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Consumers and Service Effectiveness in Interpreting Work: A Practice Profession Perspective

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The old adage *Caveat emptor*—let the buyer beware—not only warns consumers about who ultimately will suffer when a product or service fails to meet expectations, but also serves as a call to responsibility. It reminds us that consumers, not purveyors, must drive the process of evaluating and ultimately judging the quality and utility of products and services.

We view interpreting as a *practice profession*, like medicine, law, teaching, counseling, or law enforcement, where careful consideration and judgment regarding situational and human interaction factors are central to doing effective work. We contrast the practice professions with the technical professions, such as engineering and accounting, where knowledge and skills pertaining to the technical elements of a job are largely sufficient to allow the professional to produce a competent work product. Interpreters function more like practice professionals than technicians due to the significance of situational and human interaction factors on their ultimate work product; that is, factors beyond the technical elements of the source and target language (Dean & Pollard, 2001; Gish, 1987; Humphrey & Alcorn, 1995; Metzger, 1999; Roy, 2000a; Wadensjo, 1998). Interpreters cannot deliver effective professional service armed only with their technical knowledge of source and target languages, Deaf culture, and a code of ethics. Like all practice professionals, they must supplement their technical knowledge and skills with input, exchange, and judgment regarding the consumers they are serving in a specific environment and in a specific communicative situation (see both Turner and Winston, this volume).

Beyond the skills and judgment the professional must bring to the work situation, the practice professions are increasingly emphasizing the role of the consumer in effective service provision. In medicine, patients are expected to play a far more active role in their health care than was the case a generation ago. The keys to achieving greater consumer-driven quality in the practice professions are twofold: (1) adequate consumer understanding of the nature of the professional service being rendered, including its challenges and competency requirements, and (2) consumers taking a more active role in the service delivery process.

When the nature of a professional service is not adequately understood by consumers, the stage is set for a variety of untoward consequences, ranging from professional abuses to consumer inability to effectively partake of the service. Medical malpractice versus patient failure to understand and/or adhere to treatment recommendations are examples of the two ends of that untoward consequence spectrum. With any practice profession service, the ideal context for the consumption of services occurs when the nature of the service is clearly apparent to and understood by the consumer—to a degree that they can participate meaningfully in the procurement of that service. This means understanding service realities, professional competence expectations, service options, and the consequences of these various options. The medical profession incorporates such ideals in the rubric of informed consent. Patients who are sufficiently informed; reasonable in their service expectations; and responsible, active participants in their health care are a physician's delight when seeking informed consent and, ultimately, optimal health care outcomes. The same comparison could be made to consumers served by any practice profession, including interpreting.

Do consumers view interpreting services in this practice profession manner and thus participate knowledgeably and actively in interpreting service delivery? We doubt that most consumers, especially hearing consumers, have this perception of interpreting work and the active role they should play in its effective outcome; that is, beyond ''generating language'' for the interpreter to translate. Many consumers appear to view interpreters as technicians, where the consumer's participation in the interpreting process is limited to generating language, expecting that the interpreter will perform all the technical changes to that language necessary to render an accurate translation.[1] As in the practice professions of law, health care, or financial advising, consumers who participate minimally in goal-setting, choice of service options, outcomes monitoring, and so forth are at risk for receiving ineffective services or services that run counter to their true desires, and they leave the practice professional with an excessive (often unwanted) degree of power.

Where do interpreters learn to deal with limited consumer perceptions of interpreting and the burdens they impose on effective work? More generally, where do interpreters develop competency in addressing the situational and human factors that influence their professional practice, apart from the technical knowledge and skills they learn in the areas of language, culture, and ethics? The remainder of this chapter examines these and related issues, with an emphasis on the consequences for effective service delivery to consumers as well as interpreter education.

DIFFERING PERCEPTIONS OF THE COMPLEXITY OF INTERPRETING

''Interpreting is more than transposing one language to another . . . it is throwing a semantic bridge between two people from differing cultures and thought worlds'' (Namy, 1977, p. 25). People who speak different languages and come from differing cultural backgrounds experience the world in different manners; they have different *thought worlds.* Both spoken and signed language interpreters work amidst the differing thought worlds of their consumers and bear responsibility for the complex task of attempting to construct semantic bridges between them. At times, the degree of difference between these thought worlds is substantial, and the resulting semantic bridge constructed by the interpreter is complex (at best) or incomplete to a greater or lesser degree. At other times, consumers' thought worlds are very similar, so the semantic bridge constructed by the interpreter can be short and sturdy. While interpreters understand how different people and circumstances may combine to yield myriad semantic bridging experiences, usually they are the only individual present in the situation who can see that bridge from both sides and therefore the only one who perceives how effective the bridge they have ''thrown'' between consumers truly is in terms of linguistic and thought world equivalence. Unless this perception is shared with consumers, there is danger that the service effectiveness consumers presume is not in fact what occurred.

As noted, we believe that most consumers, especially hearing consumers, perceive the work of interpreters as vastly more easy and straightforward than it is and therefore do not participate more broadly and actively in the process. ''Just translate word for word what I say'' or ''Just tell him/her what I said'' are frequent consumer directives or perceptions. Most hearing and even some deaf consumers assume that if the interpreter is signing and speaking in an effort to translate between the parties, and if each party understands the language the interpreter is providing *to them*, then the source and target language messages must be being rendered faithfully and with no significant deviation from the original message (i.e., literally). Interpreters know

that these presumptions or wishes are not reality (Cokely, 1992; Roy, 2000b; Seleskovitch, 1978; Winston, 1989), but they rarely convey this to consumers. Why not?

