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Community/liaison interpreting in healthcare settings

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1 Introduction

Interpreting is the real-time spoken or signed counterpart of written translation. It is the act of re-expressing in a second language what a speaker/signer of one language has said, for the benefit of others who have limited or no comprehension of the original language. An interpreter enables speakers of different languages to communicate by attending to the words of someone speaking one language and re-expressing the speaker’s message, immediately or soon after, in another language, for the benefit of one or more listeners who do not share the speaker’s language.

One-way interpreting, from a single speaker to an audience (conference interpreting), is a well-established professional occupation. Conference interpreters usually interpret in the simultaneous mode, beginning to interpret soon after a speaker begins and continuing to interpret as the speaker continues. They also most often interpret from a sound-proofed booth, listening via headphones and connected electronically to their audience. Two-way interpreting of dialogue, i.e. assisting individuals who speak one language in communicating back and forth orally with other individuals speaking a different language, is likewise carried out in diplomatic, scientific, and commercial settings by both professional and non-professional interpreters. This chapter, however, is concerned with community interpreting, the kind of interpreting that takes place in everyday community settings where a bilingual person enables individuals speaking different languages to understand each other.

1.1 Community interpreting

Community interpreting frequently takes place informally in a wide variety of settings, as when a person who speaks the local language helps a tourist with their shopping. Yet community interpreting becomes essential, and is more likely to be prescribed, regulated and professionalised, in interactions between members of the public and providers of public services, such as medical care, or authorities such as the police and in the courts.
The central role of the community interpreter is to assist individuals through their services by enabling them to communicate almost as if there were no language barrier. Thus, the term *liaison interpreting* is often used as a synonym of *community interpreting*, to emphasise how interpreters in the community provide a linkage between individuals. Another label, preferred in some European countries, is *public service interpreting*; this label recognises that the focus of attention in the field of community interpreting is on interactions between a person who provides a service to the public, such as a teacher or a nurse, and someone in need of their services who is not able to speak their language proficiently or to understand it without assistance. In this context, interpreters also provide a public service.

Community interpreting typically takes place in two-way interactive communications and thus is also often referred to as *dialogue interpreting*. Whereas conference interpreters normally interpret unidirectionally from their weaker language (the so-called B-language) into their stronger A-language, dialogue interpreters are challenged to interpret bidirectionally, alternately from language A to language B and then from B to A. Furthermore, while conference interpreters mainly use the *simultaneous mode*, interpreting what has just been said as the speaker continues to speak, the mode of interpreting most commonly used in dialogue interpreting is the *(short) consecutive mode*: one party speaks briefly and pauses, the interpreter relays the content of what has just been said in a second language; when an addressee responds in their own language, the interpreter again interprets what was said but in the other direction. This is thus a form of triadic communication, with the interpreter participating as an intermediary between two or more primary interlocutors, typically a service provider and a recipient of services. In contrast to the typical limited role of the interpreter in other settings, a community interpreter is frequently seen to be an active participant in the communication, helping to guide, and to varying degrees actively entering into, the interaction, as first shown through empirical research beginning in the 1990s (Wadensjö 1998; Roy 2000; Davidson 2003; Angelelli 2004). Since every language, and every variety of a language, is accompanied by its distinct culture, the interpreter is often seen as both a linguistic and a cultural bridge, with responsibilities that go beyond simply re-expressing the utterances of speakers of different languages.

The term ‘community interpreting’ is commonly used as a label for any and all ways of dealing with a language mismatch (‘non-congruent languages’) that involve a bilingual intermediary in a community setting. Empirical research has revealed that often the bilingual intermediary, instead of interpreting what one party says to another, engages in two intermingled conversations: one with the service provider in one language, and another with the seeker of services in their own language. How much information is actually passed between the two principal parties is often left to the discretion of the intermediary. It is characteristic of this sort of indirect communication that one speaker will speak to the intermediary about the other party or ask the bilingual to obtain information from the other. The intermediary reports to the other party (in the third person) what has been said, rather than actually interpreting (directly relaying) the message. Thus, much of what is called community interpreting (or healthcare interpreting) is not interpreting in the strict sense at all. Rather, a sort of free-flowing mixed-language communication takes place in which information and perspectives of the principal parties are shared – or not shared – in a haphazard fashion. Pöchhacker and Kadric (1999) provide a carefully analysed case study of one such encounter.
1.2 Healthcare interpreting

For the purposes of this chapter, we will now focus on community interpreting in the context of healthcare. The subfield of healthcare interpreting is also referred to with the narrower descriptor medical interpreting, perhaps because the bulk of research on interpreting in the field of healthcare as well as programmes of training for service in the health area are centred around the crucial face-to-face verbal interactions between doctors and their patients. However, the field of healthcare is clearly much broader than physician-patient encounters. It includes such diverse areas as physical therapy, dentistry, laboratory visits, hospice care, appointment scheduling over the phone, etc. Venues in which healthcare interpreters work include hospitals, private practices, home health visits, mobile clinics, and others. Currently healthcare interpreters may work remotely, connected to other parties via telephone, two-way video, or computer linkage, provided that the infrastructure is in place in any given country.

