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"I am not a robot!" Interpreters' Views of Their Roles in Health Care Settings

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In this study, I examined interpreters' self-perceived roles and their corresponding communicative goals and strategies. Twenty-six professional interpreters (of 17 languages), 4 patients, and 12 health care providers were recruited for this study, which involved participant observation of medical encounters and in-depth interviews. Constant comparative analysis was used to generate a typology of interpreters' self-perceived roles, which are different from the roles they learned in their training. Different roles reflect differences in interpreters' concern for other participants' goals, institutional goals, and their own communicative goals. Interpreters' desire to maintain neutrality during the medical encounters influences the communicative strategies they adopt when assuming other roles. I conclude the article with the theoretical and practical implications of interpreters' self-perceived roles.

Keywords: *communication; communication, doctor–patient; conversation analysis; cultural competence; participant observation*

> We learned that we don't have to talk to patients. We learned that. We are not allowed, right? I don't like that. I can tell you, "It's not right." We are not robots. We have training; I know why we are here. But I say that because it's not true, I am not a robot.
>
> —Rachel, Russian interpreter

Recent reviews on bilingual health care have noted that professional medical interpreters can significantly improve the quality of care for patients with limited English proficiency (Flores, 2005; Karliner, Jacobs, Chen, & Mutha, 2007). Interpreters often manage the communicative contexts by shifting between various roles to achieve optimal care (Angelelli, 2004a; Davidson, 2001). The Cross Cultural Health Care Program (CCHCP), a leading training program for professional interpreters in the United States, proposed four roles for medical interpreters: conduit, clarifier, cultural broker, and advocate (Roat, Putsch, & Lucero, 1997). The CCHCP noted, "The 'appropriate' role for the interpreter is the least invasive role that will assure effective communication and care" (Roat et al., 1997, p. 18). In other words, all roles are legitimate depending on the situation. However, reviews of training programs and codes of ethics from various institutions have found that interpreter-as-conduit remains a prevalent ideology for medical interpreters (Dysart-Gale, 2005; Kaufert & Putsch, 1997). Conduit is an interpreting model that conceptualizes interpreters as robots (i.e., nonthinking, nonfeeling, and yet highly skilled translation machines), providing accurate and neutral relay to others (Dysart-Gale, 2005). Interpreters are trained not to talk to other speakers directly (i.e., they are only voices of others), not to have personal opinions as they interpret, and not to be emotional in contexts that often involve issues of life and death (Hsieh, 2006a). The emphasis of a conduit role often leads interpreters to experience conflict and distress in their role performance and others' role expectations (Dysart-Gale, 2005; Hsieh, 2006a).

Interpreters realize that they cannot be robots. Medical interpreters often need to mediate, negotiate, and reconcile other speakers' and their own communicative goals and identities (Hsieh, 2006a; Temple, 2002). Researchers have found that interpreters adopt specific strategies to actively influence the process and content of medical encounters (Bolden, 2000; Davidson, 2000). Interpreters' communicative strategies

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are often multifunctional, aiming to manage the competing demands of emergent interactions (Hsieh, 2006a; Napier, 2004). It is, therefore, difficult to provide a single typology of interpreters' strategies. In the past, researchers have developed typologies for interpreting errors (e.g., omission, addition, and others) by identifying the differences between the original and interpreted texts (e.g., Flores et al., 2003; Laws, Heckscher, Mayo, Li, & Wilson, 2004). Although changes in texts allow researchers to identify interpreters' deviations from the conduit role, this approach does not provide insight into the causes for these changes.

The problem with these typologies is that the "same" errors might be motivated by very different reasons, such as managing unethical performances, conserving medical resources, or empowering patients. As a result, the same interpreting strategy might have very different impacts on the process and content of provider–patient communication as well as patients' quality of services and health outcomes (Hsieh, 2006a; Napier, 2004). Rather than coding the changes in texts into a single category (e.g., omission), we should examine the causes for these changes and recognize interpreters' active roles in the communicative process. Identifying the underlying variables that influence interpreters' choices of strategies allows researchers to systematically understand and explain interpreters' communicative strategies, identify potential causes of problematic behaviors, and develop effective solutions in health care settings.

Medical interpreters' communicative strategies are closely tied to their understanding of their roles. For example, interpreters strategically claim roles to legitimize and justify their communicative strategies (Hsieh, 2006a). An interpreter commented that she did not interpret neutrally when she was interpreting for her mother, because she was there as a daughter, not an interpreter (Hsieh, 2006a). When interpreters provided services that overlapped with providers (e.g., providing medical information), they claimed the identity of a member of the health care team (Hsieh, 2007). From this perspective, to understand interpreters' communicative practices, researchers should examine interpreters' understanding of their roles and the corresponding communicative goals that motivate those behaviors.

Jacobs and Aakhus (2002) argued that a competent mediator should have "(1) the ability to choose which model to apply to any particular session and to any particular moment in the session and (2) the skills with which a mediator implements any particular model" (p. 200). As a trained expert, an interpreter might adopt and move between various roles that best facilitate provider–patient interactions (Leanza, 2005). The discussion of interpreters' roles has traditionally focused on the theorists' perspectives (e.g., Johnson, Noble, Matthews, & Aguilar, 1999; for a review, see Leanza, 2005). In fact, there are no studies that systematically examine how professional interpreters understand their role. Although medical interpreters might become familiar with the roles proposed by theorists through their training (e.g., Roat et al., 1997), it is possible that interpreters' experiences have prompted them to develop new understandings of their roles that are not necessarily prescribed by their training. For example, researchers found that although new interpreters tended to adhere to the conduit role, experienced interpreters actively intervened in the dynamics and processes of provider–patient communication through their appraisals of various factors (Hatton & Webb, 1993).

My objective with this article is to explore medical interpreters' self-perceived roles, situating their communicative strategies on a larger framework, namely, the communicative goals that are accomplished through these roles. Communicative goals are defined as the speaker's intended objectives (Tracy, 2002). Communicative strategy is the speaker's linguistic practice (Tracy, 2002). The typology presented here is data driven. The research questions were (a) How do interpreters see themselves? (b) Are there specific communicative goals associated with their understanding of their roles or functions in health care settings? and (c) What are the communicative strategies the interpreters employ to accomplish their communicative goals?

Method

The study from which this article is derived is part of a larger study that examines the roles of medical interpreters. The data included participant observation data from a 1-year ethnographic study and 20 in-depth interviews. The in-depth interviews were conducted 3 months after the beginning of the ethnographic study. The same data set has been used in other studies (i.e., Hsieh, 2006a, 2007), which focused on interpreters' communicative practices and experiences of role conflicts in provider–patient interactions. This article focuses on interpreters' self-perceived roles and their corresponding communicative goals and strategies.

