It is All About Adaptation and Sensitivity: the Complexity of Relational-Interactive Work in Interpreter-Mediated Non-Emergency Healthcare in British Columbia, Canada

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Abstract

This research explores the experience of navigating relational work in interpreter-mediated non-emergency healthcare consultations. Using the lived-experience of six healthcare sign language interpreters, this research reveals interpreter-mediated healthcare consultations as a site of significant and shifting complexity. For those interviewed, adaptation and sensitivity to the physical, social, and larger cultural factors at play within a healthcare consultation were essential to effectively navigating relational-interactive work. Drawing on systems theory and complex systems theory, and guided by post-intentional phenomenology, this research highlights the interconnected and entangled nature of healthcare interpreting. Ultimately, this research emphasizes that effective navigation of interpreter-mediated healthcare appointments involves an ongoing co-learning and co-navigating process navigated between people, and the need to address it as such.
Lay Summary

In this research I interviewed six healthcare sign language interpreters about their experiences facilitating communication and relationship building within healthcare consultations. Through my analysis, I noticed that to do this work effectively, healthcare interpreters need to be adaptive and sensitive. Participants emphasized that each healthcare consultation had unique factors to be navigated. The participants felt a key component of successful healthcare interpreting work was adapting to the people, social situation, and physical elements within a consultation. Often, these factors shifted within consultations as well. So, adaptation was an ongoing process for interpreters, and when they failed to adapt well, they felt it might create barriers to communication and relationship building between patients and healthcare providers. Ultimately, this research suggests that ongoing learning and adaptation is a key element in effective healthcare interpreting, as the specific and unique nature of each consultation very much matters.
Preface

This research was conceived, designed, conducted, analyzed, and written by Bryan Hemingway, with ongoing guidance provided by my co-supervisors: Dr. Laura Nimmon and Dr. Debra Russell. This thesis is original and unpublished work. Ethics approval for this study was obtained from the University of British Columbia Behavioural Research Ethics Board (H21-02118).
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List of Abbreviations

- DTES: DownTown East Side
- HCP: HealthCare Practitioner
- HSLI: Healthcare Sign Language Interpreter
- WAVLI: Westcoast Association of Visual Language Interpreters
Glossary

Accredited BC Medical Sign Language Interpreter & Healthcare Sign Language Interpreter

Within the province of British Columbia, Registered Sign Language Interpreters must pass additional knowledge and performance exams before they are able to independently interpret within healthcare settings (excluding mental health, dental, and some physical therapy settings [Wavefront Center for Communication Accessibility, 2020]). As a result, I use these terms to refer to professional Registered Sign Language Interpreters who have passed additional testing and have been assessed to meet the required level of technical and knowledge competency to begin working within healthcare consultations.

American Sign Language

American Sign Language (ASL) is a grammatically and culturally-distinct language from English (Padden & Humphries, 2005; Valli & Lucas, 2000). It is the most common signed language in Canada and the United States, though other signed languages are used by deaf communities within this area as well.

Deaf Patient

Like any identity, there is significant complexity and diversity in the definition of deaf and in the people who identify with this term. Some people see it as a medical term, denoting reduced hearing, while others use it as a cultural identifier (Padden & Humphries, 2005). As a non-deaf person, I do not seek to define this term in any general way, but for clarity I provide the following working definition: within this research, I use the term deaf patient to refer to a person who identifies as deaf (in the medical or cultural sense), uses a signed language, and uses a sign language interpreter in some of their primary care appointments with practitioners who do not
share their language. Again, this is a subsection of a much larger and more diverse population.

**HealthCare Providers (HCPs)**

Within this study, this term is used in a general way to refer to a qualified health professional\(^1\) who is providing direct care service to patients within non-emergency settings, excluding those who exclusively provide mental healthcare\(^2\). Most commonly these are doctors or nurses, but at times also refers to other health professionals.

**Hearing**

Within this thesis, the term hearing is used to identify a person who is not deaf, hard of hearing, or deafblind. It is important to note that this term is not meant to suggest that the person belongs to mainstream culture(s), but rather just to denote that they are not culturally and medically deaf, hard of hearing or deafblind.

**Interpretation**

I subscribe to the viewpoint that there is no neutral frame of reference for communication—instead, I see all communication as relational, situated, and contextually-bound (Gee, 2004; Wadensjö, 1998). Meaning is actively co-constructed by people interacting with language and each other (or an imagined other) rather than simply present in language itself (Roy, 2000; Shaffer & Wilcox, 2005; Wadensjö, 1998). With this complex understanding of language as a multi-layered and purposeful act, it becomes clear that there is no such thing as a literal translation (Wong & Poon, 2010) or interpretation. Thus, I understand and define interpretation as a purposeful, significant, and contextually-bound act of

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\(^1\) Those who work within regulated health professions as defined by the BC Health Regulators.

\(^2\) I do believe that mental health is a salient and important type of healthcare, however within the BC context, mental health interpreting and general healthcare interpreting are differentiated. Thus, I chose to focus on non-mental health interpreting.
transformation (Temple & Young, 2004) that seeks to support engagement between the people involved in a situation (including the interpreter).

**Mediation**

In the same way that language is never neutral, but rather always an assertion of a specific reality (Gee, 2004), the work of interpreters and translators deeply shapes the meaning co-constructed by participants (Baker, 2018). Within translation studies, Hatim and Mason (2005) describe mediation as the ways that interpreters deeply shape and change meaning as they construct and reconstruct meaning across languages and cultures. That is, interpreters as active co-participants construct and reconstruct meaning based on their own understanding and perspective of the context and the other co-participants (Gee, 2004), shaping the ways they create messages and facilitate interaction (Pöchhacker, 2016, Wadensjö, 1998). It is this shaping and reshaping of meaning and interaction that I refer to using the term mediation in this thesis research.

**Primary-Care Consultations & Non-Emergency Consultations**

Within this research, I define primary-care and non-emergency consultations purposefully broadly as those that were scheduled in advance, did not exclusively focus on mental health, and did not take place within a hospital emergency room.

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3 Hatim and Mason highlight that neither high mediation or low mediation, that is less or more modification of the source language, ensures improved accuracy (2005).
Acknowledgements

So, here we are, at the end for me (this is one of the last things I am writing) and the beginning for you. Before I dive into my thesis, I want to acknowledge some of those who contributed throughout this journey. This thesis would not have been possible, or be shaped in this way, without all of the connections, places, and people woven into my life.

This thesis was written on the stolen lands of the Musqueam, Squamish, and Tsleil-Waututh first nations. I am an uninvited guest on their lands and I am working to learn how to navigate this. I conceived, conducted, and wrote this thesis on your lands, and want to acknowledge that in all of the complexities it implies.

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day. Thank you for your belief in me, particularly when I failed to believe in myself. From the ongoing pandemic to housing instability, your support and presence has meant the world.

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Finally, and perhaps most importantly, thank you to all the Deaf and DeafBlind community members in the Pacific Northwest who have supported me throughout my professional and academic journey. You have shared with me your language, culture, and wisdom. I know how special these gifts are and I seek to honor it in all my work, including this research.
Dedication

To all those homeschooled and disabled kids who always saw and experienced the world in atypical ways. Though not everyone may be willing to listen, it doesn’t mean that our strange viewpoints are not without value. Find those that will listen, and listen to them; create change and be changed.
Section 1: Introduction and Orientation to this Thesis

Research emphasizes how high-quality relationships between healthcare providers and patients are critical for promoting a number of positive health outcomes (Alexander et al., 2012; Berry et al., 2008; Conboy et al., 2010). However, when healthcare consultations include an interpreter, it adds significant complexity to the relational-interactive work, as three participants are actively interacting and co-constructing meaning (Angelelli, 2004; Fatahi et al., 2008; Jacob et al., 2021; Shaffer & Wilcox, 2005; Wadensjö, 1998). How this added complexity is navigated within specific consultations largely remains unexplored. This gap leaves both healthcare practitioners and healthcare interpreters to speculate what may hinder or promote effective patient-practitioner rapport.

Similar to other cultural-linguistic minority groups, many deaf and hard of hearing Canadians often lack access to healthcare practitioners who are fluent in their signed language\(^4\). As a result, many of their healthcare appointments are interpreter-mediated. Indeed, in British Columbia in 2019, 4,391 healthcare appointments used American Sign Language\(^5\)-English interpreters (Wavefront Center for Communication Accessibility, 2020). As such, interpreter-mediated healthcare interactions are far from a rare occurrence for many Canadians. However, there continues to be limited information and resources to support the effective relational-interactive work in these interpreter-mediated healthcare appointments. As a result, this gap potentially increases health inequities that minority language communities already face in

\(^4\) This is a critical issue that should be addressed, with deaf, hard of hearing and deafblind people being encouraged and fiscally supported to become healthcare providers. Improving interpreting service and quality cannot be treated as a quick fix for inclusion (De Meulder & Haualand, 2019), which is far more complex and multifaceted.

\(^5\) American Sign Language (ASL) is a grammatically and culturally distinct language from English (Padden & Humphries, 2005; Stokoe, 1978; Valli & Lucas, 2000).
accessing care in Canada (Bowen, 2001, 2015; Raphael, 2006). There is a real risk that communicative and relational complexities may limit deaf patients’ access to the known health benefits of high-quality patient-practitioner relationships (Alexander et al., 2012; Berry et al., 2008; Conboy et al., 2010; Greene & Hibbard, 2012).

While previous research has explored the features and differences between interpreter-mediated and direct communication in healthcare consultations, little research has examined how relational-interactive work is actively navigated by healthcare interpreters within consultations. This research seeks to address this gap by drawing on and analyzing healthcare sign language interpreters’ lived experiences of patient-practitioner relationships in interpreter-mediated primary healthcare interactions in British Columbia. By doing so, this research reveals interpreter-mediated healthcare consultations as sites of considerable socio-cultural complexity, suggesting the need for ongoing interprofessional education and collaboration. Due to the complex and diverse factors at play within a consultation, there was no single, one-size-fits-all approach for HSLIs to effectively navigate relational-interaction within non-emergency healthcare consultations. Rather, ongoing and evolving adaptation to emergent factors within a consultation was the key to effective navigation. Hence, this research outlines and suggests the need to treat healthcare interpreting as an ongoing learning process co-navigated by participants within the specifics of a consultation.

1.1 Research Question

This post-intentional phenomenology-informed research study focused on and was guided by the following research question:
How do sign language interpreters experience navigating patient-practitioner relational-interactive work in interpreter-mediated primary healthcare interactions?

1.2 Study Context: Overview of Healthcare Sign Language Interpreting in BC

Based on the Eldridge v. British Columbia (1997) decision, the government of British Columbia funds sign language interpretation services for healthcare services explicitly outlined in the Canada Health Act (1985). These include most general practitioner, specialist, diagnostic and hospital care services (Western Institute for the Deaf and Hard of Hearing, 2020). This funding is provided to a provincial health organization, who in turn partially sub-contracts services to a local non-profit. This local non-profit organization screens interpreters; those that pass are accredited as Healthcare Sign Language Interpreters (HSLIs) and are added to a digital list through which medical appointments are distributed. Qualified HSLIs can then choose at which appointments they want to provide service on a per-appointment basis. Healthcare Sign Language Interpreting services are provided free of charge to deaf patients or healthcare providers by a pre-screened list of freelance interpreters.

It is important to note that the funding for mental health interpreting and healthcare sign language interpreting are drawn from different sources in British Columbia. Similarly, the funding for spoken and signed language healthcare interpretation is separate. As a result, the systems for training and providing mental health and spoken language interpreting services have developed, at least somewhat, separately from sign language healthcare interpreting. Thus, for these reasons, I chose to focus this research on non-emergency healthcare consultations that used Healthcare Sign Language Interpreters (HSLIs), as it presented a more specific (though diverse)
research context. Additionally, it was a context I had sufficient familiarity within to appropriately navigate.

1.3 Positionality: Who I am, Why I Chose to Engage in this Study, and Why that Matters

1.3.1 Who I am

Professionally, I am a hearing Registered Sign Language Interpreter with 13 years of practice experience. I completed my BC Medical Sign Language Healthcare Interpreting accreditation in 2015 and I have been practicing in this area since then. I have also had the honor to study alongside, work with, and develop deeply meaningful relationships with many members of the Deaf and DeafBlind communities. Additionally, many highly-skilled Registered Sign Language Interpreters have supported me and provided me guidance throughout my career. It is through the gifts of language and experience shared with me by members of these communities that I come to know the topic of my research.