One reason is that interpreters typically are not afforded the same respect and deference as are other practice professionals. Providing such instructive input to consumers may be problematic in that regard; it is generally not expected by consumers and may not be heeded or appreciated. Another part of the answer lies in the way some interpreters, especially novices, view the ''do not counsel, advise, or interject personal opinions'' tenet of the Registry of Interpreters for the Deaf (RID) Code of Ethics (RID, 1994). Taken in its most conservative, literal context, this tenet would seem to preclude interpreter commentary to consumers while on the job, despite arguments that such rigid interpretations of the code are erroneous and harmful (Fritsch-Rudser, 1986) or outdated and in need of significant revision (Cokely, 2000). A joint committee of RID and the National Association of the Deaf is currently revising the Code of Ethics. The present working draft includes language that allows interpreters to provide consultative opinions in some circumstances (RID, no date).

A third aspect of the difficulty in conveying interpreting complexities to consumers is the sheer multiplicity of factors beyond the words (or signs) people use that interpreters must take into account when making translation (and behavioral) decisions. Metzger and Bahan (2001), Roy (2000b), and Winston and Monikowski (2000) describe some of these factors as aspects of discourse analysis. Others include such factors in their broader consideration of sociolinguistics or interpreting in general (Cokely, 1992; Dean & Pollard, 2001; Namy, 1977; Wadensjo, 1998). It is doubtful whether consumers who subscribe to the literal or technical perception of interpreting work recognize how these discourse and extra-linguistic factors impact the moment-by-moment decisions interpreters make in selecting translations and otherwise fulfilling their professional duties.

It is further arguable that interpreters themselves may fail to perceive this broader picture of the extra-linguistic factors that pertain to accurate translation, at least in the early stages of their professional career when efforts to master sign language and the more immediate linguistic aspects of translation consume their attention. To test this hypothesis, 149 interpreters attending the 2001 RID convention were presented with written descriptions of five interpreting scenarios, each of which contained four situational elements not directly related to consumers' language use. The interpreters rated how strongly these extra-linguistic elements would impact their work in the given scenario using a 1–5 Likert scale where 1 = no impact, 3 = moderate impact, and 5 = strong impact. Their average ranking, across all factors and scenarios, was 3.2, indicating that they judged these factors to have more

than a moderate impact on interpreting work. Yet when asked where they learned about the importance of such factors in interpreting work, the majority indicated that they learned through on-the-job experience, not from their interpreter preparation program (IPP), continuing education, or supervision/mentorship. Although 50% of respondents had graduated from their IPP within the past 7 years (70% within the past 12 years), 47% of respondents indicated that their IPP was not a source of learning about the impact of such factors. Rather, 65% ranked on-the-job experience as their first or second most significant source of learning about the importance of such factors. When asked where they learned to *deal with* such extra-linguistic factors during interpreting assignments, 75% of respondents failed to rank their IPPs as a source of such learning.

As noted, several factors may contribute to disparities between what consumers think is happening in the interpreting process (i.e., literal translation based only on language utterances) versus recognition of the complex influences on translation and behavioral judgments that interpreters make, and the resulting variation in the effectiveness of their moment-by-moment semantic bridging work product. These include the low-status afforded the interpreting profession, an assumed ethical prohibition from engaging consumers in discussions of the complexity of interpreting work, and the slow on-the-job learning curve that precedes interpreters' recognition of the plurality of factors that influence their work.

Furthermore, if interpreters fail to view their IPPs as a source of learning about interpreting's broader complexities (whether this perception is accurate or not—just because these things were not learned does not verify that they were not taught), then they may not feel at liberty to discuss these complexities with consumers, for fear that the professional establishment will not back them up. This would reinforce a perception that the RID Code of Ethics prohibits such ''personal'' communication and further impedes consumer education about interpreting services. This establishes dynamics in which consumers and less experienced interpreters may ascribe to perceptions about the nature of interpreting that are simplistic and inaccurate and where seasoned interpreters with a broader viewpoint may not feel free to share these views and challenges with consumers and the profession at large. To the degree that this occurs, it is arguable that the *schema* guiding consumers' and interpreters' views and dialogues regarding this practice profession is in need of clarification or modification.

RHETORIC VERSUS DE FACTO PRACTICE

In the present context, we use the term ''schema'' to mean the global, conceptual framework that envelopes the condition or topic that

a profession deals with. A schema is the profession's overarching viewpoint of the realities that operationalize the professional's task. Schemas drive a profession's understanding of the challenges it faces and how to meet those challenges and train new professionals to do the same. Consumers of a profession's services also are guided by the profession's schema; it is how they understand the need for and the nature of the services they are receiving.

In the history of medicine, schemas of illness have changed periodically, usually through research advancements (e.g., the microscope, genetics) that force the profession, its teachers, and its consumers to periodically reconceptualize their fundamental understanding about what causes illness and promotes health.

One of the greatest dangers in a practice profession is the prevailing schema failing to adequately account for the realities encountered in professional practice. An inadequate professional schema prompts well-meaning practitioners to behave in ways they judge to be more realistic and effective but which run counter to or outside their prevailing professional schema and therefore are not overtly endorsed, or sometimes even discussed by the professional establishment or with consumers (Turner, this volume). This creates a gap between de facto (actual) practice and the prevailing rhetoric or belief system regarding how that profession conducts its work. When significant gaps exist between rhetoric and de facto practice, dangers of unexamined, unregulated, and unethical practice increase.

An example from medicine involves the topic of ''medical mistakes.'' Until recently, the prevailing rhetoric in medicine was that medical mistakes simply shouldn't be made. Accumulating research data regarding medical mistakes ultimately sparked a rather sudden shift in how the medical profession dealt with this topic. Only in the past few years has the admission of a serious problem in medical mistakes been openly acknowledged by the profession. With this openness came new efforts to address the matter, such as research grants for exploring the issue of medical mistakes, and practices that immediately benefited consumers such as writing on the body of a patient about to undergo surgery so that the proper surgical location is clearly identified. This never would have happened 20 years ago because the risk of operating on the wrong body part was not acknowledged as a sufficiently important reality of professional practice. Since it was not, de facto practice was unable to conform with the profession's rhetoric and such mistakes were hidden or dealt with as private matters, not as a significant issue in the general practice of medicine.

