Handbook of Research on

Medical Interpreting

Izabel E.T. de V. Souza and Effrossyni (Effie) Fragkou

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Handbook of Research on Medical Interpreting

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This chapter describes situations of distress and the working climate of healthcare interpreters in Sweden. A questionnaire focused on distressful situations was administered to interpreters with experience in healthcare interpreting. The results indicated that distress in healthcare interpreting could be traced back to ethically and emotionally challenging interpreting situations and working conditions, and a lack of respect for the interpreters' work. An interview study using Grounded Theory showed that interpreters' main concern was the threat to professional and private integrity. Despite the fact that in general the interpreting profession in Sweden may seem professionalized, interpreters struggle with dilemmas connected to less professionalized activities. Our study was conducted in Sweden, but we argue that the results can be generalized to other countries. Although differently organized in different countries, health care interpreters experience similar dilemmas. Equal access to equitable care can be effectively hindered by language barriers.

Among the settings where there is a need for interpreting services, healthcare contexts require special attention, given the complex nature of medical practice, which consequently imposes different challenges to interpreters. In Brazil, the language barriers faced by patients who do not speak Portuguese are handled mostly by volunteers without any specific training. This article gives an overview of the current demands for interpreters in medical settings in the country and the need for analysis and actions aimed at the development of a professional field to ensure access to health services in the country for linguistic minorities by qualified interpreters. There is a need for public policies to recognize the demand and elaborate linguistic access tools. There is an urgent need to include this specialization among interpreting studies agendas, in the Brazilian context, to include interpreting for healthcare.

Section 2
Medical Interpreting Practice

This section describes different activities and issues related to the actual performance of the duties related to the provision of medical interpreting services.

While it is claimed that the role of medical interpreters is constantly changing, perhaps it is the understanding of their role that is evolving. The aim of this chapter is to provide an initial exploration of the contextualized issues and challenges related to interpreting therapeutic communication. The qualitative data analysis of nine specialist certified medical interpreters showcase some of the therapeutic factors that influenced

their approach and practice. In addition to the interlinguistic and intercultural communicative goals, interpreters utilized their interpersonal, communication, and mediation skills to meet several therapeutic objectives. Interpreters described mediating therapeutic interaction and intervention, playing a therapeutic mediation role in addition to well-known linguistic and cultural mediation roles. Interpreters described their preoccupation and engagement in the therapeutic process, suggesting specialist medical interpreters play an important role in the therapeutic process.

This descriptive study, which is based on a PhD research conducted at the University of Zurich and at the Zurich University of Applied Sciences, explores the activity of interpreters. At first sight, the interactions between patients and doctors seem to be fluently and smoothly interpreted. Yet, a closer look at the transcripts of the consultations reveals various conversational difficulties. A striking issue in this data set are the patients' complaints about pain and anxieties which do not always reach the doctors or the nurses, because the interpreters cut out affective parts in their renditions. In such cases, the patients' concerns may simply be lost which prevents doctors or nurses from responding on the emotional level. In other situations, however, the doctors or the nurses miss the opportunity to address the patients' feelings, even if the interpreters convey the patients' concerns to them.

Interpreters and mediators working in complex humanitarian settings are faced with new challenges, both linguistic and non-linguistic. As part of on-going research, this chapter reports on cultural differences in interpreting major variables in interpreter-mediated medical encounters in complex humanitarian scenarios. The author will address the importance of cultural issues in humanitarian interpreting, based on the assumption that differences in culture can be a serious barrier to effective humanitarian communication. The author focuses on the interpreters and cultural mediators working for the Italian NGO Emergency ONG Onlus, which provides medical assistance to migrant communities in Southern Italy at its Castel Volturno clinic. The aim is to highlight the importance of a shared culture between interpreters/mediators and their clients and adequately deal with existing cultural differences in order to enact a so-called "cultural compromise" between migrant patients and health professionals with the goal to facilitate prevention, health promotion and education, and treatment.

This chapter uses an exploratory study that examines the experiences of American Sign Language-English interpreters who provide all or a substantial part of their service in the healthcare context to discuss the notion of visibility. The visibility or invisibility of the interpreter is intertwined with discussion and research on role, conduct, and the tensions that exist between the framing of the interpreter as community

member and the framing of the interpreter as professional. The exploratory study analyzes nine in-depth interviews to reveal the complexity that exists in-between. The in-between spaces are times when the interpreter is not actively engaged in interpreting and times when she is faced with the choice to remain visible or not. In these moments in-between, the construct of the interpreter as a conduit collides with that of interpreter as community partner. The findings reveal a complex set of challenges that have significant impact on interpreters' responses and actions.

Section 3
Mental Health Interpreting

This section outlines some of the complexities of the mental health interpreting subspecialty.

This article discusses some of the key issues of mental health talk in general, both in attitude as well as in words, and dwells upon the difficulties this can pose for interpreters. Subsequently, ways to deal with these difficulties are given. The issue of empathic stress is touched upon. It is argued that, with general background knowledge of disorders and treatment methods and with support to deal with emotional situations, interpreting in mental healthcare will be a very rewarding type of work. Without such preparation and ongoing support, interpreters may not always be able to join into the therapeutic communication properly, which may harm the progress of the treatment and may also hamper their own feelings of well-being and job satisfaction.

Victims of violence and interpreters share one trait: they are susceptible to trauma-related sequelae. Direct victims may develop PTSD while interpreters may develop vicarious trauma. This chapter sets out the legal basis for language access in healthcare, noting the important quality dimension added by the ACA. It then reviews the statistics for various forms of violence and presents some of its enormous societal costs. It also highlights the similarity of some of the symptoms observed in persons suffering from vicarious trauma, PTSD and burnout, but notes the difference in the genesis of these three conditions. This is followed by an introduction to trauma-informed approaches in delivering victim services. Finally, it lays the basis for identifying VT symptoms, mentions two online instruments that might be useful in assessing the likelihood of vicarious trauma, and reviews types of self-care techniques for creating a personal self-care plan.

The necessity of engaging qualified interpreters to work in partnership with mental health clinicians when serving patients with a limited English proficiency (LEP) is gaining widespread support. Numerous

research studies have documented improved patient health and satisfaction outcomes in this regard. Psychiatric practice often involves complexities of thought, language, and communication that clinicians and interpreters must appreciate. One such topic is engaging LEP patients in the mental status examination (MSE). This chapter describes the nature of the MSE, challenges when interpreting for the MSE, strategies for handling such challenges, and approaches for effective collaboration between interpreters and mental health clinicians regarding the MSE and cross-linguistic mental health care more broadly. The current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena also are discussed.

This chapter aims to provide an interpretation of the role of the mental health interpreter, using the concept of "third space" taken from the field of cultural translation and the psychoanalytical concept of transference/counter-transference. Such interpretation provides a unique and novel analysis of the work of the mental health interpreter through the perspective of the "third space", thus enabling a broader view of the interpreter's role in the therapeutic session. The authors' insights are based on a reflective journal written by the first author while working as an interpreter during a parental training in a public mental health clinic in Israel. By reviewing the different roles, powerplays, and challenges in this third space, the authors will suggest some practical recommendation regarding the training and supervision of mental health interpreters, allowing them to serve as competent and ethical mediators between the patient and the therapist.

Section 4
Medical Interpreting Education

This section identifies some interesting new approaches to medical interpreting education, as specialized training gains traction worldwide.

Mode switching is a frequent practice in healthcare interpreting, but has received very little attention. This research aims to bridge the aforementioned gap by investigating the instances of mode switching in interpreter-mediated healthcare encounters and the implications of this practice (or lack thereof) in managing effectively the administration of patients' care. To achieve this aim, the investigator created an online survey intended for trained healthcare interpreters alone. Seventy-five responses were collected over a period of three months (May to July 2019) and analyzed using a mixed methods approach. The objective was to demonstrate how interpreters envisage mode switching from the perspective of the training they received, the applicability of switching in relation to the nature of assignments that call for such shift in modes, the differences in mode switching between spoken and sign language, the institutional or other constraints (such as time limitations, number of participants, power differential among interactants) that call for or hamper mode switching, etc. The collected answers reveal a discrepancy between training and practice as well as between prescriptive requirements and reality in the field of healthcare interpreting. The respondents' comments allow the investigator to make key training recommendations.

Foreword

"May you live in interesting times" is an English phrase that is often said to be a translation from Chinese. The basis of that original Chinese curse reflects the concept that fascinating periods of time were also filled with upheaval and turmoil, and significant changes. In similar ways, this edited volume highlights the ever-changing and very interesting times found in health care related interpreting. Dr. Izabel E.T. de V. Souza and Dr. Effrossyni (Effie) Fragkou have compiled fascinating and thought-provoking research from interpreter researchers exploring the specific specialization of medical interpreting, and the rich and varied experiences of educators and interpreters working in some twelve countries. While some countries have moved beyond a model of volunteer interpreters to specialized training approaches for interpreters that work in medical and/or mental health settings, there remain other countries that demonstrate what it means to "live in interesting times". The breadth of the research studies described helps the reader to understand interpreting in medical contexts as a specialized field of practice, albeit one that looks dramatically different from country to country. We are introduced to untrained, volunteer interpreters providing services in Portuguese, with a call to action for policy development in Brazil. This is contrasted to the US, where similar experiences have led to creating training pathways to work in medical environments, and efforts to develop standards and certification requirements for such interpreters. Once more, the international content of this volume allows the reader to acquire a robust appreciation for the four countries that offer medical interpreting as a specialized certification program, along with the implementation of strategies that have worked effectively in addressing challenges.

I also appreciate that this book brings together both scholars and practitioners who work with spoken language or signed language interpreters. Increasingly, we see a convergence of learning across our shared profession of interpreting, recognizing how much signed language and spoken language interpreters have in common, as well as how much we can learn from each other – from our collective body of literature, to our advances in practice, to our struggles to be viewed as a specialized sphere of practice. For example, learning about the Swedish experience of distress and the working climate for interpreters will resonate with readers from many countries, highlighting how important is it to have a comprehensive view of the dilemmas faced by others that do the same work as we do. As a researcher, I am pleased to see the variety of research methodologies used in these investigative studies. Each chapter offers a unique contribution to our understanding of how interpreters see their role, including in the current context of humanitarian interpreting for migrants, the ways in which others perceive our services, and how interpreter-mediated interactions can result in incomplete interpretations, impacting the emotional needs of consumers. Several authors address mental health interpreting, which extends the reach of the content covered, including crucial insights into the impact of working with trauma narratives on the interpreter.

This book offers the reader a glimpse into the range of practices found in countries as diverse as Brazil, Japan, Netherlands, China, Switzerland, UK, USA, Canada, Sweden, Greece, Norway, and Israel, including the ways in which some countries are approaching the education of interpreters working in medical and mental health interpreting.

This book is a rare gem, providing a comprehensive view of the specialization, addressing the evolution of the profession, the practice aspects, the specialization of medical and mental health interpreting, and finally, examining innovative methods of educating interpreters to work with health care discourse across a range of settings. We do live in an interesting world, in interesting times, and this volume uncovers those times in ways are that are relevant and extremely timely for researchers, educators and professional interpreters.

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Preface

As I write the preface, I wish to acknowledge Effrossyni (Effie) Fragkou, the co-editor of this publication. Without her this work would not have been possible. I would like to equally acknowledge the authors of this book. Without them this book would not have become a reality. The *Handbook of Research on Medical Interpreting* comprises an eclectic international collection of the latest research on medical on medical interpreting.

Interpreting in healthcare is not the same as medical/healthcare interpreting. What does this mean? If we succeed in our objective, you will understand this once you finish reading this book. This publication is not about non-professional interpreting. It is not about community interpreting. It is not about ethics or technology or any specific theme that affects all interpreting practice. The *Handbook of Research on Medical Interpreting* focuses on issues that are specific to medical interpreting, through the framework of conceptualizing this practice as highly specialized. So how did this endeavor come about?

It came about to fill a void in medical interpreting research. Several books previously published on medical interpreting have taken an introductory approach, aimed at the larger market of professional interpreters who wish to specialize in medical interpreting. Typically these books include at a minimum a general description of the history and practice, medical terminology glossaries, and descriptors of the specialty areas in medicine that may require different approaches in interpreting, such as mental health. There is nothing wrong with this approach. It is direly needed, as this is not a well-known specialization of interpreting within the general field of interpreting, and especially as compared to conference or sign language interpreting. These books meet a very valid and urgent need within the field to supply information about services that are newly in demand. However, they describe medical interpreting mostly as a type of interpretation, and not as a *bona fide* specialization. They are not able to address, in an in-depth manner, the healthcare context, culture and values at the core of medical interpreting.

