The Interpreters' Newsletter Special Issue 2024 (29 bis), 81-104
DOI: 10.13137/2421-714X/36974 ISSN 1591-4127 (print) ISSN 2421-714X (online)
https://www.openstarts.units.it/dspace/handle/10077/2119

Interpreter Reports on Patient and Family Behaviour Impacting on the Healthcare Interpreter Role

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Abstract

This paper focuses on interpreter reports regarding behaviour of family and their relatives in the healthcare interpreting setting in Australia and how this impacted on them and their ability to carry out their role. These reports were part of a broader study in which professional community interpreters participated in a nationwide survey about the expectations of the health interpreter role. Three main themes emerged in this respect. Firstly, interpreters reported on the difficulty of dealing with situations where patients or relatives declined the need for an interpreter. Secondly, they reported experiencing issues where patients or relatives did not want the interpreter to behave impartially. Lastly, interpreters reported the impact of working in situations where emotions were running high for a range of reasons and described how this impacted on their ability to carry out the assignment. This paper will discuss examples of all three, before concluding with some suggestions of ways interpreters, interpreter educators, professional bodies, health organisations and the government could address this lack of understanding of the interpreter role.

Keywords

Health interpreter role, patient expectations of interpreter role, family expectations of interpreter role, briefing, interpreter role explanations.

1. Introduction and Background

Healthcare interpreting has been the subject of research in many countries, and researchers have focused on different aspects of healthcare interpreting, ranging from qualitative analysis of interactions (Tiselius/Sneed 2020; Klammer/Pöchhacker 2021; de Boe *et al.* 2024), to education (Crezee 2015, 2022; Niemants/Stokoe 2017; Krystallidou *et al.* 2018; Sultanić 2020; Hlavac *et al.* 2022;), interaction management (Lan *et al.* 2022), intercultural awareness (Mahdavi 2020; Gao 2021; Ra 2022), interpreter role more in general (Roy, 1993; Wadensjö, 1993) and healthcare interpreter role (Angelelli 2004, 2024). Research has addressed discrepancies in the role of the interpreter as determined by different codes of conduct (de Boe *et al.* 2021). To date scant studies have looked at the impact of patient and family behaviour on the healthcare interpreter role, and yet this is important since previous research has shown that misunderstandings about the role of the interpreter may have a negative impact on interpreter-mediated interactions (Crezee *et al*. 2020), including aspects of the Calgary Cambridge framework of health communication (Kurtz *et al*. 2003), shared decision-making and patient-centred care.

Healthcare interpreting takes place in a setting where both patients and their loved ones may be worried about the patient's health, and the outcome of any diagnostic studies. This may lead to interactions where emotions may be running high, requiring interpreters to address such interpersonal and intrapersonal challenges (Ulaş 2022; Hancox *et al*. 2023). Dean and Pollard describe such interpersonal demands as those that "usually pertain to elements of the interaction between consumers and/or the interpreter" (2011:164). It may also take place in specialised healthcare contexts such as speech pathology (NSW HCIS 2014) and the mental health setting (NSW HCIS 2014; Hlavac 2017). The findings presented in the current paper is based on a survey of the interpreter role involving Australian interpreters working in the healthcare setting (Crezee *et al*. 2020) who commented on patients and relatives not understanding their role. The paper will start by defining healthcare interpreting as a form of public service interpreting (Hale 2011b; Setton/Dawrant 2016; Crezee/Burn 2022), before reviewing the field of healthcare interpreting studies in general, different professional codes and guidelines for practice (de Boe *et al*. 2021), the healthcare interpreter role within the context of patient-centred care and shared decision-making, before moving to studies which explore different perspectives of the healthcare interpreter role.

This paper supports on a survey conducted in Australia, where the engagement of trained interpreters is government-subsidised and, generally speaking, free to patients in both primary healthcare and hospital settings. Australia introduced a national accreditation system for interpreters and translators in 1977 (Hlavac *et al*. 2018) when the National Accreditation Authority for Translators and Interpreters (NAATI) was first established. The NAATI accreditation system underwent changes following recommendations in a comprehensive report prepared by Professor Sandra Hale and colleagues (Hale *et al*. 2012). Under the new NAATI credentialing system, interpreters can either hold certification as a Provisional Certified Interpreter, Certified Interpreter or Certified Specialist Health Interpreter. Those interpreters for whom certification tests are not (yet) available may hold a Recognised Practising credential[1]. The find-

1 <https://www.naati.com.au/certification/>

ings reported on here resulted from an Australian survey involving interpreter survey respondents, all of whom reported being NAATI accredited/certified.

2. Literature Review

This literature review will look first at Public Service Interpreting (PSI) in general, since many authors consider healthcare interpreting to be a form of PSI. This will include a discussion of the different contexts and codes governing public service interpreting. Next, we will provide a definition of healthcare interpreting and a brief discussion of the influence of context (de Boe *et al*. 2021) on healthcare interpreter role, and this in turn is followed by an overview of previous studies on healthcare interpreter role.

