# Medical Assistants Acting as Advocates while Undertaking Non-professional Interpreting Work in Medical Missionary Settings in Africa

Alberto Morán-Vallejo

Kent State University, UNITED STATES

https://orcid.org/0009-0009-0835-4958

ABSTRACT

As early as 2002, advocacy work became the latest interest for agencies involved in international humanitarian aid (Coates & David 2002). Simultaneously, in the medical interpreting field, advocacy arises as a controversial ethical issue that has been discussed at length in the literature (Hsieh 2013; El Ansari et al. 2019) and incorporated in codes of ethics for medical interpreting (Tessier 2004). This paper analyzes the specific intersection of clinical duties and linguistic mediation, examining how medical assistants navigated their dual roles in a missionary setting. Drawing on the memoirs of Dr. Stoughton, a missionary doctor, it investigates how bilingual staff members—acting as non-professional interpreters—approached the concept of advocacy. The findings suggest that their interventions were driven not by linguistic ethical codes, of which they were unaware, but by their primary professional identity as medical providers. Consequently, what appears as "advocacy" or "censorship" in an interpreting context is better understood as clinical gatekeeping by nursing staff. The paper concludes by discussing the implications of these historical *ad hoc* practices for our understanding of role boundaries in non-professional medical interpreting.

KEYWORDS: advocacy, code of ethics, medical interpreting, medical missionary work, non-professional translation and interpreting

## 1. Introduction

The question of who the advocate in medical settings should be is a controversial topic widely discussed in the medical interpreting literature (Angelelli 2006; Showstack et al. 2019; Tessier, 2004). In the medical interpreting field, advocacy has recently become the focus of attention for scholars who understand this notion as an action of "protecting the rights and benefits of others such as socially disadvantaged persons who find it difficult to claim and fight for their rights by themselves" (Hattori 2025: 26). In this regard, interpreters would empower patients to act as self-advocates. However, the diversity of settings and contexts in medical interpreting makes it challenging to differentiate and situate the role of advocates throughout history. Bearing in mind the significance of interpreters' memoirs and their contribution to constructing a history of interpreting (Wolf 2023), this paper aims to look at the roles of medical assistants advocating and interpreting for patients through the memoirs of a doctor narrating two medical missions in two distinct periods: 1970-1975 in Rhodesia and 2001-2009 when the country was called Zimbabwe (Stoughton & Stoughton 2021). A mission is understood in this context as an organized effort from a group of people which shares the Christian faith (Britannica Editors n.d.) and is sent into an area to promote its faith and provide opportunities for advocacy, community development, humanitarian aid and/or discipleship.

The first section of this paper introduces the central question of means of advocacy in the variety of contexts where medical interpreting occurs. Subsequently, the second section consists of a literature review that situates the rise of international advocacy in the context of the missions under study. Drawing on the existing literature on medical interpreting and medical missionary work, this section also provides the reader with a deeper understanding of how advocacy has become a central principle in the construction of medical ethics for health care providers in a variety of medical contexts and what this means in the context of non-professional interpreting.

The third section of this paper aims to situate the medical missions within the history of Zimbabwe, providing the context for the book by Dick and Loretta Stoughton in which medical missions are narrated in the form of a memoir. Subsequently, the fourth section of this paper contains a qualitative analysis of the "multiple voices" in the memoir that shed

light on contributions to the role of advocacy from different participants at different stages of the mission. Finally, the last section concludes with the main findings of this study, its strengths and weaknesses, and directions for future research.

## 2. What is an Advocate?

The history of civil rights in the United States changed the strictly legal concept of defending the individual into the broader conception of advocating and defending rights (Borstelmann 2013). How "rights" are related to "law" and the social conception of advocacy is one of the central concerns for Siméant (2014), who situates the life of advocacy within the history of civil rights in a study that explores the reasons for the success of advocacy and how it achieved an influential international status in the last century. Understanding this concept within a world known as an "international civil society" implies recognizing the practices it designates and acknowledging its application to gain greater insight into how ideas circulate globally and how international aid is sociologically organized (Siméant 2014:323).

The boom in advocacy was underscored in the United States during the 1970s (Berry 1989), and the itinerary of the term around the world started in the late 1980s as advocacy in international aid became a category of non-governmental organization (NGO) action. As a result of these exchanges, advocacy has come to mean "the defense or even the promotion of rights and whatever helps to bring institutional changes favorable to the defense of rights" (Siméant 2014:325). Therefore, we can argue that the rise of international advocacy seems to coincide with NGOs' professionalization of human rights and international mobilization campaigns. However, understanding advocacy in non-institutional contexts has led to the evolution of the term in the field of sociology through a series of new interpretations that are also significant for cognate disciplines. An example is the theory of Transnational Advocacy Networks coined by Keck and Sikkink (1999). Here this concept is located at the center of social international relations, suggesting that advocacy captures something unique about transnational networks, which are defined as "systems organized to promote causes, principled ideas, and norms, and they often involve individuals advocating

political change that cannot be easily linked to a rationalist understanding of their interests" (Keck and Sikkink 1999:91).

The extrapolation of this term into health literacy and the ethics of medical communication raises the question of what patient advocacy entails and what values it embodies. In nursing ethics, patient advocacy is understood as the nurse's professional responsibility to "promote, advocate for, and protect the rights, health, and safety of the patient" (American Nurses Association 2015). Schwartz (2002:37) explores the role of healthcare professionals in patient advocacy in a study that relies on the question of whether advocacy means supporting any decision of the patient or if the advocate can claim to represent the patient "by asserting well-intentioned paternalistic claims on the patient's behalf."[1] This understanding of advocacy as a humanitarian action with potential (accidental or intentional) harmful consequences emphasizes the importance of advocacy within the sociology of health communication. Drawing from Translational Advocacy Networks, we can argue that advocates in healthcare settings promote the cause of healing and caring for patients through an "understanding" of the patient's needs, views, and desires. Whether that understanding should be rational and/or emotional is another debate that is centered around the philosophy of medicine and its biomedical and humanistic models (Marcum 2008).

