Globethics Repository



A National Code of Ethics for Interpreters in Health Care

This page was generated automatically upon download from the Globethics Repository. More information on Globethics see https://www.globethics.net. Data and content policy of Globethics Repository see https://repository.globethics.net/pages/policy.

Item Type	Preprint
Authors	Avery, Maria Paz
Publisher	National Council on Interpreting in Health Care
Rights	With permission of the license/copyright holder
Download date	2026-11-08 09:52:56
Link to Item	http://hdl.handle.net/20.500.12424/217525

The National Council on Interpreting in Health Care
Working Papers Series



A NATIONAL CODE OF ETHICS FOR INTERPRETERS IN HEALTH CARE

The National Council on Interpreting in Health Care
http://www.ncihc.org
July 2004

Acknowledgements

This work would not have been possible without the vital input of interpreters and others who dedicated their time and knowledge to further the health care interpreter profession. The financial support given by the U.S. Department of Health and Human Services Office of Minority Health, Guadalupe Pacheco, Program Officer, was essential in getting this project started.

We would like to acknowledge Maria Paz Avery for her work as primary author of *"Understanding the National Code of Ethics for Interpreters in Health Care"* working paper. We would also like to take this opportunity to thank the members of the NCIHC Standards, Training and Certification Committee: Karin Ruschke, M.A., Co-Chair; Shiva Bidar-Sielaff, M.A., Co-Chair 2003-2005; Linda Haffner, Co-Chair 2001-2003, current committee member; Maria Paz Avery, Ph.D.; Bruce Downing, Ph.D.; Carola Green. A special thank you to Susan Kocher for meticulously collating the hundreds of survey responses we received and Patricia Ohmans for her insightful recommendations on how to best analyze the data. Lastly, we are grateful to Esther Diaz for her help in the final months of this project.

NCIHC Board

Wilma Alvarado Little, **MA,** Co-Chair of the Board
Maria Michalczyk, RN, MA, Co-Chair of the Board
Elaine Quinn, RN, MBA, CST, DSA, Treasurer
Lisa Morris, MSTD, Secretary
Cynthia E. Roat, MPH, Chair of the Advisory Committee
Karin Ruschke, MA, Co-chair of the Standards, Training and Certification Committee
Shiva Bidar Sielaff, MA, Co-chair of the Standards, Training and Certification Committee
Elizabeth Jacobs, MD, Co-chair of the Research and Policy Committee
Alice Chen, MD, Co-chair of the Research and Policy Committee
Joy Connell, Co-chair of the Organizational Development Committee
Esther Diaz, M Ed, Co-chair of the Organizational Development Committee
Julie Burns, M Ed, Co-chair of the Membership and Outreach Committee
Susy Martorell, MPH, Co-chair of the Membership and Outreach Committee



Code of Ethics for Interpreters in Health Care

- **The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure.**

- **The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.**

- **The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.**

- **The interpreter maintains the boundaries of the professional role, refraining from personal involvement.**

- **The interpreter continuously strives to develop awareness of his/her own and other (including biomedical) cultures encountered in the performance of their professional duties.**

- **The interpreter treats all parties with respect.**

- **When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.**

- **The interpreter strives to continually further his/her knowledge and skills.**

- **The interpreter must at all times act in a professional and ethical manner.**

Understanding the National Code of Ethics for Interpreters in Health Care

"The role of interpreter is a 'tightrope' balancing act: A code of ethics is a good guide for the 'bar' carried on such a walk on the tightrope. It offers balance, some security and especially is a comfortable way to face the unknown risks faced on the interpreter's path." *Anonymous Respondent to Code of Ethics Survey*

Introduction

As the profession of health care interpreting in the United States matures and evolves, the importance of creating shared understandings of what is considered high quality and ethically appropriate principles and practices in the field becomes imperative. To this end, the National Council on Interpreting in Health Care identified three steps that needed to take place on a national level in order to standardize the expectations that the health care industry and patients should have of interpreters and to raise the quality of health care interpreting. The first step was to create and build support for a single Code of Ethics that would guide the practice of interpreters working in health care venues. The second step was to develop a nationally accepted, unified set of Standards of Practice based on the Code of Ethics that would define competent practice in the field. The third step was to create a national certification process that would set a standard for qualification as a professional health care interpreter. (NCIHC, 2004)

The Standards, Training and Certification (STC) Committee of the National Council on Interpreting in Health Care (NCIHC) took on the task of bringing the first step to fruition. The goal of the STC Committee was to create a national code of ethics that would provide the growing profession with a set of shared, essential guiding principles expressing what are considered morally appropriate behaviors for its practitioners as they perform their day-to-day duties.

To achieve this goal, the STC Committee engaged in a systematic process of reviewing existing codes of ethics, creating a draft code, conducting national focus groups to review the draft, and eliciting feedback through a national survey. The challenge was to design a code that built on and solidified existing work at the same time that it expanded upon this work to ensure its relevance to all health care interpreters, irrespective of the languages or particular venue in which they were working.

The STC Committee started by identifying and collecting existing codes of ethics in health care and other related areas such as legal and sign language interpreting. This process surfaced a number of codes that were already in use at the local level – by state and national associations of interpreters, institutions of health care, interpreter service organizations, and court programs – in the United States and Canada. The STC Committee then focused on ten codes that were considered most relevant to their work and compared them in order to identify the elements that were held in common and to analyze how each approached those issues that were most difficult and controversial in the field. Based on its analysis, the STC Committee drafted a code that included the elements shared across these existing codes as well as a few that were controversial but relevant. This draft also included a short commentary after each principle that further explained and illustrated that principle.

In the fall of 2002, the STC Committee presented the draft code to working interpreters across the country for review and comment. Focus groups were organized in nine localities across the United States. Attention was paid to the composition of these focus groups to include a broad representation of language groups and modes of service delivery (e.g. face to face and telephone interpreting). The focus groups confirmed the need for a unified national code of ethics and affirmed its development as a positive step for the profession. The feedback from the focus groups also concluded that the draft code was fundamentally complete and appropriate although some principles were seen as more or less controversial.

Based on the focus group feedback, a second draft of the code of ethics, including the commentaries, was developed, incorporating consistently recommended changes. This second draft was then introduced to a larger cross-section of working interpreters through a survey that was disseminated through the NCIHC website and state associations of health care interpreters. Approximately 2500 surveys were distributed, with a return rate of 20%. The STC Committee then analyzed the data from the 500 returned surveys.

