

3 Conceptualizing Bilingual Health Communication: A Theory-based Approach to Interpreter-mediated Medical Encounters

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The field of interpreter-mediated interactions appears to have plateaued in terms of its theoretical development. Since the important breakthrough in recognizing interpreters as active participants in discursive events (Metzger, 1999; Pöchhacker & Shlesinger, 2005; Roy, 2000; Wadensjö, 1998), researchers have examined interpreters' visibility (Angelelli, 2004), strategic management of medical encounters (Greenhalgh *et al.*, 2006; Leanza *et al.*, 2010), and impacts on patients' health outcomes (Butow *et al.*, 2011; Flores *et al.*, 2012). What is implied in these lines of research is the recognition that interpreters influence the process, content, and outcome of provider–patient interactions. However, they do not provide theoretical explanations about how or why interpreters consciously and unconsciously influence medical encounters in one way or the other. Similarly, both researchers and practitioners increasingly emphasize the role of other speakers (e.g. physicians and patients) in interpreter-mediated medical encounters in ensuring quality of care, but little has been done to incorporate these conversational others into the theoretical conceptualization of interpreter-mediated medical encounters.

These two issues prompted me to consider interpreter-mediated medical encounters from a different angle. Rather than focusing on interpreter behaviors, I am interested in examining how these interpersonal dynamics may shape the process and content of interpreter-mediated interactions. If interpreters act as active participants in medical encounters along with at least two other speakers (i.e. the provider and the patient), researchers should conceptualize interpreter-mediated medical encounters as triadic interactions (Laidsaar-Powell *et al.*, 2013; Valero-Garcés, 2005). More importantly,

the examination of the interpreter-mediated medical encounter should explore how the participants coordinate with one another throughout the emergent and dynamic processes of cross-cultural care, responding to challenges and tensions in provider–patient interactions. In other words, the focus of our analysis should be how each participant coordinates and collaborates with one other as a communicative accomplishment during medical encounters.

It is from this perspective that I adopt a normative approach to interpreter-mediated medical encounters (Baumslag, 1998). By normative, I mean a theoretical account designed to predict and explain the meanings and evaluations of communicative responses during interpreter-mediated medical encounters. Goldsmith (2001: 515) explained, ‘One important goal of a normative theory is to provide a basis for recommendations about how communicators can achieve desirable outcomes’. Rather than focusing on the accuracy and fidelity of interpreted texts, I ask, ‘How do different participants coordinate with each other during the communicative event of provider–patient interactions?’ This approach also takes into account the variations of communicative practices and their corresponding impacts. By assuming that individuals coordinate their competing goals through communicative practices, I propose that certain practices can be more effective and appropriate than others owing to the unique values and preferences within specific contexts, including clinical contexts (e.g. end-of-life care) and sociocultural contexts (e.g. organizational hierarchy and cultural preferences). Goldsmith (2001: 518) explained:

Both speech community and speech event are defined by expectations about how communication is structured (e.g., who speaks to whom, how, in what setting, for what purposes?) and about how communication is evaluated (e.g., what is the purpose of the episode, what are the appropriate identities and relational definitions for carrying out such an episode, what values are enacted in these episodes?). Any particular individual may be more or less attuned to these expectations and the degree to which particular episodes embody these expectations may vary; nonetheless, it is possible to abstract from observed practice and from participants’ articulation of their expectations a description of the social norms that define speech communities and speech events.

Taking inspiration from Goldsmith’s normative approach (Goldsmith, 2001; Goldsmith & Fitch, 1997), I propose to ask: (a) how people should behave if they wish to achieve desired outcomes and why; and (b) how people will be evaluated when they behave in a particular way.

The meanings, significance, and processes of interpreter-mediated medical discourse in a particular context may evoke multiple and potentially conflicting goals. Following the traditions of dialectic theorists (Bakhtin, 1981;

Baxter & Montgomery, 1996; Houtlosser & van Rees, 2006), I conceptualize interpreter-mediated medical encounters within the contexts of potentially conflicting goals and the dilemmas these can create. By recognizing that each participant in interpreter-mediated encounters may have distinctive goals regarding tasks, identity, and relationships and that these goals often are: (a) implicitly coordinated between participants; and (b) mediated by an interpreter (Tracy, 2013), I explore situations in which the tensions between individuals' management of these goals are high, in order to understand how communication serves as a way to manage these competing goals.

This new approach allows researchers to ask interesting research questions regarding: (a) the meanings and functions of interpreter-mediated medical encounters within specific contexts and the potentially conflicting goals speakers may have as they seek to honor competing values such as control over the discursive processes, patient autonomy and shared decision-making, among others (e.g. providers may believe that end-of-life disclosure empowers a patient to make informed decision; in contrast, a patient's family member may argue that the act of disclosure contradicts the value of beneficence, i.e. do no harm); (b) the interrelationships among communicative behaviors that are related to individuals' management of these goals and the ways in which these form meaningful practices (e.g. the different strategies an interpreter adopts to coordinate with others to empower patient without causing additional harm during an end-of-life disclosure); and (c) the ways in which the meanings and functions of interpreter-mediated medical encounters provide an account for why certain behaviors are judged to be more appropriate and effective than others (e.g. what are the guiding values that influence a provider's or a patient's evaluation about the appropriateness and effectiveness of an interpreters' strategy?).

