TOWARD CULTURALLY SENSITIVE MEDIATION: INTERCULTURAL TRANSCOMPETENCE IN SPANISH MEDICAL INTERPRETING

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Standard RI.01.01.01 involves the respect, protection, and promotion of patient rights. It dictates that hospitals must have written policies on patient rights, that hospitals inform patients of those rights, that written translations of those rights be made available in common languages, and that staff treat patients accordingly. It instructs hospitals to be respectful of patients’ cultural and personal values, religious and spiritual beliefs, and right to privacy.

The New Joint Commission Standards for Patient-Centered Communication

Language barriers represent only one dimension of effective communication with immigrant or refugee patients. Cultural norms governing the structure and content of discourse in medical encounters are also vitally important. Beliefs and expectations concerning ‘appropriate’ discourse in medical interactions—what is discussed, the timing of the conversation, who is present at the conversation, who participates in the discussion—influence deliberation over ethical issues such as disclosure of medical information and confidentiality.

Handbook of Immigrant Health, 211

I. Introduction

Lia Lee was a Hmong child with epilepsy – a condition known in her culture as “kow da pay,” or The Spirit Catches You and You Fall Down. Lee’s family believed in shamanistic animism, which interpreted the seizures as the ability to enter the spirit realm, and thus is an honorable condition. There is no Hmong word for seizure, and the family would describe something evil and otherworldly tampering with the girl’s soul. The traditional cure is to have the soul rejoined to the body; the Hmong community thus rejects invasive medicine, and holds such beliefs as ‘American doctors eat brains.’ Family relatives were used as interpreters
in this case; the girl’s parents were considered ‘non-compliant’ because they could not understand the medical prescriptions. They could not breach the cultural barrier. The child, Lia, eventually went into a vegetative state for twenty-six years. (Based on Fadiman)

Be careful how you ask women questions. Asking a Latino/Hispanic woman where she spent the night (to determine homelessness) could be offensive. It suggests sexual promiscuity, which is taboo in her culture. Ask someone from the Spanish-speaking community how to phrase this question in the least offensive way. (‘Health Care for the Homeless Clinician’s Network,” *Paso a Paso*)

Tales of communication breakdown, actual and potential, tend to involve emergent care, medical malpractice settlements, systematic and prolonged abuse, cultural impasse, and even death. Lia Lee’s case above has much to teach the interpreter trainee and trainer, but I would submit that awareness raising of the *everyday* interactions (see the patient interview item example below it) not only can prevent the more dramatic cases of cross-cultural pragmatic failure,¹ but in fact such cases, carefully considered, often stem from patterns of neglect of simple principles of cultural competence. Cultural (in)competence affects health outcomes, patient satisfaction, access to care, health equity and equality, and patient safety (medical error). Many of these factors are heavily impacted by barriers—personal, linguistic, financial, racial, institutional, and cultural—which affect the medical encounter with Limited English Proficiency (LEP) Latino patients in the United States.²

This study considers the dimension of intercultural competence in Spanish Medical Interpreting. I attempt to map medical interculturality as a transcompetence (spanning other competences) in graduate and undergraduate training and education. The work will explore: What constitutes intercultural competence in healthcare, what principles justify its inclusion in the language mediation curriculum, and what strategies and procedures may be effective in its teaching and learning? Other models locate the intercultural skill cluster as part of the medical interpreter’s “interactional competence,” in Angelelli’s term, a multicompetence embracing cognitive processing, interpersonal skills, linguistic proficiency, professional knowledge, setting-specific awareness, and sociocultural skills (*New Approaches* 25-6). Building on cross-cultural components set forth in the nascent literature, I seek a more comprehensive theorization of the medical interpreter’s sociocultural skills (which I will broaden to include knowledge, skills, abilities and attributes), a detailing of their role in the student’s cognitive maturity (toward ethnorelativism and acculturation), and an explanation of how interculturality fits in the model of integrated skill-building. Culturally appropriate medical interventions will be inserted into their wider legal and ethical situationality, including as a function
of organizational cultural competence. Medical contexts relevant to our discussion include primary care clinics, migrant health centers, farmworker programs, emergency response, telephonic and video interpreting, health education and promotion, palliative care consultations, disaster response, mental health, insurance interpreting (medical-legal interpreting), and hospice care.

The goal of intercultural expertise, I will argue, is for the student to assist as a partner in providing more culturally sensitive treatment and services in multiple environments—occupational, environmental, social, and behavioral health—and ultimately, meaningful access to care. The rise of transcultural nursing, global health, medical anthropology, the medical humanities, and cross-cultural medical ethics all are concomitant with the sharpening profile of the medical interpreter as an allied health partner enacting increasingly professionalized roles.

The shift from disease-centered to patient-centered care in recent decades (Dreachslin et al. 123) parallels in many respects the transition in education from content-centered to student-centered learning, especially in the active participation of both patients and learners in their own care and learning, respectively. In another sense, a patient is a learner (as is the provider), and the interpreter a co-learning partner in the therapeutic alliance. Both of these shifts point to a democratization of access of one kind or another. The view of the patient followed here, and thus for a Spanish for Special Purposes academic environment, coheres with the assumptions behind humanistic health care: that a person is a “unique, interdependent relationship of body, mind, emotions, culture, and spirit” (Reed and Sanderson 42).

II. Cultural Competence and Critical Consciousness

Intercultural sensitivity is not natural. It is not part of our primate past, nor has it characterized most of human history. Cross-cultural contact has often been accompanied by bloodshed, oppression, or genocide. Education and raining in intercultural communication is an approach to changing our ‘natural’ behavior.

