THE MISSING LINK: A UNIVERSAL CODE OF ETHICS FOR HEALTH CARE INTERPRETERS

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Resumen
La razón de ser de los códigos deontológicos es facilitar la comprensión de lo que suele entenderse por buenas prácticas en el entorno de trabajo. Sin embargo, los códigos por los que se rigen los intérpretes en el ámbito sanitario público en España y el Reino Unido no facilitan la resolución de ciertas disyuntivas en situaciones conflictivas. El objetivo de esta investigación es señalar las deficiencias de los principales códigos de ambos países. Con este fin, se recogieron las opiniones tanto de intérpretes como de personal sanitario. Las divergencias existentes en los resultados de las encuestas ponen de manifiesto la necesidad de cooperación entre ambas profesiones con el fin de disipar las diferencias de opinión que debilitan el papel del intérprete. Por otra parte, el sector sanitario podría beneficiarse de un esfuerzo conjunto para sentar unas bases universales a partir de las cuales cada país pueda desarrollar su propio código deontológico.
Palabras clave: *ética, código deontológico, ámbito sanitario, interpretación*

Abstract
A code of conduct should assist professionals in understanding what is considered good practice in their working environment. However, the standing codes of ethics for PSI practitioners in Spain and the UK fall short in resolving interpreters' dilemmas in situations of conflict. This paper aims at underscoring the deficiencies of the codes of conduct for health care interpreters in these two countries. To that end, health care personnel and professional interpreters were surveyed. The results highlight the need for greater co-operation between both professions to dispel the conflicts of opinion undermining the role of interpreters. Furthermore, the health care sector could undoubtedly benefit from a joint effort to draft universal standards upon which each country can develop its own specialised code.
Key words: *ethics, code of conduct, health care, public service interpreting*

1. Introduction

A comprehensive code of conduct is needed to ensure that the best possible service is delivered universally in a health care setting. Despite the fact that some of the current codes of conduct are the result of a joint collaboration between interpreters, educators and language service providers, participation from health care providers is notably absent. Yet, we must never underestimate the fact that interpreters' actions "are not dictated solely by our profession's code of behaviour, but also by codes of other professionals" (Guichot de Fortis 2014: 27). Hence, the original purpose of this investigation was to examine different scenarios which presented a dilemma for the interpreter and observe whether the codes of ethics and medical professionals' views were in agreement. The scope of the project was then expanded after it sparked a heated debate at a conference organised by the Public Service Interpreting Network Group (PSING) and the National Register of Public Service Interpreters (NRPSI) in London on the 8th November 2013 to include the opinions of interpreters present at the event and of health care providers based in Spain.

In order to gather and analyse the data, a 29-question online survey based upon a study by Anne-Marie Mesa (2000) was designed in English and Spanish and circulated amongst interpreters and medical personnel in both countries via e-mail and social media networks. Complete responses were obtained from 29 UK-based and 86 Spain-based medical professionals, and from 37 UK public service interpreters with experience of working for the National Health Service (NHS). Whilst it was the case for all of the medical personnel surveyed in the UK, only 40.7% of the respondents from the Spain survey had had experience of seeing a patient with an interpreter present.

In light of the results, the following section will examine the highest and lowest priorities of respondents and put them into perspective by observing what the current codes of conduct state with regard to these particular ethical principles.

2. Ranking of health care professional priorities

To provide a thorough overview of what is currently considered "good practice" as opposed to what medical personnel consider important, a number of codes of professional conduct from the main bodies and organisations were consulted in our analysis, including those of the American Translators Association (ATA), the International Medical Interpreters Association (IMIA), the Healthcare Interpretation Network (HIN) in Canada and the NRPSI, amongst others.

2.1 High priorities

The survey questions which received the highest number of 'very important' responses were calculated for both sample groups of medical professionals:

Ranking	How important is it that the interpreter…	UK %	How important is it that the interpreter…	Spain %
1	maintains confidentiality?	89.66	maintains confidentiality?	93.02
2	indicates when the patient has not understood?	86.21	indicates when the patient has not understood?	72.09
3	asks for clarification of technical language before interpreting if unsure?	82.76	knows the appropriate terminology?	72.09
4	reserves judgement?	79.31	does not omit anything?	70.93
5	does not omit anything?	75.86	asks for clarification of technical language before interpreting if unsure?	65.12

Table 1. Aspects defined as 'very important' by health care professionals in Spain and the UK.