Goldsmith (2001: 530) explained:

A normative theory poses questions such as the following: When a social actor wishes to accomplish some purpose in a particular kind of social contexts, what are the constraints to accomplishing that purpose, what are the discursive resources that are available for addressing those constraints, and what are the evaluative criteria by which the effectiveness and appropriateness of the actor's efforts may be judged.

This line of questions presents two major shifts in research focus, moving away from the text-centered, interpreter-oriented approach to one focusing on interpreter-mediated medical encounters. The first shift is to focus attention not simply on the frequency of individual communicative behaviors (e.g. interpreter alterations or mistakes), but on the *meanings* of such practices. The end goal of a normative approach is to account for judgments that some communicative practices in interpreter-mediated medical encounters are 'better' than others. These judgments are embedded in cultural systems of

meaning and belief, including individual assumptions about the competing goals and values as well as the expected norms in managing them. By identifying the cultural systems that facilitate the interpretation and evaluation of these practices, researchers can predict why certain practices would be preferred over others. For example, by identifying providers' preferences for in-person intimacy when disclosing a poor prognosis (Hsieh, 2015), we can speculate that providers may opt for less-qualified non-professional interpreters even when professional telephone interpreters are readily available. In other words, by identifying the values that shape individuals' interpretation and drive their communicative behaviors, researchers can prescribe communicative interventions and practices that are likely to be adopted as they are consistent with the values or goals of the participants.

The second shift is to move from a linear, positivistic view in prescribing appropriate behaviors in interpreter-mediated medical encounters to an interpretive, heuristic approach to predict and explain the evaluations of behaviors as more or less appropriate and effective. My goal is not to define, identify, or regulate the particular behavior that is deemed appropriate or effective in a given provider–patient interaction in a top-down manner. Rather, I aim to explore why certain behaviors are evaluated more favorably than others by examining how well these practices adapt to the potentially conflicting values which emerge in provider–patient interactions. To understand the conflicting values to which participants in interpreter-mediated medical encounters orient, we need to identify the meanings and functions of interpreter-mediated medical encounters. To understand the wide range of communicative strategies that can be employed to respond to interactional dilemmas, we need to first identify the communicative practices within the specific contexts.

By examining the underlying values and principles that shape participants' evaluation and interpretation of communicative behaviors, we can identify some basic features of discourse that can serve as resources to address conflicting goals. Because discursive resources are often language-specific and contextually situated, this approach allows researchers to explore the socially defined contexts (e.g. linguistic, cultural, political and clinical contexts, among others) that shape individuals' evaluation and interpretation. This approach also provides opportunities for researchers to hypothesize how and why certain discursive practices are associated with situated evaluations, investigating both the correlation and the specific processes that connect these two. For example, should interpreters relay other speakers' emotions and affective attitudes in their interpretation? Why do we think it would be necessary and valuable for an interpreter to relay a providers' positive emotions and supportive attitudes when interacting with a patient? How about a providers' prejudicial comments? What are the values or underlying principles that motivate an interpreter to screen out a provider's stigmatizing attitudes (Seale *et al.*, 2013)?

A Model of Bilingual Health Communication

The normative approach to interpreter-mediated medical encounters forms the basis of my Model of Bilingual Health Communication (the BHC Model). I have reported and synthesized evidence-based findings related to the Model elsewhere (Hsieh, 2016). In this section, I will focus on delineating the theoretical aspects of the Model: (a) the individual-level constructs; (b) interpersonal-level constructs; and (c) propositions of this Model.

The individual-level constructs are factors that shape individual behaviors and evaluations of the interpreter-mediated medical encounter (see Figure 3.1). The four constructs are: Communicative Goals, Individual Agency, System Norms, and Quality and Equality of Care. It is important to note that all these constructs are applicable to all participants in the medical encounter. However, individuals' understanding, assessment and skill level for these constructs may differ. In addition, individuals may hold competing (and potentially conflicting) understanding of these constructs, resulting in tensions and challenges in interpreter-mediated medical encounters.