Along these lines, Schwartz's analysis supports the need for patient advocates and aims to clarify the first steps in the professionalization of advocates in health care. But who ought to advocate for patients? Several potential candidates are considered in the medical ethics literature, often referring to doctors, nurses or family members (Bloche 2000; Mallik 1997; Willard 1996). When cultural and language mediation are merged with patient care, the role of language and culture in multicultural healthcare environments opens the way for medical interpreters, cultural mediators, and medical assistants, among others, to be considered professionals who can advocate (Kreuter 2004; Gavioli 2019; Baraldi 2023).

[1] Schwartz envisages the possibility of advocacy becoming a tool to reaffirm "bad" decisions from the patient; to avoid this, the advocate should inform and empower the patient, protect their rights, and make sure that patients have fair access to available resources. In addition they should support the patient and represent their views or desires without adopting a paternalistic view (Schwartz 2002: 38-39).

## *1.1 Interpreters as Advocates*

It is crucial to distinguish between professional interpreting and the activities described in these memoirs. In the field of Translation Studies, the latter is classified as Non-Professional Interpreting and Translation (NPIT). Antonini (2010) and Martínez-Gómez (2015) define NPIT as linguistic mediation performed by individuals without formal training, often characterized by *ad hoc* participation. In the context of this study, the "interpreters" were medical assistants first and foremost. Unlike professional interpreters who are bound by codes of neutrality, these staff members operated under a medical hierarchy. Therefore, their "advocacy" must be analyzed not as a deviation from interpreter ethics, but as an extension of their nursing duties to ensure patient compliance and efficient care.

In a review of traditional and electronic literature on ethical issues and codes of conduct in the field of interpreting in the United States, Mikkelson (2000) captures the divergent nature of interpreting ethics with the aim of offering implications for research and practice. In medical interpreting, she defines advocacy as a very controversial ethical issue that started to be discussed in the 2000s with the emergence of websites developed to promote cultural awareness in health care, something that expanded to conferences and professional publications in the field (Mikkelson 2000:51). Drawing on communication research and other interdisciplinary approaches to health communication and literacy, Hsieh (2003) reunites the efforts in defining bilingual health communication in the last century with the aim of generating a conceptual framework for medical interpreting. The emergence of spaces and networks to openly discuss cultural awareness and the role of the interpreter as the main topic of conversation was a turning point to foster professional and scholarly debate on the intricacies of medical communication. In addition, the U.S. Affordable Care Act 2016 mandated that medical interpreters should have had at least 40 hours of unspecified training, which catalyzed a broader conversation on the ethics that should be discussed and implemented in training.

The term "bilingual health communication" was coined by Hsieh (2003) to explore interactions that happen in healthcare involving health professionals and patients who do not share a common language and/or culture. Previous research in this field has adopted two perspectives from which we can look at these interpreting events: physicians who use interpreters and interpreters themselves (Hsieh 2003:16). The view that interpreters may function as a solution for appropriate communication in multilingual health events is sometimes linked to the notion that they can act as cultural brokers or patient advocates. However, professional role expectations are more narrowly defined in institutional and accreditation frameworks. According to the National Accreditation Authority for Translators and Interpreters (NAATI, n.d.), interpreters are required to demonstrate sociolinguistic skills and intercultural awareness primarily in order to ensure accurate and appropriate transfer of meaning across languages. As argued by Ramírez and Crezee (2024), such competencies serve to facilitate pragmatic equivalence (Hale, 2014) rather than to authorize advocacy or brokerage as core professional functions. Within this framework of role expectations, interpreters may nonetheless adopt particular communicative strategies when their own role perceptions diverge from, or align with, those of physicians and patient.

Building on the idea that contextual features continually reshape communication strategies in medical interpreting (Keenan et al., 1998), the agency associated with advocacy cannot be understood as fixed or stable. Rather, it emerges dynamically in interaction, as interpreters respond to shifting role expectations, evolving institutional contexts, and situational demands. For example, differences in physicians' communication styles, patients' linguistic and cultural needs, or the urgency of a clinical encounter may influence whether and how interpreters intervene beyond strict linguistic transfer.

Questions of who may legitimately assume an advocacy role, and to what extent such advocacy is appropriate, have been addressed differently across institutional and cultural contexts. In a study conducted in the United States, Hsieh (2013) problematizes active interpreter involvement on the grounds that it may compromise patient autonomy and

empowerment. While direct advocacy may in some cases contribute to meeting patients' immediate needs, acting on behalf of the patient can blur the boundaries between the patient's and the interpreter's agendas and communicative goals (Rosenberg et al., 2008). As an alternative, Hsieh (2013) proposes that interpreters may enhance the quality of care by facilitating patients' capacity for self-advocacy rather than assuming an advocacy role themselves. These positions highlight broader tensions in the field concerning professional boundaries, agency, and the distribution of responsibility in mediated healthcare encounters.

Drawing on previous literature, we might argue that notions of autonomy, advocacy, and empowerment may be shared, transferred, or co-constructed among participants in medical encounters. Autonomy may be shared when clinicians and interpreters jointly facilitate patients' involvement in decision-making by clarifying options and ensuring informed participation (Charles, Gafni & Whelan, 1997; Krystallidou, 2014). Advocacy may be transferred when institutional constraints or interactional asymmetries lead interpreters to temporarily assume responsibility for voicing patients' concerns (Angelelli, 2004; Rosenberg et al., 2008). Empowerment, by contrast, may be co-constructed through interaction, as interpreters support patients' active participation by reformulating questions, encouraging clarification, and reinforcing patients' expressed preferences (Hsieh, 2013; Wadensjö, 1998).