Milton J. Bennett

Cultural competence in health care has been defined as “the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy” (Lavizzo-Moury and MacKenzie 919).

Byram (91-101) lists the following assessment criteria for intercultural communicative competence, which in turn can serve as intercultural competence course goals:
1. Attitudes (*savoir être*) [saber hacer]: curiosity and openness, readiness to suspend disbelief about other cultures and belief about one’s own;

2. Knowledge (*savoirs*) [saberes]: of social groups and their products and practices in one’s own and in one’s interlocutor’s country, and of the general processes of societal and individual interaction;

3. Skills of interpreting and relating (*savoir comprendre*) [saber comprender]: ability to interpret a document or event from another culture, to explain it and relate it to documents or events from one’s own.

4. Skills of discovery and interaction (*savoir apprendre/faire*) [saber aprender/hacer]: ability to acquire new knowledge of a culture and cultural practices, and the ability to operate knowledge, attitudes and skills under the constraints of real-time communication and interaction.

5. Critical cultural awareness (*savoir s’engager*) [saber participar]: an ability to evaluate, critically and on the basis of explicit criteria, perspectives, practices and products in one’s own and other cultures and countries.

Ultimately we can characterize the teaching and learning of medical interpreting as the integration of different kinds of *savoirs* into a relational knowledge at once interpersonal and comparatist. As Dean and Pollard have rightly noted, interpreting is not a rule-based technical profession but a practice profession in which ethical-social contexts and skills help determine one’s performance. Along similar lines, in their work on training physicians, Kumagai and Lypson argue that working toward competence instead of something more evolving and dynamic, mischaracterizes the epistemology of given cultures as fixed entities:

* Cultural competency is not an abdominal exam. It is not a static requirement to be checked off some list but is something beyond the somewhat rigid categories of knowledge, skills, and attitudes: the continuous critical refinement and fostering of a type of thinking and knowing—a critical consciousness—of self, others, and the world. (783, emphasis in original)

This lifelong education toward competency reminds us not only of the unwritten and often elusive nature of knowing the other, but, as Kumagai and Lypson underscore, also of the link between interpreting and activism, that is, as an unfolding of a critical consciousness. Invoking Paulo Freire’s term in an interpreting context helps us frame information asymmetries as power differentials and injustices everywhere manifest in the health care system.
A recent counterproposal to the concept of cultural competency and its perceived limits or simplifications is the notion of cultural humility. Tervalon and Murray-García:

Cultural humility is proposed as a more suitable goal in multicultural medical education. Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations (117).

Cultural humility offers us the insight that, underlying any possible model, even preceding skill-building, is the disposition of mind to work toward provision of care for LEP patients that is of the same quality as that of English-dominant speakers.

III. Cultural Components of Health Care

III.A. Anglo-Hispanic clinical communication

Purnell’s model offers a core of awareness-raising aspects that may hinder the cross-cultural medical encounter unless certain communication features are transculturated:

*Communication* includes concepts related to the dominant language and dialects; contextual use of the language; paralanguage variations such as voice volume, tone, and intonations; and the willingness to share thoughts and feelings. Nonverbal communications such as the use of eye contact, facial expressions, touch, body language, spatial distancing practices, and acceptable greetings; temporality in terms of past, present, or future worldview orientation; clock versus social time; and the use of names are important concepts (195).

Cultural diversity training, if it is to be effective in medical education and medical interpreting, must take into account the phenomenon of language preference. Some patients, moreover, may be able to speak English but under stress may speak the non-English language of habitual use or mother tongue. Imperfect mastery of the *source* language is also often overlooked in working with LEP patients. Providers and interpreters may be called on to work directly or through relay interpreting with patients for whom Spanish is a lingua franca in their native country; such is the case with Mixtecs, Zapotecs, Triquis, Chatinos, Chinantecos, Purepechas, Nahuatlts, and Mayas who have migrated to the U.S. (Pérez et al 128). Cases arise in which the equation of
‘Mexican’ with ‘Spanish-speaking’ have had dire consequences; one man, Adolfo Ruiz-Álvarez, was committed to a mental hospital on the assumption the indigenous-language speaker was insane. He simply did not understand the Spanish with which they tried to communicate with him (Holmes 131).

Temporality—the lived metaphor of ‘time is money’ in medical culture confronting Latinos’ polychronic time use—can bring incommensurate views of treatment, of continuity of care, and of information management, into tension. A midwife in a migrant clinic describes her frustration with migrant farmworkers’ generality in their location of time and space, their disinclination to want to be specific and quantify. [...] I don’t know if you’ve tried to get a history out of somebody, “How long has this been bothering you?” or “Where does it hurt?” or “What can you tell me about your problem?” [...] Almost to the person, no matter how long you have known them, you are going to get something that is very vague, like, “A while ago, it kind of hurts here, it feels like vaguely aching,” typically minimizing the symptoms. (Holmes 137)

Compounding this tendency is the poor record-keeping attendant on migratory and seasonal workers’ frequent relocations. Hibbeln observes that most migrant farmworkers never know the names of the pesticides to which they have been exposed (176), and thus aggregate data on the population often is as scant as medical histories may be for individuals.