Healthcare is about caring for the patient or seeker of health services. In contrast with police work or the courts, where encounters are often adversarial, in the field of healthcare the focus must be on the welfare of the patient. The ‘Do no harm’ principle applies to the provider of language services as well as to the physician. The interpreter may be considered as a member of the healthcare team, with shared responsibility for health outcomes. Achieving clear communication (and cultural understanding) across different languages and cultures is not easy; that is why training and professionalism of healthcare interpreters is important, just as it is for all others who contribute to providing health services to the public. People’s lives are often at stake.

It is generally acknowledged that clear and unimpeded communication between healthcare providers and those who seek their services is essential for quality care. In spite of this, when healthcare providers and their patients do not speak the same language, it is still very often the case that only partial and ad hoc accommodations are available, such as calling upon bilingual friends and family members of the patient to assist, as will be discussed below. Under favourable social, economic, and political circumstances, however, interpreting services are provided by dedicated professionals. This approach would seem to offer the best likelihood of successfully bridging the language gap in the interest of improved healthcare for immigrants, refugees, and other speakers of minority languages.

1.3 Professional healthcare interpreting

What is a professional healthcare interpreter? On some points there is considerable agreement. We will list some of these first and then discuss areas of ongoing controversy concerning professional roles and behaviours.

A professional healthcare interpreter:

1. Has a strong command of both languages being utilised, including a reasonable command of technical medical language and concepts as well as spoken varieties of the patient’s language
2. Accurately and completely interprets what is said by a healthcare provider and a patient and any other participant in the encounter
3. Knows and follows a code of ethics/standards of practice established for the healthcare interpreting profession
4. Uses consecutive mode in most dialogue situations but is able to interpret simultaneously when appropriate (e.g. in mental health encounters)

5. Is able to sight-translate short texts such as dosage instructions

6. Maintains confidentiality and impartiality, and shows respect for all parties

7. Has formal education, at least to secondary school level, preferably two to four years at university level, and ideally a professional degree in translation/interpreting

8. Holds a licence or certification from a government or appropriate professional body, if available, based on criterion-referenced testing

A global survey of ethical codes and standards of practice for interpreters (Bancroft 2005) found substantial commonalities among standards that addressed healthcare interpreting, but also some important differences. Three principles are shared by the documents included in this review: confidentiality, accuracy/completeness, and impartiality (ibid.: 18). Others widely shared are maintenance of role boundaries and limited interventions to deal with misunderstandings and cultural issues. Recognising that bias may be present and that cultural misunderstandings between the parties do arise, some published practice standards for professional interpreters offer guidance regarding measured kinds of intervention by the interpreter.

Healthcare interpreters are often called upon to interpret for multiple speakers when people other than a provider and a patient are present, such as auxiliary healthcare staff and/or family and friends of the patient (including parents whose child is the patient). In the United States, professional interpreters are encouraged to observe a principle of transparency: ‘...during the encounter the interpreter informs all parties of any action he or she takes, including speaking for him- or herself, outside of direct interpreting’ (NCIHC 2005: 12). See also Hsieh (2016: 286–288), who offers a ‘multi-party model’ of interpreted interactions.

A central part of the interpreter’s role is obviously to re-express in a second language what a speaker has just said. For this reason, interpreters have sometimes been thought of (by themselves and others) as essentially a machine-like conduit of communication. However, it does not follow that a healthcare interpreter can or should serve merely as a conduit. The interpreter is a person, necessarily an active participant in the communication (Wadensjö 1998; Roy 2000; Angelelli 2004). Nor does it make sense that the healthcare interpreter is or should be invisible – an impossibility in this setting. The conference interpreter working in an isolated booth, or the courtroom interpreter restricted to ‘merely interpreting’ may be more or less invisible or strive to be ‘just a conduit’ for the words of others, but the interpreter in healthcare settings cannot reasonably avoid active involvement in the discourse, even while endeavouring to maintain accuracy and completeness in relaying what is said, as well as impartiality in serving the interests of all parties.

The terms ‘mere conduit’ and ‘invisible’ have been used in the research literature mainly to reject the notions that these terms imply (Ozolins 2016). Interpreters may strive to limit their personal involvement in what is essentially a privileged communication between a professional and client (the patient). However, standards of practice and interpreter training commonly recognise the active involvement of the interpreter, including (at minimum) greetings, introductions that may include explanation of one’s role, requests for clarification, redirection, and sometimes cultural explanations and intervention as needed. The best training for healthcare interpreters includes attention to ‘ethical decision-making’ as a skill to be mastered by the interpreter: how to balance...
neutrality/impartiality with active intervention in the interest of safety, fairness, and comprehension (CHIA 2002: 11–12). Hsieh (2016: 301), however, offers a note of caution:

When and how interpreters can best provide their intervention … may be dependent on various contexts (e.g., clinical, interpersonal, organisational, sociocultural, and ethical). […] As a result, interpreter training cannot offer standardized solutions to interpreter interventions. Rather, we can only educate interpreters about the variety of issues they need to consider as they contemplate whether, when, and how they should intervene in provider-patient interactions.