Communicative goals

Fundamental to the BHC Model is my assumption that interpreter-mediated medical encounters are goal-oriented communicative activities. In everyday talk, individuals hold multiple goals (e.g. task, identity and relationship goals) that are often negotiated and coordinated rather than explicitly discussed (Tracy, 2013). All participants in interpreter-mediated interactions, including the interpreter, have communicative goals. For example, an

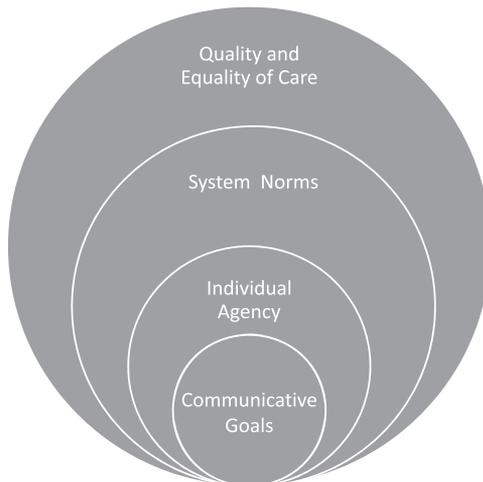


Figure 3.1 Individual-level constructs within the Model of Bilingual Health Communication

interpreter may wish to appear neutral, maintain job security or ensure the quality of care. The communicative goals can be inherent in the communicative activity but can also emerge during the dynamic discursive process. For example, although an interpreter may wish to maintain neutrality in medical encounters, the patient's lack of communicative competence may prompt the interpreter to address the imbalance of provider–patient communication by adopting a more active role in mediating provider–patient interactions.

Although individuals in interpreter-mediated interactions may share some goals (e.g. improving a patient's health), they also have unique individual goals. For example, providers may hold specific interpersonal goals (e.g. developing trust and rapport), in addition to their therapeutic goals. Individuals' multiple goals may not be compatible with one another or with others' goals. For example, patients may wish to receive Western biomedical care without giving up their cultural health practices (e.g. taking herbal medicine). On the other hand, a provider may refuse to offer treatment to a patient who insists on continuing to take herbal medicine for fear of potential interactions with the prescribed medication.

Individuals' interpretation and evaluation about the meaning and quality of interpreter-mediated medical encounters are fundamental to their understanding of their goals. A provider who wishes to show empathy with a patient may feel frustrated by an interpreter who focuses on medical information while neglecting rapport talk (Aranguri *et al.*, 2006). Finally, the ability of individuals to fulfill their communicative goals may be dependent on their and others' communicative competence as well as other contextual factors during the communicative event. For example, an interpreter may find it difficult to maintain a passive presence when a provider engages the interpreter in a conversation by asking a question directed to the interpreter (Hsieh, 2006).

In summary, although individuals are motivated to fulfill their communicative goals, they may need to reconcile their own and others' competing goals. Failure to achieve their intended goals may result in problematic outcomes (e.g. frustration, dissatisfaction and miscommunication). Nevertheless, because goals are dynamic and can be interactively constructed/negotiated, all individuals can actively collaborate and coordinate with each other to identify and fulfill each other's communicative goals.

Individual agency

Whereas communicative goals emphasize individuals' differences in their agendas, they do not address individuals' ability to fulfill those goals. In the BHC, I view individual agency as the condition needed for the fulfillment of communicative goals. I conceptualize individual agency as a socially constructed and contextually situated self that is rooted in 'everyday practices and sites that call forth and supply its meanings' (Gubrium & Holstein, 1995: 566). The meanings and functions of individual agency cannot be separated

from actors or the participants in the communicative event. From this perspective, individual agency is not just an inherent or fixed ability the human agent holds, but a quality that can be interactively negotiated and socially enacted (De Jaegher & Froese, 2009).

Why is this social constructionist approach to individual agency important to BHC? In health care settings, not all individuals have the same kinds or degree of agency. From an institutional perspective, individual agency can be shaped by power structure, institutional hierarchy, access to resources and professionalism. For example, physicians are likely to have more agency than nurses as they are at the head of a healthcare team, entitled with higher institutional power. In contrast, compared with nurses, interpreters can have even less individual agency as they do not always have an institutionalized office (e.g. interpreter services), can be outsourced to external agencies or are considered to be low-ranked or low-priority workers. As a result, a physician is likely to exert their own communicative goals over those of the interpreter when their goals conflict with one another. On the other hand, because interpreters are often trained to assume a neutral, passive presence in provider–patient interactions, they may actively refrain from intervening in the medical discourse even when they have observed problematic interactions.

At an individual level, agency is shaped by individuals' educational background, self-efficacy skills, communicative competence, emotional status and motivational relevance (Bandura, 2001). A patient with high health literacy is more likely to actively participate in the medical discourse than a patient who has minimal education and is terrified about seeking care in a cultural system that is completely foreign to him or her (Shaw *et al.*, 2009; Sudore *et al.*, 2009). Compared to a telephone interpreter who provide services at a remote location, a patient's family member is more likely to intervene in the provider–patient communication and exert their communicative goals when acting as an interpreter because s/he is more motivated to ensure high-quality care (Greenhalgh *et al.*, 2006). Physicians with low self-efficacy admitted that they actively avoided communicating with language-discordant patients (O'Leary *et al.*, 2003); fortunately, physician self-efficacy can be enhanced through training and experiences of working with language-discordant patients (Hernandez *et al.*, 2014; Thompson *et al.*, 2013).