In analyzing these data, it became apparent to the Committee that there was strong agreement on the principles as stated in the draft. It was mostly the commentaries that generated controversy in the form of disagreement with the explanations and unresolved questions about implementation. Therefore, in creating the final draft of the code, the STC Committee decided to highlight the consensus there was on the principles themselves by publishing the code as a set of principles without commentary. The STC Committee agreed that further explanation of the principles would be better left to a companion document that could offer a more thorough discussion of the issues raised and to the development of standards-of-practice that would address the practical questions of implementation.

Having considered all the feedback it had received, the STC Committee created a final draft of the code. However, before officially approving the code, the final draft was also sent to a select number of health care providers and medical ethicists for comment.

The National Code of Ethics for Interpreters in Health Care is the result of this systematic, deliberate, and reflective process. The STC Committee is confident that this code represents the principles that working interpreters believe are important to ensure the ethical practice of their profession. These principles are the ones that working interpreters have said merit serious consideration when faced with a dilemma or difficult choice and to which they agree to be held accountable.

This document provides a guide to understanding the National Code of Ethics for Interpreters in Health Care. It was apparent from the responses to the survey that not everyone in the field had the same understanding of the concept of ethics, what a code of ethics represented, what this code meant in the course of professional practice, and what the difference was between a code of ethics and standards of practice. Therefore, this document places the code in the context of ethical behavior in general and then discusses each principle in the context of specific issues and dilemmas often faced by health care interpreters. It provides an elaboration and discussion of each principle and the interrelationships among them, acknowledging that controversies still exist while offering the working interpreter a way to think about these controversies.

This document is organized around three major sections. The first section offers an explanation of ethics and ethical behavior in general as well as in the context of the profession of health care interpreting. The second section describes the core values on which this code of ethics is grounded. Finally, the third section presents a commentary on each of the principles that makes up the National Code of Ethics for Interpreters in Health Care.

What is Ethics?

> *Human beings are ethical animals.*
> *(Simon Blackburn, 2001)*

From the earliest times of human consciousness, human beings have been concerned with defining rules of conduct or setting expectations for what is considered appropriate or the right behavior with respect to oneself, others, and one's environment. As Blackburn (2001) explains, it is not so much that we, as human beings, always "end up behaving exceptionally well," but rather that we constantly compare and evaluate our own and others' behavior in order to find what the shared accepted principles of right and wrong are that govern the social group around us. These shared governing principles of right or wrong have become formalized in a number of ways. For example, cultures embody them in their norms and customs, religions in their moral precepts, governments in their laws, and professions in their codes of ethics.

The term ethic derives from the Greek word *ethos*, meaning "moral custom."
An ethic, therefore, is "a principle of right or good conduct" (The American Heritage Dictionary of the English Language). Consequently, ethical behavior is behavior that corresponds to the accepted and idealized principles expressing what is considered right and wrong.

As professions mature and become established, they begin to create an ethical environment of shared expectations and norms for acceptable and appropriate behavior in the enactment of its duties and obligations. In the words of Blackburn (2001) an ethical environment provides

> . . . the surrounding climate of ideas about how to live. It determines what we find acceptable or unacceptable, admirable or contemptible. It determines our conception of when things are going well and when they are going badly. It determines our conceptions of what is due to us, and what is due from us, as we relate to others. It shapes our emotional responses, determining what is a cause of pride or shame, or anger or gratitude, or what can be forgiven and what cannot. It gives us our standards – our standards of behavior (p. 1).

For a profession, this ethical environment is embodied in its professional code of ethics. A code of ethics, therefore, provides "a set of principles or values that govern the conduct of members of a profession while they are engaged in the enactment of that profession. It provides guidelines for making judgments about what is acceptable and desirable behavior in a given context or in a particular relationship." (NCIHC, 2002) It creates consistency and lessens arbitrariness in our choices when confronted with difficult dilemmas (Gonzales, et al., 1991).

The National Code of Ethics for Interpreters in Health Care sets the ethical environment for the practice of health care interpreters in the United States. By formalizing a set of principles for appropriate behavior into a code, an emerging profession begins to move away from the confusion of personal preferences and opinions about what is acceptable and what is not, to statements of preference that are shared and that, as a result, become "demands" on each other. These "demands" form a cohesive network of rules or 'norms' that serve to sustain the integrity of the profession and its purpose.

It is important to understand, however, that the principles contained in a code of ethics are abstract conceptions. A code of ethics, no matter how thorough or concise, cannot and does not provide definitive answers to all possible dilemmas or choices an interpreter may face. It is not a "how to" recipe nor is it an answer book for the many unique and problematic situations an interpreter may face in the real world. In fact, codes of ethics inevitably contain within them the seeds of conflict in the same way that our personal values in certain circumstances may conflict with each other. How often, for example, do we find ourselves weighing the importance of two values we hold dear in specific circumstances in our lives?

Why then have a code of ethics if it cannot provide definitive answers? To answer this question we need to go back to the purpose of a code of ethics cited earlier, that is, to provide guidance when making judgments about the right actions to take when faced with a difficult choice. Notice that the purpose of a code of ethics is to assist in making judgments, that is, to assist in evaluating the choices one has in a particular situation one is facing and then making a choice based on a consideration of the appropriateness of each action.

But who decides what the principles that provide this guidance should be? Can any one person or group arbitrarily make up the rules about right and wrong? Or can there be universal or "transcultural" rules that are generally accepted by different peoples and that can stand the test of time?

The challenge to create transcultural ethical principles is particularly salient in the field of health care interpreting. This is a profession that, by its very nature, is made up of individuals who represent a wide variety of cultural systems. Many have affiliations with other professions that may have their own code of ethics. All bring to the job their own set of personal values and beliefs that have been crafted out of their unique life experiences and circumstances. In addition, they are faced with patients and providers who, themselves, bring into the health care encounter a variety of ethical systems and expectations.

How, then, can a single code of ethics encompass all these ethical systems? Does it need to? Is it possible to arrive at a "transcultural" set of principles that define what is appropriate and what is out of line for a given group of people, engaged in the same profession, at a given point in time and place?

