Overview

- Welcome and background
- Introduction/goal
- Summary of data collected from focus groups around the U.S.
- Comparing research and practice
- Effective Practices for Interpreting in Medical Settings (Draft of document)
- Healthcare Interpreter Education (spoken and signed languages)
- Resources for medical interpreting
  - Medical interpreting website
  - Conclusions

Funding and Support

- NCIEC
- CATIE Center, College of St. Catherine

Download this presentation at:

- www.asl.neu.edu/nciec
Contributors

- NCIEC medical workteam:
  Richard Laurion, Cathy Cogen, Bev Holrah, Laurie Swabey
- CATIE Center: Richard Laurion, Rosa Ramirez, Paula Gajewski
- Consultant: Marty Taylor
- Medical interpreting website: Doug Bowen-Bailey
- Contributors: Julie Moore, Jimmy Bedon, Nancy Negley, Trudy Suggs
- Organizations: NCIHC, Mt. Sinai Medical Center
- Expert Group: Brenda Nicodemus, Carol Patrie, Karen Malcolm, Marty Barnum, Dan Langholz, Glenda Boon
- Focus group participants and facilitators

Stakeholders

- Researchers
- Educators
- Interpreters
- Consumers/Patients
- Healthcare providers
- Collaborative process

How can we prepare interpreters to work effectively in medical settings?

Approach

- Literature review – medical interpreting standards of practice and medical interpreting education – signed and spoken languages
- Interviews – issues and experts
- Expert group – effective practices draft
- Review
- Focus group design and data collection
- Website development
- Next steps: revise effective practices document, review; lit review on adult learning/practice professions; begin curriculum design
Is medical interpreting significantly different from other types of interpreting?

Legal – certification and education
Education – certification and training
Medical – spoken language interpreting – some state certifications; state and national organizations; over 134 training programs in the US

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Similarities

- language and interpreting competencies
- ethical framework and excellent decision-making skills
- professionalism
- commitment to self-assessment and life-long learning

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Ways medical interpreting may differ from other settings (Roat, 2004)

- Often triadic, with doctor, patient and interpreter in a small space.
- The perception of the interpreter’s role is heavily constrained by the setting (Angeletti, 2004)

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Questions have a different function in medical settings than courtrooms
- Dr. - patient interview, not public like some settings (courtroom, conference, classroom)
- Complex interpersonal role

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Potential differences (continued)

- Topics can be highly personal, often painful.
- In some situations, time is of the essence.
- Interpreter can be exposed to physical (health) risks.
- Interpreter can experience emotional trauma.
- Medication, equipment and injuries may impact communication.

Potential differences (continued)

- Requires the ability to be empathetic and caring, yet with clear professional boundaries.
- Gender may matter.
- Many situations are high risk (errors may have grave results).

What research is available?

- Significant research available on the importance of communication/relationship between doctor and patient, (non-interpreted), (Frey, 1998; Adler, 2002; Roter, 2002; Lee et al, 2002).
- Dialogue is one of the most important features of the medical encounter.
- Relationship leads to better outcomes of medical treatment (Frey, 1998).

Potential differences (continued)

- Very broad field – preventative, emergency, alternative, long-term, aftercare; dental, education; end-of-life care/hospice.
- Very diverse consumers – patients are all ages (children to elderly), all socioeconomic backgrounds; all educational levels; some knowledgeable about healthcare, others not; Interpreting for Deaf health care professionals is very specialized.
Example

Talk at work: Interaction in institutional settings. Edited by Paul Drew and John Heritage (Studies in Interactional Sociolinguistics)

- Original empirical research into the interactions between professionals and clients in a variety of settings, including healthcare.

Other related studies (examples)

- Conference Proceedings: Critical Link, ATA.