When insufficiencies in a practice profession's schema lead to de facto practices that differ from the profession's rhetoric, deception and practitioner stress are inevitable. Furthermore, consumers' risk for receiving ineffective, and even harmful, professional service escalates

since professional practice is insufficiently scrutinized and informed by the profession's oversight bodies and researchers and because teachers are not able to train students effectively regarding these hidden realities of professional practice.

Our teaching and practice experiences have led us to conclude that the field of sign language interpreting suffers from significant gaps in rhetoric versus de facto practice. Specifically, many consumers and less experienced interpreters believe that the work is restricted to circumscribed source-to-target language wording and structural changes, where a consumer's immediate word or sign utterances are the only input data necessary for the interpreter to perform a near-literal transposition between languages—one that is devoid of conscious or unconscious influence from the interpreter. The reality (de facto practice) of interpreting work is notably different from this. It is essential that consumers understand this if they are to participate in the effective rendering of this practice profession service.

THE REALITIES OF INTERPRETING WORK

To those who hold perceptions of interpreting work as a near literal process of transposition between languages, and where the utterances of consumers are the only data interpreters need to produce an effective work product, an honest and competent interpreter could reply:

- Translations often do not mirror the words you say.
- Translations often require information to be added or deleted.
- Translations are based on the interpreter's judgment of what consumers mean, not necessarily the words they choose.
- Consumers respond to the interpreter's translation choices, not the original consumer comments, which influences consumers and the resulting dialogue.
- The interpreter's presence and needs influence the flow of the interaction and the relationship between consumers.

While not every situation calls for diversion from the ''just translate word for word what I say'' directive, these statements more closely reflect the real work of interpreters. The purpose of the following section is to describe and illustrate each of these realities. The descriptions are of routine interpreting practice challenges and common interpreter responses to them (de facto practice). Yet consumers often do not recognize the frequency with which these ''realities'' occur during interpreting situations nor how or why interpreters handle them the way they do. The descriptions are intended to model how interpreters might explain to consumers the frequent divergence between ''just translate word for word what I say'' rhetoric and de facto practice. The illustrations of interpreting scenarios offered below are

not meant to portray ideal interpreting practices. Many different re-
sponses to a given interpreting challenge may be appropriate, although
each will have its particular consequences. Rather than prescribing an
optimal response or practice, these illustrations are meant to elucidate
the thought process that an interpreter might engage in prior to making
a translation or behavioral response to an interpreting challenge, be-
cause the interpreter's thought process is not likely to be perceived by
consumers and is critical to the evaluation of decision consequences.

Translations often do not mirror the words you say. Translations be-
tween two languages do not correspond 1:1 for each vocabulary word
uttered. Often, words in one language cannot be translated to another
language ''word for word''; therefore, verbal alterations, additions,
deletions, and approximations are a routine aspect of the interpreter's
task. This statement should be the most obvious of the five ''realities''
listed earlier, at least to interpreters (of spoken and signed languages)
and to consumers who are sufficiently fluent in two languages to rec-
ognize that the alteration of words is imperative to the effective
translation of *concepts*.

Translations often require information to be added or deleted. In part due
to the aforementioned non-equivalence of individual vocabulary
words, the addition of words (or information) often is necessary in
translation between any two languages. Furthermore, differences in
''fund of information'' between hearing and deaf consumers (Pollard,
1998) often requires an interpreter to fill in information gaps (e.g.,
briefly explain a term or issue that a consumer has referred to) that
otherwise frequently would derail communication between hearing
and deaf consumers. The deletion of information might occur when
limited time for ''throwing a semantic bridge'' forces interpreters to
disregard what they judge to be less significant words or comments
while prioritizing the inclusion and perhaps explanation of more sig-
nificant words or comments (Cokely, 1992; Napier, in press, a and b).
When consumers are communicating rapidly or in group situations
where several people may be talking at once, judicious decisions must
be made about what words or comments to ignore, summarize, or
curtail. Additions and deletions of course take place in spoken lan-
guage interpreting as well.

*Translations are based on the interpreter's judgment of what consumers
mean, not necessarily the words they choose.* Since languages do not equate
on a word-for-word basis, interpreters must understand the concepts
they hear (or see) in order to translate them. To some, this is obvious; to
others—especially those who are not fluent in two languages—it is not.
Interpreter understanding is not exclusively fostered by consumers'
word choices. Environmental context and immediate aspects of the
situation matter greatly when meaning is extracted from language. Roy
(2000a) offers an illustration of the varied meanings of the utterance

"Can I help you?" as a function of differing situational contexts and circumstances. If the interpreter does not understand what is said, the consumer probably will not, either. Implications of this reality argue for greater consumer-interpreter collaboration outside of or parallel to the immediate consumer-to-consumer dialogue to assure that interpreter comprehension is coincident with his or her translation work.

To illustrate how meaning, rather than words, guides an interpreter's translation, consider this scenario of a deaf patient undergoing an examination for back pain. After the physician conversed with the patient about the nature of the pain, what tended to cause or diminish it, and so forth, he began to palpate the area. "Tell me if you can feel this," the doctor directed. The interpreter translated this comment in a straightforward manner. The patient described varying degrees of pain as the examination proceeded. Then, the doctor picked up a pin. Again he said, "Tell me if you can feel this" (the exact same phrase as before), and he began gently poking various areas of the patient's back with the pin. At first, the patient repeatedly said "No," which puzzled both the physician and the interpreter. Unless something was amiss neurologically, the patient should have felt the pin, at least some of the time. The interpreter, who was experienced in medical work, recognized that the patient did not understand how the nature of the exam had changed and the *new* meaning of the physician's identical statement, "Tell me if you can feel this." It no longer meant "Tell me if/how this hurts," but now meant "Do you sense this?" After pausing to confirm her judgment with the physician, the interpreter changed her translation strategy and the neurological exam proceeded normally. (See Marschark, et al., this volume, for discussion of interpreters' influence on deaf consumers' cognitions.)