2.1 Public service interpreting

According to a number of authors, including Setton and Dawrant (2016), Sultanić (2020) and Crezee and Burn (2022), healthcare interpreting falls under the umbrella of public service interpreting (Corsellis 2008; Hale 2011b; Balounová 2021), which is also referred to as community interpreting (Hale 2007; Eser 2020; de Boe *et al*. 2021). According to Setton and Dawrant, both community-based interpreting and public service interpreting are "interpreting services to facilitate communication between public service personnel (medical and social services, law enforcement, etc.) and members of linguistic minorities in the community" (2016: 23). Public service interpreting is the most common form of interpreting in many countries, especially those that receive significant numbers of migrants, refugees and asylum seekers, such as many European Union membership states (Bischoff 2020), but also countries such as Australia and New Zealand.

2.2 Healthcare interpreting

Healthcare interpreting is a form of public service interpreting (e.g. Hale 2011b), where the interpreter ensures that health professionals can elicit important information from patients as part of history taking, diagnosis, prognosis and proposed treatment (Tebble 2012). The role of the healthcare interpreter varies significantly from one geographical area to another one country or state to the next (Roat/Crezee 2015; Angelelli 2020; Crezee *et al*. 2022). Healthcare interpreters also ensure that patients, in turn, can ask questions about diagnosis and treatment. This requires significant medical and healthcare system knowledge on the part of the interpreter to ensure accuracy (Crezee *et al*. 2022). Indeed, Hale summarised the interpreter's role in the medical setting as follows: "The interpreter renders each turn accurately from one speaker to another, leaving the decision making to the authors of the utterances" (2011b: 43). This requires that the interpreter maintains both accuracy and impartiality and does not yield to pressure on the part of family members of the patient to censor or omit important information.

Bischoff (2020: 3) comments that "30 years ago, medical interpreting was more commonly used, as if the use of interpreters was only relevant for physicians or in the

world of medicine". The National Council on Interpreting in Health Care (NCIHC) standards for practice define healthcare interpreting as follows:

> Interpreting that takes place in health care settings of any sort, including doctor's offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations. Typically, the interpretation occurs during an interview or encounter between a health care provider (doctor, nurse, lab technician) and a patient (or the patient and one or more family members) (NCIHC 2005:11).

Roat and Crezee define healthcare interpreting as "interpreting that takes place during interactions related to health care" adding that "healthcare interpreting is a later term recognising that the field covers interactions that are not strictly medical in nature, such as rehabilitation and mental health" (2015: 237). Healthcare interpreting can take place face-to-face or remotely, and the remote mode impacts on the interaction between all parties involved (de Boe 2021, 2024a, 2024b). The survey reported on in this paper was based on interpreters reporting their experiences in face-to-face interpreting encounters (de Boe 2021).

2.3 Professional codes and interpreter role

When reviewing previous studies on public service interpreting and healthcare interpreting, it is important to consider the different contexts in which such encounters took place. De Boe and colleagues (De Boe *et al*. 2021) have led the way in providing a detailed discussion of the geographical, socio-situational and interactional context affecting interpreter practice and interpreting studies. The socio-institutional context is important as it impacts on the "norms governing the interpreter's role as prescribed by professional codes" (*Ibid.*: 9). These roles may not only be impacted by Codes of Ethics and Codes of Conduct (NCIHC 2004; AUSIT 2012a, 2012b; New Zealand Society of Translators & Interpreters [NZSTI] 2013), but also by Standards of Practice and Guidelines for Practice (e.g. NCIHC 2005; NSW HCIS 2014; NSW Health 2017). Setton and Dawrant (2016) refer to the debate about the public service interpreter's role to either be about someone who "should restrict their role to transferring the meaning of messages" or "also give advice and opinion", "be impartial" or "be on the side of the other-language speaker and act as advocates of their cause" (2016: 23). And indeed, the overview of professional codes provided by Duman (2021) shows that these generally cover different forms of public service interpreting, without being specific to healthcare interpreting. Sleptsova and colleagues (2014) looked at different models of healthcare interpreting in terms of roles and expectations found that out of the 34 articles only two recommended strict adherence to a conduit model (Crezee 2022).

With regard to Australia, Nevado Llopis and colleagues (2021:27) write that "[a]ll certified interpreters must follow the code of ethics of the Australian Institute for Interpreters and Translators (AUSIT 2012a) which is endorsed by NAATI and many other organisations". The 2012 AUSIT Code of Ethics and Code of Conduct (2012a, 2012b) is a general code, and this applies for professional codes in many geographical areas. More detailed guidelines for practice may also apply and Ra (2022) describes the very clear guidelines provided by the New South Wales Ministry of Health (NSW

Health) for staff working with healthcare interpreters (NSW Health 2017). While having clear ethical principles and guidelines for interpreters is useful, Cox (2015) showed that interpreters may interpret those guidelines differently. The same applies to teleological approaches applied by interpreters, such as the context-based ethical reasoning as set out in Demand-Control Schema (Dean/Pollard 2011).

2.4 Interpreter training and accreditation

Countries obviously differ in terms of training, codes of ethics and guidelines for practice (e.g. Bancroft 2005; Cox 2015; NCIHC 2021; Nevado Llopis *et al.* 2021), and this has implications for the interpreter role. Crezee comments that Interpreting Studies scholars "often omit to mention whether the interpreters they describe in their studies were trained/educated, and if so what type of interpreter education they received" (2022: 149). Training usually precedes accreditation and will include a discussion of professional codes of ethics and the impact they have on the interpreter role.