There is another factor, directness of speech, which ranges on a cline, and which may frustrate time-pressed American medical providers. As interpreters have been known to cut off the patient (an ill-advised and presumptuous imposition), we should emphasize that patients’ verbal indirection may be a bid to establish all-important confianza [intimacy and trust] at the same time it may be an emotional avoidance of taboos:

“Have you had any problems with your joints?” can lead to something like “Well, I’ve been having a little pain in this hip for a few days now, since we went to visit my brother, who lives in New York, and has a big house, and with the kids and everything, I was so busy all the time.”

(Trabing and Metivier F2)

The work of Hofstede gives us tools for seeing and describing the power distance that can often obtain between the Latino patient and medical personnel, the latter of whom may be held to be unimpeachable authorities to be pleased (or at least not displeased): “People who were socialized in collectivistic, hierarchical cultures have probably learned not to disagree in public, and people from feminine [by which the author means cooperative] cultures can disagree but cannot use a confrontational style” (98). Hofstede
calls this avoiding *affective dissonance*. Even asking questions is sometimes avoided for fear of disrespecting.

Another factor, one barely registered in the research, must be emphasized, namely that many Hispanophone patients are intimidated by the false fluency of quasi-bilingual providers and wish to simplify or limit their interactions with them: “Providers who speak Spanish, but not proficiently enough for good communication, may think they are appropriately communicating when they are not and their patients may not feel comfortable asking for clarification” (Kingsley and Bandolin). False fluency, a self-monitoring problem, usually takes the form of not knowing one has invented a term, but we might easily extend the meaning to not knowing one has misunderstood. This phenomenon should not discourage medical providers from learning medical Spanish; they should, however, recognize their limits, or in theoretical terms, move from unconscious incompetence to conscious incompetence, as semi-bilingualism is an inefficiency especially when trained interpreters are available. It is far too easy for a staff member with middle-intermediate-level proficiency to confidently hear fatiga as tiredness, when in fact it may refer to ‘shortness of breath’ or ‘asthma’ (Bigby et al. 85). To give another example, some Spanish speakers are put off by hospice care when it is described as hospicio rather than cuidados paliativos: the hospicio to many calls up the idea of an orphanage or institution where family members are abandoned. Common words often have a primary or secondary regional meaning that takes years of linguistic and cultural proficiency-building. One such word is encamado: many Spanish Americans use this term to mean ‘bedridden’; the Mexican patient may be referring to being hospitalized. And when a provider asks through an interpreter “¡Son gemelos?” to a new mother, the meaning of the reply, “No, son cuates,” that must come through is: No, they aren’t identical twins, but fraternal. Will the partially fluent provider know whether a patient has had a previous pregnancy, given that many Latinas will not consider a partial term abortion to be a pregnancy? And how many will know the reproductive health euphemism, “Mi esposo me cuida” [lit., My husband takes care of me]? On a primary care intake form, the novice to intermediate speaker knows cerveza and knows vino, but how many know that not all Spanish speakers will consider them both to be alcohol? These are matters of client education: falsely fluent dialogue masks its own miscommunication with fluid, but not linguistically and culturally fluent, language. Observe how the American provider may have the best intentions, but is using his or her own misplaced egalitarianism in calling a patient “Pedro” whose cultural value of respeto leads him to expect to be called “Señor Gutiérrez.”
III. B. Cultural Factors that Affect Health Care

Some key cultural factors affecting health care will provide a framework for discussing the interpreter’s awareness and roles:

The meaning of symptoms
Perceptions of anatomy and bodily functions
Perceptions of appropriate treatment
Autonomy and self-efficacy
Gender roles
Childbirth and reproduction
Family involvement and inclusion
Orientation to prevention
Pain expression and management
Diets and dietary practices
Concepts of death and dying
Expectations of health professionals

(Dreachslin et al. 189)

Let us discuss some of these components in more detail. As for the meaning of symptoms and perceptions of anatomy, medical interpreting is a forum in which different languages’ conventional divisions of the world into different categories are dramatically contrasted. The assumptions that the human body and its subdivisions must be the same everywhere must be unlearned. In Spanish, for example, the mano can include the whole arm; the pierna may refer undifferentiatedly to both the thigh and the calf; the vientre or the tripa may refer to a bodily region rather than a specific organ; animal names are sometimes given familiarly to human body parts (pata, hocico, pezuña, rabadilla [in the sense of ‘rump’]). In any anthropological consideration of constructions of pain, one must consider that Latinos on the whole distinguish dolor de cabeza (headache) and dolor de cerebro (brainache) as distinct (Abad and Boyce 34). And, of course, “folk” ailments and syndromes, usually thought to be psychosocially manifested and having symptomology and etiologies unique to each, are well documented in the literature and should be a mainstay of the interpreter trainee’s intercultural competence repertoire: empacho, susto (pasmo), nervios, decaimientos,
‘hot’ and ‘cold’ conditions, and many others. Students can investigate the close causal relationship between body, disease, and emotion in Latino explanatory models of disease. Physical and psychological ailments may be inherited from humoral pathology—*estar colerizado, hacer bilis*—or may link physical manifestations implicitly to emotion (the root of *empachado* lies in bashfulness, a physical reticence of which, corporeally, is expressed as indigestion or intestinal blockage). Emotional states may arise from physical disorders, and therefore create somatoform symptoms (symptoms for which no pathology can be found) (Waitzkin 115-117). Clusters of symptoms of one ethnomedical syndrome may not equate to, or may overlap with, another given disease in normative Anglo culture (e.g. the correspondence between the symptoms of *bilis* and those of hepatitis). The superordinate *ataque* may have a more subordinate correspondence in English: hysteria or convulsions. And interpreters must know re-mapping strategies for socioculturally variant metaphors across the language pair: e.g., *sangre delgada* (anemia); *eclipsado* (having a cleft lip); *escaldado* (discomfort after eating sour fruit), *dolor de caballo* (stitch or cramp), *hervor de sangre* (an allergic rash), *otitis externa* (swimmer’s ear), or *hormigueos* (pins and needles). And the medical system itself often uses impenetrable culture-bound images (e.g. the ‘Medicare donut hole’: *interrupción de cobertura de medicamentos recetados de Medicare*). Even basic terms involving health insurance, as Nataly Kelly points out, may not exist in patients’ home countries: “HMO,” “deductible,” “coverage,” and “copay” (1702). Metaphorics—even dead metaphors—are a minefield of misunderstanding in medicine, but especially in cross-cultural medicine. Witness the case of the Latina patient who consented to a tubal ligation, commonly described as having one’s tubes “tied.” She reasoned—wrongly—that the procedure must be reversible, and that she could always change her mind and have them “untied” (Haffner 258).