Although the need to theorize these shifts arose with a modern conception of health communication and cross-cultural environments in recent years, the history of interpreting invites us to explore other scenarios in which advocacy is merged with other purposes as a result of ever-changing role expectations.

## 3. Memoirs and Ethics: Remembering Emotions and Faith

Memoirs are works that open the floor for new insights about the human condition and are often a great source for a deeper understanding of human values, feelings, and thoughts.

This section aims to highlight the presence and impact of interpreting activities in medical missions where the questions of emotional labor and faith play an important role. Subsequently, a review of significant literature about the use of memoirs for the construction of histories supports the idea of analyzing memoirs to better understand notions of role, advocacy and emotional regulation when interpreting occurs in medical missions.

## *3.1. Interpreters on a Mission*

Understanding the nature of faith and the importance of the emotions involved in missionary work becomes essential here to better contextualize the notions of autonomy and advocacy in medical missions. In an essay review of a volume titled *"Healing Bodies, Saving Souls: Medical Missions in Asia and Africa"* edited by Hardiman (2006), McKay (2007) emphasizes the importance of further studying missionary medicine as part of the histories of colonial medicine. A deep insight into the nature of medical missions offers an informative account of the relations between introduced and indigenous medical systems. Among these lines, Dirar (2006) states that not only were some missionaries unconcerned with acquiring knowledge of the local medical systems, but that local peoples were also selective in adapting to new medical belief systems.

These histories suggest that Christian values and medical procedures supported by faith-related motivations merged with reproductive aspects of Indigenous models of *the healer*. Therefore, missionary sources and the collaboration between indigenous people and interpreters in mission projects worldwide have drawn the attention of translation scholars interested in the history of interpreting. In a recent publication, Rademaker (2023) investigates mission contexts in Australia and the Pacific, stating that missionary interpreters both allowed for the consolidation of European missionaries' authority while also reinterpreting the missionary's message to fit local interests. Thus, interpreting was "an important tool to create opportunities for interpreters themselves as leaders of burgeoning mission communities" (Rademaker 2023:194).

Looking at what Indigenous people achieved on their own and for their communities through interpreting allows us to see that their work fulfilled obligations to Country and kin, which refers to a deep care for their ancestral land (Country) and their extended family network (Kin) (Nossal 2018). As providers of linguistic mediation and engagement to newcomers, "interpreters re-presented and re-enacted their connections with the Ancestors through language" (Nossal 2018: 208). But the purpose of the missionaries was not only to *civilize* but also to make the people understand a message of faith. Here, the role of missionaries as non-professional interpreters lies in a controversial position. When translating culture-specific items, the form of translation that diverges more significantly from the original is akin to this type of "reimagining" (Aixelá 1996). In this context, local interests are drawn closer to European authorities through interpreting, and interpreters have also *re-interpreted*, reformulated, and adjusted messages from the missionaries so that locals can be receptive to them. This "duality" in their roles situates interpreting activities in a controversial position that has been discussed in other interpreting modalities, such as court interpreting (Hale 2008) and health care interpreting (Avery 2001).

In cross-contexts with a strong social and political component, the multiplicity of interpreting roles and duties makes it hard to differentiate who the interpreter is advocating for. We can argue that language was an essential component of the missionary project to convert people to the Christian faith, a mission carried out in cooperation with local intermediaries—that is, non-professional interpreters. Their working languages involved two language pairs, with bidirectional interpreting between English and Shona—the primary indigenous language widely spoken in Zimbabwe at the time—and between English and Ndebele, another major local language in the Matabeleland region.

### *3.2. Faith and Emotional Labor*

In an attempt to further investigate the impact of faith and emotions when interpreting in missions, it is important not to disregard how interpreting happens in other contexts of

faith. When interpreting occurs in religious contexts, further aspects also start to shape the nature of the role of advocacy. In a case study at a Protestant Armenian Church in Istanbul, Tekgül (2019) discusses faith-related interpreting as emotional labor. According to Hoschschild's seminal work *"The Managed Heart,"* emotional labor

> requires one to induce or suppress feeling in order to sustain the outward countenance that produces the proper state of mind in others […] calls for a coordination of mind and feeling and […] sometimes draws on a source of self that we honor as deep and integral to our individuality. (1983:7)

The acts of displaying, eliciting, or *suppressing* emotions are the core of what emotional labor implies in faith-related interpreting, where the interpreter is exposed to active emotional involvement. There is also a component of faith in the type of non-professional interpreting that is performed in the missions under study here. To deepen our understanding of this type of emotional labor, we can also refer to previous literature that establishes role overload as one of the characteristics of community interpreting (Anderson (2002) [1976]; Drennan & Swartz 1999). A wide array of emotional implications of the roles of community interpreters is discussed in detail in Tekgül's article, such as emotional display of their own emotion, as well as replication or reflecting those of others.

In a study of public service interpreting, it has been suggested that, due to the emotional component of the task, interpreters may use strategies of emotional mirroring (Guy et al. 2014:5), such as affective intonation, fillers, mimics and gestures, and body language. This happens not only with the purpose of managing the emotional labor, but also with the purpose of conveying the message in a manner that is pragmatically equivalent (Ramirez and Crezee 2025). Similarly, Tekgül (2019:7) argues that interpreting services may end up having a greater emotional charge than the original speech, which the author describes as *emotional amplification*. In addition, wider attitudinal effects, such as intercultural mediation, spiritual involvement, and compassion (9), also contribute to an overload of emotional labor in faith-related interpreting. Referring to these instances of emotional

amplification, some authors defend that it is important to convey illocutionary intent and illocutionary force (Morris 1999), but not by amplifying that force.