Some published healthcare interpreting standards include ‘advocacy’ on behalf of the patient as an action that an interpreter may choose to adopt in support of ‘the health, well-being or dignity of the patient’ (NCIHC 2005: 10). The California Standards for Healthcare Interpreters (CHIA 2002) identifies four distinct roles for the healthcare interpreter: message converter, message clarifier, cultural clarifier, and patient advocate ‘presented in order of increasing complexity and controversy’. Interpreters are advised to adopt the advocacy role, if at all, only ‘after considering their advocacy skills and potential risks and benefits’ (ibid.: 46). To move from one of these roles to another requires ‘increasing skill, experience and caution on the part of the interpreter’. A similar concept of incremental intervention (Beltran-Avery 2001: 9–10) is incorporated into the Bridging the Gap Medical Interpreter Training offered widely across the USA by the Cross Cultural Healthcare Program (The Cross Cultural Health Care Program, no date). In this model, the interpreter is seen as ‘changing hats’ from conduit to clarifier to culture broker to advocate as necessary to aid communication and address cultural misunderstandings and conflicts.

The greatest disagreement among scholars and practitioners concerning the role of the professional healthcare interpreter relates to these notions of neutrality vs. advocacy and active cultural mediation. Language is a component of culture; when different languages are spoken, their speakers come from different cultures. One can argue that Western medicine is a (sub)culture in itself, with its own discourse, jargon, social expectations, etc. Therefore, cultural misunderstandings may arise just as linguistic ones do. An immigrant or refugee or member of an indigenous minority may need the services of a culture broker or advocate as much or more than any assistance in direct communication with a healthcare provider. The issue is whether one and the same intermediary can serve both as cultural adviser and advocate for a patient’s viewpoint, and neutral, accurate conveyor of direct communications between parties with different worldviews and possibly different agendas.

Professional guidelines for healthcare interpreters emphasise enabling clear and direct communication between healthcare providers and patients, as well as their families. Interpreters therefore aim for accuracy and impartiality in relaying what is said. Both the provider and the patient and their family members can directly ask questions, express doubts and disagreements, and negotiate differences with the help of the interpreter.

1.4 Linguistic accommodations in healthcare – a broader view

For a wide variety of reasons, the services of professional healthcare interpreters are not always available, are not always called upon even though available, or are not even
preferred as a response to language barriers that could impede the provision of quality healthcare. There exists a whole range of possible responses to the situation where the language normally spoken by a healthcare provider (e.g. a doctor) does not match the primary language of an individual seeking care (e.g. a patient). Ways of addressing the language mismatch, some of which are more satisfactory than others, include:

1. The doctor knows and uses the language of the patient (bilingual provider)
2. The doctor knows a little of the patient’s language and uses it along with their own primary language (semi-bilingual provider)
3. The doctor uses only their own primary language, perhaps supplemented by gestures and a loud voice
4. The patient knows a little of the provider’s language and uses it along with their own primary language (semi-bilingual patient)
5. A more or less bilingual family member or friend, often a child, accompanying the patient, mediates between provider and patient (family mediator, child language brokering)
6. Other bilinguals are called upon - e.g. from a nearby ethnic restaurant or from custodial/janitorial staff (non-professional interpreter)
7. Bilingual members of the medical staff are called away from their regular duties (ad hoc interpreter)
8. Staff members who are assigned interpreting duties in addition to other duties are called upon (dual-role interpreter)
9. An interpreter from the on-site interpreting staff is called upon (staff interpreter, also called a dedicated interpreter)
10. An interpreter is hired from outside the institution – a freelancer or one sent by an interpreting agency or a service organisation (on-call or contract interpreter)
11. A remote interpreter is connected via telephone, video hook-up or computer (including a staff interpreter working remotely)

Only interpreters drawn from categories 8–11 can be expected to perform professional interpreting to some degree. Dual-role interpreters (category 8) include staff employed as intercultural mediators, working directly with patients, who also interpret. In published research, those in categories 5–7 are often grouped together as ‘ad hoc interpreters’ or ‘non-professional interpreters’. However, family members, so often relied upon to interpret, are likely to behave quite differently from unaffiliated individuals and should be considered separately. Downing and Roat (2002) elaborate upon and evaluate these various alternatives.

A somewhat simpler classification developed by Hsieh (2016: 93–116) distinguishes types of interpreters as follows: professional interpreters (in-person interpreters and technology-based interpreters); bilingual medical professionals (bilingual healthcare providers and bilingual medical employees); and non-professional interpreters (chance interpreters and family members who interpret). Hsieh (ibid.: 109–110) urges researchers not to confound these distinct types of players while studying the medical consequences of language discordance.

