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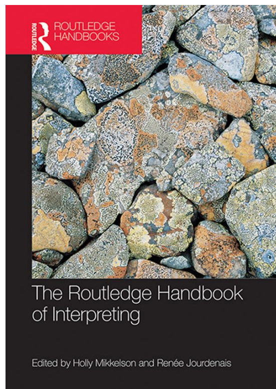

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Healthcare interpreting

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HEALTHCARE INTERPRETING

Cynthia E. Roat and Ineke H. M. Crezee

When a patient who does not speak English comes to the hospital, everything is foreign. The sights are foreign, the smells are foreign, the sounds are foreign. Everything is strange and frightening. The only thing that is familiar, the only thing that gives hope, is the voice of the interpreter.

Thomas June, medical interpreter, 1992

Introduction

Every day, in countries across the globe, hundreds of thousands of immigrants, refugees, native peoples and those who are deaf and hard of hearing seek healthcare services from providers who do not speak their languages. How will they communicate, if not through an interpreter? Over the past several decades, a combination of political, social, logistic, and economic pressures have transformed an *ad hoc* activity performed by family members and friends into a unique sub-field of the interpreting profession, with its own code of ethics, standards of practice, training programs, and (in some countries) certification. This is a field that is rapidly growing, changing, and struggling to define itself in the context of not one, but two complex industries.

This chapter will provide a survey of the field of healthcare interpreting in countries which have become destinations for migrants and/or refugees, using the experience of spoken language healthcare interpreters in the United States to illustrate a pattern of development. It will examine the pressures that have influenced the growth of the field, the work of healthcare interpreters, training and certification, and a number of other critical issues.

The chapter will end with some speculation as to the future direction of language access in healthcare in migrant and refugee destination countries, as well as a short list of recommended readings.

Definition of terms

advocacy

any action taken by an interpreter, usually on behalf of a patient, that goes beyond facilitating understanding of what one person has said to another, with the purpose of supporting good health outcomes

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bilingual provider

any staff member who provides his or her professional services in more than one language; most frequently used with reference to providers of clinical care such as physicians, nurse practitioners, physician assistants, midwives, physical therapists, speech pathologists, and other healthcare practitioners

dedicated interpreter

an interpreter whose sole function in a healthcare facility is to provide language services

dual-role interpreter

an interpreter whose primary function in a healthcare facility is something other than interpreting; e.g. a medical assistant who also interprets

healthcare interpreting, medical interpreting

interpreting that takes place during interactions related to health care. "Medical Interpreting" was a descriptor used more in the early years of the field; "healthcare interpreting" is a later term recognizing that the field covers interactions that are not strictly medical in nature, such as rehabilitation and mental health. In practice, the terms are used interchangeably and may, in the case of organizational names, simply reflect whichever term created a better acronym.

language access

any initiative to facilitate the availability of products or services across a linguistic barrier. Language access programs in health care include interpreting, translation, provision of bilingual staff, multilingual signage, multilingual communication aids, and many other resources to help healthcare personnel and patients with limited proficiency in the language of service communicate with each other.

language of lesser/limited diffusion (LLD)

in any given geographic region, a language that is spoken by a relatively small number of people. Turkish, for example, is a language of lesser diffusion in the United States, where few Turkish speakers have immigrated, but not in Germany, where there is a large Turkish community. Somali is a language of lesser diffusion in Atlanta, but not in Minneapolis. The application of this designation to a language does not in any way reflect its importance on the world stage, the number of people in the world who speak it, or its importance to those for whom it is their mother tongue.

language service provider

a company (for-profit or non-profit) that provides interpretation and/or translation services

limited-English-proficient (LEP) (as defined by the U.S. Census)

speaking English "less than very well," a self-identifier appearing on the U.S. census form

profession

"A special type of occupation [possessing] corporate solidarity, prolonged specialized training in a body of abstract knowledge, and a collectivity or service orientation … a vocational sub-culture which comprises implicit codes of behavior, and generates an *esprit de corps* among members of the same profession, and ensures them certain occupational

advantages … bureaucratic structures and monopolistic privileges to perform certain types of work" (Jackson, 2010).

staff interpreter

dedicated interpreter who is an employee of a company, facility or program

video interpreting, video remote interpreting (VRI)

interpreting that takes place through a video-conference connection; video medical interpreting (VMI) refers specifically to video interpreting used to support healthcare encounters

From *ad hoc* activity to standard of care

Healthcare interpreting has been developing slowly over the past half-century, with many ups and downs, in numerous countries around the world. In Australia, for example, a nationwide telephone interpreting service (TIS) was introduced by the Department of Immigration as early as 1973, providing telephone interpreting services in 160 languages around Australia by 2010 (Phillips, 2010). Some Canadian and American hospitals began to provide interpreting services in the 1980s, and services expanded continuously over the subsequent decades. In New Zealand, the first health interpreting service was established in 1991, following a series of medical misadventures (Crezee, 2009b, 2013), with health interpreting services being available across the country by 2014.

