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Interpreter Services

Provider–interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions

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ABSTRACT

Objective: This study examines (a) providers' and interpreters' perception of their competition in controlling the content and process of provider–patient interactions, and (b) the challenges to providers' and interpreters' collaboration in bilingual health care.
Methods: I recruited 26 professional medical interpreters from 17 languages and 39 providers from 5 specialties to participate in in-depth interviews and focus groups. Grounded theory was used for data analysis to develop themes in areas where providers and interpreters compete and assert their expertise.
Results: Providers and interpreters experience conflicts over their expertise and authority due to their practice in (a) adopting different speech conventions, (b) controlling the other's narratives, and (c) overstepping expertise and role boundaries.
Conclusion: A successful bilingual medical encounter is dependent on the interpreters' and providers' ability (a) to understand, communicate, and negotiate their and others' communicative strategies/goals and (b) be adaptive of and responsive to others' management of the communicative process.
Practice implications: Authority in bilingual health care should not be established through pre-existing categories or expertise but negotiated and coordinated during the interactive process, which would allow individuals to be adaptive to the issues emerged in the communicative process.

1. Introduction

In bilingual health care, providers and patients often differ in their understanding of the illness and preferences for treatment [1]. Interpreters often are perceived as the solution to bridge these differences [2,3]. The challenge of the interpreter-mediated medical encounter is that providers, patients, and interpreters need to negotiate meanings across various *languages*, *cultures*, and *expertise* [4,5]. Although the providers' medical expertise and interpreters' cultural and linguistic expertise may appear to be complementary, their collaboration is a complicated process that warrants further investigation [6,7].

Providers' and interpreters' collaboration is faced by tensions and challenges that are inherent in bilingual health care [8]. For example, providers and interpreters may have different understanding about interpreters' roles. Providers often expect interpreters to be neutral conduit, a default role in interpreters' training, by transferring information from one language to another [9–11]. Researchers, however, argued that interpreter-as-conduit oversimplifies interpreters' roles [12,13]. Interpreters often actively influence the medical encounters to ensure quality health care [14–16]. In addition, although both the providers and the interpreters share the goal of providing quality care, their training may lead them to focus on different aspects of patients' narratives [8,16]. Finally, because patients' illness experiences are socially constructed and culturally situated [17], it may be difficult to define the boundaries of medicine, culture, and language in patients' narratives. As a result, providers and interpreters may compete for authorities in interpreting and constructing the meanings of patients' narratives.

The objective of this study is to identify areas that providers and interpreters may experience tensions and conflicts due to the differences of their expertise and practices. By recognizing interpreter-mediated medical encounters as a complex phenomenon that requires participants to negotiate meanings, I will investigate (a) interpreters' strategies to gain control and authority over the medical encounter and (b) providers' understandings of and/or control over interpreters' practice.

2. Method

2.1. Participants and procedures

This study is part of a larger study that examines the roles of medical interpreters, which include (a) 1-year ethnography

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of bilingual medical encounters and (b) interviews and focus groups with health care providers and interpreters. This study utilizes the (b) data set.

Three months after the beginning of the ethnography, I recruited 26 professional medical interpreters (from 17 languages) [4] and conducted 14 individual and 6 dyadic interviews (each lasting 1–1.5 h). The interpreters are from two medical interpreting agencies that provide services to local hospitals in the Midwestern United States. Before the interviews, I informed the interpreters that I had worked as a medical interpreter before and was familiar with the routines and dilemmas they face in their everyday tasks. I relied on my experience as a medical interpreter and the ethnographic data to navigate the design, preparation, and interview process. I developed an interview guide to explore interpreters' (a) understanding of their roles, (b) communicative goals and practices in interpreter-mediated interactions, (c) management of bilingual health care, and (d) skills needed for quality health care. I also used follow-up questions to explore comments that suggest conflicts or tensions between interpreters' practices and beliefs.

Based on the analysis of the ethnographic and interpreters' interview data, I then developed an interview guide to examine providers' (a) expectations for medical interpreters' performances, (b) communicative needs in interpreter-mediated interactions, (c) criteria used to evaluate the medical encounter, and (d) contextual factors that may influence their expectations. I also used follow-up questions to explore the similarities and differences in the providers' and interpreters' perspectives. I recruited 39 providers from a major health care facility in the Southern United States. The providers are from 5 specialty areas: OB/GYN ($n = 8$), nursing ($n = 6$), mental health ($n = 7$), emergency medicine ($n = 7$) and oncology ($n = 11$). In total, I conducted 8 specialty-specific focus groups and 14 individual interviews (each lasting 1–1.5 h). I offered individual interviews to providers who were unable to attend the focus groups. Selected questions for both interview guides are presented in Table 1.