The organisation and practice of cross-linguistic and cross-cultural communication in healthcare is clearly varied and complex. The quality of communication that can be expected under these various alternatives is further complicated by consideration of the motivations, language proficiency, cultural competence, social status, general education
and relevant training, if any, of the particular individual who serves as intermediary in a given healthcare encounter.

2 Historical perspectives

For as long as human beings have spoken different varieties of language, those able to speak more than one have been called upon to assist others in communication. The participation of family and community members in this way existed in the past as it does now. However, the relevant history of community interpreting begins essentially in the latter half of the 20th century, with the first efforts to move toward specialisation and professionalisation of the role of language mediator and to refine ideas of what professional community interpreting is or might become.

In a major publication on court interpreting in 1991, community interpreting was described as ‘any interpretation provided by non-professional interpreters’ (González, Vásquez and Mikkelson 1991: 29). This was an accurate description for the most part for that early period. Immigrants and speakers of minority languages within a country, it was assumed, would learn the official language or would manage encounters with informal ‘ad hoc’ language assistance. Later on, change has come about from at least three principal sources, with variations in different countries. First, members of certain linguistically and culturally distinct communities, such as the deaf and hard-of-hearing community or indigenous minorities, demanded better access to services. Second, the often unanticipated arrival in many countries of refugees from other parts of the world, such as Indochinese refugees after the war in Vietnam ended in 1975, overwhelmed hospitals and other public services, some of which began adding ‘translators’ or ‘bilingual aides’ to their staffs. Third, political movements in some countries (e.g. Australia, Sweden, Canada and the United States) pushing for minority rights, including language rights, brought about the establishment of legal rights to language accommodations (e.g. the provision of election ballots and government publications in multiple languages) and availability of interpreting services without charge to those not proficient in the language(s) spoken by public servants, educators and healthcare providers.

Efforts in the direction of professionalisation seem to have begun first in Australia and Sweden. In Australia, a national accreditation authority (NAATI) was established in 1977 to register and accredit interpreters and translators and to approve courses of training. A national professional organisation of interpreters and translators, AUSIT, was founded in 1987. The first-ever textbook on community interpreting was published by Melbourne University Press (Gentile, Ozolins and Vasilakakos 1996). In Sweden, interpreting service agencies appeared in the late 1960s and state authorisation of community interpreters began in 1976 (Niska 2004). Since 1986, public authorities have been required by law to use an interpreter ‘if necessary’ in dealings with non-speakers of Swedish (Niska 2007: 298).

In the USA, it was among ASL (American Sign Language) interpreters that community interpreting (beyond the courts) first began to be thought of as a profession like translation and conference interpreting. The Americans with Disabilities Act of 1999 mandated various accommodations including interpreting services for the deaf and hard-of-hearing. Meanwhile, Title VI of the Civil Rights Act of 1964, which prohibited discrimination on the basis of national origin, has been interpreted by the federal Supreme Court, and a subsequent Executive Order, as requiring all recipients of federal funding (including virtually all hospitals and clinics) to provide appropriate language assistance
for anyone with ‘limited English proficiency’ (LEP; for details, see Chen, Youdelman and Brooks 2007). While some healthcare institutions lagged behind, others quickly organised departments of language services and hired bilingual staff to assist speakers of the locally predominant languages or began to contract with freelancers or interpreting agencies to provide interpreters as needed.

Meanwhile, community interpreters, as well as supporters, advocates and researchers from many parts of the world, came together at the first Critical Link Conference (Carr et al. 1997) held in Orillia, Ontario, Canada, in 1995, where it became apparent that there was little agreement on the appropriate roles for and practices of community interpreters. At that conference, Roberts (1997) proposed six essential steps for the development of community interpreting as a profession:

1. Clarification of terminology
2. Clarification of the role(s) of the community interpreter
3. Provision of training for community interpreters
4. Provision of training for trainers of community interpreters
5. Provision of training for professionals working with interpreters
6. Accreditation of community interpreters

The history of the National Council on Interpreting in Health Care (NCIHC) in the United States, organised around the time of the first Critical Link Conference, illuminates how at least some of these essential steps have been successfully pursued (Downing 2009; Downing and Ruschke 2012), specifically in the healthcare field. The NCIHC is not a professional organisation of interpreters; its membership is composed of interpreters, healthcare providers, educators, and researchers. The NCIHC began its work by compiling the first glossary of healthcare interpreting terminology (NCIHC 2001). Commissioned by the NCIHC, Beltran-Avery (2001) explored and clarified issues in the ongoing debate concerning the interpreter’s role. The consensus role and standards of practice of healthcare interpreters were laid out in a published code of ethics (NCIHC 2004) and standards of practice (NCIHC 2005), both extensively vetted through convenings and surveys of working interpreters. Comparable standards had earlier been published by two regional associations, the Massachusetts Medical Interpreters Association in 1986, later revised (International Medical Interpreters Association and Education Development Center 2007) and the California Healthcare Interpreters Association (CHIA 2002).