Interpreting (examples)

- Interpreted doctor / patient interviews (spoken languages) – several studies (Angelelli, 2003, 2004; Wadensjo, 1998; Flores, 2003; Kaufert & Putsch, 1997; Davidson, 1998; Tebble, 1999.)
- Limited research based on actual doctor – patient interviews using American Sign Language interpreters. (Cokely, 1992; Metzger, 1999)
- Lack of research on Deaf provider-Deaf patient interviews.
- Lack of research based on actual doctor-patient interviews with DIs/CDIs

Discourse based research on healthcare interpreting (example)

- Editors: Franz Pöchhacker, Miriam Shlesinger
- Publisher: John Benjamins 2007
Effective Practices for Medical Interpreters – draft document

- Expert group
- Secondary Review
  - Identified issues of disagreement
- Focus groups

...a credentialed professional with national certification who facilitates communication between users of signed and spoken languages in health care settings from birth to death. This includes:

- Bilingual fluency in English and ASL including sociolinguistic variation and limited language proficiency.
- Awareness of the linguistic, social & cultural influences which may impact healthcare interactions, including specialized vocabulary, discourse styles, register, power & prestige, and triadic communication.
**DRAFT**

- General knowledge of the physiological and psychological implications of health care
- Awareness of various health care approaches (e.g., Chinese, ayurvedic, holistic, homeopathic, Western medicine).
- Understanding of various health care delivery systems and the roles of self and others on the health care team (including CDIs and advocates that can enhance the interpreting team).

**DRAFT**

- Sharing information and resources through advocacy, leadership, education, and liaison with individuals in health care settings.
- Ability to balance the need for professional distance with empathy and flexibility.
- Adherences to the RID professional code of conduct.
- Knowledge of laws and policies related to health care settings.

**Focus Groups**

- One of our interests in these discussions was to find out what interpreters really do in medical settings, how they enact their role.

**Demographic survey of sign language medical interpreters**

- 8 states
- 54 participants
- 20 items – gender, age, hearing status, education, ethnicity, experience in med. Settings, CI/SI; certification; attitudes about advanced education
Years of medical interpreting experience

- 5 or less years = 16%
- 6 – 10 years = 28%
- 11 – 15 years = 16%
- 16 or more years = 31%

- 79% certified (most common certificate – RID CI/CT)
- # of years interpreting: M = 17

Readiness to work in medical settings

- 61% did not feel adequately prepared when they started working in the medical setting;
- most didn’t have education in medical interpreting in their IEP
- 24% did feel adequately prepared

Readiness to work in medical settings

- Concerns: Lack of internship/practicum in this setting; unsure of protocol, terminology, the system; not fully prepared to make ethical decisions
- What helped: strong background in sciences, med terminology; previous med experience; use of local resources; 1:1 – able to ask for clarification

What type of education prepared you to work in the medical setting?

- None
- College Courses on Related Topics
- College Courses on Medical Interp.
- Workshops on Medical Interp.
What else has prepared you for medical interpreting?

- degrees in nursing or biology
- Books, medical dictionaries
- Videos/DVDs
- On-the-job training
- Conferences
- Internships
- Personal experience
- Experience as a CODA, experience with family and friends

How would you describe the amount of simultaneous or consecutive interpreting you use in medical settings?

- Mostly SI: 43%
- About half SI, half CI: 43%
- Mostly CI: 14%

Most important knowledge areas for medical interpreters

- ASL and English needed for interpreting in medical settings – 58%
- Role and boundaries – 53%
- Ethics and professional decision-making 53%
- Knowledge of health care systems – 30%
- Culture and Diversity – 30%
- Interpreting skills – 21%

Have you worked with a DI/CDI in a medical setting?

- Never: 37%
- 1 – 5 times in my career: 34%
- Less than once a month: 5%
- 1 – 2 times a month: 5%
- 3- 5 times a month: 2.4%
- 6 – 10 times a month: 2.4%
- More than 10 times a month: 2.4%
Staff member or Private Practice

- 32% have worked as a staff interpreter at a health care facility
- 58% have not had full-time staff positions at a health care facility

What can medical interpreters do to improve the service they provide?