2.2. Data analysis

Two research assistants and I used constant comparative analysis for the data analysis [18,19], coding the data for dominant themes and categories. First, we independently reviewed all transcripts to identify the interpreters' and providers' strategies in asserting, maintaining, and negotiating control over the content and process of provider–patient interactions. Each strategy proposed by one investigator was then probed by others in a second pass through the data. We then combined similar findings; however, claims proposed by one investigator but not corroborated by others were discussed in detail with further consultation of the data for evidence to support or contradict the claim. Our first

Table 1
Interview guides for interpreters and providers (selected questions).

Interpreters	Providers
Understanding of interpreters' role	**Role expectations for interpreters**
1. Have you ever taken classes that train you to be an interpreter? Medical interpreter? If you need to explain the role of medical interpreter, what would you say?	1. If you need to describe the role of a medical interpreter, how would you describe it?
2. Do doctors/patients/interpreting agencies ever tell you what to do? Do you follow their instructions? Why?	2. If you need to describe your role in an interpreter-mediated provider–patient interaction, how would you describe it?
3. Does the hospital have guidelines for you? Do you think these guidelines/expectations are realistic or appropriate?	3. How would you describe your working relationships with the professional interpreters?
	4. What are interpreters' most valuable contributions?
	5. When working with an interpreter, what are the things that you appreciate most from an interpreter? What are the things that bother you the most?
Interpreters' communicative goals and practices	**Communicative needs in interpreter-mediated interactions**
4. What do you think is the goal of medical interpreting?	6. Do interpreters facilitate your work? In what way?
5. Who is typically in charge of the flow of communication when you interpret?	7. Do interpreters present challenges to your work? In what way?
6. Who do you think should be in charge of the flow of communication when you interpret? How do you accomplish that?	8. During a bilingual medical encounter, who do you think should be in charge of (a) the flow of interaction and (b) the content of conversation?
7. Do you feel that it's easier to interpret for some people but not others? Why?	9. Do you have problems coordinating the multi-party conversations when working with an interpreter? What are the problems? How do you usually resolve these issues?
8. Were you ever in a situation that a doctor was not respectful to the patient? How do you handle such a situation?	10. Have you ever had miscommunication or a conflict with an interpreter? What happened?
9. If you notice that the patient/provider misunderstood each other or seem confused, what do you do?	
Management of interpreter-mediated medical encounters	**Evaluating interpreter-mediated medical encounters**
10 How do you usually meet the patient? How do you introduce yourself?	11. Were you ever in situations that you were not sure if the interpreter was interpreting correctly or faithfully? What made you suspect that something may be problematic? How did you resolve the situation?
11. Do you often accompany patients in the waiting room? Other places? Why? Why not? What do you do during those times?	12. Were you ever in situations that you feel that the interpreter was not neutral? What happened? Did you do anything to manage the situation?
12. Are there any specific cultural issues that people in your culture have serious problems adjusting in the health care system in the US? How do you resolve these problems?	13. When you have miscommunication or conflicts with a patient, how should an interpreter manage the situation? Do you think that they should still translate all the emotions and possibly foul language? Why or why not?
13. Were you ever in a situation that a provider and a patient had significant cultural differences or have significant differences in their way of handling illness information? Why is that? How do you resolve the situation?	14. What are criteria you use to evaluate the quality and success of a provider–patient interaction? Do you use different criteria if it's a cross-cultural, bilingual interaction?
14. Do you try to educate doctors/nurses/patients about how to interact with each other? Why? Why not?	
Achieving quality care	**Contextual factors**
15. What is the most difficult aspect of your job?	15. Are there any situations that you will not talk to a patient without an interpreter?
16. What is the most important skill for a medical interpreter?	16. Do you think your clinical specialty influence your expectations and needs for a medical interpreter? In what way?
17. Do you think doctors/nurses should learn the skills to use an interpreter? What kinds of skills are important?	

analysis results in a list of recurring strategies. We then adopted axial coding, focusing on the providers' and interpreters' understanding and interpretation of these strategies. Finally, we used selective coding to generate a list of areas that providers and interpreters experience tensions and conflicts due to the differences of their expertise and practices. We used the same procedure discussed earlier in all three coding stages.