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Participants

I recruited interpreters from two interpreting agencies in the midwestern United States. Both agencies view medical interpreting as their primary task and have contractual relationships with local hospitals. Interpreters in this study are all considered professional interpreters and work as freelance interpreters in local hospitals (for a review of different types of interpreters, see Hsieh, 2006b). The majority of interpreters (17 out of 26) had participated in a 40-hour training course developed by the CCHCP, which is viewed as standard industry training for professional interpreters. Those who had not attended the course either had passed certification programs offered by individual hospitals or had acted as trainers in education programs for medical interpreters. The most common reason cited for not having the CCHCP training was that they had worked as medical interpreters for many years even before the CCHCP training program was available. As a result, they often were more experienced and had more seniority. Nine of the interpreters recruited reported more than 10 years of experience as a medical interpreter.

In the ethnographic study, I recruited 2 Mandarin Chinese interpreters to be shadowed during their daily routines and to participate in a series of informal interviews. Other participants (e.g., health care providers, patients, or patients' family members) were contacted before their scheduled appointment and asked for written consent to participate in the ethnographic study. Eleven health care providers, 4 patients, and 1 family member were included in the ethnographic study. All participants provided informed consent. In total, 12 medical encounters (each lasting 1 to 1.5 hr) were observed, audiotaped, and transcribed. Because I am a native speaker of Mandarin Chinese and was present during all medical encounters, I was able to address participants' concerns immediately and also took field notes (e.g., nonverbal behaviors and contextual features) to supplement the audio data. International Review Board approvals were sought and obtained prior to beginning the study.

Three months after the beginning of the ethnographic study, I conducted 14 individual and 6 dyadic interviews (each lasting 1 to 1.5 hr). A total of 26 professional medical interpreters from 17 languages were recruited, of whom 21 were practicing medical interpreters. The other 5 participants held management positions in interpreting offices and provided interpreting services as needed by their offices or agencies. The interpreters' working languages included Arabic, Armenian, Assyrian, Cantonese, French, German, Hindi, Kurdish, Mandarin Chinese, Polish, Russian, Spanish, Turkish, Ukrainian, Urdu, Vietnamese, and Yoruba. Before the interviews, I obtained informed consent from the interpreters and also 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. In these interviews, I relied on my experience as a medical interpreter and my prior data collected through the participant observation to navigate through the design, preparation, and interview process. The research questions focused on exploring interpreters' understanding and practice of their roles. The amount of data resulting from the study is uncommon when compared with what is described in the existing literature from the research field of interpreter-mediated communication (cf. Leanza, 2005; Metzger, 1999; Roy, 2000).

Procedure

Two research assistants and I used constant comparative analysis for the data analysis (Strauss & Corbin, 1998), coding the data for dominant themes and categories. First, we independently reviewed all transcripts (i.e., participant observation and interview data) to identify the interpreters' self-perceived roles. We focused on interpreters' definitions, descriptions, and enactments of their roles and responsibilities in health care settings. We also examined how these roles are contrasted with other role performances. Each role proposed by one of the investigators was then probed by the other 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 analysis resulted in an initial list of recurring roles. Some of the roles were explicitly named by multiple interpreters and discussed in detail (e.g., conduit and advocate). Some other roles were occasionally referenced by individual interpreters and shared similar characteristics. We grouped the roles with similar characteristics into one category of roles.

After identifying the categories of roles, we then went back to the transcripts to generate a list of the communicative goals and strategies that corresponded to role performances. We used the same procedure discussed earlier to develop themes and patterns of the communicative goals and strategies. We focused on

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Table 1
Interpreters' Role Performances, Communicative Goals, and Strategies

Role Performances	Communicative Goals and Their Corresponding Strategies
Conduit	Transferring Complete Information
	Including all comments (i.e., no information screening)
	Representing nonverbal messages (e.g., emotion)
	Reinforcing Provider–Patient Relationship
	Interpreting in first-person singular style
	Using verbal and nonverbal strategies to claim an invisible role
Advocate	Empowering Patients
	Acting on behalf of the patient (overt advocate)
	Providing means for self-advocacy (covert advocate)
	Assuming a conduit role (see discussion in text)
Manager	Conserving Medical Resources
	Performing tasks that are not related to interpreting
	Assuming roles that are complementary and/or supplementary to other health care providers
	Regulating Appropriate and Ethical Performances
	Managing problematic behaviors of other speakers
	Providing framework to interpret and evaluate performances
	Managing Optimal Exchange of Information
	Enhancing the speakers' understanding of information
	Managing the content and flow of information to be culturally appropriate and to provide optimal care
Professional	Being Perceived as a Professional
	Maintaining and claiming professionalism
	Disguising interpreters' nonprofessional performances

interpreters' discussions on communicative goals and strategies for these roles. When certain communicative goals were identified in the interpreters' narratives, we also looked for examples that validated these goals in both the participant observation and interview data. In addition, we paid particular attention to (a) inconsistencies that would suggest modification or qualifications to our earlier typology and (b) examples consistent with our earlier typology that could amplify or elaborate the original findings. We then finalized a list of four roles—conduit, advocate, manager, and professional—and their corresponding communicative goals and strategies (see Table 1). Whereas the conduit and advocate roles were explicitly named by interpreters, the manager and professional roles were named by the investigators to highlight the communicative goals associated with these roles.

In this article, I juxtapose interpreters' practices and narratives to illustrate interpreters' understandings of and communicative practices in their roles. Health care providers are denoted as H, interpreters as I, and patients as P. I have also assigned pseudonyms for all participants. All providers' pseudonyms begin with H (e.g., Helen and Henry), and the patients' pseudonyms begin with P; interpreters were given pseudonyms as well. The limited number of interpreters did not allow me to make generalizations about culture-specific strategies. The transcripts included two primary types of notation. The texts are CAPITALIZED when they are the speakers' emphasis and *italicized* when they are my emphasis. Unless otherwise noted in the extracts, the health care providers spoke in English and the patients spoke in Mandarin Chinese. During the medical encounter, the interpreters switched between English and Mandarin Chinese depending on the target audience of their utterances. All interpreters spoke in English during the interviews.

Results

The interpreters in this study developed elaborate reasoning about four roles they play in health care settings: conduit, advocate, manager, and professional. These roles do not necessarily correspond to the role typology proposed by the CCHCP.

Conduit

Conduit is, by far, the role that was identified most explicitly and frequently by the interpreters in this study (i.e., 21 of 26 participants claimed various forms of a conduit role). The interpreters talked about their efforts to be perceived as invisible and to construct the provider–patient relationship as the primary relationship. This is consistent with expectations that

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call for an invisible, neutral role for medical interpreters and the fact that conduit is the default role in their training (Flores et al., 2003; Kaufert & Putsch, 1997). As Sharon, the director of an interpreting agency, explained, "The role of medical interpreter basically is to be the conduit. Just to give that information and not to do anything beyond that."

Interpreters used various metaphors to explain this role. For example, interpreters talked about their role as robots or machines, functioning with great precision without getting emotionally involved. Silvia argued, "If you want to keep your job, you want to become—really, a kind of robot." Others viewed themselves as the voice of others, who only existed when the speakers talked and remained invisible through the interactions. Scott explained, "We are like the voice, we are not a person. . . . We become the voice of the professional, but we also become the voice of the PATIENT." Some described their roles as bridges, bridging the cultural, socioeconomic, and various gaps between their clients. All these metaphors are symbolic of a neutral role that does not interfere with the content and flow of provider–patient interactions. Interpreters talked about the conduit role as a way to accomplish two major communicative goals: (a) transferring complete information, and (b) reinforcing the provider–patient relationship.

