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Empathy as Praxis: Addressing Hidden Curriculum in Medical Interpreter Education

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Abstract: Empathy is a necessary yet contested component of medical care, especially within encounters involving medical interpreters, where practitioners must navigate the delicate interplay between emotional attunement and professional impartiality. This article examines empathy as a hidden curriculum in both medical interpreter training and medical education, where its role is often inconsistently addressed or entirely overlooked. In a climate of rapid technological advancement, this study asks: How can interpreter training remain human-centered while leveraging technologies that create realistic practice scenarios in which empathy remains central? To address this question, the study draws on a targeted literature review and conceptual analysis of professional codes of ethics and empathy-related scholarship, combined with the design of a custom simulation. Inspired by Stoic Hierocles' concentric circles of concern (see Figure 1) , the research introduces a new pedagogical framework that situates interpreters within a dynamic network of relationships involving patients, healthcare providers, and institutional systems. Through reflective practice, simulation-based learning, and structured exercises that engage the empathy muscle, this methodology fosters a nuanced understanding of the relationship between empathy and professionalism. The proposed framework addresses critical gaps in training programs, uniting the empathetic and ethical dimensions of interpreting to enhance communication, trust, and healthcare outcomes.

Keywords: empathy, medical interpreting, hidden curriculum, pedagogy, healthcare communication

1. Introduction

Empathy is a muscle that, like all muscles in our body, must be cultivated, engaged, and fine-tuned in order to function properly and efficiently. Yet, despite its ever-increasing centrality to human relationships and interactions, empathy is a heavily researched and highly contested concept. Scholars and industry professionals alike seem to be unable to agree on whether empathy is an innate ability or a teachable/learnable skill and whether it is inherently altruistic or strategically self-serving. Philosophers, psychologists, educators, scholars, and more find themselves at odds, even after decades of research. While some steadily hold that empathy is the foundation of ethical behavior and social harmony (Decety, 2015, p. 12; Song et

al., 2025, p. 2), others err on the side of caution (Macnaughton, 2009; Camassa, 2024, p. 134), firmly arguing that practicing empathy leads to more harm than good: emotional fatigue, biased decision-making, and blurred personal and professional boundaries.

In professional contexts, these unsettled debates become even more pronounced. Fields like medicine, social work, and education often revere empathy as a vital component of worthwhile practice, yet it is equally critiqued, being posited as an unquantifiable, intangible quality that seeks to jeopardize objectivity or hinder the maintenance of professionalism. The field of medical interpreting hosts a complex environment in which the tensions between empathy and professionalism become contrastingly evident due to the accompanying high stakes and possible conflicting cultural interactions. Unlike other public service settings, healthcare interactions combine the immediacy of personal suffering with institutional protocols that both demand and delimit empathy, making its negotiation uniquely complex. As the only person in the room able to communicate with both parties, medical interpreters must maintain three core bidirectional relationships, all of which sustain a core aspect of the appointment: the doctor-interpreter relationship safeguards the flow of accurate and impartial medical information; the doctor-patient relationship relies on the interpreter's facilitation to ensure trust and effective care; and the patient-interpreter relationship, ideally, necessitates clarity, empathic engagement, and cultural respect.

In the midst of these demands, medical interpreters must operate under institutional constraints and professional standards that prioritize impartiality above all else. In such high-stakes settings, empathy becomes paramount and yet equally precarious, with little in-between. Too little empathy can deepen misunderstanding, alienate patients, and increase risk of poor health outcomes, while too much empathy can break neutrality, cross boundaries, and harm interpreter mental health. While the need to balance empathy and impartiality is acknowledged in theory, what remains largely unaddressed is how to train interpreters to achieve this balance in real-world, high-stakes encounters (Merlini, 2019).

Medical interpreting occupies a unique and delicate position within healthcare systems. Interpreters must navigate emotionally charged encounters, linguistic and cultural complexities, and institutional constraints—all while adhering to professional standards that often prioritize impartiality. In such high-stakes environments, empathy becomes both indispensable and precarious. Too little empathy can alienate patients or deepen misunderstandings, while too much empathy can compromise the interpreter's neutrality or emotional well-being. Despite the recognition of empathy as essential, training programs continue to focus

predominantly on technical accuracy, leaving little room for developing emotional intelligence and reflective practice.

We find an overlap in hidden curricula in both medical education and medical interpreter education. Medical students receive little to no structured preparation for working with patients who require interpreters, and empathy is often discussed only evasively, if at all. Similarly, in interpreter education, empathy is framed as an incidental skill rather than a core competency, leaving interpreters responsible to use such a delicate and complex skill in sensitive situations with no formal guidance. In both professions, erasing empathy as an explicit pedagogical focus may quickly lead to professional turmoil. When empathy is left unexamined, it perpetuates systemic inequities, places undue emotional and mental burden on interpreters, creates conflict between personal and professional responsibilities, and cements the two professionals in a workflow that does not allow for their highest collaborative potential. Like a muscle that is either overworked or left to atrophy, empathy without deliberate cultivation can become more of a hurtful tool than a helpful one.