2.3. Transcription notations

Each participant is assigned a pseudonym. In the following sections, I denote interpreters with a superscript I (i.e., ^{I}) and health care providers with a superscript H (i.e., ^{H}) after their pseudonyms. The speakers' emphases are CAPITALIZED.

3. Results

Providers and interpreters experience conflicts over their expertise and authority due to their practice in (a) adopting different speech conventions, (b) controlling the other's narratives, and (c) overstepping the other's expertise and their own role boundaries.

3.1. Using different speech conventions

3.1.1. Interpreters' specialized speech practices

Interpreters noted how their specific verbal and nonverbal strategies allow them to shape the communicative contexts and create the illusion of dyadic physician–patient communication. For example, interpreters are trained to adopt a first-person speech style. Sophia^{I} explained, "For example, 'I believe you have hepatitis.' [. . .] I just said, 'Creo que usted tiene hepatitis.' I don't use third-person." The use of a first-person style implicates interpreters in an invisible role. The interpreters' management of the textual transformation is hidden and the interpreters appear to be neutral as they relay the providers' and the patients' voices. Sara^{I} explained, "When I'm interpreting, I speak in first person. I am not there. I'm the doctor, I'm the patient." Some interpreters also talked about adopting simultaneous interpreting (i.e., interpreting while the speaker is speaking). Because there is minimal time lag between the speech, simultaneous interpreting creates an illusion of monolingual talk and smoother transitions between speakers. Sara^{I} explained, "[With consecutive interpreting,] it's harder for people to interact with each other and forget that I'm there. Because they have to wait, and they are looking at someone and they are listening to someone else's talk."

Interpreters adopt specific nonverbal behaviors to reinforce the provider–patient relationship. For example, Vicky^{I} said, "I go towards the back of the patient. As far back as I can. So that when they are looking at me, then, I look at the patient. I don't look at them. I lower my eyes and that forces them to talk to the patient." Stella^{I} noted, "[When interpreting], I look at the floor, and I look at the ceiling or something. And I make sure that they talk to each other." By avoiding eye contact or standing behind a speaker, the interpreters not only become less visible but also influence providers' and patients' communicative behaviors, making them to communicate with each other directly (e.g., having eye contact).

3.1.2. Providers' normative expectations

Providers are not familiar with nor trained in interpreters' specialized speech practices. As a result, their understanding and expectation of interpreters' behaviors are based on their normative model of communication. Many perceived interpreters' behavior to be impersonal and unhelpful. For example, for some people who are not familiar with simultaneous interpreting, the overlapping talk of the interpreter and the actual speaker can be hard to understand, if not annoying or disrespectful. Cory^{H} noted,

> Before you finish your sentence, they are already speaking. That really bugs the tar out of me. Okay. But maybe they are supposed to do it that way. . . . And not looking at the person and not looking at me. And like looking straight ahead like they are inanimate objects, just rotate, you know those kinds of things. It is distracting to everybody in the room.

Cleo^{H} followed, "Because she's kind of like a robot. Language robot". Cara^{H} agreed, "Because the translator is a PERSON, for better or worse there, a person. And for them to act like they are not. It just doesn't work". Claudia^{H} concluded, "It's a human interaction that you are having with the patient".

Some providers, however, became more appreciative of the functions and values of interpreters' specialized speech practices as they became more acquainted with these strategies. For example, Candice^{H}, an oncologist, said, "[The interpreter] would be talking AS I was talking and there was NO emotional reaction. Once I got used to that style, I kind of liked it. Because the parents are looking at ME and reading MY nonverbal and MY emotions."