Accreditation often involves interpreters following professional codes and guidelines for practice such as those referred to above (Hlavac 2015; Nevado Llopis *et al.* 2021). Nevado Llopis and Foulquié Rubio (2024) draw a connection between the lack of healthcare interpreter training programmes and the use of ad hoc healthcare interpreters, which leads them to emphasise the need for accreditation of medical interpreters. They write "the use of ad hoc medical interpreters is to a large extent related to a lack of medical interpreting training programmes and certification and accreditation processes of medical interpreters" (*Ibid.*: 2).

However, healthcare interpreter specific accreditation does not seem to be widespread. Sultanić (2020) comments that there is a lack of accreditation specific to medical interpreters, despite the increased demand. She comments that countries "such as Spain, Belgium, Italy, and Switzerland, all have interpreter training programs, be it for community, legal, or conference interpreting" but that "no current certification programs for interpreting in healthcare exist" (*Ibid.*: 369). In Australia, interpreters working in healthcare may hold a range of NAATI credentials, from Certified Provisional Interpreter, through Certified Interpreter to Certified Specialist Health Interpreter[2] and there are certification programs for Certified Specialist Health Interpreter and preparatory courses run by RMIT University and Monash University. Different accreditation systems across different countries may add to the difficulty of comparing the findings of studies on healthcare interpreter role.

2.5 Interpreter role boundaries

Interpreter role boundaries are strongly tied in with interpreter training and with different professional codes and guidelines for practice and this can again make it difficult to compare findings about interpreter role in general. Studies by (Angelelli 2004,

2 See here for a more detailed description of the competencies and skills of a Specialist Health Interpreter as distinct from a Certified Interpreter: <https://www.naati.com.au/certification/cshi/>

2019, 2024) and Hsieh (2010) have focused on the role of interpreters in the United States, where role boundaries may differ from those in other geographical areas, such as Canada and Australia (Hlavac 2013) or countries in the European Union (Hofer 2020). Hale (2011b) comments that trained interpreters are generally agreed on their role, which is very relevant here, and this will again depend on the context (Hsieh 2010; Angelelli 2019; 2021; de Boe *et al.* 2021). Spoken language interpreters in Australia are expected to abide by the AUSIT (2012a) Code of Ethics which outlines a number of precepts, namely Professional Conduct, Confidentiality, Competence, Impartiality, Accuracy, Clarity of Role Boundaries, Maintaining professional relationships, Professional Development, and Professional Solidarity. The Code (AUSIT 2012a, 2012b) provides examples of how these principles might influence the conduct of interpreters and translators in particular situations.

There is one important addition to the AUSIT Code under the heading of 'Special institutional settings of interpreting work':

> In specific institutional settings where duty of care or security rules regulate the behaviour of all participants, such as in health care or high security settings, interpreters follow the relevant policies and procedures combining them with their interpreting code of ethics (AUSIT 2012a:15).

This may for instance apply if a pregnant woman discloses to the interpreter in the waiting room (i.e. before the assignment has commenced) that her partner is violent towards her. In such an instance, duty of care applies but also the fact that reporting of child abuse (in this case affecting the unborn child) is mandatory (Kenny 2024).

2.6 Interpreter role and patient-centred care

The objective of health professional-patient interactions is "to achieve the best health outcome for the patient (NSW HCIS 2014: 7). Healthcare interpreters play an essential role in facilitating effective and direct communication between the former and the latter and in what Angelelli (2004: 29) refers to as "patient-centered, sensitive healthcare". The Calgary-Cambridge guide (Kurtz *et al.* 2003) reflects the approaches healthcare professionals in many Western countries use to build rapport with patients and to involve them in shared decision-making. However, not all patients are familiar with healthcare systems where there is a focus on patient-centred care, shared decision-making and patient agency. Such intercultural issues may be reflected in patients' relatives not being happy with sensitive information or bad news being conveyed to their loved ones by interpreters (Gao 2021). In terms of accuracy, anecdotal evidence from interpreters in New Zealand Gao (*Ibid*.:) suggests that family members may ask interpreters to not interpret bad news to patients, such as a diagnosis of cancer. This will often be based on relatives fearing the negative impact of bad news on patients' mental and physical health. However, according to Hagerty *et al.* (2005:1006): "Most patients want information about the chances of a cure and the extent of disease spread and possible side-effects of treatment. Many patients want to discuss life expectancy and the effect of cancer on their life". In addition, any censoring or omitting of information in such instances will impact on central concepts of patient-centred care and

shared decision-making (Iversen *et al.* 2021). Healthcare interpreters must maintain impartiality, since they are present for patients and clinicians in equal measure.

2.7 Healthcare interpreter role as seen by other interlocutors/participants

Interpreter-mediated interactions are more successful if all parties in the interaction – health professionals, interpreters and patients and their families – have the same understanding of the interpreter role (Hale 2011b). Swabey and Mickelson note that:

> Conflict may occur when one or both of the consumers do not understand the interpreting process or the interpreter's function in that setting, when the consumers' and interpreter's expectations are incongruent, or when the interpreter does not have a clear understanding of his or her primary function in that setting (2008: 52).