To address this curricular gap, this paper proposes a recalibration of empathy's situatedness within medical interpreter education, bridging it with professionalism in training. This new curriculum is grounded in a model created by the researchers, adapted from Hierocles' concentric circles of concern that situates the interpreter at the center of overlapping relational and systemic dynamics, emphasizing the fluid and often fraught nature of empathy in professional practice and equipping them with tools for self-awareness, systemic understanding, and ethical decision-making. By integrating structured simulations, reflective exercises, and explicit discussions of empathetic boundaries, this pedagogy aims to prepare interpreters to navigate the ethical and emotional demands of their work while maintaining professionalism. In doing so, it highlights how a more deliberate focus on empathy in interpreter training can benefit not only interpreters but also the broader medical system in which they operate.

2. Literature Review

2.1 Defining Hidden Curriculum

Kearns (2012, cited in Washbourne, 2024, p. 4) describes curriculum as encompassing all planned and unplanned ideas and activities within an educational program, along with the ways these are conveyed to meet learners' needs and achieve the program's intended goals. This broad definition has informed an extensive body of curricular research, which now includes a wide range of curricular classifications within what Hafferty (2010) terms "Informal/Hidden/& Other Types of Curriculum". Hidden curriculum emerges as a large and problematic subset in

this category and may be broadly defined as unstated norms that perpetuate value systems, especially inequalities (Snyder, 1970; Hafferty & Franks, 1994).

Other scholars define hidden curriculum similarly. Kenison et al. (2017) specifically investigate hidden curriculum in caring for limited English proficiency (LEP) patients. Their study focuses on institutional structures and cultural norms that shape hidden curriculum. Kenison et al. (2017) take the passive view, defining hidden curriculum as "the set of influences that function at the level of organizational structure and culture" (p. 92). Conversely, Vallance (1983) views hidden curriculum as an actively enforced system of social control framing it as an active stakeholder, writing: "[hidden curriculum] strives for the inculcation of values, political socialization, training in obedience and docility, and the perpetuation of traditional class-structure functions that may be characterized generally as social control" (p. 9). Whether scholars view hidden curriculum as an actively enforced harmful system, or as an incognito issue that enforces harm silently in the background, we can certainly say that there is one emerging consensus: hidden curriculum works in the background and compromises core-values of professions, like empathy.

Foucault's idea of the medical gaze helps us better understand the hidden curriculum in medical interpreter education. The medical gaze, according to Foucault (1973), refers to how modern medicine tends to focus only on the clinical details of a patient, often ignoring their personal stories and emotions. While this focus can improve clinical accuracy, it can also lead to a lack of empathy, making patients feel like they are just cases rather than people. Similarly, Hafferty and Franks (1994) point out that medical students often pick up on this hidden message—that detachment and efficiency are more important than empathy. This puts medical interpreters in a tough position since they have to juggle being neutral while also staying empathetic during sensitive interactions. Yet, as Merlini (2019) notes, interpreter training rarely gives students the tools to handle this tricky balance, leaving them to figure it out on their own. By including empathy training in interpreter education, we can help students find that balance, pushing back against the overly detached approach encouraged by the medical gaze and creating a more compassionate healthcare experience for patients.

2.2 Hidden Curriculum in Medical Training: Empathy as a Compromised Value

Green and Nze (2017) expand on the works of Vallance (1983) and Kenison et al. (2017), examining perceptions around standards of LEP care from a provider perspective. Green and Nze (2017) find a concerning and common rationale among

physicians—labeling LEP patients as "poor historian" in their charts as a way of absolving themselves from the responsibility of the systemic failure at hand. This trend is devoid of empathy, and it conveys a hierarchy of value to students, whereby good communication, especially if it takes extra time (i.e., with an interpreter), is valued much lower than clinical knowledge, further enforcing complicity with this system that is designed to enforce disparate and harmful healthcare outcomes. Flores (2005) echoes similar concerns through a systematic literature review of the impact of interpreter services on quality of care, finding that substandard language service––not being provided an interpreter, having an ad hoc interpreter, or having a poor experience with an interpreter—affects over 21 million Americans a year in adverse ways, including but not limited to medication misinformation, misdiagnosis, and Health Insurance Portability and Accountability Act (HIPAA) violations. Ferguson and Candib (2002) add that viewing interpreters as just cultural mediators gravely oversimplifies their role and perpetuates the hidden curricula that impedes empathic engagement.

Hidden curriculum within the medical context has become central to understanding how values, most especially empathy, are transmitted in medical education. In their first exploration of hidden curriculum within the medical context, Hafferty and Franks (1994) delineate how medical colleges teaching ethics under dichotomous methods of thinking (skills versus orientations, education versus training, being compassionate and caring versus simply regurgitating facts) (p. 862) has influenced students' actions when faced with ethical dilemmas. Importantly, they make a point of reminding that these dichotomies often only exist on one side (skills, training, and regurgitating facts) due to both the traditional medical culture of medicine-as-science rather than medicine-as-art, and industrial demands like time, payment, and insurance (p. 863). As a result, medical students often learn, implicitly, that efficiency and objectivity always outweigh empathy in clinical practice. Hafferty et al. (2015) find medical students reflecting this notion. One interviewee discusses her encounter with a crying mother, worried about her daughter, in an interview with a standardized patient. During the session, the student's response highlights hidden curriculum causing potential damage to both parties: "Desperately trying to remember the mnemonics about how to respond to emotion or to show empathy… the student nervously blurted out 'Do you have other children?'" (p. 134).

