with me anecdotes about the rebellious nature of the patient as a 15-year-old determined to figure out her identity and the quiet and observant nature of the younger sister. I listened to Mama's own story of hope and despair. Sprinkled between every story, Mama invoked her faith and, with it, the hope of her daughter pulling through. I listened, nodded, validated, encouraged, and smiled when Mama smiled.

> *To healthcare providers: Recognize and respect cultural differences that may impact communication and healthcare decision-making. Be open to learning about your patient's cultural background and preferences and adapt your approach accordingly.*

My shift was ending. I told Mama I would see her tomorrow morning and let her know her daughter was in my prayers.

> *To healthcare providers: While their primary role is to bridge the communication gap between healthcare providers and patients who speak different languages, interpreters also understand the emotional weight that accompanies medical situations.*

The following morning, I went straight to the patient's room. From afar, I saw Mama outside in the hallway. As I got closer, she spread her arms and hugged me whilst letting me know her daughter had passed away during the night. No tears were showing—only sad and somber eyes. I gave her my most sincere condolences. We stood in the middle of the hospital corridor as she recounted the events of the night. Mama asked me if I could accompany her inside the room, which I did. She asked if I could hold her daughter's hand, and so I held it. She then asked me if I could tell her daughter what a beautiful and wonderful young lady she was. I struggled with this last request, for I did not know the young lady personally. However, I remembered the grieving woman before me had just lost her daughter, so who was I to feel uncomfortable? In the end, this was not about me.

> *To interpreters: Interpreters may struggle with the emotional toll of witnessing patients and families grappling with difficult diagnoses, treatment decisions, or end-of-life discussions. They may feel a sense of helplessness or vicarious trauma as they bear witness to the pain and suffering of others.*

We ended with a prayer in a closed circle: patient, Mama, and me. I told Mama I would be back soon and went to a quiet place to relieve some of the tears that I had been holding back.

The phone rang requesting my services to my well-known family on the cardiothoracic intensive care unit. Physicians, nurses, palliative care, and social workers filled the room. Mama sat quietly while she listened to a summary of the events that led to her daughter's passing. What a relief it was, having cried earlier and avoiding the knot in my throat that oftentimes interferes with the ability to interpret.

> *To healthcare providers: Involve the interpreter in care planning: Consult with the interpreter when discussing treatment plans or making healthcare decisions to ensure that all parties fully understand and agree upon the course of action.*

My services were no longer needed. At the end of my shift, I bid my farewell to Mama, hugged her, and left with a heavy heart and a lesson on resilience.

* * *

Witnessing Trauma: Emotional Challenges in Medical Interpretation

Maja Milkowska-Shibata

Having a background in public health but no clinical experience, I never expected to be given the opportunity to work directly with patients. This changed when I became involved in medical interpretation. During my first year of service, I mostly assisted with primary care appointments until I was assigned to my first appointment in a cancer treatment center. The moment I stepped into the distinctive atmosphere of that place, the gravity of the patients' circumstances became strikingly apparent. Each individual was suffering from a life-threatening condition, which was unlike anything I was used to witnessing.

The staff seemed to know each and every patient. I noticed a patient in a wheelchair accompanied by a relative carrying an oxygen tank. Someone brought gifts for the receptionists. A Christmas tree sat in the corner of the waiting area, ready for the holidays. The facility clearly conveyed an effort to resemble a home-like environment. "They must be regulars," I thought grimly.

After completing a routine appointment with an elderly patient who was feeling weak, the patient requested an IV drip. My official assignment was over, and I could have gone home at that point, but something compelled me to stay. As I interpreted the nurse's instructions for setting up the drip, I could not help but notice the vulnerability of the patient, who had a thin and frail physique. The patient seemed grateful for my presence, so I settled into a chair in the corner and waited patiently.

Soon, the patient drifted off to sleep, and I checked on them every now and again to make sure they were fine. The room became quiet, and I hoped the patient would not be disturbed by the sound of an ambulance or another patient seeking treatment. Although they were in capable hands, I found myself standing guard, metaphorically speaking. During the two hours it took for the drip to finish, I reflected on the emotions growing within me.

It suddenly dawned on me: I had not been there for my own father during his battle with cancer. I felt obligated to stay by the patient's side as if fulfilling a debt owed for my absence at that important time. Offering companionship to the patient was the very least I could do.

Working as medical interpreters and interacting with patients in varied life and health circumstances will expose us to a wide range of emotions. As we gain experience, helping patients teaches us humility and cultivates a stronger sense of empathy. Although not explicitly outlined in the standards of practice, we have the choice to utilize the powerful virtues of compassion and kindness to positively impact the life of a struggling patient. However, we also run the risk of becoming emotionally detached and losing the ability to act with compassion over time.

Alongside my on-site commitments, I also work remotely for an organization managing a high volume of calls in numerous languages. In this role, medical consultations occur via phone or video. This environment can make you feel somewhat isolated, reminiscent of working in a call center where strict protocols dictate the ways calls begin and end. In this setting, I am exposed to slightly different emotional challenges. Shielded by a screen and physical distance, I often feel disconnected when interpreting, even for highly emotional situations.

Yet, some interactions are hard to forget. I vividly remember a recent call during which I had to interpret for a victim of sexual assault. I felt deeply moved by their distraught voice and frightening details. For me, as an interpreter, the challenge became even more difficult as it was unreasonable to request the other party articulate their thoughts in short segments for effective communication. To keep up with the speaker, I had to jump into simultaneous interpreting, which many interpreters, including myself, find difficult. At the same time, I was slowed down by the police officer taking meticulous notes. I sympathized with the speaker but was also becoming impatient and angry with myself for experiencing these conflicting emotions. I wanted this call to end as soon as possible because it was eating me away. Still, I was there to serve a human being at a very distressing time in their life. That call will stay with me for a long time.

In my service, I work with patients who are in pain, anxious, upset, or even aggressive. Hearing about health and life adversities all day long can be genuinely distressing. And I fully recognize I am merely an interpreter, far from the major trauma. Other medical professionals face it regularly, which has only increased my appreciation for them.

When choosing this profession, you need to consider that you will likely be confronted with difficult situations that you are unprepared to handle. Working as a freelancer for multiple clients might feel like being thrown into deep waters, without the appropriate training that other medical professions receive to cope with the emotional impact of the work. Vicarious trauma, which occurs when we witness trauma that affects others, is a real concern that can lead to increased stress and compassion fatigue. I was fortunate enough to be familiar with this concept before experiencing the difficult situations mentioned earlier, but many interpreters, particularly those just starting out, may not be. Without awareness, our initial enthusiasm can easily turn into burnout.

The first step involves being mindful of and recognizing the emotions that arise within us. After a hectic shift with struggling patients, I find it essential to decompress and give myself alone time to reflect on the day's emotions. Going for a walk, deep breathing, and writing about my feelings are the things that help me the most. Practicing kindness and patience with yourself also helps. And, much as in life, there will be plenty of interactions with patients that are cheerful, grateful, relieved, and hopeful. You will experience a lot of moments where you will genuinely feel as if you have made a meaningful difference.

I am so grateful for the opportunity to assist patients in need, and I have never felt more appreciated in my professional career. I also enjoy being able to support my fellow countrymen. Since working as an interpreter, I have noticed that I am more open toward other people and more alert to their needs. Above all, I feel more humane, which makes this profession a worthwhile pursuit.

* * *

Being an Interpreter—Beyond Linguistics

Patricia Coronado

Interpreting refers specifically to the process of listening to and analyzing a message received in one language, then recreating the same message and delivering it in another language, all while preserving the meaning. An interpreter should always maintain a professional distance and be neutral to both sides of the conversation. Could I truly walk this line and perform by the book for each encounter?

At one of my medical encounters as a Spanish interpreter, I found myself in the midst of a heart-wrenching situation that involved grappling with life and death. No mother ever wants to hear that her baby has a condition that could lead to death either at birth or shortly thereafter. I had the profound experience of witnessing a woman in the final days of her pregnancy come to terms with a devastating reality.

Just before I began my duties as an interpreter, I was informed that the baby had a congenital defect in which they would be born without parts of the brain, a condition called anencephaly. If babies with anencephaly are born alive, they usually live only a few hours or days. They have no forebrain or cerebrum (the main thinking structure of the brain), and the remaining brain tissue is often not covered by bone or skin. The baby will be blind, deaf, unconscious, and unable to feel pain.

I learned that anencephaly is a serious birth defect, and the cause is not completely understood, but it's believed to be caused by a combination of genetic factors such as mutations or abnormalities, family history of neural tube defects, folic acid deficiency and exposure to certain toxins, medications, chemicals or substances. Hispanic women are more likely than women of other ethnicities to have a baby with anencephaly.

During my first session, the medical team had many questions for the mom. For each question, the mother's responses were brief; either a yes or no answer, even when I was acting as a clarifier to make sure there were no misunderstandings. In my head, I thought:

- Maybe she is in denial.
- Maybe she has faith that a miracle will happen.
- Maybe she is just afraid to ask questions.

The registered nurse wanted to make sure that mom had what she would need to be comfortable for the day of her delivery. I remember questions like:

- Will the baby be baptized?
- Would you like to have a priest or a chaplain from the hospital or church?
- Would mom or dad cut the umbilical cord?
- Do you have a special blanket to shelter the baby?

The mother remained strong and resilient, keeping her emotions inside, at least from my perspective. The meeting was calm.