Interpreters base translations on their best judgment of what consumers mean, simultaneously taking into consideration evidence from consumers' language utterances, what they see taking place in the environment (e.g., the physician picking up a pin), the goals and context of the situation, and other factors that may relate to consumers' thought worlds. Whether or not this ultimately results in an *accurate* perception of what a given consumer meant by an utterance is another question. Interpreters, of course, can misunderstand what a consumer meant. This is further support for the frequent need for interpreters to dialogue with consumers or engage in other information-gathering behavior that fosters the accuracy of the interpreter's own comprehension of the communication that is (or might) take place between consumers.

Consumers respond to the interpreter's translation choices, not the original consumer comments, which influences consumers and the resulting dialogue. Consumers are receiving the translations provided to them through the filter of the interpreter; they are not receiving the original comments

unaltered. In our experience, consumers (especially hearing consumers) often fail to appreciate how significant the interpreter is in crafting the translations they ultimately receive. As noted, translations necessarily are influenced by the interpreter's perception of the contextualized meaning of the original comments, by the need to add or delete information, by language and sociocultural differences, by consumers' thought world differences, and so forth. When consumers presume that every word coming from the interpreter has originated from the other consumer, misunderstandings can ensue. The following scenario depicts one such situation.

A medically experienced sign language interpreter needed to translate a physician's inquiry as to whether a deaf consumer was "sexually active." In a medical context, these two words carry complex meaning. The term references a wide variety of sexual behavior with either gender and without regard to social, religious, or even legal norms. It is essential in a medical setting for this term to be conveyed with the widest possible scope of behavioral meanings and yet non-judgmentally. It is quite an interpreting challenge, especially when fund of information limitations or other personal or sociocultural factors may constrain a patient's perception of "sex" to mean intercourse alone and/or socially sanctioned sexual behavior (e.g., monogamy or heterosexuality). It also is specifically challenging to translate into ASL because of the vagueness of what "active" may imply and because the term makes no overt reference to a partner. With many deaf consumers, it is difficult to convey sexual activity in ASL without making reference to a partner and, to some degree, a specific activity. Ideally, in consideration of both ASL and fund of information issues with the average deaf consumer, a conversation regarding sexual activity would unfold as a dialogue, not as a "yes" or "no" response to the physician's inquiry.

In light of these complexities, the interpreter's initial translation of the physician's question included the concepts of "either a man or a woman" as possible partners in sexual activity. The deaf consumer replied, "I'm not gay." The physician didn't understand how this response could have resulted from his question about whether the patient was "sexually active." The interpreter explained the details of her translation choice to both parties, whereupon the physician agreed that he indeed had meant sexual activity with either gender. While many other possible translation or behavioral choices could be considered here, this scenario illustrates how consumers' responses can be more directly related to the interpreter's specific translation choice than the original consumer utterance. This happens so frequently in interpreting work that consumers benefit when they anticipate such a situation may occur.

The interpreter's presence and needs influence the flow of the interaction and relationship between the consumers. Great harm in the effectiveness of

interpreting service can be caused by consumers' failure to appreciate the influence of the interpreter's presence. The interpreter is not a shadow presence devoid of influence (Metzger, 1999; Roy, 1993, 2000a). On the contrary, the interpreter can play a pivotal role in how the communication situation unfolds. The interpreter influences numerous aspects of consumers' interactions, from the basics of what they understand one another to be saying to more extraneous matters such as communication turn-taking, perceived alliances among the interpreter and consumers, when and how clarifications are requested, and the degree to which language and cultural consultation is provided. Even the dynamics of the interpreter's arriving, leaving, and needing to be compensated for her services can have a significant impact.

The interpreter's role is associated with considerable power. If her presence is diminished or denied, the interpreter retains this power unchecked. Ironically, it was the desire for interpreters to *not* have such power that gave rise to the ''just pretend I'm not here'' advice that some interpreters still convey to consumers. In contrast, only by embracing the significance of the interpreter's presence can consumers and interpreters more realistically promote the equitable distribution of power that is so important in cross-cultural interaction.

An interpreter was called into an intensive care unit and asked to translate this statement from a doctor to a patient: ''There's nothing more we can do for you; we're going to make you as comfortable as possible.'' While the concepts of abandoning further treatment and instead targeting pain management could be readily translated into ASL, the covert meaning of this medical euphemism—a pronouncement of impending death—might be missed by many deaf consumers. It is unlikely that the physician would know that. Most interpreters would recognize this and not wish to be left with the burden, and power, of choosing whether their translation should (or shouldn't) convey the impending death concept directly, without the doctor's awareness that this choice must be made. If the translation closely parallels the doctor's original words or overt concepts, it risks the patient's failure to recognize the commonly understood (by hearing people) covert implication of this statement. This could deny the patient the opportunity to request religious counsel, family visitation, or make other preparations for death. Alternately, the interpreter could chose to directly convey the covert meaning of this euphemism (impending death) but there are serious consequences to this as well, especially as a unilateral decision that the doctor is unaware of. Both choices leave the interpreter in an undesirably powerful role, to the potential detriment of the doctor, the patient, and the interpreter. In this particular case, the interpreter's choice was to explain to the doctor the nature of the translation dilemma she was facing. The doctor was unaware of the language and cultural factors involved, and he subsequently took responsibility for conversing

with the patient in a more direct and clear manner about her impending death and the palliative care plan.