At an interpersonal level, individual agency can be shaped by interpersonal relationships, social obligations and interactional dynamics. For example, an interpreter who is familiar with and trusted by the provider is likely to have higher individual agency to pursue his or her communicative goals than an interpreter who does not know anyone in the clinic. A family member acting as an interpreter may feel obligated to insist on specific ways of communication (e.g. do not disclose a poor prognosis to the patient) than a professional interpreter. An interpreter may become more aggressive in seeking information upon a patient's request (e.g. 'I don't know what questions to ask. Can you help me? Ask whatever is important').

Finally, it is important to note that individual agency also can be challenged. For example, a provider may ask an interpreter to interpret only what the patient has said and not to add additional personal opinions when conducting interpreting, which is consistent with the default interpreting model in interpreter training (i.e. interpreter-as-conduit). An interpreter may inform a provider that a particular line of questioning is culturally inappropriate and unlikely to get a truthful answer from the patient. Although individual agency is about individuals' ability and willingness to assert their communicative goals, the appropriateness and effectiveness of individuals' enactment or embodiment of individual agency is still subject to others' evaluation.

In summary, I view individual agency as a necessary condition for individuals involved in a medical encounter to pursue their communicative goals. Individual agency can be inherent in institutional structures (e.g. as a part of institutional hierarchy) as well as individuals' skills and competence. However, it also can be socially constructed (e.g. compromised, enhanced, negotiated, and resisted) through interpersonal interactions. A successful communicator can leverage others' support and contextual factors to gain more individual agency; in contrast, a less successful communicator may fail to utilize the resources available to maintain their individual agency.

System norms

System norms move the understanding of interpreter-mediated interactions beyond the examination of individual performances and behaviors to a larger context. Each individual in interpreter-mediated medical encounters assumes certain roles, functions, and behaviors under the influences and frames of the system(s). I view the system as social systems and cultures, in which there are specific norms, values, and worldviews that are imposed upon individuals within the system. In other words, individuals interpret meaning through the system to which they subscribe. From this perspective, we can argue that providers are within the culture of (Western) medicine, in which there are specific views about conceptualizing health and illness (e.g. principle of verification, germ theory and Cartesian dualism) that make a patient's cultural illness ideology (e.g. an illness caused by spirits stealing one's souls) incompatible if not incomprehensible.

System norms guide the behaviors of individuals within the system. For example, because professional interpreters are trained to value neutrality and to view the provider–patient relationship as the primary relationship in medical encounters, they adopt specific behaviors (e.g. interpreting in first-person style and avoiding eye contact with others) in an effort to minimize their presence during the interpreter-mediated medical encounters. A provider expects to assume the leading and controlling role in provider–patient interactions as they are trained to take charge of the flow of medical discourse. From this perspective, individuals' behaviors almost always are coherent and

consistent within the meaning structure of the system. In fact, when individuals fail to observe system norms, they are often made aware of their violations through social sanctions.

However, because not all individuals share the same system, participants in bilingual/cross-cultural medical encounters may experience problematic interactions. For example, a provider may have a hard time understanding why an interpreter insists on avoiding eye contact when providing interpreting services or why a patient continues to complain about haunting spirits when seeking biomedical care (Hsieh, 2006, 2010). Miscommunication can arise as a result of competing systems.

Because individuals in interpreter-mediated medical encounters are not necessarily regulated by the same systems and the systems involved may not be compatible with each other, individuals may struggle to: (a) identify the systems at play during the medical encounter; and (b) prioritize and negotiate the system that gives meaning to the current interaction. For example, a patient may choose to ignore a provider's treatment recommendation if s/he believes the provider has failed to provide an accurate diagnosis. However, a provider can contact child protective services and take away a pediatric patient from a parent if s/he suspects that the parent has endangered the child by providing substandard care (Fadiman, 1997). In other words, not all systems are of equal footing (e.g. some systems may have higher institutional, legal or moral hierarchies than others). Although the parents are considered dutiful parents in their own ethnic culture, a physician using the biomedical system to identify parents' failure in providing proper dosing for treatment can access the legal system to exert his/her control not just over the minor patient's illness experiences but also the parents' control over the child. Miscommunication owing to incompatibilities between systems can result in problematic outcomes, including intense conflicts.

The identification and prioritization of systems may prompt individuals to ignore or overrule other participants' needs and preferences. For example, although attending to patient preference is an important component in patient-centered care, a provider may decide that the legal obligation for informed consent supersedes a patient's family members' preferences about end-of-life disclosure. In other words, by aligning oneself with a system of higher power/value (e.g. the legal system supersedes the healthcare system), a person may feel legitimized to adopt behaviors that override the values of other systems (e.g. imposing informed consent against patient or family member preference). Similarly, when an interpreter prioritizes institutional goals (e.g. conserving limited resources and maintaining organizational ethics) over interpreter neutrality, an interpreter may choose to editorialize other participants' narratives and thus act as an institutional gatekeeper (e.g. keeping a patient's interview narrative on-track to avoid 'wasting' a physician's time; Davidson, 2000) or as a moral mediator to ensure the quality of care (e.g. omitting a nurse's stigmatizing comment to protect a patient; Seale *et al.*, 2013).