There was a second session in which the medical team invited me to be part of a private meeting to go over key points about this case prior to the delivery. I remember being introduced to the neonatologist, this extraordinary doctor who played a vital role as part of the medical care team.

I immediately did my own research about the functions of a neonatologist—a medical professional who manages the care of babies who are born prematurely or with an illness or congenital disability, such as prematurity or congenital malformations (birth defects), among others.

I was present on the day of delivery. As I interpreted the emotional complexity of this event, a deep sense of empathy washed over me. I realized I could serve by giving my love through my words, my silence, and my presence. I interpreted for the mom when there were English-speaking care providers, focusing on interpreting for the patient's mom and spouse when needed. I was quiet in the times when a Spanish-speaking care provider spoke to the patient and family. Lastly, I was available—the only person outside of the family who was present during the actual delivery who was not a nurse or doctor—to help interpret and provide support whenever needed.

Even with intensely emotional encounters such as this, my commitment to providing support and assistance remained unwavering. I stayed calm, silently praying for the mother and her baby. In an act of solidarity, I approached her, touching her head and hands to give her strength and comfort at a challenging time. I followed the exceptional leadership of the nurses, who demonstrated steadfast compassion and professionalism. Working with a medical team that recognizes the interpreter as a professional team member and is open to collaboration can enhance the quality of healthcare interactions. We serve as a vital link between the medical team and, in this case, the expectant mother, facilitating clear communication and understanding.

When the baby was born, they were immediately placed on the mother's chest with the dad beside them. Both parents had tears streaming down their cheeks. I learned at that moment that being an interpreter goes beyond linguistics—it is immersing oneself in the human connection of each being.

In the days after the baby's birth, I interpreted for the family as they met with the medical team, financial department, and social workers. I interpreted when the medical team gave the prognosis that the baby would most likely live only days. I interpreted when all the pertinent arrangements were made so the family could have a dignified and cost-free funeral. I interpreted when the financial assistance department assured the family they would not incur major medical expenses.

Being an interpreter in the delivery room for a mother birthing a baby with anencephaly is emotionally intricate. It involves conveying not just medical information but also navigating the delicate terrain of compassion and support. In those moments, my role extends beyond words, as I strive to provide solace and understanding amidst the profound emotions that accompany such a challenging circumstance.

Seeing the resilience and strength displayed by the parents, despite the profound sadness of losing their baby, was one of the most moving experiences of my life. The resolve shown by both the parents and the caregivers is a testament to the human spirit's capacity to endure and find courage even in the face of devastating circumstances.

In my journey to understand interpreting standards, I have found that there are times when creating a genuine human connection is crucial. Through my career as an interpreter, a profound realization has emerged: the deep power of authentic human bonds. It is my personal mission to bring love and light into every encounter. Being a mom, woman, and Latina, blending these heartfelt connections into my work adds a special human touch, making the experience richer for everyone involved.

The baby passed surrounded by love. Many friends and church members came to support the parents.

After keeping it together during each interpreting encounter, I felt the impact truly hit me a few days later. The faces of the parents and the baby showed up in my dreams.

Interpreters go beyond just interpreting words; there is an emotional side to it. We encounter stories from diverse fields: maternity, cardio rehab, and behavioral health, among others—each carrying unique emotional weight. Reflecting on this, it becomes apparent that decompressing is crucial. And although interpretation often feels like a solitary role, I have realized that having a supportive teammate to share experiences with is not only healthy but also a necessary lifeline as we navigate the emotional currents of our role.

To this day, I wish the parents find the peace they deserve.

* * *

1-800-QUIT-NOW

Catalina Meyer

As a healthcare interpreter, you are a communication tool, but more importantly, you are a bridge over a cultural barrier. Yes, we must repeat *exactly* what the provider says, and we must strive to convey the message—not so much the words but the meaning. To do this well, interpreters must be aware of cultural differences and advocate when something culturally interferes with understanding the message's meaning. Failing to do so can drastically change the outcome of a patient's treatment. We can say that it is the interpreter's job to make sure that everyone is understood linguistically and culturally and to help in one of the most important aspects of human relations: communication.

The following is an actual interaction that occurred between a provider, a patient in the Smoking Cessation Counseling Program, and me (a trained interpreter).

Interpreter: "Good morning. I am going to be your Spanish interpreter today."

Provider: "How is the chemotherapy going? Are you feeling better today? And please tell me, are you feeling less anxious now?"

As the patient uttered his first words, I realized this would be a challenging encounter. The cancer in his throat had also affected his vocal cords. In a matter of seconds, I thought how difficult it would be to lose your voice suddenly. I could not understand his speech, but I had to try. I wanted to help him, and I wanted him to feel hope.

Interpreter: In a gentle tone of voice: "Sir, would you please repeat that?" Then I added, "Wait a minute, Provider," and raised my hand to practice transparency and indicate that I was speaking as the interpreter. "The interpreter must ask for repetition."

Provider to Patient: "Let us try to modulate. Try to speak slowly."

At this point, the patient started to cry.

Provider and interpreter: "It is okay, Sir, take your time. We are here for you."

Provider to interpreter: "We struggled when using VRI (Video Remote Interpreters) for him in the past, so I requested a face-to-face interpreter for today."

Provider: "I see you have missed appointments in the last six months. I was just wondering, is everything okay?"

Patient: "It is because I have no car!" He cried and yelled.

Interpreter: Shushing. "Sir, let's do this: You talk, I'll repeat what you say, and you can please nod if I'm correct, okay?"

Interpreter: "Provider, I am asking for repetition. The interpreter needs to clarify."

The patient responded with whimpering, gestures of pain and frustration, long pauses of silence, and putting his hands to his face to cover his crying.

The provider gave him some time. She tried to redirect his emotions: "Sir, have you called the 1-800 number we gave you? Have you received all your supplies to help you quit smoking yet? How is that going for you?"

The patient, now expressing anger on his face, says, "I called many times. Translator, tell her! Many times, I called, but they do not speak Spanish! They keep hanging up on me." He begins to cry again.

Provider to Interpreter: "Interpreter, I am confused. We give the same number to all our patients in the After Visit Summary and it works just fine! Could you repeat that? Did he say he called, and they hung up the phone on him? Could you please clarify?"

Patient raising his voice: "I did! Translator, please tell her I did! They do not speak Spanish!"

The patient continued to cover his mouth with his hand while he spoke and cried, which made it difficult to understand his voice and the movement of his lips, which, in this difficult case were a helpful aid—making it easier for the interpreter to comprehend the patient's words.

Provider: "Let me double-check the 1-800 number so you can order your supplies."

The patient's frustration grew. "Here! This is the number! Are we done? I am in pain; I want to go home now."

Provider: "One moment, please, I'll call for you." The provider dialed 1-800-QUIT-NOW.

Provider: "Well, they say for Spanish press 2. I cannot request the supplies for you, Sir. You must order yourself. Did you decide what type of nicotine form you want to try? I recommend giving a break to your throat. It is better to order the patches or the spray presentation, at least for now."

Interpreter to provider: "Doctor, this is the interpreter speaking. Would you confirm the phone number with me?"

Interpreter: "Oh! It is not written in numbers, Doctor! It is written in English letters, and our patient may not read English. He may not be dialing the right number. In some Spanish-speaking countries, we are not familiar with using letters in phone numbers."

Provider: "Sir, do you know how to spell Quit-Now in English?"

Patient: "I don't know how."

Interpreter: "Here, let me write it down numerically!"

I wrote down the number for the patient, deciphering the Quit-Now letters to numerals, and added the instruction, "Para-Español presione 2!

Commentary
Learning the Language of Medical Interpreters

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Acknowledgments. To all of the interpreters I may have misunderstood, underappreciated, or taken for granted. I have learned.

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Abstract. Every day, medical interpreters encounter the vulnerabilities of patients with limited English proficiency and systemic barriers to doing the right thing for patients. The narratives in this issue of *NIB* demonstrate a love of the interpretive practice. There are many stories of advocacy that go above and beyond what is expected of them. Yet, even with national standards, tensions exist as to the boundaries of their role—how much advocacy is expected and how much is above and beyond? What are the emotional costs of advocating for patients who are so vulnerable and in a system that is both huge and changing all the time? Overall, the narratives convey a sense of being situated within teams and within healthcare organizations as moral communities. As you read their stories, circle back to this context every now and then to ground the narratives and yourself in what it means to be a member of a team and moral community. I hope this grounding will help us be better at what we do together.

Keywords. Bioethics, Medical Interpreter, Moral Community, Moral Distress, Narratives, Team-based Care

Introduction

How we "do" healthcare today is vastly different from 20 years ago, or before the pandemic, or even yesterday—and it continues to change. The narratives in this issue of *Narrative Inquiry in Bioethics* (*NIB*) draw such keen attention to the shifting sand beneath our feet that you will continue to find sand in your shoes days or weeks after reading them. The narrative authors point us to the tensions of their profession within a highly-regulated, profit-driven industry. They grapple with fully implementing their role and the personal costs of doing so. They draw attention to the responsibility of the healthcare team and their struggles to be recognized as part of it. The narratives also highlight the passion, empathy, generosity, and satisfaction in caring for people and doing right by them. Most of us do not have easy access to the perspectives of medical interpreters, so this collection of narratives feels like a gift. The lingering sand in our shoes reminds us to be more cognizant of our interpreter colleagues and their value in the healthcare moral community.