2.3 Empathy in Practice: Impartiality vs. Humanity

The ways empathy is taught—or left untaught—reveal the enduring influence of hidden curriculum in shaping practitioners' attitudes toward care and communication. Empathy is perhaps the most heavily studied within the healthcare

context, and has been defined as "a cognitive attribute, which involves an understanding of the inner experiences and perspectives of the patient as a separate individual, combined with a capability to communicate this understanding to the patient" (Hojat et al. 2002, as cited in Washbourne n.d.). This definition hinges the success of patient access, understanding, and outcomes heavily on the empathic competence of interpreters.

Despite this heavy reliance on interpreters to be able to calmly and efficiently utilize empathy within unique encounters, education and training policies for medical interpreters minimally address empathy. For example, within the National Council on Healthcare Interpreting (NCIHC) Code of Ethics, empathy is mentioned only once within the twenty-three-page document, and moreover not directly addressed, only mentioned through impartiality:

> To be impartial, therefore, is to act with an absence of favor or prejudice in making a judgment, free from favor for any or either side. [...]
> Interpreters in the health care encounter understand that they are not there as primary participants in the interaction and, therefore, are not in a position to make decisions, to advise or counsel, or to speak for the other participants. […] This is a principle that is misunderstood and misinterpreted by many to mean that interpreters should be disinterested in or uncaring with regard to the patient. To the contrary, […] one of the overarching values of the healthcare interpreter's code of ethics, a value that is shared with other health care professionals, is the well-being and welfare of the patient. In upholding this value, *interpreters fully recognize and accept the humanity and the human needs of the parties in the encounter. Responding with empathy to a patient who may need comfort and reassurance is simply the response of a caring, human being*. ("A National Code of Ethics for Interpreters in Health Care", 2004: 15-16, emphasis by Dr. Kelly Washbourne, Kent State University, unpublished manuscript, n.d.).

To prescribe empathy in this way to interpreters is to ingrain in them the same cost-benefit analysis mode of thinking that medical students have also come to internalize about empathy. The absence of any space for pre-professionals to comfortably engage with their empathic selves serves to place them between a rock and a hard place—between the institutional demands at play and the human in front of them experiencing adversity at a systemically disadvantaged level.

In a similar vein, the International Medical Interpreters Association (IMIA) Code of Ethics calls on interpreters to "participate in continuing education programs as available" (Item 10). While the directive is broad and does not explicitly name empathy, it provides an underutilized opening to embed targeted training on

empathetic engagement within ongoing professional development. Such training could equip interpreters with the skills to navigate empathy's dual nature—as a spontaneous human response and as a regulated professional act—through structured reflection, scenario-based practice, and ethical analysis. Framing empathy as a legitimate focus of continuing education would align interpreter professional growth with the same intentionality that governs technical competence, thereby closing one of the most persistent curricular gaps in the field.

Gutierrez et al. (2019) investigate this dynamic in an emotionally charged and communicatively difficult context in their study exploring how delivery of genomic sequencing disclosures impact Spanish-speaking families in the United States. Their study found that interpreters adapted clinician's statements using five main empathic linguistic tools: "contextualization, encouragement, checking comprehension, endearment, and softening" (p. 895). These tools indicate a starting point for assessment of empathic use within simulated experiences.

Merlini (2015) conceptualizes empathy as a "zone of uncertainty", that has, as such, been largely avoided, in not only medical interpreting, but conference interpreting as a whole discipline (p. 27). She narrows her focus to empathy within medical interpreting in 2019, critiquing interpreter education programs for their emphasis on neutrality/impartiality as that school of thought leaves interpreters woefully ill-prepared to navigate most encounters they find themselves in. Merlini (2019) ends with a powerful call to action, writing that "empathy is a context-dependent, interactionally achieved outcome; and empathic skills may be acquired" (p. 236). Washbourne (2014) echoes this sentiment, advocating for a shift toward empathy-focused, culturally sensitive mediation due to the important role of intercultural transcompetence in establishing trust and building rapport between practitioners and patients. He expands on this work in an unpublished manuscript, writing that "Medical interpreting, to enlarge its notion of impartiality, would do well to examine more closely these ideas from the humanistic, holistic approach" (Washbourne, n.d., p. 4).

2.4 Situated and Reflective Pedagogies for Empathic Competence

Calvo (2015) addresses hidden curriculum in translator and interpreter education by investigating the potential effectiveness of situated and reflective training approaches to scaffold learning progression (p. 306). The methods she outlines emphasize progressive skill-building and critical reflection with aim to engage students with the implicit norms embedded in their profession (e.g., within medical interpreting, codes of ethics calling for default impartiality with use of empathy). Lan's (2019) study on embodied empathy in interpreter assessment argues the value

of experiential learning in developing a core empathic competence. Hague (2015) supports this call for reflection, highlighting that empathic accuracy, the ability to imagine others' perspectives, is an underexplored and yet essential component of translator competence (p. 20). He importantly calls on his fellow instructors to heed their responsibility to help students develop their empathic accuracy, if it is indeed a vital part of competency, pushing for implementation of pedagogical methods that implore perspective-taking through engagement with the "other" (p. 25).

