Soc. Sci. Med. Vol. 18, No. 3, pp. 283–286, 1984
Printed in Great Britain

0277-9536/84 $3.00 + 0.00
Pergamon Press Ltd

RESEARCH NOTE

ROLE CONFLICT AMONG 'CULTURE BROKERS': THE EXPERIENCE OF NATIVE CANADIAN MEDICAL INTERPRETERS

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Abstract—This paper examines the role conflicts among Cree and Saulteau language-speaking interpreters working in two urban hospitals providing tertiary medical care services to Native Canadians from remote northern communities. Over an 18 month period, participant-observation and analysis of videotaped clinical consultations were utilized to develop an inventory of roles and situational contexts characterizing the work of Native interpreters in urban hospitals. Sources of role conflict were found to be associated with cross-pressures in their roles as language interpreters, culture-brokers and patient advocates.

INTRODUCTION

This paper examines the role conflicts inherent in the job demands of Cree and Saulteau language-speaking interpreters working in two hospitals that provide tertiary medical care to Native Canadians from remote, northern communities. Data from participant-observation in northern Native communities and hospital facilities and more systematic content analysis of video-taped clinical consultations were utilized to develop an inventory of roles and situational contexts that characterize the work of these Native interpreters. Sources of role conflict were found to be associated with the cross-pressures in their multiple roles as: (1) direct linguistic translators; (2) 'culture broker-informants', (involving functions of providing explanations of Native culture and language to administrators and professionals in urban hospitals); (3) culture broker-biomedical interpreters, (involving explanation of biomedical concepts to Native patients); and (4) as patient advocates, (representing the interests of the individual Native patient, a kinship group or an entire community).

ROLE CONFLICT AMONG 'CULTURE BROKERS'

Medical anthropologists emphasize that the language and symbols involved in healing processes provide relief through allowing individuals to resolve conflicts or dissonance associated with alternate roles and identities [1–3]. Using data from the interaction of patients from eight ethnic groups in hospital and outpatient settings in the U.S., Harwood emphasizes the impact of stress factors in the role of health workers who are involved in liason between groups. As culture-brokers, interpreters understand and have empathy for patients' expressions of illness in terms of traditional and biomedical explanations [4]. With growing emphasis on language and cultural interpreting and more direct involvement in patient advocacy, the impact of role conflict becomes a significant consideration for all health workers operating in intercultural situations. Within the context of our own pilot study of medical interpreters, role conflict occurred in situations in which medical interpreters were involved in translating concepts in order to make them mutually intelligible to practitioners and patients from dramatically different cultural or linguistic backgrounds and living environments.

This paper will consider the alternate roles of interpreters using case examples taken from a series of audio-taped interviews with eight interpreters and participant observation data from a pilot study in an urban hospital setting. Case material comes from an exploratory study which involved not only the interpreters themselves, but included interviews with Native patients, physicians and hospital administrators. This research is the preliminary stage of a multiphase project which will examine the roles played by interpreters within the medical setting, their contribution to medical care and the occupational stresses associated with their work. Briefly summarized, the overall program of research will include: (a) the analysis of 4000 interpreter encounters over a 1 year period; (b) a series of interviews with clinicians, patients and interpreters before and after medical encounters; (c) the content-analysis of a series of video-taped consultations in which an interpreter took part; and (d) the collection of data on the training and career patterns of interpreters over an extended period of time. In this paper we will discuss the design and preliminary observations of conflict potential in four alternate roles played by interpreters.

LANGUAGE TRANSLATOR ROLES

The first role of Native interpreters is that of language translator. This narrowest definition of the interpreter's role frequently corresponds with health care systems' definition of the function of the interpreter as providing a conduit or channel through which biomedical concepts are translated into linguistically appropriate terms. Models of the roles of intermediaries in language translation have been developed by Brislin [5] and Bloom [6], who recognize a gradient in which the professional and interpreter exercise varying degrees of control over communication processes. The role of interpreters as trans-

lators involves assisting health professionals in establishing a relationship with the client. In conventional models of language translation, the relationship is assumed to be ultimately controlled by the clinician who directs and guides the communication [5]. Another view of the role of the interpreter as language translator involves a model of interaction in which the interpreter takes over the interviewing role from the clinician, but continues to utilize a list of questions and clinical agenda established by the professional [6]. A broader view of direct language translation is recognized as involving a partnership between the language interpreter and the professional in which both participants share in building a relationship and establishing communication with the client.

Most studies of potential conflict in the roles of workers involved in language translation have dealt with factors such as, (1) the impact of linguistic distortion in interfering with accurate translation of words and concepts, (2) the interpreter's lack of familiarity with biomedical terminology, (3) their lack of familiarity with specific factors in the patient's background or home environment and (4) the potential for the interpreter to consciously modify the translation of the client's responses [6].

