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Using Family Members as Interpreters in the Clinical Setting

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In recent years, in response to growing immigrant populations and their frequently inferior care experience in the United States, many have argued that more resources should be devoted to hiring professional interpreters to help improve accessibility and quality of care.¹ Most proponents of such services have argued *against* using family members as interpreters.² This article challenges this common rejection of family interpreters as a suitable method to deliver information to limited-English-proficient (LEP) patients. Even though family interpreters may not have the same level of health literacy as professional interpreters, they may be able to facilitate understanding and informed decisions by serving as patients' cultural brokers and advocates. In considering the nature of patienthood, particularly within the context of foreign culture and unfamiliar ethos, this article argues that family involvement is often important to a patient's identity and can facilitate informed and autonomous decision making. While it is important to make professional interpreting available in cases when patients prefer or need such services, consideration of patients' cultural safety and larger decision-making contexts can help to explain why it may sometimes be more appropriate to respect a patient's wish to use family members to serve as interpreters than to impose professional services.³

ARGUMENTS FOR PROVIDING PROFESSIONAL INTERPRETING SERVICES

According to the U.S. Bureau of Census, approximately 45 million residents speak a language other than English at home, with 19 million with LEP.⁴ The healthcare situation of LEP patients is unfavorable compared to their English-speaking counterparts.⁵ Many LEP patients who face communication barriers with their healthcare providers often defer needed medical care, have a higher risk of missing follow-up appointments or leaving the hospital against medical advice, have more trouble accessing or negotiating the system, or are less likely to have a regular healthcare provider.⁶

Language barriers also pose difficulties to obtaining valid consent.⁷ In recent decades, autonomy has been considered a capstone value in Western bioethics.⁸ The doctrine of informed consent, for example, demands that physicians provide patients relevant information regarding their conditions and medical options, so that patients can deliberate and decide according to their overall priorities and interests. When clinicians and patients speak different languages, professionals may have difficulty providing relevant, understandable, and meaningful information necessary for informed decisions and eliciting treatment preferences from their patients afterward. Without direct and effective communication, healthcare providers may also struggle to establish the necessary empathy and rapport to reassure, motivate, or support their patients.⁹

LEP patients who are already vulnerable because of their health status and associated fears may be further disadvantaged if they cannot voice concerns or negotiate their priorities and care expectations with medical professionals.

As some have argued, healthcare is morally special because it can help sustain/restore normal functioning and reduce suffering.¹⁰ Commitment to equal opportunity and respect for autonomy require that patients' healthcare access and decision-making processes are not compromised by morally arbitrary factors such as linguistic background. Professional interpreters, who have proficient knowledge and skills in the patient's primary language as well as mastery of medical terminology, can promote health literacy and bridge communication gaps between patients and clinicians, and thus help to fulfill the society's moral obligation to provide equal access to essential healthcare services. Since many interpreters also have cultural understanding of the patient's background, they can help interpret not only spoken words, but also attitudes, expressions, expectations, and emotional reactions.¹¹ Some have argued that when interpreters operate as collaborators and allies with clinicians, they can serve as cultural informants and teach clinicians about the patients' world. In addition, they can facilitate assessment of patients and promote effective planning and delivery of healthcare services.¹²

While there are important ethical reasons to ensure adequate health literacy of LEP patients, many who are concerned about equal access to quality care do not stop at arguing for improving access to professional interpreters. They often argue *against* allowing family members to interpret.

Four arguments are common. First, some worry that using family interpreters is clinically unsafe and may harm patients, since family members are generally unfamiliar with the medical context and vocabulary. Despite their good intentions, family interpreters may misinterpret key concepts, distort or omit messages about important symptoms and instructions, neglect questions regarding drug allergies or medical history, or intervene in the assessment or treatment process.¹³ As one study cautions, errors made by *ad hoc* interpreters are more likely to have potential clinical consequences than those made by hospital interpreters,¹⁴ perhaps partly because of these aforementioned errors. Reliance on untrained interpreters, including family members, may therefore lend a false sense of security that accurate communication is actually taking place.¹⁵ This is particularly concerning in situations when family members appear to be biased or emotionally compromised due to high levels of stress. Unlike "neutral" professional interpreters, who are presumably objective and uninvolved intermediaries trained to systematically present clinical information, family members often bring with them their own attitudes, judgments, feelings, and/or distress that may negatively affect their interpretation and communication with the clinician and the patient.¹⁶ This potential harm is not only a liability concern, but also an important ethical worry, since ineffective care that may result from poor interpretation may deny LEP patients' equal opportunity to access essential services.