It is such a set of "transcultural" principles that the STC Committee set out to define as it listened to what health care interpreters and those who work with them had to say about what was important in how they performed their work. Through its discussions and review of the focus group and survey information, the STC Committee sought to go beyond personal beliefs and subjective opinions and, instead, distill those principles that were central to the role of health

care interpreter, principles that had to be taken seriously by all members of the profession if the integrity of their core duty as health care interpreters was to be maintained, that is, their duty to make possible the communication between two parties, the patient and the provider, who do not speak the same language in order to achieve the goal of the encounter – the health and well-being of the patient.

This core duty places the health care interpreter in a unique position. Unlike practitioners of many other professions in which the performance of the duties are, at least to some extent, transparent to the recipient of the services, health care interpreters are often the only ones present in the encounter between the patient and the provider who are fully aware of what is going on. For the most part, the interpreter is the only one who understands what each of the parties is saying to the other. This places the health care interpreter in a tremendous position of power. "Both the patient and the provider have to be able to trust that the interpreter will not abuse this power. They need to trust that the interpreter will transmit faithfully what it is they have to say to each other" (MMIA and EDC, 1996) without the interference of the interpreter's own beliefs, values, or opinions in the converted messages. They need to trust that the commitment to confidentiality on which the provider-patient relationship is based will be maintained.

Therefore, "It is the function of a code of ethics to guide the interpreter on how to wield that power (Edwards, 1988, p.22)." By adhering to the profession' s code of ethics, patients and providers are reassured that the health care interpreter is someone who can be trusted to keep the interests of the patient and the goals of the health care encounter in the forefront.

The Core Values of the Code of Ethics for Health Care Interpreters

The National Code of Ethics for Health Care Interpreters is grounded on three core values: beneficence, fidelity[1] and respect for the importance of culture. These core values form an overarching set of ideals that infuse the work of the health care interpreter and embody what interpreters care about in their relationships with the patient and the provider.

1. **Beneficence**
   A central value of the health care interpreting profession is the health and well-being of the patient. This is a core value that is shared with other health care professions. It means that the members of these professions have as their essential obligation and duty to support the health and well-being of the patient and her/his family system of supports (e.g., family and community) and to do no harm.

2. **Fidelity**
   The essence of the interpreter role is encapsulated in the value of fidelity. The American Heritage Dictionary of the English Language describes fidelity as involving "the unfailing fulfillment of one's duties and obligations and the keeping of one's word or vows. In a related nonpersonal sense, it refers to faithfulness to an original . . ." This description accurately describes the quality of the interpreter's work and the attitude with which interpreters should approach their work. In adhering to the essential function of

[1] We would like to acknowledge Marjorie Clay, Ph.D., ethicist at University of Massachusetts Memorial Medical Center, who called to our attention the core values of beneficence and fidelity in relation to the work of the health care interpreter.

their role, interpreters make what amounts to a vow to remain faithful to the original message as they convert utterances from one language into another without adding to, omitting from, or distorting the original message.

3. **Respect for the importance of culture and cultural differences**
   Culture frames the way we interpret the world, our experiences in it, and our relationship to ourselves and others. In the area of health, culture influences the meaning given to symptoms, the diagnosis of those symptoms, the expectations regarding the course of the related disease or illness, the desirability and efficacy of treatments or remedies, and the prognosis. Language and culture are closely intertwined. Linguists such as Sapir (1956) and Whorf (1978) have pointed out how language serves as an expression of the ways that a culture organizes reality.

   Health care interpreters have a twofold task in upholding their respect for the influence of culture and cultural differences as they perform their essential duty of converting messages from one language into another.

   First, the interpreter ". . . has the task not only of knowing the words that are being used but of understanding the underlying, culturally based propositions that give them meaning in the context in which they are spoken." (MMIA and EDC, 1996) Without understanding that the cultural frame of reference of the speaker is an integral part of the meaning system of that speaker, an interpreter may focus only on the surface meaning of words and miss the essential message that the speaker is trying to convey. Second, the interpreter has the task of always being aware that cultural differences in perspectives and alternative views of the world can lead to critical misunderstandings and miscommunication.

   This value is one that should be shared with other health care providers. Currently, there are more and more initiatives in health care facilities and educational programs for health care professionals that include cultural competence as an essential skill. However, until such time as all health care professionals are fully prepared to address cultural differences in their practice, it falls upon the health care interpreter to be cognizant of and able to alert both the patient and the provider to the impact of culture in the health care encounter.

Commentary on the Principles in the National Code of Ethics for Interpreters in Health Care

In this section, a commentary on each of the principles in the National Code of Ethics for Interpreters in Health Care will be provided. The commentary describes the intent of the principle and offers a discussion of some of the major dilemmas that may arise in day-to-day practice. The reader will note, however, that the commentaries do not offer answers to all possible dilemmas. Instead, it offers a way of thinking about what would be important in making ethical choices in difficult situations.

1. ***The interpreter treats as confidential, within the treating team, all information learned in the performance of their professional duties, while observing relevant requirements regarding disclosure.***

The primary intent of the principle of confidentiality is to honor the privacy of the patient and the very personal nature of the health care encounter. It puts interpreters under the obligation not to disclose information that has been learned during the performance of their duties to anyone outside the medical team responsible for the care of the patient. It is an ethical principle that is shared with other health care professions.

Matters of health and illness are intimate matters to the individual. As such, these are not matters that a patient wants to have made known indiscriminately. Decisions as to when, where, and to whom such intimate information is disclosed need to be left to the discretion of the patient. In order for the patient to be forthcoming with the information that the provider needs for the purpose of supporting or restoring their well-being, the patient has to trust that the health care system (including the interpreter) will not indiscriminately share such information with parties not associated with their care unless explicit permission has been given to do so.

The question of who comprises the "treating team," however, is not as clear cut as it may seem and may at times pose a dilemma for interpreters who may follow the same patient across appointments and different providers or even across health care facilities as in the case of freelance or contract interpreters. In the context of this principle, the "treating team" refers to all those within a particular health care facility who have primary responsibility for the care and treatment of a particular patient. Thus, when a patient is being followed within the same health care facility by different providers, they are all considered part of the treating team and privy to the information obtained about the patient. However, when the patient moves to a different health care facility, there is now a new treating team. For legal and liability reasons, this new treating team cannot access patient information held by the previous health care facility without the express written permission of the patient. Interpreters who follow a patient to this other health care facility are bound by the same need to obtain explicit permission from the patient before disclosing any information.