Our pilot observational study indicated that the most significant source of potential for conflict in language translation roles resulted from the failure of clinicians and administrators to recognize that the involvement of interpreters added a significant role to clinical encounters that directly influenced the overall social and cultural context of diagnosis and treatment. Examples of attempts to define the interpreters' role in terms of narrower language translation functions were observed in situations in which they were asked to find an equivalent concept in Cree or Saulteau for an anatomical term such as the appendix. Although in some cases appropriate terms did exist in Native languages, the interpreters often found it necessary to move beyond the direct translation of the concept to explain the function of an organ or describe a procedure in lay language.

Conflict arose between health care practitioners and interpreters when the former viewed the latter's role in the narrower sense of 'language translator'. Some health care workers became hostile when they felt that interpreters were censoring or inadequately translating a patient's reply. Since the clinicians did not know Dene, Inuktitut, Algonkian (Cree and Saulteau) or Siouan, they had no way of knowing that the interpreters were establishing rapport and/or finding culturally appropriate analogies for complex biomedical terminology.

CULTURE BROKER/INFORMANT ROLES

The second major role performed by interpreters involves the brokerage functions of explaining the linguistic and cultural perspective of the Native patient and the environmental perspective of remote northern communities to clinicians and administrators in urban hospitals. For example, an interpreter may explain why interpretations of biomedical concepts may be unacceptable from a cultural standpoint, why a treatment regimen may be unrealistic because of environmental limitations in northern communities, or because of administrative barriers in servicing bureaucracy. In terms of the concept of brokerage, the professional or administrator assumes the role of patron, seeking the interpreter's assistance in understanding the linguistic and cultural factors which influence the response of the Native patients [7]. In the role of 'middle-man', or intermediary the interpreter is supposed to provide the clinician or administrator with objective information about the Native patient's culture and community background. Information about the patient and their environment are assumed to be directly translated, rather than altered to reflect the agenda of the patient or interpreter. As broker/informant, interpreters explained to clinicians the significance of the patient's home environment in achieving compliance. For example, in the case of the children with scabies, the interpreter communicated to the medical professional the problems of obtaining water supplies for daily bathing and laundering, and problems of complying with treatment regimens because of Native patients' less specific orientation to 'clock time' or calendar dates.

CULTURE BROKER ROLES: INTERPRETING BIOMEDICAL CULTURE

Interpreters also act as intermediaries in facilitating information flows between clinicians, patients and their families by explaining biomedical concepts and providing information about the organizational structures of urban hospitals. This role involves sensitizing patients to the hospital milieu, explaining procedures, patient education, and obtaining meaningful informed consent. Although this type of brokerage function primarily involves translation of biomecical knowledge, interpreters must link their knowledge of health care procedures and human physiology with parallel knowledge of indigenous language and culture. In the context of conventional concepts of cultural brokerage, interpreters may be asked to communicate information or promote values which are not their own but those of the hospital administrator or professional. In these situations the clinician or administrator assumes the role of 'patron' [7]. An example of this aspect of brokerage was observed in a situation in which an interpeter attempted to provide health education for a diabetic patient by referring to more familiar animal anatomy and making analogies between metabolic processes in a diabetic's diet and familiar mechanical processes such as maintaining a gas and oil balance for outboard motors.

ADVOCACY ROLES

The fourth role, patient advocate, also involves elements of brokerage between the biomedical culture of the medical profession and hospital and that of the Native patient or community group. However, in these situations, the role of the 'patron' is assumed by the patient or community group and the interpreters loyalty to Native client or community takes precedence over loyalty to the medical institution or identification with biomedical approaches to treatment. For example, two cases were documented in

which interpreters had been involved in attempting to explain, retrospectively, a cardiologist's decision to implant a pacemaker while a patient was undergoing diagnostic catheterization. In these cases, the inability of the patient to understand the function of the pacemaker and the cultural aversion to having a foreign body implanted, placed the interpreter in a direct conflict situation in which it was necessary to arbitrate between the objectives of the patient and the objectives of the clinician. In the process of trying to explain the risks and benefits of having a pacemaker implanted, the interpreter moved from passive translation of the cardiologist's agenda to strong identification with the patient, as it became clear that prior consent had not been obtained. In so doing, the interpreter moved into a role of direct advocacy.

MULTIPLE ROLES AND LOYALTY CONFLICT

In any single interaction or situational context, the interpreter may combine several elements of these roles. One example was observed in a situation in which an interpreter combined the roles of informant, culture-broker and advocate. The case involved a male patient evacuated to Winnipeg for treatment. The patient was in a coma and the family insisted that a 'medicine man' from out of town be allowed to treat the individual. In this situation, the interpreter was forced to arbitrate between the physician-directed regimen in the intensive care unit and the family's insistence on holding a 4-day healing ceremony. Through combining informant, culture-broker and advocate roles, the interpreter was able to mediate the situation so that both treatment regimens could be accomodated.

In our initial observation of the occupationally defined roles played by Native interpreters in urban hospitals, it became evident that their functions as language interpreters, informants, culture-brokers and advocates often presented loyalty conflicts and dissonances resulting in feelings of stress. In representing the patient, interpreters are often faced with conflicts between their role as health system employees and their roles as culture-brokers and patient advocates.