Personally, I am also a disabled person. Having been born with a chronic illness, I have always been deeply connected to the topic of health and to the healthcare system. My personal experience with healthcare and healthcare professionals has been a mixed bag, with moments of wonderful beauty that make me smile to this day, to moments of cruelty and deep pain. My lived experience of being a patient is an ever-changing knot of positive and negative, always in the process of untangling and further weaving itself together.

As a graduate student, I am fluent in English and ASL and limited to accessing discourse and research in these languages. I am also a queer and gender-queer person and a white settler. I was raised in a low-income household and I am a first-generation university student. These elements have shaped how I move through academic space and, in turn, how I have conceptualized, designed, and engaged with this thesis research process.
1.3.2 Why I Chose to Engage in This Study

My life has always been woven together with the healthcare system, with even small policy changes having very tangible impacts on my life. So, the topic of health and healthcare has always been interesting to me and is a central feature in my life. I have always half-joked I am more comfortable in a hospital than at a house party. Yet, the topic of health is almost infinitely broad, so why this specific focus?

The focus of my thesis arose out of pragmatic need—the unanswered questions and unsettled tensions that emerged in my own healthcare interpreting practice. I soon found out that I was not the only one who had these feelings, as discussions with my interpreter colleagues revealed that they had many similar unanswered questions and tensions. Over time, my ongoing discussions with my colleagues and deaf friends began to centralize around the topic of navigating and supporting effective relationships between deaf patients and healthcare providers.

Though my interaction with the research literature, my academic coursework, and ongoing reflection has helped to refine these questions, my orientation to this topic still remains largely pragmatic. I am interested in understanding how interpreters navigate relational-interaction between healthcare providers and deaf patients, so that we might be able to improve the frequency of high-quality patient-practitioner relationships in interpreter-mediated healthcare consultations. I wanted to generate practical wisdom, or phronesis, that helps support improved education, practice, and policy.

1.3.3 Why It Deeply Matters Who I am

As I am the lens through which this research was constructed, analyzed, and interpreted, I feel it is important to articulate the ways I orientate to the topic of interpreter-mediated healthcare. Taken together, these identities and experiences inform the ways I orientate to the topic of this research. As I moved through my research, I considered it simultaneously as an
emerging health scholar; a disabled person with complex healthcare experiences; a practicing healthcare interpreter, honored with the trust of patients and practitioners; a queer person, navigating ill-fitting assumptions; and a white settler, with all of the privileges that entails. In conclusion, my orientation to this topic is both personal, professional, pragmatic, and always changing.

My lived experience shapes how I move through the world and, as a result, it has shaped this research. No doubt, the interviews and my analysis could have taken many forms had another person done the work. I have worked hard throughout this research process to become aware of, thoughtfully navigate, and refine my perspectives (explored further within the methods section), but, ultimately, it was woven within my lived experience. Thus, this is a reflectively woven research story that I crafted, but it is not the research story. Yet, I hope it brings you some level of practical wisdom and learning as it has for me.
Section 2: Literature Review: the Complexity of Interpreters’ Work in Healthcare Consultations

Below I draw on spoken and signed language interpreter literature to further define current understandings of the types of work interpreters engage in within primary healthcare consultations as well as to highlight any gaps in our current understanding. Though limited, the available literature demonstrates that interpreters engage in a significant range of mediation work in healthcare appointments, thereby making such appointments unique from those in which patients and practitioners can sign or speak directly to each other. However, what remains less clear and understudied in the literature is how healthcare interpreters conceptualize, evaluate, and navigate relational-interactive work within a healthcare consultation. This gap seems to add additional uncertainty to the often complex process of providing high quality care to patients in general (Browne et al., 2012; Innes et al., 2005) and within interpreter mediated consultations (Angelelli, 2004; Fatahi et al., 2008).

Interpreters engage in a wide range of mediation work, which has the potential to be clinically significant. Interpreters have been observed or reported performing mediation work that includes modifying the cultural-linguistic, emotional, and relational discourse between patients and practitioners. As Mapson and Major (2021) note, any social, cultural, emotional, or relational element of discourse may have clinical relevance, thereby making any interpreter mediation potentially clinically relevant too. It has been established that literal translation is neither possible nor a good measure of quality in general (Hatim & Mason, 2005) or in healthcare (Brisset et al., 2013). Furthermore, the idea of direct equivalence between source and target language renditions does not hold up to intellectual scrutiny (Pöchhacker, 2016). Thus, the mediation work of interpreters is both necessary and, often, clinically relevant, making
understanding the experience and conceptualization of interpreters of this mediation work within consultations of significant import.

Below, I summarize the cultural-linguistic, emotional, and relational work interpreters have reported or been observed conducting. While I have chosen to describe these separately for clarity, each category of mediation work should not be understood as mutually exclusive. Indeed, as Krystallidou and Pype (2018) noted in their qualitative discourse analysis of recorded healthcare interaction, evidence from one category could be co-located in another and is relative to the ways that interpreter mediation work is understood by the other participants.

2.1 Interpreters’ Cultural-Linguistic Work

Interpreters have been observed or reported making a number of linguistic adaptations within primary healthcare appointments (Ault et al., 2019; Brisset et al., 2013; Estrada & Messias, 2018; Hale, 2007). For example, Major and Napier (2012) observed that Auslan healthcare interpreters often produced expanded renditions of both patient and practitioner utterances by adding structure and making implied meaning(s) explicit in their interpretations. Similarly, in a situational analysis of primary healthcare appointments, interpreters actively converted technical medical terminology to more common language for patients (Estrada & Messias, 2018). Interpreters were also observed or reported adapting practitioner and patient statements in order to better align with the cultural norms of participants (Ault et al., 2019; Lor et al., 2018; Rosenbaum et al., 2020; Williams et al., 2018). For example, interpreters mediated cultural differences between patients and practitioners in order to avoid cultural conflict and reduce cultural distance (Pendergrass et al., 2017; Rosenbaum et al., 2020). Thus, interpreters seem to often engage in a wide continuum of cultural-linguistic mediation.

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6 A signed language used in Australia.
Though the emergence of this category is unsurprising as linguistic and cultural brokering is a common component of a healthcare interpreter’s code of ethics, these mediations can have significant clinical impact (Angelelli, 2004; 2014). What remains unclear is how these subtle, and more extensive, forms of mediation are conceptualized by interpreters within the specifics of a consultation, given that there can be significant conflict between clinical needs and role expectations of interpreters working in healthcare (Estrada et al., 2015). As Gee (2004) points out, any statement in language is ultimately an assertion of a particular view on reality; thus, even a subtle linguistic or cultural shift may assert a different reality and change how patients and practitioners understand, interact, and relate to each other. However, some level of cultural-linguistic mediation work is required by interpreters when patients and practitioners do not share the same language, thereby raising the question of how healthcare interpreters experience and make sense of such ambiguity and pressures within their practice.

2.2 Interpreters’ Emotional Work

Similar to cultural-linguistic adaptations, interpreters have reported or been observed performing a significant range of emotional mediation work. Krystalldou et al. (2020) found that interpreters both mediated the meaning and intensity of patient empathic statements, alternately decreasing, increasing, or failing to interpret the emotional content of these statements. Similarly, in a discourse analysis of audio recordings of interpreter mediated healthcare appointments, Gutierrez et al. (2019) found that interpreters used several tools to facilitate empathic communication between patients and practitioners, such as saying that the practitioner was joking, softening statements, and including terms of endearment in their interpretation.

Conversely, there is evidence that interpreters often exclude the emotional and social content of talk, instead focusing on what they believe to be more clinically relevant information
(Greenhalgh et al., 2006; Hale, 2007; Hsieh, 2007). Some researchers suggest that this is a result of interpreters aligning themselves with those who have institutional power in the situation (the healthcare practitioners) (Hale, 2007; Wadensjö, 1998). This tendency to align with the practitioners may also be influenced by the precarious nature of many interpreters’ employment and, consequently, their place in social hierarchies. Many interpreters, including the majority of HSLIs in BC, are employed as contractors on a per-appointment basis (Hsieh, 2010; Williams et al., 2018). On the other hand, interpreters’ exclusion of social and emotional content may be due to a misunderstanding of practitioner communicative goals (Hsieh, 2007), or due to the cognitive demands of the interpreting task (Mapson & Major, 2021). Either way, the emotional and social work conducted or excluded by interpreters is an area that warrants further investigation, particularly as it points toward both the wide range potential influences on interpreters and the influence interpreters may have within a consultation.

Further complicating the emotional mediation work of interpreters are the often different expectations practitioners may hold of healthcare interpreters. Some practitioners saw the social-emotional aspects of communication as irrelevant to their work and expected interpreters to eliminate such statements (Hsieh et al., 2010). Yet, other practitioners actively sought to engage patients in emotional and social ways but were inhibited in doing so by interpreter reductions or exclusion of this type of content (2010). Such findings point toward the complexity of care and decision making within interpreter-mediated consultation. These findings may also indicate that some practitioners are unsure about interpreters’ scope of practice, which has negative implications for interprofessional collaboration (Canadian Interprofessional Health Collaborative, 2010), and may further complicate the navigation of patient-practitioner relationships.
2.3 Interpreters’ Relational Work

Lastly, interpreters have been found to engage in a wide range of relational mediation work as well (Greenhalgh et al., 2006; Pasquandrea, 2011; Robb & Greenhalgh, 2006; Schofield & Mapson, 2014). In a study examining healthcare practitioners’ perceptions of the work of British Sign Language Interpreters, it was reported that interpreters’ relationship with patients often helped to facilitate patient-practitioner relationship development (Schofield & Mapson, 2014). As Mapson (2020) and Mapson & Major (2021) point out, interpreters’ relational work requires an understanding of the patient’s expectations, goals, and habits of communication, making familiarity with the patient particularly vital. Not only does this point towards relational and interactional complexity, but it also highlights the ways that structural influences may come to influence patient-practitioner relational navigation. For example, whether employment structures prioritize the same interpreter attending multiple appointments between the same patient and practitioner so they can develop familiarity.

Previous research has noticed healthcare interpreters both creating barriers to and facilitating relational work between healthcare practitioners and patients. For example, there are occasions where possibly due to a lack of familiarity with the healthcare practitioner, interpreters seem to misunderstand practitioners’ relational attempts and, as a result, are seen as barriers to effective practitioner relational work (Hsieh et al., 2010; Hsieh & Kramer, 2012). Yet, interpreters’ have also been seen to mitigate statements that they identify as potential face threats or relational damaging statements between practitioners and patients (Gutierrez et al., 2019; Lor et al., 2018; Major, 2013; Schofield & Mapson, 2014). Adding further complexity, research on non-healthcare interpreters suggests that interpreters also do their own relational work to avoid relational threats themselves and others, particularly those in positions of structural power.
(Wadensjö, 1998). Therefore, interpreters’ relational actions may reflect an orientation toward patient care and protection of patient-practitioner rapport, or as a prioritization of interpreter face work. Nonetheless, it points toward interpreter-mediated interaction as a site of considerable complexity and one of the few circumstances where interlocutors may have conflicting interactional and relational frames and still effectively communicate with each other—though arguably never fully coming into contact with each other (Wadensjö, 1998). The question of how this complexity is experienced and navigated by healthcare interpreters in regard to patient-practitioner relationships within consultations remains unclear.

There is clear evidence that interpreters actively adapt or modify emotional, relational, and cultural-linguistic discourse during healthcare consultations. Moreover, the types and range of mediation work healthcare interpreters have been noted engaging in seems to range significantly. However, what is less clear is what goals and factors may lead healthcare interpreters to change their work within and between consultations, and how they conceptualize such adaptations.

2.4 Interpreter Mediation: Collaboration and Negotiation on Unclear Grounds

As highlighted above, research has found that interpreters engage in a wide range of decision making in the form of mediation work within health settings. This mediation work is inter-relational as social work is only successful in how it is experienced by other interlocutors (Roy, 2000; Gee, 2004)—in this case, most often patients and practitioners. Thus, as social acts, the context, perspective, and experience of interpreter mediation is vital to understanding how it affects and shapes patient-practitioner relationships. While little research exists on this topic, several scholars have called for research about the ongoing negotiations between patient,
practitioner, and interpreter (Estrada & Messias, 2018; Gutierrez et al., 2019; Krystallidou & Pype, 2018).