In their narratives, you will hear echoes of moral distress as the authors encounter problems within their teams and institutions that they know negatively impact patients yet have little power to control (Hamric et al., 2006; Jameton, 1993). Some have sought advanced degrees to try to tackle problems. Others teach teams about medical interpretation. Some seek mentorship, and others try to cope on their own. Their stories are unique, yet underlying themes bring them together, namely vulnerability, the interpreter's role, educating us, and mattering. Within each theme is evidence of injustice, exclusion, bias, moral distress, or ethical dilemma alongside joy, satisfaction, pride, and compassion. Overall, the narratives and their themes are situated within teams and also within healthcare organizations as moral communities. As you read their stories, circle back to this context every now and then to ground the narratives and yourself in what it means to be a member of a team and moral community. I hope this grounding will help us be better at what we do together.

Team-based care

Improved patient outcomes, better coordination of care, and reduced clinician burnout are accomplished through team-based care; huddles, interprofessional rounds, and other mechanisms (Arora et al., 2014; Casalino et al., 2023; Lu et al., 2023; Stollings et al., 2020). When patients have limited English proficiency (LEP), they and their teams are at risk for misunderstandings, which ultimately impact patient health and the quality of care. Further, medical interpreters who are not included in team meetings are unprepared for conversations that require cultural as well as language interpretation, which further challenges quality of care and adds emotional burden to the medical interpreter. Medical interpreters are not bodies through whom words pass and magically become translated. They are *interpreters* of language and culture who must "bridge between providers with typical Western principles of patient autonomy, individual choices and decisions, informed consent and truth-telling, and patients and families who find these principles at variance with their behaviors, beliefs, decision-making processes, and practices" (Goldhirsch et al., 2021, p. 610). For these superpowers, medical interpreters have earned a spot on the team.

Moral community

A *moral community* is a group of people whose "members are bound to each other by a set of commonly held ethical commitments and whose purpose is something other than mere self-interest" (Pellegrino, 1990, p. 225).The nursing and medical professions and religious groups have identified as moral communities for many years (Aroskar, 1995; Graham & Haidt, 2010; Pellegrino, 1990; Wocial, 2018). Homogenous groups may easily identify commonly held ethical commitments and a larger common purpose. A healthcare organization is far more heterogeneous and yet, while its members are of different professions and follow different codes of ethics, its overall ethical commitments are similar, and its purpose extends beyond mere self-interest. Healthcare organizations' ethical commitments support and strengthen those who work for them or are impacted by them; teamwork, safety, competence, humaneness, fairness, respect, trust, and accountability. Margaret Urban Walker (1993) adds the reflection for decision making and dignity which "requires being a possible bearer of truth about one's experience . . ." and "being able to make others accountable as truth tellers . . ." (Urban Walker, 2008, p. 232).

Themes

There is much to these narratives beyond the themes, but these stood out strongly, and each, I found, taught me something I did not know about medical interpretation (which, it turns out, was a lot). The theme of *Vulnerability* applies to the vulnerability of patients with language access needs as well as the interpreters themselves. The second theme, the *Interpreter's Role*, appears to be evolving (Beltran Avery, 2001), with some interpreters seeing their role clearly as advocates beyond language and cultural interpretation while others seem to stick more closely to that line, similar to the nursing role where some nurses are very comfortable exploring end-of-life preferences with patients and others rarely delve into that gray territory. *Educating Us* describes nearly all of the authors' desires for non-interpreters to better understand what medical interpretation can contribute to the team and to the well-being of patients. Admittedly, tensions exist between this them and the interpreters' roles. Still, a critical need to educate non-interpreters is made very clear. Finally, *Mattering* the sense of both bringing value and being valued (Flett, 2021; Prilleltensky, 2020; Rosenberg & McCullough, 1981) has begun to add to what we know about the importance of membership in communities with strong moral purposes. Stories in this issue that relate to mattering focus mainly on the interpreters' senses of bringing value to patients and being valued by them. However, their awareness of being valued by (or not) and bringing value to the team is woven throughout and begs your re-grounding to the context of moral community and the place of those who tend to be taken for granted in it.

Vulnerability

Almost by definition, sadly, simply needing a medical interpreter makes a person vulnerable in the US healthcare system. Patients who speak a rare dialect, receive incomprehensible Google-translated discharge instructions, or for whom "providers think practicing their Spanish or miming with their patients is risk-free" (Ricci) will certainly struggle to understand why they are in the hospital, what is being done, or how they are to care for themselves when they go home. How many of us have ever realized that instructions such as "Take one pill once daily" could mean, for someone who is Spanish-speaking, take a pill eleven (*once*) times daily (Crane)? Beyond language, patients needing assistance with language interpretation are as vulnerable as any other patient. Poor health literacy, poor education, and bias are common regardless of spoken language. In one narrative (O'Leary), the author writes of a young patient with Type 1 diabetes whose family does not read well, even in their own language, and knows no math. "I would dare to say managing diabetes without basic literacy and basic math is nearly impossible," and sets this young patient up for many hospital visits and poor health. Another narrative describes a deaf child whose parents, understandably, want her to receive cochlear implants (Hostovsky); "They were probably devastated when the audiologist told them: Your child is profoundly deaf." And yet, the young child animatedly speaks ASL with the interpreter, complete with all the facial and body expressions, and tells the interpreters about her favorite school subjects, animals, color, and sports—and that she doesn't want the implants.

In their narratives, the interpreters themselves were vulnerable as well. Many authors described their involvement with their patients through end-of-life decisions for their children, domestic violence, and other challenging situations and the cost of this involvement to themselves. For example, Patiño described the importance of being a consistent presence for patients through long or difficult hospitalizations. Almazan writes, "How could you not feel personally and emotionally involved when it is clear that the young man [a patient with AIDS] is so desperately vulnerable?" Others describe the emotional exhaustion of working with patients encountering difficult circumstances—domestic abuse, end-of-life decision making, and disease. When they are excluded from team huddles, interpreters miss opportunities to ready themselves for what will be discussed or to prepare for potential cultural interpretations of treatment goals. Similarly, exclusion from debriefings leaves interpreters needing to cope with the emotional impact of difficult or contentious conversations on their own. "Far too often, providers forget about the interpreter . . . or dismiss the interpreter as if they did not experience that traumatic event too" (Ricci). Ricci also notes that "ironically, the profession with the highest degree of emotional involvement receives the least consideration [from the healthcare team]."

The interpreter's role

The authors do a wonderful job educating us about the training process and role of the medical interpreter. Several note that communicative autonomy is a key principle of medical interpretation, but the boundaries of even this central tenet seem gray. "We don't have a voice—we are the voice of others. We should be invisible," says Hsieh. But interpreting for others requires understanding cultural differences, a willingness to interpret in such a way as to give a rude provider an "out" (Ma) and engaging with patients as an advocate. DeSouza states, "It is essential to speak up for those who are in such desperate need of resources and to fight inequality and discrimination in healthcare for all patients who have communication access needs" but clarifies that "the best form of advocacy comes from doing the best we can to interpret for our patients . . ." The edges of advocacy are blurry. For example, Crane describes interpreting for a mother making decisions for her infant. At one point, the mother said she wanted to discontinue medications and "disconnect" from medical equipment. Suspicious that the mother's intentions were more nuanced, Crane talked with her for 10-15 minutes to try to better understand her wishes (which were indeed more nuanced). Will provides another example of advocacy in their description of a need for improved access to counseling before, during, and after pregnancy loss. The tensions about the boundaries of interpretation extend to interpreting providers' speech, which makes me wonder how often we remember that we are being interpreted too. Hsieh asks, "Should I exercise my power to "remove" others' unintentional mistakes? . . . Is it wrong to make a provider sound more caring than they appear in English?"

Several authors described encounters with moral distress or ethical dilemmas. They viewed the right action to take for a patient being discharged, for example, is to provide clear instructions in a language the patient can understand. This is not accomplished by copy/paste into Google Translate or attempting to use one's (perhaps distant) memory of Spanish. Interpreters recognize this as not only a missed opportunity but also as "haunting" because of the impact on patient health. Lack of reimbursement for interpretation for patients speaking rarer dialects, skirting laws to protect patients, and other systems issues were other sources of moral distress and ethical questioning. Ratway's descriptions of legal loopholes and inadequate mechanisms for calling them out in order to protect vulnerable patients are stunning. Many of us have found ourselves deeply grateful for the work of a highly skilled medical interpreter and yet my guess is that few of us have thought about how complex their role is, how regulations influence their practice, and how systems that bypass regulations put patients in danger. Interpretation means so much more than translated words.

Educating us

The authors, whose voices are rarely heard because their focus is on being another person's voice, used their narratives to teach us so that we (non-interpreter others on the healthcare team) can more clearly understand them as team members. Medical interpreter training is rigorous and standardized. The National Culturally and Linguistic Appropriate Services (CLAS) Standards intend to improve access to and the quality of interpretive services. Sanchez-Herrera noted that these standards, along with the Civil Rights Act (1964), an executive order by President Clinton (2000), and the Affordable Care Act (2010), form the "backbone for . . . Language Access opportunities." Sanchez-Herrera urges the reader to become familiar with the CLAS Standards. The U.S. Department of Health & Human Services' Office of Minority Health provides additional details about the work of interpreters and others who have helped the effort and identifies concerns about healthcare organizations' noncompliance with Joint Commission standards and other regulations (n.d.). These concerns are echoed by Ratway, who, after providing good quality interpretation and being complimented by a patient for it, states that she did nothing noteworthy and that "the bar shouldn't be this low." The sheer number of system barriers to high quality, accessible language access is eye-opening and noted by Ratway and Sanchez-Herrera. Several authors described their own impressive efforts to improve medical interpretation by pursuing graduate degrees, conducting research, engaging in policy development, and educating healthcare professionals.