To maximize the equitable distribution of power in interpreting situations, interpreters and consumers must recognize each of the aforementioned realities of interpreting work and accept shared responsibility for the entire spectrum of the communication exchange—from communication initiator to interpreter to communication receiver—and back again.

ETHICS, CONSUMERS, AND EFFECTIVE WORK

''The choices that we make, and the actions that follow from those choices, can uphold or deny the dignity of other people, can advocate or violate the rights of other people, can affirm or disavow the humanity of other people. Given the potential consequences of our choices and the resultant actions, it is reasonable to expect that we constantly re-examine those values, principles, and beliefs that underscore and shape the decisions we make and the actions we undertake'' (Cokely, 2000, pp. 27–28).

In our workshops, we often ask interpreters what fundamental ethical tenet underlies medical practice, when distilled to just one statement. ''Do no harm'' is the correct response that is always given. ''Do no harm'' as an ethical statement manifests the relationship between ethics and the effectiveness of professional practice. Professional action (or inaction) that is harmful is fundamentally unethical. Consequently, ethical decision making in the practice professions must include consideration of the impact of the professional's decisions and actions on the consumer as well as other matters, such as the concordance between the professional's decisions and actions with the principles and standards of practice in that profession.

Figure 11.1 depicts our view of the relationship between ethics and work effectiveness in a practice profession such as interpreting. In the center of the figure, a range of ethical decisions and actions is depicted that includes those that are more liberal (i.e., active, creative, or assertive) to those that are more conservative (i.e., reserved or cautious). In this central range between the dotted lines any decision or action—from
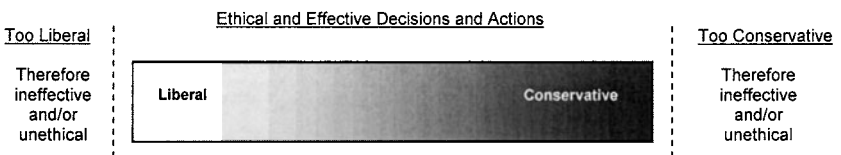

Figure 11.1. A practice-profession model of ethical decision-making

liberal to conservative—may be effective and ethical depending on the circumstances of the situation. Which decisions or actions within this range are *optimally* effective would be a matter of professional debate or perhaps interpersonal consumer or interpreter variation. Practice professionals commonly discuss liberal versus conservative approaches to their work, be it medical care, law enforcement, financial investment, or other topics. Neither end of this ethical and effective range of professional judgment and behavior is inherently better or worse, nor is the median necessarily optimal. Within this ethical and effective range of liberal to conservative practice, qualified practitioners will differ in opinion and approach. Ongoing research and consumer preferences typically inform practitioners' opinions and behaviors in that regard.

Outside the ethical and effective boundaries depicted (beyond the dotted lines) are decisions and actions that are so extreme—on *either* the liberal or conservative end of the spectrum—that they are overtly ineffective and/or unethical. Professional actions on the liberal extreme are most easily recognized. These are bold, intrusive actions that deviate markedly from professional norms and put consumers at obvious risk of harm. Stories of overly aggressive medical care, policing practices, even financial advice are common in the news.

Less aggrandized but equally harmful are professional actions at the other extreme of the spectrum—those actions that fall outside the acceptable *conservative* boundary of ethical and effective practice. Here is where failing to act or exercise some other aspect of professional judgment leads to consumer harm and, consequently, unethical practice. This end of the spectrum is more difficult to recognize. The impact of what someone has *done* (in being excessively liberal) usually is more apparent than the impact of what someone has *not done* (in being excessively conservative)*.* Yet, overly timid professional decisions can be equally damaging. Doctors who are insufficiently thorough or aggressive in treatment planning or teachers whose attentions are biased by student favoritism are behaving beyond the extreme conservative end of the ethical and effective end of this continuum. Why do practice professionals sometimes err in this overly conservative manner? There are many possible reasons, including timidity, ignorance, intolerance for risk, fear of taking responsibility, and lack of knowledge regarding the full range of ethical and effective choices at one's disposal.

Similar to other practice professions, interpreting decisions or behaviors that fall outside the extreme liberal boundary of the spectrum in Figure 11.1 are easier to recognize. These include active misuses of the interpreter's power, such as providing false translations to effect a certain result, or offering consultation outside the boundaries of one's competency and role (e.g., suggesting a diagnosis to a physician). Much of the content in the RID Code of Ethics (RID, 1994) was written to

guard against such excessively liberal interpreter conduct. Such conduct is typically associated with the ''helper'' model of interpreting practice, which was rejected by the interpreting profession from its beginnings (Frishberg, 1986; Quigley & Young, 1965; Roy, 1993).

But what about the other end of the spectrum? Can interpreters be guilty of excessively conservative professional judgment or behavior? Of course; all practice professionals can, since *bearing responsibility* is an inherent duty in the practice professions but one that can be avoided or insufficiently utilized to the detriment of consumers. Consider an interpreter who knows that communication has been ineffective or that significant misunderstandings have occurred or who was unable to do her job because conditions were not suitable for effective practice, yet fails to speak out, correct the situation, or otherwise convey to the consumers involved that their presumption of effective translation was not accomplished. This is unethical behavior beyond the reasonably conservative end of the continuum because it ultimately is harmful to consumers.