3.2. Controlling the other's narratives

3.2.1. Interpreters' intervention on providers' narratives

Some interpreters commented that they would interrupt the providers or refuse to interpret if they disagree with the providers' practice because it is (culturally) inappropriate or ineffective. For example, Sandra^{I} objected when a nurse asked a Catholic priest if he has venereal diseases because "Do you think that if I ask him, he is going to tell me if he has it?" Others adopt strategies that do not always make their intervention transparent to others. In addition to using nonverbal strategies to force providers to interact with patients directly, interpreters, at times, change the content of others' narrative to facilitate a culturally appropriate performance. For example, Roland^{I} stated that because his culture has strong stigma toward the word cancer, he would change a provider's comment "How's your cancer?" to "How's your leukemia?" because maybe the patient "didn't know that it means cancer." To facilitate patients' understanding of the medical dialogue, Sandra^{I} replaced providers' term "glaucoma" with "pressure in the eye" and "laparoscopy" with an explanation of its procedure. To ensure that the doctor does not offend the Muslim female patient when assessing risk factors, Ulysses^{I} changed "Do you have sexual contacts outside of marriage?" to "Does your husband go to other women?" Interpreters' justified their behaviors and asserted their control over information exchanged by claiming expertise in culturally appropriate performances. Providers in our study generally support interpreters' effort to assert their cultural/linguistic expertise. However, providers also expect interpreters' intervention to be transparent. Gloria^{H} explained, "If they don't use the word 'tumor,' I'd be OKAY with them changing the term but I'd like to KNOW too. So that I can be educated about what's going on in the interaction."

3.2.2. Providers' control over interpreters' performance

Although a few providers noted that they feel powerless to interpreters' manipulation over their voice, many providers have adopted creative strategies to monitor interpreters' performance despite the fact that they do not understand the other language. The most common strategy providers noted is to monitor the differences in the lengths of talk between the original and interpreted texts. In addition, providers also listened for keywords that they are familiar with in another language. Many providers argued that nonverbal behaviors, including cues that convey emotional tone (e.g., anger, confusion, or uncertainty), are universal and thus, do not require interpretation. As a result, some providers observed the interpreters' and the patients'

nonverbal behaviors and emotional tone to make sure that they are consistent with the providers' intended meaning or sentiment.

Many providers noted that they would not hesitate to challenge or question the interpreters' behavior when they believe that the interpreter is not neutral or faithful. In fact, both the interpreters and providers talked about incidents that the providers confronted the interpreter for not using the keyword or the incongruence in the length of talk (e.g., "I did not hear you said *glocoma*." "You said more. What did you say?"). Others noted that they would and simply repeat or rephrase their comments, which obligate the interpreters to interpret their narratives again.

3.3. Overstepping expertise and role boundaries

3.3.1. Interpreters' claim on medical expertise

Several providers commented that they noticed how experienced interpreters often ask questions that the provider has not said because they are familiar with the routines. Ginger[H] noted, "Using the same [interpreters] over and over in the same setting is very helpful because they are very good about anticipating and ready to help when they are needed. But sometimes, I think they try to do more than they actually should be doing." Many providers voiced concerns about interpreters asking questions or asking patients to do things that were not initiated by providers. Ginger[H]'s attitude reflects a double-bind. As interpreters gain their expertise in mediating a medical dialogue, they may begin to claim medical expertise.

Interpreters' effort to provide a culturally sensitive interpretation can be problematic as it may overstep providers' medical expertise. For example, Yetta[I] talked about her effort in helping Nigerian patients to understand U.S. providers' use of drug names:

> We don't use the medical terms [in the US]. So, mentioning [those drug names], don't mean anything to the patient. So, what I always do is explain, I try to tell them, Dulcolax is like water pills. Okay, because [laxatives over there] is not Dulcolax in Nigeria.

The problem here is that Dulcolax is *not* like water pills and laxatives are *not* the same as water pills. More importantly, Yetta[I] viewed this as information that requires her cultural expertise to facilitate provider–patient interaction when in fact, she has overstepped the boundary that separates interpreting medical information and dispending medical knowledge. Vicky[I], a Vietnamese interpreter, also commented on how American physicians often provide too many treatment options, which overwhelm and confuse the patients. She often asked the providers to pick the one that they would have chosen for their family members and just inform the patient with that treatment option. Although Vicky's judgment was based on her cultural understanding of Asian patients, it is unclear whether these strategies may have legal consequences (e.g., informed consent) or may ignore individual differences (e.g., some Asian patients may still desire patient autonomy).