As can be seen from the table above, it would appear that both sample groups place most importance on many of the same aspects of an interpreter's role, with perhaps slightly more concern for the use of the accurate terminology amongst the professionals based in Spain.

Not only were we interested in gauging the priorities of health care service providers, but also in whether interpreters placed the greatest importance upon the same aspects of their role. Rather unsurprisingly, interpreters viewed almost all aspects of their role to be important; 100% of respondents answered either "very important" or "important" to 10 of the 26 opinion-based questions.

Upon analysing the elements of the interpreters' role which were of most importance, there was one significant difference when interpreters' views were compared with medical personnel's: not showing bias towards either party (or, in other words, remaining *impartial*) during an interpreting assignment was a significant priority amongst interpreters.

After gaining an overview of the main priorities for all three sample groups, each "high priority" aspect was addressed thematically to observe whether there were any conflicts of opinion between the groups and whether the codes of conduct reflected these concerns.

2.1.1 Confidentiality

Confidentiality is one of the ethical principles always included in interpreters' codes of conduct. Unsurprisingly, our survey revealed that 100% of interpreters and around 90% of health care providers in Spain and the UK considered this principle to be "very important"; the remaining 10% judged it to be "important".

The ATA code introduces an interesting aspect to this principle (absent in codes in the UK and Spain) as it specifically mentions the issue of debriefing with a colleague in a generalised manner:

> It may sometimes be appropriate for an interpreter or translator to debrief or consult with a professional colleague or mentor.
> ●For example, (…)
> ●Or an interpreter may find it helpful to debrief with a colleague or supervisor after an emotionally-charged day of interpreting.
> ●Or a translator or interpreter may benefit from feedback on a particular situation.
> When consulting with colleagues, the translator or interpreter must give enough context to show what the problem is while limiting and disguising information so that no confidential information is disclosed. (ATA 2010: 2)

2.1.2 The interpreter: a visible or invisible agent?

The degree of visibility which an interpreter should maintain in a health care environment is a topic which warrants a much longer discussion than there is space for here; however, we felt there was one crucial element of this debate which needed to be addressed: do health care providers (and interpreters themselves) believe that an interpreter should intervene when s/he perceives that the patient has understood the message of an interpreted utterance? The difficulty for the interpreter here is, of course, that, in some cases, such a misunderstanding will be obvious and, in others, there will be more subtle indicators, meaning that s/he may well be acting upon instinct.

The results from our respondents left no room for doubt: it was the second highest priority for health care professionals in Spain and the UK, with 100% of respondents considering this to be either "important" or "very important", with the majority responding the latter. Whereas most interpreters shared this view (75.68% responded "very important" and 18.92% "important" to the same question), just over 5% considered it "not important" that the interpreter indicates when the patient has not understood. Although, statistically speaking, this is not a significantly large group, it is indicative of one of the fundamental issues currently undermining public service interpreting (PSI) in health care: a lack of universality.

Upon consulting the various codes of conduct, we were able to immediately account for this percentage of interpreters who did not view this as an important aspect of their role: in *none* of the codes was this point explicitly made; the only code of conduct to reference this issue was that of the NRPSI, which signalled it as one of the rare instances in which an interpreter may interrupt proceedings (2011: 6). We can only speculate as to why this issue is not raised in other codes of conduct; perhaps it is assumed to be "common sense" that an interpreter would automatically intervene to rectify a misunderstanding.

However, given the current situation in the UK where more and more individuals without professional training are acting as interpreters, such an assumption is dangerous. Furthermore, to ensure the safeguarding of quality interpreting, no interpreter should doubt whether this is one of the fundamental aspects of their role. Whilst a comprehensive and universal code of conduct can never replace professional training, it would be a step forward in improving the current situation.

