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Improving interpreters' normative ethics discourse by imparting principled-reasoning through case analysis

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Abstract

The vocabulary available to community interpreters regarding professional ethics is typically limited to a set of prohibitions—what interpreters *should not do*. These prohibitions are disproportionately more prevalent in ethical documents and discourse than guidance on what interpreters *should do*. Both types of guidance are examples of normative ethical messages. However, when interpreters are asked to justify decisions which lead to them taking action rather than refraining from action, they are left with insufficient vocabulary to do so. Without a broader normative vocabulary allowing conversation regarding action-taking, interpreters tend to rely on unhelpful, non-normative language such as metaphors which fail to advance professional dialogue and development of the field. Ethics scholars link such discourse deficiencies with underdeveloped reasoning abilities, often citing the need to ground normative discourse within the principles and values of a profession. "Principled-reasoning" in part involves the ability to weigh the import of conflicting ethical obligations, such as principles that compel action versus inaction. Ethicists consider principled-reasoning to be the highest order of ethical reasoning. While there are theoretical and pedagogical developments

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in community interpreting that can further principled-reasoning skills, there remain significant barriers. One is the profession's failure to incorporate widely recognised ethical principles such as non-maleficence, beneficence, justice, and autonomy in its normative messaging and discourse. Another is the profession's lack of normative terms to convey intermediate ethical concepts. A third is the still-limited adoption of structured reflective practices, such as case analysis and supervision, to impart principled-reasoning skills both during and after interpreters' formal education years.

Keywords
decision-making, demand control schema, interpreters, normative ethics, principled-reasoning, supervision

Introduction

Scholarship and discourse regarding ethics can be categorised as *normative*, *descriptive*, or *metaethical*. Each plays an important but distinct role when applied to professional practice (Beauchamp & Childress, 2012). In the interpreting profession, normative ethical viewpoints convey how interpreters *should behave* or what *ought to happen* in an interpreter-mediated interaction. Normative material is most evident in codes of ethics, standards of practice documents, and seminal textbooks (Cartwright, 2010; Dean, 2015; Hill, 2004) and can be generalist or specialist in nature. Community interpreting standards, based on normative ethical reasoning, have been created and proffered by professional organisations, businesses, institutional settings (e.g., a hospital or a court), or through training courses and programmes (e.g., Bridging the Gap, Cross Cultural Health Care Program, 2013). The jurisdiction for normative ethical guidance in community interpreting may be international (e.g., International Medical Interpreting Association) or local in nature (e.g., a county court system).

Descriptive ethical scholarship, however, seeks to document what practitioners *actually do*, which is usually the purview of sociologists, anthropologists, and psychologists (Beauchamp & Childress, 2012; Pym, 2001). Most scholarly publications regarding community interpreting ethics are of this descriptive type (Dean, 2015, 2021).

Metaethical scholarship examines the ways in which ethics is *conceptualised* by a profession, including the language used to express those ethics and the methods of ethical reasoning employed by practitioners (Beauchamp & Childress, 2012). This metaethical perspective is arguably the least prolific among available resources on community interpreting. Examples of such resources can be found in Chesterman (1993), Dean (2015, 2021), Kermit (2007), Merlini and Favaron (2009), and Pym (2001, 2006). This article, as well, is primarily a metaethical one because it focuses on how practitioners and the profession express ethical material.

In community interpreting, research into what interpreters actually do in practice (descriptive ethics) is often set in contrast to the normative expectations established by codes of ethics or in popular professional discourse (Brisset et al., 2013; Davidson, 2000, 2001; Hsieh, 2007, 2008). For over 30 years, empirical research has repeatedly shown

that interpreters do not act in the mechanistic or uninvolved ways often conveyed in normative ethics resources (Wadensjö, 1992). Instead, most descriptive ethics studies typically conclude that "interpreters behave in flexible ways and that flexibility is based on contextual factors" (Dean, 2021, p. 207). This behavioural flexibility stands in contrast to common interpreting role metaphors conveying non-involvement (e.g., conduit, bridge, invisible). Other scholars have offered different, yet still metaphorical, descriptors conveying greater involvement, such as the helper, broker, or advocate (Brisset et al., 2013; Roy, 1993; Shaffer, 2014).

Ideally, research regarding how practitioners actually behave should inform policy-making. That is, descriptive ethical information has the potential to influence the profession's normative ethical discourse and materials, an outcome that might be termed *normative resolution*. Given the ongoing disconnect between descriptive research findings and the normative messaging of the interpreting profession, it appears that normative resolution is not progressing as it should.

From a metaethical perspective, there appear to be two points of disconnect between descriptive and normative ethics in community interpreting. First, there appears to be a lack of communication and coordination between the principal experts—the researchers who record what happens in interpreting practice, and the policy-makers or professional organisations who conceive, codify, and communicate the profession's normative ethics. Just as normative ethical materials have stimulated research questions, so too should descriptive research studies stimulate normative discussions. In other words, research studies should serve as a foundation for revisions in ethical materials, but this can only happen when there is effective communication between these respective parties.

Second, and of primary concern for this article, is a disconnect in vocabulary. Devices of description, such as the use of metaphors (e.g., the interpreter was an advocate) or other figurative terms and phrases (e.g., interpreters are not machines) do not easily translate into normative ethical material. Descriptions of behaviour are *by design* non-evaluative whereas normative ethics, which seeks to convey the *ought to* and the *shoulds* of professional behaviour, are inherently evaluative. Such evaluation is fostered by a profession's adoption of principles, values, or rules (Beauchamp & Childress, 2012).

The language of principles, rules, obligations, and rights are the devices of normative ethics (Beauchamp & Childress, 2012). Yet, when interpreters reason through and justify their decisions, they frequently draw upon descriptive phrases, such as "it is like I am not really there" (Dean, 2015). The problem is, "it's like I am not really there" is a non-normative phrase. In other words, it is not a *should* or an *ought to*, nor is it explicitly grounded in a principle or rule. A coordinating vocabulary between normative and descriptive ethics can provide the opportunity for the profession to address what Chesterman (1993) called a "prescriptive force" and what Pym (2001) deemed as an essential "return to ethics."