An interpreter working with a deaf psychiatric patient with limited sign language proficiency was asked to interpret for an attorney who was required to inform the patient of his legal rights pertaining to involuntary commitment to the hospital. The attorney read to the patient from a prepared text containing complex legal concepts and instructions on how to assert his rights if he felt they were being violated. It was obvious to the interpreter that she could not effectively convey this information to the patient, not only because of his limited sign language skills but also his impaired mental status. The interpreter properly chose to inform the attorney about this difficulty and the apparent impossibility of accomplishing the desired task in the brief time allotted. The attorney said, ''Just interpret what I say the best you can'' and, after one more reading of the document, the attorney prepared to leave. The interpreter again expressed her opinion that the patient did not comprehend the information. The attorney said, ''The main thing is that he knows he has rights and can contact me if needed.'' He then wrote a brief note in the patient's chart, asking the interpreter for the spelling of her name. The interpreter was concerned that the treatment team might not be informed of her view that the communication had been ineffective and thereby presume, from the attorney's visit and chart note, that it had been. In our view, for the interpreter to ''do nothing'' would be excessively conservative and potentially detrimental to the patient, and therefore would be unethical. Many possible choices are open to the interpreter to prevent such harm. One might be to inform the treatment team leader of her opinion that the communication had been ineffective. A more liberal choice might be to add an ''interpreter note'' to the patient's chart, conveying the same opinion. These and other choices would fall within the ''ethical and effective'' area of Figure 11.1.

We believe the risk for unethical behavior at the extreme conservative end of the spectrum depicted above in Figure 11.1 is particularly significant in the interpreting profession where, until recent years, the prevailing ethical rhetoric was so polarized against the helper model that the emphasis on inaction and aspirations toward ''invisibility'' created a deontological ethical rubric (Cokely, 2000; Fritsch-Rudser, 1986; RID, 1994). While interpreting scholarship (Dean & Pollard, 2001; DeMatteo, Veltri & Lee, 1986; Metzger, 1999; Page, 1993; RID, no date; Roy, 1993; Vernon & Miller, 2001) and IPP curricula are now espousing a broader, more flexible view of the interpreter's role, many practicing interpreters trained via older models are at increased risk for such overly conservative professional judgment. As noted earlier, even interpreters trained in the past decade report that their perceptions of the broader realities of interpreting work were gained primarily through on-the-job experience.

While some situations allow, and even call for, conservative interpreting practice, others do not. The effectiveness and consequences of professional decisions and behaviors are the ultimate measures of what is ethical and appropriate in a practice profession. Like other practice professions, interpreting must prioritize ''do no harm'' and recognize that inappropriate inaction can be as harmful as inappropriate action. Consumers who believe the ''just translate word for word what I say'' myth, or who believe that the silent, invisible interpreter, in all situations, is the quintessential model of effectiveness, may ultimately be harmed if they compel interpreters to behave in accordance with these beliefs. Improved consumer education, leading to more effective collaboration with interpreters, first depends on the interpreting profession itself confronting these still-common beliefs and subsequently educating consumers, practicing interpreters, and IPP students more effectively about the realities of interpreting work.

As in other practice professions, consumers, teachers, researchers, and practitioners collectively benefit when the nature of that profession—its challenges, presumptions, and practices—are made as explicit as possible. This lessens the gap between rhetoric and de facto practice and fosters critical exchange that can lead to improved professional schemas.

THE DEMAND-CONTROL SCHEMA AND SERVICE EFFECTIVENESS

The demand-control (D-C) schema for interpreting work (Dean & Pollard, 2001) was adapted from D-C theory, based on occupational health research conducted by Karasek (1979) and Theorell (Karasek & Theorell, 1990). Karasek and Theorell recognized that occupational stress versus work satisfaction and effectiveness arise from the interactive dynamics between the challenges (*demands*) presented by work tasks in relation to

the resources (*controls* or *decision latitude*) that workers bring to bear in response to job demands. While respecting the central roles of language and culture in the practice of interpreting, the D-C schema focuses on additional factors (demands) that impact effective translation. These include *environmental demands*, *interpersonal demands*, *paralinguistic demands*,[2] and *intrapersonal demands*. (The acronym EIPI is used when referring to all four demand categories simultaneously.)

Environmental demands are interpreting challenges or success requirements that pertain to the assignment setting (e.g., understanding consumers' occupational roles or specialized terminology specific to a given setting[3] or tolerating space limitations, odors, or adverse weather). Interpersonal demands are interpreting challenges or success requirements that pertain to the interaction between consumers (e.g., cultural differences, power dynamics, differences in fund of information, or consumers' unique perceptions, preconceptions, and interactional goals.) Paralinguistic demands are interpreting challenges or success requirements that pertain to immediate, overt aspects of the expressive communication of consumers (i.e., the clarity of the ''raw material'' the interpreter sees and hears). Examples of paralinguistic demands are when a hearing individual has a heavy accent or when a deaf individual is signing while lying down or has an object in his or her hands. Intrapersonal demands are interpreting challenges or success requirements that pertain to the internal physiological or psychological state of the interpreter (e.g., the need to tolerate hunger, fatigue, or distracting thoughts or feelings.)

As adapted from Karasek, controls are skills, characteristics, abilities, decisions, or other resources that an interpreter may bring to bear in response to the demands presented by a given work assignment. Controls for interpreters may include education, experience, preparation for the assignment, behavioral actions or interventions, particular translation decisions, (e.g., specific word or sign choices or explanatory comments to consumers), encouraging ''self-talk,'' or the simple yet powerful act of consciously acknowledging the presence and significance of a given demand and the impact it is having on an interpreting assignment. In the D-C schema, the term ''control'' is a noun, not a verb, and is preferably stated as ''control options.'' We define three temporal opportunities where control options may be employed: pre-assignment controls (e.g., education, language fluency, and assignment preparation), assignment controls (e.g., behavioral and translation decisions made during the assignment itself), and post-assignment controls (e.g., follow-up behaviors and continuing education).