Finally, although all systems have their internal values and structures, systems can also be adaptive to changes as well as influences and impositions from other systems. Granted, not all systems are equally adaptive. For example, the legal system is much more rigid because any changes require legislative efforts to modify laws and regulations. However, a provider who originally subscribed to the values and norms of a biomedical system may become increasingly aware and even appreciative of the patients' cultural understanding of their illness. In fact, the ability of providers to incorporate patients' cultural worldviews in the treatment process is essential in gaining patient compliance and improving health outcomes (Dutta, 2007; Dutta & Basu, 2007). This does not mean that the provider abandons his/her original system norms. Rather, the provider learns to integrate two different systems by developing skills to communicate with the patient, using the system norms that construct meanings and guide behaviors for the patient. In cross-cultural care, an interpreter is presumed to be aware of such diverging system norms that guide both the provider and the patient's understanding and behaviors of the medical encounter. As a result, interpreters are encouraged to serve as cultural brokers in cross-cultural care (Butow *et al.*, 2012; Dohan & Levintova, 2007).

What happens when individuals' system norms conflict with one another in interpreter-mediated medical encounters? Which system gets to be prioritized over other systems? Within the context of the BHC model, answers to these questions come from a higher guiding value for provider-patient communication and cross-cultural care: quality and equality of care.

Quality and equality of care

I list Quality and Equality of Care as the overarching value for the BHC Model. While in the literature, quality of care and equality of care have been identified as two separate values, I view it as an integrated value under the BHC Model. Quality of care cannot exist without equality of care for marginalized and underserved populations. Although Quality and Equality of Care can be a communicative goal when applied in context, it also serves as an all-encompassing value that integrates differences between systems, providing the ultimate value that guides the adjudication of competing systems. In other words, when participants in an interpreter-mediated medical encounters experience conflicts owing to competing or conflicting system norms, they rely on the guiding value of Quality and Equality of Care to resolve their differences.

Traditionally, quality of care has been conceptualized using three components: structure (i.e. the organizational factors that define the healthcare system under which care is provided), process (i.e. the clinical and interpersonal care given to the patient) and outcomes (i.e. consequences of care) (Donabedian, 1980). Individuals' quality of care can be evaluated through their access (i.e. whether individuals can access healthcare structures and

process of care which they need) and effectiveness (i.e. the extent to which care delivers its intended outcome or results in a desired process, in response to needs) of structure, process and outcomes (Campbell *et al.*, 2000). Within the BHC model, I am particularly interested in process as an indicator of quality care. Interpreters are essential to ensuring access (e.g. making information and resources available to patients) and effectiveness (e.g. allowing providers to provide culturally sensitive care to achieve optimal outcomes) of clinical and interpersonal care, in which patients and clinicians rely on interpreters to communicate needs, coordinate tasks, and perform identities (e.g. an interpreter may adopt a supportive tone when interpreting to highlight the provider's friendliness).

I recognize that quality of care can be a cultural (and system) construct (Harmsen *et al.*, 2008). Individuals from different systems are likely to define and perceive quality of care differently (Campbell *et al.*, 2000). For example, for Jehovah's witnesses, not accepting blood transfusions even in life-or-death situations is essential to their faith and, thus, does not constitute a threat to quality of care for them. A Chinese patient may consider Chinese food therapy (i.e. consuming food that has specific medical effects) to be a dietary health practice that defines his/her cultural identity and cannot be separated from his/her everyday life (Kong & Hsieh, 2012). Quality of care cannot be separated from one's understanding of their well-being, which is always culturally and socially situated (Ryan & Deci, 2011; Williams *et al.*, 2011). There is a possibility that a patient, a provider, and/or an interpreter do not share the same understanding of quality of care.

In fact, some bioethicists have argued that imposing Western biomedical values on patients who do not share the same values can be problematic, if not unethical (Ho, 2008). For example, European American and African American patients were more likely to view truth-telling as empowering, enabling the patient to make choices; in contrast, Korean American and Mexican American patients were more likely to see the truth-telling as cruel, and even harmful, to the patients (Blackhall *et al.*, 2001). The differences in the functions and meanings of 'truths' in various communities can result in diverging practices. For example, Korean American and Mexican American populations are more likely to shelter patients from information about a poor prognosis and adopt a family-centered model of medical decision making; in contrast, European American and African American populations are more likely to emphasize individual autonomy and informed decision-making of the patient (Blackhall *et al.*, 1995). If a physician insists on disclosing a poor prognosis to a Korean American or Mexican American patient despite his/her family's objection, the physician is likely to increase the patient's suffering and distress, potentially causing disruption in the patient's social network. Such practices ignore the cultural meanings, functions, and practices of truth-telling.