Interpreter training in the United States has expanded slowly from a single 40-hour course developed in Seattle, Washington (The Cross Cultural Health Care Program, n.d.; now offered nationally) and a handful of short non-degree tertiary-level courses. A study of community interpreter training conducted through surveys and on-site visits in 1990–1991, limited to the United States, Canada, the UK, Denmark and Sweden (Downing and Tillery 1992), had found only a similar mix of entry-level training programmes. Today in the United States a large number of programmes are offered on-site and online by universities, colleges, and independent training organisations (Downing and Ruschke 2012), yet most practising healthcare interpreters in the United States still have received only a modicum of formal training. Beginning in 2007 the NCIHC surveyed existing interpreter preparation programmes in the United States. Based on that survey, along with a ‘job task analysis’ conducted among working interpreters nationwide and consultation with a panel
of experts, the NCIHC published national standards for healthcare interpreter training (NCIHC 2011).

While the NCIHC training guide references essential qualifications of interpreter trainers, there are few programmes designed specifically to prepare teachers in this field (the fourth step for development of the profession in Roberts 1997, cited above). In line with Roberts’ fifth step, various research reports and other publications seek to educate healthcare providers as to what to expect from professional interpreters and how to work with them. One example is a guide prepared jointly by the NCIHC and the American Translators Association (2010).

Meanwhile, accreditation/authorisation of interpreters (called in the United States ‘certification’) is now available after a long development process. Two separate organisations, the Certification Commission for Healthcare Interpreters (CCHI) and the National Board of Certification for Medical Interpreters (NBCMI), each offer certification testing in a small range of languages paired with English. Youdelman (2013) recounts the development process and how there came to be two competing certifying organisations.

Other nations have followed similar paths regarding legal status, utilisation, professionalisation and accreditation of community interpreters. Corsellis (2008) presents an overview and a case study of similar developments in Europe. Schuster (2014) offers a sociological model of progress in this field, tracing steps toward professionalisation in Israel, influenced by developments elsewhere.

3 Main research areas and methods

Many disciplines intersect around healthcare communication and interpreting, but two mostly distinct strands of research are evident: research in the medical field and research in translation and interpreting studies. This section will first elaborate on these two strands, introducing the major developments and key works within them. It will give brief information about various studies on interpreting in general that have emerged within the last two decades and then delve deeper into more recent studies focusing on healthcare interpreting in particular.

3.1 Research in the medical field

The first category is research, mostly but not always quantitative, largely published in standard medical journals. Medical research has focused on relationships between mediated bilingual provider-patient communication and medical outcomes, compliance, patient satisfaction and repeat visits, as well as costs, etc. In the late 20th century, some studies addressed the consequences of a ‘language gap’ or ‘language dissonance’, and of ‘non-congruent’ languages being spoken. If there was a bilingual intermediary present, little note was taken of how the third person’s involvement affected the communication or outcomes.

As the use of interpreters expanded, the medical literature has paid increasing attention to the presence or absence of a professional interpreter and the completeness and accuracy of the interpreter’s renditions of what others have said. For example, Flores et al. (2012), identifying and rating the seriousness of interpreting errors in recorded and transcribed clinical interviews, found significantly fewer errors of clinical significance in the performance of interpreters with over 100 hours of relevant training. Comparable
results are reported by Pham et al. (2008), who prefer to speak of ‘alterations’ rather than ‘errors’, and by Nápoles et al. (2015). More recent research has begun to explore just how the participation of a professional interpreter and the nature and quality of the overall triadic interaction can influence medical outcomes. Summarising the results of a number of studies, Terui (2017: 218) reaches this conclusion:

Using professional interpreters can lead to better care, higher satisfaction, fewer errors that lead to clinical consequences, fewer misattributions of psychiatric symptoms and diagnoses, increased patients’ adherence to follow up, reduced disparities in utilisation of services, lowering medical expenses, and improved clinical outcome.

Hsieh (2016) investigates in detail the interactions among participants in interpreter-mediated healthcare services, drawing out implications for both healthcare providers and interpreting services. She advocates assessment of the quality and outcomes of the interaction among all participants in a clinical encounter rather than a narrower focus on errors of interpretation.

3.2 Translation and interpreting studies

The other principal strand of research on mediated bilingual encounters in healthcare has come from the growing field of interpreting studies, including approaches from applied linguistics, discourse studies, sociology and ethnography. In 2004, Pöchhacker’s pioneering Introducing Interpreting Studies (2004) gave a broad and thorough overview of the field, not limited to community interpreting, which remains a valuable resource and a landmark in the discipline. In 2007, Hale’s textbook Community Interpreting came out, Part III of which offers a concise summary of research topics and publications, describes principal methods (discourse analysis, ethnographic studies, survey research and experimental studies), and offers practical advice on the conduct of research.