A rule of thumb when it comes to issues of confidentiality would be to rely on the core value of beneficence to determine who should know. In other words, might the patient's life be endangered if the provider of the moment is not given access to information that the interpreter already has? If the answer to this question is "yes," then the first course of action that interpreters should take is to encourage the patient to share this information directly with the provider. Only if this is not possible or the patient refuses to do so should interpreters consider disclosing the information themselves. There is a fine line, however, between respecting the autonomy of the patient and ensuring that the provider has the necessary information to treat the patient without harming them. Interpreters have an ethical obligation to deal with this fine line and make a conscious choice that supports the well-being of the patient.

Given that staff interpreters are employed by the health care institution, they have more flexibility when they feel it is necessary to disclose confidential information within their institution. However, the amount of flexibility they have also depends on their role within the health care institution.

Information sharing with family members

In many cultures, family members are considered an extension of the individual. In such cases, it is often said that confidentiality within the family is a non-issue. The apparent presence of such a cultural norm does not, however, allow the interpreter (or for that matter, any health care provider) to unilaterally make the decision to share information with family members. Knowledge about a particular cultural norm does not translate directly into knowledge about a particular person or family system. Whether or not a particular individual or family system adheres to certain norms is something that needs to be confirmed. But more importantly, the decision to share information and with whom to share it is still always the prerogative of the patient, and information sharing by any other party should first be discussed with the patient.

There are times, however, when the expectations regarding information sharing within the family system are not clear. If the interpreter notices that this lack of clarity is causing communication problems between the provider and the patient system, then the interpreter, acting within the parameters of their role, may raise the issue with the patient and/or provider. But again, the final decision regarding the sharing of information should rest with the patient and be negotiated with the provider not with the interpreter.

In other cases, the family may request that information be withheld from the patient, thereby circumventing the patient's right to know. Some patients may, in fact, wish this to be the case, either for personal reasons or because of cultural beliefs. Again, how, with whom, when, and what information is shared should be negotiated with the patient. It is not the prerogative of the interpreter or even of the provider to make this decision alone unless it is very clear that the patient is unable to participate in their own health care. The norms of the U.S. medical system value and protect the autonomy of the individual – it is with the individual that the "right to know" rests unless the patient has explicitly or implicitly indicated otherwise.

Confidentiality and the value of beneficence

There are circumstances when an interpreter may seriously have to weigh the seriousness and importance of the principle of confidentiality against other values and principles. Such a circumstance, as has already been mentioned, occurs when the value of beneficence – the well-being of the patient and/or others – comes into play. Situations in which there is a serious possibility that withholding information will result in harm to the patient or to others can be an exemption to the principle of confidentiality.

Two types of situation tend to arise for interpreters. One occurs when the interpreter has information about a patient from a previous clinical encounter. For example, the interpreter may know that the patient is allergic to a particular medication but the current attending provider is unaware of this and is about to prescribe or administer the medication. Is it a breach of confidentiality for the interpreter to intervene in this case?

Another situation occurs when the patient says something to the interpreter with the implicit or explicit expectation that this will not be shared with the provider who may or may not be present. Many interpreters have shared stories of sitting in the waiting room with the patient prior to seeing the provider and having the patient share information that has serious consequences or

implications related to the health and well-being of the patient. At times, this information is shared in passing and patients are unaware of the importance of what they have said. At other times, patients may explicitly say to the interpreter that this information is shared "in confidence" and that they do not want it conveyed to the provider. Such confidences have even been reported as occurring while in the clinical encounter with the provider present. Examples of the type of information that is shared ranges from statements of abuse, lack of compliance with treatment regimens, or the presence of medical conditions or symptoms in the patient or others around them. What is the interpreter to do in these situations?

First of all, interpreters have an ethical obligation to maintain transparency. The role of the health care interpreter is still not widely understood by patients and providers alike. Therefore, interpreters should be very clear, especially with patients, that their role is to interpret everything that is said while in the presence of the provider. If there is anything that the patient does not want to have known, then they should not say it. Secondly, interpreters should recognize that their commitment to confidentially refers primarily to maintaining the privacy of the patient in relation to those outside the treating team. This means that when the patient shares information with an interpreter that is pertinent to his or her health care, the interpreter may have an ethical obligation to make this known to an appropriate provider if there is danger that harm could come to the patient or to others. In all cases, however, the first obligation of the interpreter is to encourage patients to disclose the information themselves.

Information related to abuse, whether it is child abuse or elder abuse, as well as information about direct threats of harm to the self or to others constitutes special cases under the principle of confidentiality. Many states mandate the disclosure of information by designated persons such as health care providers when the abuse of a person is at stake or when a person is threatening harm to him- or herself or others. While there are no current national legal requirements mandating reporting by interpreters in cases of abuse or potential harm, individual states may have their own legal requirements for such disclosure. It is therefore, important for interpreters to know who the mandated reporters are in their state. Beyond that, interpreters should follow the same guidelines for disclosure of information as discussed above.

In addition, in those cases, where the interpreter makes the ethical choice to disclose information regarding abuse or potential harm, they also have the added responsibility to let those to whom they report such information know when the signs of abuse or indicators of potential harm could be confounded by cultural factors so that the proper investigation can be made in a way that respects cultural differences. Not to do so could jeopardize the well-being of the patient who may not be aware of the way their cultural practices could be misinterpreted.

The responsibilities of the interpreter when disclosure is necessary

The decision to disclose information should not be taken lightly. Such a decision should be taken only after every effort has been made to persuade the party from whom the information originates to make the disclosure themselves, explaining what information needs to be shared, with whom it needs to be shared, and why it needs to be shared. If, for whatever reasons, the patient refuses to do so and the interpreter then makes the ethical choice to disclose, it must be done in a responsible and respectful manner.

If interpreters are unsure of the course of action to be taken and if there is time, they should consult with their supervisor, the director of the interpreter service office or agency, or the ethics division of the health care organization. When there is no time for consultation, interpreters may have to make a decision based on their judgment as to what would be in the health care interest of the patient but should later discuss the situation at a supervisory session or a professional seminar. Such sharing of information for professional development purposes is not considered a violation of the principle of confidentiality. In these situations, however, the interpreter has an obligation to preserve the anonymity and, therefore, the privacy of the players by removing all information that could identify who the parties are.