Advances, however, have not been necessarily constant. In European countries, excellent intercultural healthcare policies, including the provision of interpreters, were introduced in some countries in the 1990s, but some have been reversed with changes in government (Mladovsky, Rechel, Ingleby and McKee, 2012). Other countries, including Spain (C. Valero-Garcés, 2014, personal communication) and Japan (T. Asano, 2012, personal communication) are still struggling in the early phases of introducing systematic language services in healthcare, while in the United Kingdom, the National Health Service reportedly still routinely asks patients to bring their own interpreter (Y. Fowler, 2014, personal communication).

A closer look at how the field has developed in one county will help to illustrate the kind of comprehensive efforts necessary to make a healthcare system change the way it manages care across language and culture, and explain why providing systemic and systematic language access in health care is so difficult. This section will outline some of the key steps by which healthcare interpreting in the United States transitioned over the past 30 years from an *ad hoc* activity to a civil rights issue to an industry standard in that country.

A timeline

Prior to the 1970s, healthcare interpreting in the U.S., as in other developed countries such as Sweden, Italy (Merlini, 2009), The Netherlands (de Boe, in press) and Australia (Pöchhacker, 2004; Pöchhacker and Shlesinger, 2007), was an *ad hoc* service, provided informally by family members (including children), friends, and untrained/untested bilingual staff. The assumption was that if one could speak two languages, one could interpret between them, and that the responsibility for providing an interpreter lay with the patient. Little attention was paid to this issue, and providers were expected to "get by" as best they could.

Then the Vietnam War, ending in 1975, brought an influx of Southeast Asian refugees into the United States. Healthcare institutions whose LEP patient populations had been principally

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Latino/Hispanic, and whose providers had made do with high school Spanish, now found themselves serving patients who spoke Cambodian, Lao, Hmong, Vietnamese and other languages for which they were completely unprepared. Community clinics sprang up in some parts of the country to serve these populations, depending heavily on the untutored interpreting of rapidly-trained foreign-born medical assistants. When patients were referred for specialty care, no interpretation was available. Overall, language represented a huge barrier to accessing quality health care for refugee and immigrant communities.

In 1974, however, a legal decision by the U.S. Supreme Court, based on civil rights legislation from a decade earlier, laid the legal groundwork for the establishment of a language access movement. Title VI of the 1964 Civil Rights Act states that:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.

In Lau vs. Nichols, families of Chinese-American students in San Francisco argued that the public schools' unwillingness to provide language assistance excluded their LEP children from participating in publically funded education, thereby violating the Title VI prohibition against discrimination based on national origin. The Supreme Court agreed, affirming that *language is an inextricable aspect of country of national origin* and therefore protected under Title VI. This decision was significant, as virtually every medical center in the U.S. accepts some form of federal funding. This interpretation of Title VI came to form the basis for legal actions over the next three decades that, little by little, propelled healthcare toward the development of interpreter service programs.

The impact of Lau vs. Nichols, however, was hardly instantaneous. By 1980, formal healthcare interpreter services could be found in only in a few cities in the U.S. In most places, healthcare institutions remained ignorant of their responsibilities under Title VI, continuing to use family and friends as interpreters. The following decade did see some significant advances. A growing number of formal complaints filed with the Office for Civil Rights resulted in investigations and subsequent settlements across the country. A few programs, most very short, to train interpreters specifically for health care began to be offered in a handful of cities. In 1986, the first professional association specifically for healthcare interpreters, the Massachusetts Medical Interpreter Association (MMIA), was founded. In 1989, Region X of the Office for Civil Rights issued guidance to recipients of federal funding, educating them on their responsibility to provide language access.

In the 1990s, the field began to gain momentum. In 1991, Washington State became the first state to use public money to pay for interpreter services for patients on Medicaid (healthcare coverage for low income persons in the U.S.). In 1994, *Bridging the Gap,* a 40-hour training for healthcare interpreters was launched. Due to a training-of-trainers program and free licensing, the course was rapidly disseminated throughout the country. In that same year, the Cross Cultural Health Care Program in Seattle convened the first meeting of the National Working Group that, five years later, was to become the National Council on Interpreting in Health Care. The MMIA published the first Medical Interpreting Standards of Practice in 1996, and interpreter associations focused specifically on healthcare began to form in various parts of the U.S., such as Seattle, Atlanta, and the Upper Midwest. In June of 1995, the first international conference on community interpreting – Critical Link – was held in Ontario, Canada, and the following year, the MMIA organized the first U.S. conference on medical interpreting. Research into interpreter use increased, and technology began to play an incipient role in the field. Telephone interpreting began to gain some adherents, and in 1995, the language services company that would

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later become known as CyraCom patented the first dual-handset phone adapted for telephone interpreting.