3.3.2. Providers' claim on institutional hierarchy

Several providers noted that they do not believe patients care or think about interpreters' performance but are, first and foremost, concerned about their health problem, a notion that implies their medical expertise should be prioritized over other expertise. Due to their institutional hierarchy, providers maintain control, power, and authority through their access to other resources and thus, can easily overrule others' opinions. For example, some providers talked about using court orders to compel patients to accept treatment that may not be culturally appropriate. Both providers and interpreters talked about incidents in which an interpreter was fired because s/he did not perform in a way that was expected by the provider. In fact, providers in different interviews all mentioned a story of an interpreter who told a patient with cancer, "Say your prayers," which was not said by the providers. In different versions of the story, the interpreter was fired, reprimanded, or the providers were cautioned about the particular interpreter during departmental meetings. This cautionary tale shared among providers reminds them not only their loss of control when working with interpreters but also their ability to exert power outside of the medical encounters.

3.3.3. Providers' diverged understanding of medical boundaries

When professionals understand each other's roles and responsibilities, they are more likely to successfully coordinate with each other and provide quality care [20]. Role boundary, however, is not always a clear-cut issue in bilingual health care and is often intertwined with issues of institutional structure, control over the medical encounters, and professional expertise. Providers from different expertise often exhibit different attitudes towards what counts as a medically meaningful dialogue. For example, Gloria[H], an OB/GYN physician, mentioned that she had a patient who kept sidetracking during a pap smear exam, talking about how "[the physicians] are turning off the husband from the ventilator that night and that he's going to die." Gloria[H] concluded, "The interpreter needs to know how to keep the patient focused if the patient is not focusing. [...] I don't need to know those things. And they are really irrelevant. What we need to stay focused on is the PROBLEM." The challenge presented by Gloria is that for interpreters to keep the patient focused, interpreter needs to make active judgment about whether certain information is medically relevant to the encounter at hand. As a result, comments such as "turning off the husband from the ventilator" may be medically meaningful in a psychiatric appointment but not an OB/GYN appointment. However, Gloria[H] also mentioned that she referred the patient to a psychiatrist, which is a medical intervention. Had the interpreter kept the patient focused, these issues would not have been brought up and a needed medical intervention may not have been provided.

Providers in emergency medicine and oncology viewed interpreters' effort to provide emotional support complementary to their care. Providers in mental health, however, were concerned about any interpreter–patient interactions. Michael[H], a psychologist, explained,

> Cause I'm not there to participate in guiding that interaction. Should the family or the patient have a lot of angst or anxiety about seeing us, the interpreter won't be able to regulate that as well as if I was there. So that may impact patient care cause they are not gonna talk with us. Or they'll become too anxious and they'll kick us out or they're paranoid or afraid or angry.

From Michael's perspective, even everyday talk may lead to issues that need to be dealt with in the medical encounter. Mira[H], a psychologist, commented, "If the patient opens up so much to the interpreter that they become so emotional or have an emotional breakdown, that can interfere with the treatment process tremendously." As a result, even though in earlier discussions, some OB/GYN providers have noted that an emotionally detached interpreter may be perceived as being impersonal or rude, these behaviors risk compromising the therapeutic process in mental health area.

As medicine becomes increasingly specialized and each physician has his or her area of expertise, providers learn to focus their patients on what is medically relevant. More specifically, physicians have learned to filter patients' talk through their areas of specialty for what is medically relevant (i.e., not anything

medically relevant would do). In contrast, medical interpreters' frame to understand a patient's talk in health care settings is holistic because they are involved in all aspects of the patient's talk in health care settings (e.g., the medical talk with various providers and the financial talk with social workers).

4. Discussions and conclusion

4.1. Discussion

By recognizing that all participants actively influence the communicative contexts [8,15,21], I view successful bilingual medical encounters as a coordinated achievement between the interpreters, providers, and patients. Although much of the literature still centers on interpreters' performance and perspectives [12,22], this study aims provide insights into provider–interpreter collaboration by juxtaposing providers' and interpreters' perspectives. By identifying areas of potential conflicts, I first explore interpreters' strategies to gain control and authority followed by providers' understandings of and/or control over interpreters' practice.

