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Finding ethics in and out of deontological codes: ethical dilemmas faced by healthcare interpreting student interns

En busca de la ética dentro y fuera de los códigos deontológicos: dilemas éticos a los que se enfrentan estudiantes en prácticas de interpretación sanitaria

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Abstract: Establishing a code of ethics is a requirement an occupation must meet to become a full-fledged profession. In healthcare interpreting, several professional associations have published their own codes. Students are introduced to these codes in the classroom, but when they access the profession they often face ethical dilemmas that may overlap with their professional obligations. This paper explores a series of ethical dilemmas faced by students that first encounter the workplace as part of an internship programme. Drawing on participant observation and post-encounter interviews, we identify ethical dilemmas, describe the interns' behaviour, and illustrate the rationale behind their choices. This allows us to isolate factors that hinder participants from strict adherence to codes of ethics (i.e., the theory-practice gap, contextual restrictions, and human emotion). In light of results obtained, we encourage trainers and interpreters to develop critical ethical thinking in different healthcare scenarios to facilitate assessing the consequences of (not) following a code of ethics.

Keywords: Healthcare interpreting, Ethical dilemmas, Code of ethics, Student interns, Training

Resumen: Establecer un código deontológico es un requisito que toda ocupación debe cumplir para convertirse en una profesión plenamente desarrollada. En el ámbito de la interpretación sanitaria, varias asociaciones profesionales han publicado sus propios códigos. Los estudiantes se familiarizan con estos documentos en el aula, pero al acceder al mercado laboral con frecuencia encuentran dilemas éticos que pueden solaparse con sus obligaciones profesionales. Este artículo explora una serie de dilemas éticos a los que se enfrentan estudiantes que entran en contacto por primera vez con la actividad profesional como parte de un programa de

prácticas universitarias. A través de observación participante y entrevistas posteriores a los encuentros, se identifican diferentes dilemas éticos, se describe el comportamiento de los estudiantes en prácticas y se ilustran las razones en las que basan sus decisiones. Este proceso permite delinear los factores que impiden que los participantes se atengan estrictamente a los códigos deontológicos (es decir, la desconexión teórico-práctica, las restricciones contextuales y las emociones humanas). En vista de nuestros resultados, se aboga por que profesores e intérpretes promuevan un pensamiento ético crítico en diferentes escenarios sanitarios para así facilitar evaluar las consecuencias de (no) seguir un código ético.

Palabras clave: Interpretación sanitaria, Dilemas éticos, Código deontológico, Estudiantes en prácticas, Formación

INTRODUCTION

Social changes often entail the emergence of unattended needs and empty spaces that must be occupied by new professional roles. This is the case of healthcare interpreting, which arose to facilitate communication between patients and healthcare providers in our ever-increasing multilingual and multicultural societies. Despite its indubitable impact on an individual's well-being, healthcare interpreting is still an underprofessionalised activity. There is no official agreement on the healthcare interpreters' role and professional tasks. In addition to this, healthcare interpreters face precarious employment situations where remuneration is low. Although some countries have taken appropriate steps towards professionalisation with an increase in their training options (Valero Garcés & Lázaro Gutiérrez, 2016; Álvaro Aranda & Lázaro Gutiérrez, 2021), to this date healthcare interpreting still does not require a higher education degree to enter the profession and there is no validation of credentials for practice universally accepted (Angelelli, 2019). Consequently, *ad hoc* interpreting practices continue to be the most recurrent and family members, partners or friends often join the patients in medical consultations (Twilt *et al.*, 2020). Healthcare interpreting is yet to hold professional jurisdiction—that is, to claim a monopoly of practice—by presenting itself to society as the most appropriate solution to a «professional problem» (Abbott, 2014).

These signs are frequently mentioned as indicators of underprofessionalisation in the sociology of the professions, a discipline seeking to study professions as a special category of occupations (Reis Monteiro, 2015) to become a fully-fledged profession, an occupation must meet a specific set of criteria covering formal, legal, jurisdictional, institutional, organisational, educational, economic, and ethical factors.

Traditionally, the professionalisation process entails establishing a professional association, as well as designing a code of ethics (Wilensky, 1964). These codes intend to regulate professional behaviour (Volti, 2008) and guide decision-making in a way that matches the responsibilities of its practitioners (Ortega Sánchez, 2010). Enforcing a code of ethics serves to exert internal control and earn public trust (Tseng, 1992 in Mikkelson, 1996), as ethical principles allow professionals to show the way they do things (Garber, 2008). In a clear attempt to boost the professional status of healthcare interpreting, several codes of ethics have been published by professional associations, such as the California Healthcare Interpreting Association (CHIA), the International Medical Interpreting Association (IMIA) or the National Council on Interpreting in Health Care (NCIHC).

Healthcare interpreting students are introduced to these codes during their education. However, when they leave the classroom and enter the profession, they often face difficult situations where abiding by a code of ethics inevitably entails facing ethical dilemmas that may overlap with their professional tasks (Lázaro Gutiérrez, 2009; Pena Díaz, 2018). An ethical dilemma involves cases in which the moral precepts or other mandatory ethical obligations enter in conflict, thus making any possible solution to the dilemma morally intolerable (Ruiz Cano *et al*., 2015). In public service and, by extension healthcare interpreting, dilemmas may be caused by a myriad of reasons, including conflicts of interest; sensitive, personal, or cross-cultural issues and conflicting expectations from participants (Hale, 2007). How do trainee interpreters conduct themselves in these contexts regarding their code of ethics? Do they find codes a useful guide or, rather, a limiting tool? What are the potential consequences of breaching the interpreters' code(s) of ethics?

This paper sets out to explore a series of real healthcare-interpreted scenarios presenting ethical dilemmas to five healthcare interpreting students interns entering the practice for the first time as part of an internship programme. Sections 1 and 2 present some basic theoretical concepts related to ethics, deontology, and their application to the healthcare interpreting (education) field. Subsequently, Section 3 describes the methodological approach, nature of data and study participants; to later on present six ethical dilemmas and three factors affecting decision-making in Sections 4 and 5. Finally, Section 6 offers some reflections in the light of our results.

1. ETHICS, PROFESSIONAL ETHICS AND DEONTOLOGY: DEFINING AN ETHICAL DILEMMA

Ethics is defined as a series of moral values or principles seeking to distinguish between good or bad and establish moral duties and obligations (Crommelin & Pline, 2007). Depending on the defining criteria, ethics can be classified into several categories. Thus, personal ethics is defined as the ethical system an individual chooses as a moral guide in life (Jacorzynski, 2009), whereas professional ethics reflects on what members of a professional group do (or should do) to be ethical in the course of their professional activity, regardless of whether this is captured or not in a code (Hortal Alonso, 2002). On the other hand, deontology addresses ethical contents from a normative, descriptive, and even prescriptive viewpoint (García Fernández, 2007). It encompasses the set of norms, rules, principles, and attitudes that regulate a profession (Vázquez Esquivel, 2011), which are reflected in a code and approved by a professional association (Hortal Alonso, 2002). The intersection of these factors is a common source of tension for practitioners, especially when professional ethics contradict the individual's ethical framework or, alternatively, there is a lack of clarity on professional norms and values. Thus, ethical dilemmas emerge when individuals must inevitably make a decision among different course of actions to choose from and, regardless of their choice, there exists a violation or compromise of one or more ethical principles (Team ARSu, 2020).