The landscape continues to evolve. Academic publications have specialized, and monographs now relate to the role of the interpreter, technology and other themes, from a variety of disciplines. There is an accepted general understanding now that interpreting is a multidisciplinary field of research, whereas originally it was understood primarily as a linguistic field of research. This diversity of perspectives brings richness to the knowledge base, and it is no different in this book. *The Handbook of Research on Medical Interpreting* attempts to provide an authoritative research compilation to cover not one specific theme, but the most important aspects and conditions currently faced singularly in the medical interpreting sector. The contextualized and grounded research you will read about in this volume speaks to the unique characteristics of medical interpreting as a multi-disciplinary practice, and not of interpreting as a linguistic practice in a particular work setting. One of these important perspectives is the medical one. We, in the interpreting world, need to give more attention to the word *medical* in medical interpreting.

This explains our choice to include the work of few medical professionals in this volume. We also made a conscious effort to strike a balance between research in spoken language interpreting, and research into sign language interpreting. This allows us to provide a more holistic view of the challenges related to the specialization and because spoken language interpreters have much to learn from sign language interpreters and *vice-versa*.

Research in medical interpreting continues to mature as the very first specialized practitioner researchers have come to the scene, focusing on much more specific aspects of their work, such as *Intercultural Mediation in Healthcare* (Souza, 2016). It is our view that the degree of understanding of situated practice is directly correlated to specialized education and experience. While one does not have to be a medical interpreter to be an expert in medical interpreting, one's expertise in a subject is highly diminished when it comes merely from observation and post-formative study, versus one that includes formative study and practice. Another interesting and unique characteristic of medical interpreting is that it has the highest percentage of practitioners practicing as employees. This affects the specialization in some aspects of the practice, such as engagement with clients and tasks and responsibilities. A professional who practices in several contexts, such as interpreting at a conference one week, and undertaking legal or medical interpreting the next, is not necessarily specialized in medical interpreting, nor a specialist medical interpreter. That professional is, however, an interpreter who practices in a medical setting. Hence, this is the difference. In other words, sporadic practice in a specialized field does not make one a specialist. To become a specialist, in our view, one requires significant specialized formative education, testing, practice, and experience. In order to understand medical interpreting to its fullest, one needs to understand medical norms and values, as medical culture is the context behind this specialized practice. Interpreters can only assimilate and internalize medical culture through regular specialized practice. Therefore, practitioner researchers are key figures in the development of this collective knowledge, with a unique practitioner's stance in relation to the general multi-stakeholder knowledge base of the field (Cochran-Smith & Lytle, 1993). The practitioners' perspective creates an expanded view of knowledge about interpreting that includes their own experience as a valid foundation for knowledge production. Whereas the majority of research relates to observation or discourse analysis, more studies are being produced that expose specialized interpreters' perspectives as key to understanding their work. As professionals, they may want to explore, examine, and fulfill the real demands of their clients: providers, patients, and employers. In order to do this, they may need to utilize specific resources and strategies to support their own perspectives as specialists. We need to give them louder voice. Therefore, we also made a conscious effort to not only include a variety of multi-disciplinary perspectives, but also to give voice to practitioner researchers.

This book wishes to cement the perspective that medical interpreting is a specialization and not a form or type of interpreting in a particular setting. The greatest benefit of researching each specialization without the interference of other specializations is the purity of the research findings. Just as conference interpreting codes of ethics and practice standards cannot be taken literally to equally serve other specializations, one cannot generalize the findings of community interpreting to be valid across all community interpreting's various specializations (medical, legal, educational, etc.). Why do we say that this is not about community interpreting? Isn't medical interpreting part of community interpreting? Let us explain. Some of the research about medical interpreting is actually research in community interpreting and is accepted by some as equal. Generalizations are made since community interpreting agglutinates different specializations. Medical interpreting is part of community interpreting, but it is not the same as community interpreting. Whereas community interpreting does include the medical interpreting

specialization, most researchers are now appreciating the importance and increased validity of situated research that incorporates the contextual therapeutic goals that are now understood to be intrinsic, and not peripheral, to the work of interpreters. The researchers in this publication have avoided conceptualizing medical interpreting as community interpreting. As you read through these upcoming chapters, it is vital that you keep an open mind and that you realize that the findings of the various studies apply solely to medical interpreting, and not necessarily to all specializations within community interpreting. Our hope is that you will appreciate the differences, and the uniqueness of medical interpreting.

Moving from community interpreting to medical interpreting hasn't been a smooth ride. Mikkelson (2009) was key in amplifying the study of interpreting and the first to expose some of the problematic issues of categorization. Obviously certain key aspects of interpreting are present in every single interpreting practice, as Mikkelson's expounded in *Interpreting is interpreting – Or is it?* Some researchers rejected the idea of categorizing interpreters into different types of interpreting. The term community interpreting was even criticized early on by Gentile, who stated that not only this label created confusion among potential users of interpreting services, but they also cause strife among practitioners (Gentile, Ozolins, Vasilakakos, 1996). Others also rejected the traditional categories, promoting the idea of studying interpreting through comparisons of different characteristics, such as proximity *vs*. distance, non-involvement *vs*. involvement, formality *vs*. informality, etc. As in any profession, there are some that reject or do not agree that specialization is beneficial to the profession. However, it is our firm belief that these are not categories, and that specialization is a natural and inevitable progression to many professions, especially one as far reaching as interpreting, which is practiced in practically all contexts worldwide.

It is true also true that in most countries there are very few opportunities for education, testing, or employment. Sometimes interpreters working in one area may not know of where the opportunities lie in another. Lack of awareness does not mean lack of existence. Most translator and interpreting associations are focused on the mainstream commercial translation and conference interpreting markets, and often its members are not even aware of the specialized medical interpreting sectors emerging in their backyards. We challenge you to look around to see what is happening in medical interpreting in your area. This is why organizations such as the International Medical Interpreters Association (IMIA) emerged in the early1980s. The organization has a plethora of information available at www.imiaweb.org. The IMIA Standards of Practice, first published in 1996, and later revised in 2007, stands true to many practice related tasks that are now being more accepted as part of the scope of medical interpreting (IMIA, 2007). However, we cannot have unrealistic expectations of opportunities in every city, province, county, and language combination. As any specialized field, the more specialized, the harder it will be to find resources to education and lifelong learning. However, virtual technology has considerably broadened the reach of education, testing, and employment, to make it virtually global. Language neutral education has also become an innovative solution to address the demand for minority language practitioners.

In the United States, sign language interpreting was formalized in 1964 with the establishment of Registry of Interpreters for the Deaf (RID). From inception these interpreters worked in all settings where deaf and hard of hearing individuals sought service. Therefore, whereas medical interpreting has existed as early as in the 1960s, medical interpreting wasn't formalized as a specialized field in the United States until the 1980s. Therefore, in some areas, medical interpreting has evolved into a specialization in its own right, with all or most of the components and requirements of a specialization. The systems and structures that support professionalization efforts include client awareness, policies, laws, formal education, employment, testing, certification, and licensing. Another important requirement that has been partially fulfilled is a strong research community to study and explore the ideas and concepts

that are specific to the sector of healthcare. Medical interpreting is the fastest growing specialization of interpreting. It also comprises of the largest job market in interpreting, so it is finally getting the attention and recognition it deserves from all stakeholders. Some readers will certainly refute this idea, but one only needs to think of the ubiquitous nature of seeking medical attention in every corner of the world. The job market is based on demand and will continue to increase, not only in countries with larger immigrant populations, but also in countries with multiple official languages, with indigenous languages, or with a medical tourism sector. Refugee migration is also increasing exponentially. Because of these factors, medical interpreting is certain to develop rapidly and with supply of highly trained interpreters significantly lagging behind demand.

The trend of specialization is inevitable in all professions. Specialization is affecting interpreting education as well. Initially, medical interpreting was typically taught in short workshops, evolving into intensive occupational courses lasting 40-120 hours. These courses were mostly provided by the private sector, due to the lack of traditional interpreting academic programs' awareness or engagement. More recently, we see general or conference interpreting academic programs incorporating medical interpreting courses into their curricula thus expanding the former into multi-course certificate programs. The first MS Degree in Health Care Interpretation, at the Rochester Institute of Technology (2019) in the United States has taken medical interpreting education to the next level. In short, despite the vast diversity of the educational spectrum still existent, specialization in interpreting education is a trend that will surely continue.

As previously stated, we wish to showcase that professional medical interpreting is much more complex than interpreting in a medical setting. Healthcare is more than a setting with different players. Consider this research question: Is medical interpreting a component of the therapeutic process or not? This is an important research question that cannot be answered in one study, but this is where the research on medical interpreting is headed. It is an important question, as it may explain and justify behaviors, attitudes, tasks or responsibilities that have been historically viewed as 'outside' the parameters of the work medical interpreters perform. The most significant contribution researchers have made to the field is that they have already observed, documented, and analyzed hundreds of thousands of hours of the behaviors, attitudes, tasks, and responsibilities undertaken by medical interpreters. Studies have shown the complex nature and practice of medical interpreting as a high level specialization with its unique attributes and stakeholder goals. It is the specialization of interpreting with more research published by healthcare providers in medical journals and other disciplines than by language-related professionals. It is time all stakeholders pay greater attention to this research and to what has been observed, and accept these practices, behaviors, attitudes, tasks, and responsibilities as the way medical interpreting is practiced, whether one agrees with it or not. Of course there will be variances of approach. However, instead of promoting a prescriptive view of the field, more adequate to paraprofessional or technical work, we may derive greater benefit from a broader conceptualization of interpreting as a multi-disciplinary professional practice, with acceptable variations of approach. In short, it is time to let go of the conduit model.

The international component of this research is important. Since there is so much variation on the development of medical interpreting practice from country to country, it was important for the editors to recruit authors from different countries to make this is a truly international one. These authors have contributed gems of theoretical frameworks by providing innovative perspectives. Medical interpreting has come of age because one can say that it is absolutely needed in every country, and has at least started to develop in most parts of the world. As one reads the different chapters, one will see that the practice of medical interpreting has expanded and evolved to a much greater extent than originally believed. This

publication also became a truly collaborative international research project, as the authors worked together, peer editing each other's work to produce a superior publication. By working collaboratively, researchers can answer questions never addressed before, including those with substantial influence on society.

We do need to recognize that medical interpreting is not equally developed in all countries. This does not mean that its safe practice does not require highly specialized professionals. There is a sad reality that non-professionals are filling the emerging demand in several parts of the world, putting patients at great risk. Of course, non-professional interpreting occurs in all markets, including the conference interpreting market. It is rather hard to forget the fake sign language interpreter who interpreted for Barak Obama, in South Africa in 2013. (Truthteller, 2003). If it can happen in a conference interpreting assignment for the president of one of the most powerful countries in the world, it can happen anywhere and for anyone. This phenomenon has plagued the entire interpreting field. If there is an emerging job market that is making medical interpreting the most demanded specialization of interpreting, why is the supply of this specialization being filled by non-professionals? There are several reasons: First, lack of public awareness and understanding of the concepts of bilingualism, interpreting, and the consequences of miscommunication in high stake interactions. Second, established professional associations are much more knowledgeable, engaged, and focused on the established job market of translation and conference interpreting, and have historically neglected these less lucrative specialized fields. Third, even when there is awareness of the importance of medical interpreting by our colleagues in conference interpreting, conference interpreters have avoided the medical interpreting market due to a pervasive idea that it is not a professionalized sector. Low compensation in the mainly non-profit health sector has also deterred the adhesion of the most qualified professionals and resulted in higher than average turnover. Last, hospitals, have historically seen and filled this ubiquitous demand with amateurs, as they are less than eager to pay well or pay at all for this 'ancillary' service. It is not surprising that the trend of specialization comes with challenges, obstacles, and, often, much resistance.

A word about the two primary labels of this specialization: healthcare interpreting and medical interpreting. Medical interpreting is the original term used by the profession's founding organization, the International Medical Interpreters Association, formed in the early 1980s, incorporated in 1986, and internationalized in 2006. To honor this legacy, this book chose to reflect this nomenclature on its title. However, this selection is done with no prejudice to the other term. Medical interpreting continues to be the term used in many countries, and choice is often a linguistic one. This argument includes the notion that, linguistically, anything that relates to medicine is simply medical and that medical is the only appropriate adjective for all that is related to medicine. Whereas the term medical generally has more credibility and branding cache than, healthcare, and is better understood by medical professionals, some avoid the term specifically not to encroach or offend the medical professions' turf. Although it is true that medical interpreting is not a medical profession, others are now considering the specialized medical interpreter as a legitimate healthcare professional, in terms of being part of the healthcare team that treats the patient. This is the advantage of the broader term healthcare. Healthcare interpreting has been an alternative term since the 90s and is gaining ground. Some stakeholders, especially researchers and educators, feel that the term healthcare is actually a broader concept than the term medical. Since interpreters interpret for healthcare administration, health insurance, billing or other quasi-medical scenarios, such as conflict zones or refugee camps, some believe that the term healthcare interpreter is more appropriate as it is more inclusive. Others have stated that healthcare interpreting simply came to be as an alternative form of interpreting in healthcare as it would be odd to say interpreting in medicine. Others have stated that it simply followed the medical sector's rebranding to healthcare. Interpretations are

as numerous as the individuals who voice their opinions, but the future may select one label, as having two names or brands for the same specialization is not something that adds credibility or cohesiveness to the specialization.