Transferring complete information. The first goal is consistent with the ideology of a conduit as it focuses on the neutral and faithful transfer of information. In Extract 001, the interpreter (Claire) performed a straightforward conduit role, helping the provider (Helen) to investigate the patient's (Paul) treatment history for his diabetes.

Extract 001

101 H: Does he see a diabetic doctor here?
102 I: Have you seen a diabetes doctor here?
103 P: No.
104 I: No.
105 P: I didn't before. I just discovered it.
106 I: I just discovered it.
107 Before, I didn't see a diabetes doctor.
108 H: But now he does?
109 I: Now you've seen a doctor? A diabetes doctor?
110 P: No.
111 I: No.

In this interaction, the interpreter followed the speakers' utterances very closely. A conduit role requires interpreters to interpret not only the verbal messages but also the nonverbal meanings of utterances. Claire talked about an incident in which she thought the provider was rude and disrespectful and she had no other choice but to "interpret everything exactly as what the doctor said, even [had] to interpret exactly the same tone, and same expression, and the same use of words." In other words, when assuming a conduit role, interpreters transfer all information (e.g., emotions and attitudes) indiscriminately. The interpreter not only includes all verbal information but also emulates paralinguistic information, such as tone of voice, volume, and pitch, as they express emotion.

The complete transfer of information also includes information that is not directed toward or relevant to the other speaker. During the interviews, interpreters talked about their indiscriminate treatment of information. Several interpreters commented that they are not only the speakers' voice but also their ears. Yetta explained, "Everything I hear, when I am there, is like the patient should hear whatever I hear." A speaker (e.g., a provider or a patient) might not be aware that the messages are not directed or relevant to him or her. Without the knowledge of the information exchanged between other parties, a speaker might grow suspicious about the relationship and interactions between the interpreter and other speakers (e.g., providers or family members). Roger noted that he would interpret information even when it was not relevant to the patient, "Because the idea is I'm a voice. The main idea is the patient knows what is going on in my presence. So, he has to know what's going on." By interpreting all information indiscriminately, an interpreter allows a speaker to become not only a participant in provider–patient interactions but also an informed bystander to other interactions in a medical encounter.

Reinforcing the provider–patient relationship. A conduit role aims to create the illusion of a dyadic provider–patient communication, which in turn reinforces the provider–patient relationship (Roat et al., 1997). Contrary to an earlier study (Angelelli, 2004a), which concluded that interpreters perceived their role as visible, several interpreters in this study talked about their effort to achieve an invisible presence in provider–patient interaction by adopting a first-person singular interpreting style (i.e., speaking as if he or she were the original speaker). Interpreters talked about how these strategies highlight the provider–patient relationship as the primary relationship in interpreter-mediated interactions. At times, ironically, interpreters violate this rule and "interfere" with the content and

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process of provider–patient communication to reinforce the provider–patient relationship. In Extract 002, the interpreter (Claire) used several different strategies to reinforce the relationship between the provider (Hilda) and the patient (Pam).

Extract 002

201 H: Does she have any family history of diabetes?
202 I: Do any of your family members have diabetes?
203 P: No [in Chinese]. No [in English].
204 H: Is this her first pregnancy?
205 I: First pregnancy?
206 P: Yes.
207 I: Yes.
208 H: Is she on any medication?
209 I: Are you taking any medicine now?
210 P: No [in English].

The first-person interpreting style for the provider's comment in line 201 should have been, "Does *she* have any family history of diabetes?" After all, this was exactly what the provider said. However, the interpreter changed the actual comment and interpreted, "Do any of *your* family members have diabetes?" (line 202), which changed it from second person to first person. One might argue that this is an effort to avoid confusion of referents. However, compared to other alternatives (e.g., "The doctor asks if you have any family history of diabetes"), Claire's strategy served an additional purpose. Whereas the provider's comment implicitly recognized the presence of an interpreter, the interpreter's utterance directed the comment to the patient and, thus, created the illusion of direct interaction between the provider and the patient. Although changing pronouns might seem to be in direct contradiction of a conduit style, the communicative goal (i.e., reinforcing the provider–patient relationship) was consistent with the ideology of conduit.

In addition to the verbal strategies, interpreters also adopted specific nonverbal behaviors to reinforce the provider–patient relationship. Several interpreters talked about how they intentionally avoided eye contact (e.g., staring at the floor or standing behind the speakers) when interpreting (see also Hsieh & Kramer, in press). In the participant observation data, the two interpreters I observed often positioned themselves in such a way that the provider and the patient were closer to each other than to the interpreter. In addition, on all occasions during which a provider pulled the curtain to perform a physical exam, the interpreters always stood outside the curtain and provided interpretation to the speakers' verbal messages.

Although a conduit role is eagerly embraced, interpreters often reported that they felt conflicted about adopting such a role, particularly when they witnessed some injustice in the patient's health care experience (see also Hsieh, 2006a). They felt the urge to depart from the default conduit role and assume the advocate role.

Advocate

The CCHCP training defined advocacy as "any action an interpreter takes on behalf of the patient *outside* [italics added] the bounds of an interpreted interview" (Roat et al., 1997, pp. 17-18) to rectify problematic situations (e.g., inequality or injustice of health care services). However, the interpreters in this study viewed advocate as a role that could be adopted both inside and outside the provider–patient interactions. The communicative goal of being an advocate is to empower a patient when they cannot obtain fair and equal health care services. In contrast to interpreters' keenness to claim a conduit role, only one interpreter, Stacey, explicitly stated that she is an advocate at all times:

> Because I am advocating for [the patients], because they might be worried, but they don't know what they are worried about. So, I ask them, "Would you like to ask if taking that medication has side effects?" So, I help them to understand some of the procedures and foresee something so that they would not worry about [it] later on.

Other interpreters viewed advocate as a role that one could assume temporarily. For example, Stella noted, "Because [minority patients] are not used to having anything, they don't know that they can ask to get better services. [When they do not ask for a better service], that's when you become an advocate." However, interpreters were cautioned against assuming an advocate role, despite the fact that it was a possible role in the training. In fact, several managers of interpreting services talked about the inappropriateness of an advocate role. Sharon, the director of an interpreting agency, argued, "[You] do more harm than good when you try to be more than an interpreter, when you try to be an advocate for the patient."

Being an advocate is contrasted against being a conduit; as a result, several interpreters discussed

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their decisions to not be an advocate. For example, Vicky explained,

> Who are you to tell the doctor what to do? Because you have patients who are very submissive, very afraid, depending on what they went through. So, the interpreter thinks that he or she has a right to advocate. But were you asked to do so?

As the interpreters contemplated the advocate role, their concerns included: Can (or should) they ask questions on behalf of a patient when the patient is too distraught, confused, or submissive to ask? Is that truly an advocating act, empowering the patients in the health care system?