Educating healthcare professionals about the role of the medical interpreter, to the cultures of their patients, and to the importance of their inclusion as part of the healthcare team was common across the narratives. Effective teams are known to positively impact patient care (Arora et al., 2014; Casalino et al., 2023; Lee et al., 2019), improve job satisfaction, and reduce burnout (Lu et al., 2023; Smith et al., 2018). At least 5 authors mentioned the importance of being included in pre-huddles or debriefs so that they understood what would be discussed with patients. Several noted that they are not often included and may, therefore, be unprepared for the discussion or unprepared for the emotional impact of the discussion. Others (Ma and Sanchez-Herrera) noted that they are often included in pre-huddles or other team meetings and that understanding the goals of care and being able to contribute to team discussions improves patient care.

A few narratives serve as excellent teaching essays on particular cultures. Hostovsky describes the beauty of ASL as a "symphonic" language, Deaf (big D) culture, and the differences between a deaf interpreter and a Deaf interpreter. You might find yourself, as I did, searching YouTube videos to see the beauty of the ASL symphony. Other authors provide insight into what it means to interpret for patients who speak rarer dialects that are similar to more common languages (e.g., Spanish) but not close enough to be terribly helpful. The rare dialects issue is challenging not only because few interpreters speak those dialects but because of the way billing and network processes are often set up, interpreters who speak these dialects may not even be accessible.

Mattering

Medical interpretation resonates deeply with both bringing value and being valued. The value interpreters bring to their patients comes through clearly in narrative after narrative. And certainly, their value is appreciated by their patients. Although some authors recounted stories indicating their perceived lack of value to the team, several authors noted that they do feel highly valued by their teams. A recent paper, co-authored by one of the narrative authors (Ma), tested an intervention to improve interpreters' inclusion and participation in palliative care team discussions and outlined the value of their role and their contribution to the team in challenging circumstances (Goldhirsch et al., 2021). In palliative care discussions, the implications of patients and team members understanding each other are clearly critical. One could argue, though, that the value a medical interpreter brings to teams attempting to teach patients about complex medical regimens, the need for follow up, who to call in an emergency, what patients truly desire for themselves, how their illness weaves itself into their life experience, how clinicians can best address questions or concerns could be enormously useful, time-saving, and anxiety-reducing for team members.

Conclusion

The narratives in this issue provide insights about a profession that non-interpreters may know little about. Deeply heart-wrenching, enlightening, sweet, kind, and caring stories lend us a rare moment to stand in the shoes of someone who, unfortunately, is often taken for granted. Their moral distress resonated with me as did their frustration with systems issues that create barriers to good work. Their ache to be more fully appreciated as a valued member of the team also resonated with me, a nurse, who has deeply felt this ache as well. For those of us who serve as clinical ethics consultants, taking into account the interpreter's perspective and including them in ethics deliberations acknowledges their value to high-quality patient care. For healthcare administrators, medical directors, unit managers, and other organizational leaders, considering ways in which the interpreter role can be more smoothly incorporated into the workings of teams and organizations acknowledges a moral community's values of accountability, respect, and humaneness (Aroskar, 1995; Epstein et al., 2020; Liaschenko & Peter, 2016; Wocial, 2018) and contributes to improved patient care as well.

While the healthcare team can learn much from the narratives and from becoming familiar with the national standards for medical interpretation, improved clarification and agreement about the interpreter's role is still needed even within the profession itself. Such clarification may improve understanding of the contributions interpreters can make as part of the team. In the meantime, some forward movement could and should be made with expanded education about the role, perhaps during medical and nursing residency programs, annual training programs, Schwartz Rounds, and any number of educational venues.

Arthur Frank (2002) once noted that we often think of other people as characters in our stories. However, the "profoundly ethical task is for people to see themselves as characters in others' stories" (Frank, 2002, p. 21). The narratives point out, although indirectly, that when we engage interpreters in our discussions with patients, those patients and the interpreters themselves see us as characters in their stories. Sometimes, those characters are absolutely lovely. Sometimes, however, it's a little embarrassing. We may not always be the characters we would be proud to see if the video of that discussion were replayed. There is beauty in those perspectives. And insight. And worry. And there is work to do and much to be gained from that work. It is time to see ourselves as characters in others' stories. I hope you learn from the narratives as much as I have.

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Commentary
Giving Voice to the Voiceless—Stories of Medical Interpreters

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Abstract. Medical interpreters are indispensable in healthcare, breaking down language barriers to restore autonomy to patients with Limited English Proficiency (LEP). By facilitating clear communication, they enable these patients to understand and make informed choices about their treatment options. However, their role extends beyond translation; medical interpreters also advocate for LEP patients within a healthcare system that can often be unjust. This advocacy can expose interpreters to the very inequities and challenges they strive to overcome on behalf of LEP patients, adversely affecting their own health and well-being. The narratives explored here shed light on these experiences, highlighting the need for systemic changes. By understanding these stories, we can better advocate for reforms that support and value medical interpreters, ultimately improving the health and well-being of both interpreters and the communities they serve.

Keywords. Autonomy, Bioethics, Clinical Ethics, Communication Barriers, Delivery of Health Care, Justice, Medical Interpreting, Narratives

Introduction

Autonomy is the cornerstone of clinical bioethics (Varelius, 2006). It empowers patients to be the ultimate decision-makers of their medical care through the process of informed consent (Varkey, 2021).

Informed consent requires a two-way channel of communication between medical providers and patients in which all relevant information is conveyed to the patient in an understandable manner, and the patient, in turn, communicates her decision to the provider. But what happens when a language barrier blocks this essential line of communication? Enter the medical interpreter.

Medical interpreters play an integral role in healthcare. By eliminating language barriers between patient and provider, medical interpreters restore autonomy to patients with Limited English Proficiency (LEP), enabling them to comprehend and choose between relevant treatment options. But that is not all that medical interpreters do. They also serve as advocates for justice within the medical system.

As evidenced by the medical interpreters' narratives, LEP patients often experience vulnerabilities beyond their inability to communicate fully with providers (Hostovsky, Almazan, Ricci, Will, Crane, O'Leary). They might, for example, also have a disability or be of a low socioeconomic status, leading to their marginalization within the healthcare system as in society at large. As conduits between these vulnerable patients and providers, medical interpreters play a pivotal role by ensuring these patients are not only heard by medical providers but also seen in their full humanity.

In doing so, however, medical interpreters often experience what can be described as "second-hand vulnerability," as seen from some of the narratives (Sanchez-Herrera and Ma). The same system that frequently overlooks the humanity of LEP patients also sometimes fails to support the interpreters who advocate on their behalf, negatively impacting their own health and well-being.

This commentary will first delve into how interpreters enhance autonomy and justice for vulnerable LEP patients to the benefit of their health and well-being. It will then explore how, in the process, interpreters experience second-hand vulnerability to the detriment of their own health and well-being. Finally, this commentary will highlight potential systemic changes, proposed by the interpreters themselves, aimed at improving their working conditions and overall well-being, to the benefit of the patients they serve.

Vulnerability of Patients Served by Medical Interpreters

Medical interpreters play a crucial role in safeguarding the autonomy of LEP patients. True informed consent is unattainable if patients cannot fully understand treatment options and communicate their choices, compromising not only autonomy but also health. For instance, Ricci recalls learning her "mother did not have access to a Spanish interpreter when providing informed consent for a procedure." The doctor told her mother "they could 'fix' her uterus," which she understood to mean "that her doctor could repair it. Only after having a hysterectomy did she realize what her doctor meant." Ricci astutely notes that given such experiences, "[i]t is unsurprising that Spanish-speaking patients still face significant disparities in health outcomes." By bridging these communication gaps, medical interpreters protect the autonomy and health of LEP patients.

However, language barriers and compromised health are not the only vulnerabilities experienced by LEP patients. Rueda Will points out that many of the patients she serves as a Spanish interpreter are "low-income, underprivileged people with serious medical conditions and a host of other socioeconomic problems." Additionally, these patients often have low literacy levels and little to no familiarity with medical terminology. (Crane). Some patients even speak indigenous languages like Quechua, Quiche, and Kanjobal. (Crane, O'Leary). As Crane explains, there "are no medical interpreters who are adept in each dialect," such that "Spanish interpreters are typically called to perform interpretations for these patients," adding another layer to the communication barrier between patient and provider. Crane highlights that these patients are rendered profoundly vulnerable by the variety of factors impeding their ability to understand treatment options and make informed medical decisions.