Non-normative terms and devices appear in normative documents. For example, some standard practice documents refer to interpreters as "members of the team" (Dean, 2015, 2021; International Medical Interpreters Association [IMIA], 2007, 2010; National Council on Interpreters in Health care [NCIHC], 2004, 2005), while others refer to role metaphors such as "message converter or message clarifier" (Bancroft et al., 2015). Just as in the non-normative discourse of interpreters, sanctioned materials

which intend to convey normative ethics sometimes do not use proper normative constructs such as principles, rules, obligations, and rights, thus impeding progress towards normative resolution.

One way to advance normative resolution would be for scholars to opine on whether or not interpreting practices documented in research studies are justifiable actions. Both Chesterman (1993) and Pym (2000) warned the translation and interpreting field of the problematic nature of not offering some ethical standard of what is right, good, and effective (see also Dean, 2015; Mason, 2000; Pym, 2001). Pym (2000) framed this call to action as concern for stakeholders, stating that "[t]ranslators, teachers, students, critics, policy-makers rightly expect our research to have something to say on the matter [of ethics]" (p. 181).

Progress towards normative resolution does not equate to sanctioning inflexibility. According to Beauchamp and Childress (2012, p. 15), the normative constructs of principles, rules, obligations, and rights are not to be understood as, "rigid or absolute standards" instead they must be "balanced and specified so they can function in particular circumstances."

Descriptive research verifies that community interpreters indeed do exhibit this flexibility (a.k.a. "balancing" and "specifying" normative constructs) in response to varying contextual factors in the work setting and in consideration of the consequences of their translation and behavioural decisions. Consequences based decision-making or *teleology* is an ethical norm in other practice professions such as medicine, law enforcement, and teaching. While teleological decision-making may well be utilised in interpreting practice, it is not effectively *talked about* by practitioners and community interpreting scholars. The constructs of teleology and the skills to verbally reason through decisions requires "a richer vocabulary than is available in everyday language" (Kahneman, 2011, p. 4). However, this is a vocabulary that can and should be taught.

In addition to her empirical research regarding interpreters' discourse (Dean, 2014, 2015), as a supervisor of reflective practice groups, Dean has led the analysis of hundreds of interpreting cases. Structured case analysis and supervision, where interpreters report on interpreting assignments and analyse them with the guidance of an expert, is one avenue for interpreters to not only improve their ethical decision-making but learn the use of normative ethical terms as a means to evaluate and justify those decisions (Dean & Pollard, 2013, 2018).

In this article, case analysis experienced and/or conducted by Dean are used as examples to illustrate the need for and value of fostering a "coordinating vocabulary" between descriptors of practice and normative discourse among interpreters. Much of the normative discourse offered by supervision group participants relies paradoxically on non-normative constructs—including abstractions (e.g., "I have to sleep at night"), metaphors (e.g., "I am like a bridge"), and other forms of figurative speech (e.g., "It's like I am not really there"). These non-normative terms and phrases signal poor reasoning skills in light of the justice-reasoning framework of Kohlberg (1976) and Rest (1979). As we shall see, the field of community interpreting can effectively reframe the devices of descriptive ethics in a more normative manner by adopting core principles and applying them to the practice of community interpreting.

The Case of the Patient in Pain

During a training course that Dean led for medical interpreters, Ellen (not her real name), a full-time staff medical interpreter, presented a case involving a dilemma that she wanted guidance on from the interpreter colleagues in the group.

Ellen was assigned to work with a deaf patient and three providers who were conducting a surgical procedure. The deaf patient was apparently in great pain, as she was screaming intermittently. One of the doctors offered the patient her hand, which calmed the patient down, but after 5 minutes, released it to continue with the procedure. The patient then began grabbing onto objects nearby to appease her pain and, in the process, knocked a container of disinfectant wipes off a nearby equipment table which also contained sterile surgical instruments. At this point, Ellen offered to hold the patient's hand, which she did until the procedure was over.

After Ellen relayed this brief story, she did not offer any additional details initially. When the other members of the group did not immediately respond, Ellen added, "I mean, it's a humanity thing" further noting that an interpreter colleague on the hospital staff had reassured her by saying, "If you feel like holding someone's hand, then you should do it!"

As the leader of this training session, I asked the group to offer their analysis of Ellen's case. I fully expected the group to quickly affirm Ellen's decision to offer to hold the patient's hand but that is not what happened. Instead, Ellen's decision was questioned. Her colleagues asked, "Were you not doing any interpreting at the time?" "Did you think this was okay because the doctor did it initially?" "Was there not a nurse there who could have held her hand?"

From a metaethical perspective, these questions reveal a concern that Ellen deviated from the prescriptive ethical ideal of *interpreter non-involvement* (Clifford, 2004; Nicodemus et al., 2011). It is possible that Ellen, anticipating this type of response, offered her additional two justifications in advance. When interpreters are new to case analysis, it is typical that there is an initial expressed concern regarding action-taking without sufficient exploration of the consequences that resulted from such action.

That interpreters consistently focus on adherence to oft-cited rules should not be surprising. Much of the ethical material in community interpreting literature is *deontological* or rule-based in nature (Cokely, 2000; Dean, 2014; Dean & Pollard, 2011; Tate & Turner, 2001). The vast majority of normative messages interpreters receive about the *shoulds* of practice—from ethical codes to the common parlance of practitioners—convey that interpreters should *take no action* or *not get involved* in anything other than message transfer (Dean, 2014, 2015). Ellen's report that she held the patient's hand led her colleagues to express concern for deviating from this *take-no-action* norm. Ellen herself likely presented this case to the group because of her own doubts as to whether this decision was proper in light of her exposure to such deontological rules.

