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# Making Sense of the Interpreter Role in a Healthcare Service-learning Program

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This study examines the interpreter role among students who serve as interpreters in a community health clinic system in the Midwestern USA as part of a community health-themed service-learning course for advanced Spanish students. Drawing on Positioning Theory (Davies and Harré 1990), I consider the ways in which three second language learners and three heritage speakers who participated in the program describe their roles as interpreters with reference to the Code of Ethics, negotiate their roles with the medical students and doctors also serving at the clinic, and make sense of moments in which they chose to advocate for the patients, or otherwise provide assistance to them, beyond interpreting. Each student encountered different types of challenges that reflected their individual backgrounds and experiences, and these challenges led to reflection, learning, and new perspectives on their roles in providing patient care. The article problematizes the role of bilingual student interpreters in community health programs and offers recommendations for preparing students to provide the highest possible quality of healthcare for speakers of minoritized languages.

## INTRODUCTION

Research demonstrates that language barriers in healthcare contexts dramatically affect the quality of care provided for Spanish-speaking Latinos in the USA (CHIA Standards & Certifiation Committee 2002; Timmins 2010). There is a growing need for interpreters in healthcare contexts in many Western nations, due to the influx of immigrants from non-English-speaking countries, and healthcare facilities often struggle to provide the qualified interpreting services required by current federal legislation (Benda *et al.* 2019; Showstack 2019). As part of an effort to provide students with preparation to use their language skills in domestic professional contexts, university language programs have begun to respond to the need for healthcare interpreters by offering advanced language students the opportunity to interpret at local community clinics through service-learning. This practice can potentially lead to a decrease in the use of ad-hoc interpreters, such as family members and office staff, support access to quality healthcare for speakers of minoritized languages, and contribute to the development of a workforce of qualified medical interpreters. However, the training of students who serve as interpreters in university service-learning programs varies widely, and in some cases the

institutions where the students serve may not have clearly established procedures for collaborating with interpreters. As Showstack *et al.* (2019b) point out, there is a need for applied linguists to engage in work to address barriers to quality healthcare for speakers of minoritized languages; in particular, scholars can contribute to an understanding of the interpreter role in settings where university students are meeting a need that is not being met by state and national resources.

The training provided to students who serve as interpreters in university service-learning programs ranges from general advanced language study to complete degree programs in translation and interpreting Spanish for the health professions, with the interpreting experience as a cumulative requirement. Healthcare interpreters are not only responsible for conveying information; in order to ensure the highest possible quality of care for the patient, they must also be able to use on-the-spot judgement to determine when they need to exercise a role as clarifier, patient advocate, or cultural broker. These additional roles are still being defined in the field of healthcare language policy, and their application may vary depending on the type of healthcare context; thus, the development of student interpreters' understanding of their role in a particular healthcare context is a crucial component of their learning process.

## SERVICE-LEARNING AND LANGUAGE LEARNING

Language education programs (Spanish in particular) have increasingly offered students the possibility of participating in service-learning as part of their language study, often framed as an opportunity to learn about how language works in a real-world context, use their language skills to interact with native speakers of the target language, learn first-hand about the local communities of speakers of that language, and practice skills that they may use in their professional lives in the future (Lear 2012). However, service-learning in language courses can go beyond the development of language skills and exposure to local communities; when students are provided with ample opportunities for critical reflection, they can also develop a profound understanding of a need in their community, critically assess their role in responding to this need, and develop a new understanding of their own identities as language users and as engaged community members (Leeman 2011; MacGregor-Mendoza and Moreno 2016). Leeman *et al.* (2011) demonstrate how a critical pedagogical approach that allows students to question widely accepted assumptions and explore their own agency in taking action for social change may inform a Spanish service-learning program. While much of the literature on service-learning focuses on the benefits for students, the impact on the individuals whose needs a project purports to address should be considered of equal or even greater importance. Stoecker (2016) points out that institutionalized service-learning structured as charity work can function as a 'safety-valve' that prevents disadvantaged groups from demanding real social change

and can also promote demeaning definitions of the poor. He argues that service-learning in higher education should be 'liberated' by building capacity within the community to work toward systemic change and creating opportunities for the people being served to become producers of knowledge.

Student involvement in healthcare communication is an ethically complex issue, because a healthcare interpreter should possess certain qualifications in order to provide interpreting services that support equal access to healthcare for linguistically minoritized groups (i.e. fluency in both languages, knowledge of terminology, awareness of interpreting conventions, an understanding of ethical principles, and ideally a certification in medical interpreting). Section 1557 of the Affordable Care Act (ACA), a 'non-discrimination' provision, was expanded in 2016 and now requires healthcare facilities that receive federal funds to offer 'qualified interpreters' to patients who are described as 'Limited English Proficient'.[1] However, some healthcare facilities that are required to comply with this legislation may encounter difficulties in providing qualified interpreting services (Showstack 2019); safety-net health clinics that do not receive federal funds and are not required to comply with the anti-discrimination provisions may be even less likely to offer qualified interpreters because their limited resources are allotted to address other clinic needs. Because of this situation, community health clinics in regions with rapidly growing Latino populations may reach out to university Spanish language programs to express a need for language assistance. However, uncertified university students who serve as interpreters in safety-net health clinics are temporarily responding to a problem with the healthcare system without resolving it. When facilitating and engaging in service-learning programs that address inequities caused by inadequate language access services, university faculty and students can explore and reflect on the societal context and moral responsibility associated with this process, and the individuals who are receiving the students' language services can be part of the discussion as well.