Medical interpreters strive to restore the autonomy of these patients by dismantling the layers of vulnerability that obstruct effective communication with healthcare providers. Through techniques like simplifying medical jargon (or "lowering the complexity," as O'Leary terms it), allowing ample time for questions, and using the "repeat-back" method to improve comprehension, medical interpreters work to ensure the patient can make informed decisions, sometimes with life or death implications. (Crane). Crane recalls sensing that a Quechua woman who asked to "disconnect" her 4-month-old baby born with heart and lung defects from medical care did not truly want to cease all life-sustaining medical treatment for her baby. "After 10 -15 minutes of repeat-back, asking questions, and explaining the provider's message at the lowest register," Crane was able to discern that the mother "wanted to disconnect the baby from medical equipment" but "continue just one medication that would keep her baby alive."

Unfortunately, not all vulnerable patients have access to medical interpreters. As Almazan notes, "[u]ndocumented immigrants do not have the luxury of having a professional interpreter by their bedside to help them navigate the complexities of their often-dire situation." Instead, "[m]ost of the time, they have to rely on the kindness of volunteers or untrained medical personnel to help them." (Almazan). For example, Almazan, then a non-clinical student in training, was asked to interpret for a young, undocumented man from Mexico with AIDS who had been receiving treatment within the American healthcare system. It quickly became clear to Almazan that the patient had not previously been assigned an interpreter such that he neither comprehended the " gravity of his medical condition" nor "what was being done to him, which included the use of experimental drugs that he had not consented to take." Given the patient's almost complete lack of autonomy within the healthcare system due to his layered vulnerabilities, Almazan found his role "quickly transition[ing] from interpreter to advocate." DeSouza echoes Almazan's experience, observing that "advocacy is one of the roles of a medical interpreter." DeSouza notes that when speaking for "those who are in such desperate need of resources," an interpreter must "fight inequality and discrimination in healthcare" to ensure true patient autonomy.

There are limits, however, to an interpreter's ability to advocate for her patients in the face of discrimination, as experienced by Hostovsky. As a deaf interpreter, Hostovsky serves patients who experience a different kind of vulnerability related to disability. In his story, Hostovsky interprets for a little deaf girl whose hearing parents want her to have an elective cochlear implant surgery. Hostovsky notes that, like most hearing parents of deaf children, the parents in his story wanted nothing more than for their child to be "normal." On the other hand, Hostovsky explains that deaf parents "celebrate the news" of having a deaf child with a "big Deaf hug and high-five" and "maybe even give the benighted audiologist a hug and a high-five too, for being the bearer of great tidings." Like such deaf parents, the little girl in Hostovsky's story sees her deafness as a blessing, not a curse and objects to having the surgery. Here, the reader senses that Hostovsky would like to advocate for his patient against her parents' well-meaning, yet somewhat prejudicial, desire to make their deaf child "normal." However, he is rendered powerless in the face of parental authority, no matter how biased it may be.

Whether successful or not, the role of an interpreter is not only to restore autonomy but also to combat systemic injustices on behalf of her patients. However, this weighty responsibility often comes at a personal cost to interpreters, as we'll see in the next section.

Impact of the Job on Interpreters

The narratives provided here reveal the significant mental, emotional, and physical toll of medical interpreting. As Sanchez-Herrera points out, "The field of Language Access is very demanding and involves encountering a lot of biases and judgmental perspectives." Interpreters, who often advocate for highly vulnerable patients, frequently experience second-hand vulnerability, wherein they are directly confronted with the biases and prejudices of the healthcare system.

Sanchez-Herrera notes that medical practitioners often "do not allow [interpreters] to do their job properly or efficiently" by devaluing the essential role interpreters play in medical care. According to Sanchez-Herrera, some medical practitioners "do not know how to work with interpreters, nor do they understand what [the] role entails. Some are rushed. Some prefer to use their unrefined skills instead of us interpreters." Ma recounts one such instance in which he experienced a lack of respect from a medical practitioner. When the husband of his patient called the doctor by her first name, the doctor curtly corrected him, stating: "Call me Doctor XXX!" Taken aback, Ma sensed the doctor's frustration was directed at him, leaving Ma feeling powerless, helpless, and even embarrassed. Ma suspects the doctor "might have been more diplomatic" in "front of her other colleagues—physicians and nurses," implying the doctor's lack of respect for Ma and his role as medical interpreter. DeSouza similarly laments that as an interpreter, "you have to work with rude providers who see you as an intruder or a disposable piece of human equipment[.]" Echoing this sentiment, Ricci notes that providers sometimes act "[a]s if the interpreter is not a human being."

Medical interpreters also frequently find themselves in extremely emotionally charged situations, which can be profoundly taxing and even traumatizing. Rueda Will recalls dissociating after translating for a woman undergoing an elective abortion. Hsiesh had to sit in her car for an hour after interpreting for a 90-year-old suicidal patient because her "arms shook so uncontrollably that [she] could not have been a safe driver." Crane had to call in a colleague to replace her while interpreting for a mother witnessing the death of her eight-year child, given how "mentally exhausting and emotionally draining" the situation was. While interpreting for a mother experiencing the stillbirth of her baby, Ricci recalls "experienc[ing] grief's abyss together" with the mother. Similarly, Sanchez-Herrera "experienced second-hand trauma" when interpreting for a domestic violence victim who chose to return to her abuser.

The stresses of the profession are compounded by suboptimal working conditions, including long hours and low pay. O'Leary describes her experience working double shifts during which she "only get[s] one or two hours, if any, of rest." Even when she does have an hour or two to sleep, oftentimes "[a]nxiety keeps [her] up" because, as she notes, "[a]nxiety shines with creativity and thrives in [the] high-paced environment" of medical interpreting. Like O'Leary, Ratway notes the grueling nature of the profession, stating: "I am exhausted." Ratway further details the low pay often attendant with these long hours. She reports that "[w]ith some language companies," she "earn[s] less than minimum wage." Consequently, despite her "national certifications and Master's degree in Interpreting and Translation Studies, medical interpreting doesn't pay the bills" such that Ratway must "supplement [her] income through multiple other jobs."

Given the critical role medical interpreters play in enhancing patient autonomy and combating systemic injustice, the profession is ripe for reform. The following section explores some of these potential improvements to better support and value medical interpreters.

The Need for Systemic Change

Ratway succinctly outlines the systemic issues facing interpreters and the communities they serve as follows:

- inconsistent access to interpreting services;
- lack of enforcement of existing laws;
- community uncertainty about where to raise concerns about poor-quality interpreting or lack of access to interpreting services, and whether such concerns will be addressed if reported;
- uncertainty about roles and responsibilities in providing interpreting services;
- lack of data collection on access to interpreters and on the interpreter workforce;
- lack of an accessible reporting mechanism for language access issues;
- low pay and poor working conditions for interpreters and few avenues for reporting issues like short paychecks, contributing to high turnover among interpreters;
- a complicated, inefficient payment structure;
- poor quality of interpretation; and
- lack of trust in the interpreting profession.

To address these issues, Ratway calls on readers to advocate for systemic change, both to improve the experience of interpreters—attracting good people and retaining them in the profession—and, in turn, the experience and health outcomes of the patients they serve.

Several of the narrative authors themselves propose changes for readers to champion. For example, Ratway successfully unionized medical interpreters in her home state of Oregon to negotiate better pay and working hours. She advocates extending these unionization efforts to other states. Ratway also champions legal reforms allowing interpreters in Oregon to bargain rates directly with Covered Care Organizations, rather than through contracting language companies. Although she has encountered obstacles to implementing such a change, she encourages others to lobby their states for direct bargaining power to ensure fair compensation.

Ratway also highlights the gap between the requirements of existing laws and their implementation. She discovered that in Oregon, "no agency had been tasked with enforcing" a "state law requiring credentialed interpreters to be made available." Consequently, Ratway reports that many of the language companies she has applied to work with do not require proof of credentials. Similarly, Ratway reports that in Oregon, medical interpreters are only provided for about 5% of the encounters for which they are legally required. Consequently, Ratway advocates for better enforcement of existing laws in Oregon and invites others to do the same in their states. She also beseeches "legislators and government agencies [to] consider how they might begin to track access to interpreters at a statewide level and formulate a plan to address any gaps they may identify."

Ricci proposes systemic changes to mitigate and prevent the emotional trauma often experienced by medical interpreters. She suggests that "[s]imple measures, such as a short pre-session before interpreting, could help prevent trauma." According to Ricci, "[i]n these sessions, the provider could directly relay the clinical context and reveal the agenda," in which "the interpreter could learn the bad news from a distance and advise the provider about cultural considerations that may resonate with the patient." As a result, both the provider and interpreter "could better anticipate patient reactions, which may soften the emotional impact for all." Similarly, Ricci suggests that "a short post-session after interpreting could help ground the interpreter and mitigate trauma." In such debriefs, "the provider and interpreter could reflect and share insights with each other as they work together to provide culturally competent care for the patient." These sessions could also foster greater understanding and respect among providers for the important role interpreters play in healthcare. Such sessions could be advocated for at both the legislative and hospital policy level.

These proposed changes, among others, are needed to better protect medical interpreters and the patients they serve against "healthcare dysfunction" (Ricci) and related negative implications to health and well-being.

Conclusion

Medical interpreters play a vital role in ensuring autonomy, combating injustices, and, as a result, improving healthcare outcomes for LEP patients. All too often, however, medical interpreting constitutes an act of self-sacrifice that negatively impacts the health and well-being of interpreters. But it doesn't have to be that way. The systemic changes posited by the interpreters themselves can go a long way toward better supporting interpreters and the populations they serve, thus improving the health and well-being of both. We readers are, therefore, called upon to do our part in advocating for medical interpreters against systemic injustices, just as they do for their patients.