From a metaethical perspective, these *take-no-action* normative messages are reflected in how interpreters express their thoughts during case discussions. Interpreters commonly say "but you're just the interpreter," or "interpreters are supposed to be neutral." Such phrases signal adherence to norms as a professional priority, which is a well-researched reasoning pattern (Kohlberg, 1976; Rest et al., 1999). Reasoning patterns typically function tacitly, only subconsciously informing individuals' decisions and

related discussions. Professional educators should be aware of reasoning patterns because they reveal practitioners' thinking; how they talk is a good indicator of how they reason and how they act in their practice (Parker & Greener, 2010; Rest & Narvaez, 1994).

Reflecting on Ellen's Case in Light of Kohlberg's and Rest's Moral Reasoning Theories

The questions posed to Ellen intimated the group's (and Ellen's) concern for rules. Justifying or critiquing an action because it does or does not adhere to a rule represents a *conventional* pattern of reasoning. In moral psychology scholarship, a reasoning pattern of the conventional type is considered a "middle" stage in moral development (Kohlberg, 1976; Rest et al., 1999). It is preceded by the *pre-conventional* stage and followed by the *post-conventional* stage (Kohlberg, 1976).

Reasoning or decision justifications that are pre-conventional in nature are based in concerns for obedience, interpersonal concordance (i.e., avoiding conflict with others), or how one is personally advantaged by the decision (e.g., "I'm looking out for number one").

The post-conventional stage is the highest order of moral reasoning (Kohlberg, 1976; Rest et al., 1999). Instead of justifying actions out of concern for oneself (pre-conventional) or out of concern for rules (conventional), post-conventional reasoning guides ethical decisions based on consideration of principles or ideals that are shared by the parties in question (Beauchamp & Childress, 2012; Rest et al., 1999). As such, post-conventional reasoning is often referred to as *principled-reasoning* (Rest, 1979).

Kohlberg (1976) refers to this stage as *post*-conventional because the intention is not to reject agreed-upon conventions outright (Rest et al., 1999). Indeed, rules and norms exist because, it is typically assumed, their effective application will yield a moral result. But when it is evident that rules may not yield the moral result, a post-conventional decision-maker is expected to think (and act) differently. This is accomplished through effectively considering and applying shared values or principles (Beauchamp & Childress, 2012; Rest et al., 1999).

One of the hallmarks of post-conventional reasoning is concern for individuals' rights—with an aim towards full, society-wide reciprocity (Narvaez & Bock, 2002). Conventional reasoning, however, places the emphasis on alignment with rules—rules which are often created and enforced by the majority and those in power. In keeping with the social justice movements of the late 1960s, Kohlberg's post-conventional reasoning sought to acknowledge those who fall outside society's mainstream (Parker & Greener, 2010). Indeed, advancing post-conventional reasoning should be of relevant concern for community interpreters and interpreting educators. By the nature of linguistic and cultural differences, at least half of those interpreters serve in community settings fall into the margins. Those who are at the margins are likely to be further marginalised when the rules that were intended to benefit those in the mainstream of society are rigidly followed. Yet, it is these very rules that Ellen's colleagues were concerned about.

Neo-Kohlbergian moral psychologist, James Rest (1979), borrowed the constructs of pre-conventional, conventional, and post-conventional reasoning from Kohlberg but proposed that these reasoning patterns do not progress as stages (i.e., that individuals do not move through them in a step-wise process). Rather, Rest suggests that these reasoning patterns are all potentially available to individuals at a given time and may function

tacitly. Rest and his colleagues came to refer to these moral reasoning patterns as schemas (Rest et al., 1999).

Rest's three moral schemas are as follows: *personal interest schema*, *maintaining norms schema*, and *post-conventional schema*. If a person justifies a decision by appealing to their own interests, they are reasoning using a personal interest schema (PIS). If a person justifies a decision by appealing to a rule, they are reasoning using a maintaining norms schema (MNS). If a person justifies a decision by appealing to values or principles that are shared by the parties in question, they are reasoning using a post-conventional schema. Rest suggests that while individuals' typically have a dominant moral schema, it is not unusual for shifts and fluidity to occur in their reasoning pattern based on the context of the situation they are in (Rest et al. 1999).

It is useful to situate the discussion that resulted from Ellen's case report in the context of Rest's moral schemas. Indeed, all of Rest's moral schemas were represented in the discussion of Ellen's case:

Personal interest (PIS):

"If you feel like holding someone's hand, then you should do it!"

Maintaining norms (MNS):

"Were you not doing any interpreting at the time?"

"Did you think this was okay because the doctor did it initially?"

"Was there not a nurse there who could have held their hand?"

Post-conventional (PCS):

"It's a humanity thing!"

The PIS statement offered by Ellen's colleague from the hospital suggests that an individual can determine or justify what is right based on what makes them feel good. The three MNS questions posed to Ellen pertain to message transfer and what may interfere with that task (Dean, 2014). These questions implied that Ellen's action may have been permissible but only as exceptions to the rule (i.e., *if* Ellen was not needing her hands to interpret, *if* the doctor first established the precedent, and *if* there was not anyone else available to do it). The only PCS (or principled-reasoning) comment was offered by Ellen herself. It was an appeal to a principle—the concern for human suffering.

If Ellen's colleagues in the training had been oriented post-conventionally, what would have come to the fore was a discussion of the *impact* of Ellen's decision to offer her hand—how holding the patient's hand ended the flailing about that was disrupting the medical team's access to the procedural equipment and possibly its sterility. That is, Ellen's decision would have been understood through the lens of teleology (a focus on the consequences of decisions). Instead, the group was oriented conventionally, towards the profession's normative proscriptions.

Moving those who reason based on conventions to reasoning based on principles is frequently the aim of professional ethics education (Rest & Narvaez, 1994). In part, this was the aim of the medical interpreting course that Ellen and her colleagues were enrolled in at the time of this case discussion (see Marin, 2020). Even with that aim, the participants

tended to resort to what was most familiar or cognitively available to them—not only the normative material in ethics codes but the ideals expressed by exemplary messages from teachers and mentors (Dean, 2014).