When serving as interpreters, students learn about the role of the interpreter, which is often assumed by interpreters and healthcare providers to be primarily a role of conveying information, or serving as a 'conduit', but is in reality much more complex (Kaufert and Koolage 1984; Angelelli 2004; Dysart-Gale 2005; Hsieh 2008; Bloom-Pojar 2018). In particular, students learn what it means to follow the *code of ethics for medical interpreters*, a set of ethical principles that medical interpreters are expected to follow. A widely used set of standards for medical interpreters was set forth by the California Healthcare Interpreting Association (CHIA) in 2002 and includes the ethical principles of *confidentiality*, *impartiality*, *respect*, *professionalism*, *accuracy*, *cultural awareness*, and *advocacy* (CHIA Standards & Certifiation Committee 2002); building on this document, the National Council on Interpreting in Health Care (NCIHC) published a similar code of ethics in 2004, which has been endorsed by over 165 organizations and is now the industry standard for interpreter training (King-Ramirez and Martínez 2018). The ethical principles come with guidelines, and interpreters are expected to be able to apply them

to specific situations, sometimes using their own judgment about a situation to make an on-the-spot ethical decision. For example, they may need to choose between impartiality and advocacy for the patient if they feel that the doctor is communicating in a way that is not culturally sensitive. The ethical principles are designed to ensure the highest quality of care, but depending on how they are implemented, the expectations for interpreters can limit how much interpreters can do to contribute to the well-being of the patient.

A handful of studies demonstrate the value of community engagement in healthcare contexts in Spanish language programs and provide guidelines and recommendations for scholars and healthcare providers interested in engaging students in community work. Martínez and Schwartz (2012) report on Spanish heritage language students' experiences in a community-based medical Spanish for heritage speakers (HS) program in which they served as interns in a health center in Texas; an assessment of the program showed that students gained a heightened commitment to the maintenance of their heritage language and improved Spanish language skills and understanding of language variation. Also focusing on Spanish HS, Belpoliti and Pérez (2019) reported on students' experiences with service-learning in an advanced Spanish for the global professions program at the University of Houston. They found that HS who participated in community health-oriented service gained confidence, developed their awareness about the needs and cultural practices of local Latino communities, and improved their language skills. Finally, in a paper aimed at an audience of mental healthcare providers, Abbott (2011) offers guidelines on how to effectively engage with Spanish language programs and ensure that community service-learning programs are beneficial to the community members they intend to serve. Despite the existing scholarship on Spanish service-learning in healthcare contexts, no study has specifically addressed the role of the student interpreter.

## THE INTERPRETER'S ROLE

Even with the existence of multiple published sets of ethical guidelines for medical interpreters, difficulties can still arise in the process of collaboration between the interpreter, patient, and practitioner. Dysart-Gale (2007) argues that the theoretical understanding of communication that shapes interpreter-mediated interactions can cause these communication difficulties. In a study of interpreter-mediated interactions in healthcare contexts, she found that participants relied on two distinct models of communication: a 'transmission model', which views communication as the transmission of meaning through messages, and a 'semiotic model', which views communication as a process through which meaning evolves. Hsieh (2008) found that interpreters use a range of strategies to resolve conflicts when managing diverse perceptions of their roles and the needs of different participants in patient care interactions.

Dysart Gale and Hsieh's work builds on an expansion of interpreter roles beyond simply conveying information that has been reflected in some ethical

guidelines since 1990; the additional roles of the interpreter include: the *clarifier*, who 'interjects specific information in cases when cultural differences create incommensurability in messages' (Dysart-Gale 2007: 239), the *cultural broker*, who provides a cultural framework for understanding the message being interpreted, mediating between the culturally based worldviews of both the provider and the patient (Raymond 2014), and the *patient advocate*, who acts outside of the bounds of the interpreted interview to advocate for the highest quality of care for the patient.[2] Raymond (2014) shows that one of the ways that medical interpreters accomplish these roles is through *epistemic brokering*, a process through which they facilitate patient–physician alignment and mediate between the framing of different types of knowledge shared by both parties. While these expanded roles support quality care for linguistically minoritized patients, limitations to the articulation of the roles has caused problems leading to continued debate (Avery 2001; Dysart-Gale 2005).