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Commentary
Ethical Tensions in the Role of the Medical Interpreter

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Abstract. Medical interpreters play central roles in the care of patients with limited English proficiency, many of whom are vulnerable to challenges in care. Yet ethical tensions arise in the care of these patients, including tensions between translating with fidelity to spoken words versus ensuring understanding; supporting values of beneficence versus autonomy; reacting with passivity versus advocacy; and interacting with patients with neutrality versus compassion. These tensions reflect the commitment of interpreters featured in narratives to providing patient-centered care through challenging circumstances. Yet interpreters are often poorly supported, with low wages, multiple stressors, and vicarious trauma as a result of witnessing difficult medical encounters and interpreting during them in the first person. Interpreters should be recognized as valued, integral care team members who recognize patients as individuals deserving of the best care.

Keywords. Advocacy, Ethics, Interpretation, Interpreter, Limited English Proficiency, Narratives

Introduction

> "These were people who needed to be heard. These were people who needed to be seen. As an interpreter, I would be able to give them a voice." —Marisa Rueda Will

Medical interpretation is sometimes conceptualized as a straightforward act of translation. Listen to the words of one person. Speak them in the language of another person. Non-interpreters often recognize that this is not an easy task; interpreters must support medical communication in real-time, using medical terminology, and often through unfamiliar dialects. Nonetheless, the medical interpreter is sometimes seen as a conduit—words enter in one language and emerge in another.

The narratives included in this *NIB* issue present a very different story. In addition to facilitating language-appropriate communication, medical interpreters often play central roles in care by advocating for patient needs and humanizing care. Many report a sense of obligation to take on these roles when the care system does not optimally support vulnerable patients. However, doing so takes time, can create inner conflict about their roles, and can create an emotional burden for interpreters who are often poorly compensated and supported. Here we explore tensions in the roles of interpreters as translators who are also agents of high quality, patient-centered care.

Interpreter Tensions

Translation fidelity versus meaning

The first tension apparent in the narratives concerns translation fidelity. Interpreters must choose whether they wish to translate the exact words of the speaker or adapt words and phrases to ensure that the intended meaning is conveyed. According to the National Standards of Practice for Interpreters in Health Care, one of the core objectives of medical interpretation is accuracy, "to enable other parties to know precisely what each speaker has said" (2005). Yet many narratives note that literal translation does not always effectively support patient autonomy because complete fidelity to the speaker's words does not always convey the intended meaning. As a result, Liliana Crane describes the interpreter's function as "the role of clarifier." Crane's choice of wording in an encounter, for example, considers the patient's literacy level, mental health, culture, and personal background, and not just the words used by the clinician. When interpreting for Ecuadorian parents of a seriously ill child, Crane invests "10-15 minutes of repeat-back, asking questions, and explaining the provider's message at the lowest complexity" to support their ability to make a complex medical decision. Giannina O'Leary describes a similar encounter with a diabetic patient's mother, who requires a needle for her daughter's insulin injection but does not know the Spanish word for needle. Only after 20 minutes of conversation is the interpreter able to understand what she needs and facilitate the needed care.

Crane and O'Leary recognize that this kind of lengthy back-and-forth is sometimes essential to facilitating understanding, which in turn supports autonomy. Crane notes, "As interpreters, we have to repeat the question differently to obtain the answer sought by the provider. If we repeat the question word by word, the answer won't change. That is when experience as an interpreter and cultural knowledge of our patients play a crucial part." However, these interactions highlight the continually shifting role of the interpreter, who must assess understanding, consider culturally relevant meaning, convey these nuances to the clinician, and respond in real-time to ensure that full communication has taken place. Is the interpreter charged with maintaining fidelity to the spoken words, or with conveying meaning in terms that a patient can understand? Crane and O'Leary suggest that the latter is the key role; as a result, interactions may be individualized to meet the needs of the patient, with fidelity considered secondary to this larger goal.

Beneficence versus autonomy

This shifting nature of interpretation can open the door to additional tensions, one of which is described by Elaine Hsieh. As a conference interpreter in the past, she understood her role as a "faithful, neutral, passive conduit of linguistic equivalences." Yet during an internship as a medical interpreter, she quickly came to question whether the role of "a human form Google Translate" was adequate to address the human challenges in medical encounters. In one encounter, a medical resident commented excitedly about the severity of a patient's scoliosis upon seeing the patient arrive at the clinic. A neutral translator would have translated these words directly to the patient. However, Hsieh, concerned about the disparaging nature of the comment, questioned whether the medical resident wanted to have this statement interpreted to the patient. The resident, surprised, changed his words to communicate that he was happy to see the patient.

Afterward, Hsieh wondered whether her actions were best for the patient. The course that she took protected the patient and the resident from what she believed was an unintentional and thoughtless comment, a strategy rooted in beneficence. However, had she translated it directly, the patient would have been aware of the resident's disrespect and had the opportunity to make decisions about further care with this knowledge, and thus have greater personal autonomy.

Hsieh's considerations mirror those expressed in "A National Code for Ethics of Interpreters in Health Care" (2004). The article states that "In adhering to the essential function of their role, interpreters make what amounts to a vow to remain faithful to the original message as they convert utterances from one language into another without adding to, omitting from, or distorting the original message." Yet the code further states that, "There are occasions, however, when remarks are made that could inadvertently be perceived as offensive by the other party and unwittingly affect the patient-provider relationship in a negative way. In such cases, interpreters might consider choosing to speak in their own voice, alerting the speaker to the possible negative effects of the remarks, reminding the speaker that the interpreter is obligated to convey everything that is said, and then allowing the speaker to reframe or rephrase their remarks if they wish to." While this is exactly what Hsieh chose to do, she continued to question her choice, highlighting this ethical tension. Is she responsible for protecting the patient from harm, or supporting autonomy?

Passivity versus advocacy

A third tension is around advocacy for patients. Several interpreters reflected on times when they felt the need to play active roles in care, especially for patients in vulnerable medical encounters with the healthcare system. As Hsieh writes, "Interpreters should not be limited to the role of a passive instrument with no agency to facilitate quality care." This tension is articulated by Leo Almazan, who, as a student, is asked to interpret for a seriously ill, undocumented patient with AIDS whom the medical staff "looked at . . . with a mixture of disdain and anger." Almazan quickly realizes that the patient does not fully grasp the severity of his condition or the nature of his treatment, some of which is experimental. Moved by his own "deep anger and profound sadness," Almazan transitions "from interpreter to advocate," becoming "a new ally trying to help someone navigate the short-, mid-, and long-term life-altering decisions he would have to make without full knowledge or understanding of his actual circumstances."

Almazan later consults with a professional interpreter about how to help the young man, and the interpreter is "truly torn," recognizing the tension between professional passivity and the patient's deep need for an ally and advocate. While recommending objectivity, the interpreter also asks, "How could you not feel personally and emotionally involved when it is clear that the young man is so desperately vulnerable?"

Other narratives touch on similar themes. For example, Paul Hostovsky describes interpreting for a young Deaf patient. Although the patient's hearing parents want her to have an elective cochlear implant surgery, the child does not wish to have the procedure. Hostovsky empathizes with the child, who can live a full and rich life as a Deaf person. The encounter pains him, although he maintains his professional role without intervening. In another instance, Hilda Sanchez-Herrera describes her interactions with a pregnant woman who experienced domestic abuse from her partner. Sanchez-Herrera asks the patient what happened and, with the patient's permission, shares the information with the medical team. Both narratives describe the powerful pull to help patients in difficult circumstances. In both situations, interpreters are the ones to recognize the challenges patients are facing, and they must decide whether to raise these issues. As Almazan notes, some situations require interpreters to "support, defend, or protect" patients, but the boundaries around these roles are often unclear, and interpreters experience little support as they work to navigate these challenges.

Neutrality versus compassion

A final tension is around the interpreter's experience as a human being who is faced with others who may be experiencing difficulties or suffering. Here the interpreter must balance neutrality with a human instinct for compassion. The NCIHC National Standards of Practice for Interpreters in Health Care recommends that "the interpreter [limit] personal involvement with all parties during the interpreting assignment" (2005). Yet as noted by Rueda-Will, "These were people who needed help. These were people who needed to be heard. These were people who needed to be seen. As an interpreter, I would be able to give them a voice."

Yilu Ma explores this tension in his narrative, recounting an incident in which a neurologist harshly corrected a patient's husband who referred to her by her first name. Ma describes himself as "totally unprepared, and honestly, shocked" by the encounter. He felt empathy for the patient and husband and anger toward the neurologist. In the end, Ma translated the statement faithfully, but "this episode of [the doctor's] open reprimand and implicit power projection stuck in my mind then and many years after."

Almazan, in his narrative about the young patient with AIDS, explores a similar tension, which extends not just to advocacy but to his feelings of compassion and care for the patient. In addition to providing interpretation, he makes time to visit the patient and sit with him. As his colleague, a trained interpreter, states, "We must be professional in what we do, but we can never cease to be human. I guess the best piece of advice I can give you is this: Treat him as you would like to be treated in similar circumstances." After many weeks in the hospital, the patient expresses gratitude for Almazan's voice: "I mean, not the actual tone of your voice or the words you used to help me understand the doctors, but the warmth and the care I felt every time you tried to help me."