Given the Christian character of the medical missions under study in this paper, we are interested in situating the impact of a message of faith within cross-cultural medical events. Specifically related to the notion of advocacy, the degree of emotional labor in community interpreting resides in the willingness to make the interpreting service user feel more at ease. Considering that personal involvement has been identified as a distinctive feature of faith-related interpreting (Tipton & Furmanek 2016:237), other professional standards like impartiality and neutrality seem to be less imperative in these contexts. Therefore, advocacy arises together with an enormous degree of emotional engagement, and the affective mode becomes essential to convey a message. This relationship between interpreters and the sacred message has been further studied in a recent publication by Olgierda Fulmanek (2022), in which the interpreter's role is discussed in various interlingual religious brokerage contexts. Through this lens, interpreters' emotional attachment (or detachment) becomes more plausible as a determining factor for decisions they make about their role.

Understanding the emotional impact among those who participate in religious settings is essential to better define and allocate the role of interpreters in medical missions. In this regard, Hokkanen's (2018) research on simultaneous interpreting in church supports the importance of managing emotions when interpreting in religious settings. Church interpreting, which often happens as a volunteering activity, is a common practice of non-professional translation and interpreting throughout the world. In recent research, church interpreting is understood as service not only to its members but also to God, and this has important consequences for the type of interpreting training required in these scenarios (Hokkanen 2018). Some of the aspects to be taken into account for this type of training are the somatic and affective experiences of the interpreter (Hokkanen 2017).

While the motivation for the Stoughtons' presence in Zimbabwe was religious, the operational structure of their clinic was strictly medical. The interpreters in this study were

not volunteers translating sermons; they were trained nursing staff and medical assistants responsible for clinical outcomes. Therefore, the "emotional labor" observed in their interactions should be analyzed not through the lens of religious ecstasy or spiritual mediation (Tekgül 2019), but through the sociology of the medical profession. As noted by Hsieh (2006), when providers act as interpreters, their primary allegiance remains with the medical institution. In this case study, the assistants' "faith" manifested practically as a commitment to the mission's medical goals, leading them to prioritize clinical efficiency over linguistic neutrality.

### *3.3. Memoirs for the Construction of History*

The effectiveness of memoirs for the construction, reconstruction and recollection of history has been the subject of notorious publications in interdisciplinary research for a long time. Lejeune's definition of memoir is fundamental for discussing personal history or the account of oneself, defined as "the account of an individual who, through a chronological narrative of events, focuses on a certain period of experience rather than the whole life span" (1989). This periodicity is a critical feature of a memoir for it to be fruitful in the development of the historiographical performance of microhistory (Creet 2014; Lung 2009; Rabe 2014). In this regard, researching specific issues of interpreting history reveal the potential of historical documents such as memoirs for constructing history.

Since the subject is necessarily the focus of the stories narrated (Wolf 2023), the subjectivist nature of a memoir is strengthened by the fact that the protagonist and the narrator are the same. In order to interpret and understand autobiographical subjects, many scholars have attempted to elucidate the distinctive features of this work so that we can better navigate through these narratives. Smith and Watson (2010: 21) trace the trajectory of "the dynamic processes of autobiographical subjectivity" in a theoretical framework that allows researchers to consider social and ideological factors in the specific contexts where the event under study takes place. Memory (reconstructed recall), experience (lived and narrated events), identity (relational selfhood), space (situated locations), embodiment (the

lived body), and agency (constrained capacity for action) are discussed here as distinctive features for understanding the dynamicity present in autobiographical narratives and, therefore, for constructing the image of the interpreters of our history.

Wolf's (2023) efforts to reassess the picture of interpreter's self-image in memoirs based on how they portrayed themselves come together in a recent essay that deals with the interpreter as an "anti-hero", here defined as an interpreter acting in a context of power and conflict, often connected with violence (239). Compared to other groups of interpreters studied so far that were considered allies of the person of power ("hero"), these interpreters acted in inhuman circumstances and reflected the conditions of the "other" (ibid.). Wolf concludes with the suggestion that "anti-hero" interpreters rarely put interpreting at the center of their self-representation, contrary to a significant number of interpreters who depicted themselves as heroes. Furthermore, the decision-making process behind interpreters' choices in multicultural contexts where conflict is present makes it difficult for them to only be "a hero." For instance, Todorova (2014) examines the memoirs of an interpreter in Jankovic's semi-autobiographical work of fiction. Here, Todorova accounts for the hardships that come with "in-betweenness," meaning that the interpreter is situated between two cultural spaces, with an impact on her roles, tasks, feelings and perceptions.

The memoir to be analyzed in this paper is not written by interpreters themselves but by doctors who worked together with interpreters in medical missions. We can argue that a depiction of the narrators' self-representation might not directly refer to the way interpreting was taking place in that moment of history. Nevertheless, this memoir still offers a great source of examples and experiences that are situated in contexts where non-professional interpreting was recurrent. Therefore, it is relevant to understand these theoretical underpinnings because they may help us uncover the message conveyed by powerful (and powerless) voices that negotiated the advocacy of patients and indigenous people during Christian medical missions. A careful reading of these sources also allows for considering social and ideological coordinates that define the context of Rhodesia/Zimbabwe in the time in which the medical missions under study took place.

