‘Sign and move on’

Interpreter awareness of legal and ethical informed consent in maternity care

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This article explores informed consent in maternity care in multilingual and multicultural contexts. Based on findings from a Royal Society of Edinburgh funded research project carried out in 2022 in Scotland, the article examines why consent is particularly crucial in maternity care, how it is usually obtained in the case of parents with limited English proficiency, and which barriers may stand in the way of truly informed consent. By focusing on the prevalent conception of informed consent as a legal requirement vis-à-vis its wider ethical implications, the objective of the article is to understand how the professional relationships between service providers, users, and interpreters may be enhanced through a discussion of the fiduciary aspect of interpreting and of advocacy for best possible outcomes.

Keywords: maternity care, public service interpreting, informed consent, fiduciary, ethics in interpreting

1. Introduction

This article was borne from a project (2022, funded by Royal Society of Edinburgh) in which we examined informed consent in maternity care in the case of parents with limited English proficiency (LEP). As in other areas of healthcare, either verbal or written informed consent is integral to maternity care. However, for parents with LEP giving consent without full understanding of the English medical language can be a significant issue, especially when the decisions taken have far-reaching consequences for the health of the mother and/or baby. Evi-

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dence shows that in the UK perinatal outcomes for women[1] from ethnic minority backgrounds are much poorer than for those from white, Anglophone backgrounds (Cheyne et al. 2019; Knight et al. 2022). Factors that contribute to these poorer outcomes include linguistic and cultural barriers that limit women giving information about their own wellbeing and needs, understanding the information provided, and providing consent.

The main objective of our project was to understand informed consent from the transdisciplinary perspective of translation and interpreting studies (Susam-Saraeva, principal investigator) and midwifery (Patterson, co-investigator). In order to further explore how informed consent is understood by those who request it (healthcare professionals, mainly midwives and student midwives) and those who mediate for it (interpreters and doulas),[2] we hosted focus groups and workshops, bringing together these professionals, as well as researchers in midwifery, translation and interpreting studies, medical anthropology and ethics, and medical history. Our goal was to set aside institutional and professional hierarchies and prejudices to enable collaboration and exploration. The project benefited equally from the perspectives of translation studies and midwifery, while the practitioners in the latter field showed a greater interest in the dissemination of our findings in the form of invited talks and impact events. The discussions and activities explored research gaps, various understandings of informed consent among professionals, and facilitators and barriers associated with informed consent in maternity care. Through role-play and kinaesthetic exercises,[3] the interactive workshops allowed the participants to experience situations in which informed consent is sought from the perspectives of parents with LEP, professionals who mediate and/or advocate for them, and those who offer them care — an opportunity to step into someone else's shoes. The examples discussed in this article are taken from the focus groups and workshops we facilitated throughout the

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[1] Throughout this article we refer to 'women' and 'mothers' but acknowledge that not all birthing people identify as such.

[2] Doulas offer support in pregnancy, birth, and the postnatal period by providing information and advocacy, and offering practical and emotional support to parents. Parents may opt for doulas who share the same language with them, though this is not always the case. If they do share the same language, doulas play a dual role of language facilitator and advocate.

[3] The kinaesthetic exercises included the broken telephone game through gestures (indicating how a chain can be problematic even in non-verbal communication), and participants in groups physically creating a tableau depicting a children's toy (e.g., a train, playpen) with others interpreting the toy in light of informed consent in childbirth, teasing out participants' associations, key concerns, expectations, and, occasionally, preconceptions.

project.[4] Descriptions and quotes from workshop scenarios relate to the actions and responses by participants as they drew on their existing experiences while role-playing and were therefore not scripted.

Detailed discussion of our findings can be found in Patterson and Susam-Saraeva (2024).[5] In this article, we would like to elaborate on one of the strands that emerged in our discussions, namely the differences and overlaps between two aspects of informed consent: consent as a legal obligation – paperwork to be signed off in case of future litigation – and consent as an ethical prerequisite in communication between healthcare providers and the woman – an ideal outcome of a conversation between two parties with unequal power relations. The implications of this duality are noteworthy in maternity care for all parents; however, they become especially crucial in communication where parents do not share the same language with healthcare providers and need translation or interpreting.

In what follows, we will first discuss what informed consent entails in the case of Parents who Speak Another Language (PSALs).[6] Throughout the article, we approach translation and informed consent as one integrated issue, as it is not possible to talk about translating informed consent without first unpacking what the latter entails and what its problematic aspects are, especially for maternity care, which will be explored in Section 2. We will then turn our attention to ethics in interpreting (Section 3), discuss the fiduciary nature of the relationship between healthcare providers, parents, and interpreters (Section 4), and finally, focus on a poignant aspect of care given during labour and birth and consider informed consent in vaginal examinations (Section 5).

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4. The first two of these interactive workshops were facilitated by the Edinburgh-based arts company Active Inquiry. The workshops took place at various locations in Scotland and attracted mainly midwives and student midwives. Later on, two workshops were conducted in Leipzig, Germany, which also attracted students of interpreting and obstetrics.

5. We also presented our work on *Maternity and Midwifery Hour*. The video recording can be accessed at https://youtu.be/Ewn8b3IuTCc and the podcast at https://podcasters.spotify.com/pod/show/midwiferyhour/episodes/8-10-Language-and-Cultural-Issues-Informed-Consent-in-Maternity-e1qteer.

6. Although for our project we used the acronym LEP, in this article we open the discussion to languages beyond English by using ‘PSAL’ whenever we are talking generally, and ‘parents with LEP’ when we are referring either to our own research project findings or to those of others who worked within an Anglophone context.

2. Informed consent and maternity care for PSALs

Consent to treatment[7] means "a person must give permission before they receive any type of medical treatment, test or examination."[8] There are at least five conditions for informed consent to take place:

1. The decision must be voluntary, without any coercion, manipulation, or pressure from others, including healthcare providers, friends, or family (or, in our case, interpreters).
2. Relevant information must be disclosed by the medical team, including the nature and purpose of the procedure or intervention, risks, and potential benefits.
3. Alternatives should be discussed, including risks, benefits, and related uncertainties.
4. The patient must be competent and able to understand relevant information, as well as the nature of consent as authorisation, and make a decision accordingly, with full consciousness and cognitive abilities in place.
5. The patient must be able to demonstrate their understanding of the disclosed facts, in the form of 'teaching back' or answering the physician's questions.