Discussions on the role of the interpreter are significant from a social justice standpoint; in the healthcare context, the interpreter may take an active role in ensuring the quality of care of the patient. Despite this multiplicity of possible interpreter roles, King-Ramirez and Martínez (2018) argue that the NCIHC code of ethics emphasizes neutrality and fidelity at the core of medical interpreting practice, in contrast with notions of benevelence and social justice that are emphasized in the ethical principles in other fields. Inghilleri (2012) questions the capacity of existing codes of ethics, and particularly the emphasis on neutrality and impartiality, to allow interpreters to both honor their professional obligations and also act socially and ethically responsibly. She points out that interpreters may not maintain impartiality when choosing to intervene to ensure that the self-interests of all parties are represented clearly, and they may not mantain fidelity when negotiating with interlocutors to ensure that all parties are granted the right to participate and be heard.

An interpreter's understanding of their role evolves with experience (Hsieh 2008) and may not be limited by a particular institution's interpretation of an ethical code. To convey a message accurately, interpreters must learn to convey both the content and spirit of the original message, which requires a sensitivity to its cultural context and the ability to use multimodal forms of communication to frame utterances (Oritz 2017); when striving to maintain the boundaries of a professional role, they may also wish to develop a relationship with the patient so that the patient feels comfortable and is able to trust the interpreter and provider; and the interpreters' role of 'advocate' requires an ability to determine when a patient's health, well-being, or dignity is at risk (cf. National Council on Interpreting in Health Care 2004). In addition, the interpreter must be able to clearly indicate what they are doing when navigating between different roles, which is accomplished using a range of multimodal cues, often including body language (Oritz 2017; Ruggiero 2018). In order to better understand the process of making sense of the code of ethics and learning to implement it, I examine six undergraduate Spanish students'

experiences with the interpreter role in their service at community safety-net clinics in Kansas, addressing the following research questions:

1 How do the students describe their roles as interpreters with reference to the Code of Ethics for Medical Interpreters, and how does the way that they make sense of their roles shape their behavior as interpreters?
2 How do the students negotiate interpreter and provider roles with the medical students and doctors also serving at the clinic, and how do they make sense of these processes of negotiation?

The first question addresses the students' understanding of their roles and how this understanding shapes the way they work, while the second question focuses on the ways in which they negotiate their own understandings of their roles with how they are positioned at the clinic. To answer these questions, I conducted case studies of six students who participated in the program, interviewing them regularly throughout the semester in which they participated.

## STUDY CONTEXT AND METHODS

The study was conducted in an urban-serving, public university located in the state of Kansas, in the Midwestern USA (henceforth 'Central Plains University'[3]). 'Applied learning' was a pillar of Central Plains University's strategic plan; a service-learning team supported instructors in matching service-learning assignments with course objectives and measured community impact based on the hours of service provided by students from each college within the university. Over 16 per cent of the population of the city where the study was conducted was Hispanic or Latino, according to the US Census, after a rapid increase in the Latino population in the region over the previous 20 years, and safety-net clinics serving the uninsured in the region had encountered difficulty providing interpreters. In response to this need, the Spanish language program at Central Plains University developed a healthcare service-learning program for its advanced undergraduate and graduate students, allowing them to serve as interpreters in local safety-net health clinics. The program was lauded by university administrators, and two local health clinics came to depend on it, regularly contacting the Spanish program to request student interpreters during periods when students were not completing service-learning requirements for a course. I present the study context and methods in first person because my positioning as the instructor of the course described in the study and the researcher who conducted the interviews, and my identity as a native English-speaking non-Latina who identifies strongly with Mexican culture and bilingual practices, are relevant to understanding the study data.

I redesigned the program's Advanced Spanish Grammar and Composition course to include a community health theme and a community service-learning requirement, and I taught the class with this new curriculum in Fall 2017 and Spring and Fall 2018. The course was included in a certificate

program in Spanish for the Professions and was a prerequisite or co-requisite for two advanced translation and interpreting courses that were required in the certificate program. During the time of data collection, about 20 percent of the students who took the course each semester were Spanish HS, while the rest were Spanish second language (L2) learners. The course curriculum included readings about Latino health and language in healthcare, health-themed grammar and vocabulary activities, lessons on the basic protocol for healthcare interpreters and vocabulary needed for the general clinic context, in-class discussion on the code of ethics, simulations of interpreting scenarios, and writing assignments related to the service-learning experience and community needs. The students were required to study the 'Ethical Principles for Healthcare Interpreters' in the well-known document *California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roles and Intervention*,[4] and the set of guidelines put forth by the National Council on Interpreters in Health Care was reviewed in class.

A retired physician and a professional medical translator with healthcare interpreting experience visited the classroom to teach a class session on the code of ethics. The class session, which they taught in Spanish, included analysis and discussion of several scenarios that the physician drew from his own experiences and provided as case studies for the students. He described each scenario to the class and asked the students to determine whether it included a violation of the code of ethics and, if it did, which ethical principle was being violated. Each semester, interpreters and medical students collaborated to present simulations of health clinic interpreting scenarios for the students, with discussion on what was done well and the errors that were (sometimes intentionally) committed. In Fall 2018, the students also visited the applied learning center in the university's school of nursing, where selected students participated in a pilot interpreting simulation with nursing students and a high-fidelity mannequin patient.