## 4. *"Steps along the Way"*: A Memoir of Medical Missionary Work in Rhodesia/Zimbabwe

*"Steps along the Way"* narrates the life-changing journey of an American family that embarks on two medical missions. Dick Stoughton is a medical doctor, and Loretta is a wife and a mother. Dick was a Naval Flight Surgeon, who was appointed to work at a naval air station in Oahu, Hawaii, where he spent two years with his family (Loretta and four boys between four months and five years). During their stay in Hawaii, the tragic loss of one of their children took them on a journey of faith that led them to do medical missionary work in Rhodesia from 1970 to 1975. At this time, some serious diseases, such as measles and whooping cough, were threatening the health and wellbeing of the people in Rhodesia.

After this mission, the family returns to Wisconsin for medical practice. Twenty-six years later, following Dick's retirement, the family decided to return to Zimbabwe (formerly Rhodesia) from 2001 to 2009. During these eight years, Zimbabwe was experiencing the devastation of the AIDS epidemic, along with poor governance, lack of supplies and hyperinflation. In 2021, Dick and Loretta Stoughton published *"Steps along the Way: A Memoir of 13 Years of Medical Missionary Work in Rhodesia/Zimbabwe",* an emotionally charged memoir that covers the two distinct periods of their missionary work. In this narrative, Dick Stoughton takes us through a dedicated and fascinating journey of medical missions in Zimbabwe, where they quickly "learned to love" the mission and hospital staff they worked with and many *others* who they met.

This memoir offers a closer look at the evolution of medical communication and patient advocacy in a context in which medical services and cross-cultural interactions between doctors, patients and interpreters are supported by having faith in each other and faith in God.

### *4.1. Early Missionaries in Rhodesia/Zimbabwe*

The first medical missions narrated in this memoir occurred in 1970, a moment in which the ethnolinguistic map of Rhodesia was not straightforward. Chimhundu (1992) explores the presence of missionary societies throughout the history of Rhodesia/Zimbabwe in the twentieth century. The unification of Shona dialects before 1931 led to periods of tribalism between the Shona and the Ndebele in the 1970s (Chimhundu 1992: 108). At this time, the creation of regional ethnic identities for the indigenous Africans was influenced by the price of Christian, Western education, and a new perception of language unity, and these identities were somehow antagonistic and open to political manipulation.

Chimhundu also draws on Ranger's previous works that describe how early missionaries of the American Catholic Church participated in the creation of the "Church Manyika Language" through translation, which was spread and promoted through the mission networks (93). Based on the idea that languages were shaped at that moment by cultural, political, and ethnographic changes in the mission networks, we can argue that missionaries themselves contributed to the evolution of dialects because, for their translations, they relied on African locals who were also second-language speakers (103).

When Rhodesia transitioned into Zimbabwe in 1980, the most significant change in the language map was the increased prominence of indigenous languages like Shona or Ndebele (Ndlovu-Gatsheni 2007). After this post-independence shift, the Stoughtons immersed themselves in a different linguistic landscape in the 2000s where "Zimbabwean English" is spoken as a product of the influences from indigenous languages and a different social dynamic (Kadenge 2010). The evolution of the ethnographic scene in Rhodesia/Zimbabwe allows for the contextualization of the medical missions under study in this paper, and uncovers the co-construction of the agency of language in periods in which Christian medical work was carried out by Americans. This explains the contribution of local agents and interpreters to the promotion of language, culture, healing, and faith in this study.

## 5. Discussion: Analyzing Interpreting Memoirs

Whereas the memoir under study is a first-person depiction of the missions, the sense of community that the Stoughtons aim to foster reveals the role and impact of many different voices united for the wellbeing of patients and local people. Interventions between doctors, patients, interpreters, and other hospital staff are analyzed here in three different sections: doctors, medical assistants, and patients' conversations.

This analysis focuses on the specific friction between the assistants' medical duties and their *ad hoc* linguistic roles. Rather than viewing "advocacy" as a shared benevolent goal, we examine it here as a manifestation of role fluidity common in NPIT settings (Antonini 2010). The following sections analyze how the medical assistants exercised power not just as translators, but as clinical gatekeepers who filtered information to facilitate the doctor's work.

### *5.1. Doctors as Advocates: Embodied Empathy*

"I would stand by helplessly, not knowing what to do other than to be quiet and supportive" (Stoughton 2021:14). In what I chose to be the opening quote for my discussion, the American doctor Dick Stoughton shows more than empathy in his words. The first pages of the prologue tell the grievous story of Dick and Loretta Stoughton in Hawaii, where they lost a child while Dick was serving as a Naval Flight Surgeon. Reflecting on this painful experience, Stoughton states that this experience made him "a more compassionate doctor with more empathy for people, especially those who lost a child" (5).

Dr. Stoughton's profound personal grief created a specific dynamic in the consulting room: a vulnerability that his medical assistants likely sought to protect. In non-professional interpreting, the mediator often assumes a protective role over the primary speaker (the doctor) when they perceive them as vulnerable or overwhelmed (Davitti 2019). Thus, the

"advocacy" performed by the assistants may have been less about patient rights and more about managing the doctor's emotional and clinical load.

Slatman (2014) explores multiple dimensions of embodiment in medical practices, taking the idea of "lived experience" as a starting point (549), and defining embodiment as the lived, perceptive, and meaningful body through which individuals experience, interpret, and engage with the world, rather than as a purely biological object. The same starting point where the narrative of empathy and embodiment in these missions unfolds here.

This emphasis on lived experience provides the same starting point from which the narrative of empathy and embodiment in these missions unfolds here, as empathy is understood not merely as emotional resonance but as an interpretive and relational practice grounded in embodied perception. Drawing on Halpern (2001), empathy is defined as the cognitive and affective capacity to understand another's experience while maintaining self–other distinction, a process that enables meaningful engagement without collapsing perspectives.