In conclusion, in this Handbook, we invite you to perceive medical interpreting as a multi-disciplinary, interactive and communicative practice. For example, the nature of therapeutic communication makes interpreting more complex than simply the strict interpretation of a set of questions and answers between two languages. The oversimplification of medical interpreting as the black box with a medical terminology toolkit has plagued the field for decades. Thankfully, this view is changing gradually, albeit slowly. There is an increased recognition that professional medical interpreters are highly specialized practitioners partnering with healthcare providers and patients toward mutually understood therapeutic objectives. By navigating in this book, you will soon come to the conclusion that the healthcare-related values, roles, tasks and responsibilities of medical interpreters are intrinsic, and not peripheral, to the core practice of medical interpreting.

The general overview on medical interpreting is definitely due for an update, thus the impetus for this publication. The relationship between research, education, and policy has become deeper and more complex, as science is called to inform educators and decision makers on policies that will continually shift concepts, benchmarks, and frameworks to form new standards. We need to stop treating medical interpreting as inferior class or practice of interpreting. The conduit model has not only limited the work of the interpreter, but also the understanding of the practice, and is a remnant of the past. While it has persisted in the field, initially due to the strict view of an interpreter as an uninvolved linguist, all stakeholders need to take notice of the overwhelming majority of specialized research that points to a broader scope of practice. Under this scope, the medical interpreter is often viewed as an indispensable part of the healthcare team, an actual partner. Interpreting is a practice profession, and the linguistic component of interpreting meaning from one language to another is only the foundation of the house, the toolkit, and not the livable space of the house, that is, the practice. Again, interpreting skills are but the tools for the interpreter to practice with. The importance of the intricacies of the objectives of the communicative event, the inter-personal and intra-personal interactions to bring the parties closer in mutual communication and understanding is not peripheral to the profession. Instead, it is the core of the work performed by medical interpreters in a variety of medical specialties and types of encounters.

Policymakers, employers, healthcare professionals, educators, and stakeholders in the interpreting profession at large will benefit the most from this research, and should review carefully the recommendation sections of each chapter in order to promote new conceptualizations to enable medical interpreters to function more effectively to meet the ultimate objective of positive healthcare outcomes. Last, we hope that this book contributes in recognizing and advancing medical interpreting as a highly specialized field of interpreting, whether or not it is well known or developed in your country. Peers and the public who come in contact with professional medical interpreters will come to respect this specialized practice. We hope you agree that the *Handbook of Research on Medical Interpreting* is an important endeavor that confirms and cements the fact that medical interpreting is a specialization of interpreting that is no longer in its infancy and that has finally come of age. There is still much ground to cover, but this book marks the moment where medical interpreting wants to be an adult, be treated as one, and be ruled and guided by its own rules and principles, not by the generalized norms of the entire profession.

ORGANIZATION OF THE BOOK

The book is organized into eighteen chapters within four sections: profession, practice, mental health interpreting, and education. A brief description of each of the chapters follows:

Section 1: Medical Interpreting Profession

Chapter 1 traces the development of the medical interpreting profession in the United States as a case study, concluding with a description of the current situation of professional medical interpreting in the United States, in terms of training, certification and the labor market, and makes recommendations for further development.

Chapter 2 provides an overview, analysis, and comparison of four certification programs by which specialized medical interpreters can demonstrate minimum standards of performance, providing recommendations for any ongoing or future interpreter certification program and for interpreting stakeholders.

Chapter 3 describes situations of distress and the working climate of healthcare interpreters in Sweden. Despite the fact that, in general, the interpreting profession in Sweden may seem professionalized, interpreters struggle with dilemmas connected to less professionalized activities.

Chapter 4 gives an overview of the current demands for interpreters in various medical settings in Brazil and the need for analysis and actions aimed at the development of a professional field to ensure access to health services for linguistic minorities by qualified interpreters.

Section 2: Medical Interpreting Practice

Chapter 5 provides an initial exploration of the contextualized issues and challenges related to the role of interpreting therapeutic communication, describing the interpreters' preoccupation in the therapeutic goals, suggesting specialist medical interpreters have an active role in the therapeutic process.

Chapter 6 reviews and analyzes the patients' expressions of pain and emotion in authentic interpreted medical consultations and how these may get lost in the interpretation, even if the interpreters convey the patients' concerns to them, negatively affecting the therapeutic relationship.

Chapter 7 reports on cultural differences in interpreting major variables in interpreter-mediated medical encounters in complex humanitarian scenarios. The author addresses the importance of cultural issues in humanitarian interpreting, based on the assumption that differences in culture can be a serious barrier to effective humanitarian communication.

Chapter 8 analyzes nine in-depth interviews to reveal the complexity that exists in in-between spaces. The in-between spaces are times when the interpreter is not actively engaged in interpreting; times when she is faced with the choice to remain visible or not. In these in-between moments, the construct of interpreter as conduit collides with that of interpreter as community partner.

Section 3: Mental Health Interpreting

Chapter 9 discusses some of the key issues of mental health talk in general, both in attitude as in words, and dwells upon the difficulties this can pose for interpreters. The case is made that without sufficient preparation and ongoing support, interpreters may not always be able to join into the therapeutic com-

munication properly, which may harm the progress of the treatment and may also hamper their own feelings of well-being and job satisfaction.

Chapter 10 discusses interpreting for victims of violence and lays the basis for identifying vicarious trauma symptoms, mentions two online instruments that might be useful in assessing the likelihood of vicarious trauma, and reviews types of self-care techniques for creating an interpreter's personalized self-care plan.

Chapter 11 describes the nature of the Mental Status Examination (MSE), challenges when interpreting for the MSE, strategies for handling such challenges, and approaches for effective collaboration between interpreters and mental health clinicians regarding the MSE and cross-linguistic mental health care more broadly.

Chapter 12 aims to provide an interpretation of the role of the mental health interpreter, using the concept of "third space" taken from the field of cultural translation and the psychoanalytical concept of transference/counter-transference, providing a unique and novel analysis of the work of the mental health interpreter through the perspective of the "third space".

Section 4: Medical Interpreting Education

Chapter 13 investigates the instances of mode switching in interpreter-mediated healthcare encounters and the implications of this practice (or lack thereof) in managing effectively the administration of patients' care. The data reveal a discrepancy between training and practice as well as between prescriptive requirements and reality in the field of healthcare interpreting.

Chapter 14 examines closely a case study to summarize and share the teaching experience for training conference-level dual-role interpreters in the medical field. The research proposes the competence-oriented task-based learning approach and examines its effectiveness.

Chapter 15 explores student interpreters' learning of medical interpreting within a situated learning context that includes senior interpreters, senior healthcare practitioners, and deaf community members. Learning within this community of practice exposes students to a multimodal nature of sign-language interpreter-mediated interaction.

Chapter 16 provides an updated knowledge in the discussion of how to define sight translation, presenting a discussion of best practices in sight translation in a health care context, not only related to the process of sight translating, but also to challenges regarding the listener's accessibility to sight translated texts.

Chapter 17 demonstrates that the work expectations of healthcare interpreters do not align with delineations of the interpreter as a language conduit or with current educational programs. it recommends a more robust and situated pedagogical schema that includes ongoing and deliberate continuing education as an interim measure to mitigate tensions between student and practitioner, theory and practice.

Chapter 18 examines the impact of a Certificate in Healthcare nine-month non-credit program on the interpreters' views of their role, responsibilities, and decision latitude. The program offers continuing education for nationally certified interpreters who already have experience in the healthcare setting but may not yet have any specialized training in that area, changing the ethical discourse for healthcare specialists and potentially negating the use of the conduit model.

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Introduction

This book represents the fruit of labor of several authors who came together with the intent to share the findings of their latest work and to present their own view of medical interpreting. Their investigations are informed by the practices used or observed, the questions raised and the solutions put forth to an array of interpreting issues occurring in various parts of the world. The editors, who have been working on this project for well over a year, are confident they achieved their goal, namely to compile a collection of empirical studies translated into chapters which introduce theoretical frameworks necessary in conceptualizing today's field of medical interpreting. To achieve this they invited authors from all areas of the medical interpreting profession spectrum (academics, seasoned field interpreters, policy makers, healthcare practitioners) to partake tested or ground-breaking methodological approaches in examining issues related to medical interpreting, to demonstrate and evaluate the efficacy of practices, common or new, and to identify the rapidly evolving sites (geographical and institutional) where interpreter-mediated encounters occur. The editors aimed to spark a meaningful discussion on and an in-depth reflection of the changing role of the healthcare interpreter as a result of the complexity of tasks and relationships occurring during interpreter-mediated medical encounters.

The chapters in this Handbook are divided into four sections, each dealing with a different yet complementary aspect of medical interpreting. The first section focuses on the medical interpreting profession in various parts of the world. The authors in this section have multiple points of departure. Some focus on case studies that pertain to a given country, as in the case of Mikkelson, who discusses the evolution of the medical interpreting profession in the United States, one of the first countries to promote professionalization of this interpreting specialization. Tiselius and Hägglund also focus on a particular case, that of Sweden, and on the threat to an interpreter's professional status and perception of professionalism when faced with situations that question the said status both at the level of self-perception as well as from the point of view of how others perceive interpreters as professionals. Queiroz discusses the case of Brazil, an un-regulated environment where the lines between community and medical interpreting remain unclear whereas the linguistic needs in specialized interpreting services in the medical field—generated by the indigenous population or by migratory flows including medical tourists—are increasing exponentially. Finally, other authors, such as Souza provide a comparative analysis of certification programs as they are at the heart of the professionalization process.

This section of the Handbook echoes recent reflections on the medical interpreter's professional status. Not so long ago, Mizuno (2012) would claim that low remuneration of medical interpreters (including sign language interpreters) was one of the major obstacles to professionalization. Souza, in the Preface of this Handbook, addresses the issue of inadequate pay as one of the most commonly occurring problems healthcare interpreters have to face in almost all parts of the world. As a result, volunteers or people

forced by circumstances to assume the role of the 'linguistic mediator' (also known as *ad hoc* interpreter) are often used by healthcare providers and public health agencies who are unaware of or oblivious to the nefarious consequences (medical, legal and/or emotional) of such practices. Operating under increasing budgetary constraints, healthcare providers would rather rely on *ad hoc* interpreters than not have interpretation at all. While *ad hoc* interpreters are still a sad reality to reckon with even in countries where healthcare interpreting is one of the most regulated professions, professionalization of specialized medical interpreters is still confused with community interpreting and remains heavily influenced by paradigms inspired by conference interpreting. One only needs to review elements of several Codes of Ethics and Standards of Practice still in effect in the medical interpreting specialization to acknowledge the extent to which concepts such confidentiality, impartiality or fidelity are reminiscent of fundamental tenets of translation and conference interpreting theories but are not longer able to meet the needs or address the complexities of medical encounters where more than one languages and cultures meet. Needless to say that current research in translation and interpreting studies has questioned the validity of such concepts.

This is a rather anachronistic view of regulatory frameworks, especially if one is to understand professionalization as a process of legitimizing the importance of expert-provided services that impact society and are recognized by the latter as indispensable for promoting the well-being and the quality of life of citizens. As Cooper and Robson demonstrate in their research into the professionalization process of accountants, the place where regulation occurs plays an important role in the outcome of the regulatory process and the legitimacy of the rules and practices produced [by its experts (professionals)] (2006: 415). This is even more true in medical interpreting where regulatory restrictions emanate from professional associations and related organizations as well as from other 'sites' that exert control over medical interpreting practices. This is the case of hospitals and other healthcare settings where healthcare professionals' attitudes, behaviors, and perceptions of 'other' professions (namely medical interpreters) influence the latter's professional outcome. One solution would be to centrally standardize the sites where medical interpreting practices occur instead of simply regulating medical interpreting alone, thus creating a regulatory framework that results from mutual professional consensus, reflects reciprocal understanding of each other's scope and limitations of practice, and distributes consequences fairly.

The second section of our Handbook draws the readers' attention on the actual practice of medical interpreting by taking into consideration the medical interpreters' current performative duties, limitations, and challenges. The role of the interpreter as mediator is discussed in this section by allowing for necessary limitations to apply. Communicative mediation, for the interpreter as well as for his/her co-actors in the interpreter-mediated encounter, is primarily performed through language. It is through language that things such as information, empathy, ethics, pursue of equity and equality to care, compassion and understanding, health literacy and patient education can be achieved. It is, therefore, imperative that linguistic competence and interpreter-specific skills remain a priority for healthcare interpreters regardless of the extent and the form of the evolution of their role.