Second, the suboptimal quality of family interpreting also raises autonomy concerns. Respect for patients' autonomy is generally considered the capstone value in Western bioethics, and the main justification for requiring clinicians to obtain informed consent for treatments. When family members are unable and/or unwilling to correctly interpret relevant information, patients' understandings of their situations, and thus their ability to deliberate according to their priorities or provide informed consent, may be compromised. People from some cultures and/or religious backgrounds consider it a taboo to discuss death and cancer directly, and it is not uncommon for family interpreters to refuse to directly interpret certain words to avoid these difficult subjects. However, despite their good intentions, these paternalistic actions may violate patients' rights to be informed of their situations and to make deliberative decisions according to their own values. Worse yet, in situations where the families may exhibit oppressive characteristics or appear to be neglecting patients' preferences to get full information, suspicions may arise regarding the families' motives in shielding patients from certain medical information.

Third, the use of family interpreters may raise confidentiality and privacy concerns.¹⁷ In the U.S., for example, professional interpreters are trained and obligated to abide by various ethical codes established by the National Council on Interpreting in Health Care (NCIHC) and the International Medical Interpreter Association, including confidentiality, impartiality, respect, and professionalism. Family interpreters, on the

other hand, are generally unfamiliar with these ethical requirements. Some medical information may be sensitive or have significant implications, particularly surrounding mental health, sexual health, genetic issues, and end-of-life care. Family interpreters who have no professional training in such ethical issues may not know how to interpret and deliver such information in sensitive ways. Moreover, patients may not want their family members to hear the news before they themselves have had a chance to digest the information or consider various implications. They may want to retain control and determine if, when, and/or how they would like to inform their families of the situation. Some conditions are stigmatized in certain cultures, and direct disclosure to family interpreters during consultation may subject patients to embarrassment and emotional devastation.

This last point brings out the fourth concern regarding relying on family interpreters. Families in certain cultures have clearly defined structures and hierarchies, such that involving intimates to interpret may alter the power dynamics and create discomfort for all those involved.¹⁸ Depending on the family structure, cultural background, and specific health conditions, some LEP patients may feel uneasy to have their intimates, particularly their children, to learn of their vulnerable situations, since that may disturb the established hierarchy within the family. At the same time, family involvement in clinical interpreting may also put additional burden on intimates who are already stressed out by the patient's condition. This is especially concerning in cases when the diagnoses are unexpected and/or grim, since it may be difficult for some family members to hear and translate about a loved one's critical illness and prognosis, and then assume their usual role within the family.¹⁹ Given that many family interpreters are also caregivers, who may have additional familial and professional responsibilities, imposition of such emotionally exhausting tasks can further compromise their well-being.²⁰ Professional interpreters, who are usually impartial strangers to the family and the patient, can relieve all parties of such additional stress and may thus be a better resource for interpreting medical information.

WHY FAMILY INTERPRETERS CAN BE PREFERABLE IN SOME CONTEXTS

There are strong ethical and clinical reasons to support the provision of professional interpreters and for clinicians to ensure that LEP patients have equal access to quality care and a right to informed consent. However, it is unclear that the four common arguments presented justify a blanket rejection of family interpreting. Depending on the intimates' familiarity with the patient's condition and their overall dynamic, their involvement does not necessarily violate LEP patients' rights and well-being. Since familial relationships are often integral in preserving LEP patients' identity and promoting their agency in the clinical setting, family interpreters may sometimes even be preferable to professional interpreters who are unfamiliar with the patient's background and culture.