Despite being different concepts, professional ethics and deontology are used synonymously very often (Vives i Gracia, 2013). This explains to a large extent why, although not identical, deontological codes, codes of ethics, codes of conduct, standards of practice and professional standards are used in healthcare interpreting interchangeably (Baixauli-Olmos, 2014). For the aims of this paper, we will not delve further into conceptual or semantic nuances and, to avoid ambiguity, the terms deontological code and code of ethics will be used interchangeably to describe a set of moral precepts or norms followed by a collective of professionals to ensure an honest practice and an honourable conduct among its members (Vidal Casero, 2003).

2. CODES OF ETHICS IN (HEALTHCARE) INTERPRETING

As indicated earlier in the paper, a code of ethics allows a profession to ensure quality and accountability to the communities it serves (Yuen, 2003). Tenets of ethical behaviour found in codes of ethics are typically laid out in the form of norms binding to all members of a profession (Kalina 2015), obliging them to adhere to a common set of rules (Moratto & Li,

2022). They require adopting shared, well-considered professional values (Baixauli-Olmos, 2017), which in turn offer practitioners a space to protect themselves in their everyday practice when confronted with ethical dilemmas (Pena Díaz, 2018). Nevertheless, codes of ethics for translators and interpreters tend to be advisory, educational, rather than regulatory, and only apply to those who join the professional associations that create them (Drugan, 2017). The underprofessionalisation of healthcare interpreting further exacerbates this problem, as interpreters are not obliged to join a professional association and, as such, practising interpreters may not even be familiar with deontological codes (Phelan *et al*., 2019).

In any case, deontological codes usually cover a series of elements, including a description of the profession, professional duties, organisational control, practitioner's rights or prohibitions and some basic principles (Muñoz Boda, 2018). In the field of healthcare interpreting, associations often coincide in four basic principles. More precisely, healthcare interpreters must respect participants' privacy and avoid disclosing information to third parties (confidentiality) and remain impartial along their work (impartiality). Interpreters must not add, omit, or alter information (accuracy/fidelity) and must be ready to declare potential conflicts of interest and withdraw from assignments which surpass their skills (professionalism/professional integrity). These tenets can be presented in isolation (e.g., IMIA, 2006) or alongside protocols (e.g., CHIA, 2002) or even good practice guidelines (e.g., NIHSSIS, 2004).

Codes acknowledge situations in which ethical principles should be overlooked. To illustrate this, healthcare interpreters may ignore confidentiality if there is evidence suggesting child abuse or suicidal tendencies. Nevertheless, exceptions to the rules are presented in a general, rather unspecific way, leaving interpreters in a difficult position regarding how and when to ignore an ethical principle in the multiple scenarios they face in practice (Raga Gimeno, 2014). Consequently, and although ethical notions may seem undisputable at first glance, they offer an unsatisfying guide for interpreters facing ethical dilemmas in conflict-ridden events (Martín Ruano, 2017a).

There exist remarkable gaps between ethical codes and the realities found by healthcare interpreters. As such, these documents are not exempt from criticism. Ethical norms seem to perpetuate the conception of interpreters as invisible linguistic conduits (Cox, 2015), which has been severely criticised in the literature, inasmuch as they need to expand this basic default role to explain cultural differences (Rosembaum *et al.,* 2020), explore ambiguous answers (Baraldi & Gavioli, 2018) or detail institutional

procedures (Álvaro Aranda, 2020). This suggests that traditional ethical codes might be only valid on paper (Pöllabauer, 2004). To support this idea, research proves that interpreters working in different fields often have trouble following ethical principles, with a special emphasis on the tenet of impartiality (Cedillo Corrochano & Valero Garcés, 2014). Furthermore, abiding by ethical rules may be unethical if, for example, unequal access to power comes to light (Clifford, 2004). Regarding healthcare interpreting, Angelelli (2008) severely criticises prescriptivism in codes of ethics and states that ethical principles should be empirically tested and grounded to address the complexity interpreters face.

This complexity becomes more relevant when focusing on the peculiarities of the field. Healthcare interpreters interact with patients that often find themselves in situations of vulnerability, which in itself is prone to raise ethical issues due to a potential emotional response in interpreters. In addition, interpreters work with other professionals (i.e., doctors, nurses, and administrative staff) that ascribe to their own set of ethical norms. Employing institutions may also impose rules contradicting the interpreters' professional values as defined by associations (Baixauli-Olmos, 2014). This makes developing a (nearly) universal code of ethics very difficult (Rudvin, 2007), especially considering that, however comprehensive, no code can predict every situation that may arise in practice. For this reason, practitioners will face events where elements present in codes of ethics will enter in conflict or, alternatively, be overlooked (Drugan & Megone, 2011). Having said this, some codes devote a section to put forward decision-making steps for interpreters facing an ethical dilemma, but they seem to be rather subjective (see, for example, CHIA 2002). This implies that in professional practice some decisions are left to the interpreter's «common sense» (Pena Díaz, 2018). Given the complexity of ethics in interpreting, it is thus not surprising that it has emerged as a prolific area of research frequently addressed in interpreters' training programmes (Moratto & Li, 2022).

Attention has been brought to the desirability of training in ethics for translation and interpreting students. Creeze & Asano (2016) reinforce that familiarising students with ethical dilemmas should be one of the topics to be addressed in education. However, this is not an easy task. Much of the criticism surrounding teaching ethics focuses on the fact that university-level trainers have long instructed students to follow ethical codes unquestioningly, instead of encouraging them to reflect on the potential consequences of their behaviour (Baker & Maier, 2011). As Dean & Pollard (2011) indicate, the interpreting profession has generally adopted a deontological ethical framework (i.e., strict adherence to pre-ordained rules), in detriment of a teleological approach (i.e., reflection on the potential

outcomes of one's actions). Ethical rules are thus often presented as a single, rigid set of norms that, as the Ten Commandments, seem to be carved in stone (Brander de la Iglesia, 2017).

In light of this, more recent calls demand widening the emphasis placed on teaching students to fulfil norms and, instead, encourage trainers to foster their critical abilities (Martín Ruano, 2017b). Looking for good or bad, right and wrong is not enough to address the complexity inherent to ethics, since students need to learn to identify ethical issues and reflect about how the latter shape their actions, to ultimately choose an action translating into an effective response in a particular situation (Drugan & Megone, 2011). Such a process resonates with the notion of professional judgement, which allows interpreters to assess whether they should apply their code in a specific situation, make a stand to enforce it or disregard it for a higher good (Hale, 2007). In this sense, Ozolins (2014) states the highest ethical priority for a healthcare interpreter is duty of care to patients. This aligns with the principles of beneficence and non-maleficence governing the ethical behaviour of healthcare personnel.