The complexity of the roles and responsibilities of a medical interpreter are also discussed in relation to prescriptive imperatives imposed by Codes of Ethics and Standards of Practice. This is where the reflection on professionalization meets the actual need for being and/or remaining professional beyond the accepted Standards of Practice, that is, the ones that would make one look professional only in name. Sadly enough, these two worlds do not always coincide, nor do they meet the world of patients, a reality in which interpreter-mediated communication needs to be patient-centered. This is made abundantly clear in Hofer's study, which focuses on how patients' expressions of pain and distress are muffled or attenuated during interpretation thus depriving medical professionals from the possibility of providing

emotional response to a situation of obvious distress. This results in the double disempowerment of the patient and the medical professional and runs counter to the actual purpose of the encounter, namely to provide appropriate care to the patient by ensuring the latter's well-being.

Such professional 'choices' may be attributed to long-prevailing educational practices in interpreting, that is, the interpreter's indoctrination to the principles of 'neutrality' and 'impartiality' as opposed to the alternative of the interpreter as 'mediator' or 'cultural broker'. As if this binary view of the interpreter was the only way to envisage the latter's complex role. If pain is expressed culturally, among other things, then conveying the shapes, forms, and degrees of pain into another language needs to be a cultural exercise as well as a linguistic one. The interpreter can no longer be perceived as the uninvolved conduit that does nothing more than echo words which form a series of sentences and supposedly convey meaning (Bot, 2003). The interpreter is not invisible to others or impervious to what is happening around him or her. A point in case is the infamous incident of the Donald Trump's Italian interpreter and her facial expression of confusion and befuddlement at President's Trump comment on Syria and the amount of sand in the Syrian desert. Savigni Ullmann's expression, an interpreter who broke protocol, resulted in many commentaries with respect to the level of professionalism demonstrated by the Italian conference interpreter. Despite being seasoned, Savigni was accused of failing to keep her composure, hence, to maintain invisibility as required by her role and position (i.e. station?) and as stated in the conference interpreters' Codes of Ethics and Conduct.

The invisibility of interpreters protects them from being held accountable for their misinterpretations or from being accused of interference, and helps them to achieve transparent communication. But it also has implications for their professional recognition, as they must act as hidden figures. Of course, they are not "truly" invisible: they are physically seen and heard, but their role is to remain in the background.

This was stated by an anonymous author, who claimed to have conducted research on the visibility/invisibility requirement of professions whose contribution is vital to the society but they are so because they have to remain hidden, with all the work being done behind the scenes. This article was published in The Commentator on October 22, 2019, and subsequently updated on October 25, 2019. By reading it, one reaches the inescapable conclusion that, for a critical mass of interpreting professionals as well as for the public opinion at large, the unmoved interpreter is the professional interpreter par excellence, the 'channel' that transmits the message to the audience without any alteration, intrusion, or opinion – including through facial expressions and emotions. (Idem)

How is it possible to break free from this antiquated notion of the interpreter as a conduit or channel when much of the groundwork of building a relationship of trust with the patient is done through communication that involves showing emotion and communicating the message of care? If empathy is a pre-requisite for medical professionals when establishing rapport with their patients in order to enhance proper diagnosis, speed up the treatment phase, and achieve positive health outcomes, it is hard to image how one would deprive interpreters of such means of emotionally and intellectually engaging with their clients, i.e. the patients. The interpreters' presence in the linguistically and culturally mediated medical encounter places them at a unique position, that of the co-constructors of the therapeutic plan (therapeutic communication) as successfully argued by Souza in her chapter. This is also what Shaffer might have had in mind when she decided to investigate the medical interpreters' visibility in what she calls the in-between spaces, in other words, the times during which interpreters are not actively engaging in the act of interpreting and have then to make a choice: remain visible or not.

Complex realities in the sites where cross-linguistic and cross-cultural communication occurs bring about a new division of labor in the field where interpreters would operate almost exclusively in the past. Rudvin and Tomassini (2008) describe an emerging hybrid professional category: the mediator. The mediator is a 'bridging figure' with a complex mandate to carry out, which ranges from avoidance of misunderstandings to anticipation of possible areas of conflict, to the creation of a commonly accepted cultural and cognitive basis for understanding, to reaching agreements when interpreting language in dialogue. Cultural mediators in medical interpreting sites no longer engage in medical interpreting alone. As stated by Radicioni in the enclosed chapter, their role encompasses social and health guidance to the migrant users applying for help.

The constant flow of migration multiplies the sites of human suffering and despair as migrants massively leave regions where war, suppression of freedom, torture and poverty prevail in search of safe havens and humane living conditions. Instances of suffering and war, which are hardly new in the history of the human race, are now viewed from the standpoint of the International Humanitarian Law and the International Refugee Law. This new perspective gives rise to what Delgado and Kherbrich (2018) label as 'humanitarian interpreting'. Humanitarian interpreters belong to a bigger field, the humanitarian field, and are entrusted with a specific mandate, namely bringing together beneficiaries (individuals whose life, body, emotional and mental integrity is compromised or at risk) and public authorities via the mediation of humanitarian organizations to which individual needing protection have recourse. Interpreters belonging to this new 'specialization' are required to have awareness of human suffering, to show empathy to vulnerable groups, and to understand the intricacies of negotiating power asymmetries.

One would argue that since time immemorial interpreters were at the frontline of conflicts and that negotiating asymmetries between individuals and institutions has always been a job requirement for conference and community interpreters alike, regardless of specialization (medical, legal, public service, etc.). For this reason, some interpreting theorists would disagree with yet another fragmentation of the interpreting field. The latter would have serious implications in the professionalization process of medical and legal interpreting, among other things, as differentiation in the sites of assignments may trigger uninformed perceptions of [the various statuses] (Hertog, 2015, pp. 230-231) of the interpreters in the broader medical and legal field. As if trials and medical procedures were held in humanitarian sites and not in hospitals, clinics or the courts.

The third section of the Handbook reflects the preoccupations of medical interpreters and mental health practitioners who engage in the administration of mental healthcare. Interpreting in various mental health settings is a growing subfield of medical interpreting that has attracted the attention of mental health practitioners and interpreters alike. This is a subfield where the presence of qualified medical interpreters during consultations, mental status exams, therapeutic sessions, etc. is indispensable and the therapeutic benefits for patients of limited proficiency of the language of the institution are well documented in the corresponding bibliography (Flores, 2005; Jacobs, Shepard, Suaya, Stone, 2004; Karliner, Jacobs, Chen, Mutha, 2007; Baker, Hayes, & Fortier, 1998). It is important to remind the readers of this handbook that mental health interpreting is a challenging subfield because many of the tenets and principles of best practices in interpreting do not apply in a typical or a-typical mental health encounter. One needs only to refer to the interpreters' introduction to their clients as a means of establishing trust as well as of laying basic rules of conduct and communication during an interpreter-mediated encounter. If the onus of introduction in a typical medical encounter falls within the interpreter, the role of the latter in a triadic mental health consultation is influenced by the requirements of the session as established by the mental health specialist and the therapeutic goals of each meeting. Mental health interpreters are

co-constructors of the therapist's plan par excellence and their role extends beyond the session itself, as the pre-session briefing and the post-session debriefing place the interpreter in the position of mediator and content 'exegetist' of the patient's narrative.

The authors in this section were concerned not only with the centrality of the interpreter's role but also with the impact of the session on the interpreter both as a professional and as a human being. The extent of human suffering cannot leave the interpreter impervious to the pain thus resulting in the risk of transference of trauma to the interpreter. The importance of self-care for the interpreters is vital to the latter's well-being and to the quality assurance of their work. To achieve this dual goal, interpreters need to be able to identify symptoms of trauma in them and to address them effectively as Feuerle suggests in her analysis. In the same vein, Bot's understanding of the interpreters' empathic stress is not only negative provided the last component of the concept, i.e. stress, is dealt appropriately through the interpreter's adequate preparation before each encounter and with the presence of an on-going system of emotional and intellectual support to ensure that optimal conditions are met in a less optimal working environment. As far as empathy is concerned, Bot considers it to be one of the elements that renders the work of mental health interpreters a rewarding one. In Fox and Pollard's chapter, the discussion on the mental status exam of a patient reveals the importance of the role and the complexity of the task especially in cases of dysfluency, which often occurs in mental health patients.

The interrelation of the sections of this Handbook is prominent in almost every chapter. However, some chapters meet the cross-sectional bridging label more than others. This is the case of Parenzo and Schuster's interpretation of the interpreter as a person who occupies a third space, as place where the interpreter, in his/her capacity as a mediator and an influential author of tension between ethics and justice is the 'host' of the talk show (the mental health consultation) that witnesses the testimony as it unfolds before their eyes, the truth as it is revealed. The host is entrusted with safeguarding the intimacy and the confidentiality of the exchange. The interpreter's work, as described by the authors, is in many respects humanitarian: it gives voice to the vulnerable; it re-establishes the balance of power; it corrects injustices while negotiating tensions. It is, however, above and foremost a medical interpreting job which is discussed from the standpoint of challenges and opportunities offered by the transference and counter-transference models of psychoanalysis. The authors caution against the interpreter's excessive empathy, possible contaminations as a result of transference and counter-transference, lack of linguistic, cultural and professional training as well as the absence of effective clinical supervision of the interpreter's work. Once again, the interpreters are not treated differently from any other specialist in the mental health setting. Instead they are considered co-constructors of the therapeutic narrative and co-signers of the therapeutic outcome.

The fourth and last section of this Handbook is dedicated to education. This is the most developed section in the book and its length testifies to the importance attributed to interpreters' education as an integral part of their professional development. This is one of the many reasons this Section needs to be read in parallel with Section 1. The variety of topics herein proves at which point academic reflection in medical interpreting has been preoccupied with developing all variety of modes used in the various interpreting sites in connection with the types of interpretation (spoken vs. sign language interpreting, general or conference interpreting) used at the medical level. It is rare that such an extensive investigation of the various modes of interpreting has been conducted in the area of medical interpreting, as suggested by Fragkou in this section, and compiled in a single publication. This is the reason why such an array of empirical research is welcome in the medical interpreting specialization. It is proof that a critical mass of ground-breaking research can support fundamental methodological approaches that, in turn, provide

solid theoretical foundation upon which practitioners as well as theorists can justify implementation of policies leading to the full professionalization of the medical interpreting specialization through the development of independent academic programs, specialized professional associations, and specialized certifications.

Despite the apparent discord between practice and education in the medical interpreting field, Sasso proposes to address the absence of real-life underpinning for interpreting in the specialized setting of healthcare by implementing educational frameworks of structured continuing education for interpreters as an interim solution to the requirement for centrally-thought-out educational solutions that will address the issue of symbiosis of academic training and real-life working conditions. In the same vein, Hughes and Stone deal with the multi-modality of sign language interpreter-mediated interaction by proposing a situated learning model whereby student interpreters team up with senior interpreters, senior healthcare practitioners and deaf community members to enhance learning by legitimizing what the authors call peripheral participation as an attempt to simulate authentic scenarios.

Guo, Yang, Zhang and Kuang explore an intra-organizational model of training dual-role interpreters in the medical field. The authors acknowledge the complexity of the medical interpreter's role and the need for meeting high practice requirements with training approaches that are at the level of the conference-interpreting training model. It becomes obvious that the conference interpreting paradigm prevails in the educational sector as well as in the field of professionalization. Interpreting schools of international reputation were established in the aftermath of the Second World War and have since then made considerable contributions in the area of conference interpreting pedagogy. The relevant bibliography and its approaches have influenced writings in other types and subtypes of interpreting as well as in their various specializations. It is, however, understood that medical interpreting requires the development of specific skills as in the case of sight interpreting discussed in Nilsen and Havnen chapter. It is our theoretical stance that one should not speak of sight translation but of sight interpreting, because, as Fragkou, Nilson and Havnen argue, sight interpreting moves from text to speech in a simultaneous way thus automatically activating a set of cognitive and performative skills that are specific to simultaneous interpreting. This explains why sight interpretation is one of the skills that precede and support the development of simultaneous interpreting competence in students. It is also a practice that extends beyond the actual triadic or multiadic communication encounter thus shifting powers of balances and realms of responsibilities from healthcare providers to medical interpreters (see Fragkou in her corresponding chapter).

If sight interpreting needs to be treated as a unique interpreting method, especially with respect to all semiotic resources that are to be utilized during the performative act of sight interpreting for patients, so is mode switching in medical interpreting. As suggested by Fragkou, mode switching is omnipresent in medical interpreting encounters, but it is often neglected, omitted or disregarded for reasons that may be attributed to lack of training of the interpreters is some modes (such as simultaneous), to institutional constraints. The analysis proposed herein challenges extensively some of the basic tenets that have permeated beliefs and practices in medical interpreting, such as the labelling of working languages as A, B, or C. The author argues that such classifications fall outside the realm of reality practice in medical interpreting thus steering educational practices and academic training of professional interpreters away from their actual needs. On the other hand, new research needs to account for the differences in concepts from one type of interpreting to the other (as in the case of language labelling in conference as opposed to language labelling in medical or legal interpreting) if pedagogy is to reflect actual profession

requirements in its subsequent specialist practice and to create, through research, a body of knowledge that tailors to the needs of each specialization.