2. The interpreter strives to render the message accurately, conveying the content and spirit of the original message, taking into consideration its cultural context.

The intent of this ethical principle is to ensure that the interpreted encounter between the patient and the provider approximates, as much as possible, what would be happening if the patient and the provider spoke the same language and shared an essentially similar cultural frame of reference. The ethical responsibility of the interpreter, therefore, is to convert messages rendered in one language into another without losing the essence of the meaning that is being conveyed and including all aspects of the message without making judgments as to what is relevant, important, or acceptable.

In the case of direct communication between a patient and a provider, messages and the meanings conveyed are not censored except by the parties themselves. It is, therefore, necessary that the interpreter convey everything that is said by either party in its entirety and in the manner in which the message is delivered, that is, without omitting from, adding to, or distorting the message. In addition, when possible, interpreters should convey the meaning of those gestures, body language, and tone of voice that add significantly to the content of the message, especially when these might not be noted or might be misunderstood by the other party.

The principle of fidelity requires that interpreters have the ability to detach themselves from the content of the message. This is not always easy especially when the substance is difficult, graphic, emotionally laden, or of a nature that elicits in the interpreter feelings of discomfort and even pain. But in no instance should interpreters decide to omit or distort messages because these are personally offensive to them or because they are uncomfortable with the language or content of the message. If they are unable to enact their role in accordance with this ethical principle, then interpreters should make this known to the parties and withdraw from the assignment.

The language patients use – to convey why they are consulting with the provider, to describe the events (occurrences and symptoms) that led to the consultation, to communicate wishes and desires for the future – is a key source of data that providers use to arrive at an accurate and mutually acceptable diagnosis and course of treatment (Woloshin, et. al., 1995). Interpreters are there to make these data accessible to the provider by transforming the data transmitted in one language into a format that the provider can understand. Providers use the interpreter's representation of what has been said as a diagnostic tool. Given this, interpreters need to be mindful that any piece of information may be an important data source. To omit or distort any of the information could, therefore, result in serious clinical consequences.

In the same way, the language the provider uses is a source of data for the patient. Through language, providers convey their understanding of the patient's concerns, negotiates an appropriate diagnosis, and offers possible remedies and treatments. Through language, the provider also builds a relationship with the patient, a relationship that can dramatically affect the outcomes of the encounter. The patient, therefore, should be able to access both the technical information and the information about the kind of relationship the provider is attempting to establish in order to make decisions that will impact his or her health and well-being. The patient can have full access to these data only if the interpreter faithfully transmits all messages from the provider.

In both cases, the interpreter provides the essential channel for communication and as such has the obligation to support the communication by rendering the content and spirit of the original message as faithfully as possible.

Faithfulness of the message within its cultural context

So far, we have laid out the importance of ensuring that the content and spirit of the original message is faithfully rendered in the other language. Why is there an additional qualifier to this that states "taking into consideration its cultural context?" How does culture affect the "faithfulness" of the rendering?

Many linguists, but most notably Sapir (1956) and Whorf (1978), have pointed out the interrelationships between language and culture. According to them, a language is in many ways an expression of culture and the way in which a culture organizes reality. Cultural experiences infuse words with meaning. The interpreter, therefore has to understand not only the words that are being used but also the underlying, culturally-based propositions that give them meaning in the context in which they are spoken.

One of the challenges interpreters often face is the appearance of "untranslatable" words, that is, words that refer to experiences and concepts that have no comparable referent in the other culture (Seleskovitch, 1978). In these instances, it is not enough for the interpreter to come up with what appears to be an equivalent word or expression, because what is key to developing communication or shared understanding is the conveyance of what the totality of that experience or concept means in that culture to that individual.

Does this mean that interpreters have to know and convey every single cultural nuance contained in every single utterance? Obviously not. But, what interpreters do have to know is that culture affects meaning and if meaning is not shared miscommunication and misunderstanding occurs. In the interest of faithfulness to the message, therefore, interpreters have an obligation to alert the parties to the possibility of cultural barriers to communication and to assist the parties in uncovering the hidden assumptions or unstated propositions in the message in order to arrive at a mutual understanding of the meaning.

Faithfulness of the converted message and offensive content

A question that is often raised by interpreters with respect to accuracy and completeness is whether the interpreter should immediately and fully convey discriminatory, prejudicial, or

derogatory remarks made by either party. Interpreters often find such remarks personally offensive and some may be unwilling to utter them even when they are not speaking in their own voice. This, however, is not an adequate or appropriate reason for interpreters to omit such messages or to "clean them up and make them nice."
Interpreters need to remember that everything that is said is a potential source of data. Offensive language use by a patient may sometimes be part of their condition. If the interpreter omits such language, the provider is losing a valuable piece of data that could lead to the appropriate diagnosis.

There are occasions, however, when remarks are made that could inadvertently be perceived as offensive by the other party and unwittingly affect the patient-provider relationship in a negative way. In such cases, interpreters might consider choosing to speak in their own voice, alerting the speaker to the possible negative effects of the remarks, remind the speaker that the interpreter is obligated to convey everything that is said, and then allow the speaker to reframe or rephrase their remarks if they wish to. For the most part, however, it is important for both the patient and the provider to get the full sense of who each other is – a sense that often comes through by the manner in which parties speak to each other

Faithfulness to the message and interpreter errors

Health care interpreters work under stressful conditions. For this reason, even the most qualified and competent interpreter will sometimes make an error in converting a message from one language into another. What is the interpreter's ethical obligation with respect to this?

First of all, interpreters have the ethical obligation to monitor their own interpreting performance. As has already been mentioned, an interpreter is in the unique position, in most cases, of being the only person in the encounter who understands both languages. Therefore, interpreters have a heightened responsibility to keep watch over their own performance and to catch any inadvertent errors they may make. When they do, and the error is of a substantive nature, it is then their ethical obligation to admit their error and correct it, not only in the interest of faithfulness to the original message but especially in the interest of the well-being of the patient.

3. The interpreter strives to maintain impartiality and refrains from counseling, advising or projecting personal biases or beliefs.

The intent of this ethical principle is to ensure that the communication and relationship between the patient and the provider remain at the center of the health care encounter.