There is evidence that how patients and practitioners understand and experience the mediation work of healthcare interpreters is influenced by a number of complex factors, some of which were hinted to in the previous section but bare explicit discussion within the context of this study. Practitioners’ experience and evaluation of interpreter mediation seems to be influenced by their expectations of interpreters and consultation goals (Ault et al., 2019; Hsieh et al., 2010; Roter et al., 2020); the familiarity and trust between the practitioner and interpreter (Major & Napier, 2019; Mapson & Major, 2021; Paananen & Majlesi, 2018; Pendergrass et al., 2017; Schofield & Mapson, 2014); and, finally, patient-interpreter trust and relationship (Major & Napier, 2012; Schofield & Mapson, 2014). These factors seem to suggest the outcome of any interpreter mediation work and action is interrelated to a number of visible and less visible factors, with any single interpreter mediation potentially being experienced in a number of ways by the other participants within the consultation.

2.5 Summary of Literature Review

Previous research has shown evidence that not only do interpreters engage in considerable emotional, relational, and cultural-linguistic mediation work, but that the effect(s) of that work is highly contextual. Yet, little previous research has explored the ways that healthcare interpreters conceptualize and navigate relational-interactive work between patients and practitioners within consultations, particularly in Canada. Considering the complexity of their work, and the importance of patient-practitioner relationships, understanding the perspective of healthcare interpreters seems vital to improving interpreter-mediated relational-
interaction work. In conclusion, this study was designed as a problem-based interdisciplinary research project, aiming to address the gaps in our current understanding as outlined above.
Section 3: Research Design and Methodology

3.1 Guiding Philosophical and Theoretical Framework

3.1.1 What is Phenomenology?
Phenomenology is at once a philosophical orientation and research methodology (Vagle, 2018). Philosophically, it challenges the mind-body dualism of Cartesian thinking, suggesting that human consciousness is always meaningfully intertwined with the world (or of the world) rather than cut off from it (Vagle, 2018). Methodologically, phenomenologists are interested in studying phenomena as experienced by humans (Vagle, 2018; van Manen, 2017). Often, phenomenology is interested in gathering material that allows the researcher to more vibrantly and richly understand a particular everyday or ordinary experience (Vagle, 2018). Plainly and simply put, phenomenology is the study of human experience that aims to produce a richer understanding of our everyday world, generating insights into experiences that are assumed to be obvious, simple, or otherwise overlooked.

3.1.2 What I Mean by Post-Intentional Phenomenology and Why I Chose to Use this Approach
“Phenomenological research is in a constant state of becoming” and thus there are a wide range of branches of phenomenology (Vagle, 2018, p. 11). Each of these branches shift the assumptions, processes, and practice of phenomenology in meaningful ways. I surveyed a number of branches of phenomenology and chose to use post-intentional phenomenology as described by Vagle (2018). Below I briefly provide a summary of post-intentional phenomenology as well as a rationale for its use to guide this research.

Post-intentional phenomenology, as described by Vagle (2018), draws on and combines post-modern and phenomenological thought. This is a complex and tentative combination, as the fundamental assumptions of these paradigms are unique (Vagle & Hofsess, 2015). This shift
reconceptualizes phenomena as “unstable, contextualized, and historicized deconstructions” (Vagle & Hofsess, 2015, p. 355), suggesting that one cannot simply trace the consciousness of a phenomenon to the phenomenon itself as everything is already complexly interconnected and entangled (Vagle, 2018). As such, this type of phenomenology shifts the focus of this study from description or interpretation of a stable essence to the ways that phenomena are multiple and are constructed and reconstructed through social factors (Soule & Freeman, 2019). That is, in post-intentional phenomenology, researchers are always seen to enter into the middle of intentionality\(^7\), and intentionality is always changing and in the process of becoming (Soule & Freeman, 2019; Vagle, 2018). Thus, while it seeks to illuminate the phenomenon, post-intentional phenomenology primarily focuses on the ways that “all phenomena are the effects of interpretive processes and are therefore open to re-interpretation” (Soule & Freeman, 2019, p. 869).

Post-intentional phenomenology is well aligned with the primary focus of my research as I am interested in not only the phenomenon of patient-practitioner relationships in interpreter-mediated healthcare consultations, but also how lifeworld, social, and contextual elements come to shape and reshape this phenomenon. Additionally, this approach, via the posting of intentionality, is interested in the different, contested, and changing experiences of phenomena both between people and across time (Vagle, 2018, p. 130).

Furthermore, post-intentional phenomenology was well aligned with the intercultural, interlinguistic, and interprofessional nature of interpreter-mediated healthcare consultations and this research. It supported my sensitivity to the various ways that the phenomenon of navigating

\(^7\) Intentionality is understood as “the ways in which humans are connected meaningfully to the world” (Vagle, 2018, p. 126).
patient-practitioner relationships is shaped and experienced. In turn, this process helped to reveal the fluidity of effective navigation of relational-interactive work and the ways that larger factors uniquely shape each consultation. Finally, on a more personal note, this form of phenomenology deeply resonated with my experience of the complexity of interpreter-mediation and my lived experience as a disabled person. In conclusion, I believe drawing on this form of inquiry helped me to build a meaningful, complex, challenging, and fruitful thesis research project.

3.1.3 A Visual Metaphor of My Understanding and Use of Post-Intentional Phenomenology

I have always felt a pull and connection to flowing water and in this connection, I have always felt most calm. Recently, on one of my many reflective walks, I realized that a river is a wonderful metaphor to describe how I understand post-intentional phenomenology. Below I present this metaphor in the hopes that it helps to clarify and describe my viewpoint.

![Figure 1. A photo I took of a small stream flowing around rocks.](image)

I see lived experience like the water flowing in this photo, always in motion. At the same time, it is always in inter-relation to the water around it, the rocks, the temperature, and current;
it is always meaningfully connected to the world. Indeed, it is hardly possible to understand the water in isolation, without the flow, movement, and interconnections between the water and the world around it. From moment to moment, it changes, and over the longer term it may become different to the extent of being unrecognizable. By using post-intentional phenomenology, I chose to focus on the ways the river flows, changes, and takes different shapes in interconnection to the world around it. That is, I chose to see and focus on the messy, unstable, and flowing connections people have with the world, and what they might help me to understand about the larger social and power structures that shape our lived experiences. So, I am interested in the unstable interconnections between the water (lived experiences) and the world around it. Through this, I hoped to point toward the possibility of social change: if we can better understand, discuss, and feel how the river is shaped by its interactions with the world, we are in a better position to reshape it.

3.2 Recruitment and Description of Participants

Below I describe the recruitment process used in this research. It is important to note that, originally, I had planned to recruit Healthcare Sign Language Interpreters (HSLIs), HealthCare Practitioners (HCPs) and deaf patients to this study. However, due to fiscal and time constraints, I chose to focus on HSLIs early in the recruitment process. This decision was made before any deaf patients or HCPs were recruited to the study. Thus, the description below focuses on the recruitment of HSLIs, as no people from other stakeholder groups were ultimately recruited.

3.2.1 My Approach to Recruiting Participants

I recruited my participants via a digital recruitment advertisement shared on the listserv of the Westcoast Association of Visual Language Interpreters (WAVLI), the provincial professional association for Registered Sign Language Interpreters in British Columbia, Canada. While most participants were recruited from the WAVLI listserv, some were given the digital
recruitment advertisement by their colleagues. Respondents were asked to contact Bryan Hemingway directly via email to express their interest.

3.2.2 Inclusion Criteria
All recruited participants had to meet the following criteria:

- At least two years of experience interpreting in primary healthcare settings
- Current BC Accredited Medical Sign Language Interpreter status or a Deaf Interpreter registered with WAVLI and the Canadian Association of Sign Language Interpreters
- Have worked as an interpreter in a primary healthcare setting within the last two years
- Have access to computer with webcam and internet access, sufficient to use Zoom

3.2.3 Description of Participant Selection Method
Ultimately, nine hearing Healthcare Sign Language Interpreters (HSLIs) expressed interest in participating in the research. From this initial group, I used purposeful sampling to select the six participants with the most diverse range of backgrounds and experiences possible. I believe this approach to sampling helped me to better understand various experiences with the phenomenon by providing a wider range of lived experiences.

3.3 Description of Recruited Participants
At the time of writing, there are only around 50 individuals in British Columbia who hold the Accredited BC Medical Registered Sign Language Interpreter qualification. With such a small number, there is a significantly increased risk of deductive disclosure (i.e., where general descriptions allow for some readers to identify the participants). For this reason, rather than describing each participant individually, I summarize the demographics of the participants in aggregate below.
### Table 1. Description of Recruited Participants

<table>
<thead>
<tr>
<th>Demographic Quality</th>
<th>Range Represented in Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34 to 53 years old</td>
</tr>
<tr>
<td>Gender</td>
<td>5 women, and 1 male</td>
</tr>
<tr>
<td>Years of Experience in Healthcare Interpreting</td>
<td>5 years to more than 20 years</td>
</tr>
<tr>
<td>Years of General Interpreting Experience</td>
<td>11 years to more than 20 years</td>
</tr>
<tr>
<td>Notable other demographic information</td>
<td>1 interpreter identified as queer; 1 identified as a Child Of a Deaf Adult (and had been using ASL their whole life); and 1 interpreter had a Deaf sibling</td>
</tr>
</tbody>
</table>

### 3.4 Description of Data Collection Methods

#### 3.4.1 Phenomenological Interviews

In this research project, I collected phenomenological descriptions through individual recorded online semi-structured interviews with six highly experienced Accredited BC Medical ASL-English interpreters. Each interview lasted between 55 minutes and 1 hour and 20 minutes, with additional time provided to orientate participants and conclude the interview (see below and Appendix One for additional information). As all participants were hearing, each interview was conducted in English (as preferred by participants), and was auto-transcribed via Zoom. In part, interviews were guided by the rich picture drawings prepared in advance by participants (described below).

**Areas of Inquiry.**

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8 Due to the imprecision of auto-transcription and to improve the quality of the analysis, all early analysis processes were conducted using a split-screen where the video, audio, and transcript were all displayed. Early analysis included reviewing and improving each coded segment of the transcript, to ensure it was reflective of the content provided by participants.
Below I outline the areas of inquiry that guided the interview (see Appendix One for a full list of questions in the interview guide).

- Examples and experiences of effective and less effective interpreter and healthcare practitioner relational-interactive work in interpreter-mediated primary health consultations
- Systemic and contextual factors that influence patient-practitioner relationships
- Factors that come to bear on patient-practitioner relationships, and how these factors were navigated

**Description of Interview Process.**

The interviews I conducted followed a general structure, though varied based on emergent elements within each unique interview. Overall, the interviews began with a focus on an example of a non-emergency healthcare consultation where the HSLI felt effective patient-practitioner relational work had taken place, guided by their rich picture drawing (described below). After, we focused on an appointment or a few appointments with less effective relational-interactive patient-practitioner work. Finally, HSLIs were asked if they had any recommendations for improving relational-interactive work in non-emergency consultations and if they had anything else they wanted to add before completing the interview.

The interview process was designed to be collaborative and interactive, with participants and researchers encouraged to ask questions and co-construct meaning (Tracy, 2020). Indeed, I would argue that the use of the rich picture method helped to further this collaborative stance by allowing participants to more actively guide the interview. As an experienced healthcare interpreter myself, I have my own experience of the phenomenon; however, I recognize that how phenomena are experienced are multiple, fleeting, and partial (in line with Vagle’s perspective...
(Vagle, 2018)). By working towards making interviews comfortable and dialogic, I was able to obtain richer and more diverse lived experience descriptions, rather than just pursue the areas that felt relevant based on my own practice experience.

3.5 Use of Arts-Based Interview Elicitation: The Rich Picture Method

In this research, I used an arts-based interview elicitation technique called the rich picture method. The rich picture method asks participants to draw a “pictorial representation of a particular situation, including what happened, who was involved, how people felt, how people acted, how people behaved, and what external pressures they acted upon” (Cristancho & Helmich, 2019). In turn, these drawings depict a situation or experience with few to no words and with little external structure imposed on them (Armson, 2011). Thus, participants are able to construct their own structure, helping to make visible the connections that shape their experience. During the interview, the completed rich pictures are then jointly explored by researcher and participant, supporting richer interviews and analysis (Cristancho & Helmich, 2019; Cristancho, 2015).