First, while it is important to ensure that patients' clinical safety is not compromised because of language barriers, it is unclear that the use of family interpreters would *necessarily* block patients' understanding, lead to suboptimal care, or harm patients' clinical interests. Professionals are generally suspicious of the ability of family members in conveying essential information to LEP patients, but it seems that such judgment should be made on a case-by-case basis, since family members may have varying abilities to interpret for their loved ones. In fact, even the aforementioned study that reports potential clinical consequences of errors made by *ad hoc* interpreters reports that there is *no statistically significant difference* between hospital and *ad hoc* interpreters in the *frequency* of errors; it appears instead that untrained interpreters, such as family members, make far *fewer* fluency errors (that is, use of incorrect word, or one that does not exist in that language) than trained interpreters.²¹ Another study reports that, even though physicians are often concerned about using family interpreters, most LEP patients are satisfied with and find comfort in the assistance of such intimates.²² Before assuming an inability to interpret, clinicians should talk with the potential family interpreter to find out how familiar she or he is with the patient's medical history and current condition, his or her own comfort level with medical terminology, potential concerns about interpreting, and so on. Such conversa-

tions can give clinicians a glimpse into the potential interpreter's grasp of clinical vocabulary, relationship with the patient, and willingness to promote the patient's understanding.

Further empirical studies would help explore the reason for such discrepancy in data, how family members come to accrue knowledge of medical terminology, and the correlation between patients' satisfaction in family interpreters and the latter's interpreting skills. One possible explanation for divergent observations is that critics of family interpreting have not considered whether, or how, intimates can compensate for their lack of formal training in various ways. Many studies that looked at *ad hoc* interpreters did not distinguish between family members and other untrained interpreters. Family members who are familiar with a patient's medical, personal, and care history often have a larger medicalized vocabulary than clinicians realize,²³ since many family members may have accompanied the patient to medical appointments, discussed with health-care professionals regarding their loved one's conditions, searched for information from other sources, and/or cared for the patient at home and in the hospital.

Even in cases when a family interpreter may lack extensive knowledge in medical terminology, she or he may still be able to explain complex issues to the patient in meaningful terms without using medical jargon. For example, in explaining the natural course of advanced leukemia to a patient, a family member may make reference to the patient's prior experience, or the situations of other relatives or acquaintances who had similar conditions to convey the message. While the family interpreter may not know or use specific medical terms, depending on the patient's medical history and other personal experience, such anecdotal explanations may suffice in facilitating the patient's understanding. In some cases, personalized explanation may be even more effective in conveying meaningful information than direct interpretation of complex and unfamiliar clinical terms. As some have pointed out, despite the promise of informed consent, even native-speaking patients often do not retain or understand a lot of the information presented to them.²⁴ There are thus reasons to challenge the assumption that the current practice of providing "objective" clinical data is necessarily the most effective method to promote understanding, and that the use of alternative methods to present the information will necessarily compromise patient comprehension.

Second, the possibility that family members can facilitate understanding in nontraditional ways can also address a concern about patients' autonomy. Recall that critics are worried that biased and emotionally involved family members may unduly edit information regarding grim news and thus undermine patients' autonomy. However, echoing Kaufert and Putsch,²⁵ I question the uncritical assumption that neutrality is possible and always necessary to promote patients' autonomy. While many differentiate between "objective" professionals and "biased" family members, it is important to note that clinicians of equivalent competence often have different instincts about how much information to disclose to their patients, which available clinical options should be offered, and how such information should be communicated. Depending on the clinicians' respective backgrounds, personalities, clinical experience, and communication styles, there can be significant variations even among professionals in terms of how and what to disclose — there can be many "versions" of the truth. Depending on the patient's situation, presenting an edited version of the overall situation to avoid a difficult subject does not necessarily confound the patient's understanding or violate his or her autonomy, as long as the communication channel is open and the patient is given meaningful opportunities to seek further information and/or clarification.²⁶ Depending on the patient's medical history, current condition, and family communication style, sometimes a patient may recognize what is happening to him or her by observing how the family interpreter communicates certain information, even if specific words (for example, "death") are never uttered.