Gender roles and family involvement are features of the encounter that may task the interpreter with especially challenging boundary keeping and conversation management. An example would be the interpreter’s need to recognize stoicism or self-abnegation in the face of pain or mortality; that is, is the patient withholding information to their own detriment? Bancroft et al (67) offers a model for the interpreter’s own voice in managing communication flow. As we have seen, note how the intervention is phrased as an offer of information, a metacommentary:

(To client): “Excuse me, as the interpreter I’m concerned there may be a cultural misunderstanding related to family roles between husband and wife. Service providers often find it helpful to hear cultural information. Is there anything you’d like to share with the provider?”
Gender dynamics also affect the provider-patient dyad and the patient-interpreter dyad, in the sense that taboo subjects, interpreting or providing care across gender ‘lines,’ trust-building, and face-saving can all interact powerfully. ‘Negotiating family’ is one of the key aspects of the coordination of care, and for the interpreter sometimes extends to facing (if not altogether happily) the patient’s decision to prefer that a trusted adult family member or friend interpret their session.

Treatment for some U.S. Latinos includes complementary and alternative medicine (CAM). While student interpreters must learn to take a non-judgmental stance toward such traditional therapies, practiced by santeros, herbalistas, espiritistas, sobadores, comadronas, chupadores, and others, they must also know that their role as interpreter may include helping providers to avoid harmful interactions with biomedical therapies and even some products themselves, for example the dangerous azogue, metallic mercury, used by santeros in spiritual cleansings (despojos) (see Hispanic Health Council). Similar warnings have been issued over the highly toxic greta (lead monoxide) and azarcón (lead tetroxide) used popularly to treat empacho (see Trotter). If the interpreter acts with Byram’s critical savoir s’engager in such cases, dangerous folk treatments should be exempted from culturally relativistic thinking, and must be kept on a ‘watch list’ should they have to be explained to the monocultural provider. More dangerously, some Latino patients do not disclose traditional self-care or healing practices or remedies, feeling they are irrelevant (Amirehsani).

International students or recent immigrants in interpreter training environments sometimes protest that they have the same Western medicines in their home countries as here in the U.S., and that they don’t treat disease with “superstitions.” Such feedback should remind the medical interpreting instructor of some key points:

1. **anti-essentialism.** Not everyone from a given country will exhibit fixed, predictable traits; far from it. *Ethnocultural identification* varies even among those who have similar life stories or who have spent the same amount of time in the United States, and income and health disparities are vast even within the same country. Thus Crezee counsels the interpreter to pref ace cultural clarifications with the idea that “this will be a subjective statement and that each individual is unique, before proceeding to make a general statement” (30).

2. **syncretism.** Many biomedical practices are followed in Spanish-speaking countries *in addition to* spiritually-guided practices and whole-person therapies, thus the Latino patient may often look to Catholic, African, indigenous, and mainstream Anglo-American beliefs, remedies, and medical philosophies.
3. **ethnocentrism.** Students’ facile notions of Western biomedical superiority can be challenged, with Landy (130), by notions that not only our own medical systems are themselves fraught with hazards (for example, antibiotics and other broad-spectrum drugs, radiation treatment, major surgery), but that our own recent forebears possessed medicines and therapies that are not greatly different from, and perhaps less effective than, those of so-called ‘primitive’ and ‘folk’ medicine.

Biomedicine’s goal of eradicating problems versus, say, restoring holistic balance, is a culture-bound approach that many practitioners—and interpreters—naively assume is universal. Raising the students’ self-awareness into their own positionality, and even their own privilege, often means their views of health may harbor intractable bias.

4. **impartiality.** Impartiality is often discussed in interpreter training and organizational ethical codes as not favoring one stakeholder’s vantage point over another’s, and not having conflicts of interest. Impartiality, if it is to serve best practices in interpreter training, must refer also to lending credence to patients’ belief systems as vital in their self-constructions on health, regardless of whether the interpreter’s own worldview is at variance with it. Rose (202) calls cultural filtration the inclusion or removal of cultural information by the interpreter; interpreters must be on guard against conscious and unconscious censorship of messages. Recent studies reveal that interpreters even play a large role in foregrounding or filtering patients’ emotions (see Farini, “The Pragmatics of Emotions in Interlinguistic Healthcare Settings”; see also Baraldi and Gavioli).

The California Standards for Healthcare Interpreters addresses this latter issue first (point ‘a’ below) in its list of components of cultural responsiveness.