The differences in providers' and interpreters' expertise can result in conflict in provider–interpreter collaboration. By identifying the problem areas, this study provides insights into potential solutions. First, it is important to offer providers training on working with interpreters. A recent national survey found that roughly 50% resident physicians reported no training on adapting their communicative strategies when working with interpreters and 67% reported no training on managing situations that they suspect the interpreter has misinterpreted [23]. The lack of training leads to provider–interpreter miscommunication. This study found that because interpreters' specialized speech practices are not intuitive to providers, providers often misconstrue the interpreters' behaviors by using their communicative norms in monolingual talk. However, when providers are familiar with interpreters' practices, they can infer the meanings constructed by the interpreters' practices in the way that intended by the interpreters. This does not mean that providers need to unconditionally accept interpreters' practices. Rather, by understanding the values and functions of interpreters' practices, providers are empowered to evaluate the appropriateness of interpreters' behaviors and negotiate with interpreters about other alternatives to achieve optimal care.

Second, effective integration of providers' expertise-specific views and interpreters' holistic understanding of patients' illness experiences is not only complementary but necessary. The complexity of bilingual health care makes interpreters' expertise essential in achieving culturally sensitive care. However, without incorporating providers' perspectives, interpreters' effort to provide culturally sensitive care may pose risk to the therapeutic processes, compromise the embedded values (e.g., self-determinism and informed decision-making) in western medicine, or overstep providers' medical expertise. From this perspective, interpreters need to develop a general understanding of the diagnostic, therapeutic, or communicative needs of different specialties and to be responsive to the providers' and patients' perspectives and concerns emerged during the medical encounters. A positive finding of this study is that providers do actively monitor the quality of interpreters' performance. However, because the institutional hierarchy provides more legitimacy to providers' authority in controlling the medical encounter [24], it is important for providers to create an environment that others (e.g., interpreters and patients) are comfortable to voice their opinions without fear of retribution (e.g., getting fired or reprimanded).

Finally, providers and interpreters need to be vigilant about the changing boundaries of medicine, culture, and language in bilingual medical encounters. These boundaries may shift as a result of the providers' specialty (e.g., mental health vs. oncology), the issues emerged during the medical consultation (e.g., a dying husband), the patients' background (e.g., cultural-specific needs), and interpreters' experience in similar medical dialogues. Assigning interpreters a restricted role (e.g., conduit) or prioritizing providers' authority over that of interpreters assumes that these boundaries are rigid and can be predetermined. These assumptions often motivate interpreters to adopt covert manipulation to avoid conflicts in bilingual health care [8,15,25]. Many researchers have argued that to achieve optimal care, both providers' and patients' perspectives need to be integrated through open communication [26,27]. In bilingual health care, shared decision-making should be applied to not only providers and patients, but also interpreters. Due to the dynamic process and emergent nature of bilingual health care, both providers and interpreters should feel empowered to challenge the each other's perspectives and derive mutually acceptable solutions based on open discussion of the optimal utilization of their expertise. From this perspective, providing a structured routine and institutional space for providers and interpreters to consult with each other before and after medical encounters about the potential (cultural) problems and consultation objectives can be valuable in promoting successful provider–interpreter collaboration.

4.2. Conclusion

This study raises an important issue in establishing and negotiating authority due to the difficulties in defining the boundaries of expertise in bilingual medical encounters. On the surface, one may argue that providers should have authority and control over medially related issues and interpreters should have authority and control over linguistic and cultural issues. However, the boundaries between what is medical, social, cultural, and linguistic are not always clear in bilingual health care. A successful bilingual medical encounter, thus, is dependent on the interpreters' and providers' ability (a) to understand, communicate, and negotiate their and other speakers' (including the patients') communicative strategies/goals and (b) be adaptive of and responsive to others' management of the communicative process. In other words, authority in bilingual health care should not be established through pre-existing categories or expertise but negotiated and coordinated during the interactive process, which would allow individuals to be adaptive to the issues emerged in the communicative process.

4.3. Practice implications

Instead of focusing on asserting their authority or control over the medial dialogue, providers and interpreters should recognize their shared goal of quality health care for the patient. For interpreters, a flexible and adaptive communicative model is more suitable to meet the complex demands of bilingual medical encounters. For providers, because the dynamics of interpreter-mediated interaction is different from typical monolingual interactions [8], developing communicative competence to evaluate the appropriateness and effectiveness of interpreters' practices and to coordinate with interpreters (and patients) is critical to achieve optimal care. Finally, health care institutions can provide significant support to provider–interpreter collaboration by offering (a) training to providers and interpreters to be familiar with each others' needs and practices, (b) institutional space for provider–interpreter consultation (before/after the appointment), and (c) an organizational culture that welcomes input from all participants of the health care team.