3.5.1 Rich Picture Drawing Use During Data Collection

Drawing on and adapting the work of Cristancho (2015), Cristancho and Helmich (2019), and Armson (2011), I asked each participant to draw their experience of an effective patient-practitioner relationship in an interpreter-mediated non-emergency healthcare appointment (see Appendix Two for specific participant instructions). Participants were asked to take 15-30 minutes to draw this experience and to send it to me prior to our online interview via an encrypted survey platform. They were not provided any example or template for their drawing, allowing them to freely create the structure and content. As they drew their experience, they were asked to include all relevant influences, feelings, people, context, physical and psychological factors, and any other elements that shaped their experience of an effective
patient-practitioner relationship. Finally, participants were asked to focus on their own experience and were encouraged not to worry about the aesthetic qualities of the drawing.

Each participants’ rich picture drawing was then used to facilitate discussion during their phenomenological interview. Specifically, interviews began by asking each participant to provide a detailed description of the consultation and the factors they chose to include in their rich picture. After this detailed description, I used follow-up prompts to explore additional aspects and clarify their experience of navigating effective patient-practitioner relationships in interpreter-mediated consultations. Thus, the rich picture drawings helped to guide interviews with participants, supporting richer and more participant-led interviews.

3.5.2 Rationale for and Benefits of Using the Rich Picture Method

When dealing with complexity and complex systems, such as interpreter-mediated healthcare consultations, what we choose to focus on deeply shapes our understanding(s) of that system and situation (Diez Roux, 2011; Wright & Meadows, 2009). The inclusion of the rich picture method in this study proved to be an accessible and engaging way for participants to help define the elements that shape their experience of interpreter-mediated patient-practitioner relationships. In turn, this helped to define the complex situation from their own viewpoint, rather than based only on the questions I asked. Similar to the arts-based process used in Cohen-Miller’s 2017 transcendental phenomenological study, I found that rich picture drawings supported a deeper level of understanding and discussion between myself and the participants in this study. Indeed, several participants commented that engaging in the rich picture drawing process helped them to reflect more deeply on their experience and include important elements that they may have otherwise failed to mention during their interview.
3.6 Self-Reflexive Journal

A self-reflexive\(^9\) journal was used as an additional point of data collection and analysis throughout the research process, as suggested in Vagle (2018). This self-reflection journal was used to document, better understand, and focus my ongoing and evolving journey with the phenomenon—a process termed ‘bridling’ in Vagle (2018). Specifically, it served as a site to interrogate, understand, guide, and reflect on the ways that my own lifeworld came to bear on the phenomenon being explored. At the same time, it allowed me as a scholar-practitioner to consider the ways that the research itself provoked and constructed specific types of knowledge and understanding. Finally, this journal allowed me to reflect on the ways that this phenomenon is experienced as multiple, contested, and at times conflicting (Soule & Freeman, 2019; Vagle, 2018). Overall, my self-reflexive journal served as a site to deepen my own understanding, reflexivity, and worldviews related to the focus of this study.

3.7 Data Analysis

3.7.1 My Orientation to Analysis

In this thesis, I drew on phronetic iterative analysis, as described by Tracy (2020), and was guided by Vagle’s post-intentional phenomenology and post-intentional analysis process (2018). Tracy’s approach centers on phronesis, that is, the generation of novel and practical wisdom that helps to promote action and social good (2020, p. 282). This approach to analysis aims to arrive at practical and novel wisdom through iterative analysis processes, moving between the analysis of collected data on one side and research questions and theory on the other (Tracy, 2020). Thus, this approach to analysis helped me to remain orientated and open to the emerging shapes of the phenomenon itself (Vagle, 2018; van Manen, 2017) and the ways it takes

\(^{9}\) Reflexion, self-reflexive, and self-reflexion is used in this research to denote a critical form of contemplative inquiry as described by Vagle (2018). Thus, it is used distinctly from general reflection.
shape through social context (Vagle, 2018). Moreover, this process was generally in line with what Vagle (2018) calls ‘thinking with theory.’ In the end, this approach was well aligned with my goal of producing useful, novel, and insightful research.

As both phronetic iterative analysis and post-intentional phenomenology see knowledge, learning, and research as built within specific social, temporal, and physical context(s) (Tracy, 2020; Vagle, 2018), they provided me with conceptual tools to become aware of and navigate my own perspective(s) as a HSLI with 13 years of interpreting experience and as disabled person as I engaged in this research. Below, I summarize the analysis process that I engaged in, as guided by phronetic iterative analysis and post-intentional phenomenology.

3.7.2 Non-Coding Analysis Processes Used
Data Familiarization Processes.

Inspired by Max Van Mannen’s whole-part-whole analysis (2017), prior to beginning any coding processes, I would listen through recorded interviews in full at least twice. As I engaged in these listening sessions of the interviews, I would take high-level notes and create entries in my self-reflexion journal. By listening to these interviews in broad ways, it helped to open myself up to new ways of knowing a phenomenon that I have experienced as both an HSLI and a patient. Additionally, the entries in my self-reflexion journal helped me to interrogate my own perspective, and the feelings that emerged in my body and mind as I engaged in these broad listening sessions. Finally, after each of these listening sessions, I would refer to the rich picture drawings, which helped to remind me of the larger context of the experience as I would often get lost in details even at this stage.

Tracing My Own Lines of Thought: Using an Analysis Activity Tracking Spreadsheet.
Throughout the coding and analysis process, I kept track of the details of activities I used within a spreadsheet. By using both an analysis activity tracking spreadsheet and a self-reflexion journal, I was able to better trace the analysis activities that led to specific lines of thought or insights. The ability to audit my own lines of thought is vital in post-intentional bridling\(^{10}\) (Vagle, 2018) and an important aspect of quality in abductive analytic processes (Rinehart, 2021; Timmermans & Tavory, 2012). The combination of the self-reflexion journal and analysis activity tracker allowed me to better bridle and understand how this research shaped my connections to the world and how this research is shaped by my connections to the world.

**Use of Rich Pictures During Analysis.**

The rich picture drawings created by participants were a salient point of data for analysis as they outlined the elements and interconnections of their experiences with the phenomenon. While interview data took precedence during the coding analysis process, the rich picture drawings were central points of reflection that I revisited regularly throughout the primary and secondary analysis process described below. Specifically, I used the rich picture drawings to help me continually revisit the macro-level context and connections highlighted by the participants. During the first-level and secondary-level coding process, I reviewed the rich picture drawing of the participant interview I was coding prior to and after each coding session.

### 3.7.3 Coding Analysis Processes

#### First-Level Open-Coding.

My first-level coding took place as interviews were continuing and focused on identifying aspects of recorded interviews that were relevant to my primary research question. Highly specific codes were created in order to remain highly sensitive to each interviewee. Thus,\(^{10}\) Bridling is a process used to remain more open to the phenomenon and how it is experienced (Stutey et al., 2020; Vagle, 2009, 2019).
initial coding resulted in a large number of descriptive first-level codes, which were integrated into more general descriptive codes as first-level coding continued. This integration into more general descriptive codes took place as the interview process was nearing completion.

Using ATLAS.ti, each descriptive first-level code was assigned both descriptive codes and filtering codes, allowing a more robust relationship network between codes to be developed. The filtering codes were:

- **Perception of influence**: positive, negative, complex
- **Source(s) of Influence**: Healthcare provider and staff, interpreter, systemic/structural/contextual

Therefore, each code was labeled with the following attributes: a descriptive label, perception of the influence, and source(s) of the influence. This allowed me to search, explore, and better compare my growing understanding of the phenomenon.

**Secondary-Cycle Coding and Use of Theory.**

As I neared completion of my descriptive coding, I began to examine the interconnection of various descriptive codes. As I did, I played with and generated various ways of organizing descriptive codes in ways that created meaningful themes\(^\text{11}\). It is during this process I began exploring and bringing theory into conversation with the data as a lens. This process of creating themes and exploring theoretical lenses often caused me to go back to re-examine descriptive coding. Sometimes, I would quickly realize that a theme or theory was misaligned with the descriptive codes and, at other times, this realization happened slowly. After trialing several theories, I found systems theory (Wright & Meadows, 2009) and complexity theory (Fraser &

\(^{11}\) To me, meaningful themes are those that help to draw out the larger elements that I noticed through the various interviews. That is, they are nodes that help me to more clearly tell the research story I was seeing in the data.
Greenhalgh, 2001; Newell, 2001; Greenhalgh & Papoutsi, 2018) to be the best fit in terms of alignment and generated insights. These theories helped me to consider and focus on the interconnections between actors and elements within a consultation, rather than just the actors or elements alone. Throughout this process, themes that were not novel or insightful were set aside in order to refocus my energy on elements that seemed to have practical wisdom.

**Use of Negative Case Analysis During Second-Cycle Coding and Use of Theory.**

As these iterative cycles of theming, applying theory, and re-examining descriptive codes started to settle and solidify, I utilized negative case analysis (Tracy, 2020) to identify potential themes and emergent understandings that were interesting but misaligned with the experience shared by participants. I used interview data when re-examining specific features, complemented by the rich picture drawings, which provided a point of large scale reflection of the overall consultation experience being examined. This process helped me to better understand my own influences on the interviews and rich pictures as it prompted me to consistently examine the source(s) of my insights, allowing me to stay closer to the perspectives shared by participants.

**3.8 Summary of Analysis Process**

In summary, my analysis process is best conceptualized as ongoing cycles, moving from insights generated from collected data, reading and considering various theoretical lenses, and writing and reflecting on my ongoing understandings of the topic. Through these cycles, I was able to better understand the experiences of the participants with the phenomenon of interpreter-mediated patient-practitioner relationships and generate the themes explored below. It is my hope that these themes contain novel and practical wisdom that can help to inform healthcare and interpreter practice, practitioner education, and policy, but that is something I leave up to the readers of this thesis to evaluate.
Section 4: Results

For the experienced HSLI participants, navigating relational-interaction in non-emergency healthcare consultations was an ongoing process of becoming aware of and adapting to the contextual factors present within specific consultations. Far from being passive, they often actively drew on strategies to better adapt to and build an environment that was supportive of patient-practitioner relational-interaction. In the absence of more official learning processes, most participants drew on less explicit sources of information to continually refine their work within consultations. For the participants, what constituted effective navigation of relational-interactive work in non-emergency healthcare was relative to the specifics of a consultation. Thus, participants stressed sensitivity, awareness, and adaptability as key qualities required for HSLIs to effectively navigate the complex and shifting web of interconnected factors that influence relational-interaction within healthcare consultations.

Table 2: Themes and Theme Components

<table>
<thead>
<tr>
<th>Themes:</th>
<th>Theme Components</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Effective Navigation is Responsive to Contextual Factors</td>
<td>1. Responding to Who Healthcare Providers and Patients Are</td>
</tr>
<tr>
<td></td>
<td>2. Responding to Physical and Temporal Space</td>
</tr>
<tr>
<td></td>
<td>3. Responding to the Socio-Cultural Context</td>
</tr>
<tr>
<td>2. Using Strategies to Support and Adapt to Context</td>
<td>1. Leveraging Contextual Knowledge</td>
</tr>
<tr>
<td></td>
<td>2. Building Comfort and Trust with Patient and Practitioner</td>
</tr>
</tbody>
</table>
3. Drawing on a Somatic Sense to Navigate Relational-Interactive Work

<table>
<thead>
<tr>
<th>3. Adaptation to the Evolving Complexity of Healthcare Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adaptation is an Ongoing Process</td>
</tr>
<tr>
<td>2. Balancing Conflicting Factors within Consultations</td>
</tr>
<tr>
<td>3. Reduced Information Increases Complexity and Uncertainty</td>
</tr>
</tbody>
</table>

4.1 Theme 1: Effective Navigation is Responsive to Contextual Factors

There was no universal, one-size-fits-all approach for navigating effective relational-interactional work between patient and practitioner in interpreter-mediated non-emergency care. Rather, for the HSLI participants, effective navigation of relational-interactive work required an understanding of, and adaptation to, the people, spaces, and places involved in the consultation. Participants highlighted this complex web of factors in their rich pictures, often drawing a complex or abstract web of factors that influenced their work within a consultation. Outlined below is one such rich picture drawing.
Reflecting on this drawing, HSLI #4 described: “This is my second drawing. The first time I just started drawing it, and I had really made the center part [the consultation] a lot bigger... I was like “Oh no I got to scrap this,” because that's only a very small part of the interaction... As practitioners, we know that, we recognize that. But, maybe it's not quite so obvious all the time. So, yeah, so I kind of just realized how important the various contexts and people's various backgrounds are [to effective relational-interactive work].”