Throughout the semester, class discussions, readings, and writing assignments addressed issues of health equity, allowing students to explore the systemic reasons for disparities in health outcomes for economically disadvantaged individuals and those whose preferred language is not English, focusing on Latino health in particular. During their service at the health clinics and in other placements, students reflected on why the community partner organizations had requested assistance in the contexts where they served; those who served as interpreters in the safety-net clinics reflected on why the patients did not have access to paid, certified medical interpreters and on the ethicality of serving as students; finally, we talked about the kinds of changes that could be made at the local, state, and national level to address the lack of resources for linguistically minoritized groups that led to requests for Spanish-speaking students. In addition, the Spanish HS in the course reflected on what it was like for them to interpret for family members as children, recognizing over the course of the semester how unprepared they had been to interpret then.

The last composition for the class was a grant proposal (in Spanish) for a local project designed to support Latino health. This assignment allowed students to propose a solution to the systemic problems that created inequities in the local community, and I encouraged the students to consider sharing their proposal with a local organization to discuss the possibility of implementing their project. The students also presented posters about their service-learning projects in the university's 'Service-Learning Showcase', providing them with the opportunity to educate university students and faculty about the community needs they addressed through their service, share their experiences addressing those needs, and make recommendations for advancing health equity in the future.

Over the three semesters that the study was conducted, about 10 of the students were approved to meet their service-learning requirement by interpreting in community safety-net clinics. After the initial stages of the service-learning program, I developed a screening procedure that included a Spanish-language interview with me within the first two weeks of the semester in which we addressed students' reasons for wanting to interpret in a healthcare context, their responsibilities as interpreters, and what they needed to do to ensure that they were prepared before starting to interpret in their clinic placement. I selected students who demonstrated an advanced level of conversational fluency in Spanish, an understanding of what they needed to do to prepare themselves, and a commitment to implementing the ethical principles studied in class. Although I initiated discussions with colleagues at the university and the clinic about a system for evaluating students' interpreting work at the clinic, the program had not yet implemented this evaluation at the time of publication. Students who chose not to interpret in the clinics or were not approved for a placement as an interpreter selected from a range of other service-learning placements, which included a food pantry, Girls on the Run, the Alzheimer's Association, and other organizations that strived to support the health of Latinos in the local community. While only 10–15 hours of service were required, depending on the semester, almost all of the students who served in the clinics continued to interpret there after they had met the required number of hours, with some students logging up to 30 hours by the end of the semester.

One of the clinics, referred to here as 'Doctors of the Plains',[5] was run and staffed by medical students from a prestigious medical school, many of whom had received some training on working with interpreters. Patient visits were lengthy there because patients were routinely visited by a medical student, a pharmacy student, and a medical doctor, and the presence of an interpreter could increase the length of the visit. The other clinic, referred to here as 'Ángeles Clinic', was affiliated with a Catholic diocese and had a handful of paid staff members, while all of the healthcare providers and interpreters were unpaid. When the service-learning program was first implemented, the personnel at Ángeles Clinic had limited knowledge of healthcare interpreting protocols and legislation. Neither clinic was subject to federal requirements for

interpreting because they were not receiving federal aid, and they had taken only minimal steps to improve language access services. The executive director of Ángeles Clinic explained that the clinic was unable to hire interpreters because its services depended solely on grants from private institutions and gifts. Before the Spanish program began to send students to interpret, both clinics had frequently utilized ad-hoc interpreters, a practice that can lead to inaccurate interpretation and has been associated with an increased rate of clinical errors (Flores *et al.* 2012).

While the perspectives and experiences of the healthcare providers, patients, patients' family members, and clinic administrators are significant components to understanding the role of the interpreter, this study only includes interviews with student interpreters and focuses on how they perceived and made sense of their role in the interpreting collaboration.[6]

## Data and participants

This study examines the experiences of six female students who took the course between 2017 and 2018 and interpreted at one or both of the safety-net clinics to meet the course service-learning requirement. To recruit these participants, I made a general announcement to my class at the beginning of each semester, and students who were interested in participating approached me after class or by e-mail; all of the students who offered to participate were included in the study. I interviewed each student regularly throughout the semester about their experiences interpreting at the clinics, filming each interview with an iPod. The study participants included three Spanish HS ('Valeria', 'Regina', and 'Daniela'), all of whom had grown up speaking Spanish in Kansas with immigrant parents, were highly fluent in the language and had completed an intermediate-level Spanish L2 course or a Spanish course for HS, and three Spanish L2 learners ('Jen', 'Addie', and 'Kelly'), who spoke more slowly than the HS, and sometimes had difficulty accessing vocabulary.[7] Based on my own assessment, Valeria, Regina, and Daniela interacted in at least an advanced-mid level of proficiency in speaking according to the guidelines set forth by the American Council on the Teaching of Foreign Languages (ACTFL) in 2012 (American Council on the Teaching of Foreign Languages 2012); Addie and Kelly exhibited at least an advanced-low level, and Jen was slightly less proficient, having participated before I developed a concrete method of approval for interpreting at the clinics. All three HS had experience serving as ad-hoc interpreters (or 'language brokers') in healthcare contexts as children. Jen and Addie had some experience as service providers in healthcare contexts, and Kelly had no experience with interpreting or healthcare, but she planned to pursue a career in professional interpreting. Valeria and Jen participated in Fall 2017; Regina, Addie, and Kelly participated in Spring 2018; and Daniela participated in Fall 2018 (Table 1).