2.1.3 Use of correct terminology and accuracy when interpreting

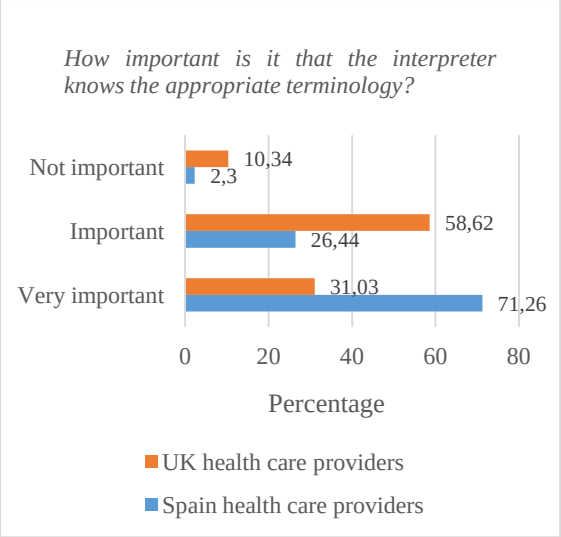

Figure 1. Terminology

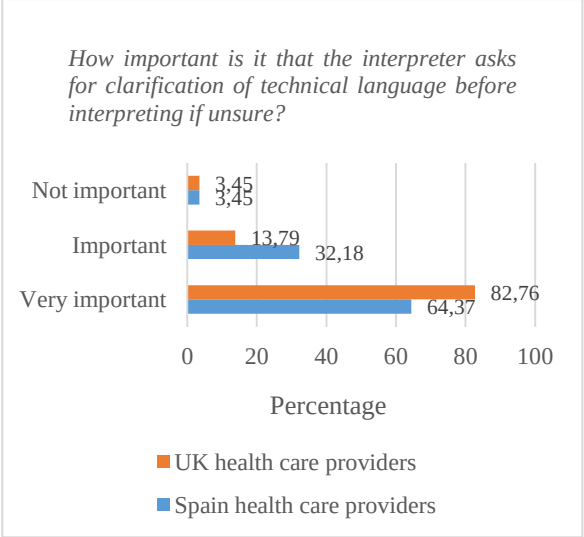

Figure 2. Clarification of technical language

Two immediate observations can be drawn from the charts above. Firstly, with the exception of nine individuals, all medical professionals considered the use of appropriate terminology to be vital when interpreting in a health care setting. Secondly, there is a substantial discrepancy amongst UK-based medical practitioners between the importance of an interpreter arriving at an assignment already aware of the appropriate terminology and asking for clarification during the course of proceeding: quite logically, greater importance is placed on asking for clarification. Interestingly, this distinction is not made by medical personnel based in Spain.

Given the importance which all three sample groups placed on accuracy, it is no surprise that almost all codes of conduct stress it is an interpreter's responsibility to be aware of medical terminology and to keep up-to-date in this area. However, few raised the issue of asking for clarification (several, it would appear, simply assume that an interpreter would do so). The US National Council on Interpreting in Health Care (NCIHC) and the HIN proved to be the most comprehensive on this matter and even included the importance of transparency when asking for clarification, and all should be prefaced with: "I, the interpreter, need clarification on…" (HIN 2007: 28).

With regard to accuracy in interpreting, one would imagine simply asking medical personnel and interpreters how important they judged fidelity to the original speech would prove to be a rather futile exercise; one could safely hazard that almost all would consider these aspects to be important. Therefore, we dissected the issue into four categories: summarising, omissions, additions and censuring/softening of patient's language.