It was not really until the first years of the new millennium, however, that healthcare interpreting took off, due to a series of critical pressures all coalescing:

- **Awareness of demographic trends**: In 2000, the U.S. Census published data showing that limited English proficiency had increased in the population from 6.1% to 8.1% over the previous decade. The report indicated that over 22 million people in the U.S. needed interpreter services (U.S. Census, 2000) and that the greatest increases had come in states that were traditionally home to homogeneous English-speaking populations. Even those who worked in the field had not realized how widespread and acute the need for interpreters had become.
- **Legal pressure**: In 2002, the U.S. Department of Health and Human Services Office for Civil Rights (OCR) published the final version of national guidance to organizations receiving federal funds regarding Title VI prohibition against national origin discrimination affecting LEP persons. The message was clear: virtually every hospital in the country needed to provide interpreters, and OCR would be investigating those that failed to do so.
- **Attention from accrediting agencies**: In 2007, The Joint Commission, a non-profit organization that accredits hospitals in the U.S., published "Hospitals, Language and Culture: A Snapshot of the Nation," an in-depth study of language access in 60 U.S. hospitals. This report led to the clear inclusion of language rights in The Joint Commission's accreditation standards. As the vast majority of American hospitals were (and still are) accredited by The Joint Commission, the inclusion of these requirements in their standards called the attention of senior hospital leadership to the necessity of implementing quality language services in a way that previous advocacy effort had not.
- **Increased standardization within the healthcare interpreting field**: After years of national consensus-building, the National Council on Interpreting in Health Care published the National Code of Ethics for Interpreters in Health Care in 2004, National Standards of Practice for Interpreters in Health Care in 2005 and National Standards for Healthcare Interpreter Training Programs in 2011. In late 2009, the National Board of Certification of Medical Interpreters launched the first national certification for Spanish medical interpreters, followed about a year later by the Certification Commission of Healthcare Interpreters' credentialing program for all interpreters.

During this decade, the federal Office of Minority Health and a number of major charitable foundations invested millions of dollars in research, organizational efforts, pilot programs, and the development of standards in the area of language access. Training programs for healthcare interpreters multiplied, with on-line versions appearing in the early 2010s. By mid-decade, half of the states in the country had interpreter associations focusing on healthcare interpreters. Research increased both in quantity and quality, making it possible to argue compellingly that qualified interpreters could impact both the quality and cost of health care (Flores, 2005). Telephonic interpreting became ubiquitous and hospitals started experimenting with video interpreting as well. Improved technology also facilitated interpreter scheduling and other logistic advances.

Most importantly, this decade witnessed a sea-change in the way healthcare administrators looked at this issue of language. Perhaps due to the work of the OCR, or the attention that industry associations were paying to the issue, senior administrators stopped asking, "Why do we have to provide interpreters?" and started asking, "How can we provide language services in the most

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cost-effective way?" Interpreting would no longer be relegated to family and friends; it was now accepted that making their services linguistically accessible was the responsibility of healthcare providers. Healthcare interpreting was emerging as a profession in its own right, with the modes of delivery and the marketplace evolving at a dizzying pace.

The argument

What, then, are the compelling arguments in 2014 for the adequate provision of language access services in health care? Overall, they can be grouped into four general areas: social justice, legal requirements, quality of care/patient safety, and cost.

Social justice arguments

The social justice arguments for language services focus on fairness. Whether using the language of "human rights" as in Europe or that of "equal access" as in the U.S., supporters argue that patients who do not speak the dominant language of the country in which they live cannot access health care as easily as the dominant population can, even though they help pay for the health system through their taxes. This applies to immigrant and refugee populations, as well as to indigenous/aboriginal populations who are linguistic minorities. Research in the U.S. and the U.K. has shown that LEP families indeed have significantly greater difficulty in accessing care than English-speaking families in the same socioeconomic strata (Jacobs *et al.*, 2001 Smedley *et al.,* 2003; Flores 2005; Bischoff, 2012). Mladovsky et al. (2012) describe "evidence from across the EU (that) demonstrates considerable, but varied, inequalities between migrants and non-migrants in health and access to health services." In Australia and New Zealand, on the other hand, access to health care is seen as a universal right which extends to access to healthcare interpreters (Phillips, 2010).

There are also strong public health reasons as to why all individuals should have access to health care. Infectious disease does not recognize language or social class. In an era in which antibiotic-resistant staff infections (MRSA), bird flu, antibiotic-resistant tuberculosis, measles, and other infectious diseases have started to appear or reappear, systematically limiting any specific populations' access to health care by limiting their access to interpreters puts the entire population at risk.

Legal and regulatory arguments

As discussed above, it was not concern over social justice but legal requirements that first pushed the healthcare sector in the U.S. to begin providing language services in a coherent way, though it should be noted that many of the legal requirements were born out of the social justice movement. Such has been the case in many countries, including Australia, New Zealand, and some European countries (Cattacin *et al.*, 2006; Crezee, 2009a; Phillips, 2010; Verrept, 2012; Bot and Verrept, 2013).

In the U.S., critical statutes and regulations driving language access include Title VI of the 1964 Civil Rights Act, discussed earlier; The Americans with Disabilities Act, which requires that institutions make "reasonable accommodation" to support access to their services by individuals with disabilities, including hearing impairment; state and local laws requiring the provision of interpreters under specific circumstances; Medicaid Managed Care contracts, which require managed care organizations providing care with federal funding to provide interpreters for LEP patients; and the standards of accreditation organizations such as The Joint Commission.