The rich pictures helped to reveal the complex web of factors that shaped effective relational-interactive work within a consultation, from microscale elements such as a patient’s current state of mind to macroscale socio-cultural contexts such as the structural barriers faced by HSLIs in specific spaces. In turn, the interviews highlighted the importance of HSLIs adjusting their work to these factors to effectively navigate relational-interactive work. HSLI #3 put it well when they said, “It's a lot to juggle and manage[...] but all of those pieces are really, really crucial to the whole thing [the consultation] going well.” Below I outline some of the contextual factors identified by the six experienced HSLIs that I interviewed.
4.1.1 Responding to Who Healthcare Providers and Patients Are

The participants emphasized a need to be sensitive and adapt their work to the specific deaf patient and health care providers in the consultation. Interpreters reported adapting their work based on their understanding of patients’ health literacy, fluency in the dominant culture’s written language, potential sources of support in their lives, and their current emotional and mental state. HSLI #1 described adjusting their interpreting work depending “on the needs of the deaf person. If it's a very academic savvy deaf person versus a deaf person who lives in a group home who needs extra support[...] There's a spectrum, and it [their interpreting work] depends [on that].” Based on their assessment of where the deaf patient falls on a spectrum of factors, participants described adjusting the speed of the interaction, seeking additional contextual or visual information from the HCP, drawing or using visual aids to convey anatomical structures, and modifying their language use.

Similarly, HSLIs often adapted their own relational-interaction work to align more closely to the HCP’s own interactional approach to the patient, for example taking on a more jovial style when a HCP was more jovial with the patient. Though it is atypical within British Columbia, HSLI #5 described how informal debriefing sessions with a nurse allowed them to better understand the nurse’s own interactional approach, describing, “[The debriefing discussions with the HCP help me] know the bigger picture, which is really helpful when I'm interpreting for the nurse. Because the nurse is definitely trying to present a non-threatening, supportive, “We have your back, we are always on your side” [message][...]I know they want to maintain that relationship in the forefront. It is really helpful [knowing that] and really shapes my decisions, and languaging, and even body posture.” With this better understanding, or “bigger picture,” of the nurse’s supportive approach to interaction with the deaf patient, HSLI #5 was able to adapt how they presented themselves and interacted with the patient, saying they
were “trying to be really non-threatening in my body language. [With this awareness] I am very much informal in how I'm sitting and my facial expression, and how much eye contact I am making, and how I attempt to get attention when the attention is not given [by the deaf patient].”

While debriefing sessions with HCPs were not reported by other participants, this type of alignment to the HCP’s interactional approach was. HSLIs refined and adapted how they navigate relational-interactive work in several ways to align with HCPs, which made deep understanding of and sensitivity to the HCP’s interactional and relational work and goals vital to their work.

4.1.2 Responding to Physical and Temporal Space

HSLIs also emphasized the need to adapt to the various physical spaces of consultation rooms, and recognized that where they stood or sat could impact opportunities for deaf patients and practitioners to visually and physically orientate to each other. As HSLI #1 explained, where they choose to stand might impact the potential for relational-interactive work, describing, “Where do we position ourselves? Anything that we do within that two by two room can really impact the relationship.” Several participants described wanting to position themselves in ways that were comfortable to HCPs and deaf patients and provide them opportunities to physically and visually orientate to each other. As HSLI #3 described, it is vital to be cognizant of these facts as “from the time you walk in in the waiting room, where do you sit, where do you put your bags and stuff like that [...] sends a message, they do impact the interaction and communication. The ability for the practitioner and the patient to have their own interaction and their own relationship.” By monitoring and adapting to the various physical layouts of the consultation rooms, HSLIs seek to make literal physical space for participants to engage visually with each other.
The addition of the interpretation process can limit the time available for HCPs and deaf patients to connect, and, as such, HSLIs reported adapting how they navigated their work to make more time for effective relational-interactive work. For example, HSLI #6 reported deciding not to educate HCPs about the interpreting process when they perceive a time pressure, saying, “[HCPs] think it's [interpreting] word for word and don’t know why there's a delay and it's just you don't have that time to educate in those situations.” Unfortunately, HSLIs indicated that education about the interpreting process was critical to relational-interactional work. Without this education, HCPs could misunderstand pauses or delays in the production of an English interpretation as meaning that the patient is done with their statement or does not have any follow up questions. These misunderstandings led to, as HSLI #5 described, moments where the “doctors are cutting patients off in their stories” unintentionally, or moments where a HCP leaves the consultation prior to the patient having an opportunity to ask clarifying questions about their health condition or medication.

Though HSLIs reported that removing this time pressure would be ideal for promoting effective relational-interactive in interpreter-mediated consultations, when HSLIs did perceive time pressures, they actively adjusted their work to balance relational-interactional needs and time pressures by modifying: linguistic features in their interpretation, how they interacted with HCPs and deaf patients, and the discourse strategies they used to navigate their interpretation within the consultation (among other adaptations).

4.1.3 Responding to the Socio-Cultural Context

Effective navigation of relational-interactive work was also tied to a sensitivity and awareness of the larger social context(s) at play within a consultation. For example, when
working in the DownTown East-Side\textsuperscript{12} (DTES), the interpreters mentioned adapting how they approached their own relational work as well as how they represented the relational work of the HCPs within their interpretations. As HSLI \#4 described, “I feel like [the context of the DTES] changes how I show up. I think I go in just wanting to be as non-judgmental as possible and not wanting to be another barrier, you know? Making somebody feel uncomfortable or like they can't disclose certain things.” Similarly, HSLI \#5 added that working in the DTES often shaped how they represented relational-interactive discourse of HCPs within their interpretations, saying, “In the Downtown East-Side, when it's people who have very significant health concerns... If I feel like the practitioners are trying to demonstrate respect in any way[...] then I try to really be respectful in my interpretation. I try to make that really explicit in my choices and my body language and the timing.” Thus, how an HSLI chose to engage in their own and represent the relational-interactive discourse of others appeared to be linked to an awareness and active navigation of the larger social context(s) at play within a consultation.

4.2 Theme 2: Using Strategies to Support and Adapt to Context

HSLIs actively engage in activities that help to prepare themselves and others to successfully navigate the complexities of interpreter-mediated relational-interactive work within healthcare consultations. As HSLI \#1 described, “Our presence will change the dynamics between the healthcare worker and the deaf person and being aware of that I think we are able to navigate ourselves better.” HSLIs reported taking steps to promote comfort and trust in patients and HCPs, leverage contextual knowledge, and, for some, drawing on a somatic sense.

\textsuperscript{12} An area of Vancouver, British Columbia with a disproportionate representation of people experiencing social and health inequities, such as poverty, under addressed mental and physical health concerns, and homelessness.
Engaging in these strategies allowed HSLIs to adapt their practice and promote conditions that were supportive of relational-interactive work in non-emergency healthcare consultations.

4.2.1 Leveraging Contextual Knowledge

HSLIs reported using contextual knowledge of the specific people and consultation to adapt their interpreting work and support a better exchange between patients and practitioners. For example, HSLI #6 described the benefit of using additional context to refine their interpreting work, saying, “When you have that background—you were there for the colonoscopy appointment and now you’re doing the follow up three months later[...] You know what’s going on [in the consultation]. You just get all that stuff, it just comes. It's just smoother.” Going on to add, “[when] you understand what the deaf patient is going through, then you can translate that, interpret that much smoother into what the health care practitioner needs to hear.” They went on to contrast this with an experience when they had little working context, saying, “I had no idea, you know, why he [the patient] was going there, you know?... And then you start talking about stuff and I was like, “I don't know what you are talking about... I just need a little bit more background.” Then I would have been okay, I can make sign choices that are better.” For the participants, having and utilizing contextual knowledge of the patient’s history allowed them to align their work to produce interpreted discourse that better met the needs of everyone involved.

Participants reported gathering this vital background knowledge in three ways. First, HSLIs used booking information such as the address and HCP’s name to do online research prior to the consultation about potential socio-cultural factors and medical jargon they may need to interpret. Second, when working with deaf patients they had not met before, HSLIs utilized waiting room conversations to learn about who the deaf person is and their reason(s) for the medical appointment. For example, HSLI #4 reported even adapting their practice to maximize
the chances of having pre-appointment conversations: “I try to get there [to the consultation] a little bit early and hope that the patient is there as well, especially if it's somebody that I've never met before. I find that, for me, that can be really important.” Finally, when HSLIs had worked with the same HCP and deaf patient regularly, they used their previous experiences to help them navigate interactions between patients and HCPs, for example, by more easily responding to and conveying differences in participants’ behavior or communication styles and differentiating between new or already known information. Thus, background knowledge was seen as a vital resource for effective navigation of HSLI’s work.

4.2.2 Building Comfort and Trust with Patient and Practitioner

Another strategy the HSLI participants used was engaging in activities to build rapport with deaf patients and HCPs in consultations. Participants felt that when HCPs and deaf patients trusted them and felt comfortable with their presence, it helped to support relational-interaction between the patient and practitioner. Working together regularly was identified as the ideal way of developing comfort and trust with patients and practitioners. However, when working with people that they were less familiar with, HSLIs tried to strategically use waiting room conversations and introductions to build comfort and trust with deaf patients and HCPs respectively. Thus, engaging in these activities both helped HSLIs more effectively align their work and support a conducive environment for relational-interactive work within healthcare consultations.

In addition to information gathering (as described above), HSLIs often utilized time in the waiting room to build working rapport, trust, and comfort with deaf patients, often discussing deaf community news or general informal small talk. They felt this helped them to attune their linguistic-interactional approach, as well as create a supportive context for interactions between patient and practitioner. These informal conversations also provided an opportunity for deaf
patients to engage in informal language assessments, a common way that interpreters and deaf people broker trust. This was summarized by HSLI #1 when they said that having a conversation in the waiting room “automatically starts some kind of trust. And also by having that communication, they [the deaf patient] can see my signing style too, right? And it's not just I need to see yours, they need to see mine, to see where my [language fluency] level is at. That usually contributes to more of a trusting communication and more of a relationship there between us [deaf person and HSLI] and then that [trust] naturally builds a relationship with the hearing person [and deaf person] too.”

This type of trust and working rapport was seen as uniquely important due to the often private and sensitive nature of healthcare conversations. As HSLI #6 described, “I think talking about yourself [to the deaf patient], who you are and stuff, is important as well... Because you are a stranger going into this person's medical room talking about their health, right, that's a huge thing, and so they need to have a bit of rapport.” By sharing some information about themselves, HSLIs attempt to support patient comfort by humanizing themselves. Indeed, as HSLI #6 noted, when HSLIs fail to humanize themselves, this “can affect the relationship in the room [consultation]”. Thus, HSLIs engaged in waiting room conversations with the explicit goal of optimizing the relational context of healthcare consultations through building rapport and trust with the deaf patient.

HSLIs reported that when HCPs appeared uncomfortable with their presence, it could negatively impact the relationship between the HCP and the deaf patient, and therefore took steps to decrease this discomfort. HSLI #2 summarized this point when they said, “I want them [HCPs] to have a positive experience with the interpreter. I don't want them to think, "Ugh, that person." And the reason they're thinking that is because of the interpreter, not because of the
deaf person, [but] they easily attach us, right? So if there's frustration with the interpreter they automatically just transfer that.” As it is not common practice in British Columbia for HSLIs and HCPs to meet prior to or after consultations, HSLIs reported trying to optimize their short introduction with the HCP to promote a sense of comfort. For example, HSLI #5 reported engaging in facework when meeting a HCP they had not previously worked with, describing, “I try to be really polite. Even if they are asking stupid questions [about interpreting], I'm really super polite. I want to really give them really good facts. And I want them to feel respected, that I'm a professional. That I'm not someone they have to be careful in front of because they don't trust me.” Thus, the HSLI participants identified that HCP comfort was a key factor in promoting effective patient-practitioner relational-interaction and engaged in forms of presentation and rapport management to promote this comfort in HCPs.

4.2.3 Drawing on a Somatic Sense to Navigate Relational-Interactive Work

Some of the HSLIs I interviewed seemed to draw on a bodily, somatic, or felt sense as a strategy for navigating relational-interactive work in healthcare consultations. Though not all of the HSLIs described such experiences, HSLI #2 and HSLI #5 both described using their felt sense of physical comfort or discomfort to navigate relational-interactional work. HSLI #5 described knowing that a complex appointment contained effective relational interactive work when they “felt very calm in my body the whole time. So that is a good thing to me, that things are going well [in the interaction].” Later, they contrasted this experience with a situation where they were less able to effectively navigate the complexities of the consultation, indicating they felt a sense of bodily discomfort. Similarly, contrasting effective and ineffective examples, HSLI #2 described the difference between when a HCP is and is not speaking directly to a patient saying, “it [talking to the deaf patient directly] puts me at ease. You know, I get really tense when people [don’t talk to the deaf person directly].” HSLI #2 then went on to describe that, in
such situations they may need to educate the HCP or otherwise adapt their work. For example, they reported educating the HCP to talk directly to the patient in response to that feeling of tension. Thus, these two HSLIs seemed to draw on a bodily sense of effective and ineffective relational-interactive work to navigate consultations.