The D-C schema links interpreting theory with professional practice. The model of ethical and effective decision making presented in Figure 11.1 is an integral component of D-C schema supervision and teaching. In a formal D-C analysis, interpreting situations are examined for

demands presented by EIPI factors. Then, the value and consequences of various translation and/or behavioral decisions (control options) in response to these factors, ranging from liberal to conservative, are explored and critiqued.

Any schema change in a practice profession must benefit four constituencies: the practitioners, teachers, researchers, and consumers. Among the benefits the D-C schema may offer these constituencies are the following: (1) a structured and objective means of identifying and analyzing a more complete array of factors that impact interpreting practice, (2) a common nomenclature through which to dialogue about these factors, (3) a method for examining the consequences of interpreting decisions that can help interpreters and IPP students hone practice-profession judgment skills, and (4) a stimulus for more open and realistic dialogue about the nature of interpreting work, which could beneficially impact teaching, research, consumer input and participation, and the establishment of qualifying standards for interpreters (either signed or spoken language interpreters).

Each of these purported benefits should be critically examined through empirical investigation. While the schema is still rather new and continues to be refined as it is being implemented in different venues, useful data are beginning to accumulate. Current research on the effectiveness of the D-C schema has two primary foci. The first is on the impact of incorporating the schema and related teaching methods such as "observation-supervision"[4] in IPPs (Dean, Davis et al., 2003, and see http://www.urmc.rochester.edu/dwc/scholarship/Education.htm). The second is examining the utility of the D-C schema and observation-supervision in enhancing interpreting work in specialty practice settings such as mental health (see http://www.urmc.rochester.edu/dwc/scholarship/Interpreter_Training.htm).

Already cited were data indicating that interpreters perceive on-the-job experience, rather than formal training, as their primary source of learning about extra-linguistic (EIPI) factors that impact interpreting work, even those who graduated from IPPs during the past decade when such information was being published and likely included in IPP curricula. Why the majority of these survey respondents failed to credit their IPPs as a source of such learning remains to be elucidated. Perhaps more concerning is the realization that on-the-job learning curves evolve while interpreters are serving consumers, often with limited supervision or access to mentoring (see Monikowski & Peterson, this volume). The consequences for consumers served during early versus later stages of this learning curve should be explored.

The aforementioned survey conducted at the 2001 RID convention also yielded data on the influence of D-C schema training on interpreters' rankings of the importance of EIPI factors in interpreting work. Of the 149 respondents, 58 had taken D-C schema courses or

workshops. Participation in D-C schema training was compared with respondents' years of working experience and the number of years since their graduation from an IPP. As might be expected, respondents who participated in D-C schema training ranked EIPI factors as more important in interpreting work than respondents who had not had D-C schema training. Respondents' work experience and their years since IPP graduation were not associated with overall EIPI rankings. Among the four EIPI factors, D-C training had the strongest impact on perceptions of the importance of intrapersonal and interpersonal demands, modest impact on perceptions of the importance of environmental demands, and the least impact on perceptions of the importance of paralinguistic demands. Years of experience had a modest influence on ranking only interpersonal demands as important. Years since IPP graduation had no discernable influence on any of the four EIPI factor rankings.

These data suggest that D-C schema training fosters insights regarding the complexities of interpreting work that practice experience alone does not provide. This is consistent with additional data emerging from another study conducted at the 2003 RID convention and external evaluations of D-C schema training in IPPs (Institute for Assessment and Evaluation (IAE), 2003). However, the training appears more effective in fostering recognition of the importance of intrapersonal, interpersonal, and environmental demands (respectively) than paralinguistic demands. This differential impact of D-C training across EIPI factors, and the finding that work experience alone appears to have modest impact on fostering recognition of the importance of interpersonal factors, raises interesting research questions but also makes intuitive sense. The interpreting challenges presented by deficient or distorted linguistic raw material (paralinguistic demands) may be so obvious as to require no special training to appreciate. The significance of environmental factors, many of which also are obvious, may require less specialized training to appreciate. While D-C schema training appears most influential in fostering appreciation of the importance of intrapersonal and interpersonal demands, work experience alone appears to lead, over time, to a greater appreciation of the importance of interpersonal demands. How this learning might be hastened, including in IPPs, is worthy of investigation, especially given how frequently in recent years interpreting scholarship has emphasized the importance of interpersonal factors in interpreting (Gish, 1987; Metzger, 1999; Roy, 2000b; Wadensjo, 1998). The data herein suggest that this emphasis is not getting through to interpreters until later in their professional careers. D-C schema training appears to hasten that learning. Furthermore, D-C schema training appears uniquely effective in fostering

recognition of the significance of intrapersonal demands in interpreting work.

Both D-C schema training and work experience appear to foster interpreters' recognition that factors beyond language per se bear relevance to professional practice (see Roy, Turner, Winston, Marschark et al., this volume). The potential negative consequences for consumers served by interpreters who have not yet developed this broader view of interpreting work are important research and practice issues. We believe these findings lend support for the value of providing D-C schema training to interpreters in IPPs as well as through continuing education, especially interpreters who are early in their professional careers. This conclusion is consistent with reports from our IPP infusion study at the University of Tennessee (Dean, Davis et al., 2003; Dean, Pollard et al., 2003; IAE, 2003), which indicate that student interpreters versed in the D-C schema analyze assignment demands and control options in a manner similar to interpreters with considerable work experience, even though many of these students are not yet fluent in ASL.

Our latest study on D-C schema training for mental health interpreting (which is being conducted in Rochester (NY), Minneapolis, San Francisco, and New York City; http://www.urmc.rochester.edu/dwc/scholarship/Equity.htm) is providing early qualitative data. This project is focused on the observation-supervision approach to interpreter training in specialty practice areas. We are examining not only changes in interpreters' perceived competency in mental health work but also consumers' perceptions of the effectiveness of services provided by interpreters trained through observation-supervision versus interpreters who have not been trained in this manner.