It is assumed that only when all of these conditions are met, can the patient either authorise or decline the proposed course of treatment (Hunt and De Voogd 2007, 599; Joffe and Truog 2009, 348–349; Montalt 2022, 25). It is, however, important to note that neither the definition of informed consent, nor the conditions stated above, are as clear-cut and straightforward as they may seem. Throughout this article, we will come back to these points and problematise them further, especially from the perspective of maternity care for PSALs.

In our research, it immediately became clear that condition (1) is fraught with complications. Consent in maternity care has repercussions for more than one life and body; it concerns both the pregnant woman and the baby (babies); therefore, there is a different kind of pressure on decision-making. There may also be significant others involved in the process, such as partners and other family members. In the case of PSALs, these additional actors often come from a different language and culture than those of the healthcare providers, maybe even that of the mother, adding layers of opinion, custom, and expectation. These significant others' influence on the mothers' decisions should not be underestimated, especially if they come from cultures where patriarchal attitudes are more influential. It is

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[7] In this article our focus is on informed consent for treatment purposes; therefore, we will not be elaborating on informed consent within the context of medical research.

[8] See https://www.nhs.uk/conditions/consent-to-treatment/.

also not uncommon for healthcare providers to mistakenly assume that a pregnant woman needs the permission of her partner, insisting "that she consult her husband before accepting the procedure" (Hunt and De Voogd 2007, 602), though within the setting of our research (Scotland), deferral of consent to partners is explicitly discouraged. Furthermore, due to the intensity of labour and the impact of hormonal physiology on consciousness, women are often unable or unwilling to communicate with healthcare providers or make decisions, usually uttering single words or brief phrases only. If forced to talk, especially in a foreign language, they need to engage their neocortex (i.e., their 'rational' brain) rather than remain within the limbic system (hypothalamus and the pituitary gland), which produces the hormones necessary for the smooth progress of labour. This can have an adverse effect on birthing physiology, such as slowing down or stalling labour. Therefore, healthcare providers will often turn to the birth partner, who they hope is aware of what is happening and the decisions that need to be made. Ideally, parents might work together on potential and sensitive scenarios in advance of labour, but this needs them to be cognisant of such scenarios in the first place. All of this can be challenging even for parents whose first language is the same as their care providers; when we consider differences in cultural expectations of the roles of midwives and obstetricians, as well as what is culturally acceptable to discuss with a (usually male) birth partner, the complexity increases. In the words of one of our participants:

> [...] Even very loving, supportive husbands can become stressed in labour scenarios and pressure the person giving birth [...] into making decisions that they might not actually want to make. [...] There's always [...] a lot of interpersonal dynamics happening which can affect whether consent is really being given.
>
> (*Researcher and doula*)

Participants also pointed out that even the interpreters may add to these layers, as they have their own conceptions and prejudices. One of the midwives who participated in our project told us of a case when the interpreter considered the information too complex to be passed on to the mother (a young bride of arranged marriage who came from a small village in India), as her health literacy was not seen as adequate. The interpreter, presumed to be untrained, told the midwife: "You do realise where she comes from, she doesn't need to understand all this." The midwife objected and told the interpreter to continue interpreting the full information.

The voluntary nature of informed consent, without any coercion or manipulation, can be jeopardised through other means in the case of PSALs. Despite the commitment to equality within healthcare, "there appears to be strong attitudes toward LEP patients in general regarding the amount of providers' time caring for LEP patients will require" (Michalec et al. 2015, 162). Healthcare providers have indeed indicated that "using an interpreter was awkward and slowed things down" causing them to sometimes abbreviate "such consultations to compensate for the extra time" (Hunt and De Voogd 2007, 601). Research points out that for healthcare providers there is a perceived difficulty associated with LEP patients, not only in terms of the need for interpreting services, but also due to

> barriers and hurdles to communicating with and providing effective and efficient care to LEP patients [...]. Put simply [...] providers noted that the LEP patients themselves represent/present a significant challenge – and that the language/communication and cultural barriers associated with LEP patients can, in fact, impact the time they can spend with LEP patients (and non-LEP patients) and the delivery of effective and efficient care to LEP patients.
> (Michalec et al. 2015, 165)

These time constraints, as well as other infrastructural issues such as lack of staff or beds, can add to the pressure experienced by the healthcare providers, resulting in the overt or covert nudging of the parents' decisions in certain directions. In our research, participants pointed out the leading and guiding that take place in maternity care, especially in stressful situations that require quick decisions, perhaps involving a risk to life. In such cases of urgency, the fulfilment of legal obligations seems to take precedence over the ethical prerequisite of providing information for purposes of consent. In the words of one of the participants who summed up parents' emotions in emergency situations: "I don't know what [the informed consent form] is saying, but I need to move on because for the sake of myself and my unborn child, for safety, this has to happen, sign it, move on" (*Interpreter 1*). Another participant in our project described the difficulties from the point of view of both a British Sign Language (BSL) speaker and a BSL interpreter:[9]

> What I find with the deaf community is they want more information because they don't understand [...] what this means. This, "we just need you to sign this so we can move on." But then, "What is it? [...] What are you asking me?" And that process takes so long because their understanding is [not] that, you know, "this is an emergency, we need to get this baby out, but we need you to consent to this, so you have to sign." We have that worldly knowledge that everything is gonna be alright, I sign this and then I go in. But our community don't have that worldly knowledge. [...]. So it makes it even more challenging. You know this is a stressful situation. You know that time is of the essence. But you're also aware that your

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[9] While the majority of our research participants had experience working with parents with LEP, we also had one participant who worked as a BSL interpreter.

> client, who you're translating for, needs so much more, but then you're also aware that the emergency staff or the staff that are there need this process to hurry up and the demands upon the interpreter are very, very difficult, very challenging during that whole process. (*BSL interpreter*)

The expert knowledge and frequently lived experience of healthcare professionals and interpreters give them an integrated knowledge and understanding regarding labour and birth. The parents, on the other hand, are unlikely to have this depth of knowledge and when faced with complex situations, need time to make sense and integrate. They would also have their own embodied knowledge and understanding about their own pregnancy and any previous births, based on their life experience, family, friends, and culture. This knowledge may complement, contrast with, or contradict the medical understanding, terminology, and perception of the same life process. In addition, both healthcare professionals and parents have their own expectations, visions, hopes, and fears around the birthing experience.

Urgent situations can bring all these emotions into sharp relief. The urge to 'move on' can draw from and feed complex senses of duty of care, responsibility for life and safety, risk of litigation, trauma, and distress in the birthing room. In such situations, informed consent becomes less about ethics and more about necessity. This is true regardless of linguistic and cultural differences. In the case of LEP parents, cultural expectations can exacerbate this picture. The need to conform to the norms of the host country and its medical institutions (i.e., the need not to look like a 'problematic foreigner') may take precedence over the need to understand what is actually happening, and the women may choose to go along with the suggestions without actually giving informed consent.