As mentioned previously, this Handbook cannot be read linearly. An effective reading would require a cross-sectional, contrastive analysis of the chapters as research conclusions found in one chapter or section inform theoretical hypotheses and preliminary conclusions in another. The themes and methodological tools selected by the authors are suggestive of the coming to age not only of medical interpreting as a profession, but mainly of research on medical interpreting as a separate, identifiable, and epistemologically classifiable specialization within the interpreting studies discipline. Multidisciplinary in medical interpreting research enriches the investigatory tools while expanding theoretical considerations. At the same time, it is suggestive of the complex web of agents, practices, challenges, sites of performance, expectations and solutions to problems that cannot be accounted for, properly described, adequately analyzed, subsequently theorized and translated into best practices without the contribution of all the disciplines that represent the professional categories directly or indirectly involved in medical interpreting. Ultimately, we want to expand this cross-sectional, cross-disciplinary discussion and invite our readers to actively engage with the authors of this book to promote knowledge, to expand our evolving yet mutual understanding of medical interpreting, and to contribute to the latter's professional and academic emancipation.

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Section 1
The Medical Interpreting Profession

This section showcases the uneven development and status of medical interpreting as a professional activity and specialization in different parts of the world.

Chapter 1
Development of the Medical Interpreting Profession in the US: A Case Study

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ABSTRACT

This chapter traces the development of the medical interpreting profession in the United States as a case study. It begins with the conception of interpreters as volunteer helpers or dual-role medical professionals who happened to have some knowledge of languages other than English. Then it examines the emergence of training programs for medical interpreters, incipient efforts to impose standards by means of certification tests, the role of government in providing language access in health care, and the beginning of a labor market for paid medical interpreters. The chapter concludes with a description of the current situation of professional medical interpreting in the United States, in terms of training, certification and the labor market, and makes recommendations for further development.

INTRODUCTION

Although interpreting is an activity that dates back to prehistoric times, it did not become professionalized until the 20th century (Baigorri, 2015; Pöchhacker, 2004, p. 28). In particular, medical interpreting (also known as healthcare interpreting) arrived rather late on the scene, at first being viewed as a part of community or public service interpreting and then gradually emerging as a separate specialization in the 1980s (Pöchhacker, 2004, p. 15; Pöchhacker, 2011, p. 220; Roat & Crezee, 2015, pp. 238-239). Although in the 1970s Australia had been the first country to establish a service to provide interpreting (over the telephone) in a variety of community settings, including medical facilities, interpreters did not tend to specialize in a particular setting at that time. In the 1980s, a few hospitals in Canada and the United States began to provide interpreting for patients using paid interpreters. Similar efforts took hold

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in Europe, albeit sporadically (Roat & Crezee, 2015, p. 238). It should be mentioned that even though the interpreters were "professional" in the sense that they were paid employees rather than volunteers, they received little or no training and were hired based on self-reported bilingual proficiency.

During the following three decades, the number of job openings for paid interpreters and training programs for preparing them steadily increased (Tipton & Furmanek, 2016, p. 1). According to Tipton and Furmanek, "the countries with the highest influx have naturally become prominent players in the field of healthcare interpreting practice and research" (p. 116). They cite the United States in particular, with the United Kingdom and Spain being the European leaders in this regard. Outside of Europe and North America, they mention noteworthy developments in the United Arab Emirates, South Africa, Chile, and Mexico. It is significant that sign language interpreting, at least in the United States, became professionalized earlier than spoken language interpreting (Downing & Ruschke, 2012), though even among sign language interpreters, healthcare interpreting was not recognized as a separate domain until relatively recently (Swabey & Malcolm, 2012, p. ix). Despite this slow development, however, it can be said that now, in the second decade of the 21st century, medical interpreting is in the process of becoming a full-fledged profession in its own right, with national standards of practice, training programs at accredited colleges and universities, and certification exams as a prerequisite for employment in salaried positions—all typical characteristics of a profession, according to Abbott (1988), though these elements of professionalization are not as ubiquitous as one might desire (Pöchhacker, 2004, pp. 29-30).

This chapter is intended to trace the development of the medical interpreting profession in the United States as a case study to illustrate a general pattern that has emerged in many countries, at different times and at different rates. It will begin with an overview of the different conceptions of the role of the interpreter in healthcare settings. The importance of government participation, in the form of legislation and regulation, will be examined, along with the role of hospital accreditation bodies. The chapter will also illustrate how professional organizations have been key players in the professionalization of medical interpreting, mainly by establishing standards of practice and developing certification programs based on valid and reliable assessment tools. Efforts to train prospective interpreters to enter the field and to provide continuing education for working professionals will be explored, describing degree and certificate programs at different levels of education. After analyzing the current labor market for medical interpreters in the United States, the chapter will conclude with recommendations for the future. Thus, the overall objective of this chapter is to show how the profession of medical interpreting has evolved in one country so that lessons can be learned from successes and disappointments as other countries replicate its experience.

BACKGROUND

As noted above, in the early years of its development the medical interpreting profession was viewed as part of community or public service interpreting rather than a distinct field. The taxonomy of interpreting has changed over the years and has been approached from a variety of perspectives by different authors (e.g., see Pöchhacker, 2011). According to Ozolins (2014), interpreting can be classified by mode, by setting, or by professional status. Tipton and Furmanek (2016, p. 3) point out that "terminology continuously evolves as it is tried and tested, and moves in and out of different contexts." They note that the way a particular type of interpreting is classified depends on who is doing the defining: interpreters and interpreting researchers, institutions, or "others" (pp. 3-4). According to the table provided by Ozolins

(2014, p. 35), the term "health interpreting" is the category used by interpreters, interpreting scholars, and institutions. Terms such as "interlinguistic medical mediator" and "bilingual patient navigator" are used in specific locations (Tipton & Furmenek, 2016, p. 3), but the latter authors use "healthcare interpreting" and "medical interpreting" interchangeably, occasionally referring to subspecialties such as "mental health interpreting."

Definition of Medical Interpreting

In their overview of the profession, Roat and Crezee (2016) define healthcare interpreting/medical interpreting as follows:

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. (p. 237)

These authors distinguish between "dedicated interpreters," whose "sole function in a healthcare facility is to provide language services," and "dual-role interpreters," who mainly perform other jobs such as receptionist, nurse, or lab technician, as well as "bilingual providers," medical professionals who interact directly with patients in their own language (p. 237).

For the sake of consistency, in this chapter, "healthcare" will be spelled as one word when used as an adjective, and as two separate words when used as a noun (e.g., "healthcare interpreting" and "interpreting in health care"), though there is no such consistency in the literature or in general usage.

Literature on Medical Interpreting

The first research on medical interpreting was conducted by scholars specializing in medicine and public health, who began to write about the impact of interpreters on medical encounters as interlingual communication became increasingly common in the second half of the 20th century. According to Pöchhacker and Shlesinger (2007), one of the earliest works on medical interpreting was Bloom et al. (cited in Pöchhacker & Shlesinger, 2007, p. 2), who in 1966 published an analysis of interpreter roles in interviewing. In the area of mental health, in 1975 Price (cited in Pöchhacker & Shlesinger, 2007, p. 2) examined psychiatric interviews mediated by interpreters. Other studies of a similar nature followed in the 1970s and 1980s, before the first interpreting scholars began researching interpreted interactions in health care and other community settings. In particular, Cecilia Wadensjö broke ground by studying interactions between personnel in Swedish healthcare or childcare clinics and Russian-speaking patients or clients (Wadensjö, 1992). Her work led to considerable research by other scholars looking into interpreting in healthcare encounters, with an emphasis on discourse-based analysis and cross-cultural communication in healthcare settings (Pöchhacker & Shlesinger, 2007).

Since the focus of this chapter is the United States, the work of researchers in that country will be emphasized here, without intending any slight to the significant contributions of scholars in other countries. And as Souza (2016, p. xx) points out, "The United States leads the world in medical interpreting," since it has the most hospital-based interpreting departments and boasts robust standards of practice and

certification programs specifically targeted to healthcare interpreters. Prominent books and articles by academics based in the United States include Angelelli (2004); Angelelli and Jacobson (2009); Crump (2012); Dean and Pollard (2009); and Swabey and Nicodemus (2011). The first practical manuals specifically designed for medical interpreters (and not part of guides for community interpreters) were published in the United States (Araújo-Lane, Lane, Ready & Phillips, 2004; Bridging the Gap, 1994; Mikkelson, 1994). Though these training manuals were not published by university presses or academic publishers, they drew in part on empirical research in their approach to interpreting pedagogy. As colleges and universities, as well as private entities, began developing certificate programs to train medical interpreters, professional organizations also began adopting standards of practice. The Massachusetts Medical Interpreters Association (MMIA) published the first Medical Interpreting Standards of Practice in 1996 (Roat & Crezee, 2015, p. 239), and the California Healthcare Interpreting Association (CHIA) adopted similar standards in 2002 (Downing & Ruschke, 2012, p. 217). The National Council on Interpreting in Health Care (NCIHC), which emerged from an informal working group in the mid-1990s, published a number of standards and guidelines for interpreters and healthcare professionals, including a national code of ethics, standards for training programs, and national standards of practice (Downing & Ruschke, 2012).

PROFESSIONALIZATION OF MEDICAL INTERPRETING

The first medical interpreters were friends, family, or untrained bilingual personnel at medical facilities such as hospitals and clinics (Downing & Ruschke, 2012). Salaried positions and training did not become available in the United States until the late 1980s and early 1990s, and even then, coverage was only sporadic (Roat & Crezee, 2015). Professional associations such as the American Translators Association, founded in 1959 (American Translators Association, 2018) welcomed members who were medical translators and interpreters but did not specifically cater to their needs. Similarly, the National Association of the Deaf (NAD), established in 1880, though primarily an organization defending the civil rights of the deaf and hard of hearing, also represents interpreters as a key element in exercising such rights (NAD, 2019); and the Registry of Interpreters for the Deaf (RID), founded in 1964, focuses on interpreters exclusively, but neither organization has specialized divisions (RID, 2018a). The first professional association that sought to represent medical interpreters exclusively was the Massachusetts Medical Interpreters Association (MMIA), founded in 1986 (Roat & Crezee, 2015, p. 239). Another key organization representing professional interpreters was the California Healthcare Interpreting Association (CHIA), which was founded in 1996 (Downing & Ruschke, 2012).

As medical interpreting evolved, views of the interpreter's role changed too. According to Witter-Merithew (1999), community interpreters in general were initially viewed as helpers or "benevolent care-takers," since they were mostly friends and family who volunteered their services. When interpreters began to be paid for their work, they were told to act like machines or robots and refrain from showing any emotion or empathy. Souza (2016, p. 13) calls this the "conduit" role, a mere "channel for linguistic conversion" who simply converts words from one language to another without taking factors such as culture into consideration. Similarly, Downing and Ruschke (2012, p. 215) describe debates in the 1990s about the "neutral interpreter" (the conduit) versus the "active interpreter," who may intervene in the event of a cultural misunderstanding. According to the standards of practice developed by CHIA (2002, pp. 41, 48-49), the conduit or "message converter" role is indeed part of what medical interpreters do,

but it is the most basic function. As communication inevitably becomes more complex, interpreters become "message clarifiers" and possibly "cultural clarifiers," and in extreme situations they may become "patient advocates." This view is based on the "incremental intervention model," which establishes a "'pyramid' or 'ladder' of increasing interpreter involvement in the content of the conversation" (Avery, Roat et al., cited in CHIA, 2002, p. 49).

Professional Standards

Standard setting for medical interpreters developed in the context of the evolving views of the interpreter's role. In 1996, the MMIA developed the first standards of practice (Roat & Crezee, 2015, p. 239), and shortly thereafter the above-mentioned CHIA standards were published in 2002. These two documents served as the basis for the National Standards of Practice for Interpreters in Health Care, issued by the National Council on Interpreting in Health Care (NCIHC) in 2005. These successive normative instruments represented efforts to flesh out the models of the interpreter's role developed in the late 1990s and early 2000s. They included ethical principles as well as practical guidelines for responding to specific situations likely to arise in healthcare settings. The NCIHC standards of practice were a companion to the code of ethics the organization had developed in 2004, such that each standard is linked to a principle in the code of ethics (NCIHC, 2005, p. 2). In addition, the NCIHC has published a number of working papers, such as a guide to interpreter positioning and guidelines on sight translation and written translation in medical settings (Downing & Ruschke, 2012, p. 217), and has developed standards for training programs (NCIHC, 2011).