In cross-cultural care, interpreters are faced with challenges regarding cultural differences with regard to disclosure practices and information

management, which are fused with meanings about identity and relationships. For example, in Chinese culture, if a son fails to assume the responsibilities of information management for the parent as patient (e.g. seeking information about treatment options or concealing information from the patient), he may face public criticism that he is inadequate as a son (Muller & Desmond, 1992). On the other hand, if a Chinese father gives permission for his son to take over the responsibilities of information management and to be a proxy decision maker (e.g. making decisions about treatments), the father is demonstrating his commitment to his family and community (Ellerby *et al.*, 2000). Rees and Bath (2000) found that, when mothers with breast cancer withheld information from their daughters, it often was motivated by their identity as a mother because they wanted to protect their daughters. Miller and Zook (1997) noted that AIDS patients' care partners negotiated and legitimized their roles through actively seeking information from physicians. Therefore, information management in a family is not just about patient autonomy but also about family members' identities as part of the family (Blackhall *et al.*, 2001). Failing to respect these cultural meanings of health practices can result in major disruptions in patients' well-being. From this perspective, quality of care cannot be achieved without considering the cultural construction and meanings of patients' sense of well-being.

For marginalized and underserved populations, including language-discordant populations, quality of care cannot be separated from equality of care (Aligning Forces for Quality, 2010). For the BHC model, I define equality of care as the extent to which the language-discordant populations share comparable access to and effectiveness of care as language-concordant populations. More importantly, equality of health is 'conditional upon a respect for personal preferences [or in medical ethics, the principle of 'autonomy'] and upon a prohibition on reductions in current health' (Culyer & Wagstaff, 1993: 455). From this perspective, like quality of care, equality of care is not beyond the influence of system as individual preferences are often shaped by their cultural norms.

In reality, all participants in interpreter-mediated medical encounters often need to manage a potentially delicate and complicated balance between personal preference and health outcomes. Despite the fact that Quality and Equality of Care cannot escape the influences of (cultural) systems, individuals within different systems can learn to recognize and acknowledge the transcending values of Quality and Equality of Care. For example, a provider can recognize and respect a parent's desire to provide the best care for his/her child, despite their disagreement on the treatment procedures. Similarly, interpreters can educate providers, patients, and their family members about the cultural differences in the meanings and functions of truth-telling in end-of-life care, allowing all participants to become aware of other participants' legal obligations and social needs. Rather than advocating universalistic values of quality of care (Beauchamp, 2004), I propose that individuals from different (cultural) systems can generate an integrated value of Quality

and Equality of Care. Because the participants are from different cultural systems, the values they bring to the integrated value meta-system may not always be compatible or consistent with each other. Different groups of participants may agree on different definitions of Quality and Equality of Care depending on the situational/interactional contexts. As a result, what really constitutes the integrated value of Quality and Equality of Care is not a fixed value. Rather, it is constantly co-constructed and negotiated among multiple parties and is meaningful and appropriate at the particular point in time and place. All participants should collaborate to develop a prioritized list of diverse values, accessing resources to strengthen their claim and control over the definition of Quality and Equality of Care.

In summary, I view Quality and Equality of Care as a value system that guides the practices of all involved in interpreter-mediated medical encounters. The value is not a fixed, preexisting, or universal value. Rather, it is contextually situated, interactionally managed, and locally defined in the communicative process (i.e. the meanings of Quality and Equality of Care are shaped by the contexts in which participants negotiated its meanings during their social interaction that is situated in a specific time and place). Nevertheless, it allows individuals with competing systems to acknowledge others' perspectives and forces all participants to subject themselves to the meta-value of Quality and Equality of Care that is co-constructed by all involved in the medical encounter.

Interpersonal-level constructs within the model of bilingual health communication

Whereas individual-level constructs shape individual behaviors and evaluations of the interpreter-mediated medical encounter, interpersonal-level constructs delineate the dimensions through which these individual-level constructs operate. Based on the literature and my own research, I have included two interpersonal-level constructs: (a) Trust–Control–Power; and (b) the Temporal Dimension.

Trust–Control–Power

Trust–Control–Power has been identified as a major theme in bilingual health care. This dynamic can exist at the micro, interpersonal level of provider–patient–interpreter interactions and at the macro, system/cultural level of healthcare institutions and the society at large (Brisset *et al.*, 2013). By recognizing interpreters' active role in bilingual health care, recent studies have highlighted the importance of *relational contexts* (e.g. interpersonal trust and therapeutic alliances) in shaping providers' and interpreters' collaboration with each other (Gray *et al.*, 2011; Hsieh *et al.*, 2010; Robb & Greenhalgh, 2006). In addition, providers and interpreters often compete for control over the communicative process by monitoring others' performance,

setting boundaries of time, space and content of provider–patient interactions, and adopting specific verbal and nonverbal strategies to control others' behaviors (Hsieh, 2010; Mason & Ren, 2012; Zimányi, 2013).