In addition, at least two other HSLIs used words that might infer a somatic feeling when describing how they effectively navigate interactive-relational work within a consultation. For example, HSLI #3 described knowing that it was an effective relational-interactive consultation by saying “I was getting that as well. That [sense of] light, safety, and feeling good in the interaction. And my story is that the doctor was as well.” Thus, for some HSLIs there were indications that the experience of effective relational-interactive work had a knowable—if not perfectly stable—somatic or felt quality that they drew on to navigate the complexities of healthcare consultations.

4.3 Theme 3: Adaptation to the Evolving Complexity of Healthcare Consultations

For the HSLIs I interviewed, developing an awareness of, and adapting to the socio-cultural contexts within a consultation was not a single event, but an ongoing process, and involved refining their work within consultations, and from consultation to consultation. The participants emphasized that successful navigation of relational-interaction work required a high degree of sensitivity and self-reflexivity, as even a small misalignment in their work could have significant impact on the relationship between HCPs and deaf patients. HSLI #2 emphasized this need to be highly sensitive to the shifting context(s) and needs within an interaction when they said “[there are] little tiny micro things that happen that we need to be aware of, because they do send a message, they do impact the interaction and communication... And they do have an
imprint on or an effect on what is already, potentially, a precarious power dynamic, you know?

So I just think awareness when you are there, reflecting on it [our work], wondering about it.”

4.3.1 Adaptation is an Ongoing Process

For the participants in this research, understanding the socio-cultural and relational factors within consultations was an emergent process requiring ongoing learning and adaptation. As HSLI #3 said, “I think there's so much to be aware of when you're in the situation [the consultation]... [relational-interactional work requires] just constant awareness, constant reflection.” As indicated in this quote, participant descriptions often emphasized complexity and self-reflection as an ongoing or constant process. This was also captured by the fluidity of HSLI #3’s rich picture drawing (shown above), which conveys a sense of movement and blurriness. Thus, for HSLI #3, and the other participants, there appears to be instability in the factors at play, making ongoing learning and adaptation a hallmark of effective work within consultations.
As though navigating this blurriness was not complicated enough, the various relational and socio-cultural factors described earlier often come to bear on the consultation simultaneously. As highlighted in HSLI #5’s rich picture drawing shown to the left, relational and socio-cultural factors within a consultation often become partially entangled. Though the relational-interactive context of the consultation (represented by the yellow circle) is partially distinct from the socio-cultural context (represented by elements outside of the circle), they influence the consultation (the arrows into the consultation space). Overall, HSLIs’ rich pictures in particular emphasized that various factors can influence each other, as they often depicted multiple salient factors acting within the same consultation. Furthermore, HSLIs indicated needing to navigate various factors simultaneously, rather than sequentially. Taken together, the interviews and rich picture drawings of participants emphasized a shifting and complex web of partially entangled factors of which HSLIs must continually be aware and adapt to.
4.3.2 Balancing Conflicting Factors within Consultations

Effectively navigating relational-interactive work often required not only adapting to several factors simultaneously, but often navigating conflicting factors. For example, within consultations, HSLIs reported instances when attending to the rapport needs of a HCP could directly conflict with attending to the rapport needs of deaf patients, or vice-versa. For example, HSLIs thought that, when HCPs made interpreter-directed comments during a consultation, this could have the potential to damage trust and comfort between HSLIs and the deaf patients. Moreover, such interpreter-directed communication could de-center and exclude the deaf patient. At the same time, failing to respond to interpreter-directed comments could result in the HCP becoming uncomfortable and or seeing the HSLI as non-collaborative or rude. As HSLI #6 described, “So the doctor feels miffed [by how I did not react to their joke]. So now the doctor is going into this appointment feeling kind of miffed by this interpreter. Like this strange guy is in my room and they are not joking, they're not talking to me, it is awkward you know?”

This discomfort could negatively impact relational work between patient and practitioner. At such moments, HSLIs tried whenever possible to find an approach that balanced the needs of HCPs and deaf patients, summarized by HSLI #3 when they said, “It's kind of like, oh somebody [HCP] makes a comment [directed to the interpreter] and [you] deal with it, roll with it, and we're back [to focusing on the interaction], but nobody's [patient or HCP] feeling excluded.”

HSLI #3 went on to describe that how they often navigated this situation was to quickly “acknowledge [the HCP] and navigate away and back to our focus [the patient/consultation].” However, HSLI #3 acknowledged that what feels quick to them might be perceived as too long by the deaf patient, emphasizing the intersubjective complexity of healthcare interpreting work. Thus, within healthcare consultations, effective navigation of relational-interactive context often
requires not just attending to several factors simultaneously, but addressing or balancing conflicting factors too.

4.3.3 Reduced Information Increases Complexity and Uncertainty

HSLIs reported facing significant shifting complexity within healthcare consultations and recognized how much their work could impact the relational-interaction between patient and practitioner. Despite the critical role they played in fostering relationships, HSLI participants reported that the healthcare system fails to structurally support them in gathering the information necessary to effectively navigate their work. For example, a lack of policies encouraging briefing and debriefing between HSLIs and HCPs and HSLI continuity in consultations between the same HCP and deaf patient limited the information they had to navigate their work. Without better information sources, participants drew on less formal sources of information to navigate their work, such as their own observations of the other participants. This reduced access to formal information was seen as increasing the ambiguity they faced in their already complex work. As HSLI # 3 summarized, “I always walk away [from healthcare consultations] with lots more questions and wondering how it can be tweaked next time and there’s so many factors out of your control.” Without improved sources of information or continuity, which allows them to gather information through time, participants were often left with significant “questions and wondering” about the success of their relational-interactive work.
Section 5: Discussion & Conclusion

In this discussion, I explore some of the complexities raised by my research, starting from the individual before moving to the interpersonal and interprofessional. Similar to Major (2013), through this research I have come to see relational-interactive work as a fundamental aspect of healthcare interpreting. Thus, in this discussion as a whole, I seek to highlight some ways we might better promote effective relational-interactive work in interpreter-mediated consultations, rather than simply focusing on proving the necessity of healthcare interpreters engaging in such work. Ultimately, in this discussion as a whole, I argue that this research reveals the need to see and support healthcare interpreting as an ongoing learning and adaptation process that is co-navigated by all parties within the complexities of the consultation, and not as a simple or even complicated problem for which a single solution may be found.

5.1 Interpreter-Mediated Primary Care as a Complex Problem

This research depicts healthcare interpretation as a site of complexity in which the production of successful relational-interactive work is not the result of one factor, person, or policy, but the interaction of these elements (Newell, 2001; Wright & Meadows, 2009). Simply defined, a complex system is “a dynamic and constantly emerging set of processes and objects that not only interact with each other, but come to be defined by those interactions” (Cohn et al., 2013, p.42). Within this study, participants emphasized sensitivity and adaptation to the needs and goals of HCPs and patients, and the contextual factors within a consultation were key components of effective work within their healthcare interpreting practice. Therefore, as in the definition of complexity above, what counts as a successful interpretation seems to be at least partially entangled with the context, goals, and people within the consultation. These interconnected elements were described by research participants as being dynamic within
consultations, and unique between consultations, making effective interpreting work a dynamic
dance between all involved.

Treating consultations as a complex problem, rather than a simple or complicated
problem, has significant implications for how we might view and improve relational-interactive
work in interpreter-mediated healthcare. In simple or complicated systems, understanding the
component parts in isolation may be sufficient to develop clear solutions (Newell, 2001).
However, in complex systems, patterns and behaviors emerge through the ongoing interactions
between multiple parts (Greenhalgh & Papoutsi, 2018). In healthcare consultations, this means
that learning, adaptation, and sensitivity are key components of producing quality care (Innes et
al., 2005; Plsek & Greenhalgh, 2001). This lens is well-aligned with the interconnections
between their work and the unique web of factors within healthcare consultations that were
emphasized by research participants, particularly in their rich picture drawings, and to which my
focus was drawn. Using a complexity lens, we can understand interpreting as an ongoing process
that is intertwined with, and at least partly defined by, the interaction between the specifics of
context and people involved.

5.2 Individual-Level Complexity

5.2.1 Variation as a Feature, not a Bug

The interpreters I interviewed conceptualized interpreting as entangled, describing the
quality of their work as interlinked with the contexts, people, and goals present within the
consultation. This interconnected web of factors was captured particularly clearly in participants’
rich picture drawings, which often depicted multiple interconnected factors that were described
as uniquely shaping the healthcare consultation and thus what was effective work. There was no
universally-agreed upon description of effective interpreter-mediated relational-interactive work;
rather, the meaning of 'effective' was defined uniquely by each participant based on their own perspective of the context and people within the consultation. As a result, seeking to promote high-quality relational-interaction, participants modified their work based on their understanding of the situation and the salient factors within the consultation, such as adapting their language level. Indeed, the one constant was the need for adaptation to the ever-changing nature of the work.

This entangled conceptualization of healthcare interpreting may explain some of the variation in interpreter practice noted in previous research, including significant variation in emotional, relational, and cultural-linguistic mediation work (Ault et al., 2019; Greenhalgh et al., 2006; Hale, 2007; Hsieh, 2007; Krystallidou et al., 2020). Indeed, this variation of work has led previous researchers to conceptualize interpreters in a wide range of ways, from gatekeepers and advocates to co-diagnosticians (Álvaro Aranda et al., 2021). However, rather than viewing this variation as problematic, conceptualizing healthcare interpreting as being inter-socially and inter-contextually entangled work may instead emphasize variation as an important factor in interpreting. This conceptualization is in line with the ways research participants emphasized the importance of adaptation, sensitivity and reflection to the shifting and interconnected factors of health consultations. Thus, while not all variation in healthcare interpreter practice is likely appropriate or the sign of a successful interpretation, when conceptualized as a site of complexity, variation in practice itself may be both expected and necessary for effective practice.

5.2.2 Making Adaptation Central to Interpreting Work: The Issue of Bias and Assumptions

Participants in this study reported engaging in ongoing assessments of patient, HCP, and contextual factors in order to support adaptation of their work, suggesting that interpreter
assumptions and implicit bias\textsuperscript{13} are a salient component of interpreter-mediated care. While previous research has identified the need for assumptions in general communicative-interaction (Gee, 2004), and in interpretation and translation work (Hatim & Mason, 2005), less research has explored the potential impact of interpreters’ perspectives on patient care. Yet, it is known that when working within complex consultation systems, the internal rules and assumptions people have impacts the overall consultation (Innes et al., 2005). Therefore, in seeing healthcare interpreters as part of a complex consultation system, this research highlights the potential negative impact of interpreters’ implicit bias on patient care.

While healthcare policies often conceptualize interpreters as simple transmission lines (Álvaro Aranda et al., 2021), this research adds to previous research that conceptualizes the work of healthcare interpreters as complex, adaptive, and extensive (Angelelli, 2004; Hale, 2007; Major & Napier, 2019; Robb & Greenhalgh, 2006). As service providers for a minority language community, the work of interpreters is also inherently connected to equity. Browne et al. (2012) note that within primary healthcare centers, how healthcare staff and HCPs interact with and tailor their work to patients has the potential to reinforce or reduce the health inequities experienced by minority community members. This is a particularly important consideration as participants in this study reported modifying their work based on their assessment of a wide range of patient specific factors, including the patients’ health literacy, fluency in the dominant culture’s written language, and emotional and mental state.

Interpreters, like healthcare providers, are not immune to bias nor how it affects how they interact with others in their work (Bath & Girault, 2011; Gallon, 2018). And, just like healthcare

\textsuperscript{13} Defined in this paper as: an unconscious stereotype, prejudice, or association that someone makes about a category of people or an attribute of a person (FitzGerald & Hurst, 2017).
providers, adaptation was a key aspect of relational-interactive work, thereby making identifying and challenging the assumptions on which they are making these adaptations a key consideration. Without reflection and careful consideration, adaptation work may be misaligned due to implicit or explicit bias, further entrenching health inequities faced by marginalized people and minority language users in Canada specifically (Browne et al., 2012; Raphael, 2006).