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Quality of care and patient safety arguments

To healthcare providers such as doctors and nurses, the most compelling argument for language services is that they cannot provide quality care if they cannot communicate clearly with patients and families. Building rapport, eliciting a health history, understanding symptoms, obtaining informed consent for tests, sharing a potential diagnosis, explaining treatment options, negotiating a treatment protocol, teaching about a condition or how to use medical equipment, doing a follow-up – all require clear communication. As a matter of fact, doctors report that the most common (and cheapest) diagnostic test they do is the medical interview. So, if communication is impeded by language barriers, quality of care is clearly impacted (Flores, 2005; Smedley *et al.*, 2003; Mladovsky et al. 2012).

As a corollary, lack of clear communication compromises patient safety. Recent research from The Joint Commission has shown that LEP patients are more likely to have serious incidents based on communication failure while hospitalized, and that those incidents are more likely to lead to serious outcomes than communication failures with English-speaking patients (Divi *et al.*, 2007).

Communication lies at the heart of healthcare. Without it, providers cannot provide good care, and patients are at risk. It is surprising, in fact, that clinicians are not more worried than they are about the quality of the interpreting on which they depend.

Financial arguments

Language services cost money. A large urban medical center in the U.S. can easily spend $2–3 million/year on interpreting, which usually comes out of a hospital's general operating budget. In an economic climate of cutbacks and budget tightening, common everywhere around the world today, how can hospitals be expected to make this kind of investment?

In fact, the use of qualified interpreters, while not lowering the cost of care, will certainly help a hospital avoid costs it would have otherwise incurred in caring for LEP patients; this is called "cost containment." For example, a 2002 study from Boston showed that LEP patients who received interpreter services in the emergency room (ER) had lower overall cost of care over the next three months (including the ER visit and the interpreter) than LEP patients who did not get an interpreter (Bernstein, *et al.* 2002). Their overall cost of care was even lower than that of English-speaking patients seen in the ER at the same time for the same diagnosis. Other research has shown that the use of qualified interpreters lowers admission and readmission rates, shortens hospital stays, decreases referrals for unnecessary diagnostic tests, and increases clinic through-put, all of which have implications for the cost of care (Flores, 2005).

The bottom line is that it is cheaper to care for patients who do not speak the dominant language using qualified interpreters than it is to do so without qualified interpreters. To hospital administrators facing serious financial constraints, this may be one of the most compelling arguments for language services.

Other "levers" for making change

The arguments made above have been effective over time in the United States in convincing healthcare institutions to implement language access programs, largely because they take advantage of the motivations specific to the American social, economic, legal, and political system. Other countries will have different systems with a different mix of motivators, and so advocates there may use different arguments to plead the case of language access. For example, there has been

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interest in Japan in boosting medical tourism, leading the Ministry of Tourism to look into encouraging the use of medical interpreters as a means of attracting foreign patients (M. Ishizaki, 2012, personal communication). Yuko Nishimura, a professor of social anthropology at Komazawa University in Tokyo, has suggested that, as Japan is a country with a low birth rate that finds itself with a dwindling work force, large manufacturers may support language programs in health care in order to provide services to a growing immigrant labor force (Nishimura, 2005). In parts of Europe, on the other hand, where human rights are a strong value, language access is presented more as a human rights issue (Fernandes and Pereira Miguel, 2009; Chimienti, 2009).

Regardless of the specific arguments used to support the provision of interpreter services, the fact remains that a lack of qualified interpreters leads to poor health outcomes for patients who do not speak the majority language.

Healthcare interpreting today

Healthcare interpreting as a field is evolving so quickly that anything written here about current practices today may actually be out of date by the time this book goes to press. There are also tremendous variations depending on language pair, geographic location, and modality of service delivery. That said, following is a description of what a prospective interpreter might expect regarding work in this field. While all interpreting work shares some commonalities, there are certain aspects of interpreting in health care that set it apart.

Is healthcare interpreting different from interpreting in other settings?

One might argue that, give or take some specialized vocabulary, the work of interpreting is the same regardless of venue. After all, whether in the hospital, the courtroom, or the lecture hall, all interpreters work to convey in one language the oral or visual messages uttered in a different language.

Venue does make a difference, however. Venue will determine to a large degree the purpose of the communication, the context of the communication, and the consequences of miscommunication. For example, consider an adversarial legal proceeding. Lawyers may want everyone to understand what they say, but sometimes they are trying to create an impression instead, and other times they are trying to create confusion for a particular purpose. While the consequences of miscommunication can be quite serious, the responsibility for successful communication lies with the lawyers, who are considered the advocates for the parties they represent (see Chapter 12 on court interpreting).

Compare this to a healthcare encounter. In healthcare, the interactions are collaborative, meaning that all the participants generally want the same outcome; they want the patient to get well and stay well. Everyone involved wants to understand and to be understood, because the consequences of miscommunication can be quite serious – even fatal. The levels of power and preparation of the participants are quite different, with providers holding most of each, leaving patients often feeling quite disempowered. For this reason – because the requirements of the communicative interactions are different – healthcare interpreters often take a broader role than interpreters in legal settings.

The day-to-day work of healthcare interpreters

Interpreters can be found in every healthcare setting imaginable: hospitals, clinics, skilled nursing centers, mental health centers, public health departments, home health visits, inpatient and

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out-patient settings, emergency rooms, primary care, specialty care, pharmacy, rehabilitation centers, school-based clinics, rural and urban settings, even prisons. They may provide their services in person, over a telephone, or through a video-conference connection, working from home, from an office or from a call center. Healthcare interpreters may be full-time staff or they may work as freelancers.