The latter can occur in settings such as the speech and language therapy interaction, where interpreters may be asked to also provide metalinguistic commentary (NSW HCIS 2014; Crezee/Marianacci 2022) and also when interpreting in forensic psychiatry (Burn/Wong Soon 2020) or other mental health contexts. This paper's aims focus on interpreter reports of either patients or their relatives denying the need for an interpreter or wanting the interpreter to not act impartially; or where high emotions such as anger and aggression had a potential impact on the interpreter role.

Hale notes that "[t]ypically, the participants of interpreted interactions, including the interpreter, are completely ignorant of each other's needs, roles, or goals, and have conflicting ideas of which each party should be doing" (2011b: 348). She adds that "trained interpreters are generally agreed on their role, which consists of interpreting as accurately and impartially as humanly possible, with all the inherent complexities those two mandates imply" (*Ibid*.: 351). Problems may arise when other parties in the interpreter interaction do not - or sometimes do not appear to want to - understand the need for interpreters to convey information accurately and impartially.

Sturman *et al.* (2018) conducted focus discussion group interviews with general practitioners, interpreters and representatives of culturally and linguistically diverse (CALD) communities in Australia and identified some confusion around the interpreter role in all three of their participant groups, including patients. Indeed, previous studies (Cox 2015; Tang 2017; Gao 2021; Marianacci 2022; Cannard 2024) have shown that patients may view the interpreter as a support person and patient advocate, regardless of whether the professional code of ethics in a particular geographical area allows interpreters to step outside their role boundaries. Patients may prefer family members to interpret for them, because they trust them. Some authors have argued that there is a place for non-professional interpreters in the healthcare setting in some instances, with interesting examples being discussed by de Boe and colleagues (2021) while others, such as Butow argue that this is "highly problematic" (2015: 251). Butow argues against the use of untrained interpreters such as family members, saying that it "can be highly problematic" (*Ibid*.: 251). She explains that:

> [u]ntrained interpreters may have an emotional investment in the communication (such as protecting the patient from distressing news), a relationship which precludes dis-

cussion of certain topics (such as sexuality), a lack of linguistic skills in one or other of the languages being used, and a diffidence in questioning the doctor if they do not understand words or concepts (*Ibid*.).

In her study, Hale (2011a) reported on perceptions attributed by interpreters to their non-English-speaking clients. According to Hale (*Ibid*.: 241), 19.3% of her interpreter respondents thought that their non-English speakers perceived them as "compatriots who were there to help out", in other words as an advocate, rather than an interpreter. This aligns with findings by Tang (2017) some of whose interviewees mentioned interpreter-mediated interactions with their responses showing a lack of understanding of the interpreter role. One of Tang's interviewees said he felt aggrieved that the interpreter had not explained his cardiology results to him, when that was in fact the doctor's role, not that of the interpreter (Tang 2017).

For his doctoral study, Britz (2017) explored the experiences of interpreters and mental health professionals working with interpreters in refugee settings in New Zealand, stating that "clinicians and interpreters bring different concerns and notions to the experience of interpreting and that these may be hidden from each other" (i). This seems to suggest that the interpreters in Britz's doctoral study did not explain their role to either the mental health professional or the refugee clients. Ideally, the interpreter takes the floor to explain his or her role to the patient, health professionals and any relatives who may be present at the interview during the introduction stage of the interview (Tebble 2014). Interpreters should include the fact that everything that is said during the interaction will be kept confidential and add that *everything* said will be interpreted.

There appears to be limited research on interpreter reports of patient and family behaviour and how this impacts on the interpreter role, with Sturman and colleagues maintaining that there is "very little existing literature about patient perspectives" (2018: 234).

3. Methods

3.1 Data Collection Methods

Using surveys to elicit interpreters' views on professional practice (Wang 2014; Cheng 2015; Magill 2017; Korpal/Mellinger 2024) is a cost-effective method of collecting data from large groups, particularly when surveys are posted online (Field 2020). The authors conducted two anonymous surveys among Australian-based healthcare interpreters. First, a pilot survey was disseminated as a Word document to in-house interpreters in a large public hospital (Northern Health). Next, the survey link was posted on both the website of the National Accreditation Authority for Translators and Interpreters (NAATI n.d.) as well as on the website of the Australian Institute of Interpreters and Translators (AUSIT n.d.).

3.2 Participants

Survey participants consisted of 233 qualified interpreters who responded to an Australian-wide online survey on healthcare interpreter role expectation. This equates to

some 5% of the approximately 4,500 interpreters working in Australia at that time (personal communication with an executive of a major language service provider, July 2019). All (n=233) nationwide interpreter survey respondents reported living in Australia and being NAATI accredited/certified and were thus familiar with the AUSIT Code of Ethics (AUSIT 2012a). In other words, the interpreter respondents may all be assumed to have had a clear professional understanding of the interpreter role, and their reports may be seen in this light.

An overwhelming majority (93%) of respondents said they regularly worked in the healthcare setting. A majority (60%) had more than 10 years' experience working as professional interpreters, while another 19% of respondents had between 5 and 10 years of experience. Almost all respondents (85%) said they worked in the healthcare setting, which included hospital wards, outpatient clinics, primary healthcare and mental health settings. Just under half (45%) of the respondents said they were frequently assigned agency work in the healthcare setting, while 26% of interpreters were occasionally assigned agency work in the healthcare setting. One fifth (20%) of respondents were employed on a casual basis in the healthcare setting, while only 8% of respondents were permanently employed in the healthcare setting on a full-time or part-time basis.