For sign language interpreters, the RID began publishing standard practice papers in 2007, including guidelines for interpreting in mental health (RID, 2007a) and healthcare settings (RID, 2007b). Other papers deal with issues of interest to medical interpreters, such as self-care, multiple roles, video remote interpreting and team interpreting (RID, 2018d). These brief but valuable papers offer many guidelines that apply to spoken-language interpreters as well.

In conjunction with standard-setting, professional associations promoted training programs to instill the values and impart the skills described in the standards, as well as performance testing as a means of determining who was qualified to serve as a medical interpreter. Downing and Ruschke (2012, p. 218) report that training offerings for medical interpreters originally consisted of "single short courses offered by community service and healthcare organizations (e.g., hospitals, language service agencies, and government-funded Area Health Education Centers)." Online training has become increasingly common, mostly introductory courses but also more in-depth offerings. Longer programs hosted by community colleges and universities have also emerged, but they are "only in relatively few scattered institutions across the country." A movement to develop certification exams also emerged, though early efforts failed to go beyond the piloting stage. While the professional associations were still just talking about certification, two states seized the initiative and developed exams for their own purposes. The Washington State Department of Social and Health Services began testing interpreters working for its agencies in 1995; and at around the same time California offered the first certification exam for medical-legal interpreters providing services for medical evaluations in workers' compensation cases, though that exam is no longer being given (Gonzalez, Vasquez and Mikkelson, 2012, p. 1198). Eventually, two national certification exams were developed, as will be detailed below.

THE ROLE OF GOVERNMENT

One of the characteristics of strong professions, according to theorists (e.g., Tseng, 1992), is support from government institutions in the form of regulations and enforcement. In the case of the United States, the federal government's greatest contribution to the development of the spoken-language medical interpreting profession has been through the Office for Civil Rights (OCR) of the Department of Health and Human Services, which published guidelines for organizations receiving federal funds regarding the prohibition of national origin discrimination set forth in Title VI of the 1964 Civil Rights Act; and the Office of Minority Health, which provided funding for research, pilot programs, organizational efforts and standard-setting (Roat & Crezee, 2015, p. 240). Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency," was issued on August 11, 2000, explicitly requiring all federal agencies to "work to ensure that recipients of federal financial assistance provide meaningful access to their LEP [Limited English Proficient] applicants and beneficiaries" (cited in Gonzalez et al., 2012, p. 9). Specifically, under this order all federal agencies were required to issue regulations and guidance to assist state and local agencies receiving federal funds—including public health departments and public hospitals—to provide language access to their constituencies, and every agency was to create a Language Access Plan to meet the needs of its LEP clients. The order also provided for sanctions against agencies that discriminated and strengthened the authority of the Department of Justice Civil Rights Division to investigate violations. In 2002, the Department of Justice published a document called *LEP Guidance,* which defined a federal financial assistance recipient as any public or private entity receiving federal government funding or federal funds through a third party (Gonzalez et al., 2012, pp. 247-249). In the United States, practically all medical facilities fall under this umbrella if they serve patients who receive Medicaid (health insurance for low-income persons) or Medicare (health insurance for the elderly).

In addition, the Americans with Disabilities Act (ADA) of 1990 guarantees the rights of deaf and hard-of-hearing individuals, among many others with disabilities, including their right to a sign language interpreter. Though many deaf people do not consider themselves "disabled," they nonetheless benefit from many of the provisions of this law. In the context of health care, it explicitly provides for hospitals and other medical settings, emphasizing the critical importance of communication in this realm (ADA, 2003).

Although "language access" does not necessarily mean providing professional interpreting services, there are guidelines that define who is competent to interpret. The Affordable Care Act of 2010 required in Section 1557 that healthcare facilities use "qualified" interpreters to provide language services, and it defined a qualified interpreter as "someone who abides by interpreter ethics, is able to speak English and one other language fluently, and understands the necessary vocabulary required to effectively interpret in a healthcare setting" (United Language Group, n.d., p. 4). Many government agencies have developed their own standards for determining whether someone is qualified to interpret or translate. For example, the Department of Veterans Affairs, which includes health care for military veterans, lists a number of factors that should be taken into consideration when assessing someone's abilities to interpret or translate:

- Demonstrated proficiency in communicating information accurately in both English and the other language.
- Identifying and employing the appropriate mode of interpreting (e.g., consecutive, simultaneous, or sight translation), translating, or communicating fluently in the target language.

- Knowledge in both languages of any specialized terms or concepts particular to the component's program or activity and of any particular vocabulary used by the LEP person.
- Understanding and following confidentiality, impartiality and ethical rules to the same extent as VA staff.
- Understanding and adhering to the role as interpreter, translator or multilingual individual. (U.S. Department of Veterans Affairs, n.d., p. 8).

At the state level, some states have been in the vanguard with respect to regulating the medical interpreting profession. As mentioned earlier, Washington State and California implemented certification programs for certain subsectors of the field. In Massachusetts, Chapter 66 of the Acts of 2000, the Emergency Room Interpreters Law (ERIL) requires that acute care hospitals "provide competent interpreter services at no cost to all non-English speaking patients who seek emergency care or treatment, 24 hours per day, seven days per week" (IMIA, 2010). In its 2003-2004 session, the California Legislature considered a bill that would prohibit healthcare facilities from using child interpreters, but it was held up by the Senate Appropriations Committee (Orellana, 2009, p. 152). The state did, however, pass a law requiring acute care hospitals to develop language access programs and post them on their websites in the appropriate languages, informing patients of their language rights and instructing them on how to obtain the services of an interpreter. The law also states that hospitals must inform their staff about procedures for providing interpreting services. It describes the characteristics of a qualified interpreter, but it also says that patients can opt to use a family member instead of the interpreter provided by the hospital (AB 389, Hospitals: Language assistance services, 2015). Many states specify the languages into which materials must be translated, based on the makeup of their own populations, but according to the United Language Group (n.d., p. 6), there are still major gaps in compliance with federal government provisions.

Moreover, the national body that accredits hospitals in the United States, the Joint Commission, includes language rights in its accreditation standards (Roat & Crezee, 2015, p. 240). Though it is not a government agency but an independent non-profit organization, the Joint Commission is a key player in healthcare standard-setting. As such, it can exert major influence on hospitals' language access efforts. Its standards include provisions for including a patient's communication needs in medical records by specifying the preferred language for discussing health care (Joint Commission, 2018a) and guidelines for practitioners who wish to communicate directly with their patients in a language other than English (Joint Commission, 2018b). On its website, the Joint Commission cites a study that concluded, "Language barriers appear to increase the risks to patient safety. It is important for patients with language barriers to have ready access to competent language services. Providers need to collect reliable language data at the patient point of entry and document the language services provided during the patient–provider encounter" (Devi, Koss, Schmaltz & Loeb, 2007, cited on Joint Commission website, 2010).

THE ROLE OF PROFESSIONAL ASSOCIATIONS

Professional associations representing medical interpreters have already been mentioned in connection with standard-setting and certification. In this section their contribution to the professionalization of medical interpreting will be examined more closely. It should be noted first that many professional bodies for translators and interpreters are broader in scope, but they have subdivisions targeted to the needs of

medical interpreters. A prime example is the American Translators Association (ATA), which started a Medical Division in 2002 to represent medical interpreters and translators, some of whom are clinicians as well. It publishes a newsletter called *Caduceus* and offers workshops at national and regional conferences on topics related to medical interpreting and translation (ATA Medical Division, 2018). In the sign language interpreting sector, the Registry of Interpreters for the Deaf (RID) has represented interpreters nationwide since its founding in 1964 (RID, 2018a), but does not have specialized divisions.

As stated earlier, in 1986 the MMIA (which would later change its name to the International Medical Interpreters Association, IMIA) became the first professional association of medical interpreters. Eventually it would form chapters in 19 states plus the District of Columbia (IMIA, 2018). The MMIA was followed by CHIA in 1996, while the Medical Interpreter Network of Georgia (MING) was established in 1999 with the mission to "Promote equal access to health care services for Limited English Proficient individuals by supporting professional medical interpretation, and by serving as a resource for medical interpreters and providers in Georgia" (MING, 2016). The Texas Association of Healthcare Interpreters and Translators (TAHIT) was founded in 2004. Notably, it produced a powerful public service video in 2010 that went viral and was seen multiple times throughout the United States (TAHITOnline, 2010). Other state-level professional associations include the Oregon Health Care Interpreters Association (OHCIA) and the Tennessee Association of Medical Interpreters and Translators (TAMIT). It is important to point out that the IMIA website lists some states that have both IMIA chapters and separate organizations representing medical interpreters, but it is not clear if all of them are active. Links provided on both the IMIA and the NCIHC websites include several which are dead, suggesting the short life of some professional associations in the fledgling field of medical interpreting.

A look at the websites of some of the more active professional associations reveals the wide variety of activities they engage in: announcing or providing links to news stories and events of interest to medical interpreters, publishing a newsletter, offering training workshops both for interpreters and for the medical professionals who work with them, as well as publicizing other training opportunities, making terminology resources available, and promoting issues such as cultural competency and ethics. A cursory review of just one association's website yields the following workshop topics on offer: "Whole-Hearted Interpreting for Half-a-Heart Babies," "Interpreting for Chemical Dependency Patients," "Basic Principles for Medical Interpreters," "Vicarious Trauma," and "Disaster Preparedness" (CHIA, n.d.a). Those are single sessions, some of which are online, above and beyond the association's annual conference, which features scores of speakers and topics. Thus, education is one of the primary benefits of belonging to a professional association. The events sponsored by the organizations are great opportunities for networking, and are often attended by medical professionals, representatives of colleges and universities that offer certificate programs, and publishers of educational materials. Some of these professional associations also engage in lobbying for language access and advocacy for national certification (TAHIT, 2018), though as volunteer organizations they have few resources to pursue such efforts.

A number of non-profit groups also support professional associations and provide some of the same resources on their own websites. For example, the National Council on Interpreting in Health Care (NCIHC) calls itself a "multidisciplinary organization whose mission is to promote and enhance language access in health care in the United States." It aims to set standards, develop and monitor policies and research, sponsor "a national dialogue of diverse voices and interests on related issues," and act as "a clearinghouse on programs and policies" (NCIHC, n.d.a). Its website features a wealth of resources, including position papers, links to important research, and FAQs, as well as information about its advocacy efforts. The NCIHC also provides webinars for interpreter trainers. Another non-profit organiza-

tion that has had a major influence on the medical interpreting profession is the Cross Cultural Health Care Program (CCHCP), which was founded in Seattle, Washington in 1992. It provides training (for interpreters, interpreter trainers, and healthcare facilities) and consulting on language access, including needs assessments. Its Bridging the Gap training, mentioned earlier in this chapter, has been a model for short courses everywhere and is still going strong. In addition, the CCHCP educates "patient guides" or "patient navigators," who help patients understand the healthcare system and communicate with their providers. These navigators may also help with financial, legal, and social support, and work with insurance companies, employers, case managers, or lawyers (National Cancer Institute, n.d.). The CCHCP sells an array of publications, ranging from language-specific glossaries in more than 24 languages to books on cross cultural health and health disparities, as well as curricular materials (CCHCP, n.d.). Another example of a non-profit community organization specializing in medical interpreting is MAMI, which was originally the Multicultural Association of Medical Interpreters of New York but now goes by its acronym exclusively. Its main focus is education, offering courses in medical interpreting and training for providers on working with interpreters, among other subjects, but it also serves as an interpreting agency.

TRAINING PROGRAMS

Another hallmark of strong professions identified by Tseng (1992) is a recognized body of knowledge that is passed on through university degree programs. Roberts (cited in Mikkelson, 1996, p. 86) also highlights training (of interpreters, of interpreter educators, and of medical professionals who work with interpreters) as key steps in the professionalization of the field. The IMIA maintains a searchable directory of training programs that currently numbers 27 (IMIA, 2019a). In addition, a division of the IMIA, the Commission for Medical Interpreter Education (CMIE), accredits training programs and lists 10 accredited programs on its website (IMIA, 2019b).

Degree Programs

Although there are myriad degree programs throughout the world specializing in spoken-language conference interpreting, few feature medical interpreting amongst their offerings. In the United States, as of this writing the Middlebury Institute of International Studies at Monterey (MIIS) offers a specialization in community interpreting to its Spanish translation and interpreting students as part of their M.A. studies, including three courses in medical interpreting (MIIS, 2018). Similarly, the University of Texas Rio Grande Valley (UTRGV) includes medical interpreting in its translation and interpreting undergraduate and graduate programs. Unusually, the M.A. program is fully online (UTRGV, 2018). Wake Forest University offers both an M.A. and a graduate certificate in Intercultural Services in Healthcare (Downing & Ruschke, 2012, p. 219; Wake Forest University, 2018a). For sign language interpreters, there are many degree programs in the field, but few offer specializations in medical interpreting (for a complete list of degree programs, see RID, 2018b). In addition, the Rochester Institute of Technology offers a full M.S. program in healthcare interpretation for sign language interpreters (Rochester Institute of Technology, n.d.). There is certainly a great need for more degree programs like these across the country.