Staff interpreters

Most large urban medical centers in the U.S. today have at least some staff interpreters working in the languages of highest demand, and this is probably true of major cities all over the developed world. Harborview Medical Center in Seattle, for example, has had as many as 70 full- and part-time interpreters on staff at a given time. Staff interpreters usually work a set schedule, but they may be expected to take varying shifts to assure full coverage. They interpret for pre-scheduled appointments as well as for the unscheduled patients being seen in the emergency room and urgent care departments. Staff interpreters most often interpret in person, but more and more medical centers are also using them to interpret over the phone and through videoconferencing connections, so as to maximize flexibility, effectiveness and efficiency.

Working as a staff interpreter has a number of benefits for those who love being of service: the security of a full-time job, predictability of assignments, being perceived as an integral part of the healthcare team, being warmly welcomed by providers and patients alike, and having the support of interpreter colleagues. On the down side, staff interpreters in healthcare often have stressful work schedules and are intimately involved with some of the most intensive human experiences imaginable. Because they cannot routinely turn down assignments, they may find themselves working closely and repeatedly with unpleasant patients and providers, and in uncomfortable situations. Working as a staff interpreter can be highly rewarding, but it is not for the faint of heart.

Dual-role interpreters

Many healthcare facilities, especially those in areas with one or two dominant immigrant or refugee language groups, will train their bilingual staff to also function as so-called dual-role interpreters. They are hired initially for other healthcare roles – nurse, laboratory technicians, etc. – and interpret as a secondary job.

Like staff interpreters, dual-role interpreters enjoy the benefits of full-time employment. Unlike staff interpreters, most dual-role interpreters only interpret in their own work area in the facility, so they do not need the same wide range of vocabulary that a staff interpreter, who serves all the facilities' providers, must know.

Dual-role interpreters face their own challenges, though. As they do not interpret all the time, their skills can easily atrophy. They also may not think of themselves as interpreters, passing up opportunities for training and continuing education.

Freelance interpreters

Many interpreters choose to work as freelancers, also called "contract interpreters:" independent business people who interpret in a variety of healthcare, legal, social service, and educational settings, who may work in person or remotely, and who may mix interpreting with translation. Freelancers enjoy tremendous freedom and flexibility in choosing the work they want to do and the clients for whom they want to do it. They can also experience wide variety in their assignments.

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At the same time, maintaining a small business requires excellent organizational skills as well as a fair amount of time to secure jobs, invoice for payment and address the legal requirements of having a small business.

Remote interpreters

Some interpreters work as employees or contractors for language service providers that specialize in telephonic or video interpreting (Phillips, 2010). These interpreters may work in a call center, where they take incoming calls from many healthcare facilities and, indeed, from non-healthcare settings as well. They also may work from home. Until recently, this was true only for telephonic interpreters, but advances in internet and encryption technologies are making it possible for freelance interpreters to provide video interpreting from their home offices as well, creating greater flexibility for the entire industry (see Chapter 22 on remote interpreting).

Qualifications to work in the field

Because healthcare interpreting is developing unevenly across the country and the world, the qualifications required for employment in the field depend entirely on the location, the languages spoken, and work preferences. In a common language pair like English-Spanish, in a city with sophisticated language access programs, prospective interpreters need better credentials than in a less-developed area, working in a language of lesser diffusion. So instead of addressing the qualifications needed to obtain employment, this section will address instead the qualifications necessary to do this work well.

Life skills

Interpreting is a service profession. Healthcare interpreters work regularly with patients and families at their worst: sick, anxious, confused, sometimes even angry, desperate, despairing. They work with providers who are rushed, often frustrated, and frequently unskilled in working cross-culturally. So, here are some characteristics skilled healthcare interpreter should have:

- An enjoyment of people and a desire to be of service to them.
- Excellent communication skills.
- Patience and ability to stay calm under pressure.
- Compassion, but also clear personal boundaries.
- Comfort with the highly intimate content of healthcare discussions.
- Self-awareness and a commitment to emotional self-care.

Someone who intends to work as an on-site interpreter will also need to be comfortable with the sights, sounds, and smells of the healthcare environment.

Language skills

All interpreters must have excellent language skills. The National Standards for Healthcare Interpreter Training Programs in the United States recommend fluency at a professional proficiency level according to the scales developed by national language testing bodies (NCIHC, 2011). Of course, interpreters never stop honing their linguistic skills in all their working languages; this is a life-long endeavor.

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In addition to being generally fluent in at least two languages, healthcare interpreters must also dominate a wide range of healthcare-related vocabulary in both their languages. This can be a challenge, as there is often a signal lack of linguistic equivalence between the language of healthcare and that of many immigrant, refugee, or indigenous/aboriginal patients. Folk terminology and culture-specific issues relating to different patient attitudes towards health and illness, the "discussibility" of certain topics, and expectations towards managing chronic conditions rather than "curing" them may also be a challenge (Crezee, 2013). It may be necessary to create word pictures where no single term exists, or to engage in paraphrasing. In addition, bilingual medical glossaries do not exist in many language pairs, making the development and maintenance of a bilingual medical vocabulary even more difficult.