We need to take the concern of medical paternalism seriously, which might allow professionals who have little knowledge of a patient's desires and backgrounds to withhold information for the patient's own good. Many clinicians are strangers to their LEP patients, and are unlikely to know for certain what may constitute a patient's best overall interest and preferences.²⁷ However, intimates are often in a different situation — many are familiar with the patient's goals and values, and how she or he processes medical and other important information. In some situations, family members may have even more knowledge regarding a patient's medical history than the clinician, since the patient may not have sought prior clinical help for the

current condition, or the medical chart may not contain previous information from the patient's home country. For example, the spouse of a patient probably knows a lot about the patient's medical history, prior medical procedures, impact of such interventions, and so on. Such information can help the family member in delivering information to the patient in an understandable and relevant way.

While empirical studies are needed to confirm this hypothesis, it is possible that some family interpreters who omit information at the time of consultation will continue to provide clarification and further information for the patients when they return home. Incidentally, many patients indicate that the ability to help after the consultation is important to them.²⁸ While most studies focus on the information exchange at the consultation, it is important to note that this setting may not show the whole picture. For example, some family interpreters are also caretakers, who may consider it unnecessary to give the patient all the medication information right at the clinic or hospital, especially if they will receive printed instructions. Since some caregivers/interpreters will be helping the patient with medication and other forms of care, it may not be of utmost importance to give the patient all the specific and detailed information at the facility. The family interpreter may want to explain omitted information in private (for example, after the clinician has left the room) or once the patient has returned to a more familiar and comfortable setting, that is, his or her home.

Third, the fact that many family members typically have intimate knowledge of and involvement in LEP patients' medical and personal backgrounds also helps to address critics' worry of confidentiality. While many argue against using family members as interpreters on grounds of protecting patients' privacy and confidentiality, such arguments only require physicians to clearly explain the sensitivity of information and confidentiality implications, either through printed materials in the patient's first language, or by providing patients ready access to professional interpreters. Even though the requirement of confidentiality prohibits professionals from divulging information to others without the patient's consent, it does not preclude LEP patients from *voluntarily* giving their family members access to their medical information. Some LEP patients who have strong bonds with their intimates may consider the family their advocates or decision-making unit, and may consider privacy and confidentiality familial rather than individualist concepts, that is, they may be open with their family members regarding their situation but not with others outside of the family, including an interpreter. Sharing our most private information with our intimates and allowing them to take care of us can be part of what it means to be loved or to be part of the family.²⁹ In fact, some patients with stigmatizing conditions may particularly want to keep information within the family, especially if the cultural community in the new country is relatively small and the interpreter is also a member of the same community. These family members may also be the patient's caregiver or hold power of attorney, or have interpreted for the patient in other settings that involve personal information, such as financial matters. The confidentiality consideration should, therefore, be evaluated in reference to the patient's familial context and overall decision-making pattern.

This last point helps to address critics' fourth concern, that is, how involvement of family interpreters may affect the family's dynamic and intimates' well-being. Certainly, prior to the consultation, it would be helpful for a professional interpreter to explain the process to ensure that patients and family members all understand various privacy and sensitivity implications, and that all parties voluntarily consent to the interpreting arrangement. But it is important not to pit patients against their families during this time of illness and stress. It is worth noting that many patients are not only concerned about their clinical well-being; they are also worried about how their situation may impact their families.³⁰ While it is important to consider how caregiving and interpreting duties may affect intimates' well-being, respect for autonomous agency also requires that we allow patients and their families to determine an acceptable level of involvement by themselves, based on their own assessment of their ability and boundaries. Many LEP patients from these cultures rely on family members to be their main support network and advisors, particularly in times of illness and crises. Family life often embraces a rich array of exchanges, and these intimates may not think of what they are doing for one another as giving help or sacrificing.³¹ They may consider their care for each other as part of their collective responsibility and group self-definition.³² Allowing adult patients and their consenting family members to deliberate with each other to determine the appropriate level of involvement provides all

affected parties the opportunity to decide how they can promote each others' agency and autonomy. Some patients and their intimates may prefer to have family members rather than professionals interpret because they trust that their family members are in a special position to help make decisions that will promote all parties' overall interests.