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References

[1] Zanchetta MS, Poureslami IM. Health literacy within the reality of immigrants' culture and language. Can J Public Health 2006;97:S26–30.
[2] Flores G. The impact of medical interpreter services on the quality of health care: a systematic review. Med Care Res Rev 2005;62:255–99.
[3] Karliner LS, Jacobs EA, Chen AH, Mutha S. Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature. Health Serv Res 2007;42:727–54.
[4] Hsieh E. Understanding medical interpreters: reconceptualizing bilingual health communication. Health Commun 2006;20:177–86.
[5] Kaufert JM, Putsch III RW, Lavallée M. Experience of aboriginal health interpreters in mediation of conflicting values in end-of-life decision making. Int J Circumpolar Health 1998;57:43–8.
[6] Greenhalgh T, Voisey C, Robb N. Interpreted consultations as 'business as usual'? An analysis of organisational routines in general practices. Soc Health Illness 2007;29:931–54.
[7] Robb N, Greenhalgh T. "You have to cover up the words of the doctor": the mediation of trust in interpreted consultations in primary care. J Health Organ Manage 2006;20:434–55.
[8] Greenhalgh T, Robb N, Scambler G. Communicative and strategic action in interpreted consultations in primary health care: a Habermasian perspective. Soc Sci Med 2006;63:1170–87.
[9] Leanza Y. Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. Interpreting 2005;7:167–92.
[10] Fatahi N, Hellstrom M, Skott C, Mattsson B. General practitioners' views on consultations with interpreters: a triad situation with complex issues. Scand J Prim Health Care 2008;26:40–5.
[11] Dysart-Gale D. Communication models, professionalization, and the work of medical interpreters. Health Commun 2005;17:91–103.
[12] Dysart-Gale D. Clinicians and medical interpreters: negotiating culturally appropriate care for patients with limited English ability. Fam Community Health 2007;30:237–46.
[13] Angelelli CV. Medical interpreting and cross-cultural communication. Cambridge, UK: Cambridge University Press; 2004.
[14] Rosenberg E, Seller R, Leanza Y. Through interpreters' eyes: comparing roles of professional and family interpreters. Patient Educ Couns 2008;70: 87–93.
[15] Hsieh E. Conflicts in how interpreters manage their roles in provider–patient interactions. Soc Sci Med 2006;62:721–30.
[16] Hsieh E. Interpreters as co-diagnosticians: overlapping roles and services between providers and interpreters. Soc Sci Med 2007;64:924–37.
[17] Lawton J. Lay experiences of health and illness: past research and future agendas. Soc Health Illness 2003;25:23–40.
[18] Strauss A, Corbin J. Basics of qualitative research: techniques and procedures for developing grounded theory, 2nd ed., Thousand Oaks, CA: Sage; 1998.
[19] Charmaz K. Constructing a grounded theory: a practical guide through qualitative analysis. New York: Sage; 2006.
[20] Keenan GM, Cooke R, Hillis SL. Norms and nurse management of conflicts: keys to understanding nurse-physician collaboration. Res Nurs Health 1998;21: 59–72.
[21] Aranguri C, Davidson B, Ramirez R. Patterns of communication through interpreters: a detailed sociolinguistic analysis. J Gen Intern Med 2006;21: 623–9.
[22] Flores G, Laws MB, Mayo SJ, Zuckerman B, Abreu M, Medina L, Hardt EJ. Errors in medical interpretation and their potential clinical consequences in pediatric encounters. Pediatrics 2003;111:6–14.
[23] Lee KC, Winickoff JP, Kim MK, Campbell EG, Betancourt JR, Park ER, Maina AW, Weissman JS. Resident physicians' use of professional and non-professional interpreters: a national survey. J Am Med Assoc 2006;296: 1050–3.
[24] Bot H. Dialogue interpreting in mental health. New York: Rodopi; 2005.
[25] Hsieh E. "I am not a robot!" Interpreters' views of their roles in health care settings. Qual Health Res 2008;18:1367–83.
[26] Zubialde JP, Mold JW. Relational value: bridging the worldview gap between patients and health systems. Fam Med 2001;33:393–8.
[27] Zubialde JP, Aspy CB. It is time to make a general systems paradigm reality in family and community medicine. Fam Syst Health 2001;19: 345–59.