The participants in this research outlined how any physical or social actions they take within consultations, no matter how small, may hinder HCPs and patients’ ability to engage in relational-interaction with each other, for example creating discomfort that could impact patient disclosure. By highlighting the adaptive and interconnected nature of healthcare interpreting work, this research reveals implicit bias in interpreting work to be a salient consideration for the quality of care provided to minority language patients. Without reflecting on their own implicit ableist, audist, racist, sexist, and other implicit bias, an interpreter very easily could become “just one more barrier” to high-quality care for patients (HSLI #4).

5.3 Interpersonal and Interprofessional-Level Complexity

5.3.1 The Ongoing Alignment Process as a Key Aspect of Quality in Interpreter-Mediated Consultations

By focusing on relational-interactive work, this research reveals interpreter-mediated healthcare consultations as a site of complexity where alignment between the interpreter and other participants matters. As Cristancho et al. (2017) expertly describe, in complex team-based care, it is not about any one perspective but about understanding, appreciating, and co-navigating the perspectives of all participants. Within this study, participants repeatedly emphasized not just their own perspectives, actions, and goals, but the importance of understanding how these did and did not align with the other participants’ understanding(s) within the consultation.
Furthermore, Cristancho et al. (2017) suggest that in complex team-based situations, effective care should be conceptualized as an ongoing process of meaning-making between team members, rather than a discrete solution-oriented task. In the case of interpreter-mediated healthcare interactions, building a shared and aligned understanding of the salient factors, roles, and goals of the patient, practitioner, and interpreter seems to be central to this ongoing process of meaning-making between members. These insights were seen in data which spoke to the importance of healthcare interpreters’ gaining and leveraging their contextual knowledge, balancing conflicting factors, and the ongoing nature of adapting their work. This extends previous research which suggested interpreter-mediated healthcare should be explored as an ongoing negotiation between all parties (Estrada & Messias, 2018; Gutierrez et al., 2019; Krystallidou & Pype, 2018). It also posits that these negotiations are an ongoing process critical to co-navigating alignment between parties, rather than one aimed to arrive at any specific solution.

Roy (2000) described interpreting as inter-relational social work; thus, interpreting work is only successful when it is recognized as successful by other participants. This research extends this work into a healthcare context and adds to it by suggesting that effective interpreting is also, partially, defined by how it aligns with participants' perspective on salient and non-salient factors within the context. In exploring moments of conflicting needs between patients and HCPs, participants revealed the complex intersubjective nature of effective healthcare interpreting work. Participants described needing to balance different, and at times competing, understandings of which factors were most salient within a consultation in order to promote effective relational-interactive work, with unbalanced responses having the potential to damage trust and rapport with HCPs and patients. For example, if interpreters conceptualize time
pressures as a salient factor, they may eliminate or reduce emotional talk in favor of explicit medical information. Though this may be in alignment with some HCPs’ perspectives, other HCPs may see it as creating barriers to effective care work (Hsieh, 2007; Hsieh et al., 2010; Hsieh & Nicodemus, 2015). Another important layer to consider is patient preference and perspective. If a patient conceptualizes healthcare consultations as a simple medical exchange, then the decision to eliminate or reduce emotional talk may be acceptable. However, if they conceptualize their emotions as a key component in their care or humanness, then any reduction of emotional content may reduce the quality of the interpretation from their perspective. Thus, this research emphasizes that, to some extent, the quality of interpreting is defined not just by other people but their perception of what factors are salient in relation to the current communicative context.

The above example and my analysis outlines the importance of building toward a shared understanding of the healthcare consultation between HCPs, interpreters, and patients. As participants’ rich picture drawings and the discussions about their drawings highlighted, consultations often contain a shifting web of multiple interconnected factors that need to be navigated simultaneously, not sequentially. Without a shared conceptualization of salient and non-salient factors, it is possible for any interpreter action to be simultaneously understood as high-quality and low-quality within the same context. Building on previous research that emphasizes the uniquely triadic nature of interpreter-mediated healthcare (Fatahi et al., 2008), the entangled viewpoint that emerged through my analysis highlights alignment as an ongoing, multifaceted, and important consideration for effective relational-interactive work in interpreter-mediated healthcare consultations.
5.3.2 The Importance of Interprofessional Learning in Interpreter-Mediated Consultations

This research adds to a growing body of research calling on interpreters to be considered and integrated as a member of interprofessional teams when patient and HCP do not share a language (Álvaro Aranda et al., 2021; Hsieh & Nicodemus, 2015; Krystallidou et al., 2021; Taylor et al., 2022). Far from engaging in simple language transfer, participants in this study reported engaging in relational-interactive work prior to and during the consultation with patients and HCPs (when possible) in order to promote comfort and trust—which they saw as promoting effective relational-interactive work. Said another way, they sought to respond to the needs of all participants in the consultation, a complex and adaptive learning task. Interprofessional collaboration and care with healthcare interpreters has similarly been seen as a complex learning task by physical therapy trainees (Taylor et al., 2022) and genetic counselors (Ault et al., 2019). This suggests that the complexity experienced by the HSLIs interviewed in this study may be felt by HCPs as well.

Considering the complexity captured in this study, and potentially experienced by HCPs, it is surprising to note that debriefing sessions between HCPs and HSLIs were reported to be extremely rare. Communication is a central component of effective interprofessional care (Canadian Interprofessional Health Collaborative, 2010). And, as Rodríguez Vicente et al. (2021) highlight, when a healthcare interpreter conceptualizes the salient factors differently from the HCP, they may eliminate salient elements from patient utterances, thereby impacting communication. In their example, an interpreter who was less aware of the patient-centered care values guiding an HCP’s practice reduced the spiritual context and framing expressed by a patient within their interpretation (2021). Without a shared understanding of the salient aspects and factors within a consultation, interpreters may produce work that is misaligned with HCP
and patient needs. This in turn may decrease the opportunity for HCPs to tailor their own engagement, one factor in producing equity-centered patient care in primary care (Browne et al., 2012). Indeed, this aspect of both interprofessional work and interpreting may be the reason that several participants in this research emphasized that without sufficient contextual knowledge they are often unsure of how to produce an effective interpretation for patients or HCPs. Considering the salience of information sharing in complex situations (Clancy et al., 2008; Fraser & Greenhalgh, 2001), it is again surprising that debriefing sessions between interpreters and HCPs was an extremely rare experience for participants in this study. The one participant who was able to engage in semi-regular informal debriefs with an HCP found it helped them gather critical contextual knowledge, align their work with the HCP’s goals and approach, and build an interprofessional working relationship—all of which they felt helped to improve the relational-interactive work within the consultations.

5.3.3 The Importance of Familiarity and Continuity of Care

Participants in my research described the importance of contextual knowledge and working together regularly as a resource for adaptation of their interpreting work and promotion of trust and comfort between themselves and HCPs and patients. Previous research has identified familiarity as a critical component of relational work in employment (Mapson, 2020) and within healthcare settings (Mapson & Major, 2021). Familiarity may reduce the cognitive load of interpreters and helps to promote rapport with interpreters (Mapson & Major, 2021), as well as trust between all participants (Rosenbaum et al., 2020), thereby contributing to a more effective interaction. Similarly, in previous research, HCPs felt rapport between interpreter and deaf patients helped to facilitate effective relational work between patients and HCPs (Schofield & Mapson, 2014). In the case of this study, participants felt that familiarity in the form of
increased contextual knowledge and experience with specific HCPs, patients, and contexts helped them to be more sensitive to salient factors within the consultation and adapt to the needs of others. Thus, by identifying ongoing learning and trust building as key aspects of healthcare interpreting, this research adds support to previous research that identified familiarity between participants as promoting relational work in interpreter-mediated interaction (Mapson, 2020; Mapson & Major, 2021).

In this research, healthcare interpreters conceptualized their work as collaborative which may further increase the importance of familiarity, particularly considering the complexity of interpreter-mediated healthcare consultations outlined thus far. This collaborative stance was seen in the ways participants described trying to better understand and adapt their work to align with the goals and needs of HCPs and patients, seeing this ongoing adaption process as an important part of effective healthcare interpreting work. Two recent studies on the impact of familiarity between medical providers (nurses and medical residents) and medical trainees found that working together helped to promote higher team effectiveness on complex tasks and clinical effectiveness, respectively (Iyasere et al., 2022; Joshi et al., 2018). Therefore, it may not be surprising that familiarity emerged as a key resource for interpreters in this study. Similar to previous interprofessional research, both including and not including interpreters, this thesis suggests that familiarity is a resource for healthcare interpreters that supports their ability to work in alignment with the other participants and context. Seeing effective relational-interactive work in interpreter-mediated healthcare as an ongoing process of learning, shared meaning making, and adaptation between participants further reinforces the importance of familiarity with both the people and the specific context(s) of the consultation.
5.4 Implications

Drawing on the insights I have gained through this thesis research, below I make recommendations for improving practice, education, policy, and research. It is my hope that these ideas help to spark meaningful discussion and change. If interpreting work is contextual, no doubt some of these will not be supportive of, or possible to apply in, some contexts. However, I encourage those who do choose to take up any of the recommendations below to do so in an equity-centered way that puts minority language communities at the center of the process.

5.4.1 Implications for Practice

- **Reflecting on and challenging internal bias should be a key component of ongoing healthcare interpreter practice.** Interpreters in this study outlined adaptation as a key factor of successful relational-interactive work, making it important how they understand both the context and people within the consultation. Therefore, it is recommended that ongoing reflection on and challenging their assumptions and implicit biases should be a key component of a high-quality healthcare interpreting practice. Moreover, interpreters should be provided with the tools, resources, and support for this ongoing and important work.

- **Healthcare interpreters should be considered members of the interprofessional care team.** This research depicts the work of healthcare interpreters and HCPs as a complex and ongoing collaborative process. As such, this research adds to the growing body of literature that identifies the work of healthcare interpreters as clinically significant (Angelelli, 2004; Mapson & Major, 2021; Robb & Greenhalgh, 2006) and explicitly calls for healthcare interpreters to be members of the interprofessional care team (Krystallidou et al., 2021). Therefore, it is recommended that both healthcare interpreters and HCPs
approach working together as an interprofessional collaborative care practice with a particular focus on building a shared understanding of the consultation.

5.4.2 Implications for Education

- **Adaptation should be seen as a key component of effective healthcare interpreting work.** This research has emphasized the importance of healthcare interpreters being able to identify and adapt to the ongoing complexity of emergent factors within healthcare consultations. While linguistic-interactional skills are obviously a key component of healthcare interpreting, the ability to adapt their work in novel ways seems to be an often overlooked but critical component of healthcare interpreting work. Thus, education programs for healthcare interpreters should be designed to support not just skill development but adaptive expertise as well. Such education programs do not need to be created from scratch, but should draw on the growing literature on this topic within health education scholarship.

- **Interprofessional collaboration training programs should include healthcare interpreters, particularly in practice-based training scenarios.** The addition of a healthcare interpreter, while important for patient safety (Bowen, 2015), adds considerable complexity to the consultation and relational interaction process between patients and HCPs. Navigating, collaborating, and adapting within this complexity is unlikely to be an inherent skill for either healthcare interpreters or HCPs. Thus, education for HCPs and healthcare interpreters should focus on providing both knowledge- and practice-based education and training. These opportunities to learn and work together in practice-based scenarios may help to develop sensitivity and skill in both practitioners.

- **Interdisciplinary case-based learning should be a part of professional maintenance for healthcare interpreters.** How healthcare interpreters conceptualize, and what they
are sensitive to within, healthcare consultations matters. In moments when they understand or respond to different factors than the other participants within a consultation, they may provide a reduced quality of service or become a barrier to patient care and relational-interactive work. This makes it important for healthcare interpreters to learn about other ways of seeing and adapting to consultations. Therefore, it is recommended that healthcare interpreters be required to regularly engage in case-based presentation and learning with other healthcare interpreters, HCPs, and (ideally) representatives from the language minority communities they serve. In particular, exploring moments of complexity and multiple perspectives, factors, and approaches may help healthcare interpreters to increase their sensitivity and gain diverse perspectives on healthcare consultations.