CULTURAL SAFETY AS KEY TO UNDERSTANDING

Patients' trust and reliance on their family members in the clinical setting bring out one important consideration that is often neglected by critics of family interpreters, who seem to assume that clinical safety is mainly or even solely based on receiving detailed clinical data from neutral professionals. Certainly, opportunities to review relevant clinical information are important; but the larger context of information delivery and patient experience is also significant. I argue that clinical safety and ability to understand presented materials may partly depend on whether the patient feels *culturally safe*. While professional interpreters can help promote health literacy by using mutually intelligible terminology and vocabulary to decipher complex clinical data, the focus on providing "objective" clinical data does not capture other fundamental and systemic issues that continue to affect LEP patients' ability to comprehend and cope with their situation.

Cultural safety is not just about individual interactions — it is about the *environment* or the overall framework in which patients receive care. A culturally safe environment is one that facilitates and engages in respectful practices as well as delivers safe services, as defined by those who receive the care.³³ It acknowledges and respects that patients come from diverse backgrounds with varying needs and cultural references. Patients in a culturally safe environment feel empowered to voice their concerns without having to worry that their concerns or experience will be marginalized or dismissed as irrelevant, strange, or backward.

Various structural and institutional considerations can shed light on LEP patients' lack of cultural safety. Despite promises of patient-centered care and respect for autonomy, power structures continue to dominate relationships between clinicians and patients.³⁴ LEP patients in the clinical setting not only enter a different linguistic territory; they also face a highly controlled and bureaucratic culture that likely is in stark contrast with their prior care experience. While Western medicine offers promising clinical results, it sometimes alienates patients by inadvertently treating them as collections of symptoms or diseased body parts rather than as whole persons with rich personal stories, cultural histories, and relational frameworks. Advanced medical procedures are carried out in sterile settings, where patients are studied, tested, and prodded by unfamiliar instruments in mechanical and invasive ways. Their diets, diagnostic or check-up schedules, access to specialists, consultation time, and discharge plans are determined mostly by strangers, not out of patients' autonomous choices but primarily based on lab/bed availability, cost-benefit considerations, professionals' convenience, insurance coverage, and so on.³⁵ Given the increased provision of care by health-care teams and division of labor, patients may have little contact with any particular provider, and they often experience no continuity of care. Specialized medicine causes patients to be attended by more clinicians than ever before, and care has ironically become increasingly impersonal and fragmented. Healthcare team members, especially in intensive care, are strangers at the bedside who usually only focus on their own specialized area. Even though many professionals are well meaning, they are often overworked and can only attend to patients in a very specific set of clinical circumstances. Contemporary medicine has inadvertently reduced many patients with full histories and relational identities to diseased body parts and medical jargon.

While it is important to note that such experience is not unique to LEP patients, it may be particularly disconcerting for those who are accustomed to holistic care methods. Many LEP patients have minimal formal education and/or little economic means, and may be unfamiliar with symptom-focused Western medicine, the hierarchical institutional medical system, complex payment and insurance schemes, and hospital diets.³⁶ It is therefore not surprising that many immigrant patients would first talk to their family and friends or are cared for by their intimates at home before considering professional help.³⁷ This may particularly be the case for immigrants who have low incomes and inadequate health insurance.

Professional interpreters who are familiar with a patient's linguistic and cultural histories can explain medical terms in culturally relevant ways and bridge communication gaps between clinicians and the patient. However, some LEP patients may have difficulty relating to interpreters who are of a different professional or socioeconomic background and with whom they have had minimal contact. Moreover, individual sensitivity and particular attempts by professional interpreters may still be inadequate in ensuring cultural safety and changing the overall care environment. Depending on the institutional cultural dynamic and a patient's care history and experience in the hierarchical medical structure, even a well-meaning professional interpreter may be perceived as yet another stranger or bureaucratic representative at the bedside. Most patients have had limited interaction with professional interpreters, some of whom only offer services over the phone. Also, since hospital or clinic-based interpreters are primarily accountable to the institution that employs them, some LEP patients may mistakenly perceive these professionals as the institution's gatekeepers, rather than as their advocates.