- More education, training and mentoring
- More observation, shadowing and supervised opportunities
- Learn medical terminology and concepts in ASL and English
- Take preparation seriously
- Do not be afraid to ask for clarification or explanation
- Be compassionate
- More knowledge of classifiers, ethics, dental signs, hospice care
- More consecutive
- Better understanding of discourse and culture
- Better understanding of ethics in healthcare, healthcare systems
- Study anatomy and physiology – English and ASL (classifiers)
- Flexibility, ability to problem solve

Do you see a need for post BA education in medical interpreting?

- Post-baccalaureate certificate:
  - Yes = 60%
  - No = 21%
- MA degree
  - Yes = 26%
  - No = 35%

Comments about post-baccalaureate education

- More important for full-time medical staff interpreter than generalist
- YES – stakes are high
- Need experience, hands-on learning
- This specialized field requires specialized knowledge and skills
- Concerns: pay may not justify an MA; lack of experiential learning; should be part of a BA
Other representative comments from survey

- Need skills, knowledge, experience and heart
- Need training to work with Deaf healthcare professionals
- IPPs need to have opportunities for students to gain experience observing and working under supervision
- Doctors/nurses need education about Dts/CDIs
- Need credentials and education to get the respect we deserve
- Need strategies for communicating medical concept/terms in ASL

Focus group synthesis

- How do interpreters talk about their work in the medical setting?

Topic Areas in draft effective practices document

1. Health care systems
2. Culture and diversity
3. Self-care and boundaries
4. Preparation
5. Ethical and professional decision-making
6. Language and interpreting
7. Technology
8. Research
9. Legislation
10. Leadership
11. Advocacy
12. Professional development and continuing education

11. Advocacy (DRAFT)

- In the healthcare settings, “advocacy” is an action taken by a healthcare interpreter intended to further the interests of, or rectify a problem encountered by one of the parties to the interpreting session, usually the patient (California. Standards for Healthcare Interpreters, 2004.)

- When the patient’s health, well-being or dignity is at risk, an interpreter may be justified in acting as an advocate (NCIHC, 2005)
A Perspective from spoken language medical interpreting on involvement and visibility

  - Message converter
  - Message clarifier
  - Cultural clarifier
  - Patient advocate

- Bridging the Gap: incremental intervention
- Transparency
- Continuum of visibility

Based in research

- Interpreter as participant; interpreter visibility (Wadensjö, Metzger, Angelelli)

- Angelelli refutes the "myth of invisibility" by showing that medical interpreters are visible, interactive agents in interpreted communicative events.

- Empirical studies of community interpreting (Wadensjö 1992, 1998; Metzger 1999; Bolden 2000; Roy 2000) use discourse analysis to uncover what actually takes place in interpreter-mediated encounters between professionals and patients who do not speak the same language.

- Common theme: the interpreter as an interactive participant in cross-cultural communication rather than as a relayer of linguistic messages from one language to another.
Invisibility and Neutrality (Angelelli, Metzger)

- Simplicity and control (one reason for myths of neutrality and invisibility)
- The interpersonal role has been downplayed, giving the focus to the cognitive and linguistic dimension
- Need to able to analyze meaning and its co-construction; raising awareness of what “meaning” entails
- Affect, trust, respect are important and should be taken into account in assessing interactional ability (IPRI or other tools to measure interpersonal and social skills)

Medical interpreters perceived themselves as more visible than court or conference interpreters

- Interpreters construct, co-construct, repair and facilitate the talk.

What focus group participants talked about...

- Power (who has it; how to use it appropriately; empowerment: the power of language; giving power, limiting power)
- The role of the interpreter is VERY active.
- Continually making decisions (linguistic, cultural, situational, ethical, interpersonal, legal, system)
- Intimacy and personal nature of the medical setting
- Support / advocacy

Prescribed vs. actual role

- Discussion is important for educating interpreters
- Supports observation, mentoring, practica, internships
- Need standards of practice that accurately reflect the scope of our work
Across all groups

- Roles and boundaries are different in medical settings than in general interpreting settings.
- Providing info on how to get interpreting services; the need for qualified interpreters; describing role; deaf-related resources; communication access
- Deaf healthcare providers – some specific requests
- However, the definition of roles, boundaries, support and advocacy were not consistent across groups.