Accomplishing patient empowerment. The findings of this study showed that interpreters developed three different advocate styles to accomplish patient empowerment, the communicative goal of this role. Each advocate style was based on very different understandings of empowerment. The first advocate style was to act on behalf of the patient (i.e., overt advocate). For interpreters who chose to be overt advocates, they essentially acted on the patient's behalf. In other words, they might have sought information, provided answers, and requested services for a patient without consulting with the patient. In Extract 003, the interpreter (Christie) acted as an overt advocate, requesting information regarding stem cell storage from the provider (Hilary).

Extract 003

H: So, I can go track down the genetic counselor. Maybe she might.
I: Okay. Okay.
H: But we don't.
I: Yeah. That's okay. If you can find the information.
H: People come all the time with the stem cells retrieval. But all we do is (.) collect.
I: Okay. If you can find out any kind of facility that can help. (.) Thanks.
H: You're welcome. Otherwise, she's gonna come back in one week. She will be on the low risk side (.) because there's nothing that we would do differently. She has all her genetic counseling, all of the testing for the baby with the amniocentesis, herself, and her husband. So, there's nothing we'd do differently. (.) And she can follow up on the low-risk side with Dr. (name) or Dr. (name).
I: Okay. Where's the low risk-?
H: Just down the hall?
I: The same thing for the room 4C? When she checks in to 4C?
H: Same waiting area, just when she comes in, she just [goes] down the hall.
I: She said that when you come back next month—next week, originally, you belonged to the high-risk group, but because all examinations for you, your husband, and your child were normal, so, she said, when you come back next time, you will be seen by the doctors for low-risk patients. But you come to the same clinic, 4C.
P: Oh, okay [in English].

In this interaction, the presence of the patient (Paula) was minimal because the interpreter had requested services and information on her behalf. In fact, the provider was talking directly to the interpreter. When interpreters act as an overt advocate, the primary speakers in the provider–patient interaction become the interpreter and the provider. In the interviews, interpreters also talked about assuming the role of overt advocate. For example, Roland explained that he became an overt advocate in a provider–patient conflict: "At that point, it was me advocating for her. I was like her legal advisor. I was just pushing her and *asking her not to say anything*. And *just let me take care of it*, which I did." By assuming the role of overt advocate, interpreters essentially made the patients invisible and made judgments about the types of services and resources needed by the patients.

The cultural differences in provider–patient relationships/interactions, as well as individual factors (e.g., educational background and socioeconomic status), all influence a patient's ability to obtain quality health care services. As a result, an interpreter might feel compelled to take over the patient's role in an effort to ensure that the patient has comparable care to their English-speaking counterparts. Stacey noted that,

> [The patients] don't ask you questions. I know that they have concerns. So, if I know them, and they have a serious problem, I tell them whatever thing that [appears] in their mind, even though they don't know how to voice their concern to tell me, give me a key, give me a word or something that they don't understand. So I can be their voice. So, I ask different questions to the doctor on their behalf.

As an experienced expert in the medical environment, an interpreter might, in fact, be more resourceful than

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the average English-speaking patient and obtain better services for their patients. The overt advocate role, however, puts the interpreters' presence front and center, which can challenge their ability to claim neutrality/invisibility and thereby threaten their clients' autonomy/authority.

The second advocate style is to provide means of self-advocacy to the patient (i.e., covert advocate). By providing means of self-advocacy, interpreters provide patients access to resources available in various areas (e.g., medical knowledge and relevant information). Patient empowerment is accomplished by covertly improving patients' health literacy. Whereas interpreters as overt advocates require patients to accept other-advocacy, interpreters as covert advocates encourage patients to act as self-advocates. The trick of covert advocacy is to allow patients to appear as their own advocates while, in reality, interpreters are the ones who provide the means for the patients to do so. Covert advocacy can take several forms. First, an interpreter might coach a patient about how to request proper services or information without the providers' knowledge. In Extract 004, the patient (Paula) complained that the hospital provided water with ice for her to drink after her delivery, a practice that contradicts a Chinese custom specifying that after delivery women should only drink hot water.

Extract 004

401 P: Yeah, these days—I drank chilled water in
402 the hospital.
403 I: Actually, they have hot water in the hospital.
404 If you tell the nurse, she'd give you hot water.
405 P: I said—I told her that I don't want ice. So,
406 it's not icy. She didn't put ice in it.
407 I: No ice. Right. Right. You should tell her,
408 "[switch to English] hot water."
409 P: Hot water [in English].

This interaction happened when the patient (Paula) and the interpreter (Christie) were alone in the exam room, waiting for the provider. The interpreter informed the patient about services available in the hospital (lines 403 to 404) and the proper way to ask for the services (lines 407 to 408). The interpreter used the English term "hot water" (line 408) instead of saying its equivalent Chinese term, showing that the interpreter was providing the patient with the tool to obtain the services. The patient's verification of the information and repetition of the English term in line 409 shows that she understood the interpreters' communicative goal of empowering the patient.

Interpreters who adopted the covert advocate role often assumed this role outside the presence of providers. Times in which the interpreters and patients were alone created opportunities for interpreters to become an advocate without compromising their neutral conduit role during the interpreting process. For example, after the physician left the room, a Spanish-speaking father explicitly told Sara that he did not know what questions he should ask the physician; in response, she coached him to ask the physician to provide clarification of the diagnosis, to discuss alternative treatments, and to explain long-term consequences of the disease. In another case, after witnessing a provider's prejudicial attitude, Colin informed the patient that if he wished to file a complaint, he would be able to take him to the complaint office and interpret for him. In such situations, by providing access to illness-related information and health care facilities, interpreters significantly enhanced the patients' abilities to obtain quality care. These instances of covert advocacy took place outside the presence of providers. As a result, interpreters were likely to appear neutral (i.e., a conduit) in provider–patient interactions.

Second, an interpreter might covertly provide hints or suggestions to the patient during a medical encounter. In Extract 005, the patient (Paula) indicated her concerns in an earlier conversation with the interpreter that her baby was losing weight. After the provider (Heather) asked the mother about her feeding pattern, the interpreter (Christie) initiated the following information exchange sequence.

Extract 005

501 I: Didn't you want to ask the doctor why she
502 [weighs] less today than when she was born?
503 P: Yes.
504 I: Another question, before, the nurse weighed
505 her, and she was born 7 pounds 11 oz., then
506 today, the weight is only—It lost about 6 oz.
507 H: 6 oz. It's normal.
508 I: She said it's normal

The interpreter might feel that the patient's concern was appropriate to be the next topic after information was exchanged about the baby's feeding patterns. Such a judgment might require a speaker's ability to understand the norm of information exchange patterns in provider–patient interactions,

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which an interpreter might have more experience with than the patient. Christie, in fact, prompted the patient to ask the question. In the interviews, interpreters also talked about their covert strategies (e.g., hinting or reminding patients about topics to discuss with the providers) of advocating for the patient.

Third, interpreters might help a patient be a more competent participant in provider–patient interactions. For example, interpreters can covertly help a patient seek information in a more effective and appropriate way by elaborating on a speaker's comment to improve a patient's ability to request services, to understand medical procedures, and to engage in effective provider–patient interactions. In Extract 006, the interpreter (Claire) elaborated on the provider's (Hilda) comment to improve the patient's (Pam) understanding.