Hale and Napier’s book Research Methods in Interpreting (2013), designed essentially as a practical guide to graduate-level research, breaks down research methods into the following broad categories: the use of questionnaires, qualitative ethnographic methods, discourse analysis and experimentation. It also includes a section on research on education and assessment. Also valuable, as an explication of research methods broadly in the field of translation and interpreting as a whole, is the book Researching Translation and Interpreting, edited by Angelelli and Baer (2016). In Part I, the editors offer an overview of new and expanded theoretical approaches. They invited leading researchers to offer chapters in Part II outlining research domains such as bilingualism, cognitive processes, pedagogy, and professional identity, and in Part III the contributors describe research methods, including methods relevant to community interpreting research such as case studies, conversation analysis, interviews and focus groups, and survey-based studies, among others.

Research on interpreting today is primarily concerned with the role and behaviour of the bilingual intermediary and the nature and quality of the communication itself. In their introduction to the volume of selected papers from the sixth Critical Link conference, the editors refer to ‘the sociological turn in Translation and Interpreting Studies whereby focus on settings and people in increasingly multilingual societies is deemed more important, or at least more pressing, than focus on language per se’ (Schäffner, Kredens and Fowler 2014: 4). They also note that research methods have evolved, as exemplified
in papers in their book, to include recorded interviews, questionnaires, recorded and transcribed clinical interactions and observations, reports and documents of participants.

3.3 Current contributions and research on healthcare interpreting

Research on healthcare interpreting has expanded in the past decade both in quantity and geographical range. A literature review of healthcare interpreting studies published between 2007 and 2017 (Liu and Zhang 2019) noted the close correlation between governmental support and enhanced interpreting services and research, mainly in the United States and Europe. That research found important variations also in specific settings, such as mental health, and found both positive and negative evaluations of ad hoc versus professional interpreters. For example, providers felt that patient empowerment could be achieved through the greater accuracy of communication provided by professional interpreters, while patients generally felt more empowered by the advocacy and support provided by informal interpreters (Liu and Zhang 2019: 2).

Research continues, however, to reveal inadequacies in cross-cultural healthcare communication in virtually every location studied. Problems are attributed to lack of funding, lack of appropriate training, supervision and remuneration of interpreters, and the continued use of untrained staff and family members as interpreters. It is interesting that research participants often express satisfaction with the communication even when transcription and analysis of recorded interactions reveal critical communication lapses; Lesch and Saulse (2013), in a study of interpreting in South Africa, offer an illustration of this. The authors recommend improved policies for interpreting services and better training for providers on how to work with interpreters.

Taibi (2014) has brought attention to the situation in the Arab world, where, he says, community interpreting services are generally lacking. This lack exists despite a sizeable national language minority in Tunisia, a large migrant population in the United Arab Emirates, and the large numbers of religious pilgrims in Saudi Arabia. Taibi suggests strategies for change based on the experiences of Australia, Canada, and those European countries that have developed such services.

In much of Western Europe, however, language services remain uneven and varied in nature from country to country. An extensive survey in 2014–2015 by Angelelli (2018) investigated translation and interpreting services available in five EU member states (Germany, Greece, Italy, Spain and the UK) for EU citizens when they cross borders from one member state to another. The study revealed great diversity and widespread failure to attain EU human rights goals. Thus, in these five countries the survey found that EU citizens who crossed national borders frequently did not receive the quality language services promised under Directive 2011/24/EU. Specifically, except for the UK, where translation and interpreting services are ‘mandated by the country’s Equality Act 2010, language services are neither mandatory nor frequent in healthcare organisations’ in the countries studied (Angelelli 2018: 121). When study participants were asked to indicate to what extent translation and interpreting services were utilised, the response ‘only as a last resort’ was selected by 57 per cent of those working in Spain, 41 per cent in Greece, and 70 per cent in Germany, as opposed to only 22 per cent of participants in the UK (ibid.).

Gentile (2017) describes cutbacks in legal interpreting in the UK and in healthcare interpreting in the Netherlands, where privatisation of interpreting services has led to decreases in service quality and pay rates, leaving many qualified interpreters to quit the
field. Thus, in the Netherlands, ‘informal interpreters’ are increasingly relied upon in healthcare settings rather than professional interpreters, previously available through government funding.

Research at the University of Amsterdam focused on patients’ perspective on interactions between General Practitioners and female Turkish-speaking immigrant patients supported by informal interpreters, whose role ‘besides providing linguistic translation’ was to ‘perform the roles of advocates and caregivers of the patients’ (Zendedel et al. 2018: 158). The focus in a series of interviews was on patient satisfaction with respect to trust and perceived empowerment, rather than on interpreter accuracy, neutrality and confidentiality as in many previous studies. Although none of the women interviewed had ever had the services of a professional interpreter, all indicated a preference for informal interpreters, nearly all of whom were family members, mainly on the basis of trust and the feeling that they were empowered through their interpreter-advocate (ibid.: 165–166); some indicated that they would trust professional interpreters more with respect to confidentiality.

