Thirty years ago I brought a battered woman and her young daughter to my home after interpreting for her at a local emergency room. The woman’s husband had hit her in the face and all over her body. This was not the woman’s first visit to the emergency room with similar injuries inflicted by her husband. Despite the circumstances, the husband, who had lived in the U.S. longer than his wife and spoke English very well, was in the emergency room waiting to interpret for his battered wife.

Luckily, the providers in the emergency room called for a staff interpreter and asked the husband to wait outside. In private, the woman told us that her husband beat her when she refused to have sex with him. She was now ready to move out of this relationship and was taking her young daughter with her.

As an interpreter, I helped the providers make calls to shelters for battered women. Unfortunately, all the shelters were full. A staff member at one shelter told me that they would no longer accept Portuguese women due to a prior incident when a Portuguese client got lonely and called her husband, divulging the shelter’s address. This put the other residents in danger because the shelter had promised a secret and safe location.

I was young, new in this country, and horrified that even the organizations I trusted were treating our patients as second-class citizens. I was very supportive of women’s rights issues and felt a strong urge to save this woman from her monster of a husband. For this reason, I became what I now call a “band-aid” interpreter.

The woman and her daughter moved in with me, a decision approved by her providers, who had in some ways indirectly encouraged me to “take care of my own.” Everything was fine until the night the woman’s husband followed me home and threatened to hurt us all. It was then that I realized I had put both myself and the patient at greater risk than when we were at the hospital.

I had put a temporary fix on a problem I felt no one could solve.

Because the patient was a Portuguese speaker, a compatriot, and a woman, I wanted to rescue her. This incident occurred over 25 years ago, and at that time professional boundaries for providers, teachers, clinicians, and interpreters were not as clear as they are now. The lines were blurred and often crossed by even the most caring professionals. Although my actions at the time represent an extreme example of “band-aid” interpreting, how many of you have not felt a certain amount of outrage when you sensed a patient’s basic rights were being denied?

“Fixing” Things Does Not Make Them Better

I believe there are moments when every interpreter will feel the urge to “fix” an unfair situation. For instance, a few years ago at a conference, a well-respected interpreter told a story that I
now summarize for you. A young pregnant Latina underwent her first gynecological exam and was apparently nervous about having a provider see and touch her private parts. The provider made some comments to the effect that he was surprised at her shyness during the exam, especially since she had not been shy about getting pregnant. The interpreter felt that the provider was out of line and did not interpret these comments to the patient. The interpreter felt that if the patient were to understand the provider’s comments, she would be offended and would likely not return for prenatal care. Thus, the interpreter concluded her story with the following observation: sometimes an interpreter needs to step out of the conduit role and be a filter and advocate for the sake of the patient.

I can empathize with this interpreter. We had both felt the urge to provide an immediate “fix” to what we saw as a problem no one else could handle, but did our actions carry a long-term benefit? Did the battered preter should take before making the decision to become a patient advocate in the triadic encounter. These are:

1. Focus on the inner and outer circles of your professional identity.
2. Understand the role of the provider.
3. Apply the “Six Ws” as a guide when stepping outside the conduit role, (see page 23).

The Inner and Outer Circles of Your Professional Identity

All of an individual’s decisions relate to his or her inner and outer circles. Your inner circle consists of what you expect from yourself, whereas your outer circle is based on your perception of what others expect from you. As a professional interpreter, you need to understand both of these circles and how they relate to each other.

Most of us became medical interpreters because we share a strong belief in providing equal healthcare access to non-English-speaking and limited-English-proficient (LEP) patients. Our profession is not always held in high regard by the outer circles, as reflected in many comments made by providers (“I don’t need you.” “These people are a burden to the system!” “Why don’t they learn English?”). Thus, we are interpreters, not because we are supported by the outer circles, but because we feel a strong push from our inner circles to do what we think is right.