2.5 Implications for Pedagogy: Toward a Structured Empathy Curriculum

The intersections found in the literature between hidden curriculum, empathy, and LEP standard of care point to significant gaps in medical education and medical interpreter training. Within their respective fields, each pre-professional is currently being educated in such a way that teaches them to view each encounter from an objective perspective with logic akin to cost-benefit analysis. Reichmann et al. (2024) recognize this gap and propose interdisciplinary training programs that simulate real-world scenarios that require collaborative roleplaying between each pre-professional, such as simulated birth involving midwives, interpreters, and physicians. Programs such as those proposed by Reichmann provide a solid foundation for a pedagogy of empathy, as they demonstrate the ability to prepare students to navigate ethical and emotional complexities of healthcare.

The literature consistently demonstrates that, despite empathy's recognized importance for effective patient care, it is rarely treated as a structured, assessable component of either medical interpreter education or medical training. Instead, its development is left to incidental learning, where it is shaped by institutional norms that prioritize impartiality and technical accuracy over emotional engagement. This neglect reinforces the hidden curriculum and sustains systemic inequities in care for LEP patients, as both interpreters and providers enter practice without guided preparation for balancing empathy with professionalism in high-stakes encounters. Closing this gap requires a pedagogical model that integrates empathy training with technical skill development and that can adapt to the evolving demands of healthcare education. This need shapes the guiding question for the present study: In a climate of rapid technological advancement, how can medical interpreter training remain human-centered while leveraging technologies that create realistic practice scenarios in which empathy remains central?

3. Methodology

This study combines a targeted literature review that functions as a conceptual analysis of professional codes of ethics, empirical studies on empathy, and relevant

pedagogical models with the design and examination of a custom simulation to demonstrate the potential of structured empathy training. While this is not an empirical document analysis in the formal qualitative research sense, the review systematically engages with and interprets key documents and scholarly sources to identify gaps and tensions in existing approaches. The study also introduces a framework, which we have named the Interpreter's Empathy Matrix (IEM), based on Stoic Hierocles' concentric circles of concern, applied to empathy in medical interpreting, offering a new way to conceptualize and engage with the interpreter's responsibilities at various levels of interaction, from self to systemic.

This study had its origins during week 9 of TRST 70004 (Translation Pedagogy) during Fall 2024 Semester at Kent State University. Dr. Kelly Washbourne (instructor) introduced to the class a framework for a new freshman honors colloquium. This framework was adapted from Hierocles' concentric circles of concern, a philosophy previously unknown to us. The course description reads:

The curricular model is a variation on Hierocles' concentric circles of concern, embracing the Stoic principles of *oikeiôsis* ('belonging' or 'affiliation') and cosmopolitanism… Hierocles' goal was to contract the circles until we widen our empathy and obligation to all… The core values underpinning the class are interrelatedness and intersubjectivity. (Washbourne, 2024, p. 3)

This pedagogy offers students a safe space to engage with their most vulnerable selves–a point Dr Washbourne emphasizes in his course rationale: "This is likely to be the only course students have in their careers, barring pursuit of teaching licensure, that fosters strategic reflection" (2024, p. 3). He further emphasizes the core concept of the course; students find or fashion themselves through engagement with "the other", an idea that may be upheld as deeply paradoxical to some.

The rationale behind finding oneself through engagement with the "other" was striking, and it became the catalyst that set up the creation of this new model. Further, the emphasis on interrelatedness and intersubjectivity provided a solid foundation for adaptation to the highly complex communicative dynamics of the medical interpreting context. These demands stem from established professional codes, such as the National Code of Ethics for Interpreters in Health Care (NCIHC, 2004), which emphasizes both impartiality and empathy as fundamental ethical principles. Impartiality is the preferred default, and the empathic self should only be stepped into when an obvious need for comfort and reassurance arises. Understanding this clear contradiction between policy and what is expected in practice, the authors, all practiced interpreters with experience in navigating our complex medical system, set out to adapt Hierocles' concentric circles model, drawing on the inspiration from Washbourne (2024).

Hierocles' original model focuses on broadening one's sense of belonging from self to humanity, with the innermost and outermost circles reflecting this. Dr. Washbourne's adaptation of the model to the student context retained this core principle of broadening, while narrowing the focus to specific relationships students encounter in academic and personal growth. Washbourne's model became a prime example that Hierocles' idea is adaptable to any context, and so its application to medical interpreting was born. Further research into the Stoic philosophy of Hierocles provided detailed groundwork for the creation of this new model. Stoics not only focus their attention on issues of daily and urgent human significance, but they do so in a way that emanates "universal respect for the dignity of humanity in each and every person regardless of class, gender, race and nation…" (Calloway-Thomas, 2018, p. 497).

We began by ensuring the framework preserved the concept of an expanded self, found in both models of inspiration, while refining the focus toward the medical interpreter's immediate relational spheres. The adapted framework similarly narrows the scope to the immediate relational and systemic dynamics experienced within the medical interpreting context, demonstrating applicability to other communication-oriented disciplines. Our new framework situates the interpreter within a series of interrelated spheres:

[1] Self - representing the interpreter's identity, value set, emotions, and boundaries;
[2] Patient - highlighting the communicative relationship between the patient and the interpreter (often requiring empathy);
[3] Healthcare Provider - representing the interpreter's role in mediating impartial communication and fostering trust among the triadic relationship; and
[4] Institutional Dynamics - representing the broad societal and systemic forces that shape medical encounters.