In a journal article, Pöchhacker (2006) succinctly outlines the development of research specific to healthcare interpreting, encompassing such diverse disciplines as nursing, linguistics, mental health, medical and social sciences, and communication studies, in addition to more traditional interpreting studies, citing prominent examples in each area. His review also distinguishes the varying themes of research such as interpreter performance, communication practices, and goals and outcomes with respect to the service provided. Pöchhacker concludes by emphasising the overarching focus of this research on quality, which must ultimately be assessed in terms of benefits and the associated costs.

To close this sampling of recent research, a US study published in the Journal of Transcultural Nursing (Estrada and Messias 2018) looked at goal-directed triadic communication between providers (nurse-practitioners), well-qualified interpreters (also serving as patient navigators), and Hispanic patients with limited English proficiency, through examination of recorded and transcribed sessions and post-session interviews. The study revealed productive joint efforts at problem-solving. In the authors’ words, ‘three modes of co-constructed, collaborative knowledge generation [took place]: constructing connections, constructing mutual understanding, and constructing effective system navigation strategies’ (Estrada and Messias 2018: 500). Both the interactional model and the research design in this study appear worthy of emulation.

4 Critical issues

This section will look at some of the issues that have a bearing on the provision and effectiveness of healthcare interpreting, such as the availability, or otherwise, of language services in diverse immigrant languages; achieving balance between interpreting, cultural mediation and advocacy; and the development of training and assessment.

4.1 Adequate language services in diverse immigrant languages

The diversity of languages and dialects and their associated cultures across the world presents a unique challenge for the field of community interpreting when combined with the scope and scale of migration in today’s world that is bringing so many diverse languages into proximity within a given local community. Newcomers, or their children,
may learn the dominant language(s) of their new home in due course; the problem is the linguistic and cultural barriers that arise immediately upon arrival for immigrant adults with respect to the dominant local community.

This is a problem unique to community services, which need to be able to reach all individuals equally regardless of their language. National governments can conduct their core functions in one or a handful of languages. International conferences routinely make their communications accessible to attendees in a small number of languages through the services of professional conference interpreters. Such a broad organisation as the European Union has, with considerable cost and difficulty, been able to accommodate an increasing number of languages in its deliberations and communications. Any service that requires face-to-face interaction with any and all members of the general public, however, is increasingly likely to face a unique challenge: that significant, and often growing, proportions of their local population do not share a common language with those who provide public services such as healthcare. Moreover, the languages and dialects spoken may be highly diverse.

For instance, well over one hundred distinct languages are spoken at home by public school students in New York City (some estimate that as many as 800 languages may be spoken in the city by all age groups). Parents of these students may not speak English or may speak it with a limited degree of proficiency. Therefore, such routine functions as parent-teacher conferences and healthcare encounters cannot be performed equitably without some linguistic accommodation. For a widely spoken minority language such as Spanish in New York City and in many parts of the United States, a hospital may be able to hire full-time Spanish-English interpreters with appropriate skills and training. For other languages not widely spoken in a given area (languages of limited diffusion, or LLDs) the same solution may be unavailable. Today, this kind of communication barrier is common in major cities, and even in villages and rural areas, in many parts of the world.

From the point of view of the potential interpreter of an LLD (for example, Tigrinya, Khmer or Nuer in the United States) there likely will be no language-specific skills training available. Moreover, the demand for interpreting in a given LLD may be so low that it would be unprofitable for a bilingual speaker of this language to seek training or accreditation, even if available, or to envision a career in interpreting. This is the obvious reason why volunteers and family members with some command of the provider’s language are so often called upon and is part of the rationale for providers choosing to ‘make do’ without needed language assistance.

As a consequence, it may be very difficult to locate anyone able to interpret with professional competency between a provider of health services and a given patient who may show up to receive healthcare. Remote interpreting via telephone, video or a computer link offers a partial solution by linking an interpreter of an LLD, located anywhere in the world, with a patient who speaks that language and a service provider. Remote interpreting assignments may thus provide enough work for the interpreter of a less widely spoken language to support a career in interpreting.

With respect to widely spoken language pairs, the ethical mandate to offer professional interpreting services in healthcare is only countered by costs, political will, awareness of need, and sometimes the reluctance of providers to utilise services already available. The critical problem is how to provide equivalent services in the case of the many other languages, with respect to which cultural barriers may be greater. There may be fewer educated bilinguals ready to be trained and employed as interpreters, and demand for
their services may be limited in a given geographical area. Until solutions can be found for this imbalance, language services will remain unequal for speakers of different languages in the same locality.

4.2 Finding the right balance between interpreting and cultural mediation/advocacy

A second critical issue facing the field of healthcare interpreting centres around the role(s) of the professional interpreter is the possible contributions of bilingual family members, and needed support for immigrant and minority patients in addressing cultural conflicts and misunderstandings.