Putting aside the issue of power and control or dominance in this triadic (clinician-interpreter-patient) relationship,³⁸ the process of working with two professionals (simultaneously in an unfamiliar setting during a time of vulnerability) can be physically and emotionally exhausting. Since family involvement has sometimes been integral to patients' recovery and continued well-being, and family members may be able to continue to clarify and provide information after a consultation, intimates can serve as crucial cultural brokers and advocates for patients. They are constants in a plethora of health professionals, and can provide the much-needed reminder that patients are not merely collections of dysfunctional body parts or unfamiliar argot, but are moral agents who have full histories and important relationships. Since most professional interpreters do not usually have the opportunity to inquire into a patient's personal background or values, some LEP patients may take comfort in having medical information, particularly news that may have important implications on their functioning, capabilities, and mortality, come from a trusted and loving family member rather than a stranger.³⁹ Some LEP patients may have already been marginalized as "the other" in clinical and larger societal settings, so they may be more inclined to trust their family's judgment and resist medical domination or doctors' claim of beneficence.⁴⁰ In these cases, involvement of their intimates can be integral to maintain or restore their identity and cultural safety.

THE CASES OF CONTROLLING AND PROTECTIVE FAMILY INTERPRETERS

So far I have argued that family can be an important part of patients' identity and a valuable resource for LEP patients in the interpreting process. However, there are situations in which a patient may prefer to have a professional interpreter, but may appear to be pressured or inveigled into abiding by family members' wishes to take over the process. LEP patients who come from societies that focus on hierarchical status and cooperative harmony may not verbalize their concerns,⁴¹ particularly to strangers. In these cases, how should clinicians resolve such potential familial conflict?

While many professionals are well meaning, they only have limited contact with their patients and attend to them under a very specific set of clinical circumstances, and thus may be unfamiliar with a family's history and dynamics. Certainly, within their capacity, professionals need to carefully evaluate whether patients understand their right to use a professional interpreter, and whether their expressed desire to use a family interpreter in the consultation process truly represents their values. Attention to potential signs of neglect and abuse, such as a family's explicit and adamant refusal to consider a patient's well-being, or repeated attempts to override a patient's preference to involve a professional interpreter, can be helpful. However, professionals need to keep in mind that a patient's change of mind upon family influence may not be a reliable indicator of abuse or neglect. Given the realities of stress and vulnerability, many patients may prioritize familial harmony over having a professional interpreter deliver the information, especially if they generally trust their family interpreter's integrity and ability. Professionals who have little knowledge of a patient's familial background should generally trust the patient's expressed wishes and refrain from making

premature assumptions that an LEP patient who accepts the family's wishes to interpret over the patient's initial desires are necessarily under undue pressure.

Some general strategies can help to support patients' interpreting preferences and deal with potential conflicts. For example, through printed materials in the patient's language and/or a professional interpreter, registration staff and/or clinicians can first explain to patients and families, preferably separately, their right to professional interpreters and the services these professionals offer. Such initial communication would allow LEP patients a chance to first meet the professional interpreter, learn how she or he can help communicate essential information and relieve pressure on the family, and discuss this with family members to determine if they would like to take advantage of such services. Patients who are concerned about family pressure and feel awkward about verbalizing such worries can indicate their preferences using a form (for example, check the appropriate box). Such conversations and tools can provide staff with an initial, albeit limited, glimpse of the family dynamic. If a patient chooses to use a family interpreter, the professional interpreter can facilitate the process in a different way; she or he can enhance family members' ability to interpret by clarifying unfamiliar terms and information.