One area in which this becomes most evident is in the situations where the role expectations of the clinician, using an interpreter, and the expectations of the patient, who views the interpreter as his/her representative, come into conflict. Conflict was observed to occur when the clinician became aware of active involvement of the interpreter in brokering concepts and patient agendas and accused the interpreter of sensoring or inadequately translating the patient's reply. In many cases the conflict occurred because the professional did not understand that apparent delays and apparent digressions were related to the interpreter's attempt to establish rapport or find culturally appropriate terminology or analogies for explaining biomedical concepts.

Conflicting loyalties arise from the interpreter's role as a kinsman and advocate and job-related loyalty reinforcing identity with the objectives of the hospital and health care system. Interpreters working in northern community settings, such as health representatives, may experience major role conflicts in counselling relatives or close friends. Andrewartha describes this phenomenon among Inuit interpreters working in remote Arctic communities:

> The pressures on a worker to 'help the family' with social assistance or to keep out of family matters in the case of child neglect can be extremely strong, very persistent and quite distressing to the worker [8].

Among interpreters observed in the pilot study, kinship and community identities were more defined in terms of extended family groups and regional groupings. Cross-pressures occurred when interpreters worked with patients from their community, a neighbouring community in their language area, or people from the same extended family. In working as a translator or advocate for a single patient, urban-based health interpreters had to insure that the confidentiality of the case was maintained by not feeding back information through their own informal networks. Reciprocally, interpreters were aware that descriptions of their own role in assisting individual patients or in advocating the health-related concerns of whole communities were communicated back to members of their family and home community.

Another source of role conflict for Native interpreters relates to their own 'elite' status among members of their home community. The impact of attributing elite status to indigenous health workers and other members of the servicing bureaucracy has been analyzed by Vallee and others, in terms of the emergence of an elite and basis for class stratification both within the social structure of remote northern communities and within urban migrant enclaves [9]. Interpreters working in urban hospitals also were observed to have high status among members of their home communities. Several informants commented that this status 'distanced' them from some members of their community.

Our preliminary observations of the training and work of Native interpreters did not reveal 'over-identification' with the health care delivery system or with the professional role model. However, several of the workers recognized the hazards of losing identity and linkages with the community and their families. Most respondents felt that alienation was less of a hazard for interpreters working within their home communities. In northern communities, more so than in urban settings, continuing use of indigenous language and accountability of the interpreter directly to the community were regarded as checks preventing the worker from becoming too heavily identified with the external medical care system.

An additional source of role conflict for Native health workers operating in both remote northern communities and within urban health care facilities relates to gender of the interpreter, as most are women in the 25–60 year age range who have exercised leadership roles. About 70% of the primary medical care utilization in northern communities and 65% of urban Native utilization, outside the pediatric age groups, involves women [10]. Female interpreters in urban hospital settings face reported communication problems in encounters involving male patients who were reluctant to accept their role in advocacy.

POWER RELATIONSHIPS WITH MEDICAL PROFESSIONALS AND ROLE DISSONANCE

In our preliminary observations, we also attempted to assess potential for role conflict related to: (1) interpreters' relationships with other professional groups and (2) their experience in attempting to build an appropriate paraprofessional or professional career stream. Alternative sources of dissonance were observed in terms of (1) the interpreters' anxiety about their job performance, (2) their perception of self-worth and competence in relationship to professional expectations and (3) their perceptions of opportunities for career development and continuing education.

Analysis of conflict related to the interaction between medical professionals and interpreters must deal with the relative power relationships between the two roles. The medical professional's status is legitimated by a university degree and clinical credentials reflecting a systematic period of academic and clinical training. The interpreter's knowledge of an indigenous language and culture conveys power only within the interpreting situation and is unaccredited as a professional or paraprofessional credential. In clinical situations, the professional has ultimate control over clinical decision making, but must delegate control to the interpreter in order to establish communication with the client.

Without systematic training or credentialling, interpreters' power and legitimacy is primarily limited to situations in which a medical professional requires culture-brokerage. The development of a clear career stream for interpreters with opportunities for systematic training and credentialling may resolve some problems associated with role dissonance [8].

Our preliminary observations of situations involving role conflict suggests that the training and credentialling process for interpreters must incorporate elements of informality and flexible time scheduling. Training opportunities must allow the interpreter to move easily between situations in the community and in the hospital. It should also be recognized that effective approaches to training and credentialling interpreters may inculcate values which conflict directly with the organizational requirements of the hospital and model of career development followed by other professions. Effective career development programs must develop forums for dealing with these conflicts and general role dissonance inherent in the work of culture brokers.

Acknowledgements—We wish to acknowledge the contribution of Ms Margaret Smith, Ms Esther Moore, Ms Lorna Guse and Mr Joe Connor to the pilot study of interpreters. We would also like to thank Ms Lynn Zdan, Dr P. Gilbert, Dr P. Kaufert and Dr D. Fish for their editorial contributions. Initial funding was provided by the University of Manitoba Presidential Outreach committee and the University of Manitoba Social Sciences and Humanities Research Council. Additional funding from the National Health Research and Development Program will be used to carry out further research on the roles of Native Interpreters in health care promotion.

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