The interpreter must have intercultural self-awareness and other-awareness, and is empowered to trigger a role switch to cultural clarifier in cases in which communication repair is needed:

a. Identify and monitor personal biases and assumptions that can influence either positive or negative reactions in him/her, without allowing him/her to impact the interpreting.

b. Recognize and identify when personal values and cultural beliefs among all parties are in conflict.
c. Monitor and prevent personal reactions and feelings, such as embarrassment or frustration, that interfere with the accuracy of the message, and to recognize such reactions may be similar to or different from [those of] the patient and provider.

d. Identify statements made by providers and patients indicating a lack of understanding regarding health beliefs and practices, and to use applicable strategies suggested in the cultural clarifier role to prevent potential miscommunication.

e. Seek continually to update their knowledge and understanding of the dynamic cultures of patients, health care providers, and the culture of the health care system in the United States. (The California Endowment 119)

The last point is important to stress: Continuing education in cultural knowledge, and thus in cultural responsiveness, is an ethical issue, not only one of subject area competence. Part of one’s continuing education is to engage in one’s own cultural self-assessment in order to bring into awareness those elements that may cause, in Andrews’ phrase, cultural blindness.

It may come as a surprise that interpreters do not bear the burden of “decoding” every cultural cue into a univocal meaning, but in the professional protocol are in fact given more of an information-gathering role as part of their cultural interfacing:

The Medical Interpreting Standards of Practice describes cultural interface as one of the core duties of medical interpreters. This involves using culturally appropriate behavior and recognizing and addressing instances that require intercultural inquiry to ensure accurate and complete understanding. [...] Cultural interfacing does not mean ‘assuming’ that a cultural belief or value is a fact in the situation. Medical interpreters are not cultural anthropologists or cultural ‘experts’. Medical interpreters know certain cultural values that might assist in the communicative event but should not be relied to know all cultural beliefs and values of a particular linguistic group. (Hernández-Iverson 7)

Latinos have the lowest preventive care utilization of any U.S. racial and ethic group (Kang-Kim et al). As preventive medicine may be an unfamiliar concept for many low-acculturation Latinos, the interpreter will need to prepare to give some patients context for such practices as well-baby visits, various screenings, smoking cessation counseling, and primary prophylactics. One translation of the McGill Pain Questionnaire (“Valoración geriátrica”) manipulates these dimensions to conform to target culture norms,
modulating intellectual categories from the English version to experiential categories of pain descriptors (“como agujas,” “como si desgarrara,” “como hierro candente,” “como si fuera a explotar,” “que amarga la vida”). Even physiological reactions to pain are read through a lens of culture. One doctor described migrants pulling away during certain parts of worker compensation tests, which he notes is interpreted as malingering, when in fact it is the workers’ fear of pain (Homes 140). Many Latino patients, it should be noted, are unaccustomed to quantifying and verbalizing their pain.

As for death and dying, the normative cultural value of fatalism (“De algo se tiene que morir uno” / “La sanidad es la voluntad de Dios”) can affect every aspect of interpreting, particularly hospice care. End-of-life care must take into account “familismo” (orientation toward family) and the inclusive decision-making this practice entails. The conveyance of bad news may be delayed or avoided in a way that conflicts with patients’ rights as they are conceived of in many healthcare systems. In the United States, for example, the family are not the decision-makers in matters of sharing sick family members’ health information with them, but rather the patient decides what the family may know (Henderson-Iverson 1; NCIHC 8; See Clifford for a scenario in which this issue was the crux of an ethical debate). Bad news does not equate, however, to resignation to death. Consider the case of one Mexican mother who was told that her child would not survive through the night and that hope had run out. The interpreter balked, giving a zero rendition (non-interpretation) of the message because “you never tell a mother in our culture to give up hope” (Scolari, qtd. in Joint Commission 20).

Conflicts between systems may occur most pointedly in matters related to the afterlife and the conception of the body. The case of the Latino patient who was taken to surgery to have a traumatic amputation of the right arm, followed by ten days’ recovery, is instructive in this connection. When discharged, the patient went to the hospital administrator; thinking he was merely going to be thanked, the administrator instead was met with the patient’s pleas that the amputated arm be buried with him in his village back in Mexico. The body being part of the soul, the arm was part of him. The arm, already in formaldehyde and soon to be incinerated, could not practically be retrieved. An age-old, deep-seated belief system thus came up dramatically against the legalities of the modern technologized hospital (Estrada 104-5). Thus one overarching cultural dimension that interpreter training must account for is spirituality. Zuñiga Rojas (217-19) finds that the concept includes such dimensions as “spiritual well-being” and “spiritual needs”. Some patients’ reticence to seek care, or to discuss health problems, derives from the cultural explanation that illness derives from sin. Thus not only is unhealthiness stigmatized, the external locus of control means that the patient
believes his or her sickness is consequent on, and even punishment for, past actions, and that he or she must suffer for them.

Patients may hold any of a number of unique perceptions of physicians, some of which are conducive to health care partnering, and others not, and some of which can even conflict with the interpreter’s duty of care:

- healer/miracle worker
- expert
- God’s worker
- shaman
- confidant or friend of the family
- authority figure or recipient of unquestioned respect
- pill dispenser
- last resort for healing
- someone who inflicts pain
- partner in making health decisions

(Health Resources and Services Administration)

Part of the challenge is that none of these roles, even if true, can be true always in all circumstances, creating expectations management problems. These attributions, many of which arise in dialogue interpreting with Latino patients, can even lead to a kind of “transference” to the interpreter, and concomitant role boundary issues arise—what interpreter has not been asked medical advice, having earned the patient’s trust merely through camaradería lingüística?