As shown in Table 1, the students who participated in the study had a diverse range of majors and post-graduation plans. In addition to their majors,

*Table 1 Participants*

| Pseudonym | HS/L2 | Major | Experience | Post-graduation plans |
|---|---|---|---|---|
| Valeria | HS | Spanish education | Language brokering | Become teacher; later return to studies |
| Regina | HS | Psychology | Language brokering; professional interpreting | Research to improve mental healthcare |
| Daniela | HS | Elementary education | Language brokering | Become English for speakers of other languages or dual language teacher |
| Jen | L2 | Nursing | Certified nursing assistant | Become a registered nurse |
| Addie | L2 | Social work | Had volunteered at clinic as healthcare provider; taking translation and interpreting course simultaneously | Travel |
| Kelly | L2 | Spanish | Taking translation and interpreting course simultaneously | Become professional interpreter |

Regina, Jen, and Kelly were also pursuing an undergraduate certificate in Spanish for the Professions through the language department at the time of data collection, and Daniela declared the certificate about halfway through the Fall 2019 semester; Addie and Kelly were taking an introductory course in translation and interpretation in addition to the grammar and composition course at the time of data collection. Going into the service-learning experience, all of the participants had a clear understanding of why the experience would be beneficial to them in their studies and/or their future work. In the interviews, they described positive learning experiences and a sense that they were making a difference in the lives of the patients they served.

While all of the students who participated in the study were identified as females, most of the doctors in Ángeles' general clinic, who also occasionally provided care at Doctors of the Plains, were older (often retired) males, which may have contributed to an imbalance of power that was observed in some interactions; the doctor at the women's clinic was a female in her early 40s, and the medical students at Doctors of the Plains were both males and females.

## Data analysis

I conducted the interviews in Spanish and English and transcribed the data with the help of a bilingual research assistant. To analyze the data, I drew from grounded theory (Strauss 1987) to identify salient themes in the interviews; I coded the transcribed interviews based on themes that emerged from

the data and fine-tuned the codes using multiple rounds of coding. The research questions emerged from the data through this coding process.

In a second phase of analysis, I drew from positioning theory (Davies and Harré 1990) and narrative analysis (Wortham 2001; De Fina 2003) to gain a deeper understanding of the roles ascribed to the participants by others, how they negotiated their roles and how they made sense of their positioning when describing their experiences. Davies and Harré (1990) define 'positioning' as 'the process by which selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines' (Davies and Harré 1990: 38). When the students describe their experiences as interpreters, they position themselves in particular roles in negotiation with the code of ethics for medical interpreters that they studied in class, the social practices of the specific clinic where they are interpreting, and the ways in which they have been positioned and have come to understand their roles as language users in different contexts in their lives.

My analysis of participants' narratives draws on Wortham's (2001) distinction between the 'narrated event' and the 'storytelling event'. Bamberg (1997) shows how the notion of positioning can be applied to the analysis of storytelling by considering how the narrators position characters as agentive or non-agentive, use the narrative for a specific purpose (e.g. to instruct the listener), and index identities. I look at both the event that the participant describes (the 'narrated event') and the resources the participant used to position herself through storytelling. By taking this approach, I am able to analyze the students' positioning in particular moments at the clinic (to the extent possible with the interview data) and also the way the students position themselves and others in their descriptions of these moments. This approach to narrative positioning allows me to understand how the students convey their sense of agency or lack of agency, of being an expert or novice, and a teacher or a learner, within their stories, when telling them to an interviewer who is institutionally positioned as a researcher and a teacher.

## STUDENT'S ROLES AND THE CODE OF ETHICS

The first research question addressed how the students described their roles as interpreters with reference to the Code of Ethics and how their understandings of their roles shaped their behavior at the clinics. Findings suggest that at times students' empathy and concern for the patients made it difficult for them to follow certain ethical principles as outlined in the CHIA and NCIHC guidelines.

All three of the HS who participated in the study described feeling a deep understanding of the challenges faced by the Spanish-speaking Latino patients for whom they provided interpreting services at Doctors of the Plains and Ángeles Clinic. In general, this awareness and sense of shared experience was beneficial to the process; at times it was also challenging for the students to maintain a professional distance. For Valeria and Daniela, being able to relate

to the patients sometimes made it difficult for them to maintain a professional distance from them, causing these students to reflect on their interpretations of the principle of professionalism. For example, Valeria described a situation in which she was in a room with a patient waiting for a healthcare provider to find a thermometer to replace one that was not working, and the patient began to ask her questions about her work as an interpreter; Valeria said she felt uncomfortable because she knew that this was not part of her job. However, she used her own judgement to decide that the right thing to do was to engage in conversation with the patient.