What, then, does it mean for interpreters to act impartially? The dictionary offers the following synonyms for *impartial – fair, equitable, unprejudiced, unbiased, objective*. To be impartial, therefore, is to act with an absence of favor or prejudice in making a judgment, free from favor for any or either side. Impartiality applies primarily to the content of the messages that are being conveyed by the parties in the health care encounter. In effect, it means that interpreters do not judge the content of the messages in order to make decisions about what should be transmitted or not, or how it should be transmitted. It also means that interpreters do not judge any of the parties in the encounter. It means that interpreters respect the autonomy of each party in the

encounter and their right to speak for themselves in the manner they wish to. It means that interpreters respect the right of the parties to make decisions for themselves; therefore, interpreters should not take sides or attempt to persuade either party.

Interpreters in the health care encounter understand that they are not there as primary participants in the interaction and, therefore, are not in a position to make decisions, to advise or counsel, or to speak for the other participants. This means that interpreters have an obligation not to let their personal biases and beliefs intrude into the patient-provider encounter either through direct counseling or advice to either party or by injecting their biases and beliefs as if they belonged to one of the speakers. When they do speak for themselves, they are fully aware that their function in the encounter is that of a communication facilitator and as such their responsibility is to the process of communication and the facilitation of a mutual understanding of meaning. Therefore, it is not within the interpreter's set of duties to give advice or to counsel either party with respect to the goals of the health care encounter.

This is a principle that is misunderstood and misinterpreted by many to mean that interpreters should be disinterested in or uncaring with regard to the patient. To the contrary, as was discussed earlier, one of the overarching values of the health care interpreter's code of ethics, a value that is shared with other health care professionals, is the well-being and welfare of the patient. In upholding this value, interpreters fully recognize and accept the humanity and the human needs of the parties in the encounter. Responding with empathy to a patient who may need comfort and reassurance is simply the response of a caring, human being.

4. The interpreter maintains the boundaries of the professional role, refraining from personal involvement.

The intent of this principle is twofold: 1) to provide transparency in the service that is being provided, and 2) to avoid potential conflicts of interest.

Transparency

To maintain professional boundaries means that interpreters fulfill only the duties of a health care interpreter while engaged in the performance of that role and do not assume any duties that are outside that role. Therefore, interpreters, while in an encounter in which they have been engaged to provide interpreting services, should not assume duties that pertain to other roles whether they are qualified in those roles or not, unless there is an explicit understanding by all parties that the interpreter will do so. This principle is especially important for those interpreters who are cross-trained in other health care professions such as nursing. Individuals who are trained in such dual roles have to be very transparent about which role they are engaging in at any particular moment. If there is a need to take on their other roles or responsibilities for the well-being of the patient, they should be transparent by letting the relevant parties know when the shift occurs.

To work within the professional boundaries of the interpreter role also means that interpreters are aware of the limitations of their duties as well as the limitations of their abilities as a health care interpreter. Again, the element of transparency is key. There are times, for example, when an interpreter may not have the desired qualifications for the particular setting in which they have

been called to interpret (e.g., a mental health interview) but is the only interpreter available. In most cases where interpreters do not have the desired qualifications, the ethical obligation is to withdraw. Where withdrawal from the assignment is not a practical option, interpreters may continue but only after having made known to all parties concerned what their capabilities are and, at the same time, committing to doing the best job they can.

Personal involvement and conflicts of interest

This principle also admonishes interpreters to refrain from becoming personally involved with the people for whom they interpret. The status of a patient, especially when it is compounded by the inability to speak the language of the provider or know how to negotiate the health care system, places a person in a very vulnerable position. Interpreters should not exploit this vulnerability to their advantage.

Personal relationships also carry different types of expectations and demands that could interfere with the performance of the role of interpreter. Avoiding personal involvements minimizes the risk of creating conflicts of interest between competing expectations and demands.

This does not mean that interpreters cannot be friendly and caring or that interpreters are prevented from establishing rapport with both patient and provider, as can occur during a formal or informal pre-session. The development of rapport with patients and providers during a pre-session is a part of the interpreter's professional role and does not necessarily represent personal involvement. Establishing rapport means that the interpreter interacts with the patient in a respectful, culturally appropriate, and courteous manner, not only within the interpreted encounter but also on other occasions. In fact, good rapport between the interpreter and the patient can contribute to the development of a therapeutic relationship between the patient and the provider. If the patient feels comfortable with the interpreter, it is likely that the patient will transfer this feeling to the provider.

The question of maintaining professional boundaries that precludes personal involvement with the patient can sometimes pose dilemmas for interpreters who come from the same small or closely-knit cultural-linguistic community as the patient. In such communities, it is inevitable that the interpreter will have some level of personal involvement with the patient outside the world of the health care system. The responsibility of interpreters in these cases is to ensure that any such personal relationships do not interfere with the ethical performance of their duties both within the clinical encounter as well as outside the clinical encounter. For example, interpreters are bound by the principle of confidentiality not to discuss what they may have learned about the patient while in the clinical encounter with members in the community or even with family members unless given explicit permission to do so by the patient. For interpreters who are part of the social fabric of the community for whom they interpret, there is often a fine line between information gathered only while in the performance of their interpreter duties and information that might have been learned outside the encounter. Dealing with this fine line is not an easy task, but the interpreter's ethical obligation is to make appropriate decisions in order to maintain the privacy of the patient.

5. The interpreter continually strives to develop awareness of her/his own and other (including biomedical) cultures encountered in the performance of their professional duties.

The intent of this principle is to acknowledge that culture is a central factor in the health care encounter and is integral to the creation of meaning.

First and foremost, interpreters have to work at understanding the cultural basis of the way they themselves make sense of the world. How we see the world influences the meaning we give to experiences – what we understand and what we remember. By developing awareness of their own culturally based understandings and biases, interpreters are better able to focus on the meaning of the messages expressed by others and refrain from unwittingly interjecting their own perspectives or biases. This ethical principle actually assists interpreters in fulfilling their obligations under another ethical principle, that of impartiality.