The pressure to 'sign and move on' may prevail even without immediate or direct risk to life. In one of our improvised project scenarios, during a long first-stage of labour the birthing mother[10] requested stronger pain relief. Epidural was the next option as alternatives had been exhausted, but the mother was unsure about what it involved. The midwife gave some brief information through the interpreter. When the anaesthetist, acted by a midwife, arrived, already stressed about an impending elective c-section, they immediately asked the midwife to prepare the equipment and proceeded to give further information. This involved thrusting a printed list of epidural pros and cons at the interpreter for sight translation. Meanwhile, the anaesthetist continued with the preparation for the procedure, before the mother had received all the information and been able to

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[10] The roles were taken up randomly by the participants – a midwife could play the interpreter, an interpreter could play the birthing mother or obstetrician, and so on.

consider it between frequent and strong contractions. She finally gave her consent when the tray was already placed right beside her. In such situations, the immediacy of physical space and time makes it very difficult for informed consent to be fully voluntary.

In other cases, information may be somewhat euphemised or sugar-coated, presumably not to alarm the parents. For instance, after the use of opioid pain relief options, the baby may be born 'sleepy' rather than 'flat and needing resuscitation'. A simple question such as "Does it harm the baby?" is often met with an answer that only skims the surface, distilling information down to the core: "Your baby's not going to die from an epidural, so it will not harm the baby." Harm is not always clearly defined and is therefore difficult to interpret. Similar nuances may be sought when an obstetrician says: "I strongly advise a c-section." In such cases, it is difficult for English-speaking parents to feel as if they have any other option. Depending on how this sentence is translated, however, PSALs may have different reactions. In English, this particular construction is as urgent as it gets, but in other cultures it may be taken as a suggestion, not even a recommendation. Doctors may be expected to say: "You have to go for a c-section now," or even "We are taking you to the theatre now." Different conventions of conversation may lead to different outcomes in these interactions. While our project did not specifically focus on this weighted aspect of healthcare discourse, it is nevertheless important to flag it in relation to informed consent in childbirth. The presence – or the lack – of an interpreter and the way any such discourse is interpreted, will undoubtedly impact upon parents' decisions, and ultimately the care given to them.

It is also well-known that within maternity care nudging can morph into manipulation, even if parents share the same language with healthcare providers: "Some care providers talked about 'pulling the dead baby card' when their need for control and power was more important than women's control, whether or not the baby was at risk" (Hall et al. 2012, 21). In the words of one of our participants, "practitioners often talk about risk in a way that doesn't leave a lot of room for discussion" (*Researcher and doula*) and interpreters should ideally be familiar with the implications of such discourse. Given the protection the parents are expected to provide for their baby and faced with the fear and anxiety of a loss, they usually opt to comply. During labour and birth, women report feeling vulnerable and susceptible to the influences of others. There can be substantial pressure on women "to set aside their own interests for 'the good of the baby'" (Herring 2020, 153).

As a possible mitigation of time and space constraints, our participants emphasised the need for covering as much information as possible antenatally. However, they also pointed out that antenatal appointments are already very short for the amount of information that needs to be discussed, even for parents who speak English. Furthermore, from a legal point of view, it is unclear when informed consent can be sought and obtained for a particular intervention in pregnancy, labour, and birth. A priori consent is very problematic, as people can and do change their minds as situations unfold. Yet, good practice and better outcomes are possible when women receive a clear explanation of what might happen during labour and birth in advance, and therefore have some understanding to build from.

As for the conditions of informed consent (2) and (3) above: existing research on PSALs in the case of maternity care has noted that these parents are often given minimal information on the nature and purpose of the procedure or intervention, risks, and potential benefits, and often no information at all on alternatives, including not carrying out the procedure or intervention. In their research on prenatal diagnosis and genetic counselling in the US with Spanish-speaking parents, Hunt and De Voogd (2007, 601) found out that PSALs were often unaware of the limitations of information received through interpreting, and therefore would claim to be "very satisfied with the consultation." This was despite the fact that consultations with them were often limited in content; the information provided was so little that alternatives to accepting high risk procedures such as amniocentesis "were never mentioned" (Hunt and De Voogd 2007, 602). The voluntary nature of informed consent in prenatal diagnosis is particularly charged with moral judgements and personal values, as parents need to weigh the risks of a genetic/chromosomal condition in the baby versus provoking miscarriage. Therefore, clinicians are expected to be nondirective in their communication:

> While nearly all consultations without a language barrier were nondirective, this was so for only about half of the Spanish interpreted consultations. In some of these, the clinician failed to indicate that the procedure was optional; in others, the interpreter did not clearly translate that it was optional; and in still others, the amniocentesis was presented as simply the next step in the clinical process.
>
> (Hunt and De Voogd 2007, 601)

The brevity of information provided to PSALs may have other underlying reasons beyond the time constraints discussed above. At one of our interactive workshops with student midwives, a scenario brought to life by the participants was about a mother with LEP arriving at the hospital with a show (the mucus plug that seals the opening of the cervix and can come away tinged with blood at the start of labour). The mother, not aware of what a show might look like, was acting very concerned about bleeding and something bad happening to her baby. The midwife tried to sooth her by repeating brief sentences of comfort, such as "It's OK, it's alright, nothing to be worried about," duly translated into Spanish by the interpreter. The protests of the increasingly panicky mother continued, until the observing classmates pointed out that the midwife was not actually providing any detailed information regarding the show.

Unconscious bias in medicine has been documented and studied for many decades, at least since the work of Franz Fanon on the infantilising tendencies of physicians in colonial contexts (1967 [1952], 31–32). According to these tendencies, information may be simplified or omitted in line with categorisations, generalisations, prejudices, or ethnocentrism of healthcare providers, who may revert to a different register, more appropriate for addressing younger patients:

> Physicians' perceptions of patients may systematically vary by patient race, socioeconomic status, or other demographic characteristics. In turn, these differences in perceptions may explain some of the variance in physician behavior toward and treatment of patients [...] The very nature and context of physicians' work may enhance the likelihood of stereotype usage. There is evidence that time pressure, the need to make quick judgements, cognitive load, task complexity, and 'busyness' increase the likelihood of stereotype usage.
>
> (Van Ryn and Burke 2000, 814)

Furthermore, it was noted that healthcare providers "expressed concern and distress that they do not always understand and are not always competent of the cultures of their LEP patients, stating that they often worry about offending their LEP patients while caring for them" (Michalec et al. 2015, 163). This caused "feelings of inadequacy among the participants, which, in turn, affected their own interactions with the patient and the delivery of care" (163). It is possible, therefore, to argue that the healthcare providers may be tempted to cut the interaction short in order to avoid further embarrassment and awkwardness, without disclosing sufficient information on the treatment or alternatives, thus contributing to the infantilisation of parents with LEP.