Certificate Programs

Certificate programs in medical or healthcare interpreting are far more common (in fact, the UTRGV offers one as an alternative to receiving a degree). It is difficult to develop a definitive list of such programs because, like small professional associations, they tend to be short-lived (Downing & Ruschke, 2012, p. 218). As of this writing, the NCIHC website has live links to the Des Moines Area Community College, the Madison Technical Community College, the New York University Professional Certificate in Medical Interpreting, and the University of Massachusetts Amherst Medical Interpreting Program (NCIHC, n.d.b). The CHIA (n.d.b) website lists 18 universities or colleges just in California that offer courses or certificates in medical interpreting. It also provides a link to the University of Arizona Summer Medical Interpreter Training Institute, a 2-week course. In addition, the University of Minnesota has a certificate program in interpreting with a health interpreting track (Downing & Ruschke, 2012; University of Minnesota, 2018).

Short Courses

As stated above, the larger, more active professional associations feature stand-alone workshops on specific topics and a wide variety of educational sessions at their annual conferences. The target audience for these courses is primarily working interpreters wishing to fulfill the continuing education requirement to maintain their certification (see the section on certification below). In addition to professional organizations, colleges, and universities, private programs have emerged as an important source of training. Prominent among them is the above-mentioned Bridging the Gap, a 40-hour language-neutral course developed in the 1990s by the Cross Cultural Health Care Program and now offered by authorized trainers throughout the country (Downing & Ruschke, 2012, p. 218). The CHIA (n.d.b) website lists 13 other private entities that offer short courses in medical interpreting in California. Many of these are online programs that can be taken from anywhere in the country. The 40-hour standard set by *Bridging the Gap* has been adopted widely, but it seems to be an arbitrary number, as there is no empirical evidence that this length of training is the ideal one.

Another source of training is internships in large hospitals and medical centers, usually associated with medical schools. A prime example is the Stanford Health Care hospital complex, which allows qualified interpreting students at the Middlebury Institute (MIIS) to participate in a summer internship where they shadow professional interpreters, receive instruction, and engage in supervised practice. Mt. Sinai St. Luke Hospital in New York City offers a similar internship (Heh, 2016).

Other Training

In addition to the education of interpreters themselves, an essential feature of the training landscape is both courses to train trainers and those aimed at medical professionals who work with interpreters, helping them learn to form an effective team. Downing and Ruschke (2012, pp. 220-221) discuss the early development of both types of programs, mentioning a couple of university-level efforts that no longer exist today, in addition to Wake Forest University's Postgraduate Certificate in the Teaching of Interpreting, which is still in place (Wake Forest University, 2018b). The authors sum up the situation regarding the training of medical professionals very clearly:

It is abundantly clear that training healthcare providers to work with interpreters and providing guidance for the effective organization of language services that employ interpreters are nearly as important as the proper preparation of interpreters. This aspect of the development of the field has primarily involved local or regional efforts in the form of very brief trainings for hospital staffs and others. Curricula for short trainings, ranging from 1 or 2 hours to a full day, have been developed by several organizations and been offered during staff meetings, grand rounds, and conferences (Downing & Ruschke, 2012, pp. 221-222).

Professional associations also play a key role in providing client education. For the interpreting profession in general, the ATA sponsors a robust client outreach program with training materials that members can use and a multilingual brochure for users of translation and interpreting services (ATA, 2019). The IMIA offers a number of resources for client education (IMIA, 2019c), as do numerous other regional associations. The Office of Minority Health of the U.S. Department of Health and Human Services does have a link to a website called "Think Cultural Health" (U.S. Department of Health and Human Services, n.d.) where information can be found about online cultural competency courses for populations such as healthcare administrators, emergency personnel, nurses, and physicians.

CERTIFICATION

Certification, or accreditation, is another important aspect of professionalization; indeed, Roberts (cited in Downing & Ruschke, p. 222) considers it to be the final step in attaining full status as a profession. These authors point out that "certification" is the term most commonly used in the United States, but credentialing has two parts: assessment of qualifications through performance testing, and a legal designation protecting the title of practitioners who have passed such tests (which they call "licensing"). Given that the profession cannot even decide between the terms healthcare interpreter and medical interpreter, it is hard to imagine that full legal protection of the title like that enjoyed by sworn translators in many countries will be attained anytime soon in the United States. Nevertheless, as Roat and Crezee (2015, p. 246) note, though few employers require any certification as a prerequisite for being hired as an interpreter, "being certified is certainly one way for interpreters to differentiate themselves from other candidates for interpreting jobs." Downing and Ruschke (2012, pp. 222-223) report that there is a consensus that there should be some sort of national certification for the specialty of healthcare interpreting, but they then describe the difficulty of agreeing on a single national program.

It should be noted that American Sign Language interpreters have long had certification programs, originally through the National Association of the Deaf (NAD) as well as the Registry of Interpreters for the Deaf (RID). Those two organizations eventually merged and consolidated the various levels of certification offered (for more information, see RID, 2018c). At no time, however, has there been any specialized national certification for sign language interpreters in the medical field. Exceptionally, the state of Texas certifies sign language interpreters under its Department of Health and Human Services for interpreting in healthcare settings (Texas Health and Human Services, n.d.).

When stakeholders began discussing how a national certification program for spoken-language healthcare interpreters, might be developed, the NCIHC sounded a note of caution. Its website contains a statement of the organization's position in this regard:

- **Certification as a complex undertaking.** The NCIHC believes that the development of a national certification process goes beyond the creation of a test. We believe that certification is a complex process in any field but especially so in a field in which the content is steeped in difficult linguistic and cultural issues. While we wholeheartedly agree to the need for scientifically rigorous assessment methodologies, we still have much to learn about creating an equitable and fair process that will allow all competent interpreters, regardless of background, to be able to demonstrate the knowledge and skills they possess as interpreters, and that will not result in high numbers of good interpreters failing simply because of a certification tool's inability to adequately assess knowledge and skills across cultural and linguistic differences.
- **Inclusiveness and consensus building.** The NCIHC believes that any effort to develop national standards or assessment must be a collaborative, consensus-driven process in which all stakeholders have the opportunity to participate. In order to address the complexities of certification in a respectful manner and to ensure the transparency of the development process, we will need to find a variety of ways to include the voices of as many stakeholders as possible, especially those who do not have the opportunity to participate in large national meetings.
- **Neutral leadership.** The emerging health care interpreting field incorporates many stakeholders: patients, interpreters, health care institutions, advocates, interpreter associations, language companies, non-profits and for-profits. It is imperative that the national dialogue be led by a neutral party whose primary interest is the well-being of those in need of interpreting services. Each entity involved must make known the nature of its interest in certification, including potential conflicts of interest and/or benefits that it may accrue as a result of the work. In order for a national certification process to be credible, care must be taken to avoid even the appearance that any vested interest has unduly influenced the development process. (NCIHC, n.d.c, emphasis in original)

Two Certification Programs for Healthcare Interpreters

Despite the reservations expressed by the NCIHC, two different entities proceeded to develop separate certification exams for entry-level interpreters: the Certification Commission for Healthcare Interpreters (CCHI) and the National Board of Certification for Medical Interpreters (NBCMI). Both the CCHI and the NBCMI began testing interpreters in Spanish only (Downing & Ruschke, 2012, p. 223), since that language is by far the most in demand throughout the United States. This was also the case with the national certification program for court interpreters, the Federal Court Interpreter Certification Exam, which began in 1979; but aside from brief periods when certification was also offered for Haitian-Creole and Navajo, Spanish continues to be the only language for which the exam is available (for a detailed history of national and state court interpreter certification in the United States, see Gonzalez et al., 2012). Beyond Spanish, no single foreign or indigenous language is spoken by a large enough population to justify the expense of designing linguistically and culturally appropriate exams for each of the 149 languages spoken in the United States (Downing & Ruschke, 2012, p. 223). Fortunately, the two medical interpreter certification bodies have been able to develop exams in additional languages. The CMI Credential, which is what the NBCMI calls its certification, is available in Cantonese, Korean, Mandarin, Russian, and Vietnamese (NBCMI, 2016a). The CCHI does not list the languages for which it has exams on its home page, but with some hunting it is possible to find out that there are tests in Arabic, Mandarin, and Spanish, for which successful candidates earn the Certified Healthcare Interpreter (CHI)

credential (CCHI, 2018a). For all other languages, there is an English-only credential called the Core Certification Healthcare Interpreter (CoreCHI), based on a written examination.

Screening of Candidates

There are eligibility requirements for both testing entities' exams. The prerequisites for taking the CMI exam are a minimum age of 18, at least a high school education, and 40 hours of training in an approved course in medical interpreting. In addition, proof of oral proficiency in English and the other language must be provided, in the form of standardized test results or diplomas (NBCMI, 2018, pp. 5-6). Interestingly, the prerequisites for the CCHI exams are identical to these (CCHI, 2018b, p. 14). Each of the organizations also uses an English-only written exam as a screening device, though the CoreCHI credential is awarded based on the written exam alone. The candidate handbook published by the NBCMI provides no information about the minimum score required on the written exam in order to qualify for the oral exam. The CCHI handbook states that a passing score on the written exam is 450 or higher, but it is difficult to correlate that figure with the fact that the exam has 100 multiple-choice questions (CCHI, 2018b, p. 34). The NBCMI written exam consists of 51 questions on 1) roles of the medical interpreter, 2) medical interpreter ethics, 3) cultural competence, 4) medical terminology "in working languages" (presumably, this section is available in the four tested languages), 5) medical specialties in working languages, 6) interpreter standards of practice, and 7) legislation and regulations (NBCMI, 2018, pp. 10-11). The CCHI's CoreCHI exam has 100 multiple-choice questions on these subjects: 1) professional responsibility and interpreter ethics, 2) managing the interpreted encounter, 3) healthcare terminology, 4) U.S. healthcare system, and 5) cultural responsiveness (CCHI, 2018b, p. 9. Both entities administer the exams at computer testing centers, and candidates receive the results immediately.

Oral Exams

One can deduce from various materials available on the website that the NBCMI oral exam consists of role-play scenarios, but no detailed information is provided about how they are administered. According to the candidate handbook, the exam is evaluated according to the following criteria, weighted variously according to their relevance to medical interpreting proficiency: 1) mastery of linguistic knowledge of English, 2) mastery of linguistic knowledge of the other language, 3) interpreting knowledge and skills, 4) cultural competence, 5) medical terminology in working languages, and 6) medical specialties in working languages (NBCMI, 2018, p. 12). The CCHI oral examination for the CHI credential consists of four consecutive interpreting vignettes, two simultaneous interpreting vignettes, three sight translation passages, and a multiple-choice question designed to test translation skills. It is 60 minutes long and includes the following tasks: 1) interpret consecutively, 2) interpret simultaneously, 3) sight translate, 4) translate, and 5) maintain fidelity to the message (this last element is measured in all of the preceding four tasks) (CCHI, 2018b, p. 10). Again, both testing entities administer their oral exams by computer at nationwide testing centers. Both the CMI and the CHI/CoreCHI certifications require credentialed interpreters to fulfill continuing education requirements in order to maintain their status.

Certified Interpreters

A search of the directory of interpreters on the NBCMI website reveals a total of 2,304 certified interpreters, though there could be more who have not maintained their registration. As is to be expected, the number of Spanish interpreters listed there far exceeds that of the other five languages (NBCMI, 2016b). All interpreters bearing the NBCMI credential must "recertify" every five years by paying a fee and showing proof of 30 hours of continuing education (NBCMI, 2016c). As for the CCHI, its annual report for 2017 boasts "over 3,370 nationally certified healthcare interpreters by the end of 2017: 2,643 CHI™-Spanish, 736 CoreCHI™, 127 CHI™-Mandarin, and 73 CHI™-Arabic certificants" (CCHI, 2018c). Similar to the NBCMI, CCHI requires its credentialed interpreters to renew their certification every four years and show proof of continuing education. Thus, it is clear that the two credentialing bodies are almost the same in terms of the exams they offer, their prerequisites and renewal requirements, and the number of interpreters who have gone through the certification process. Although a higher number of interpreters are certified by CCHI, the non-language-specific CoreCHI credential accounts for much of the difference. It is unknown whether a significant number of interpreters possess both types of certification. In any case, there is obviously a great deal of buy-in among practitioners and employers for the credentialing of medical interpreters. It is unfortunate that efforts are divided between two organizations. The field of healthcare interpreting is projected to grow at a rapid pace in the coming years (see the next section of this chapter), and it remains to be seen whether one of the certifying entities will prevail over the other, and whether support for credentialing will continue.