At the core of intercultural competence, humility, awareness, skills or whatever emphases users of these terms wish to give, lies the ethical imperative to be other-directed in our dealings with difference. Note how many of the examples given in Rudvin and Tomassini at bottom are cases of acting in accordance with what may be said, how things may be said, how things may be done, who may do things, and who may know things, written and unwritten codes covering virtually the panoply of our social selves and their competing loyalties:

interpreting a diagnosis to a terminally ill patient—as required in the politics of Western bioethics—with no mitigating communication strategies; views on birth (delivery, diet of mother and baby, breastfeeding, naming rituals); sexuality/reproduction (fertility, impotence, contraception, abortion); terminal illness (sharing and disclosing bad news); informed consent (the involvement of the family); death (rituals, burial); disease (taboo diseases such as leprosy, tuberculosis, or [...] even cancer; suicide; the body (description, touch, uncovering); diet (“hot,” “cold,” balancing energies); the description
of symptoms (through metaphors, connotations); the expression of pain and [...] mental health (mental illness, depression, suicide). [And finally] confidentiality—with whom should or should not information be shared? [...] Differences in attitude towards these issues often hinder communication, collaboration, diagnosis, treatment and patient compliance. (54)

Culture, then, in our classroom, is not a list, or a formula, or even a series of if-then routines, but the ongoing learning of an intercultural communication ethics. Let us consider just a few of the procedures, materials, and performances that might best help situate this learning in graduate and undergraduate medical interpreter training environments.

IV. Pedagogy: 19 Orientations and Observations for Better Intercultural Practice

Although interpreting is often taught in language departments, its methods, goals, and protocols ought to be more rigorously brought in line with the best practices and principles of medical education, especially in the use of task-based learning, notions of dutiful and compassionate care along with respect for persons, ethnosensitivity training, continuing education, and even an emphasis on a “clinical phase,” or practice. Medical education in turn is borrowing notions from communication theory to improve culturally appropriate caregiving. The content, organization, materials, and procedures of the young profession of medical interpreting can also better reflect work in intercultural studies; in conceiving of the medical interpreter as a “double migrant” seeking ethnoconvergence in two directions, we might also consider importing conceptual frameworks from conflict resolution theory. A non-exhaustive primer follows:

- A conceptual framework for introducing cultural competence in health care is Purnell’s model (see above). Its nineteen assumptions can be explored with interpreting students, including culturally competent care, cultural respect, acculturation and adaptation, cultural changes over time, and cultural transmission. Purnell draws on research from “organizational, administrative, communication, and family development theories as well as anthropology, biology, ecology, nutrition, pharmacology, religion, history, economics, political science, and linguistics” (ibid. 3).
- One way to organize the scope of interculturality in a medical interpreter training environment is along the lines of the six Cultural Competence Health Practitioner Assessment subscales: Values & Belief Systems, Cultural Aspects of Epidemiology,

- Theorizations from intercultural communication studies (othering, dealing, projection, middle culture, and intercompetence) can be brought to bear on oral mediation training and education.

- Interpreter Cultural Mediators (ICMs) are an increasingly common job description, expanding the cultural role of the interpreter (e.g. http://ethnomed.org/about/related-programs/community-house-calls-program/icm-manual98.pdf), and creating an intersection of clinical health, public health, and outreach (see Pérez and Luquis). The ICM is a good construct on which to build discussion about role boundaries and role evolution. Other service providers who interpret (dual role interpreters, promotoras) or intercultural mediators (see Verrept) may be comparatively mapped in a pro/con template. Particularly where cultural divides exist, supervised interpreter trainees might profitably be involved in community health needs assessments conducted by a campus department or school of global health.

- Independently or in partnership with departments of health and human services, or others, at one’s institution, use texts such as “Providing Quality Health Care with CLAS: A Curriculum for Developing Culturally and Linguistically Appropriate Services” (Ton et al) to create a plan and portfolio of language services for a defined population.

- Student research groups can initiate focus group feedback from Spanish-speaking heritage students on health education/patient education materials. In general the role of health literacy ought to be brought into a more central position in interpreter training. Survey instruments (Pérez and Luquis) can be designed, administered, and analyzed.

- Underlying any human interactions is a “script” that conditions, but does not determine, the course or outcome of the exchanges. The interpreting classroom must allow for the improvisational unfolding of identity, and must provide an “education in unpredictability” and perspective-taking. To that end, improvisational techniques, semi-scripting of dialogues, predicting, and discourse analysis all have their place.

- Cultural curricula in interpreting tend to focus exclusively on an “othered” perspective of the Latino, relatively ignoring the entire
vantage point of Latinos’ perceptions of Anglo biomedical culture. What are the perceptions in both directions that can limit quality of care? What can the interpreter trainee do to counteract the sense of anomie and dehumanization Latino patients sometimes feel?

- If medical regionalisms are integrated early in students’ experience with LSP courses, work with synonymy, meronymy, and register can sensitize learners to relationships between term frequencies, prescriptive and descriptive usage, and the effects of migration, acculturation and bilingualism on medical discourse in medical dialogues. Low literacy and low health literacy must be factored into the curriculum in sight translation (intake forms, drug dispensing), alternative technologies, etc.