Also, in relation to condition (2), not all the information regarding treatment and informed consent comes from healthcare providers. Our research participants pointed out that nowadays parents often use social media and websites in their own languages, which may contradict the information available in the host country. As a result of this interconnectedness, comparison, and contrast, parents with LEP may feel the care offered to them is sub-par, because there is not much 'fuss' about uncomplicated pregnancies in the UK, such as monthly scans or obstetric care. For instance, expat Brazilian mothers in the UK often do not understand why they are not offered elective c-sections before they go into labour, as this is the expectation and norm in Brazil (Susam-Saraeva and Carvalho Fonseca 2021, 363). Women may therefore listen to the healthcare advice given to them, but more often than not, choose what is familiar through their home environment. This was reflected in a comment by one of our interpreter participants about a client who, once outside the hospital building, turned to her and said: "It is ridiculous what they suggest, I am not going to do it." This may be one of the crucial differences between linguistic and cultural issues regarding maternity care as opposed to other healthcare areas: the fact that pregnancy, labour, birth, and postpartum are as much cultural and social processes as physiological ones.

It is clear that condition (4) regarding competence, understanding, and consciousness will be problematic for PSALs, not only in terms of the lack of proficiency in the host language but also in terms of unfamiliarity with expectations around informed consent in the host medical culture. Informed consent is not a universal concept and is not encouraged, enforced, or expected to the same degree in each healthcare system. In our research, we have found that women may not be familiar with the idea of making their own decisions regarding their bodies – occasionally they may not even have the necessary anatomical knowledge to be able to make those decisions – and are happy to delegate such decisions to family members or healthcare providers. These cultural norms could be taken into account if an ethical practice of informed consent is aimed for; if both parents should be involved in the decision-making, then irrespective of legal constraints, proceeding without discussing with both parents may be culturally unsafe.

Such a situation is not limited to maternity care; in other domains, "patients often do not demand the robust decision-making responsibility that the concept of autonomous authorization presupposes, and in fact frequently prefer a lesser decision-making role," assuming that the physicians will fulfil their duty to promote the patients' best interests (Joffe and Truog 2009, 348). What is specific to maternity care, however, is the impact of "heteropatriarchal media cultures" shaping "what is possible or desirable" in pregnancy, labour, and birth; as a result, "achieving a clear sense of what one wants [becomes] challenging" (Ford 2021, 122). This is a tension even within the same language and culture, and is in itself a translation between the discourse of healthcare providers and that of the pregnant woman.

Furthermore, during labour and birth, mothers are on a different plane of awareness compared to other situations that may need medical attention; it is therefore particularly important to adjust communication on informed consent to the needs of the labouring person at any given time during the process. The cocktail of hormones present in mothers' bodies places them in a different zone, often referred to as 'labourland'. They may or may not hear what is going on around them, and may or may not be aware of the people in the room. While they are certainly conscious in the sense that they are not unconscious, their cognitive relations to time and space change, impacting on how they may communicate with others, including their interpreters.

As for the final condition (5) about being able to demonstrate their understanding of the disclosed facts, in the form of teaching back or answering the physician's questions, PSALs are once again at a disadvantage. They may not be able teach back due to the limited time allocated to interpreted medical consultations, their lack of health literacy,[11] or their general reluctance to show any ignorance as they are already in the weaker position in the interaction. In the words of one of our participants who specialises in indigenous languages:

> Any exchange with any public service or any figure of authority obviously develops against the background of historical discrimination, and [...] members of minoritized communities were ashamed of the need for an interpreter. And in some cases, when they had little or no knowledge of [the majority language...] they pretended they understood even if they didn't. Because they didn't want to be considered as stupid, or [...] the corollary of that, being discriminated more than they already were. (*Researcher in translation and interpreting*)

PSALs may also not be asked to teach back, due to the aforementioned biases and prejudices on the part of healthcare providers. In the genetic counselling consultations mentioned above, only the significant points were provided to parents with LEP, with little or no option for the parents to ask questions or to interject (Hunt and De Voogd 2007, 602); that is, to demonstrate their understanding. And as Montalt (2022, 25) points out, for informed consent to take place, "disclosure is not enough. Uninformed and ill-informed patients, and patients who are not informed in a language familiar to them, cannot consent in a valid way."

There are many inconsistencies and inadequacies in how informed consent is practised in contemporary healthcare settings (Tunzi, Satin, and Day 2021, 33), and scholars writing on the subject often indicate a gap between its theory and practice. In view of these problematic aspects, scholars have come up with alternative conceptualisations, such as understanding consent as "occurring along a continuum, divided into the discrete categories of traditional informed consent, assent, and nondissent" (35). In this framework, traditional informed consent would only be for "interventions that are medium to high risk, physiologically invasive, or nonroutine; are known to generate a range of different responses from patients; provide an important opportunity for patient education; or would achieve better outcomes if patients were formally informed" (ibid.). Working specifically on maternity care, Ford (2021, 118) proposes 'attuned consent', emphasising the relational and affective aspects of informed consent:

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[11] This is of course also the case for parents who are native speakers of the language spoken in the medical institution but may have low levels of literacy.

> [...] etymologically, consent means 'with feeling' or 'feeling together,' derived from the French *sentir* around 1300. *Feeling together* connotes agreement, approval, and accordance. [...] Feeling, whether of emotion or bodily sensation, suggests a kind of attunement, sensitivity, and anticipation, something coproduced, as opposed to the patriarchal conceit of two self-contained individuals stating their positions as if in a vacuum.

This understanding of consent as a relational feeling is crucial if birth-induced trauma is to be reduced and prevented. From this perspective, other questions than the legal ones come to the fore: What would need to happen for someone to feel that they have given consent? What would the environment and the interactions need to be like, including those with an interpreter? How much leeway and initiative do interpreters have to ensure that ethical requirements for informed consent take place? Let us now turn our attention to ethics in public service interpreting (PSI) in general, and healthcare interpreting in particular, to begin to formulate some answers.