Just under a quarter of respondents (23%) reported working between 6 and 10 hours per week, while 14% said they worked between 10 and 15 hours per week, and 16% said they worked more than 15 hours per week. Just under half of the respondents (47%) reported working less than 6 hours per week. A large majority (80%) of respondents said that they had completed more than 100 assignments in their career. It is notable that some 33% of those who engaged with the survey found themselves in awkward situations. It is these experiences that we profile here. See Table 1 below for a summary of this data.

Table 1: Healthcare interpreter respondents' anonymous online questionnaire.

	Nationwide survey
Number of interpreter respondents	233
NAATI accredited	233
Working in healthcare setting	93%
Work experience	Over 10 years: 60% 5-10 years: 20%
Healthcare settings worked in include	wards, clinics, primary healthcare, mental health
Frequency of work in healthcare setting through an agency	Frequently: 45% Occasionally: 26%
More than 100 assignments completed	80%
Permanent employment as full- or part-time healthcare interpreters	9%
Employed in health setting on casual basis	20%
Hours worked per week	< 6 hours: 47% 6-10 hours: 23% 10-15 hours: 14% >15 hours: 16%

3.3 Analysis

Qualitative responses relating to family member and patient expectations of the healthcare interpreter role were collected. Some 233 interpreter responses in the online surveys, 163 (70%) commented on the expectations of patients and family members as part of their additional comments to a range of questions. A thematic analysis was conducted according to Braun and Clarke's (2022) six phases of thematic analysis. This included the second author familiarising herself with the data, and manually generating provisional codes, which allowed for themes to emerge as the codes were refined and reduced. The first and third authors, independent of each other, manually checked the initial coding as they developed and reviewed the emergent themes. They continued by refining the themes ensuring that each of the themes accurately represented the data. The three most salient themes are the focus of this article: 1. Patients or relatives saying there is no need for an interpreter and/or trying to interact with the healthcare professionals on their own; 2. Patients or relatives asking the interpreter to refrain from acting impartially; 3. The interpreter role being affected when tensions or emotions run high on the part of patients or their families.

4. Main Findings

The main themes that emerged involved patients or relatives denying the need for an interpreter, or asking interpreters to take sides, and the interpreter role being impacted when emotions run high. Respondent comments have been reproduced as they were, in that grammatical or typographical errors have been left as they were in the original respondent comments.

4.1 Patients or relatives insisting interpreters are not needed.

Just under one fifth of respondents (18%) reported a number of instances where behaviour by patients or their relatives had impacted on their interpreter role. The most frequently recurring comment involved patients or their relatives reportedly insisting that an interpreter was not needed:

> Sometimes the consumer totally ignores the interpreter and tries to communicate with the HCP [healthcare professional] on their own. At times they even say that they did not ask for an interpreter and do not need one. It is very embarrassing if the HCP asks the interpreter to leave. In such instances, the HCP should explain the role and necessity of the interpreter and stress that the interpreter be present and assist only if necessary. (Respondent 14)

This would obviously not be an issue if the patient was in fact proficient in English to be able to effectively advocate for their own healthcare decisions in that language, however this was seldom reported to be the case.

> Patient insisting that they didn't need an interpreter while their command of English was problematic. (Respondent 69)

> Something that happens relatively often, is when the family or the patients themselves maintain that they did not ask for and do not need an interpreter. Then you hear them speaking their own language at some stage, and you realise that, in case of the family, they do not have the language skills to interpret to the patient or, in case of the patients, that they do not have such great comprehension of the English language especially in a medical environment (Respondent 50).

Sometimes patients reportedly ask their relatives or other trusted persons to interpret, and this was brought up by several respondents, with one saying: "Patient asking relatives to interpret instead of interpreter". Respondents also mentioned relatives wanting to act as the interpreter, with one stating: "[t]he patient's daughter kept interfering with my interpreting", and another reporting that "[t]he patients' relatives often interfere and talk over me" and a third stating that "[p]artners interfere and want to be the interpreters"

This is obviously a matter of concern, since family members may either misunderstand and incorrectly convey medical information or censor questions or information they deem inappropriate (NSW Health 2017). In addition, health consumers may not respond to questions honestly because they do not want relatives to be aware of their health history, especially in relation to more intimate health issues.

When patients or their relatives insist that interpreters are not needed this is impactful on a number of different fronts. Firstly, accuracy and impartiality may be impacted when a family member interprets. Secondly, when information is not conveyed accurately, patient-centred care and shared decision-making are affected, as patients who are not accurately informed cannot make informed decisions about treatment. Thirdly, if healthcare professionals in turn do not insist that a professional interpreter should be used, this might perpetuate the issue, as is clear from the example below:

> Once, when I went to one of the hospitals in Melbourne CBD, the elderly lady had brought her English-speaking relative to the appointment. I introduced myself to the healthcare consumer and the professional. When I started interpreting, the relative kept interrupting by trying to interpret for the lady. The doctor said: "One of you interpret",

In situations such as these, healthcare professionals should be clear as to why they would allow a family member rather than a professional interpreter to do the interpreting in view of both accuracy and impartiality, as will be discussed in the next section.