Preliminary data suggest that observation-supervision training has positive impact on interpreters but an impact that differs as a function of their degree of experience in the mental health field. Interpreters with less work experience in mental health settings report that observation-supervision provides them with an appreciation for ''big picture'' issues (e.g., the nature of a suicide assessment), whereas interpreters with more mental health experience report learning subtle aspects of this specialty practice area (e.g., the importance of a therapist's modeling what words parents should use when speaking to their child in times of stress or conflict). Most interpreter participants are reporting that observation-supervision gives them an enlightened perspective on their own (intrapersonal) reactions to interpreting work, in mental health settings and beyond, underscoring the data cited earlier indicating that D-C schema training appears to have a unique impact on the appreciation of the significance of intrapersonal demands. Even those with many years of experience in the mental health field report new awareness of how their personal reactions to this

service environment affect their work and new ways to cope with those reactions during and after work assignments.

Interpreters and mental health professionals who are participating in this project report that the professional-to-professional dialogues they engage in during observation sessions are mutually educational. The interpreters are gaining insight into the thought world of clinicians, while the clinicians are gaining greater appreciation for the nature of interpreting work. This improved collegial relationship may benefit consumers served by such interpreter-clinician teams.

The aforementioned survey and evaluation findings are beginning to document the value of the D-C schema approach to interpreter training. However, this research has not yet expanded beyond investigations of hypothetical or secondhand observed work situations to include actual, in situ work behavior, apart from the qualitative data emerging from our mental health interpreter training study. Nor have we yet analyzed consumer perceptions, experiences, and consequences regarding interpreters who are trained via the D-C schema or observation-supervision. Those investigations will be crucial in further evaluating the utility of the D-C schema and related teaching approaches for interpreters and consumers alike.

SUMMARY AND CONCLUSIONS

The primary reason for the publication of this volume is to provide increased visibility and motivation for the conduct of interpreting research. Both in signed language and spoken language interpreting, there is little research data to guide interpreter education and practice. There is even less empirical study of interpreting as it pertains to consumers, especially consumers outside of educational settings. Interpreters in medical, legal, mental health, and other settings provide a crucial professional service that has profound—even life and death—consequences for consumers. Yet consumers (and researchers) know little about what interpreters really do on the job, how well they do it, and how consumers can more effectively collaborate with these practice professionals toward better service outcomes.

Interest has grown recently in the conduct of research in the related area of doctor-patient communication. As if direct doctor-patient communication were not complicated enough, only a few studies have been published that address the impact of interpreters (usually spoken language interpreters) in medical settings (Bot, 2003; Ferguson & Candib, 2002; Flores, et al., 2003). Given that medical settings are the single largest assignment venue for freelance sign language interpreters (Rivers, 1999), additional study of the added complexities, risks, and benefits associated with interpreter services in these settings is badly needed.

Further empirical study of the validity of D-C schema concepts and the impact of D-C schema training and observation-supervision on the effectiveness of interpreting practice is encouraged. Many topics could be addressed. Is observation-supervision more effective than traditional practicum training for student interpreters? What are optimal ways of advancing consumer education regarding the multiplicity of factors that influence interpreters' translation and behavioral decisions? Is the practice profession model of ethical and effective decision-making (Figure 11.1) useful in fostering dialogue and mentoring on interpreting ethics? What more can be elucidated regarding the learning curve following IPP graduation where interpreters acquire experience and judgment capabilities regarding the EIPI complexities of their work, especially the impact on consumers? Can this learning curve be shortened via modifications of IPP curricula or practicum, internship or continuing education programming?

Offering new models of practice is a common method for critically examining and seeking to enhance the utility of professional work and training. Models make explicit the assumptions and approaches used in an occupation. When models are made explicit, new information—whether from research, consumer input, or other sources—can be used to modify and further enhance a model's utility or, if not, foster the adoption of better models (Hanson & Oakman, 1998). Whether or not the D-C schema for interpreting work ultimately proves to be a useful model for guiding interpreting practice, IPP teaching, and interpreter evaluation will depend on the scrutiny of researchers, practitioners, teachers, and consumers. While some evidence is accumulating to suggest that this schema and observation-supervision are benefiting IPP students and practicing interpreters, ultimately, such benefits are moot unless they lead to more effective interpreting services for consumers.

NOTES

1. Throughout this chapter, we use the term ''translation(s)'' when emphasizing the linguistic end product of an interpreter's work. Cokely (2002) notes that translation refers to the transfer of ideas from source to target language regardless of form (e.g., written, spoken, or signed). The term ''interpretation'' is broader in that interpretation includes the complex cognitive process the interpreter engages in prior to deciding upon the final end product, or translation, rendered. Since this chapter primarily deals with the consumer's perspective of that end product, the term ''translation'' is used.

2. In the 2001 publication, this category was termed ''linguistic demands'' but that term was changed because language (or translation between languages) is the over-arching *raison d'etre* of an interpreter's work and, in that regard, language is an aspect of all four demand categories.

3. In the 2001 publication, we included terminology (i.e., technical vocabulary) in the (former) category of linguistic demand. We now view technical vocabulary and other specialized terms or phrases as environmental demands, since specialized terminology tends to be dictated by the specific work environment of the interpreter (e.g., a medical, legal, or computer technology setting).

4. Observation-supervision involves interpreter trainees observing potential work situations (e.g., medical appointments) when there are no deaf consumers or interpreters present. Guided in these observations by special forms developed in accordance with the D-C schema, interpreters later gather in semistructured supervision sessions led by mentors well-versed in the D-C schema to conduct EIPI analyses of the observed situations and to propose and analyze the consequences of various control options as they relate to an array of hypothesized deaf consumers who *might have been* in these or similar situations.

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