Extract 006

601 H: Has she ever heard of Equal?
602 I: Have you heard of Equal? The English term
603 for this sugar, Equal, they call it substitute
604 sugar, it's not a naturally produced sugar.
605 They call it substitute sugar. Americans call
606 it substitute sugar; the brand name is Equal.
607 P: No.
608 I: No.

Claire's elaboration on the name Equal helps the patient to better understand the provider's information by providing background information about what a sugar substitute is and that Equal is just a brand name. Understandably, it is risky for interpreters to adopt covert advocacy during a medical encounter because the turn-taking patterns and the length of utterances might allow other speakers to notice the interpreter's advocate role. Nevertheless, interpreters might opt to maintain a covert or less visible presence because of their desire to appear neutral.

The third type of advocate reflects the interpreters' ever-present struggle to be neutral. Faced with the challenges of being neutral and the insufficient care often received by minority patients, interpreters created a twist on the meaning of patient empowerment. The third type of advocate assumes that patients are competent individuals who act on their own behalf. Empowering a patient is not intervening on their behalf, nor giving the interpreter's opinions. In other words, patient empowerment is accomplished through respecting patients' autonomy and acting as a conduit. Shirley, manager of the interpreter office of a major hospital and a trainer for an interpreting program, explained, "By NOT empowering, by giving your opinion, going immediately into an advocacy role as a medical interpreter, I feel that you keep [that patient], that parent or that guardian, or primary caretaker, from becoming empowered." Essentially, this is a conduit role because it legitimizes the interpreter's choice of not taking any initiative. Interpreters who identify with this type of advocate, in fact, do not provide any advocacy at all. By blurring the lines between patient empowerment and patient autonomy, these interpreters justify their conduit role as patient advocacy.

In summary, although empowerment remains the central concern for interpreters, the three types of advocate are based on drastically different beliefs about patient empowerment. Interpreters' understanding of patient empowerment not only influences their communicative behaviors during the medical encounter but also their interactions with others outside of the interpreting session.

Manager

Few interpreters in this study explicitly used the term manager to explain their roles. Several interpreters talked about their roles as cultural broker, gatekeeper, mediator, or moderator. As we examined the interpreters' narratives on these roles, it was evident that these roles highlighted interpreters' active management of various resources. Thus, I have chosen to use the term manager to describe this category of role. Interpreters inevitably need to decide what the appropriate communication for quality health care should be and how they can achieve this goal. Shirley explained,

> [The most important skill for a medical interpreter is] knowing the basic, your code of ethics as a medical interpreter, and knowing that you are going to have to navigate within five of them in one instance, and have the luxury of two seconds to decide what to do while remaining transparent, and not tainting the outcome.

Thus, a manager becomes an active participant in a provider–patient interaction. A manager's decision not only influences the process of communication but also the outcome of health care services. Three major communicative goals emerged as interpreters talked about the manager role: (a) conserving medical resources, (b) regulating appropriate, ethical, and relevant performances, and (c) managing the optimal exchange of information.

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Conserving medical resources. Researchers have noted that interpreters provide services that overlap with providers, investigating symptoms, filtering patients' reports, and evaluating the significance of information with or without providers' knowledge (Angelelli, 2004a; Davidson, 2000; Hsieh, 2007). The current study supports these findings but also highlights some other areas in which interpreters might be influential in managing medical resources, taking on roles that conserve medical resources (e.g., medical treatment and providers' time).

First, interpreters might act as a (covert) codiagnostician, a finding that is consistent with previous studies (for a detailed review of the codiagnostician role, see Hsieh, 2007). By adopting the role of codiagnostician, interpreters might help providers identify the problem more effectively and, thus, conserve medical resources. For example, Vicky discovered new symptoms that were never brought up in earlier provider–patient communication but were important to the diagnosis. Sandra found out that the treatment failed because the provider was not aware that the patient has diabetes. These investigations might occur with or without a provider's knowledge. Interpreters' involvement as a codiagnostician might begin even before patients meet with their providers. For example, Stacey mentioned that in a particular case, if she had seen the infant patient beforehand, she would have discouraged a first-time mother from seeking medical treatment because "it was not a big deal." Sara viewed time in the waiting room as opportunities to investigate potential problems, because "people started talking more to me and told me what the problems were at home." These conversations, outside the presence of providers, provided crucial information that allowed interpreters to situate patients' medical conversations in a context to which the providers might not have access.

Second, an interpreter might act as a bystander to medical encounters. Interpreters often work with the same patients during different appointments and, thus, acquire knowledge of the patient through multiple appointments. Interpreters might verify information (e.g., providing next-turn response or back-channel confirmation) that they already know to shorten the provider–patient interaction and only interpret messages that they were not able to verify. In Extract 007, the patient (Paula) had brought her newborn baby for the first follow-up after her delivery. She and the interpreter (Christie) had met before in several prenatal appointments, whereas the provider (Heather) was meeting both the patient and the interpreter for the first time.

Extract 007

701 H: Is it her first baby?
702 I: No, the second one.
703 H: Boy or girl?
704 I: Boy or girl?
705 P: Girl.
706 I: A girl.

In this interaction, the interpreter treated the provider's information-seeking comments differently. The interpreter provided answers (line 702) without interpreting the message to the patient, but then interpreted the provider's question in line 704. In a way, by initiating answers without prompting or verifying information independently, interpreters are able to reduce the time of provider–patient interactions.

Interpreters know and interpret all utterances in a medical encounter. As a result, they can conserve medical resources by providing information that happened during the medical encounter and, thus, reduce the patients' use of medical resources (e.g., physicians' time). In Extract 008, the interpreter (Christie) initiated the conversation with the patient (Paula) and summarized the provider's (Heather) instructions after the provider had left the exam room.

Extract 008

801 [Provider left the room]
802 I: This form is for today. [hands over the form
803 that the provider gave her earlier]
804 P: Two-thirty. Is this for today?
805 I: Yeah, September 12. [checks the date on the
806 form]
807 P: Is it the same appointment or is it another
808 appointment? Is there an appointment at
809 2:30? Should I come again?
810 I: No, this is your appointment today.

In this interaction, Christie conserved medical resources by independently providing, verifying, and confirming information for Paula (lines 802 to 810), which reduced the actual encounter time with the provider. Several interpreters mentioned that after the provider leaves the room, patients might ask questions to verify their understanding of the diagnosis or medication. Some interpreters said that they would confirm information that had already been discussed during the medical encounter and seek the provider's clarification when needed. These strategies allowed interpreters to conserve medical resources by determining the optimal use of providers' services.

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Finally, interpreters might act as a flexible backup, providing variable services when needed. Medical resources (e.g., providers' time) are limited. Many interpreters talked about how physicians' communicative behaviors reflected their lack of time or cultural sensitivity to provide optimal care for minority patients. In the participant observation data, it was not uncommon to find patients discussing their emotional and social stress with the interpreter (outside the presence of providers). Interpreters, at times, might provide empathy, counseling, and comfort to the patients. For example, a pregnant mother (Paula) talked to the interpreter (Christie) about her concerns for her first child, who suffered from a genetic disease.