4.2 Patients or relatives asking interpreters to take sides

Respondents reported different instances of an apparent misunderstanding around the need for interpreters to remain impartial, either by taking their side or by omitting information when interpreting. Some of our survey respondents added comments about family members trying to direct the way the interpreter was to convey information, with one respondent commenting that "Family members request not to interpret the whole message."

Another interpreter reported a similar instance, stating:

> Family members insist not to tell their parent of their actual impairment and condition.

Another respondent speculated on the reasons family members or patients might see the interpreter as their ally:

> Family members or the healthcare consumer may expect the interpreter to be 'on their side' … 'because we come from the same background' … and they expect interpreter to be hostile towards the professional, or they tell the interpreter 'details' but they don't want the details to be translated … which requires special actions by the interpreter, e.g. telling the professional what is going on or reminding the consumer of your role … It can become very tricky!

In the above example, the interpreter might have prevented this misunderstanding of their role if they had introduced themselves clearly at the start, and if they had then interpreted everything that is said, also if it is said in an aside. Another two instances of patients expecting interpreters to take their side appeared to involve the ethical principle of duty of care, which may apply in cases where there is potentially a high risk to the patient or to others. Two interpreter respondents reported instances where patients had confided information to the interpreter that they then kept from the healthcare professional. In the first example, the respondent saw the situation as one that invoked the ethical precept of duty of care and acted accordingly.

> …was in a situation where healthcare consumer was not telling the truth regarding taking his medication. He told me that he does not take the medication but throws them down the toilet. He was a mentally ill person. As I could not approach the Doctor, because he was with other patients, I did report it to my Supervisor at the Hospital interpreting team. Nothing was done. Within 3-4 weeks the same patient tried to murder his family, fortunately, he did not succeed.

In the second example, the respondent does not provide information as to what they did, and whether they considered it their duty of care to report what the patient had said based a potential threat to life.

> Health professional leaving the room and leaving me with the patient. Then the patient starts telling me important details about their health condition.

However, deciding when to exercise this duty of care is not always straightforward. In the first example above, it would appear that the patient may have been flushing antipsychotics down the toilet, thereby potentially increasing the risk of being a harm to themselves or others. The interpreter reported this to his supervisor, and it would seem this was the best course of action since he or she was unable to talk to the medical professional at that point in time – even though it appears the supervisor took no action. The second example leaves more room for questions, as the respondent does not state whether the health professional returned and what the respondent said or did when the health professional returned. The AUSIT Code of Ethics states quite clearly that interpreters must disclose information when mandated by law, for instance where a pregnant woman discloses to the interpreter that her partner is being violent towards her. In that instance, reporting is mandatory because violence towards a pregnant woman is considered a form of child abuse (AUSIT 2024).

In other instances, interpreters reported relatives asking them to step outside their role boundaries by not interpreting bad news. One respondent reported:

> I was asked by daughters not to mention the word "cancer" even if it was the doctor's diagnosis. Daughters were happy that "Oncology" signs were up, as they were sure their mother did not know what that mean, so she wouldn't know which Department she was in.

Another respondent reported similar experiences and brought up the patient-centred approach preferred by the healthcare professionals as being in contrast with the family's wishes to not tell the patient about their diagnosis:

> I have been in a situation a few times where family members think that the patient should not be told everything as this will affect them mentally but the healthcare professionals' perception on this is often the opposite.

Interpreters reported dealing with this differently, with another respondent reporting:

> Once in Palliative care a cancer patient's wife kept disrupting the conversation to twist the meaning of what's been said. At the end I had to talk to the doctor behind a closed door of what had happened & what the wife did made the job impossible to carry out.

Again, healthcare professionals need to be aware of the risks of allowing family members to act as interpreters, not only because both accuracy and impartiality might be at risk, but also because any censoring by family members might fly in the face of health professionals trying to achieve shared decision-making and trying to follow the concept of patient-centred care.

The next section will look at situations where interpreters felt affected by emotions of fear due to behaviour by patients or their relatives.

4.3 Interpreter role being affected when tensions run high

Several respondents reported on situations where patients or their relatives had been aggressive towards the interpreter or the professional, resulting in intrapersonal or interpersonal challenges (Dean/Pollard 2011). Where interpreters have to work with clients who are in a panic or angry and aggressive, this requires interpreters to come up with appropriate controls. For one respondent, this consisted in moving into whispered interpreting mode:

> In the Emergency Ward the mother of the ill child was panicky and could not speak coherently, nor give me the chance to interpret, so I had to do it in the chuchotage mode.

One respondent simply stated that "[s]ome clients (…) tend to be very angry when their request is not granted" without elucidating how this had affected them in their professional role. Others reported situations where patients had been aggressive towards the health professional, merely stating that it had made them feel a bit "uncomfortable" without specifying the impact on them in terms of carrying on with the interpreting:

> I have been a participant as an interpreter in an assignment where the non-English speakers became upset and rather aggressive with the healthcare professionals. This was a bit uncomfortable.