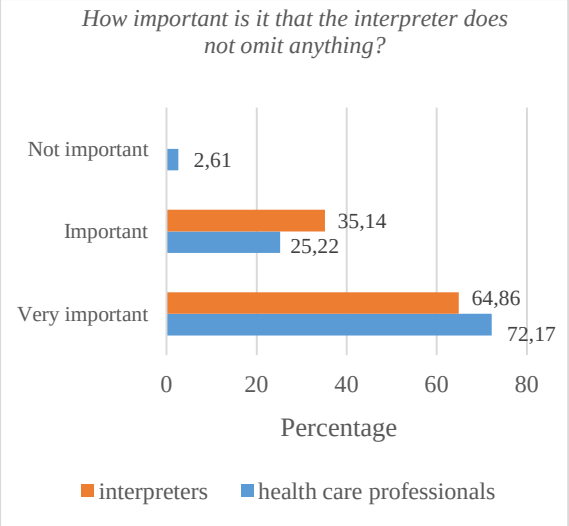

Figure 3. Omissions

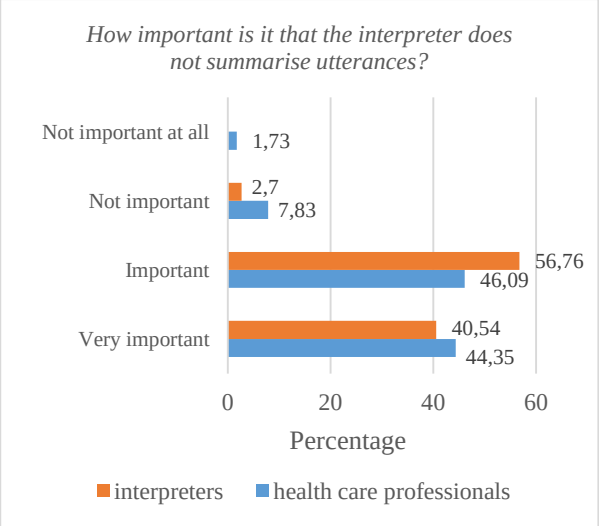

Figure 4. Summarising

As one might expect, with the exception of two individuals, all the interpreters surveyed considered these four aspects to be "important", with the majority deeming them "very important". A rather concerning anomaly in the data was one interpreter who considered additions not to be important, a practice which could prove to be dangerous if not fatal in certain circumstances; it could be the case that said interpreter had a very specific sort of addition in mind, however, as there was no room for further comments or explanations post this question, we can only speculate.

The most interesting phenomenon observed across all three sample groups was the contrast between the responses regarding the importance of an interpreter either summarising or omitting. Most codes of conduct are very explicit in forbidding the summarising, omitting, adding or distorting of either party's speech when interpreting. However, some codes added that a summary could be provided when requested, and indeed some comments from medical professionals revealed that a summary is *preferred* in some cases. Notably, it is only the HIN code which clarifies that this should be performed "only with the knowledge and consent of all parties" (2007: 23), a rather crucial aspect overlooked by all other codes.

Worth noting is that only two codes (*The National Standard Guide for Community Interpreting Services* from Canada and the British NHS' *The Best Practice Guide: When to Use Interpreters*) actually elaborated on *why* said issues were important; the former warns that interpreters could be found liable as well as referencing studies illustrating the negative consequences of such practices and the latter recommended using a professional interpreter in therapy sessions as friends and family members could be prone to deliberately distort the speech, e.g. omit abusive language, not to offend the medical professional (2008: 5).

2.2 Lower priorities

In order to gain a broader perspective, the elements of the interpreter's role which were perceived as lesser priorities by medical personnel were also analysed.

Ranking	How important is it that the interpreter…	UK %	How important is it that the interpreter…	Spain %
1	knows British culture?	55.17	knows Spanish culture?	22.09
2	explains non-verbal language?	37.93	explains non-verbal language?	17.44
3	remains emotionally detached from the situation?	31.04	explains differences in cultural values?	16.28

4	is available for a follow-up appointment?	27.59	remains emotionally detached?	16.28
5	is empathetic?	20.69	does not show bias towards the patient?	13.92

Table 2. Aspects defined as 'not important' or 'not important at all' by health care professionals in Spain and the UK.

Again, there were shared views in both groups. However, results revealed an interesting contrast between the UK and Spain-based medical professionals: a higher percentage of respondents in the UK answered "not important" or "not important at all". It would appear that a higher proportion of the sample group in Spain considered the majority of aspects to be "important", whereas the UK group more frequently judged things to be "not important". This could be due to the fact that the professionals in the UK, generally speaking, had more experience of working with interpreters and therefore had clearer views about what they did and did not need or value.

The issues presented on the table above can be grouped thematically into three separate categories: cultural awareness, impartiality and empathy and emotional involvement.

2.2.1 Cultural awareness

Awareness of a patient's culture is a point which is repeatedly stressed in many of the codes of conduct; the NCIHC code is as extensive as to include the importance of the knowledge of a patient's "biomedical culture", such as traditional remedies (2005: 7).

Survey results showed that this aspect was key for medical professionals also and, in many cases, more important than knowledge of the culture of the host country (in this case Spain and the UK).

Again, the issue of an interpreter's visibility was raised as many health care providers wanted interpreters to act as a kind of *cultural mediator* and explain differences in cultural values.