In the classroom, ethical dilemmas can be approached by means of several tools. For example, students of the MA in Intercultural Communication, Interpreting and Translation in Public Services (University of Alcalá, Madrid, Spain) take part in roleplays and subsequent discussions illustrating ethical dilemmas and assessing different solutions. Similar approaches are described in other Spanish educational centres, which may include discussion activities based on videos (Aguirre Fernández Bravo, 2019) and sometimes involve healthcare professionals in designing and representing roleplays (Sanz Moreno, 2017). Despite its usefulness, these are simulated encounters and trainers are advised to develop opportunities for students to observe professional interpreters' authentic performances, thus introducing a higher degree of authenticity (Kaczmarek, 2012). Other proposals take shape in the form of theoretical workshops, such as *La ética de la interpretación y autocuidado para los intérpretes* (2020), in which ethical dilemmas are approached together with self-care.

3. METHODS, DATASET AND PARTICIPANTS

We aim to examine how five interpreting postgraduate students conduct themselves in relation to codes of ethics in language-discordant events during their internships at a public hospital located in Madrid (Spain) that is home to an onsite team of healthcare interpreters. The name of the institution will not be specified due to confidentiality issues. Following our goal, we identified ethical dilemmas registered by participant observation in a dataset drawing upon healthcare interpreted events and post-encounter interviews (Álvaro

Aranda, 2020). For the purposes of this research, six ethical dilemmas were examined using an exploratory case study approach, which allowed us to analyse data with no hypothetical formulations or constraints (Streb, 2010). Our analysis is thus preliminary and framed within conversational analysis (Lazaraton, 2003).

Permission was obtained to conduct research twice a week for five months in 2017 after signing a confidentiality form and presenting the study to individuals in positions of authority at the institution. When fieldwork began, participants were informed about the aims of the research and were given a guarantee that confidentiality and privacy would be respected. In addition, participants granted oral consent in every session before data collection, which was adequately registered, sometimes making use of interpreters to overcome linguistic barriers. They were also reminded that they could withdraw consent at any time. It should be noted that obtaining written consent was discarded due to time restrictions before medical visits and the patients' low level of (health) literacy, or inability to write or read. Due to the sensitive nature of the setting, healthcare visits could not be video, or audio recorded, which made it impossible to transcribe conversations fully. However, manually written fieldnotes, which were taken in situ during participant observation in the field, allowed the author to register pertinent verbatim excerpts and these were used for analysis.

In any case, participant observation allowed us to isolate ethical dilemmas. Following Team ARSu (2020), selection criteria for ethical dilemmas included (i) situations compromising at least one ethical principle as laid out by most existing codes (confidentiality, impartiality, accuracy/fidelity, professionalism/professional integrity), (ii) which required interpreters to make a decision among different courses of action available. In a subsequent step, we described the participants' behaviour as observed in the workplace and delved into the rationale behind their choices by means of post-encounter interviews, which were manually written or first recorded and then transcribed. Interviews did not follow a script, as they included questions based on what was observed in each case, which allowed participants to be introspective about their behaviour in practice (Amos Hatch, 2002). This process illustrated factors preventing healthcare interpreters of the sample from strict adherence to ethical codes.

Five healthcare interpreting students enrolled in the study (Table 1). To protect their privacy, each of them has been assigned a general code (e.g., Interpreter 1). Regarding their background at undergraduate level, all interpreters had pursued a four-year degree in either Modern Languages, Translation, Interpreting or Cultural Studies. These programmes provide

students with a solid understanding of a minimum of two languages and introduce them to the cultural systems of the people who speak those languages. Concerning their postgraduate background, participants were all enrolled in the MA in Intercultural Communication, Public Services and Translation of the University of Alcalá, Spain (MA CITISP). As part of this programme, students completed a module focusing on healthcare interpreting and translation, in which they became familiar with ethical codes both theoretically and through practical exercises. The latter involve roleplays that include ethical dilemmas and emotional impact, and also test professional role boundaries, as well as subsequent discussions about these topics (Álvaro Aranda *et al.,* 2021).

Participant code	*Gender*	*Age*	*Nationality*	*Mother tongue*	*Working languages*	*Undergraduate background*	*Postgraduate background*
Interpreter 1	Female	23	Spanish	Spanish	French-Spanish	Modern languages	MA CITISP
Interpreter 2	Female	22	Spanish	Spanish	French-Spanish	Translation and interpreting	MA CITISP
Interpreter 3	Female	23	Spanish	Spanish	French-Spanish	Modern languages and translation	MA CITISP
Interpreter 4	Male	22	Spanish	Spanish	French-Spanish	Modern languages and translation	MA CITISP
Interpreter 5	Female	23	Moroccan	Arabic	Arabic-Spanish	Semitic and Islamic studies	MA CITISP

Table 1: Profile of participants

In addition, students must follow an internship programme to successfully complete the MA's. More precisely, participants developed an unpaid internship programme at the hospital in which data was collected. They attended the institution for approximately a month, five days a week, five hours a day. Following the internship offer, their tasks included facilitating communication between allophone patients and providers in healthcare events, which covered medical consultations, test delivered by nurses, delivery of samples, accompanying patients, assisting them with administrative procedures or interpreting in healthcare education workshops. This allowed them to interact with administrative staff, doctors, nurses, orderlies, x-ray technicians, patients, relatives, or companions.

During these interactions, several ethical dilemmas were found. To guide decision-making at the workplace, students were expected to rely on the theoretical notions acquired during their training and the ethical principles imposed by the interpreters' organisation at the hospital, which

placed special emphasis on confidentiality, impartiality, accuracy and refraining from taking personal advantage of any information obtained during their work. Additionally, in this hospital in particular interpreters are considered part of the assistance team and must abide by the ethical code of healthcare providers, which underlines the principles of non-maleficence and beneficence (Álvaro Aranda & Lázaro Gutiérrez, 2022).

4. ANALYSIS

Healthcare interpreters are typically presented to ethical codes during their training, but they are often confronted with ethical dilemmas in the course of their work that may jeopardise strict adherence to ethical principles. This section aims to gain a better understanding of the ethical issues faced by five student interns and their behaviour regarding codes of ethics when they first encounter the workplace. Drawing on our dataset, we conducted an inductive search to identify ethical dilemmas as described in Team ARSu (2020). Six pertinent scenarios (i.e., situations in which at least one ethical dilemma occurred) were selected for analysis based on their illustrative potential and suitability for our purposes (Table 2).

	Title	**Ethical principle(s) at risk**
Scenario 1	Don't tell him anything	Accuracy/Fidelity Impartiality
Scenario 2	If you want to let him know	Accuracy/Fidelity Beneficence
Scenario 3	Take this, hold here, give me that	Professional integrity
Scenario 4	I could fill that gap	Professional integrity
Scenario 5	If you don't want me to say something, shut your mouth	Accuracy/Fidelity
Scenario 6	That's not the patient's fault	Accuracy/Fidelity Impartiality

Table 2: Description of scenarios involving ethical dilemmas

To present each scenario, a description of the context, participants and ethical dilemma(s) is first provided. Subsequently, we examine the interpreter's behaviour and decision-making process, to conclude with an assessment of the situation. For reasons of clarity, all excerpts are shown in their original language and accompanied by a translation into English made by the author. Parentheses present actions, such as leaving a consultation room or shrugging unknowingly.