- Knowledge of medicinal herbs used in traditional Latino treatments, and the herbs’ names and properties, ought to form a standard part of training: culantrillo, tilia, sábila, uña de gato, cabellos de elote, anís, flor de azahar, damiana, estañiate, eucalipto, gordolobo, and ruda (see Juckett), to name just a few.

- Non-verbal communication deserves its own module in medical interpreting (see Vargas-Urpi), as well as time devoted to pragmatics, proxemics, and chromenics; students may analyze discourse features and feedback signals such as backchannel, pauses, turn-taking, and phatics in an actual interpreted encounter (How do they compare across languages? For example, can a patient’s “ajá” [‘yes’] be shown to mask incomprehension or disagreement?)

- To foster an empathic connection with patients, study of the recent history of countries from which trauma survivors may be emigrating and seeking mental health therapy is advised. While dialogue interpreting in mental health counseling is a highly advanced subfield for any interpreting student, the issues surrounding this work, including awareness-raising about refugees who might be suffering from Post-Traumatic Stress Disorder (PTSD), depression, or other disorders, may be incorporated into the course plan. Other mental health work may be done; for example, dementia screening instruments in English and Spanish may be contrasted for cross-cultural differences or potential misunderstandings. Again, cultural ascriptions of meaning occur in cases of mental health as well, and ought to be identified: Latinos, for instance, often confuse the symptoms of depression for nerves, fatigue, or physical ailments (American Psychiatric Association).

- The notion of culture contains that of medical culture; medical culture in turn entails navigation of “the system,” physically,
bureaucratically, and economically. Patient education, then, will include education not only about well-being but about being a patient in a different organizational culture. The Bridging the Gap program, for example, prepares interpreters to hear questions from confused patients about navigating the system (57-8): “Why can’t I go to any doctor I want to? Why can’t I make an appointment directly with a specialist?” etc.

- Students can read and train with materials that clinicians use: protocol on how to work with interpreters, hospital interpreter training handbooks, etc.; it is profitable to roleplay materials from provider’s point of view, that is, embodying the roles of caregivers to gain their perspective. Students may also produce materials, such as dynamic learning objects, for providers, particularly as the content relates to cultural awareness.
- Job ad surveys may be collected and studied: how many include cultural competence components and which components are they? Are they consistent with interpreters’ codes of ethics?
- Bridging high context and low context incongruities is a situation-specific skill following on an introduction to the work of Hofstede and (Edward T.) Hall.
- The interpreter cannot occupy neutral ground in the creation of doctor-patient dynamics. Students can consider how power is affected merely in the choice of, for example, extant Spanish renditions of the term “patient compliance”:

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<table>
<thead>
<tr>
<th>patient-centered</th>
<th>clinician-centered</th>
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<tbody>
<tr>
<td>la cooperación del paciente</td>
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<td>la colaboración del paciente</td>
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<td>la adherencia del paciente</td>
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<td>el acatamiento del paciente</td>
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<td>el cumplimiento del paciente</td>
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<td>la obediencia del paciente</td>
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This range demonstrates the approaches defined in McEwen et al: the emancipatory and negotiated approaches (“wellness model” and “capacity model,” respectively, both empowering), and at the bottom, the medical or “illness model” approach. Protections of patient autonomy such as informed consent forms may be unknown to patients from clinician-centered cultures; attending to this unfamiliarity in part means ensuring that these forms are not
gist interpreted, rendered hastily or incomprehensibly, or even, as Crezee notes (91), with the patient half anesthetized.\(^8\)

- Pre-sessions with a provider as well as debriefings are a skill to be mastered in the interpreting classroom. Pair or trio work can be done to refine these meetings into collaborative efforts. Each member of a triad can be given a role (unbeknownst to others or in confederacy) that creates a cultural competency barrier that our interpreter must help overcome.

- Assessment of intercultural competence and related learning objectives may be built around an adaptation of Interagency Language Roundtable’s competence levels. Note that the organization inscribes many different components: speech acts (e.g. “can effectively […] command, argue, persuade, dissuade, negotiate, counsel, and show empathy”) as well as the abilities to facilitate, use and understand cultural allusions, nonverbal cultural cues, and situational knowledge. Negotiating “[v]alues, beliefs, traditions, customs, norms, rituals, symbols, taboos, deportment, etiquette, attire and time” constitutes this expertise ([http://www.govtirl.org/skills/competence.htm](http://www.govtirl.org/skills/competence.htm)). Katan (329-340) proposes Milton Bennett’s Developmental Model of Intercultural Sensitivity (DMIS) as a useful way of matching tasks with interpreting students’ levels. Similarly, Borkan and Neher developed a Developmental Model of Ethnosensitivity, ranging from fear and mistrust, through denial and differences, to cultural integration.

Conclusion

Medical interpreting finds its stakeholders in two high-stakes yet common encounters: health care and cross-cultural communication, each of which alone is daunting enough. Equivocality, Weick’s term (1969) for multiple possible ways of sensemaking in an organization and the resulting uncertainty, can run especially high in these cases, in which complex encounters involve cultural and linguistic incongruity. Medical interpreting applies not a magic algorithm but a flexible yet principled strategy for managing uncertainty and inherent risk. Few subjects demand more of our students’ mastery of the four dimensions of learning than interpreting in this knowledge domain:

- Declarative learning (knowing “what”)
- Procedural learning (knowing “how”)
- Conditional learning (‘knowing “when” and “where” to apply previous two)
- Reflective learning (knowing “why”)

\(^8\)
If a cultural turn is truly to reach interpreting didactics, interculturality and culturally discordant encounters must be defined as the problem domain, rather than as situations calling for mere linguistic bridging. Equating Spanish-language proficiency with cultural sensitivity or cultural competence is a reductive understanding of language, and ignores crucial dimensions of communication such as the sociopragmatic. “Culture” thus cannot be an add-on course feature in interpreting, and students must come to understand culture as an all-pervading, all-encompassing macrocompetency or transcompetence affecting and constituting their attitudes, knowledge, skills, and behaviors in the field (see Byram, above). That is to say, cultural competence and humane medical care itself cannot be separated.