The Case of the Potential Medical Mistake

About 15 years earlier, I (Dean) had been in the same position as Ellen. During a medical interpreting assignment, I, too, decided to take action and deviate from the norm of non-involvement. Unlike Ellen, the subsequent discussion of my case did not happen with interpreter colleagues, but with a medical ethicist, Dr Shao (not his real name). Like Ellen, I was a hospital staff interpreter. I had interpreted for many meetings involving Dr Shao and knew that he was a member of the hospital's medical ethics board. I asked him if he could advise me regarding the interpreting situation I had been in and the decisions I made. He agreed, arriving at my office with a notepad in hand, ready to document the details of my case. Keeping any identifying information confidential, I presented my case.

At the end of an outpatient medical appointment involving a pregnant deaf woman, the medical provider announced that he would prescribe ibuprofen for her pain. Her pregnancy had been discussed during the appointment, yet the prescribed medication was contraindicated, that is, possibly harmful to developing foetuses. (I knew this from having interpreted many medical appointments with pregnant women.) Neither the patient nor the provider appeared to recognise that prescribing this medication was a potential medical mistake. I used several subtle interpreting strategies to try to alert the deaf patient's attention to this issue (e.g., raised eyebrows, using third person vs the traditional first person approach), but without success. The provider was writing out the ibuprofen prescription when I decided to overtly ask, "Did you say you were prescribing ibuprofen?" My question triggered the intended response. The provider recognised his potential mistake, tore up the paper prescription and explained to the patient why he needed to prescribe a different pain medication.

After presenting these details to Dr Shao, I asked if he thought what I did was ethical. Dr Shao put away his unmarked notepad, rose to his feet, and in a rather nonchalant manner, said that anyone working in medical settings should be prepared to address potential medical mistakes.

With just this one comment, Dr Shao concluded our meeting. I recall feeling disappointed with the lack of a lengthier deliberation about my experience. I thought my case was intriguing and would instigate a back and forth of, "what about . . . " and "maybe you should have . . . " but Dr Shao assured me that my decision was sound and then respectfully departed.

It is clear to me now that what I was expecting was exactly what happened during Ellen's case discussion. I expected to be peppered with questions or comments that expressed concern for taking action and deviating from the norm. As with Ellen, these were the very questions I was asking myself and the reason I sought Dr Shao's advice in the first place.

In hindsight, Dr Shao was thinking and acting based on a schema of principled-reasoning. In his final words to me, he offered a principled explanation which justified my

actions. For him, and for all medical professionals, the principle of *non-maleficence* or "do no harm" supersedes any conventions of interpreter behaviour. Dr Shao did not feel it necessary to deliberate the case with me, because applying the principle of non-maleficence reflects a higher level of moral reasoning (post-conventional) than the justification of following a rule (conventional).

Reflecting on Both Cases in Light of Beauchamp and Childress' Four Core Principles

Rules and other conventional norms of interpreting do not offer the same type of "rich vocabulary" (Kahneman, 2011) as principles do, because rules and norms are unable to capture behavioural flexibility. Furthermore, figurative language that arises from descriptive ethics research also does not offer the same ethical traction as principles. Dr Shao was able to respond to me quickly and with assurance because of his familiarity with medical ethics training.

Beauchamp and Childress (1985, 2012) famously asserted that there are four core principles of biomedical ethics. While typically discussed in the context of medical practice and research, these core principles can equally be applied to professional practice in general (Jonsen, 1995), including the community interpreting profession (Dean & Pollard, 2018). These four core principles are briefly defined as follows:

1. Non-maleficence: Avoiding the causation of harm.
2. Beneficence: Not just preventing or lessening harm, but making choices that benefit individuals, including the need to balance potential benefits against potential risks.
3. Justice: Equitable distribution of benefits and risks (i.e., avoiding bias).
4. Respect for autonomy: Supporting an individual's right to make decisions for themselves.

As the term implies, *core principles* are foundational and standard in biomedical ethics (Beauchamp & Childress, 2012). These principles have been deemed as universal and prima facie (Gillon, 2003). Furthermore, they should be understood as a collective whole and, therefore, *functionally equivalent* (Beauchamp & Childress, 2012).

The four core principles also convey an internal balance; the principles of non-maleficence and beneficence are counterbalanced by respect for autonomy and justice (Beauchamp & Childress, 2012). For example, a beneficent outcome may not be what an autonomous individual prefers (e.g., "the right to die") or a desire for individual beneficence may conflict with justice-based triage decisions.

Beauchamp and Childress' four core principles have been adopted by service-based professions even those outside of the field of medicine (Jonsen, 1995). While there is evidence that these core principles play a role in ethical codes for community interpreters (Dean, 2015, 2021), there is little evidence that the profession has overtly sanctioned or operationalised them. Operationalising principles or, as is termed in the ethics field, *specifying them* to each unique profession, is the requisite next step.

A principled-reasoning assessment of both interpreting cases above could be reframed in light of Beauchamp and Childress's principles. In Ellen's case, comforting those who

are suffering is consistent with the principle of beneficence, while preventing the patient from disrupting nearby medical equipment is consistent with the principle of non-maleficence. In my case, by addressing and preventing a potential medical mistake, non-maleficence was the operationalised principle.

In my (Dean's) reflective supervision sessions, interpreters have presented cases where the principles of justice and autonomy also have come to the fore. This is less common, however, because interpreters are already more attuned to these values. For example, justifications for equal access are grounded in concerns for justice, and respecting the self-determinacy of the service users is grounded in concerns for autonomy. The problem is that far less consideration is given to the values of non-maleficence and beneficence. Furthermore, decisions that are rooted in principles like justice and autonomy are more aligned with the profession's normative materials than those that compel actions out of concern for non-maleficence and beneficence.

Neither Ellen nor I were trained in these ethics principles. Instead, we were left with the rule-based vocabulary of interpreting, only able to frame our decisions as exceptions to the rule, or to defend them using the language of descriptive ethics. Ellen ultimately proclaimed, "It's a humanity thing!" to justify the simple action of taking the hand to comfort and protect someone writhing in pain. If Ellen had been equipped to present the case using principles and principled-reasoning, the discussion would have unfolded differently (and most likely quite briefly), if she even deemed the case as worthy of presenting at all—similar to how Dr Shao perceived my case as clearly not problematic.