3. Ethics in public service interpreting

In PSI "ethics is intricately interwoven with the role of interpreters" (Pöllabauer and Topolovec 2021, 211), and yet, public service users and providers, interpreting studies scholars, and interpreters themselves "have divergent, often contradictory views of interpreters' roles in institutional encounters" (ibid.). The role is deemed to be ambiguous (De Cotret, Brisset, and Leanza 2021, 104), "fluctuat[ing] according to context and expectations" (Okoniewska 2022, 139):

> Role is discussed in interpreting studies with varying degrees of plasticity of social expectations. From a functional perspective, interpreters play the role of language conveyers; from a broader perspective, they act as conveyers of culture; and, finally, from a communicative perspective, mediators whose role is shaped by interaction. (ibid.)

Similarly, Clifford (2005, 237–238) presents the working relationship between a physician and an interpreter as a three-stage process. When the interpreter is new to the physician, with little prior opportunity to build mutual trust, the latter will try to maintain control over the communication process. This is the stage when translating everything as closely as possible will be the expectation — the interpreters' role will be that of the 'language conveyer', as above. According to Clifford (240), even at this early stage, interpreters who are aware of differing or clashing ethical principles will do a better job. This awareness of where the healthcare provider is coming from, as well as where the parents are coming from, can help the interpreters empathise with their values without having to take sides. At the second stage, once some professional trust is built, the interpreter can provide contextual information on cultural, religious, or ethical aspects, becoming the conveyer of culture and giving a glimpse to each party's values. Finally, at the third stage, based on increased mutual trust, the interpreter may become a mediator and part of the team, be involved in briefings before and after, help "mediate knowledge gaps" on the part of both the provider and service user, and explore different cross-cultural communication strategies (240–241). However, it is also important to bear in mind that healthcare providers who already have experience working with interpreters or working in a team environment in general have an easier time working collaboratively with interpreters and are not overly concerned about losing control or responsibility in the clinical encounter (Clifford 2004, 108–109). Conversely, if they have little experience, they may insist on a word-for-word translation and on an interpreter who is "as unobtrusive as possible, giving the practitioner full control over the dialogue with the patient" (105).

Such an evolving relationship between healthcare providers and interpreters, and between interpreters and birthing women, is not always possible due to infrastructural issues. However, when it does happen, it seems to give the best results. In our research, cases where continuity was provided were particularly mentioned as better practice, such as that of a female genital mutilation (FGM) specialist midwife who asked for the same interpreter in all her interactions with a woman. This continuity of carer and interpreter ensured better in-depth conversation and increased the knowledge and confidence of the interpreter regarding FGM and birth, with longer-term trust developing between all parties. In another case, a postnatally complex situation, the community midwife managed to get the same interpreter for a number of days. In the midwife's words, "the interpreter was reliable and interested – she *cared*," taking a personal interest in the situation and the initiative to continue the care. One interpreter recounted working with a small team of interpreters to provide some level of continuity and to optimise a second birth following a previous traumatic one, during which a family member was the only available interpreter in BSL.

In healthcare interpreting, research has highlighted the benefits of continuity for at least two decades, emphasising the positive outcomes of working with the same interpreter(s) to increase trust and cooperation (Edwards, Temple, and Alexander 2005, 87–88). It has been recommended that "where possible, professional interpreters should take responsibility for a 'case load' of clients with who [*sic*] they establish an ongoing relationship" (92). This would not only help service users to establish rapport with interpreters but could also alleviate some of the concerns of healthcare providers about interpreting in general. However, since the turn of the century, in most countries – but especially in the UK where our project was based – there is a drive towards outsourcing interpreting services. Such infrastructural constraints render the adoption of this recommendation a remote possibility for the time being.

According to the research by De Cotret, Brisset, and Leanza (2021), healthcare providers prefer a collaborative positioning of interpreters along the axis of 'active' and 'proactive', both of which inspire trust by demonstrating professional behaviour (as opposed to 'hyperactive' or 'reactive' positionings). While active positioning includes transmission of all verbal and non-verbal communication, explanation, clarification, and interruption when necessary, as well as being "resolutely part of the action" (De Cotret, Brisset, and Leanza 2021, 111), proactive positioning comprises empathy, warmth, courteous behaviour, vigilance, stability, a certain level of sensitivity to the situation, foresight, and – at the same time and in a somewhat contradictory fashion – neutrality (defined as 'in the background, self-effacing, impartial, discreet, invisible') (110–111, 115–116). The healthcare provider "can easily conceive neutrality as coexisting with other qualities of the interpreter, such as emotional investment and the ability to connect with those present or look after them" (120).

The invisibility of interpreters is a thorny issue; they are often active participants in the communication process and have to make complex decisions (Pöllabauer and Topolovec 2021, 214; Susam-Saraeva et al. 2023). This clinging to neutrality is partly to do with the general misconception among laypeople that interpreting is straightforward and can be done by any bilingual person, which itself is tied to the misconception that communication is a "direct and uncomplicated" matter of simply choosing the right words (Clifford 2004, 96). The service providers and users

> may possess very little understanding of interpreting, but they do have very strong expectations about it. 'All the interpreter has to do,' they seem to think, 'is to take the other person's thoughts and put them into the words of my language.' Faced with this kind of misperception, it is difficult for the interpreter to move beyond it. In other words, interpreters become fenced into the conduit model, because uninformed people expect a conduit-like performance from them.
>
> (104–105)

Beyond these expectations on the part of participants in the interpreting encounter, there are other factors which push the interpreters into the confines of the conduit model. They may be more focused on getting the medical terminology right or on accurately describing the proposed procedures. They may put more weight on the healthcare providers' concerns in this regard, rather than really hearing and communicating the woman's concerns and wishes. Furthermore, training and ethical codes or guidelines provided for public service interpreters often derive from conference interpreting, with its unilinear, non-dialogic understanding of communication, assigning a more mechanistic role to interpreters, which is often far removed from the real-life situations public service interpreters find themselves in (Pöllabauer and Topolovec 2021, 213; Susam-Saraeva et al. 2023).[12]

In research on PSI ethics, recent contributions have placed more emphasis on teleological ethics (an ethics that recognises the significance of behaviours in terms of their actual consequences or outcomes, and evaluates them on such terms), rather than on deontological ethics (an ethics that is based on the morality of strict a priori rules or guidelines) (Pöllabauer and Topolovec 2021, 212–213). From our perspective, one aspect of the proactive positioning is particularly relevant: "Generally speaking, proactive positioning refers to the idea that it is possible to foresee, to a certain extent, or minimize potential problems and relational tensions rather than simply to react to them" (De Cotret, Brisset, and Leanza 2021, 115). Therefore, learning more about the intricacies of informed consent in maternity care for PSALs can enhance both the professionality of interpreters and the service they can offer. It can also increase — somewhat controversially — their responsibility to act as advocates.