Grounded in embodied lived experience, empathy thus becomes the mechanism through which personal history informs ethical engagement and advocacy in concrete sociohistorical contexts. In Rhodesia in the 1970s, many children died of preventable diseases like measles and whooping cough. As the Stoughtons decided to embark on missionary medical work from 1970 to 1975, Dick cannot leave his own experience behind to show empathy and act as an advocate for patients in difficult situations.

> […] It really meant the child was near death, and there was nothing for me to do. Still, I ran down the hill […]. I went to let the mother and the nurses know I deeply cared about the welfare of every patient, even when there is nothing more I could do to help. (130)

Stoughton shows empathy and concern for the health of the patient as a main priority repeatedly throughout the narrative. However, the emotional struggle of some situations leads the author to show some vulnerability when dealing with sensitive situations. "I couldn't let myself become emotionally involved — it was just too painful. And yet, the nurses and students were emotionally involved and crying with each death. Some days it seemed too much to bear" (217). This supports Tekgül's idea of *emotional amplification* in faith-related settings (2019). Therefore, we can argue that, in this context, doctors also might be subject to displaying their own emotion and/or replicating those of others, to the extent that this emotional overload is made explicit several times as something influential for the proper execution of this medical practice: "I could not continuously focus on AIDS. I needed to have other outlets, or I would go mad worrying about why I wasn't doing something to help the situation" (219).

Not only with words, but also with caring, deliberated actions, Dick Stoughton advocates for what is culturally appropriate for his patients' success. The following extract is an example of this:

> The nurse asked, "Could you please complete the death certificate now? The brother wants to go to the authorities for a burial order". In filling the form, I could not put "AIDS" as the cause of death. It wasn't politically correct. Not acceptable. People were still refusing to believe that such a disease existed. It was like leprosy in Biblical times. […] I wrote "I.S.D." as the cause of death, meaning "Immune System Disease". (ibid:217)

This interaction serves as a prime example of "adversarial advocacy" often seen in NPIT settings. The nurse/interpreter does not merely translate the doctor's diagnosis; she actively negotiates the medical record ("Could you please complete..."). By guiding the doctor to use "I.S.D." instead of "AIDS," she is advocating for the family's social protection against stigma. This aligns with the findings of Hsieh (2006), who notes that bilingual health professionals often step out of their neutral roles to act as "cultural brokers," protecting patients from the social consequences of their medical reality.

These examples illustrate not only moments in which Dick Stoughton directly assumes the role of advocate for patients, but also how advocacy in the memoir emerges as a relational practice. Through embodied memory and lived experience, Stoughton narrates empathy as an interpretive stance that informs action in contexts of medical vulnerability. At the same time, his narrative voice foregrounds the involvement of other agents—patients, family members, missionaries, and medical staff—whose actions and constraints shape advocacy. The memoir thus presents advocacy not as the expression of an autonomous subject, but as a negotiated form of agency co-constructed across bodies, spaces, and social relations.

### *5.2. Medical Assistants and Interpreters as Advocates: Navigating Clinical and Linguistic Roles*

Interestingly, the first interpreter we encounter in this memoir is not given a name, and this occurs several times throughout the book. "Through an interpreter, the father said […]" (10) is a recurrent hedging to introduce information that had been interpreted at the moment of the clinical visit. However, many other participants involved in language and cultural mediation are visible, recognized and described by Dick Stoughton. Sister Anne Marie, fluent in Shona, is the first interpreter to come into the scene. Whereas not much is said about her first appearance, we can investigate the role of nuns as interpreters in further examples.

Even though the Stoughton took Shona lessons three evenings a week before the mission (31), it was not enough for them to understand. Therefore, there was a need for mediation in the doctor's office. "[…] they only spoke Spanish around each other, and Sister Ruth never did learn English very well. On the other hand, she was fluent in Shona" (33). Here, Sister Ruth, as a nurse running the clinic, shows knowledge and experience in communicating with local patients, but there is still another gap for these conversations to be intelligible for the doctor. This was the role of medical assistants.

> Sister Ruth was a nurse and ran the clinic with three African "medical assistants" —women who had three years at a mission hospital training school. They were amazingly educated, with excellent practical knowledge. Since Sister Ruth spoke little English, most of my conversation was with the medical assistants, and they interpreted between Sister and me[2]. (ibid.)

This description highlights a classic Non-Professional Interpreting (NPIT) dynamic. The "interpreters" here are defined explicitly by their clinical rank ("medical assistants") rather than their linguistic function. In professional interpreting, the role is to be a neutral conduit (NAATI 2012). However, for these medical assistants, "interpreting" was merely one task within their broader clinical duties. As highlighted by Martínez-Gómez (2015), such *ad hoc* interpreters often prioritize institutional goals—such as efficiency and patient compliance—over linguistic accuracy. Within this framework, Stoughton and Sister Ruth's intervention can be understood not as neutral translation but as clinical filtering: they likely summarized the patient's complaints into medical terminology for the doctor, rather than facilitating the patient's voice verbatim.

Through the intervention of medical assistants, we can better explore the role of advocacy within their responsibilities. "She not only interpreted from Shona to English, she interpreted in a way she thought would please me. I explained to Patricia [medical assistant] —and other interpreters— that I wanted to hear everything the patient said" (34). This is an example of censoring from the part of interpreters so that they prioritize the doctor's understanding of the event. The purpose of their interpretations was to make the doctor understand the patient, leaving aside the patient's autonomy to communicate with the doctors. The doctor's desire to hear his patients faithfully makes the difference, as we can see in the quotation below.

[2] Dick Stoughton acknowledges here a terminological difference that turns into a cultural issue between countries. In the British system of health care, *all* Registered Nurses (RN's) are called "Sister". So just because someone is called a "Sister" it did not necessarily follow that that Sister was a Nun; in fact, most of the times, that was not the case (33).