The Need for Intermediate Ethical Concepts and Reflective Equilibrium

It is challenging to apply the four core principles to decision-making in the brief form in which they are conveyed above. Beauchamp and Childress note this as well, stating that the principles are "too bare a starting point for thinking through problems" (Beauchamp & Childress, 2012, p. 17). Narrowing the scope of broad ethical principles and applying them to the specifics of a given profession is the function of a profession's *intermediate ethical concepts* (Bebeau & Thoma, 1999).

Intermediate ethical concepts are specific to a profession and serve as a middle-ground between broad ethical principles (e.g., autonomy) and more directive rules (e.g., obtaining fully informed consent before deciding on a medical treatment). In other words, it is not sufficient to document broad principles in a profession's sanctioned ethical materials such as codes of ethics; a profession needs to denote how broad principles are to be specified (Beauchamp & Childress, 2012) or effectively articulated at an intermediate level (Bebeau & Thoma, 1999).

Intermediate ethical concepts provide more specific behavioural guidance than do the core principles (Beauchamp & Childress, 2012; Dean, 2015). Granted, some ethical documents in community interpreting identify broad principles and define them using illustrative behaviours. For example, the broad principle of "accuracy" is illustrated with sample behaviours such as, "the interpreter corrects errors in interpretation" (NCIHC, 2005, p. 5; see other examples in IMIA, 2007, 2010; NCIHC, 2004, 2005). However, the profession generally lacks intermediate ethical concepts that are outgrowths of principles and *sanctioned* by professional organisations and policy-makers (Dean, 2015). In either

their broad state or through specification, the four clusters of principles can both compel or contain action (Dean & Pollard, 2018). In other words, the argument is not whether interpreters should take action or not, but what type of action or inaction is necessary in the context of the interpreting situation.

Intermediate ethical concepts are those which are operationalised to be useful to practitioners. Operationalising principles within a specific context is fundamentally different to applying a rule. For example, it is more cognitively straightforward to abide by the rule of *do not advise* than it is to determine how the related principle of autonomy functions within the particulars of an interpreting situation (Fritsch-Rudser, 1986). Is advising prohibited when deaf or hearing individuals do not have sufficient information or ability to make autonomous decisions? The application of a rule is a simpler, more *cognitively available* reasoning process (Kahneman, 2011), whether an interpreter is making a decision, or justifying or critiquing one. Ellen's colleagues responded by using what was most cognitively available to them (rules) because that is the ethical vocabulary ubiquitous in interpreting ethics materials and discourse (Dean, 2014, 2015).

Advancing teleology and principled-reasoning requires more than a series of relevant principles and their application to the context of a situation (which intermediate ethical concepts would facilitate). There are other important normative constructs that pertain to decision-making wisdom and which underscore the significance of decision-making flexibility. A particularly important one is *reflective equilibrium* (Hundert, 1987), that is, the weighing of *conflicting* ethical obligations before making a decision (Beauchamp & Childress, 2012). In many situations, practitioners must choose between two (or more) desirable, ethical options. This has been referred to as *balancing*, defined as "the process of finding reasons to support beliefs about which moral norms should prevail" (Beauchamp & Childress, 2012, p. 20) in a given situation. Opting for one principle over another depends on the "relative weight and strengths of different moral norms" (Beauchamp & Childress, 2012, p. 20; see also Hundert, 1987). Engaging in reflective equilibrium, the task of balancing and weighing relevant yet competing ethical principles cannot be solved by merely creating a better ethical code; these challenges are too situation-dependent. It is not possible to create an ethical code for professional practice that is free from conflict or exceptions to the rules (Beauchamp & Childress, 2012). Rather, Dean and Pollard (2013, 2018) emphasise that choosing one value over a competing one implies that the value not chosen is not abandoned but rather, has been "forfeited," even if temporarily. It is the interpreter's obligation to be aware of having forfeited a desirable value, and, where possible, to seek an opportunity to remediate the consequence(s) of having done so.

Normative Reframing of Descriptive Ethics

Ellen and I did not have the benefit of intermediate ethical concepts sanctioned by policy-makers in our profession's normative literature, nor knowledge regarding the need for reflective equilibrium. While we did not lack the ability to *function* in a manner consistent with such higher order principles; we lacked the *verbal reasoning skills* (i.e., principled-reasons skills) to justify our decisions (Narvaez & Bock, 2002). It is common for interpreters participating in case analyses to employ descriptive terms and phrases because their ethical lexicon is limited by the broader profession's heavy reliance on deontological, rule-based education and ethics messaging, usually focused on the

inaction ideal. Thus, when action is warranted and defensible, interpreters are left only to reach beyond their limited normative vocabulary and espouse what has been proffered by descriptive ethics in the field, that is, figurative language (Dean, 2015).

In her work leading case analyses, Dean commonly hears figurative language used in regard to both inaction and action.

Examples of figurative language that appeals to inaction include the following:

- *You're just the interpreter, you're not the (teacher, doctor, lawyer).*
- *What if you hadn't been there?*
- *What if the patient could hear/understand some English)?*
- *What about the precedent you are setting for the interpreter who comes after you?*

Examples of figurative language that appeals to action include,

- *I'm a person first.*
- *I have to sleep at night.*
- *I'm an advocate . . . ally . . . member of the team . . . cultural mediator or broker*."

While these questions and comments are intended to be normative (i.e., they are trying to convey something about what should or should not be done), they are figurative and therefore non-normative in how they are expressed. That is, they are not employing normative devices such as principles, rules, obligations, and rights. Some of these same metaphors and figurative devices are employed in research and teaching publications in the interpreting field (Davidson, 2000, 2001; Hsieh, 2007; Dysart-Gale, 2005; Bergson & Sperlinger, 2003; Rumsey, 2019).