Extract 009

P: They tested the blood and said it was a genetic disease. But now, when I had this baby, we test the amniotic fluid; my husband and I tested our blood, and there was no such condition. I don't know why my son had this problem. All my family members, everybody, none had this condition.
I: None had this condition. (2 sec) Don't worry about it.
P: No. This is really a worrisome problem. Because his situation is very difficult, he has granulation everywhere. The granulation just happens without any patterns.
I: I understand. I know what you mean. (5 sec) But you have to face the problem with ease.

In the interviews, some interpreters talked about how they conserved providers' time by providing services that generally are not associated with the job descriptions of medical interpreters. Some interpreters talked about how they assumed the role of a social worker, counselor, or person with empathy to provide better service to their patients. For example, Roland mentioned that he stayed after the appointment to comfort a pregnant patient who was first diagnosed with HIV because "the social worker really didn't do much at a cultural level."

Regulating appropriate and ethical performances. Interpreters are in a position to monitor other speakers' performances. When assuming the role of manager, interpreters do not side with any speaker but evaluate whether the information is appropriate and ethical to the provider–patient interaction, and choose their communicative strategies accordingly. Interpreters might adopt various linguistic strategies (e.g., metacommunicating or invoking a different communicative context) to accomplish these goals. Sandra talked about one incident in which two providers argued about the diagnosis in front of a patient. I asked other interpreters how they would manage this situation. Some interpreters said that they would ask the doctors if they should interpret the argument. Others said that they would politely ask the providers to stop the discussion and leave the room. Sherry said, "Sometimes, you don't even have to say it. Just by looking at them, they'd look and they'd just walk out. They'd just walk out." These strategies allow interpreters to navigate the problems of speakers' (culturally) problematic performances.

In Extract 010, the interpreter (Christie) modified the provider's (Hester) comment to the patient (Pearl), who was concerned that her unborn child had a large head for the age of the fetus. The following interaction took place during the patient's follow-up ultrasound examination.

Extract 010

H: The baby is growing fine and everything looks normal. It's measuring normal.
I: She said that the baby is growing well. All measurements are very normal.
P: Then, last time she said that-
I: How about last time you mentioned that the-
H: It's measuring normal. That's what I'm saying [in an abrupt and mildly irritated tone]. (Everything's) measuring normal.
I: It is measuring normal now. [in a calm tone]

The providers' response in lines 1007 to 1009 seems inappropriate because of her tone and impatient attitude. The interpreter, however, removed the inappropriate emotion of the provider's comment but kept the medical information in her translation (lines 1010). Some interpreters argued that they did not interpret the inappropriate emotions or attitudes (or even comments) because the speakers already had access to that information (e.g., they could see or feel it or they had some level of proficiency in English). Interpreters might even manage their clients' performances outside the medical encounter. For example, Stacy said that she informs her clients about appropriate ways to present themselves (e.g., sitting straight in the waiting room), even when her interpreting services are not needed.

Interpreters also might choose to provide other speakers with a framework in which appropriate performances are specified. For example, Valerie talked

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about an incident of provider–patient conflict in which she eventually informed a patient, "[You] made the doctor upset so don't ask [the physician] any more. Because if he could have done it, he would have done it for you already. . . . Don't try to convince him that you are right." Valerie, in a way, silenced the patient's voice by pointing out her inappropriate behavior and specifying the appropriate norm that is accepted in provider–patient encounters.

Managing an optimal exchange of information. The results of the current study suggest that interpreters' management of information can manifest in several ways. First, interpreters talked about modifying information to improve the providers' and the patients' understanding. For example, Yetta noted that there is no equivalent term for the word hip in her language, so she explained it by saying it is "something that supports you when you sit." Failure to manage information might lead to serious consequences. Sandra said that she once found out that a Spanish-speaking psychologist agreed to have his baby circumcised without knowing the word circumcision. She reflected, "He was a psychologist in Mexico. I thought that he knew what it was, especially because I used the correct Spanish word. But he did not know that term." Such an incident reminds an interpreter that a linguistically equivalent translation is not a guarantee that there is understanding. Differences in speakers' socioeconomic status, or educational or cultural background, can lead to ineffective communication, as well. For example, Sandra said that she once interpreted glaucoma as pressure in the eye because she believed that it was important for the patient to understand the meaning of the diagnosis rather than abstract terminology.

Second, an interpreter might modify information for cultural reasons (e.g., certain comments might be considered inappropriate or offensive in another culture). This, however, is different from the cultural broker role discussed in the interpreters' training. A cultural broker requires an interpreter to provide others with the cultural framework to understand the communication (Roat et al., 1997), whereas interpreters who manage information for cultural reasons do not necessarily make that perceptible to other speakers. For example, several interpreters talked about how American physicians ask questions that can be perceived as disrespectful or offensive to patients. Knowing that the answers might be crucial to a patient's diagnosis, interpreters did not simply omit the providers' questions, but modified the information. For example, Ulysses explained how he modified the providers' information-extracting methods.

> [Providers] ask about sexual contact outside of the marriage, which is really [a] very bad question. BUT, I ask them. It is very *offensive*. . . . I said, "Does your husband go to other women?" . . . In that way, you give the responsibility to the husband, because Muslim women are very faithful to their husbands. That is the way that I get the answers.

Although Ulysses did not necessarily see his behavior as a violation of the conduit model ("BUT, I ask them."), the actual question interpreted ("Does your husband go to other women?") is drastically different from the original question (e.g., "How many sexual partners do you have?"). The person being questioned and the implied threat to face because of infidelity are shifted from the female patient to her husband.

Third, interpreters manage both the content and the flow of information (i.e., who gets to know what). Interpreters also talked about screening the relevance of information. The conversation depicted in Extract 011 took place upon Hank's (H1) and Heather's (H2) return to the exam room after consulting about the initial diagnosis in Hank's office.

Extract 011

1101 [H1 knocked on the door and came in with H2]
1102 H1: Okay, umm, that was fast.
1103 I: He said he came back real fast.
1104 H1: I thought that people would remember—I used
1105 to—Just one more thing, I changed my mind.
1106 H2: I couldn't (totally examine) her eyes though,
1107 she was not opening her eyes.
1108 H1: Yeah.
1109 [H1 examines the baby's body]
1110 H1: The other baby has spots on the face or
1111 spots on the body?
1112 I: Does your other child have red—
1113 H1: White spots?
1114 I: White spot on the face or the body?
1115 P: Yes.
1116 I: Yes.

The interpreter (Christie) did not interpret comments that were not directed to the patient (Paula), which suggests that the interpreter was actively evaluating the relevance of the information. When a comment was directed toward the patient, the interpreter interpreted the comments immediately (e.g., lines

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1102 to 1103 and 1110 to 1116); however, when the comments were not directed to the patient (i.e., lines 1104 to 1109, the interpreter did not interpret that information. Interpreters talked about how they made these decisions. Sandra explained, "If a patient is not involved in that conversation, then I don't translate."