Embedded in the multiple layers of interpreting ethics discussed above is an additional tension when PSI takes place in environments where marked and institutionalised power differentials are involved — a tension between trust, neutrality, and advocacy. From the service users' point of view, interpreters who simply "pass on words" may not be enough; they prefer interpreters "to be proactive, pleading their case and giving advice" as they themselves have little understanding of how official systems, including that of the healthcare system, work in the host country (Edwards, Temple, and Alexander 2005, 85). If the service users feel that "professional interpreters [a]re only concerned with the service providers' or their own interests, not those of users" (87), they prefer to take a family member or friend with them instead, as "they could trust these people to act in their best interests in carrying out interpretation" (90).

From the interpreters' point of view, taking on an advocacy role is fraught with difficulties, and when and how to do it is unclear. Countries like Australia

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[12] It is important to note here that the focus on accuracy, neutrality, or invisibility in PSI is, on the whole, a 'Western' phenomenon: "Studies from non-Western countries seem to indicate a greater acceptance of a more active and advocative role of the interpreter" (Pöllabauer and Topolovec 2021, 218), possibly indicating to the conference interpreting roots of PSI based on socio-cultural expectations in Western institutions. Similarly, the principles of informed consent "were spawned by historical events in the West — the Protestant Reformation, the Enlightenment, and the Nuremberg Trials — which in turn suggests that we cannot expect these particular principles to have universal currency" (Clifford 2005, 234).

and Canada strictly advise against interpreters taking on such roles, while the US National Council on Interpreting in Health Care (NCIHC) has preferred to openly discuss the possibility of advocacy. According to their guidelines, quality medical interpretation calls for accuracy, confidentiality, impartiality, respect, cultural awareness, role boundaries, professionalism, professional development, and advocacy (NCIHC 2005, 2021). At face value, there seem to be contradictions here, especially between impartiality and advocacy; however, advocacy is presented as something interpreters should consider only if they find themselves in a serious ethical dilemma (The Health Collaborative 2018):

> In accordance with Standard 31 of the NCIHC Standards of Practice, healthcare interpreters may intervene with an act of advocacy on the rare occasions when the potential for serious imminent harm to a patient is not addressed and the danger of harm remains. In doing so, healthcare interpreters maintain the integrity of their role using an intervention that is within the holistic scope of that role. Their allegiance when advocating is to the value of beneficence – preventing harm in support of the health and well-being of the patient. In the words of the NCIHC Code of Ethics: 'When the patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if less intrusive actions have not resolved the problem'.
>
> (NCIHC 2021, 51–52)

This tension between trust and advocacy can be best explained through a slight detour into legal discourse, by looking at translators and interpreters as fiduciaries (Montalt 2022).

4. Translators and interpreters as fiduciaries

As noted in Section 3, in all service settings trust emerges "as a key feature in people's understandings and experiences of the process and ideals in needing and using interpreters" (Edwards, Temple, and Alexander 2005, 90). Compared to friends and family members taking on interpreting, the professional interpreter's role "is based on an impersonal form of trust. Their obligation to adhere to good standards of practice, expert knowledge and competence, lack of personal or institutional bias, and maintenance of confidentiality, form the basis for this trust" (91). This impersonal trust within the context of healthcare interpreting can be explained through the use of the concept of 'fiduciary'. According to Montalt (2022, 25–26), a fiduciary relationship can better describe "what happens in ethical terms in IC [informed consent] between the translator or interpreter as entrusted agents of interlingual and intercultural communication, on the one hand, and both the patient and the health professional as beneficiaries, on the other hand." Fiduciary is defined in legal terms

> as a person entrusted with power or property to be used for the benefit of another and legally held to the highest standard of conduct. Fiduciaries advise and represent others and manage their affairs. Usually they have specialized knowledge or expertise. Their work requires judgment and discretion. Often the party that the fiduciary serves cannot effectively monitor the fiduciary's performance. *The fiduciary relationship is based on dependence, reliance, and trust.*
> (Rodwin, cited by Joffe and Truog 2009, 352; our emphasis)

Trained and certified medical interpreters bring their specialised expertise and knowledge into hospital settings. They are also expected to use their judgement and discretion in enabling complex communication and interaction between service providers and users, even in difficult circumstances and under potentially stressful conditions. Both the healthcare provider and user rely on the interpreter as a fiduciary: someone with whom they can entrust their thoughts, feelings, plans, or recommendations. When it comes to the birthing room, however, there are additional layers of complexity in relation to dependence, reliance, and trust:

> In an unmedicated or lightly medicated birth, the birthing person often experiences a tipping point at which embodied intensity takes on a new level, which I heard described as a 'point of no return,' where 'the only way out is through,' and words are not really accessible anymore. The birthing room is a semiotically dense space where bodily attunement enables nonlinguistic understanding. Ideally, understanding and intimacy create a situation of interpersonal trust.
> Such trust emphasizes dependency instead of autonomy, in contrast with a paradigm of rights and transaction that presumes self-interest is primary. Feeling safe and surrounded by trustworthy people facilitates giving up control, and a prominent discourse of surrender and 'trusting one's body' posits relinquishing certain kinds of control as key to accomplishing birth. Consent that is centered around embodiment enables trust. (Ford 2021, 123)

Where does this withdrawal from verbal communication on the part of the birthing woman and "consent that is centered around embodiment" leave the interpreter, who mostly relies on words being spoken and whose very body is expected to be invisible? How does it impact the interpretation of any informed consent, if the fiduciary relationship between patient and healthcare provider, and that between both and the interpreter, requires the ethical framework to be extended beyond the limitations of informed consent, patient autonomy, and patient values often evoked in relevant literature (e.g., Clifford 2005, 234; Hunt and De Voogd 2007, 599)? To begin to tease out some answers, we will discuss the distinction between fiduciaries as agents or representatives versus fiduciaries as advisers (Joffe and Truog 2009, 353–371). Joffe and Truog draw these distinctions in the context of physicians' role but we will be adapting them to that of interpreters. In the former, the fiduciary is expected to act

> on the client's behalf and in service of the client's welfare in the relevant domain. In the typical case, there is no need for the agent-fiduciary to seek authorization for each action; rather, the overarching authorization that the client grants to the fiduciary upon entering into the relationship — to represent the client and to act as an agent for his welfare — entails the license to act on the client's behalf. (353)

For our purposes, the clients here are both healthcare providers and users. The interpreter cannot ask for authorisation for every single utterance and the parties involved have to rely on the interpreter's willingness to act as an agent for their own welfare. Compare this with the adviser-fiduciary model:

> Advisers differ from agents in that the main role of the former is to provide information and guidance to their clients, whereas the main role of the latter is to represent their clients in decision-making situations. Although duties of fidelity and loyalty govern the fiduciary's advice-giving role, the adviser-fiduciary lacks authorization to act on the client's behalf without the client's explicit consent. [...] However, viewed as an adviser-fiduciary, the physician has a duty not simply to act as an agent for the patient's welfare, but rather to help the patient make choices that cohere with and advance his individual life plan. In order to satisfy this demanding duty, the physician must do more than merely provide information that can serve as the basis for the patient's decision; she must take affirmative steps to ensure that the patient has a sufficient understanding of that information to make a decision that promotes his life plan. (353–355)

Adapting the adviser-fiduciary model to the relationship between healthcare provider and interpreter or between service user and interpreter is trickier than the agent-fiduciary model, partly because of the infrastructural issues alluded to in Section 2. For an interpreter to be familiar with the individual life plan of a birthing mother, they would be expected to have supported them throughout their antenatal appointments, clarified their birth plans, if any, and acquainted themselves with the parents' hopes and fears about this particular pregnancy and birth. Such interactions also go against the widespread preconceptions about neutrality and invisibility of interpreting, as discussed in Section 3.

However, the expectations of service providers and users about 'proactive' interpreting (professional interpreting based on care), the caveats regarding situations that may require advocacy on the part of the interpreters, and the specificities of the birthing environment which necessitate relational, intimate and embodied trust are more aligned with an adviser-fiduciary model in interpreting, rather than the agent-fiduciary model which has implicitly prevailed. Such a shift in perspective is crucial if the interpreting of informed consent in maternity care is to focus not only on legality, but also on ethics. To clarify our arguments further, we will now turn our attention to a particular intervention in maternity care and discuss vaginal examinations during labour as a noteworthy and illuminating case.

5. Vaginal examinations

Although "informed consent for invasive healthcare procedures is a fundamental ethical and legal obligation for clinicians" (Lee et al. 2017, 863), the definition of what constitutes an invasive procedure from the points of view of the healthcare provider and birthing woman may differ. Often euphemised as 'internal examinations', 'examinations', 'VEs', or 'let's just check how you're doing', vaginal examination is one area where distinctions between invasive procedure, birth, and sex become further blurred: "Non-consensual intimate examinations in childbirth are distinct from other forms of obstetric violence, at least partially because of their clear similarities with certain forms of sexual violence" (Shabot 2020, 195). As Ford observes:

> [...] consent is important but inadequate in birth. Sex and birth are both highly embodied experiences. Not attending to the ways bodies express themselves is bound to be inadequate for producing satisfying, respectful sex or birth. Defensive consent discourse has an important function in asserting that the birthing person is in charge of what happens to her body, yet innumerable qualitative factors produce the difference between a satisfying birth experience and a traumatic one. (Ford 2021, 126)

Vaginal examinations have long become routine procedure in most maternity care settings around the world. Healthcare providers carry out these examinations on a regular, often daily basis, to assess the cervix to determine labour progress, to ascertain the position of the foetus, and to rule out complications. Yet, for women undergoing a vaginal examination, the procedure is far from routine (Montgomery 2020, 39). These are complex examinations most women find painful and/or intrusive, distracting from the flow of labour. In particular, for the one in four women who experienced sexual abuse or assault, vaginal examinations can be particularly traumatic, leading to flashbacks and possible re-traumatisation (Montgomery 2020, 44). More often than not, medical professionals rely on *implicit* consent for vaginal examinations: if the woman consented to receive medical care during labour and birth, vaginal examinations are seen as part and parcel of giving birth and are presented as such (Herring 2020, 143, 147–148), with no mention of the possibility that women can decline them. The interpreters, unaware of the implications, may partake in this view themselves — in the words of one male student interpreter during a vaginal examination and interpreting scenario: "Well, this woman came to the hospital to give birth — she should just listen to what they say." Alternatively, the conduct of the birthing woman can be taken "as evidence of a consenting state of mind," (148), such as getting on to the examination bed or removing clothing to enable the examination.

It is important to recognise the fact that from a legal perspective, "consent operates to justify an act which is prima facie wrong. It can (or can help) render a prima facie wrongful act justified 'all things considered'" (144), such as a trespass into someone's home versus a dinner invitation. When a medical intervention such as vaginal examination is considered, it becomes particularly important to ensure that there is full, "sufficiently 'rich'" consent that can do "the moral work required" (147). The view that "it can only be rape where there has been positive resistance, or that silence can be taken as consent, is outdated and based on patriarchal assumptions. […] The same is true in cases of vaginal examination" (149).

Researchers have found that, even if initial consent for vaginal examination may have been sought, sufficient information of what it involves may not have been given to women (Stewart 2005); or, the medical staff may proceed regardless of recognising any distress on the labouring woman's part, without double-checking whether the consent is revoked (Montgomery 2020, 44). These "nonconsensual practices result in loss of dignity, loss of autonomy, and trauma, converting birthing subjects into objects of medical scrutiny without agency" (Shabot 2020, 195). More importantly, they constitute

> a special case of obstetric violence, where women frequently lack the epistemic resources to recognise the practice as violent not only because of the inherent difficulty of recognising violence in an 'essentially benevolent' setting such as the medical one but, even more so, because of the pervasive sexual reification of women under patriarchy and the pervasive shame to which women are subjected. (196)

When we go back to Tunzi, Satin, and Day's (2021, 35) proposed distinction between traditional informed consent, assent, and nondissent, it is clear that the case of vaginal examinations falls between assent and nondissent. According to the authors, the former,

> a solicited expression of assent, documented in the medical record, should be the standard for low-to-medium-risk interventions that are routine and fall within the community standard of care and typically generate an affirmative patient response without a lengthy discussion yet that still require some basic description and explanation in order to be understood by most individuals. (36)

The authors list "physical examination of sensitive body areas" as the first example for interventions requiring assent (36). However, whether vaginal examinations "typically generate" a *voluntary* affirmative patient response is uncertain, given the pressures on women to care for more than one life and body, and the power differentials involved in a birthing room. As for nondissent,

> an explanation of care without an overt negative reaction from the patient may be the standard for the great majority of primary care interventions that are very routine, low-risk, and are typically accepted by patients. Examples include *performing routine physical examinations* [...]. To meet the nondissent standard, patients should be informed what is going to happen and why, and they will be told that, unless they indicate otherwise, the default intervention will proceed.
> (37; our emphasis)

As mentioned above, vaginal examinations are very routine in medicalised births, and therefore risk sliding into the final category of nondissent. In busy clinical settings where there is little opportunity to get to know the birthing women antenatally, the healthcare providers "will not necessarily anticipate any difficulties as they seek consent for a 'routine' procedure" (Montgomery 2020, 42). If the interpreter has not had a chance to work with the woman beforehand, they will not know their preferences or past history either; therefore, they will not be able to fulfil their adviser-fiduciary role. In the care offered to birthing women, it is important for care providers and interpreters to recognise the differences between "silence, acquiescence or consent" (Montgomery 2020, 50). Consent is and should be seen as a "'positive' notion. The legal issue is whether or not the patient consented to the procedure, not whether the patient failed to oppose the treatment" (Herring 2020, 146). As Montalt (2022, 27) observes:

> Within the same culture and language, silence, for example, can sometimes indicate abstention, acquiescence, and lack of interest as well as consent. When mediating between languages and cultures, the meaning of silence and other gestures and forms of nonverbal and verbal behaviour becomes far more complex.