Ellen's claim that she was acting out of her humanity is just one of several beneficence-like phrases that interpreters use. Others have claimed that "I'm a person first" or "I have to sleep at night" (Bergson & Sperlinger, 2003; Rumsey, 2019). Yet, justifying a decision based on one's humanity or how one benefits personally is problematic. Stating that one is human, or a person, puts the emphasis on personal discretion and not on professional expectations. Ellen's colleague stated, "if you feel like holding someone's hand, then you should do it!" Using such non-normative phrases communicates to service users and other stakeholders that the practitioners' individual feelings are driving decisions and not sanctioned professional principles.

It is also common for conversations that employ figurative language to become macro-level discussions and to transcend the bounds of a specific case being examined. When this occurs, the conversation is no longer about that case. Instead, it turns into a broader discussion about interpreters' scope of practice and expertise. Such discussions, consciously or unconsciously, are presumed applicable to all such settings and situations (e.g., medical, legal, educational), all potential consumers, and all interpreters. This is not how a teleological case analysis occurs. Teleology situates decisions within a specific to assess the consequences and relevant principles at stake (Dean & Pollard, 2011, 2013).

Deliberating about practitioners' decisions and their ethical implications is an important normative function in case analysis (Proctor, 2000), but back-and-forth appeals for

action (or inaction) using figurative language or hypothetical situations do little to advance practice-based critical thinking and ethical analysis—and by extension do little to improve in-situ decision-making (Rest & Narvaez, 1994).

One way that professionals engage in constructive, normative-based discourse as a means of developing sound ethical reasoning is through the reflective practice of professional supervision (Hundert, 1987). Honest dialogue with one's colleagues is how a profession is developed (Palmer, 1998), and how new practitioners learn to specify or operationalise the profession's sanctioned principles and values (Bowers, 1999). Supervision is "a designated interaction between two or more practitioners within a safe and supportive environment, that enables a continuum of reflective critical analysis of care, to ensure quality [consumer] services, and the wellbeing of the practitioner" (see Curtis, 2017, pp. 2–3; see also Dean & Pollard, 2013).

Supervision as a technique for advancing ethical thought and action in the profession of signed language interpreting was proposed over 30 years ago (Fritsch-Rudser, 1986). In the last 15 years, there have been advances in the United States, the United Kingdom, Europe, and Australia to employ supervision as a professional development tool for interpreters (Curtis, 2017; Dean & Pollard, 2011, 2018; Hetherington, 2011, 2012). There is also evidence that supervision plays a role in the professional development of interpreters in other parts of the world (LeClerc, 2019).[1]

What is less clear in the interpreting profession is how the term supervision and related concepts such as mentoring are being defined, what the aims of supervision are, and how supervision is conducted. This is not the case in other professions where supervision and other forms of reflective practice are an established component of educational programmes and professional practice (Bernard & Goodyear, 2009). Clinical supervision in the field of psychology is a tradition and as such, enjoys a greater research base (Brunero & Stein-Parbury, 2008).

There is limited research into the value and function of supervision in signed language interpreting, but evidence suggests that it can advance teleologic, principled-reasoning (Curtis, 2017; Forman, 2019; Wilbert, 2018). Curtis (2017) conducted an international study of the practices and benefits of supervision for signed language interpreters. Her study surveyed over 100 interpreters who had engaged in supervision groups that used the framework of the demand control schema (DC-S).

Developed by Dean and Pollard (2011, 2013, 2018) as an approach to interpreting work analysis and decision-making, DC-S is values based and designed to advance principled-reasoning using normative ethical constructs. Part of the design of DC-S and its use in supervision is to provide participants with the *verbal assistance* (Narvaez & Bock, 2002) necessary to effectively express their thinking and to examine their actions within an established ethical framework (i.e., principled-reasoning). Supervision leaders are trained to use concepts and vocabulary that are distinctly different from traditional ethical discourse in interpreting. Instead of prescriptive rules and non-normative discourse, supervision leaders provide the normative and coordinating vocabulary necessary for a principled-reasoning discussion (Dean & Pollard, 2011). For any professional practitioner, outcomes based, principled-reasoning takes time to develop and master, but for community interpreters, there is also a period of remediation—not only to learn the constructs of normative ethics, but to unlearn both non-normative and rules based conventions. In order for a case analysis discussion to be effective, non-normative language

referring to action or inaction is deconstructed to reveal the values or principles derived from interpreting codes or other relevant principles from the service setting (see Dean & Pollard, 2018 for a list of proposed values in community interpreting). Supervision leaders model the effective application of such principles to the specific context of the case being examined.

Curtis used Proctor's (2000) framework to identify the following three functions of supervision: a *normative* function (i.e., advancing practitioners' sense of accountability and concordance with the professional standards of a field), a *formative* function (i.e., enriched learning), and a *restorative* function (i.e., advancing the wellbeing of the practitioner). Given the prevalence of interpreters' use of conventional reasoning and non-normative language when discussing interpreting cases, DC-S-based supervision places heavy emphasis on Proctor's normative function. Curtis' respondents reported that DC-S group supervision yielded all three of the above benefits, with the normative function being the most significant (Curtis, 2017).

Conclusion

Descriptive ethics do not share the same vocabulary with normative ethics (e.g., principles, rules, obligations, and rights). Because of the prevalent use of metaphorical language and other types of figurative speech, interpreters often express what is normative using non-normative (descriptive) terms and phrases (Dean, 2015; Dean & Pollard, 2018). If the limited vocabulary of what is normative is only available in terms of rules, then the ethical development of community interpreting is unlikely to advance beyond the deontological, conventional moral reasoning stage. To advance reasoning skills towards principled (i.e., post-conventional) reasoning, interpreters and interpreter educators need to utilise normative constructs that allow for situational and behavioural flexibility.

There are three main targets for improvement in this regard: (1) to adopt and specify broad ethical principles into sanctioned intermediate ethical concepts (i.e., operationalise the four core principles for community interpreting practice); (2) to institute case analysis, structured reflective practices, and supervision in education and accreditation processes; and (3) to address the misuse of non-normative terms and phrases (e.g., *conduit*, *advocate*, *team member*) that do not improve practitioners' ethical rigour, judgement, and decision-making. The profession's lack of development in regard to the use of normative ethics and related pedagogies has not only compromised the principled-reasoning skills of community interpreters; they set interpreters apart from those service professionals that interpreters encounter and collaborate with in their everyday practice, who do reason in these more advanced ways.