Other factors

- Health literacy
- Socioeconomic status
- Education level
- Knowledge of the system
- Support network
- Severity of illness
- Cultural differences
- Age
- Spoken language interpreters
- Experience working with interpreters
- Use of charts and models (perceived as "advocacy" by some)
- Medical to legal

Visibility (Angelelli)

<table>
<thead>
<tr>
<th>Visibility by text ownership</th>
<th>Strategies for doing text ownership</th>
<th>Impact of text ownership on medical/personal information</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
<td>Reorganizing the monolingual interface</td>
<td>Highly consequential</td>
</tr>
<tr>
<td></td>
<td>Raising cultural references</td>
<td>Inconsequential</td>
</tr>
<tr>
<td>Low</td>
<td>Expanding silent/summarizing power</td>
<td>Highly ritualized</td>
</tr>
<tr>
<td></td>
<td>Exploring venues</td>
<td>Inconsequential</td>
</tr>
<tr>
<td></td>
<td>Sitting up and down the register scale</td>
<td>Highly ritualized</td>
</tr>
<tr>
<td></td>
<td>Controlling the flow of traffic</td>
<td>Inconsequential</td>
</tr>
<tr>
<td></td>
<td>&quot;Opening/being/positioning of self&quot;</td>
<td>Highly ritualized</td>
</tr>
</tbody>
</table>

In pairs or groups (up to 4):

Maintaining confidentiality, discuss examples of situations where advocacy and/or support occurred or did not occur when it could have.

1. Describe the situation in terms of what the interpreter did or did not do, and your perspective on the result.
2. How are advocacy and support the same and/or different?
3. What boundaries, do you feel should be followed when interpreting in medical settings? How are these boundaries the same or different from other settings?
Focus group synthesis

- Competencies specific to medical
- Boundaries, role
- Decision-making
- Culture and diversity
- Dis and CDIs
- Charts
- Sight translation
- Conveying meaning

Other themes...

- Humble, comfortable, professional
- Leadership role when access to communication is at risk.
- Layers of decision-making

Examples – Medical Interpreting Education – Spoken Languages

- Portland Community College
- University of Minnesota
- U of Mass (online)
- The College of Charleston (post bac)
- Cambridge College
- Bridging the Gap
- University of Arizona

<table>
<thead>
<tr>
<th>Program</th>
<th>Duration</th>
<th>Credit Requirements</th>
<th>Exam</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland Community College</td>
<td>132 hours</td>
<td>Written, oral exit</td>
<td>Medical, dental</td>
<td>Recognition document</td>
</tr>
<tr>
<td>The College of Charleston</td>
<td>12 credits</td>
<td>Post-bac four 7-week express courses</td>
<td>Master's Certificate in Medical</td>
<td></td>
</tr>
<tr>
<td>Cambridge College</td>
<td>180 hours</td>
<td>3 semesters</td>
<td>Undergrad certificate</td>
<td></td>
</tr>
<tr>
<td>Cross Cultural Healthcare Program</td>
<td>40 hours</td>
<td>5 days</td>
<td>Non-credit</td>
<td></td>
</tr>
</tbody>
</table>
University of Arizona

- 6-day medical interpreter training institute
- Introductory lectures on CI, SI, sight translation
- Specialized terminology – vocabulary building in forensics pathology, regional dialects, A & P
- Major diseases introduced through practice dialogues with patients and caregivers
- Intensive interpreter skill development (using medical script)
- Nci.arizona.edu