Daniela, on the other hand, felt that because of her sensitive, trusting, and open personality, interpreting was not for her. She said:

> **Excerpt 1: Daniela**
> I'm a person that's very sentimental, and when I was interpreting for the counseling last Monday, I wanted to cry you know, 'cause it's just some things are very intense, you know and I feel for them, I wanted to give her a hug, you know and I was like this isn't for me. . . . It's hard for me to see someone go through something like that and not be able to like hug them and be like "everything's gonna be OK." . . .

Daniela used this narrative to demonstrate that, despite her plans to continue to interpret at the clinic, she felt that interpreting would not be an appropriate career choice for her. Throughout the narrative, she positions her own emotional sensitivity and sense of empathy as a barrier for her ability to interpret in a professional way; later on in the narrative she attributes these qualities to her Latina identity. Both Valeria and Daniela had an intuition that told them to connect personally with the patients that seemed to conflict with their understanding of the principle of professionalism; while Valeria followed her intuition, Daniela felt that she had to hold back to act professionally.

Some of the other students found themselves going beyond what they perceived as the interpreter role to provide additional assistance to the patients. For example, during a flu vaccination clinic, Jen helped a patient find the resources she needed for further care. Excerpt 2 shows how Jen described this incident:

> **Excerpt 2: Jen**
> I was with this older couple, and you know I was translating with them, and then the woman like, they just started talking about like they're from Texas, and we were waiting in line to get their blood sugar and blood pressure checked, and then she started talking to me, asking me about the clinic, and I explained like kind of what it is, so then she talked to me about some feminine problems she was having, and then I got to like, because she felt comfortable talking to me about that, I went to one of the doctors, like medical students who work with JayDoc and we got her set up with the women's night.

Jen used this narrative to show how she felt that she was making a difference in the healthcare experiences of the patients outside of her basic role as an interpreter. She represents both the patient and herself as agentive characters but attributes the positive outcome to her own role as someone to whom the patient felt comfortable sharing her experiences and to her own actions in response to the information she received. Jen was very clear that she was doing the right thing, and she felt that the code of ethics principle of 'professionalism and integrity' limited her opportunities to provide this kind of assistance/help in this way. In this narrative, she indexes a value for her position as someone to whom the patient felt comfortable talking, a notion that is not emphasized in the codes of ethics put forth by the CHIA and the NCIHC. Even though both Valeria and Daniela had personal experience interpreting for family members in healthcare contexts and more advanced language skills than the L2 learners in the class, Jen expressed much greater confidence in the value and acceptability of the personal connection she developed with the elderly couple; this difference in interpretation may be related to diverse expectations for HS and L2 learners in the service-learning context.

Kelly encountered a couple of situations in which she was not sure how the Code of Ethics required her to react. In one incident, an elderly male patient was making jokes about a symptom he was experiencing that affected a reproductive organ. Kelly's perception was that the patient was making an effort to lighten a potentially awkward situation, and she said she wasn't sure whether she should laugh at his jokes. In Excerpt 3, Kelly describes this experience:

**Excerpt 3: Kelly**

> And so I don't know if that was like unprofessional? And I shouldn't have laughed or shouldn't have like joked back when they joked to me? Or if it would have been RUDE if I didn't, and so I just opted with not being rude, but I didn't know what to do.

Kelly used this narrative to demonstrate how she felt unsure about how to react in this particular situation. Similar to Excerpt 2 from Jen's narrative, Kelly was conscious of the social relation she and the patient co-constructed through their interactions; however, in contrast to Jen, Kelly positioned herself with uncertainty as to how to respond and in this way indexed a novice interpreter identity through her storytelling. According to the CHIA ethical guidelines, to maintain the principle of *professionalism and integrity*, interpreters must 'Respect the boundaries of the professional role and to avoid becoming personally involved to the extent of compromising the provider-patient therapeutic relationship' (CHIA Standards & Certifiation Committee 2002: 28). In a subsequent class session that responded to students' uncertainties, the physician and healthcare interpreter who were providing counsel for the program argued that Kelly should not have laughed because it was not professional behavior.

Throughout students' reflections on their role at the clinic, there was an underlying concern for the comfort of the patient, and students were aware that patient comfort with the physician and their treatment plan reflected much more than simply having an interpreter who knew medical terminology in Spanish. They understood that the connection between the healthcare provider and the patient was a key component of the patients' comfort level and that the interpreter made a significant impact on this relationship. They were also sensitive to the ways in which the doctors positioned the patients through their interactions; for example, Addie described one provider who seemed to doubt what the patient was telling her about his symptoms.

While the students were in the process of developing their understanding of their roles as interpreters in Doctors of the Plains and Ángeles Clinic, the healthcare providers at the clinics were also developing their understanding of the interpreter role. Depending on their level of training and experience working with interpreters, some providers had expectations that were quite different from those of the students.