4.1. Scenario 1: Don't tell him anything

Interpreter 1 must accompany a Sub-Saharan 15-year-old male patient to get a blood test. Blood holds great symbolism in Sub-Saharan

African cultures, as it embodies life and strength (Navaza *et al*., 2012), and fear of needles, mistrust of hospitals and concerns of discrimination are important barriers (Klinkenberg *et al.*, 2019). In fact, false myths regarding blood reutilization and distrust of Spanish doctors were commonly observed in our dataset. The patient displays clear signs of fear: he has teary eyes and speaks with a trembling voice. Before arriving to the box, the patient reinforces his refusal to get his blood drawn and starts to turn around, which requires an intercultural mediation from the interpreter. He asks how many blood collection tubes are required and expresses his fear and discomfort. The patient agrees to the test only when the interpreter reassures him that blood tests are common procedures used to diagnose illnesses and disorders in healthcare centres. Eventually, they enter the box and meet the nurse.

Excerpt 1

1. Interpreter 1: Hola, soy la intérprete de francés. [*Hello, I'm the French interpreter*]
2. Nurse: ¿De qué idioma? ¿Francés? [*Which language? French?]*
3. Interpreter 1: Sí. [*Yes*]
4. Nurse: Salut, attends un moment. Dile que se descubra. [*Hello, wait a second. Tell him to uncover (his arm)]*

(The patient sighs)

5. Interpreter 1: Si tu as peur, ne regarde pas comment elle prélève le sang. [*If you're scared, don't look how she draws blood*]
6. Nurse: Le han pedido algo más y no sé si es para el mismo test. Un momento. [*They asked for something else and I don't know if it's for the same test. Wait a moment*]

(The nurse leaves)

7. Interpreter 1: Elle revient tout de suite. Elle est sympa, elle parle Français. [*She'll be back shortly. She's nice, she speaks French*]

(The nurse comes back)

8. Nurse: ¿De dónde viene? Vous venez d'où? [*Where's he from? Where're you from?]*
9. Patient: Côte d'Ivoire. [*Ivory Coast*]
10. Nurse: J'aime Africa. Je connais Mali, Sénégal… J'aime voyager. Africa est mon pays favori. [*I like Africa. I know Mali, Senegal… I love travelling. Africa's my favourite country*]
11. Interpreter 1: Está un poco nervioso por los análisis. [*He's a bit nervous because of the tests*]

(The nurse touches the patient's arm)

12. Nurse: No duele, tranquilo. [*It doesn't hurt, don't worry*]
13. Interpreter 1: Ça ne fait pas mal, t'inquiète pas. Quiere saber cuántos tubos. [*It doesn't hurt, don't worry. He wants to know how many tubes*]
14. Nurse: Solo tres, bueno, cuatro. [*Just three, well, four*]
15. Interpreter 1: Elle va retirer quatre tubes. [*She's gonna take four tubes*]

(The patient sighs in relief)

16. Nurse: No tiene las venas muy bien, pero no le digas nada. [*He doesn't have very good veins, but don't tell him anything*]

(The interpreter remains silent. The nurse struggles and moves the needle. The patient winces in pain)

17. Nurse: Dile que la vena no va bien y que hay que buscar otra buena. [*Tell him this vein isn't okay and we need to find a good one*]

> 18. Interpreter: La veine n'est pas bien and il faut en trouver une autre qui soit bonne. Ça m'arrive tout le temps. [*The vein isn't okay and it's necessary to find another good one. That happens to me all the time*].

This excerpt is a typical example of an ethical dilemma. In this case, the interpreter surpasses her prescribed role as a linguistic conduit in different ways, which reflects patient advocacy and intercultural mediation to facilitate the job of the nurse and increase the patient's comfort level. This helps understand the special situation of healthcare interpreters in Spain, as they are expected to perform interpretation and mediation tasks, which leads some authors to label these professionals as MILICs or «Mediadores Interlingüísticos e Interculturales» [Interlinguistic and Intercultural Mediators] (Grupo CRIT, 2014). More precisely, the interpreter advises the patient not to look if he is scared (turn 5) and ventures information that has not been articulated in the presence of the nurse but is, however, elicited from previous dyadic interaction with the patient (turns 11 and 13).

Acting paternalistically, the interpreter gives the nurse an opportunity to address the patient's fears in turn 12 (i.e., «It doesn't hurt, don't worry»). Later on in the interaction, the nurse confides in the interpreter and comments on the patient's veins. She openly requests not to render the message (turn 16). The interpreter remains silent, overlooking the principle of fidelity. As the nurse is struggling to draw blood and the patient is displaying facial expressions of pain, the interpreter disregards the principle of accuracy in turn 18, when she shares personal experience (i.e., «That happens to me all the time»). When asked about this situation in a post-encounter interview, the interpreter justifies herself:

Post-encounter interview 1

> 1. Researcher: ¿Por qué no le has contado lo que ha dicho la enfermera sobre sus venas? [*Why didn't you tell him (the patient) what the nurse said about his veins?*]
> 2. Interpreter 1: El código ético es una cosa y está bien, pero en algunos casos... la decisión es tuya. No le he dicho nada porque estaba ya muy nervioso. [*The code of ethics is one thing and it's okay, but in some cases… the decision is yours. I didn't tell him anything because he was already very nervous*].

This interview sheds insight on the interpreter's decision-making process in scenario 1. She mentions the code of ethics and accepts its general validity, at least in theory. Nevertheless, she prioritises assessing the peculiarities of each situation encountered in professional praxis before deciding. In this case, she overlooks the ethical code and sacrifices its principles for the «higher good» governing the interaction: ensuring that the patient remains calm so the nurse can take his blood successfully. This can be considered as an example of collaborative work with the healthcare provider, since the interpreter eradicates barriers that can jeopardise the nurse's work (see Álvaro Aranda *et al.,* 2021).

4.2. Scenario 2: If you want to let him know

As stated earlier in the paper, participants of the sample sometimes accompany patients to hand in urine and stool samples. In scenario 2, Interpreter 3 accompanies a Cameroonian 19-year-old patient to deliver his samples to detect parasites in his gastrointestinal tract. Detection of stool parasites usually relies on at least three independently collected stool samples. However, the patient only hands in two containers.

Excerpt 2

1. Laboratory assistant: Tiene que traer tres botes, no dos. [*He needs to bring three containers, not two].*
2. Interpreter 3: Tu dois apporter trois échantillons, pas deux. [*You need to bring three samples, not two*].
3. Patient: Voilà ce qu'ils m'ont donné. [*That's what they gave me*].
4. Interpreter 3: Esto es lo que me han dado. [*That's what I was given*].
(The laboratory assistant sighs).
5. Laboratory assistant: Le cogeremos solo los dos. Este viene abierto y, si es así, puede que se pierda la muestra. Si se lo quieres decir… [*We'll take just these two. This one's open and, if that's the case, the sample might go to waste. If you want to let him know…*].
(The interpreter remains silent for approximately thirty seconds).
6. Interpreter 3: Asegúrate de cerrar bien los botes. [*Make sure to close the containers properly*].
(The patient nods once, but he is looking elsewhere).
7. Laboratory assistant: Veo que le importa poco. [*I see that he doesn't really care*].
(The interpreter looks away and stays silent).