Secondarily, this principle also acknowledges that there are many cultures that interpreters may encounter in the course of performing their duties. Does this mean that interpreters have to know everything about the patient's culture? Or the provider's culture? Or the culture of biomedicine? Obviously, this is impossible. No single interpreter, or provider for that matter, is expected to know the particular cultural beliefs and values that may apply in any given situation. Culture is an abstraction that is mediated in each individual by their unique circumstances and experiences, such as their personality; family values and beliefs; class, gender, education and other personal characteristics; and level of acculturation into another culture. Culture, therefore, is manifested in each individual in a different way.

The ethical obligation of interpreters is to possess enough understanding of culture and cultural practices and beliefs to be able to facilitate communication across cultural differences, seeking to minimize, and, if possible, avoid, potential misunderstanding and miscommunication based on cultural assumptions and/or stereotyping. Under certain conditions, such as clashing cultural beliefs or practices, a lack of linguistic equivalency, or the inability of parties to articulate the differences in their own words, the interpreter should assist (with the explicit consent of all parties to this intervention) by sharing cultural information or helping develop an explanation that can be understood by all.

Having background knowledge of the major cultural systems operating in the clinical encounter provides interpreters with two central skills: 1) they are able to comprehend more fully the meaning in the message of the speakers, and 2) they are able to generate hypotheses about how cultural factors may be affecting a lack of communication between the two parties and assist the parties in negotiating shared meaning.

Whose responsibility is it to be culturally competent?

With the tremendous increase in the number of patients from a variety of cultural and linguistic backgrounds arriving in the health care system, health care professions and institutions have begun to implement policies, structures, and expectations for cultural competence. Given this, some health care interpreters question why they have an "obligation to be culturally competent."

The answer to this question is simple: cultural competence is a value and an ethical principle that should be shared by all members of the medical team, including the interpreter. The reality, however, is that in most instances, interpreters will still be the member of the team most likely to have the knowledge and understanding of cultural factors that impinge on the process of communication and the creation of meaning. Therefore, in keeping with the principle of fidelity to the original message and in keeping with the goal of the clinical encounter – the well-being of the patient – the interpreter has the obligation to develop their understanding of the cultures of relevant others in the encounter and to bring this knowledge into their practice.

6. The interpreter treats all parties with respect.

The intent of this principle is to remind interpreters that they have an obligation to treat everyone in the encounter with dignity and courtesy, respecting the rights and duties of each individual, including their own.

An essential implication of this principle is that the interpreter respects the autonomy and expertise that each party brings to the encounter. Patients have the right to decide what is best for them after having received appropriate and relevant information. Providers have the duty to present their knowledge clearly and objectively so that the patient is able to make informed choices. Interpreters have the duty to convey all messages faithfully and completely. By respecting the rights and duties of each party in the encounter and treating all parties equally and with dignity, interpreters can help build mutual respect within the interpreted encounter.

7. When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must be undertaken only after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.

Interpreters cannot help but be a "witness"[2] to what they have seen or experienced in the health care encounter—good or bad, right or wrong. Unfortunately, in the course of their practice, interpreters will sometimes see injustices or ethically inappropriate behavior that may jeopardize one or more persons in the encounter or that may negatively impact different groups within the health care institution. In such cases, interpreters may find it ethically necessary to take an advocacy role, that is, to speak out in their own voice in order to "plead a cause" or attempt to "right a wrong."

The idea of advocacy in relation to health care interpreting has been and continues to be a controversial one. In the first draft of the code, the STC Committee had not included a principle that addressed advocacy. Feedback from the focus groups, however, clearly indicated that working interpreters were asking for guidance on advocacy. Many felt that they were being asked to take on this role inappropriately while others felt constricted from doing certain things because it would be considered advocacy.

[2] My thanks to Margarita Battle, former director of interpreter services at Massachusetts General Hospital for the introduction of the concept of "witness" early on in the emergence of this profession to bring attention to the fact that interpreters often see and experience things that cannot and should not be ignored.

A large part of the controversy, however, comes from the confusion that exists about the meaning of advocacy and what its implications are in practice. On the surface, advocacy appears to be a contradiction of the ethical principle of impartiality – the obligation not to judge, take sides, or express personal opinions and biases with respect to the content of the communication in the clinical encounter. But these proscribed actions are clearly not examples of advocacy. The act of advocacy should derive from clear and/or consistent observations that something is not right and that action needs to be taken to right the wrong. On a deep level, advocacy goes to the heart of ethical behavior for all those involved in health care – to uphold the health and well-being (social, emotional and physical) of patients and ensure that no harm is done.

Interpreters are seen in different ways by the parties. On the one hand, they are often said to be a potentially intrusive presence, inhibiting the close, private relationship between patient and provider. On the other hand, their presence is "forgotten" or considered inconsequential. In this latter situation, a party may say or do things that go beyond the bounds of respectful interpersonal interactions or ethical practice. When what the interpreter sees or experiences has a significant likelihood of serious negative consequences for a patient or patients, or, for that matter, for others in the system, and every effort to resolve the matter judiciously with the parties involved has been unsuccessfully tried, interpreters have the ethical obligation – like any other professional in the same situation – to take action and advocate on behalf of the wronged individual or individuals. Essentially, they have an obligation to "bear witness," that is, to bring forth evidence of the wrongdoing to the appropriate parties in order to redress the wrong that has been done.

Assuming an advocacy stance, however, should never be taken lightly. Interpreters should undertake this action only after careful and thoughtful analysis of the situation. In coming to this decision – to advocate or not – they may want to seek the advice of supervisors and colleagues in the field, remembering, however, to preserve the anonymity of the parties involved when seeking such advice. In some cases, they may want to consult an ethicist. In every case, they need to find out what the appropriate mechanisms and protocols are for such action in the institution in which they are interpreting and follow them. In every case, interpreters should conduct themselves in ways that respect the privacy and rights of the parties involved.

8. The interpreter strives to continually further his/her knowledge and skills.

The intent of this principle is to ensure that interpreters continue to develop their understanding of the content and context in which they interpret and continue to sharpen their skills.

The ability to interpret accurately and completely is, to a large extent, dependent on how much background knowledge the interpreter has of the content and the context of the communication (Seleskovitch, 1978). In the field of health care interpreting, the areas of knowledge that are most salient include the medical context (e.g., the basic parts and functioning of the body and common disease syndromes and their respective treatments) and the socio-cultural context of the patient populations for whom the interpreter interprets (e.g., beliefs about wellness and illness, folk illnesses and remedies, and the impact of assimilation and acculturation on the presentation of illnesses). This does not mean that interpreters are expected to have the depth and breadth of knowledge that health care professionals or anthropologist have in their respective fields. However, the more background knowledge the interpreter has, the more likely it is that the

meaning of the messages will be fully understood and therefore, the more likely it is that the conversion will be faithful to the original message.