The self, patient, and healthcare provider were first considered in the model's creation, as they are the immediate people being interacted with. This framework centers the interpreter within the direct relationships they are managing, and each relational sphere represents a place for distinct ethical and empathetic considerations. Those considerations represent the unique ethical challenges faced by interpreters, and they are how we filled in the remaining spheres found on the model. Our addition of the institutional and systemic dynamics at play within the medical context model—the circles of language, medical context, ethical responsibility, systemic inequities, and global health—represent where empathy must be negotiated within hierarchical and inequitable structures.

Moreover, these relational spheres are not static; they overlap dynamically, multiple times and between multiple people through the duration of an interpreter-

mediated medical encounter. To be specific, an interpreter's interaction with a patient is not just shaped by their immediate communicative dynamics; institutional protocols demanding quick turnaround, and high-cost treatment options, along with systemic insurance inequity fundamentally alter the direction of the appointment. The curriculum is structured to engage students with each relational sphere through modules that target each level, guiding students progressively from self-awareness to systemic awareness, mirroring the dynamics of Hierocles and Washbourne (2024)—from self to humanity, and from local to global (see Figure 2), respectively.

The adaptability of this empathic pedagogy extends beyond medical interpreting, and it holds significant potential for other educational contexts, especially medical education. The literature revealed empathy as a large part of the massive body of hidden curriculum in medical schools. The IEM, for example, could be used in teaching student doctors how to work with an interpreter, replacing the "healthcare provider" sphere with "interpreter". Alternatively, this model could be adapted for use in what Hafferty (2015) calls "On Doctoring" courses, described as focused on providing an understanding of how to balance the dual role of physician in the community and the clinical setting through small group learning experiences, usually in the first two years of medical school (p. 129). To adapt the IEM to this setting, the "language" and "healthcare provider" spheres could be moved as needed and used as a guiding framework for the course. This adaptability aligns with our aim to close this empathy gap between interpreters and providers, between providers and patients, and between patients and interpreters. The adaptability also highlights our model's roots in Hierocles' concentric circles and Washbourne's student-focused application, both of which expand empathic awareness while accommodating delicate relational dynamics.

4. Discussion

4.1 Reframing Empathy as a Core Competence

The discussion surrounding the poor standard of care for LEP patients in the United States must focus on the hidden curricular gap between medical students and interpreting students. Empathy emerges as the largest hidden curriculum in both professions, and treatment of empathy as a pedagogical afterthought rather than a core competence to be developed and refined within these contexts functions as an acceptance of substandard care for LEP patients. Hafferty et al. (2015) capture exactly why empathy must be treated as a core competence within these educational contexts: "Studying medical education means, above all, embracing the importance of context. All relationships, from the dyad to entire societies, take place within an array of environmental factors that can influence, sometimes profoundly, what is

happening within the particular situation we seek to understand" (p. 131). If we continue training our medical students and student interpreters to operate under the current system that values clinical data and impartiality above all else, we are effectively turning a blind eye to entrenched layers of context that each stakeholder to the medical encounter presents with.

Returning to the guiding research question—In a climate of rapid technological advancement, how can medical interpreter training remain human-centered while leveraging technologies that create realistic practice scenarios in which empathy remains central?—the findings of this study suggest that the Interpreter's Empathy Matrix (IEM) (see Figure 3) provides a practical and adaptable solution. By embedding empathy training within reflective practice and simulation design, the IEM ensures that technology-enhanced scenarios are not limited to procedural skill-building but also serve as deliberate opportunities to cultivate and assess empathy in alignment with professional impartiality. This approach addresses the persistent curricular gap identified in the literature review, where empathy is acknowledged in theory but rarely given structured pedagogical attention (Merlini, 2019; Gutierrez et al., 2019). It also aligns with recent calls in healthcare education for simulation models that integrate ethical, emotional, and technical competencies to prepare practitioners for the realities of high-stakes, intercultural communication (Reichmann et al., 2024). By grounding technology use in an explicitly human-centered framework, the IEM bridges the theoretical and practical aspects of empathy training, positioning interpreters to meet the dual demands of impartiality and empathetic engagement in real-world healthcare encounters.

4.2 The Interpreter's Empathy Matrix in Practice

The core of this framework lies in the adaptation of Hierocles' concentric circles of concern to what we have now named the *Interpreter's Empathy Matrix* (IEM). Our model conceptualizes empathy as an extension outward from the self, encompassing relational responsibilities at various levels—the patient, the provider, and systemic structures—with each successive circle. In medical interpreting, this model serves as a tool to bring together the theoretical and the practical, aspects that still remain largely separated in interpreter training.

Empathy as a hidden curriculum may be disrupted by explicitly addressing how systemic biases influence every aspect of a healthcare interaction. We strived for the model to be applicable to every lesson in a 16-week medical interpreting course, under the didactic rationale that each traditional lesson within a medical interpreting course, from note-taking to terminology to certification, may be enhanced through the use of the model in tandem. For example, traditional lessons on interpreter note-

taking focus on the history behind it, universally known symbols, and best practices. To incorporate the use of the IEM and reflective practice, the lesson might be accompanied by reflecting on how systemic biases infiltrate note-taking, such as with a survey asking students to examine how their worldviews influence their note-taking approach. Scaffolding the learning of the technical aspects of interpreting with guided reflection and time carved out for structured discussion disrupts the enforcing of the harmful cycle wherein interpreting students come to learn that objective interaction that focuses only on transferring impartial medical information is the correct path to take.