Studies have shown that bilingual family members accompanying a patient can contribute in many ways, such as clarifying cultural viewpoints and patient complaints and advocating for the patient (or the provider). However, research has also shown that, untrained in interpreting and not reticent to assert their own views, family members who interpret often inhibit clear, direct, and accurate communication between provider and patient. Accompanying relatives of the patient can be given the opportunity to offer their perspective without being expected to interpret as well. What reason other than cost-saving and convenience is there to call upon bilingual adult family members to take the role of interpreter? This important question becomes more urgent in face of what Gentile (2017) describes as the de-professionalisation of interpreting under nationalistic political pressures and budget constraints even in countries that have previously supported professional interpreting.

A related issue is this: to what extent can a professional interpreter be expected to provide accurate and impartial interpreting (suppressing personal opinions) and also to provide cultural brokering and guidance for the benefit of patients unfamiliar with Western healthcare? Can the interpreter do both or are these two distinct roles?

Verrept (2008) discusses the establishment and history of a government-sponsored intercultural mediation programme in Belgium in which bilinguals trained as culture brokers are employed rather than professional interpreters filling a more limited role. Culture brokers meet separately with patients to share information and learn about their concerns in addition to interpreting where needed. A major obstacle from the beginning has been the reluctance of providers to bring in the mediators rather than continuing to rely on family members for interpreting. However, evaluations found significant improvements in quality of care when the mediators’ services were used. Patients were more willing and able to discuss their concerns with the mediators than directly with their physicians. To adequately fulfil their broad role, mediators needed extensive training. In this type of programme, support and advocacy for individual patients are emphasised over the usual impartial role of the interpreter (which by contrast may appear to serve the needs of the provider over those of the patient). This is a model that might work well in other settings.

Other solutions to the problem of providing both cultural support for patients and interpreting services have also been implemented. A paediatric specialty hospital in Seattle, Washington (USA), established a separate position of ‘bilingual patient navigator’ to serve alongside the regular interpreting staff (Crezee and Roat 2019). Bilingual navigators are assigned to assist selected families – those judged most likely to benefit from their services – by guiding, teaching, and supporting them, as well as interpreting as needed. Other patient families receive the usual professional interpreter services. An
external evaluation of the programme at the end of two years (in 2011) showed ‘significant improvement’ in multiple areas including a lower no-show rate, shorter average length of stay, a greater number of interpreted encounters, and significant cost savings (ibid.: 7–8).

4.3 Development of training and assessment

A third critical need is to work toward agreement on adequate levels of general education and professional training for interpreters. While good models and practices regarding certification of skills exist, there is a need for new ideas on the best ways of training interpreters and on how to prepare interpreter trainers. These questions are most acute with respect to initial training and assessment of interpreters of LLDs where the barriers include the lack of qualified trainers who speak these languages and bilingual training materials, as well as the problems of adequate testing and certification for multiple language pairs.

5 Future directions

The field of community interpreting has come into its own over the past 30 or so years with respect to both practice and research. Yet clearly major issues remain, and development is uneven. The fundamental issue of whether professional interpreters or (trained) cultural mediators (or untrained volunteers and family members) should be preferred to assist bilingual communication in healthcare still demands attention. Legal requirements, social priorities, the extent of cultural differences between providers and seekers of their services, and the number of speakers of particular minority languages in a given area will all continue to influence the choices being made. Nevertheless, further research bearing on the issues, especially with regard to ethical questions, barriers to understanding, and health outcomes, is needed.

In addition, there is a need for better understanding of each party’s active role in mediated bilingual communication. This can lead to improvements in the design of interpreter training and the creation of instructional materials (role plays, glossaries, readings, etc.) as well as making appropriate training and educational programmes for prospective community interpreters more widely available.

Notes

1 The preferred term is interpreting rather than interpretation. One reason for preferring the participle is to emphasise the interactive and transitory nature of interpreting, which unlike translation does not result in a permanent record. Another reason is to avoid confusion with other meanings of the word interpretation, as in the interpretation of a work of art or of a body of medical data (NCIHC 2001: 5).

2 To simplify the phrasing in the remainder of this chapter, I will refer to speakers and hearers, without direct reference to communication involving signed languages. Much of what is said here applies equally to interpreting into and out of signed languages.

3 The demands on court interpreters are in many ways unique. Court interpreting is thus sometimes included under the community interpreting label and sometimes not. Since our focus here is on the medical setting we will not enter into this discussion.

4 Categories 1, 2 and 7 would also perform ‘professionally’ but according to their own medical profession’s standards, not according to the standards of the interpreting profession.

Further reading


This article traces how, over time, open discussion among interpreters and other stakeholders led to broad agreement on healthcare interpreters' roles.


This important book investigates interpreting from the perspectives of both interpreters and medical providers and proposes a new theoretical framework for future research and practice.


A study of the quality of communication in bilingual medical interviews, showing the value of interpreter training in reducing transmission errors.


A thorough treatment of medical and legal interpreting, including contexts of practice, ethics, training, and research.


An influential document guiding current practices of professional healthcare interpreters.

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References


Community/liaison interpreting