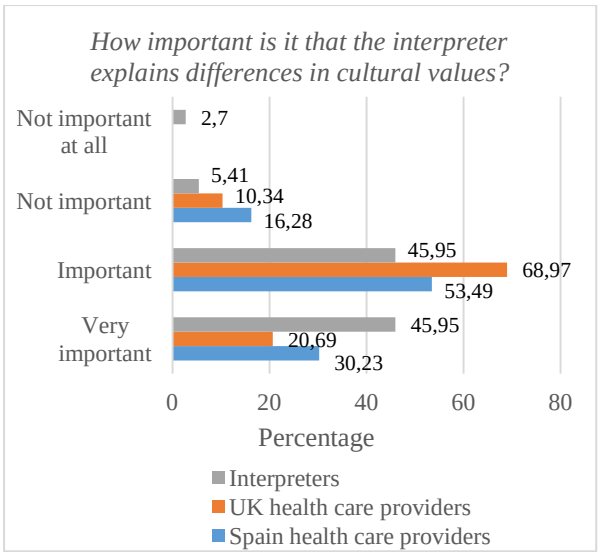

Figure 5. Cultural awareness

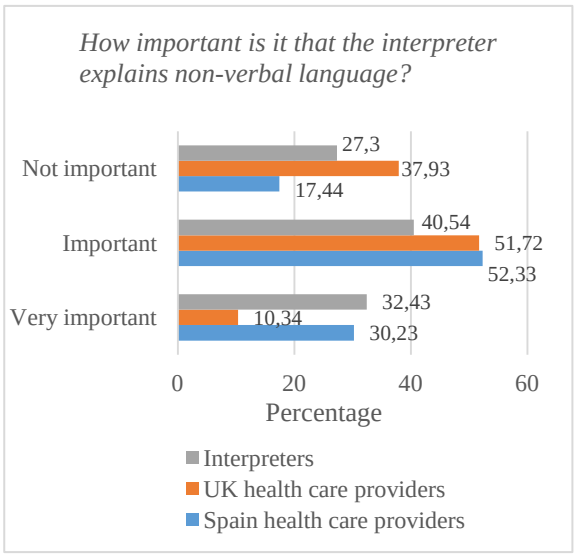

Figure 6. Non-verbal language

However, as we can see from the figures above, there was once again a minority of interpreters who had opposing views on the matter. The role of the interpreter as a cultural mediator is a debate which has caused great controversy (about which there is not sufficient space to discuss here), and is perhaps the cause for this outlying percentage. However, this conflict of opinion indicates an area which needs to be examined further to ensure that interpreters are meeting the needs of health care service providers.

An interesting element of cross-cultural and intra-linguistic communication is non-verbal language, and given that it is visual (and therefore something which a medical professional can perceive independently of the interpreter), it did not appear amongst the top five priorities for health care providers, but instead ranked as the second least important aspect of an interpreter's role. Once again, we encountered contrasting views as interpreters placed greater importance on this aspect of their work (see Figure 6).

It should be noted that the above results do not necessarily indicate a lack of concern amongst health care providers with regard to non-verbal language, but there are instead two distinct possibilities to explain this data. Firstly, this question was not relevant for many of the Spain-based health care providers due to the increasing use of telephone interpreting in recent years and, secondly, the respondents may well consider themselves to be capable of accurately interpreting a patient's non-verbal language. Nevertheless, in face-to-face situations, it is doubtful that many would dispute the importance of correctly interpreting non-verbal language -it was one of the NRPSI's limited scenarios in which an interpreter could interrupt either party "to alert the parties to a possible missed cultural reference or inference" (2011: 6)-. Indeed, the further removed the two cultures are, the greater the implications could be (especially when differing religious beliefs are also added to the equation). Perhaps this is an area where more awareness of the interpreter's role is needed amongst medical professionals.

2.2.2 Impartiality

The survey was designed to address six different facets of impartiality, namely the interpreter's bias towards any of the parties, discretion in terms of judgement, respect for the beliefs of the patient and the medical professional, neutrality and objectivity. In general, both interpreters and health care professionals agreed on the importance of these aspects in health care settings.