The interpreters in the two cases just mentioned felt the need to take protective action in favor of their patients. Their inner circles, or self-expectations, were based on values such as respect and the desire to come to the defense of persons perceived as powerless. But as much as our inner circles speak to us, are they in harmony with our outer circles? In other words, are we acting according to what is expected of a professional interpreter? Do we abide by professional standards of practice? Do patients really want us to intervene?

Keeping Your Balance

Our lives as professional interpreters are a balancing act. Because our profession is in its infancy, the outer circles often determine the qualifications of an interpreter based on the outcome of the triadic interview. Interpreters feel this pressure and it moves them to act as “band-aids” in the interaction or else as “hunters of metacommunication.” There also exists among some medical providers a phenomenon of “medical laziness,” in which the provider steps aside from his or her role and allows the interpreter to assume it, as in the case mentioned below.

At a party, I listened to a social worker as she described a “great session” with an interpreter for a local managed care company:

“I just had a great session with an interpreter. She was so caring, so connected. She knew exactly what to do, and she talked this Haitian family into joining the hospice program…”

“I first tried to explain to the family about our services, but the interpreter knew right away that they would not get it. So they went…”

Conflict can create a feeling of isolation if not processed at the right time, but it can also create a world of opportunities for professional and personal growth.
into another room and the interpreter talked and talked to them. I could have never done it by myself!"

I reflected on the social worker’s story and then asked her if the results were not what she had expected. I also asked the social worker if she would have had such a high opinion if the interpreter had not intervened for her and simply interpreted. The social worker replied that she understood my point, but that there had been such a racial and cultural disconnect between her and the Haitian family that the interpreter’s actions were necessary. I then asked if she had ever perceived a disconnect with other patients or families. She answered that she had on a few occasions. When I inquired as to what steps she had taken in those cases to bridge the divide, she replied, “Different things, but at least I could speak their language.” It is interesting that this social worker did not try those same “things” in the presence of the interpreter!

Later, I learned of a similar case in which the interpreter had opted to refrain from “fixing” and stuck to being a conduit. After two hours of an intense session with a hospice nurse and an interpreter, an Italian-speaking family decided not to accept the hospice program. Some time later, the hospice supervisor called our interpreter agency to complain that the interpreter had appeared disheveled, had smelled of urine, and that the session had not gone well.

“Not gone well?” I said.

“Yes, the interpreter was not advocating for the nurse.”

“I’m sorry, but the interpreter is not supposed to be a treatment advocate. The interpreter is a conduit!”

I will never know for a fact if the interpreter smelled like urine, but I can tell you that this accusation left the interpreter shaken and traumatized. She felt attacked as a professional and as a person. After much investigation, however, it became clear that it was not the quality of the interpretation that bothered the provider. Rather, it was the fact that the interpreter would not consent to persuade the family to accept the recommended treatment option. There was clearly an “anger” emanating from the provider, as expressed by the hospice supervisor, which stemmed from the outcome of the session. In the absence of an outlet for expression, our interpreter became a target.

Understanding the Role of the Provider

Interpreters need to trust that most medical professionals have received at least a basic training in communication skills. According to J. R. Curtis and the LEARN model, there are five actions a provider may take when listening to a patient:

1. Listen with sympathy and understanding to the patient’s perception of the problem.
2. Explain your perception of the problem.
3. Acknowledge and discuss the differences and similarities.

Even with this model, Howard Stein acknowledges that providers and patients (and in our case, interpreters) develop conscious and unconscious feelings toward each other. The term transference refers to unconscious feelings of the patient toward the provider. Countertransferences are the unconscious feelings of the provider toward the patient. Stein writes that the dynamic of conflict is likely a result of projective identification, or externalization by relocating unconscious feelings that may cause
Remember to ask the Six Ws

1. Who owns the information?
2. Whose job is it to share the information?
3. With whom can I share it?
4. Who is going to be affected by my actions?
5. What does the law say?
6. Would a professional interpreter association support my action?

pain when re-experienced. People often rid themselves of this pain by attaching it to another person. The following hypothetical situation provides a good example of transference, countertransference, and projective identification.