Interpreters, at times, took a stand on how and to whom certain information should be relayed. For example, in some cultures, the responsibility for information control (i.e., information seeking and withholding) often is assumed by family members rather than patients (Blackhall, Frank, Murphy, & Michel, 2001; Kaufert, Putsch, & Lavallée, 1999). Vicky explained that because of her cultural norms, if a provider asks her to inform a patient of a poor prognosis, she replies, "I would rather discuss this with the family. I would tell the husband"—a response that restricts providers' control over the flow of information.

Professional

No interpreter in this study indicated that he or she felt ill equipped as a professional, although all five managers of interpreter services felt that the 40-hour training was the minimum necessary for professional quality interpreting. Many interpreters differentiated themselves from individuals who are simply bilingual, taking pride in their professionalism. It is evident in the data that the interpreters viewed themselves as professionals and wanted to claim authority and establish control. Several interpreters explicitly talked about their identities as professionals. Interpreters' understandings of being a professional are often situated against an ongoing debate: Are interpreters patient advocates or physician aides? The attempt to be a professional is, in a way, to break away from the constraints of being controlled by others. Peter explained,

> The interpreter should have control of all situations; you never let go of something and lose the control. So, I think that's kind of a professionalism, that I am in the middle of exchanging information and it is my task to be in charge and to be in control.

The concept of controlling provider–patient communication is not unproblematic. For example, an interpreter might be reluctant to respond to other speakers' requests about their role performances if they think that those expectations violate their professionalism (also see Hsieh & Kramer, in press). A provider, however, might not easily accept, or might even feel betrayed by, an interpreter's refusal to follow his or her request (e.g., informing a patient of a poor prognosis).

The communicative goal of this role is be perceived as a professional in health care settings. However, the strategies for achieving this goal might vary drastically. Interpreters might adopt strategies to ensure that their performances meet the professional standards. Alternatively, interpreters might use different strategies to disguise their nonprofessional behaviors. Whereas the communicative goals of other roles focus on meeting the needs and expectations of the provider, the patient, or the institutional standard, the communicative goals for the professional role center on the interpreters' own needs.

First, interpreters try to maintain professional performances in various situations. In the interviews, all interpreters said they would not hesitate to interrupt a provider–patient interaction and to seek clarification from the participants if (a) they felt that there were misunderstandings between the speakers, or (b) they did not understand a specific term, concept, or procedure. In Extract 012, the interpreter (Claire) initiated a question to clarify the drug named by the provider (Helen) without first checking with the patient (Paul).

Extract 012

1201 H: Has he ever been given Adefovir before?
1202 I: Did he give you- I think it's called Adefovir
1203 P: No.
1204 I: Excuse me, the interpreter would like to
1205 clarify, do you mean is it a brand name of
1206 medication? Adefovir.
1207 H: Hepsera is the trade name, Adefovir is the
1208 generic name.
1209 I: Adefovir is the name of the drug, the drug
1210 name for the brand.

In Extract 013, the interpreter (Christie) was interpreting for a pregnant patient (Paula) and was not familiar with a term that the provider (Hilary) used.

Extract 013

1301 H: She was supposed to be transferred back to the
1302 low-risk clinic. The last thing I want to tell her
1303 about is the kick count. Is she doing kick count?
1304 I: Hmm, excuse me, what is kick count?
1305 H: Maybe she might [know].

In these two examples the interpreters initiated questions to clarify the other speakers' comments. For example, in line 1201, it was not clear exactly

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what Adefovir was, and Claire initiated a question to ensure that her understanding was correct. In line 1304, Christie requested a definition of kick count. After all, if she does not know what that is, it is hard for her to translate the term into a different language. The provider, however, was not aware of Christie's dilemma and, thus, refused to clarify the information (i.e., line 1305). When interpreters take the initiative to clarify or verify information that they are not sure about, they inevitably draw attention to their imperfection. Nevertheless, they also demonstrate their commitment to provide quality services.

In addition to requesting the definition of a term, interpreters might sometimes need to stop the flow of communication to clarify an entire procedure. In Extract 014, after the provider (Hannah) tried several times to explain the use of testing strips and the patient (Pam) remained confused, the interpreter (Claire) stopped the provider–patient interaction and asked the provider to explain again.

Extract 014

1401 H: Yeah, every time you are going to check
1402 your blood sugar, you are going to use one of
1403 the strips. You are going to use 10 strips in this
1404 [disk] and that's finished. You are going to-
1405 I: Open another new one.
1406 H: You are going to change four times.
1407 I: Yeah, that's what I meant.
1408 H: Four times you are going to change. But the
1409 first one that you are going to put in a box, okay.
1410 I: Yeah, only the first time.
1411 H: If it comes two in a box, then, every time you
1412 get a new box, you have to check the first one.
1413 I: Only the first one. The rest is-
1414 H: The rest is the same number. They are the
1415 same. So they don't have to.
1416 I: Yeah, that's what I understand. Okay.
1417 [Switch to Chinese and went on to explain
1418 to the patient] In a new box, there are
1419 usually four strips. . . .

Although the patient was not involved, Claire was not acting on the patient's behalf (i.e., advocate), but was checking her own understanding; her primary concern was not the patient's understanding but her own. She demonstrated her understanding by filling in information that the provider had said earlier (e.g., lines 1405, 1410, and 1413). In addition, her comments in lines 1407 and 1416 (i.e., "That's what I meant." "That's what I understand.") informed the provider that she had understood and interpreted the information correctly. In short, the interpreter demonstrated to the provider that the patient's confusion was not the interpreter's fault.

In the participant observation data, interpreters often talked to the patients about other patients that they had worked with, which also allowed them to implicitly establish the identity of an experienced expert. Interpreters also explicitly claimed professionalism when they interacted with speakers. Yetta said that she let the patients know that they can "just talk to the doctor and whatever they say is safe with [her]." Sharon said that she would introduce herself when she first met the patients, and let them know that "everything will be repeated and everything will be kept confidential." In the participant observation data, I did not find any examples of self-introduction in which the interpreters provided detailed information about the appropriate roles. Most of the time, the interpreters just identified their roles as interpreters. It is possible that the interpreter felt a need to limit his or her self-introduction (so they did not infringe on the provider's time), a point mentioned by several interpreters. Although interpreters' comments reflected their awareness about the time constraint, they also understood the self-introductions as a time to define specific identities. For example, the interpreters sometimes claimed specific identities when introducing themselves. In Extract 015, the patient (Paula), who had worked with the interpreter (Christie) on other occasions, met the provider (Heather) for the first time.

Extract 015

1501 [The provider enters the room.]
1502 I: I'm the interpreter for the mom during the
1503 pregnancy.
1504 H: Congratulations, momma.
1505 I: Congratulations.
1506 P: Yeah, thank you.
1507 H: Is it her first baby?
1508 I: No, the second one.

By informing the provider that she had worked with the patient in the past (lines 1502 to 1503), the interpreter implied that she knew the patient's medical history. This was later demonstrated by the interpreter's volunteered answer (line 1508) to the provider's question about the patient's history.