However, it is worth noting that, although all the interpreters who responded to the survey considered showing bias towards any of the parties involved as negative, medical personnel's responses reveal that bias towards the patient is, from their point of view, slightly less important than bias towards themselves. This could be explained by the fact that, in this particular communicative event, the health care providers are in a position of power vis à vis the patient. Therefore, the interpreter favouring the medical professional may be regarded as more unfair than if they were to demonstrate bias towards the patient.

Reserving judgment and remaining objective were considered "not important" and "not important at all" by a small percentage of interpreters, which quintessentially goes against the core principles found in any code of ethics for interpreters. Certainly, it must be borne in mind that, within health care, different forms of treatment may entail different considerations for both the interpreter and the medical professional. For example, one respondent commented: "In psychology, many of these issues are very important, in particular neutrality and ability to translate/interpret language as close to the original statement as possible. (…)". However, modification of behaviour should never be at the expense of ethical principles.

Most codes of conduct include impartiality as one of their core ethical principles and point out it is the duty of an interpreter to decline any assignment where s/he might be personally involved. Interestingly, three respondents from the sample group of medical personnel said they had experience of working with interpreters, but said "interpreters" were generally either volunteers or the patient's relatives or friends who often lacked the cultural awareness and linguistic proficiency needed to interpret. Despite the obvious risk of mistranslation and misunderstanding deriving from this, it would appear that the use of *ad hoc* interpreters is still common practice in health care settings.

2.2.3 Empathy and emotional involvement

To determine the importance both the medical professionals and the interpreters give to the emotional involvement of the interpreter in any given scenario, the following two questions were put forward:

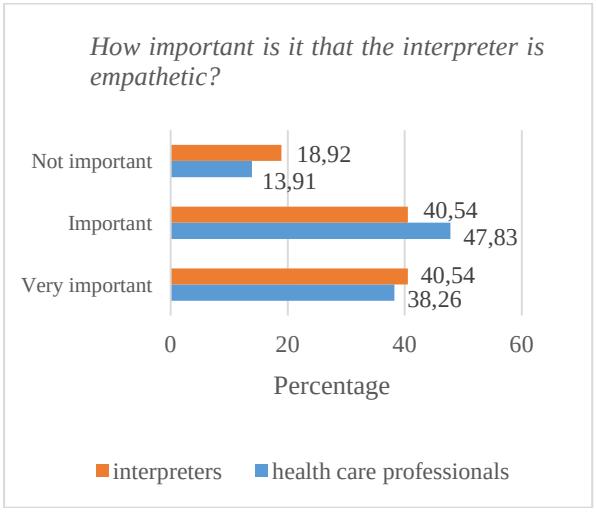

Figure 7. Empathy

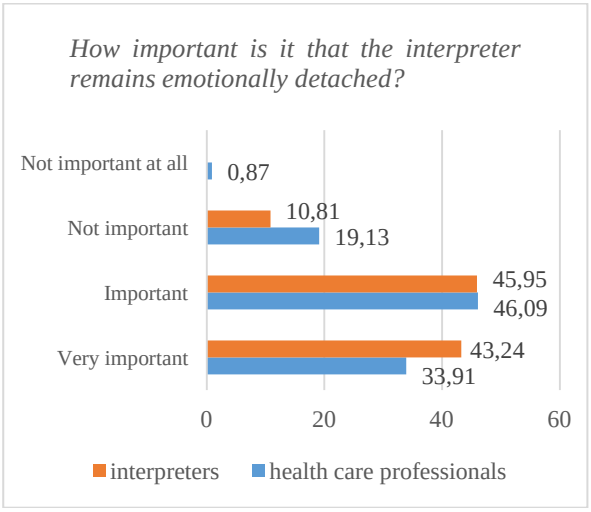

Figure 8. Emotional involvement

With regard to empathy, it can be observed that a vast majority of respondents considered it "important" or "very important" that the interpreter is empathetic (around 80% of the UK medical professionals, 90% of those in Spain and just over 82% of interpreters). In fact, two respondents made reference in their comments to "patience" and "kindness" as qualities they valued in an interpreter. Here, the difficulty lies in finding a balance between "being empathetic" and "remaining emotionally detached", the latter being an aspect covered in almost every code of ethics.

When examining the second question, we can clearly see some discrepancies in the responses depending on the sample group. Whilst the majority of medical personnel considered it either "important" or "very important" that the interpreter keeps an emotional distance from the situation, 30% of those surveyed in the UK and 15% of those in Spain did not judge this to be important (with one respondent in the UK thinking it was "not important at all"). In contrast, 90% of interpreters considered this principle "important" or "very important", highlighting yet another area where there is not a clear consensus between sample groups.