As noted by the laboratory assistant, the patient fails to bring the minimum number of samples required for an intestinal parasite's examination. She points out that the patient has only brought two samples (turn 1) and the interpreter conveys this observation (turn 2). The patient simply justifies himself by shifting the responsibility to the doctors that requested the samples (turn 3). In turn 5, the laboratory assistant warns the interpreter that one of the samples might be contaminated, and leaves rendering this message to the patient to the interpreter's best judgement. After a brief silence, she instructs the patient to make sure the sample containers are appropriately sealed in the future, but betrays the ethical tenet of accuracy when she overlooks informing him about the potential contamination of one of the samples (turn 6). The patient, however, does not seem interested, as he just nods and avoids eye-contact. The nurse criticises his attitude in turn 7, which is not interpreted to the patient. This violates the tenet of accuracy. Later on, the interpreter reflects on her decision:

Post-encounter interview 2

1. Researcher: ¿No sabías si contárselo o no? [*You didn't know whether to tell him (the patient) or not?*]

2. Interpreter 3. Es una de esas situaciones en las que no sabes si transmitir información por la situación que pueda generarse luego. Imagínate que el paciente se enfada o algo así. ¿Qué se gana? [*That's one of those situations in which you don't know whether to transmit information (or not) because of what could happen after. Imagine that the patient gets angry or something like that. What do we achieve?*].

Interpreter 3 balances the consequences of different courses of action available in the situation at hand. She considers the benefits and shortcomings of rendering (or omitting) the message and, eventually, she chooses the latter, even if it means sacrificing the tenet of fidelity. To some extent, she is also violating the principle of beneficence, as one of the patient's samples may be contaminated, in which case he will need to come back to the hospital and have the test repeated. However, in this case the interpreter is guided by conflict prevention and avoidance. She deems it important to maintain a distended atmosphere among participants, a decision largely influenced by the patient's unconcerned attitude and the subsequent laboratory assistant's criticism in turn 7. Nonetheless, it is worth mentioning that the patient's reaction might have been different had the interpreter informed him about the potential loss of the sample. In any case, ethical reasoning and decision-making happens in interaction and is heavily dependent on contextual features, such as the other participants' reactions and attitudes.

4.3. Scenario 3: Take this, hold here, give me that

Interpreters of this study break down communication barriers in consultations with providers of different areas of specialty, such as tropical medicine, traumatology, or gynaecology. Encounters sometimes cover more than medical interviews and complementary tests are additionally performed. In scenario 3, a twenty-seven-year-old Congolese woman attends a sexual health consultation with her daughter, who is two and a half years old. The doctor must elicit the patient's health history and take some samples for analysis. Unfortunately, the female nursing assistant that usually helps the doctor is absent and there is just one male staff available for several, simultaneous consultations. This leads the provider to ask for the interpreter's help to perform a vaginal swab, which she accepts. The interpreter also allows the toddler to sit on her lap and draws with her in a piece of paper whilst the patient is getting changed.

Post-encounter interview 3

1. Interpreter 1: El hombre no estaba y he tenido que hacer de auxiliar. He sujetado los tubos de las muestras, me he puesto unos guantes. «Saca esto, sujeta aquí, dame aquello...» Y la mujer mientras en la camilla con las piernas separadas (...) Después, mientras se cambiaba la mujer, he cuidado a la niña y la he estado entreteniendo [*The man wasn't available so I had to be the (nursing) assistant. I've held the sample tubes, I've put some gloves on. «Take this, hold here, give me that…» And, in the meantime,*

the woman was in the examination table with her legs spread. I've taken care of the little girl and I've entertained her whilst the woman was getting changed].

This scenario presents a challenging ethical dilemma. Following the tenet of professional integrity, interpreters must withdraw from situations that imply surpassing their duties as communicators. As there is no alternative option available to perform the vaginal swab at that time, the interpreter flouts her code of ethics. She handles specialised medical materials and plays with the patient's daughter. While standard training advocates for interpreters to «stick to interpreting», contextually bound factors and institutional constraints force the interpreter to adapt herself to the situation and expand her role. More precisely, she acts as a nursing assistant and babysitter, which reinforces the idea of healthcare interpreting as a situated practice where the connection between setting, expectations and actual performances come to the fore (Angelelli, 2019). This might be common to all healthcare occupations, as staff may need to go beyond their clinical role to ensure the health of their patients (e.g., counsel or help them overcome administrative procedures).

4.4. Scenario 4: I could fill that gap

As shown in Table 1, most participants of the sample have French and Spanish as their working languages. Scenario 4 presents an exception. Interpreter 3 must accompany an English-speaking Tanzanian forty-one-year-old female patient to a sexual health consultation, get a blood test and collect a urine collection container. No English<>Spanish interpreter is available to facilitate communication at the time of the appointment and, thus, Interpreter 3 is asked to provide her services. As reported by the interpreter, several providers participate in the interaction.

Post-encounter interview 4

1. Interpreter 3: La médico hablaba muy bien lo que es el inglés, pero la enfermera no. Entonces, bueno, la enfermera me llamó para que yo acompañara a la paciente a hacerse unos análisis de sangre muy, muy, muy urgentes. Y, bueno, yo estaba allí, e intentaba interpretar. Y una cosa muy, muy curiosa que te iba a contar es que la médico hablaba en inglés con ella, pero cuando la médico hablaba con la enfermera, entre ellas, no le contaba lo que le había dicho, entonces la paciente miraba raro. Entonces yo en inglés, aunque bueno, lo tengo un poco oxidado, pero lo intenté, intenté explicarle lo que pasaba, ¿sabes? Como la médico ya hablaba inglés pues yo tampoco podía meterme mucho, y ya eran términos muy técnicos que no conocía. Lo único que… para lo que me sirvió esa intervención es para… digamos, corregir ese agujero de… Bueno, qué están contando. Que fue lo que yo hice, la única intervención que yo hice. Luego ya cuando la tuve que acompañar a sacarse sangre, ahí sí que tuve que estar 100 % porque… Casi ninguna enfermera hablaba bien inglés. Entonces, lo que tuve que hacer fue… explicarle… tuve que explicar en qué consistían los análisis de sangre, explicarle que tenía que mear en un bote, tres botes, la noche anterior, la orina del día anterior y todo eso, y que el lunes tenía que venir porque no podían hacer unos análisis y tal, y que no estaba bien. Entonces tuve que explicar toda la situación yo en inglés, ¿sabes? Oxidado, ya, eh… porque hace ya un año y medio que no