Interpreters are taught to explain their role at the outset of the interpreted interaction, so that when interlocutors communicate in an angry fashion, it is clear that the interpreter is merely conveying what is said, as well as the illocutionary force (Morris 1999). In the next example, the interpreter had explained that their role was to interpret everything said, exactly as it was said, but even so, the healthcare professional mistakenly thought that the interpreter was the one who was being aggressive.

> The Deaf client was abusive and swearing. The professional thought it was me being aggressive even though I had explained my role.

Several interpreters reported on situations where they had experienced clients being angry in the mental health setting, and with some reporting feeling frightened, and one even removing themselves from the situation:

> The consumer had mental health issues, started to verbally abuse the interpreter. The interpreter removed themselves from the job.

In this case it was clear that the interpreter had felt unable to continue the interpreting assignment in the view of this aggressive behaviour. In other situations, respondents reported that they had calmly continued interpreting even when being seated very close to clearly confused and aggressive clients:

> During a mental health tribunal hearing at a high-security mental hospital, the Cantonese-speaking health care consumer was under police custody. When the tribunal members asked him did he know why he was brought to the hearing, he got upset and talked faster. I have to catch up but I did speak at a moderate pace to facilitate the recording. He then blamed everyone in the room of putting him under custody in a mental hospital. I kept my calm and interpreted accurately. Then he shouted the 4-letter foul language in English while rising from his seat and wave his fist in the air. I was sitting next to him and I felt a bit intimidated, concerned for my own safety. However, I continued my calm interpreting while the security staff went over to restrain him. Seeing the customer was emotionally unstable, the tribunal hearing concluded that the customer has to remain under mental health treatment for another 6 weeks. I continued the interpreting till the tribunal called off the meeting. When it was over, one of the tribunal members showed her concern about me. I replied I was fine because a nurse gave me a good briefing in the beginning, and I was prepared. The tribunal member also complimented me on my calm posture.

The respondent said that after returning to the office and debriefing with their line manager, they had recommended that should similar cases arise in future, the healthcare interpreter service staff should "advise the booking party to have someone ready to brief our interpreters upon our arrival at the hearing." This is very good advice and should be part of the guidelines for practice for healthcare professionals working with interpreters, especially in the mental health setting.

It seems clear that it is very important for healthcare professionals to brief interpreters working with patients who may be mentally unstable and to look after their safety. One respondent reported:

> I have felt extremely uncomfortable when a professional left me alone in a consultation room for a rather long period of time after letting me know that the patient has severe mental health issues.

Healthcare professionals need to ensure that interpreters know what to expect, while also making sure that they remain safe in situations such as the one reported here.

5. Discussion

The findings presented here were based on comments made by NAATI accredited/certified Australian-based interpreters who responded to a healthcare interpreter role expectation survey and commented on conduct by patients and/or their relatives which impacted on their ability to carry out their role as healthcare interpreters. An analysis of the comments yielded three main themes: patients and their relatives denying the need for an interpreter; patients or their relatives expecting interpreters to take their side; and the impact on interpreters when emotions or tensions run high.

Where family members or patients insist that an interpreter is not needed, interpreters need to interpret this and leave the decision up to the healthcare professional as to whether they want to use the services of the professional interpreter. However, it is imperative that healthcare professionals learn about interpreter role and the importance of accurate and direct health professional patient communication, mediated by professional interpreters. This might enhance their ability to decide when they might be able to engage with patients or clients directly and when it might be imperative that an interpreter is utilised. This is even more important in the light of reported instances of interpreters being asked to not act impartially. Respondents in this study relayed instances of patients telling professionals that they did not need an interpreter and of families asking them to leave out certain information when interpreting. This appears to support Craig's (2018) findings that it is not unusual for different cultural and ethnic groups to find it difficult to talk about some topics such as mental health, substance abuse, health issues relating to sexual or domestic violence and the like or for females to share gynaecological histories with male health professionals (*Ibid*.). Health professionals cannot treat effectively on the basis of incomplete information, and this is likely to be exacerbated when family members or informal interpreters interpret for health consumers. Duty of care may be compromised if a family member is used to interpret rather than engaging a professional interpreter.

6. Conclusions

6.1 Main Findings

Interpreter reports on instances where patient and family behaviour impacted on their ability to carry out their role in the healthcare setting align with recommendations by

Sturman and colleagues (2018) regarding professional development and special training for professionals working with interpreters, however, it is imperative that members of culturally and linguistically diverse communities are also aware of what to expect from an accredited, professional interpreter who is bound by a professional code of ethics. However, there may be additional reasons for patients and relatives to insist that they wish family members to interpret for them, or to interfere with the interpreting. Patients may continue to insist on using family members because they do not trust that what is said will be kept in confidence by the interpreter. In this case, there would appear to be a lack of awareness that interpreters are professionals bound to interpret everything that is said accurately and impartially. In some cases, relatives may insist that they can interpret - or may try and interfere with the interpreting - precisely because they understand that the interpreter is bound to interpret everything that is said, and relatives may not want this to happen for a number of reasons. Interestingly, feedback from oncology patients in Australia on interpreters' accuracy was very good (Hyatt *et al*. 2017). The majority of respondents felt that they were confident with the accuracy of their interpreter (89-92%) and explanations of medical terminologies (86-93%) and felt comfortable with the interpreter (85%-91%) (*Ibid*.: 889).While family members may assume they are protecting their relatives from bad news, the latter may in fact want to be aware of their outlook and make decisions accordingly.