## NEGOTIATION OF INTERPRETER AND PROVIDER ROLES

Because of the contrasts between students' and providers' expectations, the process of negotiation of interpreter and provider roles became a valuable learning experience for both groups. Therefore, my second research question addresses how the students negotiated interpreter and provider roles with the medical students and the doctors who provided patient care at the clinics, and how they made sense of this process of negotiation. Two of the common themes that the students described were: (i) providers who did not speak directly to the patients and (ii) negotiation of their legitimacy and value as interpreters (primarily the L2 learners).

Most of the students who participated in the study reported one or two situations in which the provider and/or the patient directed their speech to the interpreter rather than to their interlocutor; there were also a few additional incidents in which doctors committed more extreme breaches of protocol. As the protocol for interpreting was reviewed and demonstrated in class, the students were aware that that they were responsible for making sure that protocol was followed and that patients' communication needs were met; however, some of the students felt uncomfortable with the responsibility of informing a doctor that they were making a mistake.

In an unusual incident, Kelly encountered a situation in which a doctor encouraged a patient to speak to him in English despite the fact that the patient had requested an interpreter. Excerpts 4 and 5 are from the narrative in which she told me what happened, not only to answer my interview questions, but also to ask me for help in determining what she should have done and what we could do to follow up on the situation. She describes the incident in Excerpt 4:

**Excerpt 4: Kelly**

> . . . when he looked to me the doctor was like, just try to speak in English, it's going to make it easier on us, and on you. . . . Yeah, and that's what made me uncomfortable, 'cause I was like "I'm here to interpret. I asked at the beginning if you prefer to speak in Spanish, and he said yes. And so I didn't know whether I should overstep the boundary, and tell the doctor, no, he wants to speak in Spanish, yeah, and that's what made me uncomfortable . . .

In this case, Kelly uses the phrase 'overstep the boundary', to describe advocating for the patient. Patient advocacy is a very important part of the interpreter's role, and thus she would not actually be overstepping a boundary in terms of her role as an interpreter were she to do so. However, she was uncomfortable because of her role as a student, and she positions herself in a non-agentive role in this story. Kelly references her role as a student in Excerpt 5, which is from the same interview:

**Excerpt 5: Kelly**

> . . . I didn't want to be a little [Central Plains University] interpreter (shrugs shoulders) and say something, but at the same time, they're there for the patient and like I felt the patient wasn't getting, like, what they deserved.

This excerpt indicates that Kelly perceived limitations to her authority based on her role as a student (and perhaps as a young female). When referring to herself in the imagined scenario of challenging the doctor's authority, she uses the adjective 'little', to represent an inferior position in relation to the doctor and perhaps the clinic staff. Her comment that 'the patient wasn't getting what he deserved' suggests that she was concerned with social justice for this patient and had continued to feel unsettled about the doctor's unjust treatment of him. This situation was later used in a class discussion as an example of a moment in which the interpreter needs to advocate for the patient, and Ángeles Clinic investigated the situation on behalf of Doctors of the Plains.

## DISCUSSION AND IMPLICATIONS

The students who participated in this study found themselves making challenging calls about what was best for the patients at the clinics. In some cases, they stepped outside of their roles as interpreters or pushed the boundaries of the ethical principles as they understood them because of their concern for the patients' well-being. The students understood their expected roles primarily as conveyors of information, but they were also aware of their potential to serve as patient advocates, clarifiers, and cultural brokers. Nonetheless, they expressed uncertainty about how to articulate these roles and may not have always made the optimal decisions for each context. They also called into question the emphasis on professionalism in the codes of ethics put forth by

US institutions because of their consciousness about the importance of personal relationships in communication. Their identities as students of the Spanish language may have contributed to the uncertainty they experienced, and in some cases their position as young women in relation to the older retired male doctors may have made it more difficult for them to assert their authority; in addition, the HS may have positioned themselves differently from the L2 students due to their diverse linguistic and cultural experiences and perceptions of diverse expectations for Latina students. The findings demonstrate that the students would have benefited from additional training, including opportunities to critically assess the code of ethics for medical interpreters and their own roles at the clinics and additional activities designed to support their sense of agency in making ethical decisions in the interpreter role.

Although the students wanted to prioritize their concern for the well-being of the patients, they encountered significant limitations to this desire. The institutional approach to service-learning that framed student engagement as charity work molded to fit into a course's learning outcomes did not prioritize input from the people being served themselves and was not conducive to projects that challenged the structure of organizations or the scarcity of resources provided at the state and national level. For example, the patients may have been better served by a project that advocated for certified interpreters at the clinics without providing a safety valve. In addition, the students made assumptions about patients' feelings toward the ways that interpreters positioned themselves and constructed professional boundaries and personal relationships. In order to determine how to best meet the needs of the people being served, service-learning has to be framed differently by the institutions that support it.