> Florence, a surgical assistant who also worked in outpatient, was my interpreter that day. I was glad to have her because she didn't try to "interpret" in a manner to please me, but just gave me what the patient actually said. (221)

We should not ignore that there is difference of more than 30 years between the two interventions analyzed here. It is likely the doctor's perception of interpreting services changed over time, as well as interpreting performance at the beginning of the twentieth century started to focus on advocating for the patient according to the shift to patient-centered communication in health communication (Naughton 2018). However, we can still see that Stoughton's purpose was to hear the voice of the patient, not just a "rendition" adjusted to his own interests.

So why did they feel the need to advocate, as they saw it, and who did they feel they were advocating for? These two questions remain unexplained in many medical situations in this book, but from their interventions, we can situate them in different parts of the spectrum of medical communication. The visibility or invisibility of the interpreter was not always clear; indeed, the interpreter appeared and disappears in the scene according to the interests of the other parties.

> The next man had a "personal problem" and didn't want the nurse in the exam room. I asked her to leave […] After he dressed, I asked the nurse back in to get his story" […]"Sister, it would be so much better if you stay with me, and we saw the patients together" […]"I called Sister Ruth in for explanation." (35-37)

These three extracts provide evidence of the "powerless" position of the interpreter, always subject to the desires of the medical crew. Dick's willingness to work with them led to very satisfactory results when it refers to understanding situations and contexts.

However, conversations between Dick and the assistants occasionally left patients *at the back of the room*, resulting in the invisibility of the patient during long periods of

interaction and, therefore, patients were excluded. A conversation between Dr. Stoughton and Sister Perpetua in the operating room illustrates this point. "What happened, Sr. Perpetua? […] She told me: "He was working […] "How long ago was that?" "About two hours. They took him here […]" (102). This kind of third person interpreting when the patient is also present leads the doctor to seek a shift in the directionality of the event: "With Sister Perpetua interpreting, I turned my attention to the patient. "How are you feeling Edward?" (103).

But Sister Perpetua was not only an advocate for the doctor but also looked for opportunities to empower patients and make them feel at ease. We might not be sure about what type of advocacy this is, but we can argue that patients became comfortable enough to communicate with a foreign doctor, contributing to their wellbeing and autonomy over their own health.

> Sister Perpetua gathered everyone. […] This African nun talked to them in their native language, hands waving here and there, voice fluctuating […] She joked with them, cajoled them, shouted at them, and joked again. She involved the audience by having them repeat instructions, asking questions, and answering them. The African men and women loved to talk […] Finally, she gave a short talk on the prevention of malnutrition. (138)

According to medical ethics and some of the most influential interpreter codes of ethics, such as NCIHC (2005), this behavior exceeds advocacy, putting the interpreter in a controversial, biased position that is far from impartial (Kalina 2015). However, this view of the interpreter as an advocate is not universal and is heavily influenced by the specific institutional culture of the United States. In other jurisdictions, ethical codes have historically taken a stricter view on role boundaries. For example, the Australian National Accreditation Authority for Translators and Interpreters (NAATI) has traditionally emphasized impartiality, viewing advocacy as potentially compromising the interpreter's neutral stance (NAATI 2012). This divergence suggests that "advocacy" is not an inherent linguistic function but a role superimposed by specific healthcare systems.

Furthermore, recent scholarship has begun to distinguish between the role of a "medical interpreter" and that of a "bilingual patient navigator." Studies such as those conducted at Seattle Children's Hospital (Crezee & Roat 2019; Taylor et al. 2019) highlight that while interpreters are restricted to linguistic conversion, navigators are explicitly empowered to guide patients through the healthcare system and advocate for their needs. This distinction is critical for the present case study: the medical assistants in Stoughton's memoirs were likely functioning less as neutral interpreters and more as *ad hoc* patient navigators, leveraging their medical authority to "advocate" in ways that would be ethically impermissible for a standard interpreter.

It is therefore important to highlight the multitasking responsibilities assumed by these professionals in the absence of formal professionalization. At the time, medical assistants and nurses often fulfilled multiple roles simultaneously, including linguistic and cultural mediation, which made strict impartiality difficult to sustain. Within this context, interpersonal trust—understood as the expectation that another will act competently, ethically, and with concern for one's well-being (Hall et al. 2001)—became central to clinical interactions. This trust, built through repeated embodied encounters, often legitimized interpreters' involvement beyond neutral mediation, even as it complicated contemporary ethical assessments of bias and role boundaries.

What is fascinating is the potential separation between *scientific* medical treatment and a more *humanistic* perspective of healing, which sometimes happens through an encounter with faith and out of medical settings. This is illustrated in a visit to the *n'anga*, a witch doctor or traditional healer that was a central figure in the beliefs of rural people. People would resort to the *n'anga* to relieve anxiety about their health issues and find satisfaction within the periods of treatment of their conditions. From the doctor's perspective, this seems to challenge his promotion of the patient's wellbeing.

> I learned that the ancestors always have to be placated. To me it seemed like good psychological counseling and maybe that was "the good" the n'anga could do. If only they would stick to the psychological side of it. My problem was that he or she many times gave exactly the wrong medicine and made the person with real medical problems worse instead of better. I hoped that our visit to a real live n'anga would shed some light on his practices. (155)

Here, a separation between humanistic health care and scientific treatment becomes blurred. The *n'angas* often acted as counselors, but their advice also had an impact on treatments and medical issues that were considered detrimental by the doctor. The contact between spirituality and scientific treatment here is what leads to different expectations when it refers to the healing of the patient.