Training

Regardless of whether it is required for employment, basic training as an interpreter is absolutely critical in order to provide professional services. While some people are naturally adept at the linguistic conversion required for interpretation, the ethics and protocols that make a good interpreter must be learned. In the United States, 40 hours of basic training is commonly viewed as the absolute minimum, to be followed by significant continuing education. Many employers expect to see much more: between 60 and 120 hours, with an additional practicum. The number of college-level programs in healthcare interpreting is growing, as is the availability of on-line training. The International Medical Interpreter Association maintains a list of some of these programs on its website at www.imiaweb.org – accessed 16 Oct 2014 – *(see also Chapter 25 on pedagogy).*

Certification

Certification specifically for healthcare interpreters is available in very few countries. Australia has had a national accreditation system for interpreters for decades (Tebble, 1998; Hale, 2012), but the "professional" level tests are not specific to healthcare interpreting (Hale, 2012). A similar system for the accreditation of general interpreters (and translators) has existed in the past in The Netherlands. New Zealand, although a small country, has offered language-neutral healthcare interpreter training programs at tertiary level since 1991 (Crezee, 2009b), but there is no certification test per se.

In the United States, on the other hand, circumstances have led to the concurrent development of two national certification tests for healthcare interpreters: the Certification Commission for Healthcare Interpreters (http://www.healthcareinterpretercertification.org/ – accessed 16 Oct 2014) and the National Board of Certification of Medical Interpreters (http://www.certifiedmedicalinterpreters.org/ – accessed 16 Oct 2014). While relatively few employers currently require any kind of national credential for healthcare interpreters, being certified is certainly one way for interpreters to differentiate themselves from other candidates for interpreting jobs.

Critical issues in healthcare interpreting

Role boundaries of the healthcare interpreter

Without doubt, the most persistent and difficult debate in healthcare interpreting has been and continues to be the scope of the interpreter's role. The National Council on Interpreting in Health Care spent years deconstructing this issue, and even today it is the basis of most of the ethical and logistical dilemmas facing interpreters in this venue. Different countries have adopted

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different models, from the relatively more restrictive role definitions in Canada (HIN, 2007) and Australia (NAATI, 2014; AUSIT, 2014) to the more comprehensive model in Belgium (Verrept, 2012). The U.S. lies somewhere in the middle.

The crux of the question is this: are healthcare interpreters primarily healthcare workers whose specialty is language, or are they language professionals who work in healthcare? The truth is, they are both, in a way that is unique to this field. The issue is examined more closely below:

The quintessential vision of the interpreter is the objective "black box:" a message in one language goes in and the equivalent message in another language comes out (Bot, 2013). Of course, this is a gross oversimplification of how language and communication work. A message is understood only within the context of culture, prior knowledge, and shared meaning. So, to what degree are interpreters responsible for simply reproducing the message? To what degree are they responsible for assuring understanding? To what degree are they responsible for the outcome of the healthcare encounter? Consider the following statement from a cardiologist:

> We've gotten the results from the MRI and several of your coronary arteries appear to be partially occluded. I think our next step would be angioplasty to see if we can open those up without having to do a full-fledged by-pass.

Even conscientious interpreters might disagree how to render this speech. One might argue that it is best to just interpret what was said, maintaining the register and using equivalent acronyms if they exist, letting the patient ask if he does not understand. Unfortunately, whether because of cultural norms or a sense of disempowerment linked to immigrant/refugee background and low socioeconomic status, many patients who need interpreters are unlikely to admit that they do not understand. Some will argue that assuring understanding is the physician's responsibility, not the interpreter's, while others feel that the consequences of the patient not understanding are so high that everyone should take responsibility.

In trying to ensure understanding, though, some interpreters can go too far. If interpreters explain the message, lower the register, take out the acronyms, and check for understanding, they run the risk of explaining concepts incorrectly. In addition, assuming that the patient needs the interpreter to lower the register can be patronizing; some patients will understand the higher register just fine. More interventionist interpreters may point out that they do not try to explain concepts that they do not understand, and that, after years of experience, these are few and far between. They may argue that they can identify a patient's level of education by his use of oral language, and that careful observation of body language will reveal if the patient does or does not understand. But can an interpreter do that over the telephone? And, if the interpreter lowers the register the doctor will never know that the register was too high to begin with. On the other hand, when a doctor is a poor communicator, will he or she pick up on cross-cultural cues that the register is too high?

And so the discussion goes on.

The truth is, both sides of the argument are largely correct. As healthcare workers, interpreters have a moral imperative to help the patient understand; clear communication and understanding between patients and providers is at the absolute heart of good healthcare. Biomedicine is complex and sees the patient as an educated partner in decision-making, but patient health literacy is often low, and healthcare systems do not do a good job of bridging the gap. In addition, the systems for accessing care are complicated and confusing. Combine these challenges with anti-immigrant sentiment and outright racism, and many limited proficient patients do not receive the care they need or to which they are entitled. Interpreters, as the linguistic and cultural link between patients and the healthcare system, can make the difference.