> practico, o más, entonces, bueno. Pero bueno me salió bien y me entendió, ¿sabes? Vamos, que tampoco fue… Yo además las palabras me iban viniendo, pero sí que tuve que intervenir bastante y lo que hice fue importante porque tuve que explicarle pruebas y las pruebas si no las hace bien a lo mejor la hemos fastidiado.
>
> [*The doctor spoke English really well, but the nurse didn't. So, well, the nurse asked me to accompany the patient to get some really, really, really urgent blood tests. And well, I was there, and I tried to interpret. And something very, very interesting that I was going to tell you is that the doctor spoke in English with the patient, but when she spoke with the nurse, between them, she didn't tell the patient what she'd said, and then the patient had a puzzled look. So, I, in English, even though, well, I'm a bit rusty, but I tried, I tried to explain to her what was going on, you know? As the doctor already spoke English, I couldn't get involved a lot, and there were many technical terms that I didn't know. The only thing that… My participation was useful… Was to… Let's say, I could fill that gap of… Well, what they're saying. That's what I did, the only thing I did. After I had to accompany her to take the blood test and I had to do my best there because… Hardly any nurses spoke English well. So, what I had to do was… Explaining… I had to explain it to her what the blood tests were about, explain it to her that she needed to pee in a container, three containers, the night before (…) So I had to explain the entire situation to her in English, you know? Rusty, uh… Because I haven't practiced in a year and a half, maybe more, so, well. But that went well, and she understood me, you know? (…) What I did was important because I had to explain the tests to her and if she doesn't do the tests properly maybe we've messed it up*].

Interpreter 3 reveals that she is familiar with her professional limitations, as she comments repeatedly that her command of English is rather limited, which she defines as «rusty». Additionally, she points out that she struggles with specialised terms. Following the ethical norm of professional integrity in a general sense, she should have declined the assignment, especially considering that she is a student intern. In the reality of the workplace, however, she faces a situation with no alternative solution, as there is no other source of interpreting available at the time of the appointment. This is contemplated as an exception to the principle of professionalism in IMIA (2008). Thus, the interpreter seeks «the lesser of two evils». She is aware that her limited level of English will not guarantee an immaculate interpretation, but also acknowledges that the patient is not kept in the loop when the providers interact with each other. This is particularly evident when the patient has a puzzled look, and she tries to rectify the situation by filling the gap. In so doing, she ensures the patient is still part of the interaction and aware of future steps to monitor her health condition. Furthermore, the nurses' poor command of English in a subsequent communicative event prevents the patient from understanding how to perform the urine collection test, and this triggers the interpreter's involvement again.

4.5. Scenario 5: If you don't want me to say something, shut your mouth

Participants sometimes enable communication in healthcare promotion workshops. In scenario 5, an interpreter not included in the current sample of participants interprets for a group of French-speaking, Sub-Saharan patients,

while Interpreter 5 does whispered interpreting (*chuchotage*) into Arabic for another patient. In the course of this activity, she encounters and ethical dilemma that she addresses as follows:

Post-encounter interview 5

> 1. Interpreter 5: Los pacientes africanos han hecho muchas preguntas sobre la sangre. Estaban muy preocupados por si se vendía. Y el chico para el que he interpretado me ha preguntado: «¿Pero por qué preguntan eso? ¿Son subnormales o qué?» Al principio lo he ignorado y he hecho como que no lo oía. He seguido interpretando, pero como no paraba, [nombre de la persona que imparte el taller] ha parado el taller porque parecía que estábamos teniendo una conversación paralela muy larga y le he dicho: «Me pregunta que por qué hablan tanto de la sangre». No he dicho lo de «subnormal». Como el chico no entiende nada, cree que he dicho lo de subnormales y me dice: «Joé, ya no te digo nada» y yo le he dicho: «Eso es lo que tienes que hacer. Si no quieres que diga nada, te callas la boca». [*The African patients were asking many questions about blood. They were very worried about their blood being sold. The guy I was interpreting for was asking me: «Why're they asking that? Are they retarded or something?» I ignored it at first and pretended I hadn't heard him. I carried on interpreting, but he wouldn't stop and [name of staff delivering the workshop] interrupted the talk because it seemed like we were having a very long side conversation and I told him: «He's asking why they're talking about the blood so much.» As the guy doesn't understand anything, he believes that I've said the thing about «retarded» and he says to me: «Damn, I'm not going to tell you anything anymore» and I said: «That's what you have to do, if you don't want me to say something, shut your mouth*].

The interpreter is confronted with a patient attempting to engage in a side conversation with her. To prevent conflict, she acts as if she did not hear anything, but the patient does not desist. Consequently, the person delivering the workshop interrupts the activity to inquire about the situation, which translates into an additional ethical dilemma. Rendering the patient's comment entails transferring the ethical dilemma both to the provider and French<>Spanish interpreter. Additionally, there is a risk that the other patients understand some of the words, which further complicates the interaction. Thus, the interpreter decides to provide a general explanation, in which she purposefully chooses to omit the insulting remark. However, the Arabic-speaking patient does not understand Spanish, and he believes the interpreter has informed everyone and reproaches her. When confronted, the interpreter does not explain what has truly happened, but reinforces her code of ethics and sets a precedent for future occasions. Thus, she deploys a flexible approach to her ethical code. The interpreter assesses when strict adherence damages the situation potentially, when to «bend» ethical principles and when to impose them.

4.6. Scenario 6: That's not the patient's fault

Interpreters of the study often assist foreign patients with administrative procedures of the hospital. These are important steps to access the

healthcare system and receive medical assistance. For instance, patients' hand in referral slips and identification stickers to book medical appointments. In scenario 6, Interpreter 3 encounters an ethical dilemma when accompanying a patient to book his next hospital's visit:

Post-encounter interview 6

1. Interpreter 3: Y luego, bueno, le tuve que acompañar porque tuvo un problema en Admisión porque no tenía papeleta, una papeleta, y el médico había escrito mal los números, pero igualmente los números se veían, de su historia. Tuve que acompañarlo y la señora, una señora que no había visto nunca, ahí en Admisión, me dijo… es que claro, vienen aquí y vienen sin papeles y sin nada y claro, yo es que si no tengo la pegatina, no puedo… No sé qué. Y digo, bueno, ya, pero es que eso no es culpa del paciente. Y me dice, ¿qué me estás queriendo decir? Dice… the thing is that here... Y digo nada, simplemente es eso, que no es culpa suya. Y que el comentario de… es que viene sin papeles. Yo es que ese comentario no me ha gustado. [*And then, well, I had to accompany him because he had a problem in the Admission's office because he didn't have a document, a document, and the doctor had wrongly written down the numbers, but the numbers could be seen anyway, of his history. I had to accompany him, and a woman, a woman I'd never seen before, there in the Admission's office, she told me… They come here, they come without any papers, without anything, and without the sticker I can't… Whatever. And I said, yeah, well, but that isn't the patient's fault. (…) And she said… What're you trying to say? And she said… But here. And I said «Nothing, it's only that, it's not his fault (…)» That comment about… He comes here without papers. I didn't like that comment*].