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Note

1. It was out of concern for the quality of interpreter supervision that the Interpreting Institute for Reflection-in-Action and Supervision (IIRAS) was created. IIRAS, based in Oregon in the United States, has trained and accredited leaders who provide individual and group supervision to interpreters in several countries.

References

Bancroft, M. A., Beyaert, S. G., Allen, K., Carriero-Contreras, G., & Soccarrás-Estrada, D. (2015). *The community interpreter: An international textbook*. Culture & Language Press.

Beauchamp, T. L., & Childress, J. F. (2012). *Principles of biomedical ethics* (7th ed.). Oxford University Press.

Bebeau, M. J., & Thoma, S. J. (1999). "Intermediate" concepts and the connection to moral education. *Educational Psychology Review*, *11*, 343–360.

Bergson, M., & Sperlinger, D. (2003). "I still don't know what I should have done": Reflections on personal/professional dilemmas in sign language interpreting. *Deaf Worlds*, *19*, 6–23.

Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision*. Canadian Counselling and Psychotherapy Association.

Bowers, M. B. (1999). Supervision in psychiatry and the transmission of values. *Academic Psychiatry*, *23*(1), 42–45.

Brisset, C., Leanza, Y., & Laforest, K. (2013). Working with interpreters in health care: A systematic review and meta-ethnography of qualitative studies. *Patient Education and Counseling*, *91*(2), 131–140. https://doi.org/10.1016/j.pec.2012.11.008

Brunero, S., & Stein-Parbury, J. (2008). The effectiveness of clinical supervision in nursing: An evidenced based literature review. *Australian Journal of Advanced Nursing*, *25*(2), 86–94.

Cartwright, B. E. (2010). *Encounters with reality* (2nd ed.). Registry of Interpreters of the Deaf.

Chesterman, A. (1993). From 'is' to 'ought': Laws, norms and strategies in translation studies. *Target*, *5*, 1–20.

Clifford, A. (2004). Is fidelity ethical? The social role of the healthcare interpreter. *TTR: Traduction, Terminologie, Rédaction*, *17*, 89–114. https://doi.org/10.7202/013273ar

Cokely, D. (2000). Exploring ethics: A case for revising the code of ethics. *Journal of Interpretation*, 25–60.

Cross Cultural Health Care Program. (2013). Bridging the gap for medical interpreters—A course description. https://xculture.org/bridging-the-gap/

Curtis, J. (2017). *Supervision in signed language interpreting: Benefits for the field and practitioners* [Master's thesis]. Western Oregon University.

Davidson, B. (2000). The interpreter as institutional gatekeeper: The social-linguistic role of interpreters in Spanish-English medical discourse. *Journal of Sociolinguistics*, *4*(3), 379–405. https://doi.org/10.1111/1467-9481.00121

Davidson, B. (2001). Questions in cross-linguistic medical encounters: The role of the hospital interpreter. *Anthropological Quarterly*, *74*(4), 170–178. https://doi.org/10.1353/anq.2001.0035

Dean, R. K. (2014). Condemned to repetition? An analysis of problem-setting and problem-solving in sign language interpreting ethics. *Translation and Interpreting*, *6*, 60–75. https://doi.org/10.12807/ti.106201.2014.a04

Dean, R. K. (2015). *Sign language interpreters' ethical discourse and moral reasoning patterns* [PhD thesis]. Heriot-Watt University.

Dean, R. K. (2021). Healthcare interpreting ethics: A critical review. In S. Susam-Saraeva & E. Spišiaková (Eds.), *Routledge handbook of translation and health* (pp. 198–215). Routledge. https://doi.org/10.4324/9781003167983-16

Dean, R. K., & Pollard, R. Q., Jr. (2011). Context-based ethical reasoning in interpreting: A demand control schema perspective. *Interpreter and Translator Trainer*, *5*(1), 155–182. https://doi.org/10.1080/13556509.2011.10798816

Dean, R. K., & Pollard, R. Q., Jr. (2013). *The demand control schema: Interpreting as a practice profession*. CreateSpace Independent Publishing Platform.

Dean, R. K., & Pollard, R. Q., Jr. (2018). Promoting the use of normative ethics in the practice profession of community interpreting. In L. Roberson & S. Shaw (Eds.), *Signed language interpreting in the 21st century: An overview of the profession* (pp. 37–64). Gallaudet University Press.

Dysart-Gale, Deborah. (2005). Communication models, professionalization, and the work of medical interpreters. *Health Communication*, *17*, 91–103.

Forman, J. (2019). *Studying supervision as a pathway to moral reasoning for interpreters* [Master's thesis]. Rochester Institute of Technology.

Fritsch-Rudser, S. (1986). The RID code of ethics, confidentiality, and supervision. *Journal of Interpretation*, *3*, 47–51.

Gillon, R. (2003). Ethics needs principles—Four can encompass the rest—And respect for autonomy should be "first among equals." *Journal of Medical Ethics*, *29*(5), 307–312. https://doi.org/10.1136/jme.29.5.307

Hetherington, A. (2011). A magical profession? Causes and management of occupational stress in the signed language interpreting profession. In L. Leeson, S. Wurm, & M. Vermeerbergen (Eds.), *The sign language translator and interpreter: Preparation, practice and performance* (pp. 144–165). St Jerome.

Hetherington, A. (2012). Supervision and the interpreting profession: Support and accountability through reflective practice. *International Journal of Interpreter Education*, *4*(1), 46–57.