The physician’s axiom to “Do no harm” is the interpreter’s as well. The interpreter’s mindset and complex of skills play this preventive role, in addition to educative, corrective, supportive, and mediative ones. The famous Belmont Report defined beneficence as the imperative to maximize possible benefits and minimize harms. The humanization of care calls for beneficence in interpreting decision-making, which is a highly pragmatic and even a cost-effective principle, at the same time it ensures a high standard of care. Culture is more than a social nicety; it constitutes the very basis of the interactions the interpreter initiates and facilitates. This is the spirit of the meaningful care we seek to foster, where culture, we might say, is the twelfth bodily system, and includes not only the whole body, but the whole person.
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Tervalon, Melanie and Jann Murray-García. “Cultural Humility vs. Cultural


NOTES

1 Thomas (99) introduced two types of cross-cultural pragmatic failure: *pragmalinguistic failure*, which involves inappropriately encoding an utterance or its force or speech act strategies with respect to target norms, leading to a misunderstood intention behind the utterance; and *sociopragmatic failure*, which may involve breaking taboo or etiquette norms. Interpreters as a matter of course work in these cross-cultural channels, even routinely mitigating providers’ failures through back-channel questioning or even softening of potential violations.

2 Aguirre-Molina identifies the primary barrier (economic), the secondary barrier (systemic or structural level issues, which may include health education materials in the preferred language, and institutional barriers to care), and a tertiary barrier (sociocultural level, including language and culture). Hoberman describes the phenomenon of *medical racism* and racialized interpretations of pain sensitivity. Mediation and advocacy roles and role identities in part have developed in response to such inequities. Moreover, “[i]ntercultural education also includes increasingly, influenced by critical pedagogy, a critical component which should lead [learners] to commit to combat inequality and forms of prejudice, oppression and discrimination” (Dervin and Liddicoat 15). See also Rose (144-147, following Sue et al), who describes racial microaggressions (microassaults, macroinsults, and microinvalidations). Medical interpreting ethics and pedagogy must guide the interpreter in developing strategies to deal with such exclusionary language (e.g. “The interpreter can render this but please realize that your comment may be taken as an implication that all Latinos are uninsured.”)

A note on the term LEP: Technically, interpreters are needed not only because the patient cannot communicate well in the dominant culture’s language, but also because of the provider’s “limited bilingual proficiency,” or LBP, to coin a term. In other words, the onus, the “limitedness,” might better be ascribed to all interlocutors who are language discordant for a given situation, not only the patient.

3 As data on this resistance throws the problem into sharper relief, institutions must advise more strongly that providers use the *teach back method*: the patient confirms what the provider imparted, ensuring the patient has understood what was intended. I am not aware of studies
on whether LEP patients feel “profiled” by this well-meaning practice, especially if it is not commonly used with, for example, the same institution’s English-proficient patients.

4 The medical interpreter can make an unobtrusive offer of this sort at the same time fulfilling the tenet of transparency (rendering everything said to all parties): The comment to the client is relayed to the provider(s), keeping everyone in the loop and mutually trusting. The decision to refuse further inquiry into the cultural misunderstanding would belong to both medical personnel and to the patient.

5 We might expand this brief list with adverse drug interactions, hospital-acquired infections, and antimicrobial resistance (AMR). And Brannigan’s point is worth pondering: that “for all its life-saving wonders, assumptions underlying organ transplantation may dissociate ‘person’ from body, reflecting an increasing depersonalization of the human as merely a body and its attendant parts so that vital organs become mere commodities” (40).

6 In the literature, the term cultural responsiveness embraces awareness and action; viz.: “A measure of the knowledge, skill and sensitivity of healthcare professionals and their organizations to become aware of the individual and system needs of culturally diverse populations, and their subsequent receptivity and openness in developing, implementing and evaluating culturally-appropriate individual and institutional responses to these needs” (California Standards for Healthcare Interpreters, CHIA). Cf. the IMIA’s cultural interface and the NCICH’s cultural awareness. Leininger’s culturally congruent care, from intercultural nursing, may also help the theorization of the interpreter as intercultural agent: “those cognitively based assistive, supportive, facilitative, or enabling acts or decisions that are tailor-made to fit with an individual’s, group’s, or institution’s cultural values, beliefs, and lifeways in order to provide meaningful, beneficial and satisfying health care, or well-being services” (Leininger 49).

7 On interpreting pain, see also Angelelli, “Challenges in Interpreters’ Coordination.”

8 Medical interpreting protocol usually requires that interpreters not produce sight translations of informed consent forms except if the documents are very short, but the interpreter can ensure that a provider read them in full and that the documents be consecutively interpreted. Anecdotal evidence suggests that there is pressure exerted on LEP patients to simply sign though they are given but a vague summary of the document’s
contents. This practice militates against patient-centeredness. Ideally all such documents would be translated in advance, but compliance with this Title VI stipulation that vital documents be translated tends to be low.

* See also NCIHC on beneficence.