The narratives make clear that interpreters also come to these encounters as humans with their own experiences and histories. While these histories can promote healing and best care, interpreters must learn how to balance them. For example, Marisa Rueda Will writes about her experiences interpreting in cases of abortion and stillbirth before her own daughter, Maya, was stillborn. After Maya was born in the very room where Rueda Will had previously interpreted for other patients, she initially recused herself from similar cases. Now, however, with the passage of time, she considers herself "specially qualified" to serve as an interpreter in similar cases. In these cases, while technical aspects of interpretation may remain the same, she brings compassion, understanding, and a desire to help others who are experiencing some of the most difficult moments of their lives.

Consequences and challenges

The narratives also describe the significant emotional burden of serving as an interpreter. DeSouza discloses, for example, that "nothing could have prepared me for the heart-wrenching moments that are part of this job." When Hsieh interprets for a patient with suicidal thoughts, she recalls that she "was unprepared for the emotions that rushed through my body. I did not realize nor anticipate my vulnerability when interpreting for a patient with suicidal thoughts after a long day, speaking in her voice and experiencing her despair." Like Hsieh, Nilsa Ricci notes that "speaking in the first person erodes the boundaries between self and non-self, exposing me to emotional trauma."

Interpreters also note that they lack the support and resources to adequately cope with traumatic events. Referring to the suicidal patient, Hsieh reveals that "none of my training mentioned interpreters' experiences of vicarious trauma when working in situations where they may develop strong identification and intense emotions. I was shocked to realize there were few self-care resources and scarce training to help interpreters in these situations." Similarly, DeSouza recalls, "When you go through school to become a medical interpreter, depending on the program you take, there will be a few comments on self-care and mental health, but nothing that deeply describes the emotional burden that may envelop an interpreter in several specialties, including interpreting life-changing diagnoses or losing a patient." Some narratives also describe processes designed to enhance support, such as inclusion in debriefings and care planning conferences. The spectrum of included narratives underscores how critical this support is for interpreters and for their ability to, in turn, support their vulnerable patients. Nonetheless, many narratives also describe the rewards of the role; as Crane writes, "Interpreting requires additional layers besides being bilingual, such as extensive knowledge of medical terminology, a love for the profession, patience, and a solid vocation to help others."

Conclusion

These narratives reveal a remarkable depth of commitment and care from interpreters, who are often poorly compensated and supported. While their roles have tensions, each of these tensions arises from a desire to provide the best care. Through personal or medical circumstances, patients who require interpretation are often highly vulnerable, and interpreters patch holes in the healthcare system, supporting knowledge and decisional autonomy. Most notably, they are often the primary team members who recognize patients as fully human. Far beyond their role in translation, interpreters are indispensable agents of person-centered care; their needs must be considered to ensure that this vital aspect of care can fully support vulnerable patients.

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Commentary
Voices from The Clinic: Interpreters, Patients, and Power

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Abstract. This commentary examines the experiences of medical interpreters through a collection of narratives exploring the complex interplay of language, culture, and power dynamics within the healthcare setting reported by medical interpreters. By analyzing themes of power differentials, language barriers, and vulnerability, this commentary highlights the critical role of interpreters in bridging communication gaps and advocating for patient needs. In addition, this commentary explores the personal and professional challenges faced by interpreters, emphasizing the impact of working conditions on interpretation quality. This commentary contributes to a deeper understanding of the experiences of medical interpreters and underscores the importance of supporting their work to improve patient care and health outcomes.

Keywords. Bioethics, Cultural Competency, Healthcare Communication, Interpreter Ethics, Interpreter Experiences, Language Barriers, Medical Interpreting, Narratives, Power Dynamics

Introduction

Nearly 10% of the US population has Limited English proficiency (LEP) (United States Census Bureau, 2023). The Centers for Medicare & Medicaid Services (2022) define people with LEP as those who speak English less than very well and speak a language other than English at home. Individuals with LEP may then speak English well, not well, or not at all. Even those who speak English well may still struggle to come up with or understand words in English when faced with stressful and traumatic situations, as is very often the case in healthcare situations (Centers for Medicare & Medicaid Services, 2022). Interpreters provide an essential service for LEP patients who are at an exceptionally high risk for experiencing communication errors, which can lead to serious adverse events and poorer health outcomes (Karliner et al., 2007; Wasserman et al., 2014).

The promise of a fulfilling career awaits those who enter the field of interpreting. They envision themselves aiding those with limited language in accessing crucial healthcare services. Their expectations include comprehensive training, ongoing education, and respect commensurate with their vital role. However, the reality for these professionals frequently falls short, leading the weary into different low-paying jobs, albeit often an improvement from their previous circumstances.

These *NIB* narratives collectively point to systemic inequities within the healthcare system. Fractured communication is not an isolated incident but rather a repetitive symptom that requires structural solutions. In this commentary, I will highlight several themes that run through the stories presented here, which offer a poignant and multifaceted exploration of the healthcare landscape, particularly as it intersects with language, culture, and power dynamics. The narratives collectively highlight the challenges faced by marginalized populations within the medical system and the critical role of interpreters in bridging communication gaps.

Themes Within the Narratives

Power differentials

Power differentials refer to the unequal distribution of power, authority, and control between individuals or groups within a particular context. In healthcare, these differentials are often pronounced and can significantly impact patient outcomes, communication, adherence, compliance, and overall quality of care. In fact, the "Healthy Immigrant Effect"— that is, the initial health benefits that Limited English Language immigrants possess when they arrive in the US—diminishes over time (Pandey et al., 2021).

The interpreters who shared their stories and experiences in *NIB* illuminate the power differentials between healthcare providers, patients, and interpreters. This is particularly evident in the ways in which language and cultural misunderstandings can exacerbate existing inequalities, as seen in several of the stories.

In Yilu Ma's case, while interpreting for a Mandarin-speaking patient, the physician asserts their power and position by responding quite harshly to the patient's husband when he greets the doctor in English by first name. Ma writes, "The doctor showed her irritation in front of a third party—me, the medical interpreter. I felt she almost directed that to me and right in my face, and yet I felt powerless, helpless, and even embarrassed. I wondered if the doctor would do the same in front of her other colleagues—physicians and nurses." In the telling of this experience, Ma exhibits what several of the authors expressed—they don't feel like equals on the healthcare team.

Several of the authors describe instances when a member of the healthcare team made them feel less-than. Laisson DeSouza writes, "Sometimes, you get to work with lovely providers who respect you as a professional and a human being, and sometimes, you have to work with rude providers who see you as an intruder or a disposable piece of human equipment (. . .) [and] a burden."

Healthcare providers hold significant power due to their medical expertise and authority. Patients can be marginalized due to language barriers, cultural differences, and dependency on healthcare professionals, and medical interpreters occupy a precarious position, caught between the provider and the patient, experiencing powerlessness and disrespect. The authors discuss language and cultural misunderstandings, emphasizing how these factors can exacerbate existing power imbalances, leading to negative consequences for all parties involved.

Language

Language (or lack thereof) is a barrier. The stories underscore the profound impact of language barriers on patient care. Miscommunication can lead to misdiagnosis, delayed treatment, and a general erosion of patient trust. In fact, as demonstrated by Pandey et al. (2021), lack of language proficiency also compromises the development of trust between patients and their clinicians.

Liliana Crane provides a helpful example. "The first question a provider asks when the patient arrives at the Emergency Department (ED) is, 'Why are you here?' or 'What brought you here to the Emergency Department?' It seems a simple question. However, often I hear these answers: 'I am here because my wife/husband brought me in the car.'" Crane explains that interpreters must often repeat questions differently to obtain the answer the provider seeks. "Cultural knowledge of our patients plays a crucial part [in interpreting]." Crane discusses some of the other barriers that come with language differences, explaining that "take this medication once daily" may be in discharge instructions, prescriptions, or medication labels. "Once" means "one time" in English. However, Crane points out that these directions could have dire consequences for Spanish speakers— "once" in Spanish means "eleven."

Marisa Rueda Will's story centers around interpreting during situations involving pregnancy loss. Rueda Will says these are often the most ethically conflicting cases with which she is involved. A pregnancy loss parent herself, Rueda Will understands the importance of finding a dependable support system after pregnancy loss but says, "Conversations with a professional medical interpreter and healthcare provider before, during, or [immediately] after a pregnancy loss are likely some of the few opportunities that LEP patients will have to receive proper counseling." Sadly, due to language barriers, pregnancy loss parents who have LEP are largely left after the event to navigate their grief without professional help.

The absence of an interpreter in a medical encounter may mean, as Hilda Sanchez-Herrera describes, that a patient is given the wrong diagnosis because of a language barrier. The patient was diagnosed with 'Locked-In Syndrome' —a complex medical condition with sensory loss due to neurological damage in which hearing is preserved (Das et al., 2023). What, in fact, had happened is that the patient had not responded to the provider's commands because of a lack of understanding of the provider's language. After the interpreter's intervention, the patient started their recovery journey.

Language barriers are not merely inconveniences; they are significant obstacles to effective patient care, often leading to miscommunication, misunderstandings, and adverse outcomes. Several of the stories highlight the human cost of these breakdowns, from delayed diagnoses to the exacerbation of emotional distress. To bridge this divide, healthcare systems must prioritize language access, invest in qualified interpreters, and implement culturally competent care models. To be clear, healthcare executives (including supervisors, managers, and directors) must be knowledgeable about how to address language barriers within their organizations. By addressing these challenges, we can move towards a healthcare system that truly serves the needs of all patients, regardless of language or cultural background.