Hill, A. L. (2004). Ethical analysis in counseling: A case for narrative ethics, moral visions, and virtue ethics. *Counseling and Values*, *48*(2), 131–148. https://doi.org/10.1002/j.2161-007X.2004.tb00240.x

Hsieh, E. (2007). Interpreters as co-diagnosticians: Overlapping roles and services between providers and interpreters. *Social Science and Medicine*, *64*(4), 924–937. https://doi.org/10.1016/j.socscimed.2006.10.015

Hsieh, E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Qualitative Health Research*, *18*(10), 1367–1383. https://doi.org/10.1177/1049732308323840

Hundert, E. M. (1987). A model for ethical problem solving in medicine, with practical applications. *American Journal of Psychiatry*, *144*, 839–846.

International Medical Interpreters Association. (2007). Medical interpreting standards of practice. https://www.imiaweb.org

International Medical Interpreters Association. (2010). IMIA guide on medical interpreter conduct. https://www.imiaweb.org

Jonsen, A. R. (1995). Casuistry: An alternative or complement to principles? *Kennedy Institute of Ethics Journal*, *5*(3), 237–251.

Kahneman, D. (2011). *Thinking, fast and slow* (1st ed.). Farrar, Straus and Giroux.

Kermit, P. (2007). Aristotelian ethics and modern professional interpreting. In C. Wadensjö, D. B. Englund, & A. L. Nillson (Eds.), *The critical link 4: Professionalisation of interpreting in the community* (pp. 241–249). John Benjamins. https://doi.org/10.1075/btl.70.26ker

Kohlberg, L. (1976). Moral stages and moralization: The cognitive-developmental approach. In T. Lickona (Ed.), *Moral development and behaviour* (pp. 31–53). Holt, Rinehart and Wilson.

LeClerc, S. (2019). *Exploring the uptake of reflective practice in the sign language interpreting profession across Europe* [Master's thesis]. Magdeburg-Stendal University of Applied Sciences.

Marin, J. (2020). A medical interpreter training program and signed language interpreters' decision latitude: Exploring the impact of specialized training. In I. Souza & E. E. Fragkou (Eds.), *Handbook of research on medical interpreting* (pp. 421–455). IGI Global. https://doi.org/10.4018/978-1-5225-9308-9.ch018

Mason, I. (2000). Models and methods in dialogue interpreting research. In M. Olohan (Ed.), *Intercultural faultlines: Research models in translation studies: Textual and cognitive aspects* (pp. 1–15). St. Jerome.

Merlini, R., & Favaron, R. (2009). Quality in healthcare interpreter training. Working with norms through recorded interaction. In S. Hale, U. Ozolins, & L. Stern (Eds.), *The critical link 5. Quality in interpreting—A shared responsibility* (pp. 187–200). John Benjamins. https://doi.org/10.1075/btl.87.15mer

Narvaez, D., & Bock, T. (2002). Moral schemas and tacit judgement or how the Defining Issues Test is supported by cognitive science. *Journal of Moral Education*, *31*, 297–314. https://doi.org/10.1080/0305724022000008124

National Council on Interpreters in Healthcare. (2004). National Code of Ethics for Interpreters in Health Care. https://www.ncihc.org

National Council on Interpreters in Healthcare. (2005). National Standards of Practice for Interpreters in Health Care. https://www.ncihc.org

Nicodemus, B., Swabey, L., & Witter-Merithew, A. (2011). Establishing presence and role transparency in healthcare interpreting: A pedagogical approach for developing effective practice. *Rivista di Psicolinguistica Applicata*, *11*(3), 69–83.

Palmer, P. J. (1998). *The courage to teach: Exploring the inner landscape of a teacher's life*. Jossey-Bass.

Parker, D., & Greener, P. (2010). Ethics research: Moral psychology and its promise of benefits for moral reasoning in the military. In J. Stouffer & S. Seile (Eds.), *Military ethics: International perspectives* (pp. 25–47). Canadian Defence Academy Press.

Proctor, B. (2000). *Group supervision: A guide to creative practice*. SAGE.

Pym, A. (2000). On cooperation. In Olohan, M. (ed.) *Intercultural Faultlines: Research Models in Translation Studies I: Textual and Cognitive Aspects*. St. Jerome Publishing, pp. 181–192.

Pym, A. (2001). Introduction: The return to ethics in translation studies. *The Translator*, *7*(2), 129–138. https://doi.org/10.1080/13556509.2001.10799096

Pym, A. (2006). Introduction: On the social and cultural in translation studies. In A. Pym, M. Schlesinger, & Z. Jettmarova (Eds.), *International conference on translation and interpreting* (pp. 1–25). John Benjamins. https://doi.org/10.1075/btl.67.02pym

Rest, J. (1979). *Development in judging moral issues*. University of Minnesota Press.

Rest, J., Narvaez, D., Bebeau, M., & Thoma, S. (1999). A neo-Kohlbergian approach: The DIT and schema theory. *Educational Psychology Review*, *11*(4), 291–324.

Rest, J. R., & Narvaez, D. (1994). Summary: What's possible?. In J. R. Rest & D. Narvaez (Eds.), *Moral development in the professions: Psychology and applied ethics* (pp. 213–224). Lawrence Erlbaum Associates.

Roy, C. B. (1993). The problem with definitions, descriptions, and the role metaphors of Interpreters. *Journal of Interpretation*, *6*(1), 127–154.

Rumsey, D. (2019). *Ethics, professionalism, and decision making for sign language interpreters: A pragmatic and thoughtful approach*. Independently Published.

Shaffer, B. (2014). Evolution of theory, evolution of role: How interpreting theory shapes interpreter role. In E. A. Winston & C. Monokowski (Eds.), *In evolving paradigms in interpreter education* (pp. 128–150). Gallaudet University Press.

Tate, G. T., & Turner, G. H. (2001). *The code and the culture: Sign language interpreting—In search of the new breed's ethics*. Douglas McLean.

Wadensjö, C. (1992). *Interpreting as interaction: On dialogue-interpreting in immigration hearings and medical encounters* [Doctoral dissertation]. Linköpings universitet.

Wilbert, C. L. (2018). *Case conferencing decreases occupational stress for VRS interpreters: A qualitative study* [Master's thesis]. Saint Cloud State University.

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