4.3 Addressing Pedagogical Challenges in Empathy Training

While the proposed framework offers a structured approach to empathy training, significant challenges still persist in its pedagogy. For example, implementation of such a framework forces students to think on a deeper and more personal level, an action that requires the sort of cultural shift we seek within the medical context: a shift from the philosophy where technical skills often overshadow emotional intelligence. Resistance to reflection from students is a significant pedagogical challenge itself, but its analysis is outside the scope of this paper.

Additionally, empathy training within the medical interpreting context carries the risk of reinforcing cultural stereotypes, demanding meticulous attention in the curricular design. Simulation activities specifically carry this risk, as logistical constraints like limited class time and instructor expertise, and institutional demands enforce oversimplification of simulation design. In their design, simulated medical interpreting activities must be rooted in authentic and diverse scenarios that reduce identities to their stereotypes, but this is quite hard to achieve when the institutions at play both prescribe an objective and formulaic approach to patient care.

Empathy as an agent of manipulation remains another cited concern among scholars and healthcare practitioners. Empathy is situated, and some argue that regardless of formal training, empathy will still function to be manipulated by stakeholders. Washbourne (n.d.) investigates this idea and delineates two specific contexts wherein empathy is purposefully manipulated; on one hand, “empathy may be manipulated by malingerers who wish to gain an advantage by eliciting it in their interlocutors”, and on the other, empathy’s manipulations may be consistent with and supportive of the therapeutic goals of the treating professional (p. 7). This distinction alone highlights just how complex empathy’s nature becomes in the medical setting. Medical interpreters can see patients with a vast array of struggles and diagnoses in a day. Expecting interpreters to understand how to tactfully utilize empathic strategies within each separate encounter with no dedicated and formal

training mirrors what it might look like if medical students were thrown into clinical training with no formal situated simulations in their pre-clinical years.

4.4 The Role of Simulation in Developing Empathic Competence

Simulations offer space for students to engage with the minute complexities in a controlled and dynamic setting that will arise in their future as practicing interpreters. Simulation activities may easily be tailored to ultra-specific demands by altering dialogue speed, complexity in speech patterns and tonal variations, and demands from other stakeholders. This customizability ensures that students of varying proficiency levels are still exposed to diverse scenario parameters.

That customizability is a critical contribution of simulations to empathy training. Simulations are often created in a way that enforces the systemic and institutional demands that play a part in the encounter, and deliberate pedagogical attention to empathy as a core competence in student interpreters will allow for simulations designed to recreate the high-stakes and emotionally charged scenarios that the students will encounter within a real-life encounter. To give an example, a simulation involving a Hispanic mother who is resistant to the recommended end-of-life care due to the family-orientedness of her culture and her desire to her own home will force students confront uncomfortable and conflicting demands from all possible stakeholders to a medical encounter. Within that scenario, a provider is pushing for hospice care, the LEP patient is pushing to die with dignity in her own home, and a child of the mother insists on a hybrid option, where his mother might receive end-of-life care in their own home. Institutional and systemic influences naturally come about within this simulated experience, and the interpreter must balance an extreme demand for empathy with impartiality to the provider's message, all while tactfully adjusting tone and register. The IEM provides a place for interpreters to debrief their experiences and attempt to make sense of them, while uncovering their own biases, emotional triggers, and tension managing strategies.

Simulations also importantly provide a space for students to discover the limits of their technical and empathetic skills. For example, a simulated task like interpreting for a recent refugee or a terminally ill pediatric patient can reveal finer gaps in students' ability to recognize and respond to non-verbal cues, an essential part of a refined empathic competence, that might go unnoticed in traditional role-playing. Simulations, moreover, promote the development of perspective-taking, a well-known foundational component of empathy.

We must reiterate that the success of simulations hinges on the authenticity of their design. Real-life medical encounters are seldom predictable or formulaic; they include interruptions, overlapping speech, and unspoken emotional cues—

simulations should reflect such realities by including these embodied elements. In doing so, not only is realism enhanced, but students are forced to work on a holistic approach to their practice, synthesizing verbal and nonverbal communication to render the wholeness of what the patient (and ideally the provider) convey. Simulated scenarios also must be designed in a way that reflects systemic inequity, forcing students to examine their own positionality and ethical hierarchies. By reflecting on these experiences, using the IEM as a lens, students are encouraged to see empathy not only as an occupational skill to be turned on and off as needed, but as a moral imperative that equips them to find the balance between advocating for equitable patient outcomes while also maintaining professionalism and impartiality. Appendix B contains a script for a medical interpreting scenario designed by the researchers.

4.5 Integrating Reflective Practice into Empathy Pedagogy

Scaffolding simulations with reflective practice is integral to the development of empathy as a core competency. Interpreting students move through the four levels of competence modeled for developing any social competence: unconscious incompetence, conscious incompetence, conscious competence, and unconscious competence (Krajcso, 2011, pp. 274-75). If students engage in simulated interpreting experiences, and stop at that, they will remain stuck within either conscious incompetence or conscious competence. The goal for all interpreting students should be to develop a sense of empathy they are unconsciously competent with, meaning that students "internalize all that has been learned, applying it fully and automatically" (Kracjso, 2011, p. 276). After engaging in a simulation, students must be given a space to critically analyze their experiences; it is within that space that students uncover implicit biases, refine decision-making processes, and enhance their understanding of systemic inequities. It is our intention that the IEM provide a basic depiction of all relational levels that interpreters are involved in, cementing itself as a reference point within reflective practice for students to constantly refer back to.