Trust–Control–Power as a dimension shapes how participants negotiate the various individual-level constructs with respect to one another. For example, when individuals have diverging communicative goals, individual agency or system norms, who gets to control the provider–patient interaction? Does the person with the most power get to control the interaction? What kinds of power? The provider has legitimate power (i.e. institutional hierarchy) and expert power (i.e. medical expertise); in contrast, the interpreter has expert power with regard to language and culture and the informational power, as they control the content and process of communication through their interpretation (Mason & Ren, 2012; Nugus *et al.*, 2010; Raven, 1993). On the other hand, the patient has reward power (e.g. offer more business through repeated visits) and coercive power (e.g. threats of terminating provider–patient relationships) as they can always choose to find a different provider if the provider fails to respect the patients' request to use a family interpreter, who maintains social power with the patient through long-term relational trust. In other words, Trust–Control–Power is not fixed; rather, it is constantly enacted and resisted in the communicative process.

From this perspective, Trust–Control–Power as a dimension reflects individuals' efforts and competition in defining their interactional (and professional) boundaries. This can be particularly tricky in cross-cultural care because the boundaries of medicine, language, and culture are often overlapping and blurred because patients' illness experiences cannot be separated from their culture or language. For example, a Chinese male patient may use the term '腎虛' (pronounced shenshu) to describe his illness, which literally means 'weak kidney' in English. However, for male patients, this term can be used to describe various symptoms, including bodily coldness, poor memory, defective cognition, palpitations, dizziness, premature ejaculation, poor erectile function, back pain, and urinary frequency and weakness (Hinton *et al.*, 2005). Patients' understanding of their illness and illness symptoms are situated in their lifeworld (Lo & Bahar, 2013; Todres *et al.*, 2007), which is infused with their cultural beliefs, social experiences, and folk ideologies. As interpreters assist in cross-cultural care, they inevitably need to tread on the boundaries of medicine as they bridge the blurry boundaries of medicine, language, and culture. Despite the providers' claim and power over medical expertise, they face challenges in sharing their control over the process of care and meanings of medicine with interpreters in cross-cultural care.

In addition, trust, control, and power are interdependent and intertwined. For example, as an interpreter develops more trust with the provider, the interpreter is able to have more power to control the process and content of provider–patient interactions (Hsieh, 2010). On the other hand, when a provider adopts a utilitarian view of interpreters' roles and function (i.e. treating

an interpreter as a utility to be wielded at the will of a provider), interpreters' relationships with patients can be viewed as resources to be exploited for therapeutic objectives (Hsieh & Kramer, 2012). In other words, even interpreters' goals and relationships are subject to providers' control.

Temporal Dimension

Time is a theoretical dimension (e.g. how time affects the ongoing relationships and the quality of care in interpreter-mediated medical encounters) that has rarely been discussed in the literature of bilingual health care. This can be partially attributed to the conduit model of interpreting, in which interpreters are often viewed as translation machines. If interpreters are no more than conduits, providing mechanical and faithful relay of information from one language to another, time would not make any difference in the quality of interpreting or the quality of care. After all, a good hammer remains the same tool, regardless of the time elapsed. A user is unlikely to develop a closer bond or relationship with a certain tool, resulting in different usage patterns when using an old machine versus a new one. In short, in the traditional literature of healthcare interpreting, the Temporal Dimension in interpreter-mediated health care is irrelevant and thus undertheorized. Nevertheless, we know that even the analogy of a hammer is problematic. Even with a tool as rigid as a hammer, we do become more comfortable with the one we have grown accustomed to using. We learn its unique characteristics and develop tricks that make the specific hammer work better in different situations.

However, when researchers and practitioners do consider the temporal dimension in interpreter-mediated interactions, time is often perceived to be an enemy, a point of human weaknesses, of interpreter-mediated medical encounters. For example, the Temporal Dimension of interpreter-mediated health care makes it possible for interpreters to develop relationships with their clients, making them susceptible to the corruption and pressure of interpersonal relationships. Traditionally, the industry has developed specific strategies to prevent potential problems as a result of the Temporal Dimension of interpreter-mediated health care. For example, to avoid interpreter–patient bonding, some interpreting agencies establish internal rules to minimize repeatedly pairing the same interpreter with the same patient. In contrast, there seems to be less anxiety about and no internal rules against pairing the same interpreter with the same provider. In fact, recent studies have suggested important benefits when the provider–interpreter pair can develop effective patterns of collaboration over time (Hsieh *et al.*, 2010). I am intrigued by the tensions within the normative assumptions: time as a point of corruption to the patient–interpreter relationship versus a point of enhancement to the provider–interpreter relationship. It is possible that such tensions in thinking about the impacts and functions of time reflect an emphasis on institutional control (e.g. prioritizing providers' control and needs over that of patients) in healthcare settings.