2. Researcher: ¿Lo tradujiste? [*Did you translate that to the patient?*].

3. Interpreter 3: Se lo expliqué luego [*I explained it to him later*]..

4. Researcher: ¿Y cómo se lo tomó? [*And how did he take it?*]

5. Interpreter 3: [Nombre paciente] es que es muy… muy tranquilo. Le he dicho mira, ha pasado esto. He estado hablando con ella porque como ha dicho que tú no tenías, bueno lo de los papeles no se lo dije, pero se lo dije de otra forma. Se lo dije como tú no tenías la pegatina y muchas veces dice que venís [los pacientes], en general, sin pegatina y yo le he dicho que no, que no es culpa tuya. *[(Name of patient) he's very… Very calm. I told him look, this happened. I was talking to her because she said you didn't have, well, I didn't tell him that thing about the papers. But I told him in a different way. I told him like… As you didn't have the sticker and many times you [the patients] come, in general, without a sticker and I told her that it's not your fault*].

Scenario 6 readily illustrates that interpreters may struggle to follow their ethical codes in practice. In this case, it is unclear whether the administrative worker is seeking the Interpreter's 4 complicity or venting her frustration, as identifications stickers are required to book a medical appointment. In any case, Interpreter 3 clearly struggles to remain silent and, rather, leaps to the patient's defence. Emotions play a part in this decision, as the interpreter states that she did not approve of the staff's comment (turn 1), which prompts her to engage in a side conversation that does not get fully interpreted to the patient. Disregarding fidelity, and in an attempt to prevent conflict, the interpreter gives the patient a general overview of the situation, without going into specifics.

5. FINDING ETHICS IN AND OUT OF CODES

Cases presented in the previous section illustrate ethical dilemmas faced by novice healthcare interpreters. Participants deploy a flexible approach to these challenging situations and choose what they believe to be «the lesser of two evils», even if sometimes their decisions imply flouting their codes of ethics for a «higher good» or «greater cause» seemingly governing interactions. In this sense, ethical codes provide interpreters with general principles serving as a point of departure for decision-making, but in professional practice they acquire a broader sense that may lead them to deviate from strict compliance. Based on the interpreters' comments and situations observed, decisions are heavily influenced by three factors: human emotion, contextual restrictions, and the theory-practice gap.

5.1. Human emotion: Why not make people having a hard time smile?

As illustrated in scenario 6, healthcare interpreting is a professional activity riddled with human emotion, which poses ethical dilemmas to practitioners. Patients often find themselves in situations of vulnerability that are further exacerbated by cultural and institutional differences, linguistic barriers or low levels of literacy, and asymmetrical relationships with providers. In such situations, interpreters need to balance strict adherence to ethical codes and the emotional dimension inherent to their work. As stated by Dam (2017, p. 230), «the scene is set for clashes between personal morality and professional ethics». The following post-encounter interview illustrates how interpreters struggle to follow ethical principles when emotions are present:

Post-encounter interview 7

1. Interpreter 3: Es imposible... no imposible, pero muy complicado siendo algo humano ser totalmente neutra... No imparcial, imparcial sí que tienes que ser en todo momento, pero no... No mostrar... No ayudar a esa persona si esa persona necesita en ese momento, por ejemplo, yo qué sé, algo de comer y ves que esa persona de verdad lo necesita y que... hombre, el código deontológico te dice que fuera... de puertas para fuera se acabó. Pues, oye, pues... Eso no es así, no es real. Muchas veces... Y acompañarlos y a lo mejor hablar con ellos... El código deontológico... Muchos profesores te dicen: «no, tú cuando estés en el pasillo no hace falta que hables con él, te separas de él, tal, para no crear un vínculo». Pero es que es muy complicado. Y yo me pregunto... ¿por qué? A ver, no voy a crear un vínculo con el paciente porque... Pero... ¿por qué no hablar con él, sacarle una sonrisa a esas personas que lo pasan mal? Y por lo menos sacarle una sonrisa, que yo creo que es muy importante. O sea que con el código deontológico sí, se aplica, quizá más dentro de la consulta que fuera, pero hay cosas que no... No puede ser cien por cien. [*It's impossible… Well, not impossible, but very difficult as it's something human, to be completely neutral… Not impartial, yes, you need to be impartial at all times, but not showing… Not showing… Not helping that person if that person needs it at that moment, for example, I don't know, something to eat and you see that that person really needs it and that… Well, the deontological code tells you that… Outside the consultation room it's over. Well, listen, well… It's not like that, it's not real. Many times… And accompanying them and maybe talk to them… The deontological code… Many lecturers*

tell you: «No, when you're in the corridor you don't need to talk to him, you move away from him, so as not to create a bond.» But that's really complicated. And I ask myself… «Why?» Well, I'm not going to create a bond with the patient because… But… Why not talk to him? Why not make people having a hard time smile? And at least make them smile, I think that's really important. So the deontological code yes, it's applied, maybe more in the consultations than outside, but there're things that… That cannot be like that 100%].

Although neutrality and impartiality are concepts often used interchangeably (Zimányi, 2009), Interpreter 3 distinguishes them. She emphasises the need to be impartial (i.e., not favouring any of the parties involved) throughout her work, but also refers to the impossibility to remain neutral or, as she understands the concept, unaffected by the patient's emotional (i.e., distress) and physical (i.e., hunger) needs. Additionally, she highlights that ethical codes are mainly applied in the course of medical consultations but suggests that they may not offer an optimal solution in other activities in which interpreters also take part, such as accompanying patients or waiting with them in the corridor (see Álvaro Aranda, 2021, for the roles enacted by interpreters in activities different to consultations). As also stated in the post-encounter interview, the interpreter somewhat questions the advice received in the classrooms during her studies, and this leads us to our next point.

5.2. The theory-practice gap: It's a different world

Interpreters participating in the study denounce a gap between what they should do in theory, as seen in the classroom, and the reality they encounter in the workplace. This resonates with the situation described by Angelelli (2008), who considers that there exists no converging dialogue between theory and practice but, rather, a parallel conversation. This is readily illustrated in the following excerpt:

Post-encounter interview 8

1. Researcher: ¿Cuáles son los aspectos más positivos de esta experiencia? [What're the most positive aspects about this experience?]

2. Interpreter 4: El aspecto en sí más positivo de haber estado aquí ha sido la experiencia que he adquirido y poner en práctica lo aprendido en el máster y la carrera, y también ver que hay diferencias entre lo que te dicen en clase y luego la… vamos, ponerlo en práctica, que… Que hay unas cuantas. [*The most positive aspect about being here was the experience I acquired and putting into practice what I learned in the Master's and my undergraduate degree, and also seeing that there're differences between what you are told in class and then, well, put it into practice. There're several differences*].

3. Researcher: ¿Has aplicado la formación recibida a esta experiencia profesional o por algún motivo detectas una contradicción entre la realidad del centro y la teoría de las aulas? [*Did you apply your training to this professional experience, or do you see a contradiction between the reality you found at the hospital and the theory taught in the classroom for some reason?]*

> 4. Interpreter 4: En sí al principio intenté aplicar la formación recibida durante mis años de estudios, y luego… Es que es eso, es que vi que hay… Es un mundo diferente, así que al menos la formación recibida me ayudó para tener una base y ya… Luego es… Como lo vaya desarrollando yo. [*At the beginning I tried to apply the training I received during my studies and then… Then yeah, I saw that there's… It's a different world, so the training received at least helped me to have a base and then… Then it's… How I develop it.].*

Interpreter 4 reflects on the dissimilarities between the knowledge acquired by means of lectures, roleplays and class discussions and the reality found during his internship, which he defines as a «different world» (turn 4). However, it should be noted that he considers training as an important foundation proving to be a useful tool to analyse situations and resolve conflicts in professional practice. It could be considered that training and education provide interpreters with basic theoretical skills related to ethics, but decision-making in healthcare contexts is heavily influenced by a constellation of factors external to interpreters. This is key to understand our next section.