In cases in which patients profess to want family members to interpret potentially because of subtle familial pressure, clinicians can discuss with patients various ways to support their preferences without creating more familial animosity, such as by having both professional and family interpreters available. Relationships between family members and patients are often far more complicated than traditional dichotomous notions of oppression and equality acknowledge. Since professionals are usually unfamiliar with patients' family dynamics, it is more important for professionals to follow their patients' own assessments and expressed wishes than to second-guess and paternalistically "free" them from their families.⁴² Although some LEP patients do appreciate the opportunity to interact with professional interpreters rather than their family members, others who have spent all their lives in an oppressive relationship and have not been able to break free of such controlling influence may have even less courage or desire to do so when they are surrounded by strangers and plagued with illness or injuries. While the family may be exerting undue pressure on a patient, it may still be the patient's most important support system and part of his or her identity. As some have argued, targets of oppression rarely experience themselves solely as victims.⁴³ Moreover, it seems reasonable to assume that most families, including those that appear controlling, are not malicious toward their members or the patient; they do not usually use the clinical setting as the tool to exploit their members.⁴⁴ The family may be such an integral part of the patient's identity that denial of the family's opportunities to interpret may cause more distress, further isolate the patient, and increase the patient's powerlessness in an unfamiliar setting. Since some of these patients will return to their family upon discharge, and interpreters usually do not work with patients outside of the clinical setting, it may be counterproductive for well-meaning professionals to pit patients against their families.

There are other situations in which a patient clearly prefers using a family interpreter, but clinicians worry that the latter will intentionally omit relevant information on protective grounds. For example, a family member may refuse to allow a professional interpreter to be present due to the worry that the professional interpreter may use certain words (for example, cancer) that can affect the patient's psychological well-being or are considered taboo in the patient's culture. The family interpreter may also try to persuade a clinician not to use certain language in a consultation. In these cases, it may be helpful for clinicians to first use a professional interpreter to ask the patient about past interpreting experience and the familial decision-making model, and talk to the potential family interpreter to find out how she or he might deliver the information. It is important to distinguish cases in which the patient's family member simply does not want to use certain words, from cases when the interpreter refuses to convey particular ideas. As we considered earlier, family interpreters can sometimes deliver a message and facilitate understanding without using certain terminology.

After listening to both the patient and the family, clinicians can remind them of the benefits of having professional interpreters present to clarify, and to offer multiple opportunities and methods to disclose and interpret essential information. When professionals reframe the conflict as an opportunity to learn more

about the patient's and the family's concerns, they can acquire better understanding of the patient's and family's priorities and negotiate a suitable approach to deliver information.⁴⁵ Such an approach may also help a family to be more receptive to accessing other supporting resources that can enhance the patient's care and also ease the family's burden. At the end of a consultation, clinicians can ask, again through printed materials or a professional interpreter, if patients *and* family interpreters would like any clarification. Clinicians can also provide translated materials and contact phone numbers in printed form in the patients' language to be given to patients upon discharge, and let them know that the team welcomes further discussion and clarification.

CONCLUSION

In closing, it is important to emphasize that I am not arguing against the use of professional interpreters or the careful presentation of clinical data. Family interpreters are not always available, and they should not replace other much-needed efforts to improve patients' cultural safety. More importantly, their potential ability and willingness to serve as the communication liaison should not be used as an excuse to not make professional interpreting services and other resources available. After all, there are likely different preferences among LEP patients and their family members regarding interpreting methods. It is also important to find out whether a desire on the part of patients or family members to not utilize a professional interpreter is the result of a perception that the offered professional services are inadequate or inappropriate.

I also acknowledge that further empirical evidence needs to confirm the ability of family members to enhance patients' understanding and to facilitate informed and voluntary decision making. To fully respect patients' agency and to promote their well-being, a case-by-case approach to determine the suitability of family interpreting is more helpful than a blanket policy prohibiting such communication methods. While professional interpreters can be a valuable resource for LEP patients who prefer such services, some LEP patients may be concerned not only about one particular consultation, but also the care situation after the visit. Since most interpreters are strangers who will not be able to assist in person after the consultation, family members who can offer continual language and care assistance may be particularly valuable to LEP patients.⁴⁶ When professionals deny family involvement in the name of protecting patients' safety, autonomy, and confidentiality, they may ironically be exacerbating their vulnerability and perpetuating their marginalized status.

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NOTES

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3. This article will focus on using competent *adult* family members as interpreters, not whether minors should serve as interpreters.

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