As in the case of sexual consent, the lack of protest to vaginal examinations should not be interpreted as implied or tacit consent, especially in the case of survivors of childhood abuse, as silence has already been a part of their life. Compliance may arise from the "dissociative state that is very common in women who have experienced previous trauma" (Montgomery 2020, 46). While from a legal perspective, these situations would not be seen as examination without consent and healthcare providers may genuinely believe they have the woman's consent, the procedure can be experienced by the women as disempowering, violating, or confusing (47–48). The autonomy assumed on behalf of the birthing women may not be available to survivors; they may not be able to protest, raise concerns, or change their minds after any initial consent. This is especially true for cases where memories of abuse may be buried deep and are then triggered during labour and birth (47).

6. Conclusion

In this article, we explored how interpreting informed consent in maternity care may differ from other areas of healthcare, with a particular focus on the distinction between legal and ethical informed consent. As Montalt (2022, 29) observes:

> In theory, IC should not only have medico-legal validity; it should also be truly meaningful to the patient. In the practice of translation of IC, the medico-legal dimension, and often its defensive role, take centre stage and the ethical, cognitive and affective dimensions tend to vanish.

We discussed some of the factors that play a part in this vanishing act, such as nuances of language and culture, patriarchal frameworks and expectations, space and time pressures, and intimacy and urgency of labour and birth, emphasising that the perinatal period is not only a physical, but also a cultural and social process. Based on our own project findings, as well as on available scholarly literature, we argue that interpreters working in maternity care need to be aware of (1) time pressures and unconscious biases on the part of healthcare providers that can lead to brevity of information, stereotyping, infantilisation, manipulation, or coercion; (2) any unease towards PSALs felt by healthcare providers, and their possible lack of training in working with PSALs (or with interpreters for that matter); (3) the different consciousness birthing women enter into (the 'labourland'), its effects on communication, and consequences of interfering with it; (4) possible reluctance on the part of women in taking responsibility for their own bodies and health; (5) different cultural expectations and interpersonal dynamics between women, their family members, and healthcare staff; and (6) the crucial difference between legal and ethical informed consent from the perspectives of service providers and users.

Interpreting in the context of maternity care for parents with PSALs often involves women with refugee or asylum-seeking status. For them, motherhood in a new country may take place against a complex backdrop of hardship, possibly including a history of torture and subsequent PTSD, domestic abuse, sexual slavery, and FGM (Susam-Saraeva and Carvalho Fonseca 2021, 351). Regardless of whether a woman discloses such a history of abuse or not, "respectful, trauma-informed care enables staff to respond to spoken and unspoken messages from women" (Montgomery 2020, 50). Such respectful care has to include that given by interpreters. Both healthcare providers and interpreters should do everything in their power to uphold whatever autonomy women can muster given their own baggage and institutional power differentials.

Research shows us that women remember their birthing experiences for years (Takehara et al. 2014), often for a lifetime. If women feel respected and involved, these memories are mostly positive, regardless of any interventions that may have taken place (Menage et al. 2020). Lack of involvement in decision-making and lack of respect, on the other hand, are key factors in birth-induced trauma, regardless of events during labour and the outcome of the birth (De Schepper et al. 2016; Simpson and Catling 2016; Reed, Sharman, and Inglis 2017; Patterson, Hollins Martin, and Karatzias 2019; Sun et al. 2023). If this trauma is not addressed, women do not 'move on'. A very common expression when describing birth trauma is "anyway, my baby's alive, I'm alive…". More can be done to ensure the person says instead: "I felt like I was involved. I felt like I was respected and consulted."

Currently, rather than a thoroughly ethical approach, it is the malpractice litigations based on patients' perceptions of poor communication with and care by healthcare professionals that tend to be cited as a leading cause for calls for more and better interpreting provision in all areas of healthcare (Hunt and De Voogd 2007, 604; Lee et al. 2017, 864). However, based on the PSI ethics discussed in Section 3 and the links between the expected proactive role of the interpreters, trust, and advocacy, it may be high time to rethink interpreters' roles in maternity care. In the words of one project participant:

> […] Ascertaining informed consent can actually be quite problematic in interpreter mediated encounters, and I think that […] deserves more attention to how interpreters can ensure that people have really understood and can make an assessment of the situation, *probably over and above what the interpreting codes stipulate.* (*Interpreter trainer and researcher*; our emphasis)

In our discussion on the ethics of interpreting we have seen that the conduit role, in which interpreters are expected to "passively convey information from one language into another, often cannot be or is purposely not upheld in practice as interpreters adopt hybrid roles, especially in asymmetrical situations or *exchanges of a sensitive, intimate nature*" (Pöllabauer and Topolovec 2021, 215; our emphasis).

There are situations which call for the interpreters to serve "as helpers or advocates of the less powerful party" rather than "facilitators of abuse" (ibid.) who "do absolutely nothing" and thus "take the side of the oppressor" (Susam-Saraeva et al. 2023, 147). Especially when issues of social justice, discrimination, vulnerability, and structural barriers to access healthcare services are at stake, interpreters are invited to empower their clients, encouraging them to self-advocate, by, for example, increasing their health literacy (Pöllabauer and Topolovec 2021, 218). If the adviser-fiduciary role has any potential for interpreters, ensuring full and rich informed consent (such as for vaginal examinations) may be not only the duty of healthcare providers but also that of interpreters. For attuned and embodied consent to take place, interpreters may need to assume their role not only as conveyors of language and culture, but also as mediators. In particular, in the admittedly rare situations where continuity of care by both healthcare staff and interpreters can be ensured, the latter will find more opportunities to gain knowledge and build trust as a member of the team, fulfil a (pro)active role as adviser-fiduciary, and, when absolutely necessary, be able to offer advocacy.

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