3. Conclusions

From the survey responses received from all three sample groups it is clear that there are areas of uncertainty and differences in opinion in certain aspects. In order to ensure and maintain high standards of PSI in health care in both Spain and the UK, a more comprehensive and universal code of conduct is needed, with input and collaboration from health care service providers. In addition to this, it is important that medical professionals are more aware of the nature of the interpreter's role.

Currently, the AUSIT code of conduct (2012) recommends interpreters to explain their role to those unaccustomed to working with them, but it would be in the interest and benefit of all parties involved to work towards a situation in which an interpreter is not obliged to do so, and health care providers are more aware of the parameters of an interpreter's role. Furthermore, nowadays cooperation in PSI is common at a European level (Graham 2012)

but is still not afoot at a wider scale. In this sense, the United States, Australia and New Zealand are exemplary models which could be the basis of creating a comprehensive and universal code of conduct.

In addition to the quantitative results gained from the survey, some of the respondents' comments revealed several interesting points:

- It seems that there is a lack of awareness in Spain in terms of PSI within the health care sector. Interpreters are available, yet medical professionals are unaware of how to benefit from their services. Respondents' comments ranged from "I think the Spanish government has not even considered this option [providing interpreters in health care], and it is really necessary", to "I don't know if we have access to interpreters. Is it the patient who has to ask for this service? Where? How does it work?".
- Furthermore, when asked about cultural differences, many Spain-based health care providers pointed out that, for example, the need for interpreters is less when treating English-speaking patients, and greater when treating native Arabic, Romanian, Chinese speakers, or those speaking only languages found in Eastern European countries. Some of them also mentioned immigration and adoption as the reasons behind Spain's increasing multiculturalism.
- Interestingly, even though many medical professionals based in Spain didn't know how to get access to an interpreter, telephone interpreting (TI) was mentioned by many doctors based in Andalusia. In 2009, this pioneering autonomous community set up a TI service called "teletraducción", thanks to which patients and doctors now have 24-hour access to an interpreter in 46 languages. Remote interpreting is more widely used in the United Kingdom as a solution to the geographical distance between the interlocutors and the interpreter, or as a response to the need for interpreters of rare and minority languages. However, in Spain, despite the positive feedback from users of this TI service, there is not such system at a national level.
- It was alarming to observe that three UK-based interpreters noted the lack of accountability of health care service providers. In particular, they pointed out the need to instruct practitioners on how to report "grievous professional misconduct" of medical personnel and social workers. Undoubtedly, this should be taken into consideration when updating the code of ethics that serves as a point of reference for novice and seasoned interpreters alike.

From our results, it can be inferred that the interpreting community would definitely benefit from a universal code of conduct which embeds the best of each of the existing codes and which takes into consideration the feedback from practitioners within both professions.

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5. Appendix

This is a sample of the online survey that was sent to medical professionals in the United Kingdom. The survey was translated for Spain-based respondents and adapted for interpreters.

1. Job title

_____

2. How many times would you estimate you have seen a patient with an interpreter present?

_____

(The following 26 questions could be answered with "not important at all", "not important", "important" or "very important")

In your opinion, in an assignment in the health care sector, how important is it that an interpreter...

3. has a perfect command of English?
4. does not summarise utterances?
5. does not show bias towards the patient?
6. does not show bias towards the medical professional?
7. knows the appropriate terminology?
8. does not omit anything?
9. reserves judgement?
10. respects the beliefs of all parties?
11. is empathetic?
12. explains non-verbal language?
13. maintains confidentiality?
14. has a perfect command of the patient's language?
15. remains neutral?
16. does not add anything to what is said?
17. knows British culture?
18. is patient?
19. warns the medical professional that their questions may offend the patient?
20. is available for a follow-up appointment?
21. remains objective?
22. knows the patient's culture well?
23. asks for clarification of technical language before interpreting if unsure?
24. does not answer on behalf of the medical professional?
25. does not censure/soften the patient's language?
26. explains differences in cultural values?
27. indicates when the patient has not understood?
28. remains emotionally detached from the situation?

29. Any additional comments:

_____