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However, as many interpreters enter the healthcare interpreting field because they are natural helpers, they are at high risk for overstepping, taking over the encounter, explaining incorrectly, patronizing patients who do understand, and, in the end, compromising the good health care they meant to facilitate. Where is the balance between converting language with no concern for understanding, and going beyond appropriate role boundaries?

In the mid-1990s, the Cross Cultural Health Care Program in Seattle, WA, published a basic training for healthcare interpreters that introduced a model for understanding the interpreter's role, called "incremental intervention" (Cross Cultural Health Care Program, 1999). This model sought to create some boundaries around the interpreter's role while at the same time allowing sufficient flexibility for the interpreter to meet the communicative needs of patients and providers in diverse types of encounters. This model posited that the interpreter's purpose in the healthcare encounter was to "facilitate understanding in communication between people speaking different languages." Anything beyond facilitating communication was not part of the interpreter's role. Within this purpose, interpreters might have to move between the roles of Conduit, Clarifier, Culture Broker, and occasionally Advocate in order to overcome barriers to understanding. Conduit – the accurate rendering of meaning, maintaining tone and register – was considered the default role, in which interpreters began and which interpreters left temporarily only when misunderstanding was occurring. For example, if inappropriate register was leading to misunderstanding, the interpreter would temporarily become a "clarifier," lowering the register and checking for understanding, then go back to conduit interpreting. If a cultural difference was leading to misunderstanding of what was said, the interpreter would act as a culture broker to point out the misunderstanding, then immediately go back to being a conduit. Within this framework, interpreters were to choose always the least invasive role that would lead to clear communication, allowing them to tailor their practice to the needs of the specific individuals for whom they are interpreting.

Incremental intervention provided the field with a framework to more specifically discuss the interpreter's role, and while the first three roles became widely accepted, the final role of advocate continued for years to be a stumbling block for many. Interpreters trained for other settings felt this role violated the interpreter's "neutrality," while language company owners worried about liability if interpreters got involved in contentious situations with company clients. Professionals rooted in healthcare disciplines argued that ALL healthcare workers, including doctors and nurses, are called upon to advocate for patients on occasion. And interpreters coming from a social justice viewpoint saw advocacy in the face of ill treatment as a human responsibility.

Finally, in 2004, the National Council on Interpreting in Health Care (NCIHC) published the National Code of Ethics for Interpreters in Health Care. In response to demands from the field for some concrete guidance regarding advocacy, the NCIHC added a canon to the code stating that:

> when a patient's health, well-being, or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem.
>
> *(NCIHC, 2004)*

Even this carefully considered statement has not laid to rest the debate on the interpreter's role in health care. Within the intimate conversations between patient and provider, the interpreter still

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walks a razor's edge between intervening too little and intervening too much. Today, however, this discussion has moved outside of healthcare interpreting to involve legal interpreting and sign interpreting, and the choice is now being posed as between interpreting as a technical profession or interpreting as a practice profession (see Chapter 20 on ethics).

Future directions

What can we expect in the healthcare interpreting world of the future? As mentioned before, the field is growing and changing at such a pace that it is difficult to predict, but here are some likely directions:

- The need for healthcare interpreters will continue to grow.
  A quick look at demographics and patterns of immigration in much of the developed world should convince us that the need for interpreters in all public sectors will only continue to grow in the near future. In countries where birth rates are below replacement level, the lack of a viable workforce will build economic pressure for increased immigration. These immigrant populations will need health care, and the ever growing body of evidence showing the positive impact of language services not only on quality of care but on cost containment must lead to increased language access in countries with significant immigrant populations.
- Training and certification will become more widely required.
  As the availability of training programs increases, as more interpreters become certified, and as the expectations of healthcare providers for quality interpreting grow, it is likely that more employers will require basic training and credentialing of interpreters, both to assure quality services and to protect themselves against legal liability.
- Remote interpreting will expand, at least in technologically advanced countries.
  The growth of remote interpreting – especially video interpreting – is the one certainty in this field. While on-site interpreters can arguably provide a wider range of services to patients and families, hospitals will not be able to meet the growing demand for language services with on-site interpretation alone. A freelance on-site interpreter, running between hospitals and clinics, might be able to complete three or four interpretations in a day, while an in-house on-site interpreter might accompany eight or nine patients in an eight-hour shift. A remote interpreter, however, can attend to triple that number, because she does not have to travel between appointments, find parking, or wait for a provider who is running behind. Remote interpreters are available in an average of 15–30 seconds, whenever the providers need them, in a wider range of languages than on-site interpreters. As language access programs become more sophisticated, they are getting better at using telephonic interpreting for shorter, more routine interactions and video interpreting for longer, straightforward interactions, while saving their staff interpreters for the emotionally difficult encounters. So, while there is no doubt that providers and patients prefer an on-site interpreter, and while there is growing evidence that video and telephone interpreters may feel more isolated than on-site interpreters (Wilson. 2013), remote interpreting is definitely here to stay.