4.6 Assessment

Simulated experiences can be conducted in the classroom in a multitude of different approaches. The first approach would be for the teacher to initiate the simulation within the classroom and take more of a monitor role while the students themselves perform these simulated experiences. The students would also have the benefit of being able to ask the instructor questions during the simulations, and the instructor will be able to provide clarity. Remote learning is increasingly more of a style of

classroom learning, and the simulated experience can easily cross over into remote learning, as simulations can be done through video calls as well. Furthermore, if the instructor would like the students to take full responsibility for the simulated experience, they could either task them individually or in groups to perform the simulated experience and record their experience for post-grading later on.

Simulations, requiring meticulous design, also require complex assessment processes that consider more than competence with technical skills required by the profession. We propose a multi-step assessment process, aligning with the Systemist Model proposed by Martínez and Hurtado (2001). Our assessment process is modeled as follows:

A. The first step would be to have the students self-evaluate their own translation or interpretation performance throughout the simulated experience. This can be done in between different phases of the simulations or also after it is fully complete. The primary benefit of having the students self-evaluate during the process would be to help both the student and instructor pinpoint the exact areas of the simulation that were pain points for the student. If students are working in groups or pairs, they could independently review each other and submit the assessment to the instructor as well, which would add an additional perspective for the instructor to take into consideration during the grading process.

B. The second step would be for the instructor to perform the assessment as well. The instructor could incorporate two different types of evaluations: an error-based evaluation and a descriptive-style evaluation:

- Error Style Evaluation: The instructor could set up a grading rubric that reflects the potential errors that could arise during the simulated experiences performed by the students. The instructor could then allot a given set number of points to each potential error and then deduct points depending on the performance of the students. Han (2020) suggests that one benefit of an error-style assessment is that "...error analysis is objective, systematic and reliable, because of explicit quality criteria…" (p. 259).
- Descriptive Style Evaluation: The instructor could provide a written report or descriptive-style evaluation which details the instructor's feedback on different parts of the simulated experience, highlighting what the student needed to do more or where they excelled in the performance of the task. This evaluation would provide further explanation for the student.

C. The third step would be to initiate a cooperative assessment between the instructor and student, where they would both meet and discuss the performance of the simulated experience as a whole. The instructor could point out where the student excelled as well as where the student could improve upon, thus preparing

them further for more simulated experiences or also curricular tasks in the classroom. During this assessment, the student would have the chance to explain their decision-making during the simulated experience and discuss directly with the instructor any ideas they have to enhance their translation or interpretation skills.

The Systemist Model is one in which "A highly active role is given to the evaluee, who may also be the evaluator; self-assessment plays an important role (self-assessment understood here not merely as the individual awarding himself a particular grade, but also as being aware of the result of the work carried out and of the process followed)" (Martínez & Hurtado, 2001, p. 276). The proposed assessment is not prescriptive; however, the variety amongst different personalities and skill sets among students necessitates a multitude of different assessment formats. Simulation experiences are fairly intense and can generate a bountiful amount of discussion points between instructors and students pertaining to what has been simulated and how the students respond.

While challenges remain in cultivating empathy within medical interpreter education, reframing it from a hidden curriculum element to an explicit, assessable core competence offers a promising pathway forward. The Interpreter's Empathy Matrix (IEM) directly addresses the guiding research question by demonstrating how technology-enhanced simulations, when paired with structured reflection, can remain grounded in a human-centered pedagogical approach. Such integration ensures that technological tools are not used solely to replicate procedural tasks but to deepen students' ability to balance impartiality with empathetic engagement. This approach responds to the literature's call for training models that prepare interpreters for the complex, intercultural realities of healthcare encounters (Merlini, 2019; Gutierrez et al., 2019; Reichmann et al., 2024). By aligning technological innovation with explicit empathy training, interpreter education can move toward a future where practitioners are equally equipped with technical precision and the capacity to respond humanely in the most demanding of professional contexts.

5. Conclusion

The persistent challenges faced by LEP patients in receiving care in the United States may be largely attributed to the hidden curriculum found in both medical education and medical interpreter training. Empathy, central to promoting equitable outcomes and rapport with patients, remains an implicit expectation rather than an explicit focus, leaving interpreters to navigate communicative dynamics (often more complex than the medical issue at hand) with little to zero formal preparation.

This paper introduces a pedagogical framework designed to address this critical gap through simulated experiences, reflective practices, and a modeled

representation of the relational dynamics in an interpreter-mediated encounter, adapted from Hierocles' concentric circles of concern, aptly named the *Interpreter's Empathy Matrix* (IEM). The focus of the model intersubjectivity and interrelatedness positions interpreters within their spheres of relational responsibility, ranging from the self to the systemic. By situating empathy within this structure, our framework not only begins to disrupt the hidden curriculum but does so in a way that enables students to critically engage with their own biases, nurturing a refined interpreter who may more confidently handle the complex and dynamic interplay between theoretical understanding and actual lived experiences of LEP patients.

In essence, our framework challenges current interpreter education to prioritize empathy as a teachable and assessable competency. Yes, technical training will also be important in the profession of medical interpreting, but we call on instructors to move slightly beyond purely technical training and integrate pedagogy that aims to hone interpreters' emotional intelligence. Utilization of reflective practice organized around the IEM as a framework in tandem with technical skills training ensures that students refine their technical and ethical skills at the same time, constantly examining their interplay in real-life encounters.