If clinicians bow to the patient's wishes and accept family members as ad hoc interpreters, there could be several negative consequences: incorrect understanding of medical information could result in incorrect interpreting; censoring important information by family members, patients not wishing to answer sensitive questions in front of and 'through' relatives increases the risk of adverse health outcomes. Patients may spend more time in hospital or may be discharged with incomplete knowledge of the discharge instructions, resulting in preventable readmissions. Interpreters may invariably face assignments where tensions run high. This may result in a range of response, from interpreters merely feeling "a bit uncomfortable", to feeling threatened and feeling the need to remove themselves from the assignment. Obviously, briefings would help interpreters to mentally prepare themselves, however previous research has shown that briefings are rare (Martin *et al.* 2022).

6.2 Limitations

One of the limitations of the study is that the data consist of reports by interpreter survey respondents, in a survey that sampled approximately 6% of interpreters in Australia. Respondent comments revealed the need for wider research into patient and family conduct in the interpreting setting, as well as the need to ask respondents separately about face-to-face interpreting or remote interpreting. Interpreter comments about aggressive behaviour in interpreter-mediated interactions suggest that research should focus on this occurring in the general health setting as opposed to the mental health-specific context.

6.3 Further research

While the surveys yielded some interesting findings, it would have been advantageous to supplement these with findings from focus group discussions involving clinicians, healthcare interpreters and representatives of communities whose members regularly need interpreting services in the healthcare setting. This will allow researchers to probe more deeply into the nature of relevant findings and would have allowed participants to provide their own perspectives in more detail. Further research could involve focus discussion groups with patients from different migrant communities, to explore their perspectives on the interpreter role and their experiences with interpreter-mediated interactions.

A number of respondents commented on feeling unsafe interpreting for patients with mental health issues who were either "very taken with them" or aggressive. Further research should involve separate surveys focusing on interpreting in the general healthcare setting and the mental health setting.

6.4 Recommendations

The incidental survey findings reported on here reflect the need to ensure that patients and their families are more aware of the interpreter role. This can be achieved if the health interpreter clearly explains his or her role in both the health professional's and the patient's language, and if healthcare professionals insist on using the services of the interpreter assigned. The latter means that healthcare professionals must allow time for interpreters to introduce themselves and their role, and that they understand the risks of family members potentially censoring information, which would impact on professionals achieving shared decision-making and patient-centred care

In terms of working in settings where tensions and emotions may run high, the authors recommend that interpreters are prepared for the possibility of working with aggressive patients or relatives in general, during training and subsequent professional development sessions. Interpreting in the mental health setting may involve working with patients who are confused or upset due to their mental health condition or due to the challenges of detoxing. Briefings by healthcare professionals are essential, for interpreters to be prepared for aggressive behaviour to some extent and safety measures should also be put in place. The guidelines set out by Hlavac (2017) are particularly useful for interpreters working in mental health settings. Work has been undertaken and continues to be progressed in this area to assist clinicians. The 2019 Guide for Clinicians Working with Interpreters in Healthcare Settings was developed as an adjunct to the Competency Standards Framework for Clinicians (Migrant and Refugee Women's Health Partnership 2019 a, b). The Guide for Clinicians identified that some patients might prefer the same interpreter throughout their care. They advise that the interpreter should be informed prior to highly specialised consultations, such as mental health consults among others. Further, they note that debriefing and feedback may be necessary between the clinician and the interpreter to acknowledge the complexity of the consultation.

The authors acknowledge there are roles here for universities, government departments and professional bodies in raising awareness about the role of professional

interpreters. This could be done by a media campaign, posters in hospitals and healthcare centres in both English and community languages. Information on the interpreter role could also be disseminated in different migrant communities through community translation. Obviously, patients and relatives may still deny the need for an interpreter or wish to take over from the interpreter for a variety of reasons, even if they are aware of the interpreter role, but education would be an important first step.

At the same time, interpreters and clinicians themselves have to do more in terms of Principle 9 of the AUSIT (2012a, 2012b) Code of Ethics, i.e., respect and support their fellow professionals and uphold the reputation and trustworthiness of the profession. This can be done relatively easily if all interpreters introduced themselves and their role to patients upon each assignment. Tebble (2012) explained the different stages of the interpreter-mediated medical interview, including the stage where the interpreter explains his or her role. Interpreter educators could ensure that trainee interpreters practice explaining their role to both patients and professionals in role-play scenarios. Interpreters sometimes report that they are not given the opportunity to introduce themselves. The potentially adverse effects of not introducing themselves and their role means that interpreters need to insist. Clinicians need to ensure that interpreters are briefed before interactions where emotions may potentially run high. They also play a role in explaining the role of the healthcare interpreter to patients *and* their families, repeating this if necessary, thereby maximising the potential for effective patient-centred communication.

Acknowledgements

We want to thank all of our respondents for their input and time. Heartfelt thanks to Hoy Neng Wong Soon for ensuring all the references were correct in *EndNote*.

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