  Why will video interpreting expand in particular? Research has shown that, if patients and providers cannot have an on-site interpreter, they prefer video to telephonic interpreting (Locatis *et al.*, 2010). Interpreters also feel that in encounters with significant educational or psychosocial content, they were able to do better with video interpreting (Price *et al.*, 2012). But most importantly, healthcare facilities are busily installing the wireless internet systems on which video interpreting depends, not for the sake of language access but for application with electronic medical records. These improvements in internet access, together with the

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decreasing cost of tablet computers, the growing number of language service providers offering video interpreting, and the ability to connect with freelance remote interpreters at home through highly encrypted connections, will push the growth of this service over the coming years (see Chapter 22 on remote interpreting).

- Healthcare interpreting will become more specialized, and additional career paths will develop. Until very recently, the focus of the healthcare interpreting world has been on developing systems to identify and deliver an interpreter – any interpreter – into a healthcare encounter and on improving the basic skills of healthcare interpreters in general (e.g. Crezee, 2013). However, as more employers are requiring basic training and eventually credentialing, and as remote interpreting makes it possible to pull from a national or international labor force instead of a local one, there will likely be a growing focus on specialization within the field.

  Why is this needed? Healthcare includes a broad set of services, with extensive specialized vocabulary, goals and techniques. The purpose of a primary care doctor's interview and that of a mental health practitioner are often not the same. The best techniques for interpreting for children are different than those used with adults. Interpreting well in a trauma bay, or on a call to an emergency switchboard, or at the end of life requires an understanding of the particular purpose of communication in that setting, the processes, the roles of participants and the needs of the speakers, all of which differ. A general healthcare interpreter can interpret in these specialized encounters, but as the choice of interpreters increases, preference will be given to interpreters who know these fields best.

  So, the future may demand interpreters who not only specialize in healthcare interpreting, but specialize further in mental health interpreting, interpreting for trauma, pediatric interpreting, etc. Already, specialized training is becoming available for interpreters serving victims of trauma and torture (such as the Healing Voices program; see http:voice-of-love.org/about), and one telephonic interpreting company (Pacific Interpreters, 2014) has provided specialized training in pediatric interpreting for its own interpreters. Training on interpreting in palliative care can be taken on-line or a curriculum can be downloaded for free (Roat *et al.,* 2011) and workshops on mental health interpreting are in high demand.

  It is also likely that additional career paths for healthcare interpreters may develop. At the moment, the only real path for experienced healthcare interpreters who want to advance is to either expand into other areas of interpreting or go into administration of language access programs. However, new roles for healthcare interpreters are developing. For example, there is a new movement in the United States toward training Bilingual Patient Navigators to help people learn to interact effectively with the complex healthcare system in the U.S. These individuals, who often serve medically complex patients and families with long-term health problems, are not only interpreters but also teachers who patiently instruct and model for patients how to make and change appointments, how to ask questions of providers, and how to effectively advocate for themselves within a system. They also teach providers how to identify and negotiate cultural barriers to care. This hybrid role is just one of many that are emerging in which interpreting is a part, but not all, of the skills required.

- Interpreters may be required to become translators as well.
  There is a large push almost everywhere to contain the ever-rising costs of health care. One mechanism for doing this is the use of technology to facilitate communication. In the U.S., as part of the 2010 economic stimulus package, the U.S. government offered a significant financial incentive to hospitals and clinics to implement electronic medical records, which can be easily accessed by all of a patient's healthcare providers, reducing time delays and medical errors. As part of the implementation of this plan, 2014 will see a parallel push to facilitate more electronic consultation between patients and their doctors, using email, texting and other rapid forms of

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written communication. Of course, healthcare facilities will have to make these services equally available to limited-English-proficient patients in order to comply with civil rights legislation. It will no longer be enough to have interpreters available for patient visits. Facilities will require linguists who can rapidly and accurately translate the written message of an email, a text or even perhaps a tweet. Currently, many interpreters do not have the skills to handle written text, even if their non-English language has a commonly used written form, which many languages do not. Interpreter training programs rarely teach translation skills, nor is it clear that the sort of skills taught to literary translators are the same skills needed for these short, rapid translations. All in all, the move to electronic communications raises a myriad of questions for language access services and creates a fascinating new horizon for interpreters and translators alike.

Conclusion

Healthcare interpreting is certainly not for everyone, but there is tremendous satisfaction in knowing how much one is helping people who are so very much in need of help. This is a field that is still developing, a field that needs skilled linguists, compassionate hearts, creative problem-solvers, and a new generation of leaders.

Further reading

National Code of Ethics for Interpreters in Health Care. National Council on Interpreting in Health Care. July 2004. 23 pgs. www.ncihc.org

This Code of Ethics was developed with national input and has been adopted by many health care institutions across the U.S. It has been translated into Spanish and Japanese as well.

National Standards of Practice for Interpreters in Health Care. National Council on Interpreting in Health Care. Sept. 2005. 13 pgs. www.ncihc.org

These Standards of Practice, like the Code of Ethics on which they are based, were also developed through a national consensus-building process. They serve as a basis for healthcare interpreter practice throughout the U.S.

National Standards for Healthcare Interpreter Training Programs. National Council on Interpreting in Health Care. April 2011. 37 pgs. www.ncihc.org – accessed 16 Oct 2014.

The Standards for Training Programs are based on the Standards of Practice. They are, again, the results of a long process of outreach and consultation with experts in the field, including interpreters from all over the U.S.

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