The second strategy to achieve the communicative goal of a professional role is disguising nonprofessional performance. Understandably, in the interviews no interpreters talked about faking understanding to make themselves look professional. However, in the

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participant observation data, it seemed that interpreters, at times, interpreted in ways to disguise their misunderstanding or mistakes, which I will term false fluency. False fluency is associated with particular communicative goals, such as protecting the interpreters' face. In other words, the interpreters intentionally worked to present an illusion of fluency, although they were aware that their understanding was problematic. In Extract 016, a pregnant patient (Pearl) was receiving an ultrasound. The technician (Hazel) pointed out the fetus' different features but the interpreter (Christie) was not sure about the terms Hazel used.

Extract 016

1601 H: Placenta (the voice is low and unclear)
1602 I: I'm sorry, what did you say?
1603 H: Placenta, the afterbirth.
1604 I: Oh, it's just the area that's similar to the
1605 belly button.

The interpreter's question in line 1602 indicates that she didn't hear what the provider had said. The provider's comment ("Placenta, the afterbirth") in line 1603 shows that the provider made an effort to ensure the interpreter's understanding. By adding "the afterbirth," the provider negated the possibility that the interpreter was not familiar with the term placenta. Nevertheless, the interpretation indicates that the interpreter was trying to disguise a problematic information exchange sequence. The interpreter hedged ("it's *just the area that's similar to* the belly button") in her interpretation. Because the interpreter was able to see the monitor and could see where the provider pointed (although she did not know what the provider said), she knew that the area was near the baby's belly button. As a result, the interpreter disguised the fact that she didn't know the term by making something up as a reasonable guess.

Discussion

The current study highlights an important aspect of interpreter-mediated activity that has rarely been systematically examined: How the various roles are understood and enacted by interpreters. Interpreters justify their communicative behaviors by claiming roles (Hsieh, 2006a). Recently, some researchers have focused their attention on interpreters' understanding of their roles. For example, Dysart-Gale (2005) explored how interpreters' understandings of their roles differ from the conduit role. Angelelli (2004a) used case studies to illustrate interpreters' complex understandings of their roles. Although both researchers noted the complexity of interpreters' understanding of their roles, neither one provided a systematic examination of how the various roles are understood and enacted by interpreters.

This is the first study to develop a typology of roles from the interpreters' perspective. This typology represents a normative account of the interpreters' views. It is critical for researchers to understand the role performances from the interpreters' perspective, because interpreters generate these role performances to respond to the challenges, conflicts, and dilemmas that they encounter in their everyday work. By understanding how interpreters understand different roles, researchers can systematically examine (a) the communicative goals that motivate nonconduit behaviors, and (b) the communicative strategies that are employed in these role performances.

The findings of this study demonstrate that although all interpreters were familiar with the roles presented in the CCHCP training, their self-perceived roles did not always coincide with the ones proposed by the CCHCP. For example, by discussing their advocacy strategies during an interpreter-mediated interaction, interpreters indicated that they extended the boundaries of the advocate role prescribed in their training. By assuming the manager role, interpreters monitored resources and issues that might not have been related to language (e.g., medical resources).

An unanticipated finding of this study is that interpreters adopted communicative strategies that are more than the "nonthinking, robotic" transmission of information, even when they thought that they were assuming the conduit role. Interpreters utilized both verbal and nonverbal strategies to reinforce the provider–patient relationship. By manipulating linguistic features, interpreters created the illusion of a dyadic interaction. By being silent when the primary speakers communicated directly with each other, the interpreter empowered the speakers to establish rapport and trust with each other. By avoiding eye contact or standing behind speakers, interpreters not only became less visible but also influenced others' communicative behaviors, making them communicate with each other directly (e.g., having eye contact). From this perspective, a conduit role is not a nonthinking, robotic way of interpreting, but includes specific communicative strategies to accomplish the communicative goals of reinforcing the provider–patient relationship.

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Although several researchers have argued that interpreters view themselves as active participants in medical encounters (Angelelli, 2004a; Dysart-Gale, 2005), the current study shows that interpreters' enactment of various and shifting roles can be influenced by their desire to maintain the conduit role during medical encounters. For example, when adopting covert advocacy, interpreters influenced the content and process of provider–patient interactions without the providers' knowledge and, thus, could maintain the image of a conduit during the medical encounters. When witnessing problematic interactions, some interpreters in this study felt conflicted but still believed that intervening would compromise patients' autonomy and their own neutrality (see also Hsieh, 2006a). Researchers have argued that interpreters' practices provide them with a new understanding of their roles (Angelelli, 2004b; Dysart-Gale, 2007). However, because the conduit role was highly emphasized in their training, it is important to recognize how their training influences their practices and its implications. For example, although covert advocacy might empower patients and allow interpreters to maintain neutrality, it excludes providers in the communicative process. Providers are denied opportunities to assess patients' true health literacy and to adapt to patients' needs. Alternatively, if interpreters do not believe that they should intervene in problematic situations, there might be serious threats to quality and ethical health care services.

This study's findings also suggest that interpreters are concerned about the goals of the institutions (e.g., conserving medical resources or managing others' performances), which is not part of their training. In CCHCP's training, the cultural broker and clarifier roles focus on the other participants' understanding of and control over the provider–patient interactions. Although some interpreters still used the terms cultural broker or clarifier, their narratives focused on ensuring that the interactions were culturally appropriate and sensitive. Their strategies reflected more emphasis on the institutional standards than on other participants' needs and objectives. For example, when interpreters refused to interpret certain information, they limited the providers' ability to communicate with patients. Although the communicative goals of the manager role can be beneficial to institutions, researchers need to examine these communicative strategies closely. Although some strategies might be problematic (e.g., changing the providers' question), others might be appropriate. For example, allowing interpreters to confirm information exchanged during the medical encounter and to seek clarification with providers if necessary is an effective way to utilize interpreters as trained experts and to conserve institutional resources. The process of identifying and examining the strategies related to the manager role will require researchers and others in the health care community to contemplate individual expertise, ethical boundaries, and institutional needs for participants involved in bilingual health care. Nevertheless, medical interpreters might prove to be an extremely valuable resource in not only providing linguistic services but also cost-effective and culturally sensitive care.

Finally, it is important for other speakers to recognize interpreters' communicative goals of maintaining and claiming professionalism. If other speakers fail to recognize interpreters' communicative goals during interactions (e.g., seeking clarification), the interpreter might have difficulty eliciting others' appropriate communicative behaviors and ensuring effective provider–patient interactions. The communicative strategies of the professional role reflect a delicate balance and a double bind of interpreters' management of identities and communicative goals: They need to ask questions to ensure quality services, but if they ask too often they might be perceived as incompetent. If other speakers recognize this dilemma, they can adopt preemptive strategies to avoid potential problems. For example, a provider can tell the interpreter that the particular treatment is complicated and that he or she expects the interpreter to interrupt and ask for clarification. A successful medical encounter requires effective collaboration and appropriate performances from all participants. Providers' interactions with interpreters are critical to the success of bilingual medical encounters.

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