### *5.3. Patients as Advocates: Developing Patients' Autonomy*

The most common diseases during the 1970s were measles and whooping cough, together with tropical diseases such as typhoid, malaria, leprosy, and tuberculosis. After 26 years in Wisconsin, when Dick and Loretta came back to Zimbabwe for another mission in 2001, the scene was completely different. "The AIDS epidemic was scything down victims like so many wheat stalks in a defenseless field" (197), Stoughton states, as he experiences the struggles of patients suffering from the extreme consequences of this autoimmune disease. We must recognize that different pathologies have an impact on medical practice, as well as all the political[3], sociological, economic[4], and ethnic changes that occurred between the two periods that could be the subject of further investigation.

What it is very plausible in this new era of missions is that there was a commitment from the part of the whole medical team (including assistants and interpreters) to provide the

[3] The impact of black guerilla warriors between 1976 and 1980 was noticeable and led to changes in the sociological map of Zimbabwe. "A white minority aristocracy was replaced by a black majority aristocracy, and the poor continued to suffer" (203).

[4] "After Independence in 1980, money poured in from around the world, resulting in massive building projects […], plus a new and expanded road system. Now the foreign money had dried up, tax revenues were failing, and the country couldn't afford the upkeep" (199).

patient with tools for self-advocacy. In other words, we can see several attempts to educate the patients and promote self-care, which would lead them to a more informed, deliberate decision-making process on their own, as well as positively impacting health outcomes. Some of these examples perfectly align with the literature in the sense of "providing means of self-advocacy to the patient" so that patients are empowered to act as self-advocates (Hsieh 2013:41). The question of who should be considered the most appropriate agent to provide the means of self-advocacy remains open. In some health care contexts, this has been studied as the aim that bilingual patient navigators aim to achieve (Creeze & Roat 2019) in contrast with the medical interpreters working at the same hospital.

Morality plays and dramas were a useful tool to educate mothers without lecturing them. Student nurses would put on a short "drama" in the form of a 10-minute play where the observing mothers asked questions as the nurses continued to interpret how to feed their children. "The morality plays were well received and had a good impact on the mothers" (141). In terms of advocacy, whereas this does not have a direct impact on the way patients advocate, it indeed provides them with tools so that they can improve their practices and routines. Instead of waiting for the doctor to tell them what they should do, these mothers would come back home with a higher degree of autonomy on how to nourish their children.

Another example of a shift towards patient autonomy resides in the challenge of getting people to accept they had the AIDS virus and should do something about it. To eliminate the stigma, some prevention programs were established with the aim of promoting safe sex, having all the children tested, talking about being HIV positive, living positively with HIV and delivering at the hospital so that the baby could be treated right away. The following extracts support the effectiveness of the program.

> Within a year of implementation, the "Mother-to-Child" prevention was merely another part of normal care, just like taking blood pressure, weighting the mother, or palpating the abdomen to determine the position of the baby. It has always amazed that we can be so resistant to change, but when we start doing it and seeing the results, it becomes such an easy part of routine care" (224). "Their bravery on facing the community stigma by speaking about AIDS went a long

> way to break down barriers so others would eventually step forward for treatment and speak out in the same brave manner. (225)

These programs looked at health care from a more humanistic perspective in which communication becomes the key for a successful treatment. The "mother-to-child" prevention program was not only an important step in removing the stigma, but it also contributed to a successful AIDS treatment program. This is also a step forward in the construction of advocacy in the context of these missions. Whereas there is no clear, defined advocate, the act of advocating or self-advocating is starting to shift towards a more patient-centered perspective from which medical issues are addressed.

## 6. Conclusion

This discussion does not seek to provide a generalizable answer to the question of advocacy in medical interpreting, but rather to explore how advocacy emerges in a highly specific historical and institutional context: medical missionary work in Rhodesia in the 1970s and 2000s. As emphasized by de Boe and colleagues (2021), context must be foregrounded when examining ethical roles, and the examples discussed here derive from a narrow corpus situated in conditions of medical scarcity, religious motivation, and the absence of professionalized interpreting structures. Within this framework, advocacy does not appear as a stable or codified role, but as a shifting and relational practice negotiated among doctors, patients, and medical staff.

The memoir illustrates how ethical orientations in these missions were primarily constructed around concern for patient health and survival. However, this orientation should not be conflated with contemporary understandings of interpreter advocacy. The individuals who mediated linguistically and culturally in these encounters were not trained interpreters, but medical assistants and nurses whose primary responsibility was clinical care. Their communicative interventions were therefore shaped first and foremost by medical urgency, institutional hierarchy, patient literacy, and faith-based objectives. As a result, what may retrospectively be described as advocacy sometimes overlaps with

practices that could also be interpreted as selective mediation or even censoring—an ambiguity explicitly acknowledged within the narrative itself when the physician requests unfiltered access to patients' voices.

From this perspective, advocacy in the memoir is best understood as a situated, provisional response to crisis rather than an ethical imperative grounded in professional interpreting codes. While certain practices resonate with later developments in health literacy and patient empowerment, these moments should not be extrapolated to interpreting more broadly or read through the lens of contemporary interpreter ethics. Instead, they point to historically contingent forms of agency that precede professionalization and that contribute, retrospectively, to understanding how notions such as impartiality, advocacy, and trust were negotiated before they became formalized.

Acknowledging the limited applicability of these findings is therefore essential. This analysis does not claim to represent the work of professional interpreters across geographical or institutional contexts but rather highlights how multilingual medical staff navigated ethical tensions in a specific missionary setting. Read in this way, the memoir supports the use of autobiographical narratives as historical sources (Wolf, 2023), offering insight into how ethical roles in mediated medical encounters were practiced, contested, and gradually transformed. Future research would benefit from broader contextualization, including comparative historical data, ethnolinguistic change in Zimbabwe, and further exploration of related dimensions such as cultural brokerage, embodiment, and non-verbal communication, in order to more fully trace the evolution of advocacy and interpreter ethics over time.

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