The vulnerability of marginalized populations

The authors' descriptions of encounters with undocumented immigrants and Deaf individuals reveal the heightened vulnerability of marginalized populations within the healthcare system. These groups often face systemic barriers and discrimination, compounding their health disparities.

In his story, Leo Almazan shared an acute example of a challenge experienced by one particularly vulnerable patient—a young man in his early twenties who had walked through the desert to reach the US border. On the journey, the man drank stagnant water, causing him to acquire an aggressive infection. His condition was exacerbated by AIDS, from which he was also suffering. Almazan felt that the patient's physician had contempt for the young man and that the man was not aware of the gravity of his condition. Of particular concern, the patient had not consented to take the experimental drugs he was being given.

Hilda Sanchez-Herrera writes about interpreting for a pregnant woman who needed assistance at two appointments—one with a maternal fetal medicine specialist and another with an otolaryngologist. The otolaryngologist says nothing about the woman's watery eyes or swollen face, which Sanchez-Herrera noticed prior to the appointment. On the walk over to the second appointment, Sanchez-Herrera asks the woman if she is ok. The woman starts to cry and softly explains that her partner had hit her that morning. While Sanchez-Herrera works within the confines of her profession to get help for the woman (e.g., obtaining the patient's consent to share the information with her providers, protecting the patient's privacy, and involving a social worker), one has to ask: Why didn't the patient's otolaryngologist express any concern?

The vulnerability experienced by undocumented immigrants and other LEP patients is a stark reminder of the disparities that persist. These marginalized populations often encounter a healthcare landscape marked by neglect, discrimination, and a lack of culturally competent care. To address these inequities, a comprehensive approach is required. This includes implementing culturally sensitive training for healthcare providers and, more so, ensuring access to quality care for all and protecting the rights of vulnerable populations. Ultimately, creating a healthcare system that truly serves the needs of all patients necessitates a fundamental shift in values and practices.

Workforce conditions and challenges faced by interpreters

Embarking on a career in medical interpreting holds a unique allure for bilingual individuals seeking an escape from the monotony of frontline, low-paying jobs such as bilingual operators, receptionists, or loan officers, although some will seek this career when they want to follow a career in medicine because interpreting exposes them to the medical field (Wechsler & Tamasi, 2024). In my observation as a medical interpreting instructor in Arizona, a significant portion of these aspirants hail from Mexican American heritage and are naturally fluent in Spanish, though their formal education unfolds in English public schools. Among them, a notable group comprises accomplished professionals—holders of terminal degrees like PhDs, MDs, engineers, and physicists—who have concluded illustrious careers in Latin America. However, due to the formidable challenge of having their degrees recognized in the USA, these individuals end up as interpreters. They may use their experience as medical interpreters as a springboard to other careers: healthcare, social work, or to pay for college, as some employers allow a very flexible schedule, such as night shifts or a couple of hours a couple of days.

Within the healthcare setting, medical interpreters play a crucial role. They facilitate effective communication and care. However, they also highlight the challenges and ethical dilemmas faced by interpreters, who often serve as cultural brokers and patient advocates. But interpreters also suffer: While the patient's voice is mediated through the interpreter, their experiences of vulnerability, fear, and confusion are palpable and affect interpreters emotionally.

Paul Hostovsky, an ASL interpreter, demonstrates this profoundly when he is called to interpret in tandem with a Deaf interpreter for a young Deaf daughter and her hearing parents who want the girl to have elective cochlear implant surgery. Hostovsky and the Deaf interpreter painfully relay the little girl's pleas not to have the surgery. The mother questions, "You want to be able to hear, don't you?" The girl shakes her head *no* and cries while the two interpreters lament silently for the girl. In this case, Hostovsky cannot serve as an advocate for the girl—it wouldn't be appropriate, and that is a painful thing for an interpreter to grapple with and accept. In this case, neither the two interpreters nor the little girl have any agency in the matter and must accept the little girl's circumstances.

Medical interpreters sometimes experience traumatizing experiences when they witness patient suffering and the ethical challenges they encounter under the pressures of their role. Yilu Ma discusses the "vicarious trauma" that interpreters often experience in their work. He is just one of several authors who share an experience that caused deep distress. Almazan, a Spanish speaking student, also demonstrates the moral distress that he experienced while compelled to advocate for the patient with AIDS who had traveled on foot to the US. Concerned about crossing a line, he sought advice from a professional interpreter who advised him, "We must be professional in what we do, but we can never cease to be human." From then on, Almazan visited the patient daily, sometimes just sitting and talking with him, which he says left him feeling "exhausted mentally and emotionally." He is simultaneously motivated to keep helping in whichever way he can.

From personal observations of and correspondence with people who work as interpreters, I have come to learn that in some healthcare systems, interpreters are allowed a mere 10-minute break after a strenuous 90-minute stretch of a continuous 8-hour interpretation shift. Anyone who has undergone this experience understands the toll it takes on one's stamina, witnessing the interpreter's initial enthusiasm gradually give way to fatigue as the day progresses, inevitably compromising the quality of their service. Video remote interpreting and telephone interpreting introduce a new set of challenges, tethering interpreters to computer screens and subjecting them to micromanagement.

In her story, Giannina O'Leary walks us through a day in the life of a hospital interpreter. Her first hour on the job "is all about phones. [. . .]. I continue picking up the phone, listening to messages, calling people back, and documenting the messages that were not answered." O'Leary goes on to share that she has an anxiety disorder. "If I think I am making a mistake, that I am not learning fast enough, or that lives could be in danger (like, for example, in a hospital), my thoughts race, and I am incapable of focusing on anything." O'Leary often works the night shift and says that she usually only gets one or two hours, if any, of rest before having to go to work. Nina Ricci adds that her "sense of self is breached because the first person (interpreting using the pronoun *I* to convey the message directly and maintain the authenticity of the patient's message) is no longer reserved for my own self . . . (eroding) boundaries between self and non-self, [and] exposing me to emotional trauma."

The challenges do not end there. Supervisors, managers, and directors, often oblivious to the intricacies of the interpreter's craft, expect interpreters to multitask, ignoring the fact that medical interpreters in their consecutive interpreting rendition must be extremely focused on their interpretation while also using their hands to do notetaking (Speroff, 2020). It is hard to understand why some supervisors, managers, and directors can be so ignorant of the interpreters they supervise.

Like many interpreters, Felicity Ratway works as an independent contractor. In her story, Ratway shares that she is exhausted from working long hours interpreting and driving to and from appointments for little pay. "Medical interpreting doesn't pay the bills. I supplement my income through multiple other jobs." Additionally, Hilda Sanchez-Herrera shares her experience that after interpreting for a woman who had suffered domestic violence, a social worker had identified that she was experiencing second-hand trauma from the patient-medical encounter. And Elaine Hsieh narrates her vulnerability, and how unprepared she was for the set of emotions she experienced when interpreting for a suicidal patient. It was at that moment that Elaine realized that her problem was not in terminology but because (she) was "ill-equipped to manage the tasks, identities, and relationships in provider-patient interactions." When reflecting on challenges faced by interpreters, the problem seems to be that "we seldom advocate for ourselves to ensure that we have better working conditions and are seen as an important part of the care team," says DeSouza.

Conclusions

From a patient's perspective, the narratives evoke empathy for fellow patients who are often marginalized, misunderstood, and silenced. Through interpreters and their vivid narratives, we understand the importance of empathy in healthcare and their role in humanizing the experiences of suffering patients. From a practitioner's perspective, on the other hand, although not developed completely, the narratives coincide in signaling the need for healthcare professionals to be more sensitive to cross-cultural communication and cultural competency and receive training on how to use interpreters more effectively (Espinoza & Derrington, 2021) if we really want to deliver quality care, which is something I sometimes doubt as it sometimes looks like there is a double standard between providing excellence in quality of care between those who speak English and those who do not.

The medical interpreters' narratives offer immense valuable insight for policymakers, healthcare providers, and researchers seeking to improve health equity and access to care. The disproportionate burden of illness among marginalized populations calls for policies that address social determinants of health and promote health equity. Patient autonomy is also at stake if LEP patients do not know what their rights and options are. This issue is central to debates about patient rights and shared decision-making. Policymakers and healthcare organizations should invest in interpreter recruitment, training, supervision, and support to improve the quality of care for language minority populations.

Medical interpreting is a profession fraught with challenges, complexities, and a profound sense of responsibility. While these individuals play a pivotal role in bridging language and cultural divides within healthcare, their contributions are overlooked and undervalued. From the emotional toll of witnessing patients suffering to the logistical hurdles of demanding work schedules and inadequate compensation, interpreters face a myriad of obstacles. To ensure the well-being of both patients and interpreters, it is imperative to recognize the critical nature of their work, provide adequate support, and implement measures to mitigate the stressors inherent in the profession. This includes investing in interpreter training, mental health resources, adequate breaks, and fair compensation. Additionally, fostering a collaborative environment between healthcare providers and interpreters is essential for optimizing patient care and interpreter satisfaction. By addressing the challenges faced by medical interpreters, healthcare systems can enhance the overall quality of care delivered to linguistically diverse patient populations. It is essential for those in leadership roles to gain a deeper understanding of the demands placed on interpreters to foster an environment conducive to their success and the quality of service they provide, which is, to be clear, patients.

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