5.3. Contextual restrictions: you don't always have the theory in mind because the reality doesn't allow you to

Healthcare interpreting is a situated practice (Angelelli, 2019) and it needs to be understood together with the constraints associated to the setting in which it occurs. Echoing this statement, interpreters of the sample indicate that they are sometimes unable to follow the tenets presented in their ethical code due to limitations imposed by their working environment, together with expectations and petitions made by patients and other professionals with whom they work and maintain hierarchical relationships.

Post-encounter interview 9

> 1. Interpreter 5: Muchas veces, no puedes, no… o sea, no puedes solo estar con el… la teoría al 100 % delante de tus ojos. No siempre la teoría la tienes por delante porque es que muchas veces en la realidad no te lo permite, entonces eso. Eh… Por ejemplo el código deontológico y todo esto a veces no puedes aplicarlo al 100 % (...) Cuando pasas por una experiencia como esta de interpretación en las prácticas con… en un hospital o en cualquier otro servicio público ves que tienes que adaptar muchas cosas de la teoría y de lo que has aprendido. Entonces eso es fundamental, porque si no, no puedes avanzar, no puedes. Tienes que adaptarte. [*Many times you can't, no... I mean, you can't always be with... the theory before your eyes 100%. You don't always have the theory in mind because many times the reality doesn't allow you to, so yes. Eh… For example, the deontological code and all of that sometimes you can't apply it 100% (…) When you have an interpreting experience like this one in my internship at… a hospital or any other public service you see that you need to adapt many theoretical things and that's what I learned. So that's essential because otherwise you can't move forward, you can't. You need to adapt*].

The interpreter states that the working environment and its demands undoubtedly shape her behaviour in practice. To quote her, sometimes interpreters need to «adapt theoretical things» learned in class «to move forward.» This may imply that trainee interpreters are often presented with complex and even contradictory messages, underlining once again the theory-practice gap previously mentioned. In these circumstances, interns of the sample learn to balance the theoretical knowledge acquired in the classrooms with other important elements also affecting interactions, such as contextual or even institutional restrictions.

6. FINAL REMARKS

This paper examines ethical dilemmas faced by healthcare interpreting trainees at a Spanish hospital located in Madrid. For the purposes of our study, ethical dilemmas included situations in which at least one ethical principle was compromised and required interpreters to decide among different courses of action available (Team ARSu, 2020). To guide their behaviour, trainees resorted to the theoretical notions received in their training, as well as the ethical principles imposed by the internship institution (i.e., confidentiality, impartiality, accuracy, refraining from taking personal advantage from any information obtained in their work, beneficence and nonmaleficence).

Throughout the fieldwork, participant observation and post-encounter interviews revealed that interpreters of the sample deploy a flexible approach to challenging situations and disregard ethical principles at times. Participants choose what they believe to be «the lesser of two evils», even if this implies flouting their codes of ethics for a «higher good» or «greater cause» governing interactions. In this sense, codes of ethics provide interns with guidelines serving as a point of departure for decision-making, but in professional practice they may need to deviate from strict compliance. More precisely, students perform tasks beyond interpreting that include handling healthcare materials when there is no other option available (scenario 3). On the other hand, they sacrifice the tenet of fidelity when it entails assuaging the patient's discomfort, facilitating the provider's clinical work (scenario 1) or avoiding conflicts (scenarios 2, 5 and 6).

Based on the previous observations, it can be stated that interpreters seek effective responses to respect their paramount ethical priority—duty of care to patients (Ozolins, 2014)—which aligns with the tenets of beneficence and nonmaleficence common to other healthcare professions. As seen in our dataset, trainees sometimes justify breaching the code of ethics to stand for these principles. Nonetheless, their understanding of these tenets may lead to challenging situations. This is illustrated in scenario 6, in which the

trainee interpreter does not fully render the staff's criticism and, instead, only provides a general overview of the situation. In this case, she filters the message to avoid a conflict, but sugar-coating nuances present in the source message also involves concealing the administrative worker's real attitude. In turn, she removes the patient's right to get angry or know what is truly happening. This leaves the patient in a situation of inferiority and vulnerability as opposed to Spanish-speaking patients, who would be informed and could replicate, if they so wish.

On the other hand, preliminary findings indicate that interpreters are influenced by the theory-practice gap, human emotion, and institutional expectations or restrictions. Healthcare interpreting is a situated practice (Angelelli, 2019) and, consequently, ethical dilemmas do not occur in isolation from the participants' attitudes or contextual limitations. Thus, there appears to be a conflict between interpreters' standardised training regarding professional ethics and institutional expectations (post-encounter interviews 1, 7, 8, 9), in line with previous criticism on teaching ethics (e.g., Baker & Maier, 2011; Brander de la Iglesia, 2017; Dean & Pollard, 2011; Martín Ruano, 2017b). Prescriptivism found in ethical codes thus leaves interpreters in a difficult position when confronted with demanding situations. Interpreters of the sample considered professional practice as «a different world» (post-encounter interviews 7 and 8), in which abiding by ethical tenets blindly does not always provide clear-cut solutions.

This disconnect between theory and practice does not necessarily mean that ethical codes are not useful tools, but they are ignoring voices from the workplace. Teaching ethics and deontology must not overlook the experiences of practitioners to enrich and foster the link between education and practice. Drawing on our data, interpreters are expected to perform tasks exceeding interpretation in consultations, such as accompanying patients and assisting them with administrative procedures. These tasks bring the interpreters' role close to that of intercultural mediators (Pokorn & Mikolič Južnič, 2020), and this should be included in existing or future codes of ethics, which usually advocate for interpreters as linguistic conduits. This is particularly relevant in geographical contexts such as Spain, where healthcare interpreters are expected to develop interpretation and mediation tasks (Grupo CRIT, 2014).

Furthermore, interpreters should be encouraged to develop critical-thinking skills in their training. They must be ready to assess the potential consequences of their actions and balance the influence of institutional constraints, interactional goals, and participants' attitudes or needs, together with their own. To facilitate reflection and knowledge-sharing, it could be

interesting to develop a collaborative, open-access platform for practising interpreters, trainees, academics, and healthcare providers to interact with one another and discuss experiences regarding ethical dilemmas. These experiences could be filtered and organised under different labels (e.g., patient's requests, provider's expectations, prejudices, cultural differences...) that may offer extremely valuable information to revisit deontological codes and education programmes. In this sense, a selection of events could be discussed by an interdisciplinary panel involving the voices of medicine and healthcare interpreting at different levels (i.e., practitioners, trainees, and trainers) to agree on convenient ethical behaviour, and/or assess the potential consequences of different courses of action, which could be further tested in focus group discussions with migrant patients.

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