Time is an important dimension in any system. Most systems are open systems that develop adaptive changes in response to outside influences as well as internal tensions. Because interpreter-mediated provider–patient interactions simultaneously involve several different systems, each of which entails its own unique values and norms, the participants are likely to face tensions, challenges, and conflicts owing to the diverse systems, including practices and values, in play. However, time as a dimension makes integrations of diverging systems possible, at the individual, organizational, and even cultural levels. For example, interpreters intentionally develop a particular way of speaking (e.g. first-person interpreting styles and avoiding eye contact when interpreting) to systematically reinforce the provider–patient relationship and to claim an invisible role (Hsieh, 2009). For a person who is not aware of the meanings of such practices, interpreters’ performance may appear strange, rude or even disruptive. Because of the institutional pressure to conserve providers’ time, interpreters often feel that they do not have sufficient time to educate providers about their specialized practices (Hsieh, 2008). However, when a provider learns the meanings and functions of such practices in an interpreter’s speech community, a provider may come to appreciate the interpreter’s performance (Hsieh, 2010).

Similarly, time makes it possible for people who are initially unfamiliar with each other’s behaviors and intentions to develop rapport and trust, allowing them to be more flexible and adaptive to each other’s needs and expectations. For example, as physicians become more familiar with patients’ cultural values, they may be more willing to modify their communicative practices to accommodate patients’ needs. This is the basis of interpreters’ role as a cultural broker. We assume that, as participants in interpreter-mediated medical encounters become more knowledgeable about different cultural norms and values, all will become better at understanding and interacting with one another.

It is important to note that recent literature on acculturation has demonstrated that individuals are unlikely to abandon their own cultural values once they become familiar with or even adaptive to the new cultural practices (Kramer, 2013; Wade *et al.*, 2007). Rather, individuals tend to develop layers of consciousness and pluralistic approaches to managing different areas of life. Time does not make a person forget or abandon his or her original cultural norms. Several studies have demonstrated that acculturation level does not predict individuals’ health practices in abandoning prior health beliefs and health practices (Ma, 1999; Wade *et al.*, 2007); rather, interactions between systems allow individuals to develop multiple repertoires. For example, a Chinese patient may prefer to adopt a biomedical model for acute conditions but rely on traditional Chinese medicine for chronic illnesses (Chung *et al.*, 2012). An American physician may welcome shamanistic practices for patients’ spiritual well-being but feel strongly about ensuring accurate medication and dosing practices (Brown, 2009).

Finally, rather than painting a rosy picture of time as a theoretical dimension, researchers also need to recognize that, without meaningful interactions, time may perpetuate miscommunication. For example, patients may become increasingly agitated when a provider fails to acknowledge or accommodate their cultural practices and values after repeated interactions. Such feelings may prompt a patient to avoid care and minimize interactions with clinicians. When a problematic performance by an interpreter becomes an institutional cautionary tale shared among healthcare providers over time, there can be increasing distrust of all interpreters that may result in widespread distrust for inter-professional collaboration within the organization (Hsieh *et al.*, 2010). In short, the Temporal Dimension within interpreter-mediated health care does not guarantee improved interactions over time.

Propositions of the Bilingual Health Communication Model

By adopting a heuristic approach, I have sought to generate a theoretical framework for conceptualizing interpreter-mediated medical encounters as interactive, goal-oriented communicative activities that are situated in the larger communicative event of provider–patient interactions. In addition, the BHC model presumes that Quality and Equality of Care is a shared value that guides all participants' interpretation of and practices in interpreter-mediated medical encounters.

Given the individual-level and interpersonal-level constructs proposed in the BHC Model, I propose the following general propositions that guide the understanding and assessment of interpreter-mediated medical encounters:

- (1) Successful BHC is dependent on the ability and agency of individuals to negotiate and adapt to competing and/or emerging goals. Moving away from the focus on interpreter performance, this proposition views interpreter-mediated medical encounters as a collaborative achievement among all participants.
- (2) Evaluation of the appropriateness and effectiveness of the strategies used by interpreters requires considerations for their corresponding short-term and long-term impacts. One strategy may have desirable short-term impacts in clinical care but entail problematic consequences for long-term provider–patient trust.
- (3) The desired interpreting style is dependent on contexts. Rather than adopting a positivist stance in pursuing the ideal interpretation through equivalences between two languages, the BHC Model acknowledges that several contexts are essential in participants' understanding of and preference interpreter-mediated interactions and interpreters' performances. These contexts can include but are not limited to the clinical, interpersonal, and sociocultural contexts.

Conclusion

A successful interpreter-mediated medical encounter is a coordinated achievement among all participants involved. By recognizing that the communicative process, meanings of an illness event, and even the quality of care are socially constructed, the Bilingual Health Communication Model provides multiple opportunities and entry points for theory development and practice implications.

The best practice for interpreter-mediated medical encounters is not a fixed formula that can predict standardized results. Rather, optimal interpreter-mediated encounters take place when all participants are able to appropriately and effectively identify and negotiate their communicative goals, exercise individual agency, acknowledge differences in their normative expectations *and* find ways to generate compatible, if not shared, understanding of Quality and Equality of Care. The best bilingual health communication does not rely on the interpreter to do a perfect job; rather, it counts on all individuals to be problem-solvers, adopting flexible and adaptive strategies to meet the challenges emerged during the communicative process of cross-cultural care.

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