5.4.3 Implications for Policy

- **Healthcare interpreters, HCPs, and minority language communities should establish policies for regular briefing and debriefing sessions between HCP and healthcare interpreters.** Healthcare interpreting is a complex process; therefore, ongoing learning and meaning making between practitioner, patient, and interpreter should be centralized. One way to support interprofessional learning between HCPs and interpreters would be to develop policies making briefing and debriefing practices between HCPs and healthcare interpreters an expected and paid component of providing care when healthcare interpreters are used. Moreover, the inclusion of the minority language using patients in these debriefs should be considered and explored as a critical component of patient-centered interprofessional care (Canadian Interprofessional Health Collaborative, 2010). At the least, briefing and debriefing practices should be developed in deep consultations with minority language communities to ensure they are conducted in culturally safe ways.
• **Continuity of healthcare interpreters should be prioritized and emphasized as a key consideration in the quality of care for patients.** In this research, ongoing meaning making, rapport, and understanding emerged as central components of effective relational-interactive work in interpreter-mediated consultations. This emphasizes the importance of continuity of the care team, including the healthcare interpreter, adding to previous research that identified familiarity and rapport as important factors for interpreter-mediated healthcare consultations (Mapson & Major, 2021; Schofield & Mapson, 2014). Therefore, it is recommended that where possible (and when it is aligned with patient and HCP preference), continuity of healthcare interpreters be prioritized in medical interpreter assignment systems. Such policy would likely help support the ongoing meaning making process and the maintenance of trust and working rapport between HCP, patient, and healthcare interpreters.

• **Healthcare interpreters should be paid for relational and informational gathering labour.** As identified throughout this research, the quality of healthcare interpreting seems to be partially reliant on the ways a healthcare interpreter understands and becomes sensitive to the factors within a consultation and those with whom they interact. It is therefore surprising that some of the adaptation strategies captured within this study relied on HSLIs’ unpaid labor. Specifically, as per-appointment contract workers, HSLIs were often unpaid for waiting room discussions with patients and research prior to their appointments. As the provision and quality of interpreting is a patient safety issue (Bowen, 2015), leaving this type of rapport and information building work to unpaid labour potentially exposes deaf patients and other minority language patients to increased risk. Rather than relying on healthcare interpreters to do unpaid work out of the kindness
of their hearts, policies should enshrine both the importance of and payment for this type of work.

- **Expectations and processes for healthcare interpreters to report abusive behavior of HCPs should be clarified.** Though not the focus of this research project, and thus not previously mentioned, 4 of the 6 HSLI participants mentioned moments where they observed a HCP engaging in abusive behavior toward deaf patients. These incidents ranged from HCPs leaving the consultation room when a deaf patient was taking too long to reply to a question, to explicitly racist, homophobic, and fatphobic statements. Though these situations were mentioned in passing and not explored in depth, participants mentioned feeling unsure if they were meant to report such behavior and how to do so. Considering the significance of such incidence to patient care and safety, expectations and ways of reporting such incidents should be established and made clear to healthcare interpreters.

5.4.4 **Implications for Future Research**

- **Exploring interpreter-mediated relational-interactive work from patient, HCP, and healthcare interpreter perspectives simultaneously is an important next step.** In complexity science, the perspectives used to understand a problem have a significant influence on our understanding and definition of that problem (Newell, 2001). This research has outlined interpreter-mediated healthcare consultations as a site of considerable complexity from the viewpoint of healthcare interpreters. However, this is just one of at least three perspectives within such consultations. Therefore, future research should explore and compare the perspectives of HCPs, patients, and healthcare interpreters, ideally on the same consultation experience. By doing so, we may better
understand the complexities, factors, and overall interpreter-mediated consultation system, thus allowing for more refined recommendations for practice.

- **Examining how patients, HCPs, and healthcare interpreters co-navigate and co-adapt to each other in and across consultations is a critical component for improving practice.** Adaptation and alignment to the other participants appears to be a key component in effective relational-interactive work in interpreter-mediated healthcare consultations. A critical next step is to explore how this adaptation takes place within and across a series of consultations with the same interpreters, healthcare providers, and patients. Such research may help to illuminate both individual and group adaptation, learning, and understanding within and across a series of consultations, and further support the refinement of training, practice recommendations, and policy.

- **Inclusion of contextual factors may help to improve future healthcare interpreter research.** Variation in interpreter practice may be, at least partially, explained as attempts to adapt their work to the specifics of a consultation. This makes it important to understand not just the actions taken by interpreters, but their reasoning(s). Therefore, future research in interpreting may be enhanced by pairing practice-based evidence with interpreter rationale, capturing the action, rationale, and perceived context.

- **Future research on interpreting should consider the inclusion of arts-based methods of analysis and data collection.** Though a rather late addition to my research proposal, the rich picture drawings were a highly illuminating part of this research. The rich pictures helped to support more fulsome data collection by serving as a point of reflection before and during the interviews. They also significantly aided in a generative analysis process by serving as a reflection point between specific factors and the larger
consultation being discussed. Based on my literature review, arts-based methods seem to be relatively rare in interpreting research, but they might be a particularly rich addition to this field.

5.5 Limitations

This research, like all learning projects, is not without limitations. Though this research was originally intended to include interviews with deaf patients and HCPs as well as interpreters, fiscal and time limitations resulted in the choice to focus on interviewing healthcare interpreters early in the recruitment process. As such, those interviewed represent only one of at least three perspectives on interpreter-mediated healthcare consultations, limiting and shaping the understanding that emerged through this research process (Newell, 2001). Additionally, those interviewed skewed toward interpreters with more experience, limiting the potential understanding of how less experienced healthcare interpreters conceptualize and navigate relational-interactive work in practice. Finally, this research relied on arts-based and interview data, thus there may be important and unobserved gaps between this research and real-world practice; what people think they do and what they actually do may be significantly different.

Drawing on systems and complexity theory helped to illuminate the interconnections between interpreter work and other factors; however, it may have also led me to overlook individual factors that contribute to successful relational-interactive work in interpreter-mediated consultations. In a similar vein, having 13 years of interpreting experience likely made me more sensitive to some factors over others. Though I challenged myself to think anew about this topic via several ongoing reflection tools (such as my self-reflexion journal), this research is still from my own perspective and I cannot think what is unthinkable to me (Vagle, 2018). As a disabled
scholar navigating this research within a pandemic, I became attuned to the ways that place and space impact lived experience, which again shaped this research.

Though saturation and generalizability were not the aim of this research, nor the research paradigm chosen, a richer diversity of participants may have helped to reveal other factors of complexity that were missed in this research study. As a result, much like the interpreting process described, this research should be seen as a starting place for conversations, questions, and improving interpreter-mediated healthcare, not as a definitive answer to navigating relational-interactive work in healthcare settings.

5.6 Conclusion

For the participants in this study, interpreter-mediated healthcare consultations are sites of considerable socio-cultural complexity. They emphasized that there is no single, one-size-fits-all approach for HSLIs to effectively navigate relational-interaction within non-emergency healthcare consultations. Rather, ongoing and evolving adaptation to emergent factors within a consultation was the key to effective navigation. In the absence of policy and practice that support sources of information with which to evaluate and refine their work, such as debriefing with HCPs, they drew on less clear information sources. This appeared to add complexity and uncertainty to the already complex task of effectively navigating relational-interactional work in healthcare consultations. Ultimately, this research emphasizes the need to see and support healthcare interpreting work as an ongoing learning process co-navigated between people within the specifics of context.
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Appendices

Appendix One: Interview Guide

Healthcare Sign Language Interpreter Interview Guide

Area of Inquiry: Rapport Building (if needed)
- What was your path to becoming an interpreter?
- What draws you to medical interpreting?

Area of Inquiry: Features of Effective Interpreter-Mediated Patient-Practitioner Relationships
- Thinking about an effective patient-healthcare practitioner relationship in a non-emergency appointment that you interpreted, could you tell me about the experience you drew? (Probe regarding: features, experience, relational qualities, and interactional qualities)

Potential Prompts:
- You drew __, could you tell me more about that?
- You drew __, can you describe how this affected the rapport between the deaf patient and practitioner?
- You drew a connection between __ and __, could you tell me more about this?
- From your perspective, what made this an effective patient-practitioner relationship?
- From your perspective, how did ___ contribute to an effective patient-practitioner relationship?
- Is there anything that the healthcare practitioner did that helped to build an effective patient-practitioner relationship? If so, can you describe what they did?
  - From your perspective, how did this help to promote an effective connection?
- Is there something that you did that helped to promote an effective relationship between the deaf patient and healthcare practitioner? If so, can you describe what you did?
  - From your perspective, how did this help to promote an effective relationship?
Area of Inquiry: Barriers to Interpreter-Mediated Patient-Practitioner Relationship

- Turning to barriers, can you tell me about a non-emergency appointment that you interpreted in which there were barriers to effective rapport building between the deaf patient and practitioner? (Probe regarding: features, experience, relational qualities, and interactional qualities)

Potential Prompts:
- From your perspective, how did these barriers contribute to less-effective patient-practitioner rapport?
- From your perspective, is there something that the healthcare practitioner did that created barriers to the development of patient-practitioner rapport? If so, can you describe what they did?
- Did ___ (a barrier they mentioned) impact your work as an interpreter? If so, can you describe how?
- As an interpreter, are there things that you have done that are less supportive of rapport between deaf patients and practitioners? If so, can you give me some examples?

Area of Inquiry: Demographics

- How long have you been working as a healthcare interpreter?
- What is your educational background?
  - Have you taken any training specific to working in a healthcare setting as a medical interpreter? If so, what?
- I have a few questions about who you are, please only answer the following questions if you feel comfortable:
  - What is your age?
  - What is your gender?
  - Is there anything else you think it is important for me to know about you?

Area of Inquiry: Closure and Perspective Gathering

- In terms of supporting effective patient-practitioner relationships in interpreter-mediated primary care appointments, is there any advice you would give to other healthcare interpreters?
- Is there any advice you would give to healthcare practitioners who want to improve their relationships with deaf patients in interpreter-mediated consultations?
- Do you have any other recommendations for supporting effective patient-practitioner relationships in interpreter-mediated primary care appointments?
● In terms of patient-practitioner relationships in interpreter-mediated primary care appointments, is there anything we have not yet talked about that you want to draw my attention to?
● As we wrap up, do you have any questions for me?
● Thank you!
Appendix Two: Rich Picture Drawing Instructions

Examining Interpreter-Mediated Primary Healthcare Relationships

Drawing Instructions

Introduction:

You are being asked to take 15 to 30 minutes to reflect on and draw an effective relationship between a Deaf patient and healthcare practitioner in a non-emergency appointment that you interpreted.

Specifically, you will draw a rich picture. A rich picture is a drawing that shows a situation that you experienced that includes: “what happened, who was involved, how people felt, how people acted, how people behaved, and what external pressures were present”14. The rich picture drawing you create will be used to better understand your perspective and experience, and guide our discussion during our one-on-one interview.

Required Materials for Your Rich Picture Drawing:

In order to complete your drawing, you will need to use either:

- A pen or pencil and a standard piece of paper.
  - You can also use colored pens, felts, or pencils.
- A digital camera or cell phone to take a photo of your finished drawing.

OR

- A digital drawing program on your computer/Ipad/tablet that you are comfortable using.

Rich Picture Drawing Instructions:

1. Take a few moments to think about a non-emergency appointment where there seemed to be an effective relationship between the Deaf patient and healthcare provider. Take your time to consider details of the situation, including the features of the relationship, context, and navigating the relationship in your interpreting work.

2. Take 15-30 minutes to draw the effective relationship between the Deaf patient and healthcare practitioner during the non-emergency appointment you interpreted. Take

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time to include all the important features of your experience of the relationship between the Deaf patient and healthcare practitioner, this might include:

- Who was there and how they felt and acted.
- What you did, felt, and thought.
- Representation(s) of the relationship itself, in whatever way(s) make sense to you.
- Any interconnections between the things you draw.
- Things that seemed to positively or negatively influence the relationship between the patient and practitioner, including things outside of the appointment you are focusing on.

3. When you feel like your drawing is finished, either take a photo of or save your drawing.

4. **Upload your rich picture drawing** prior to our interview, using this [Qualtrics survey](#).

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**Tips for drawing a Rich Picture:**

- **Avoid including words or signs in your drawing as much as possible.** We will explore your drawing together during our interview, so it only needs to be clear to you.
- **To maintain privacy, please do not include the names of anyone you depict in your drawing.**
- **Draw any connections between the things you draw, if you feel there are any connections.**
- The aesthetic qualities of the drawings do not matter, please feel free to draw your experience in whatever ways you want to.
- **Draw things that seemed to have contributed to or hindered the effective relationship between the Deaf patient and healthcare practitioner that you experienced,** including more abstract influences or things that happened before the appointment.

Thank you so much, I look forward to exploring your drawing together during our interview. **If you have any technical issues or questions, please feel free to contact Bryan Hemingway:**

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