As noted by Urciuoli (2013), students participating in community service-learning projects should not overlook the value of the community members' contributions, knowledge, and experience. One student who took the course described in this study and completed her service-learning hours distributing food at a community food pantry insightfully described a learning experience about her relationship with the clients to whom she provided services. In her final presentation for the course, the student commented that she felt uncomfortable positioning herself as an authority in relation to the clients and explained that a more effective mindset was that of a 'mutual partnership in improving clients' wellbeing'. While other students in the course would not have described themselves as authorities in relation to the patients and clients they interacted with in their service-learning assignments, the student who served at the food pantry was unique in her explicit reference to a partnership relationship. The relationship between the students/the university and the individuals whose needs are being addressed through a service-learning project can be developed further than it was in the partnership addressed in this study. In a healthcare service-learning project, patients' voices can be incorporated into the development of a project and its evaluation. After the period of data collection for this study, the language department in which the study was

conducted became involved in a community engagement project that was focused on engaging Latino patients' voices in conversations about healthcare for Spanish speakers. Ideally, this type of community-based project should inform any service-learning program and can even form the basis of a service-learning project for a course (Ramos-Pellicia 2018).

In addition to positioning community voices differently, instructors of service-learning courses also need to be cognizant of the ways in which students are positioned. As DuBord and Kimball (2016) point out, the previous experiences of ethnolinguistic minorities within their own communities are often undervalued in comparison to the service provided by their white peers outside of their own communities. In this study, Valeria felt that her peers did not understand her experience growing up with parents who needed language assistance and did not have health insurance; this feeling could have been remedied by a greater focus on allowing Latino students to share experiences of their own that may have mirrored those of the patients in some way. In addition to recognizing the value of diverse student backgrounds and skill sets in classroom discussions, it is also important for instructors of service-learning courses to question whether they hold different expectations for different groups of students and whether they adequately recognize the value of the skills of HS and other ethnolinguistic minorities.

While the students' presence as interpreters at the safety-net clinics was likely an improvement over the previous situation where anybody who identified as bilingual may have interpreted for the patients, the data suggest that many of these students were not ready to be sent into the field. Making sense of the code of ethics for medical interpreters is a complex process, and while the students certainly learned from their experiences at the clinics, their experiences took place in a situation where the stakes were too high to offer a learning experience to a student whose in-class training was limited. Before sending students to the field to interpret, it is essential that they complete advanced-level interpreting courses and have the opportunity to make on-the-spot decisions in interpreting scenarios that do not include real patients. Shadowing of professional interpreters (Monroe and Shirazian 2004) would also be beneficial.

To reach optimal patient outcomes, much work is needed to prepare all of the stakeholders in community health clinics to best address the patients' needs and provide quality care. The majority of the students who interpreted at the clinics affirmed that the in-class simulations of interpreter-mediated medical interviews helped them immensely to prepare for the interpreter role. In addition to having volunteers perform the simulations in front of the student audience, students can also participate in such simulations by playing the role of the interpreter. The simulations can include contexts in which the interpreter needs to make on-the-spot ethical decisions, such as deciding to advocate for the patient or serving as a cultural broker. Another way in which students can test their ability to apply ethical guidelines to specific situations is through an analysis of case studies of how interpreters have responded in particular contexts, similar to the cases shared by the retired physician but presented either through

videos or a detailed written text. With this exercise, instructors can offer students the opportunity to critically reflect on how interpreters can provide services in a way that promotes social justice for the patients, rather than simply following the code of ethics as it is presented to them.

The study findings also suggest that there is a need for supervision and mentoring on healthcare language policy for the entire healthcare system. Interprofessional programs that include students from different programs of study could be useful for teaching aspiring healthcare providers and interpreters to work together (Showstack *et al.* 2019a). For example, students who plan to serve as healthcare interpreters and healthcare providers can participate together in provider–patient–interpreter simulations drawing from models currently used in trainings for medical students and nurses: the standardized patient, a model developed by professors at the University of Kansas School of Medicine in which medical students interact with actors trained to play the role of a patient, and simulations with the high-fidelity, life-sized mannequins that are currently used in nursing programs across the USA. As long as the role of interpreters continues to be unclear to providers in healthcare contexts, it is very important that the interpreter makes their role clear at the beginning of every interpreting scenario (Gavlovych 2017). Scholars of language and the health professions should collaborate to create an educational model that will allow interpreters, healthcare providers, language policy makers, and community members to better understand and address the components of communication that contribute Latino patients' well-being, a crucial element of social justice in healthcare (Powers and Faden 2006).

## NOTES

1 In addition to the recent revisions to section 1557, the Joint Commission, a nonprofit organization that certifies and accredits healthcare programs and organizations across the USA, added new standards in 2010 that require hospitals to identify patients' communication needs and communicate effectively with patients when providing care, treatment, and services in a way that meets those needs (Joint Commission, 2010).

2 Dysart-Gale (2005) cites Diversity Rx. (n.d.). 'Models & practices: Choosing a role,' available at http://www.diversityrx.org/HTML/MOIPR3.htm. Accessed 17 July 2002.

3 A pseudonym.

4 The CHIA guidelines can be found at http://chiaonline.org/CHIA-Standards.

5 Pseudonyms are used for the clinics to protect the anonymity of the patients and healthcare professionals.

6 The researcher chose not to collect data at the clinic itself because the clinic had been selected as a site for a separate but related patient engagement project.

7 All participant names are pseudonyms.

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