Program Content Overview

<table>
<thead>
<tr>
<th>Location</th>
<th>Courses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portland</td>
<td>Clinical Interpretation; Med. Term.; Dental Term.; A &amp; P; Health care interpreting; MH-interpreting; Telephonic interpreting; Interpreting Skills; Practicum</td>
</tr>
<tr>
<td>Charleston</td>
<td>Fundamentals of Medical Interpreting: Sight Translation in HC; Languages and Cultures of HC; Context. Interpreting in HC</td>
</tr>
<tr>
<td>Cambridge</td>
<td>A &amp; P; Role of Interpreter; Cross-Cultural Communication; Interpreting 1 &amp; 2; Internship</td>
</tr>
<tr>
<td>Cross Cultural Health Care Program</td>
<td>Basic interpreting skills (role, ethics, interpreting, managing flow); HC system (how doctors think, medical procedures, anatomy); culture in interpreting: communication skills for advocacy; professional development</td>
</tr>
</tbody>
</table>

Online Medical Interpreting Education

- University of Massachusetts
- 8 classes: ethics; terminology (anatomy, pediatrics, dental, labor, internal, ortho, cardiology, AIDS, neurology); consecutive interpreting; sight translation
- Multilingual; all materials in English
- Open to interpreters, translators, bilingual healthcare workers, doctors, social workers and anyone interested in improving bilingual health care
- Non-degree, February - May

Patterns across programs

- Require bilingual fluency
- Medical terminology: A & P.
- Consecutive interpreting in HC
- Sight translation
- Ethics, role, boundaries, advocacy
- Cross-cultural communication
- Health care system
- Differences
  - MH, dental, domestic violence; HIV/AIDS; pediatrics; telephonic
  - Crisis for interpreters
  - Internship
Differences

- Exit and entrance requirements
- Depth of coursework
- Observation; practicum or internship
- Simultaneous interpreting
- Training vs. education
- Decision making
- Discourse analysis
- Ongoing professional development
- Role

Educating healthcare professionals

- One of the characteristics of medical knowledge is that it is immense and constantly changing.
- Health professionals must acquire and remember a tremendous number of details, making memory processes critical.
- Theories of learning that focus on memory (e.g., ACT, dual coding, levels of processing) are therefore especially relevant. Cognitive flexibility theory which emphasizes a case study approach involving context-dependent and realistic situations applies directly to medical education.

Educating medical interpreters

- Certain cognitive processes and skills are critical in medical practice, e.g., decision-making, reasoning, and problem-solving. Problem-solving, in particular, has been the basic pedagogy for many medical curricula (e.g., Barrows & Tamblyn, 1980; Elstein., Shukman & Sprafka,1978; Norman &Schmidt, 1992).
- The medical environment is very stressful. Health care workers are frequently required to make important value judgments, so research on attitudes is also relevant.
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(continued)

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Website and Resources

www.medicalinterpreting.org

Challenges

- Not enough available, qualified interpreters for regular and emergency work.
- No specific standards for medical interpreters.
- Hospitals and clinics often unaware of interpreter role, function and qualifications.
- Many patients require spoken language interpreters (Spanish, Hmong, Somali) and similarities and differences not clear to providers/hospitals.
Demand for medical interpreters is high, but insufficient education/training is available.

Little research available on sign language interpreting in the medical setting.

What will interpreting in Health Care look like in 10 years?

- More d/Deaf healthcare professionals?
- More d/Deaf people from other countries or with language needs other than ASL and English?
- More Certified Deaf Interpreters? (CDIs)
- More d/Deaf people with other disabilities?
- Increasing need to interpret for end-of-life/hospice care?
- Use of technology to provide interpreting services?

Access to communication in healthcare for Deaf people and language access for Deaf health care professionals

Multi-pronged approach
- Education of interpreters
- Education of patients
- Education of health care providers
- Systemic changes in the health care system (language rights/access)
- Including access for Deaf health care practitioners

Thanks for coming!

laswabey@stkate.edu

CATIE Center
The National Consortium of Interpreter Education Centers

The College of St. Catherine
Collaborative for the Advancement of Teaching, Interpreting, and Language Education