Interpreters are also responsible for continuing to improve and enhance language skills and their skills of interpretation. With respect to language skills, interpreters should strive to continually improve their proficiency in both languages, including the use of appropriate syntax, fluidity of expression, level of comprehensibility, and clarity of pronunciation. Because languages are constantly changing, part of interpreter's responsibility is to keep up with new developments and with varieties of each language with which they may be less familiar. With respect to the skills of interpretation, interpreters should work to strengthen their ability to convert messages in either direction accurately but also quickly and fluidly. Other skills of interpretation include improving their ability to hold longer and denser chunks of meaning before having to interpret or using mnemonic devices to assist their memory.

Professions are dynamic systems and adapt to changes in their environment. New knowledge is created, different methodologies discovered, and new technologies created.
The ethical obligation to further their knowledge and skills resides in the individual interpreter, not in their employers. There are many opportunities available to interpreters to continue their professional development – belonging to a professional organization, reading the current literature, making good use of on-the-job training and supervision, and participating in workshops and conferences to name a few.

9. ***The interpreter must at all times act in a professional and ethical manner.***

The intent of this principle is to ensure that interpreters always strive to act in a manner that maintains the integrity of their work and upholds the values and ethical principles of their profession. This means that they perform their duties competently; monitor their own performance and behavior, including knowing when to withdraw and when to admit and correct an error; conduct themselves with dignity; respect other professionals at the same time that they expect respect for their profession; and do not discriminate against anyone in the provision of their services whether based on personal characteristics such as race, class, sexual orientation, or ability to reward them for their services.

To behave ethically means that interpreters do not use the knowledge they gain about individuals while in the enactment of their duties for their personal advantage. They do not withhold their services in order to receive favors from the parties. They do not exploit the vulnerability of the patient who depends on them in order to be able to receive the services they need for their well-being.

Professionalism and gifts from patients[3]

What does this principle mean with respect to gifts from patients? Patients often bring gifts as an expression of appreciation and gratitude for the services they have received. Such behavior is also often a reflection of cultural traditions. Is accepting such gifts an ethical violation?

[3] This section was patterned after the American Medical Association's Code of Ethics, principle E-10.017 Gifts from Patients.

There are two rules of thumb that interpreters can use to decide whether accepting gifts would constitute an ethical violation on their part. First of all, interpreters should know and adhere to the policy of the health care institution in which they are interpreting with respect to the acceptance of gifts. Many institutional policies acknowledge the human desire to show appreciation, a desire that is often also embodied in cultural values and traditions. Such policies recognize that a refusal to accept a gift may be construed as an insult that could destroy trust in the relationship. Therefore, they offer guidelines as to what types of gifts are acceptable and which are not. Second, and most importantly, the interpreter should try to determine whether the act of gift giving is an attempt to influence the interpreter and secure preferential or special treatment. A possible indicator of the motivation behind the gift giving is the value of the gift. If the value is beyond what would normally be considered a "token of appreciation," it should raise questions as to the appropriateness of accepting the gift.

Whether the interpreter chooses to accept a personal gift, or to graciously decline the gift, or to accept it only on behalf of the interpreting office, interpreters have the obligation to make clear to the patient that their duty is to provide competent service in a fair manner to all patients without added reward or compensation.

Concluding Remarks

As mentioned at the beginning of this document, a code of ethics is a guiding document, not a 'how-to" recipe. In the commentaries, you have seen that many of the principles are interrelated. You have also seen that there are times when the principles may conflict with each other in a specific situation. Conflict in ethical behavior is inevitable. What a code of ethics simply does is offer those principles that a practitioner of the profession needs to seriously consider and weigh as they make choices about their behavior.

Ethical principles are abstract, idealized concepts of what is appropriate. But these abstract principles cannot answer the questions that arise out of the intersections of different people and unique circumstances. Professionals have to evaluate the consequences of each course of action they might take and ultimately make a choice. A code of ethics provides the professional with those ideals and values they need to consider in making those choices so that the purpose of their profession is furthered and its integrity maintained.

It is the hope of the NCIHC and the STC Committee that the National Code of Ethics for Interpreters in Health Care will contribute to raising the quality of practice in the profession by providing clarity and consistency at the national level. At the same time, the NCIHC and the STC Committee recognize that the National Code of Ethics is a living document that will continue to evolve as the field develops and matures.

References

Blackburn, Simon. *Being Good.* Oxford: Oxford University Press, 2001.

California Healthcare Interpreters Association Standards & Certification Committee. *California Standards for Healthcare Interpreters: Ethical Principles, Protocols and Guidance on Roles & Intervention.* 2002.

Edwards, A.B. "Ethical Conduct for the Court Interpreter." *The Court Manager*, 3, No.2 (1988): 22-25.

Gonzalez, Roseann D., Victoria F. Vasquez, and Holly Mikkelson. *Fundamentals of Court Interpreting: Theory, Policy, and Practice.* Durham, N.C.: Carolina Academic Press, 1991.

Massachusetts Medical Interpreters Association and Education Development Center, Inc. *Medical Interpreting Standards of Practice.* Newton, MA: Education Development Center, Inc. 1996.

National Council on Interpreting in Health Care. *A Code of Ethics for Health Care Interpreters: A working paper for discussion.* www.ncihc.org, 2004.

Sapir, Edward. *Culture, Language, and Personality.* Los Angeles: University of California Press, 1956.

Seleskovitch, Danica. *Interpreting for International Conferences.* Translated by Stephanie Dailey and E. Norman McMillan. Washington, D.C.: Pen and Booth, 1978.

Whorf, Benjamin Lee. "The Retention of Habitual Thought and Behavior to Language." In *Language, Thought, and Reality.* Edited by John B. Carroll. Cambridge, Mass: M.I.T. Press, 1978.

Woloshin, Steven, Nina A. Bickell, Lisa M. Schwartz, Francesca Gany, and Gilbert Welch. "Language Barriers in Medicine in the United States." *JAMA.* 273, No.9, (1995): 724-728.