While this new framework offers a promising step toward mitigating harmful healthcare outcomes for LEP patients, its success depends on the willingness of educators, professionals, and institutions alike to embrace a curriculum that challenges the relationship between empathy and professionalism. Future research should explore a practical implementation of our model across diverse contexts, which could be accomplished in a number of ways. For example, one might collaborate with an interpreter training program to pilot the framework and build custom teaching modules, with reflective exercises built around the IEM as a core element. Evaluation of student outcomes through a mixed methods approach (such as pre and posttests, and qualitative feedback) would assess the effectiveness of the framework in encouraging empathy preparedness. To assess long-term effects, one might follow students who trained under the framework into their professional practice, searching for changes in empathic effectiveness over time. As important as this pedagogy is, it is equally important to carve out time and resources for the development of this curriculum and training materials. With no resources to revamp the curriculum, instructors cannot begin to adopt it.

Ultimately, while this proposed framework aims to refine interpreter training to focus on the development of an empathic core competence, its scope is much larger. It further seeks to develop practitioners who are not only competent in their clinical knowledge, but are well attuned to their inner empathic selves, making them capable

of recognizing the delicate needs of those that they serve. Empathy has a long history of being hidden within medical education and medical interpreter training, hindering the great collaborative potential between the two professions. Only when empathy is treated as the heart of their training, medical practitioners and interpreters will continue to operate within the small box that their corporate bodies put them into that of the objective provider, burned out by systemic demands and therefore complicit in the maltreatment of LEP patients in the United States.

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Appendix A

This appendix shows the two models that the researchers drew inspiration from, as well as their own created model, in the sequence in which the progression occurred.

Figure 1: Hierocles' Concentric Circles of Concern

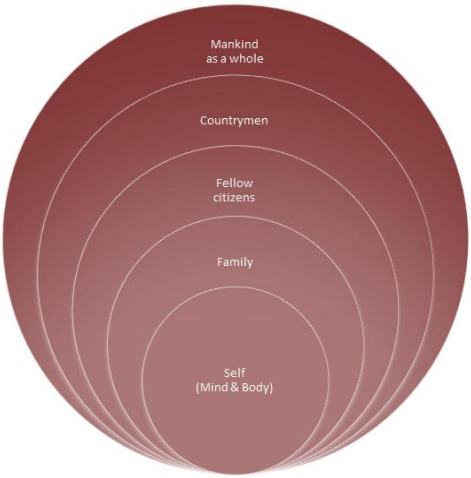

Figure 2: Washbourne's Local to Global

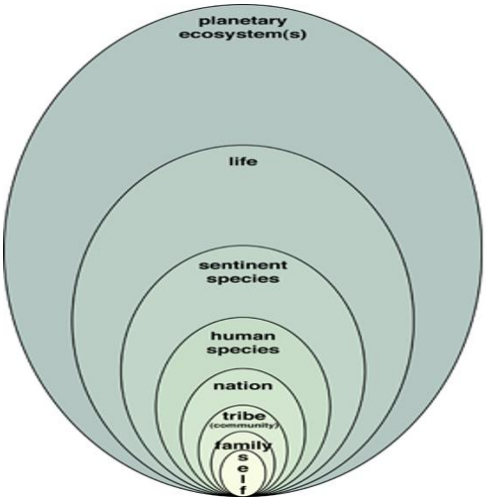

Figure 3: Interpreter's Empathy Matrix (IEM)

Appendix B

This appendix offers a script for a medical interpreting simulation designed by the researchers.

Find a Google Slides file presenting this simulation here[1].

[D1] Doctor: Good morning, Mary. I heard that you're a new expat here in Washington, DC. I'm sure you work with some kind of government office and are only going to be here for a little bit, so I hope that you enjoy it as much as possible. I'm going to go over some of your test results today. I don't have too much time, so let's try to get through this as quickly as possible, and I'll explain a little about the medication and get you on your way soon. I'm sure you're very busy.

[M1] Mary: Thank you, doctor, but the nurse who called me to schedule the appointment didn't give me much detail about the situation. My cancer was in remission only a few months ago, and I have questions…

[D2] Doctor: I'm sure the update I give you will answer all of your questions, and you'll be able to move on with your day.

[M2] Mary: But doctor, I'm confused. Am I out of remission? I thought I took all of the necessary steps.

[D3] Doctor: Well, it appears not so. Your cancer is starting to spread again; however, it is not too major. I think God is just allowing you to have another test of faith.

[M3] Mary: Too major? What does this mean? Isn't all cancer bad? I am not Christian.

[D4] Doctor: Oh, I see. Yes, you are right, but if you resume taking your pills, then this will slow down the growth, and perhaps we can perform surgery to remove any remaining cancer.

[M4] Mary: I am still recovering from my last surgery.

[D5] Doctor: You didn't inform the department of this during your last visit? You need to tell us about these things.

[M5] Mary: I don't speak English, and my last interpreter wasn't as good as this one. I think there was miscommunication.

[D6] Doctor: My apologies; I didn't mean to offend you. Let's get your prescription ready and then schedule a follow-up to discuss our options.

[M6] Mary: Thank you, doctor, and I would like to meet next week.

[1] To obtain viewing access to the full simulation presentation referenced in Appendix B, please contact any of the authors directly.