A patient goes into shock and dies. Soon after, another diabetic patient arrives in the emergency room with elevated blood sugar. The provider angrily tells the patient, “You need to do what I say or next time you’ll leave the hospital in a hearse (projective identification)” The interpreter senses the provider’s aggression and, not knowing the provider’s past experience, rebuts with frustration (transference) by saying, “Doctor, as a professional, you should know that in this patient’s culture it is common to seek folk treatments!”

A similar interaction might happen with any patient who does not follow the provider’s recommendations, not just LEP speakers. With any communication there is always a potential for conflict. Conflict can create a feeling of isolation if not processed at the right time, but it can also create a world of opportunities for professional and personal growth. In our hypothetical case, the provider was not a good listener. She may have felt unimportant, or perhaps she cared so much for the patient and was pained to see her fade into death. Out of an unconscious fear of losing another patient, this provider resorted to a defense mechanism and fought back with the hope of avoiding another loss.

What was lacking in our provider (and in our interpreter) was an appropriate response to conflict. Both jumped to an analysis of what they perceived as the problem without first consulting the other parties to the interaction.

The Circle Chart

Roger Fisher and William Ury developed the Circle Chart to outline a respectful process for conflict resolution. According to this process, one must identify concrete examples of the perceived wrong. Together, both parties should go over a list of the problems. Once this is done they enter a second stage where analysis or diagnosis of the issues may be offered. The third stage is the approach, where they begin to work on strategies for resolution. This is done on an intellectual level. As a result of this thinking, the fourth step, action ideas, takes place. In the action idea phase, both parties take actual steps toward dealing with the problem.

The Circle Chart steps are crucial to our work as interpreters. The process led me to reassess my prior actions as a “band-aid.” Before opening the band-aid box, become a consultant and coach to the provider. Remember: a coach does not tell the provider what to do, but rather enhances the patient-provider relationship by adding background information on specific cultural challenges, thus promoting a healthy provider-patient dialogue.

The Six Ws

Working with human beings is not all black and white, and there are those moments when an interpreter may feel that he or she is crossing a boundary. It is what you do before and after your intervention that makes you a professional. When making your decision regarding when and how to intervene in a session, consider the Six Ws, a tool I developed for medical interpreters.

1. Who owns the information?
2. Whose job it is to share the information?
3. With whom can I share it?

4. Who is going to be affected by my actions?

5. What does the law say?

6. Would a professional interpreter association support my action?

**Respecting Boundaries**

In summary, good interpreting is not only based on accuracy, but on how the interpreter manages the dynamics of the triadic encounter. In almost any interaction, there will be some type of conflict. With any conflict resolution process, all sides need to be heard and understood and find common ground. The band-aid interpreter acts on the basis of personal assumptions, and neither the provider nor the patient is consulted regarding the nature or resolution of the program. When tempted to intervene and “fix” a dynamic, the interpreter should first question the short-term and long-term impact of this action. Ask yourself, “Is this about a need to satisfy my inner and outer circles, or is this about the patient and provider?”

Intervening in a triadic encounter for the sake of respect is risky. According to William Isaacs, “respect means honoring boundaries.” It also means that “when you respect someone, you do not intrude or you do not withhold yourself or distance yourself from them.” A band-aid may be good for immediate relief and can temporarily protect the patient from germs or infection, but eventually it will fall off. When it does, the damaged skin will still be there. Looking back at our cases of band-aid interventions, was the wound ever healed?

It is not easy to resist the urge to intervene when interpreting during an uncomfortable situation in a triadic encounter with a provider and patient. However, this does not mean that you cannot take steps for positive change. As an interpreter, you may use the post-session time and supervision meetings to share concerns and promote a healthy dialogue that will lead to more permanent changes.

Often, it is the work behind the scenes of a triadic encounter that results in resolution. According to Kenneth Cloke and Joan Goldsmith, true resolution “requires a shift in how we think about conflict and behave in its presence…. We reach resolution when we do not run away from confrontation and no longer see people with whom we disagree as enemies.”

**Notes**