CURRENT LABOR MARKET AND WORKING CONDITIONS

In its candidate handbook, the NBCMI cites Bureau of Labor Statistics figures from 2014 indicating that approximately 7,000 interpreters and translators were employed in healthcare industries in this country, 5,100 in hospitals and nursing care facilities and 1,900 in ambulatory healthcare services. It also points out that many interpreters are self-employed, working on their own or through language service companies, and most of them work full time (NBCMI, 2018, p. 3). Thus, it is impossible to know how many medical interpreters are currently working in the United States, but the Bureau of Labor Statistics projects a 17.7% growth in employment for translators and interpreters in general between 2016 and 2026 (Bureau of Labor Statistics, 2018). According to the NBCMI, medical interpreters and translators account for 15.7% of interpreters and translators in the United States (NBCMI, 2018, p. 3).

The job duties of medical interpreters have been described in numerous publications, among them Crezee (2013), Tipton and Furmanek (2016), and Roat and Crezee (2015). The nature of the work does not differ much in the United States compared to other countries. As it is elsewhere, the work is performed by a combination of staff interpreters, dual-role interpreters, and freelancers or contract interpreters. According to Salary.Com, a compiler of compensation data, "the average Medical Interpreter salary in the United States is $43,973 as of September 28, 2018, but the range typically falls between $38,694 and $48,205. Salary ranges can vary widely depending on many important factors, including education, certifications, additional skills, the number of years you have spent in your profession" (Salary.Com, 2018). Since Spanish is by far the language of greatest demand for interpreters in the United States, it is worth narrowing the search to that language. ZipRecruiter, an online job search app, reports that a Spanish Medical Interpreter annual salary ranges from $20,000 to $64,000 nationally, with the average

income being $42,226 a year (ZipRecruiter, 2018). These figures are for salaried staff positions. Other sources report on the average income of contract interpreters. For example, Indeed, an online job board, states that a typical medical interpreter earns "$30.91 per hour in California, which is 105% above the national average. Salary estimates are based on 101 salaries submitted anonymously to Indeed by Medical Interpreter employees, users, and collected from past and present job advertisements on Indeed in the past 36 months" (Indeed, 2018). Though the word "salary" is used, judging by the list of sources from which the company drew this data, it appears that interpreters who are paid by the hour are likely to be contract interpreters working for language service providers.

Remote Interpreting

One aspect of the work that may be more prevalent in the United States, given the distances involved in this large country and the pervasiveness of high technology in the healthcare industry, is remote or technology-based interpreting (either over the telephone or, increasingly, through videoconferencing). Depending on how it is defined, telemedicine, the remote diagnosis and treatment of illness by means of technology, can trace its origins to the early 20th century, but its first application in a form we would recognize today came in 1967 when doctors at Massachusetts General Hospital in Boston conducted medical consultations for airport employees and travelers who were ill at a nearby international airport (Strehle & Shabde, 2006). According to the American Telemedicine Association, "There are currently about 200 telemedicine networks, with 3,500 service sites in the US" (American Telemedicine Association, 2018). In light of demographic trends, these networks inevitably involve working with remote interpreters. Roat and Crezee (2015, p. 245) mention that interpreters may work for language service providers specializing in remote interpreting, whose clients include many healthcare facilities. Hsieh (2016) and Braun (2015) both point out that in-person interpreters are widely preferred to remote ones, but Hsieh also notes that "technology has been central to the delivery of interpreting services for over 40 years (Hsieh, 2016, p. 98). In an article published in the *ATA Chronicle*, Suzanne Couture asserts that "over-the-phone and video remote interpreting are being implemented more quickly in medical settings than ever before" (Couture, 2018, p. 24). For example, the Health Care Interpreter Network (HCIN), a "nonprofit organization led by former hospital executives and technologists dedicated to creating an efficient and high-quality service for video health care interpreting," offers interpreting services to medical facilities throughout the United States (Couture, 2018, p. 24). Even though it is becoming increasingly common, this mode of interpreting has raised questions about the effectiveness of communication and quality outcomes (Hsieh, 2016, p. 98). Nevertheless, in her discussion of video remote interpreting in healthcare settings, Braun (2015, p. 359) argues that "empirical studies of interpreter performance, quality and interaction are largely absent."

Among the concerns expressed by Hsieh (2016) and Braun (2015) are the working conditions faced by remote interpreters, who often work in isolation in home offices, or in large call centers. Couture (2018) describes a study of interpreters participating in the HCIN in which they were asked about their experience and needs as remote interpreters, with a view to increasing access to professional development opportunities and improving morale, consistency, and the quality of service. She found that convenience was what attracted interpreters most to working remotely, whereas sound and connectivity issues were the most challenging part of the work (p. 25). Couture concluded that to ensure optimum performance and job satisfaction in remote interpreting, training should include an emphasis on visualization and

note-taking, techniques for managing the flow of communication, self-care, and access to resources for terminology research and preferred protocols (pp. 25-26).

Another area of concern in the United States is the fact that technology-based interpreting companies often establish call centers off-shore in order to cut costs. Interpreters who live in other countries may be "unfamiliar with the norms and practices of healthcare settings in the United States" (Hsieh, 2016, p. 98), which could undermine quality. She points out some crucial differences between remote interpreters and their in-person counterparts:

In addition, these interpreters are unlikely to develop long-term relationships with providers or patients as they are randomly assigned to different tasks as needed. This also means that unlike in-person interpreters, these interpreters are unlikely to have any background knowledge about provider-patient relationships/interactions based on prior interactions. In short, while technology-based interpreters are often considered and touted as professional interpreters, their unique characteristics suggest that they may have very different interpreting styles than in-person interpreters." (Hsieh, 2016, p. 99)

Health Insurance

Unlike other wealthy countries, the United States does not have a national healthcare insurance program, but instead relies on a combination of private insurance coverage for the general population and government programs for the poor and elderly. As a result, "Interpreters working in the U.S. healthcare system encounter a great deal of communication related to insurance coverage" (Crezee, Mikkelson & Monzon-Storey, 2015, p. 34). Medical interpreters in this country face a bewildering array of plans, billing documentation, and technical terms not encountered by interpreters in other countries. For this reason, in the first of a series of language-specific versions of her seminal 2013 work, *Introduction to Healthcare for Interpreters and Translators*, Ineke Crezee and colleagues included an entire chapter on healthcare insurance in *Introduction to Healthcare for Spanish-speaking Interpreters and Translators* (2015). The chapter defines healthcare insurance, describes different kinds of insurance plans, explains billing procedures, and provides an English-Spanish glossary of insurance terms.

CONCLUSION AND RECOMMENDATIONS

This chapter has examined the short history of the medical interpreting profession in the United States. It began with an exploration of role definitions, starting with interpreters as volunteer helpers or dual-role medical personnel who happened to have some knowledge of languages other than English and evolving towards trained, credentialed professionals with a robust set of standards guiding their practice. The role of government in providing language access in health care was examined, along with the key contributions of professional associations in developing codes of ethics and standards of practice. This was followed by a description of training programs for healthcare interpreters, train-the-trainer efforts, and courses for medical professionals on working with interpreters. Next came a discussion of efforts to impose standards by means of certification tests and the emergence of two competing credentialing bodies. Finally, the current labor market for medical interpreters in the United States was described, and some aspects of interpreters' working conditions were discussed.

It can be concluded from the above analysis that medical interpreting can be considered a relatively well-developed profession in the United States—at least compared to its status in other countries—though it is far from being as powerful as the medical and legal professions. For purposes of this discussion, it helps to return to Roberts' (cited in Mikkelson, 1996, p. 86) prescriptions for professionalization: to become a profession, an occupation must 1) clarify terminology (settling on a clear definition and a universally recognized name for the occupation), 2) clarify the role of the interpreter, 3) provide training, 4) provide training for trainers, 5) provide training for professionals working with interpreters, and 6) achieve accreditation of interpreters. First, terminology has not been clarified entirely, since the terms "healthcare interpreter" and "medical interpreter" tend to be used interchangeably, although at least there is a little less confusion between interpreting and translating among those who contract their services. Additional confusion of terminology is caused by the two different certifying bodies and doubts among employers and potential interpreters as to which credential should be required for employment. Second, a great deal of work has been done on clarifying the role of the interpreter, primarily through the development of standards of practice (strangely absent from Roberts' list, but mentioned repeatedly in Tseng, 1992 and Mikkelson, 1996). And third, although university degree programs are still few and far between, there is an abundance of short courses and certificate programs for medical interpreters, and the NCIHC (2011) standards for training programs represent an attempt to ensure a certain level of quality. As for the fourth and fifth items on Roberts' list, train-the-trainer courses are available through several providers, though more could be achieved in that regard. Similarly, efforts to train medical professionals who work with interpreters are becoming more widespread, but until all teaching hospitals routinely provide such courses and they become an expected part of the professional development of any employee in a healthcare setting, it cannot be said that a satisfactory level of client education has been attained. And finally, the sixth step, achieving accreditation, can be checked off, despite the disruptive effect of having two rival credentialing bodies. In short, perhaps four of the six elements of professionalization have been achieved to some extent.

Aside from Roberts' list of criteria, other important characteristics of strong professions can be identified in the medical interpreting profession in the United States. For example, according to the control theory of professions cited by Tseng (1992), an alliance with the State can strengthen a profession through laws and regulations that help practitioners exert control over their work. The contributions of the Office for Civil Rights and the Office of Minority Health have been invaluable for ensuring that healthcare institutions employ professional interpreters and adhere to certain standards of care for their LEP clients. The quasi-public Joint Commission that accredits hospitals has also played a key role. Furthermore, grants from government agencies and public foundations have supported professional associations' efforts to develop standards and design training programs, and have also fostered research on health outcomes in interpreted interactions. All things considered, much has been accomplished in the professionalization of medical interpreting in the United States, but much also remains to be done. The recommendations listed below, while not exhaustive, may provide some guidance for future actions.

Recommendations

1. To alleviate the confusion mentioned in this chapter that has been caused by the existence of two different certifications, an effort to find common ground and merge the two bodies would benefit medical interpreters, healthcare facilities, and the patients who rely on interpreters to communicate with their providers. The NCIHC, having laid the groundwork for national certification and played

such a fundamental part in the development of the profession, would be the ideal entity to facilitate this undertaking.

2. Increasingly, colleges and universities whose language programs are struggling, due to budget cuts and a reduced emphasis on the value of language studies as part of a liberal arts education, are turning to translating and interpreting as attractive subjects that can provide more practical preparation for employment. Given the projected increase in job openings for translators and interpreters, and in the healthcare industry, institutions of higher learning can best fulfill their mandate to prepare the generations of the future by expanding their course offerings to include medical interpreting and translating. It is often taken for granted that interpreters make good translators and vice-versa, but that is not necessarily the case. Medical interpreters are often expected to translate documents, and they should receive the appropriate education to equip them for that task. Existing faculty at these schools may not have the expertise to teach medical translating and interpreting, but they can avail themselves of the train-the-trainer programs that are growing in number throughout the United States. Furthermore, as colleges and universities revive their language departments, perhaps high schools will be encouraged to continue and even expand their language offerings to produce the number of fluent speakers of foreign languages that this country needs.
3. The degree and certification programs that should expand as the above recommendation is implemented will mean better-qualified applicants for medical interpreting positions. As of this writing there is a shortage of skilled labor in the United States, which means employers must raise wages and offer more attractive benefit schemes in order to draw the most qualified applicants. It is to be hoped that the prevailing wages of staff interpreters at hospitals and clinics will rise accordingly. In addition, the prestige of the profession will be enhanced by the presence of better-educated, better-paid interpreters, who in turn should be treated as equals by healthcare professionals, thereby improving the collaborative environment for patient treatment.
4. Although the United States has been in the vanguard in many aspects of medical interpreting, it can learn from experiences elsewhere in the world, not just in health care but in other fields as well. Here are just a few initiatives that could yield some fruitful results:
    a. The AVIDICUS projects funded by the European Commission have carried out research on video-mediated interpreting in different settings and have produced numerous reports, guidelines and training materials (AVIDICUS, n.d.). The project's findings on user experiences, effectiveness of communication, and best practices are very relevant to the remote interpreting that is becoming increasingly frequent in the U.S. healthcare industry.
    b. Some countries have developed the concept of intercultural mediators as an adjunct to interpreters, who focus entirely on the linguistic aspects of message transfer, or as a separate role played by interpreters themselves. For example, in Belgium, intercultural mediators

strive to ensure that the healthcare delivered in Belgium is of equal quality and accessibility for both nationals and foreigners. In order to achieve this, they act as interpreters, but they also facilitate the communication in more complex ways (e.g. clarifying misunderstandings, explaining cultural elements, and supporting doctors and patients in the performance of their duties). (Van de Geuchte & Van Vaerenbergh, 2017, p. 120)

In view of the communication difficulties arising in an increasingly diverse immigrant population in the United States and the constraints on medical interpreters' capacity to mediate cultural misunderstandings, perhaps the experiences of medical facilities in countries such as Belgium could provide insight that would enable healthcare professionals in this country to bridge cultural barriers.

c. In Australia, government-run interpreting services fill the needs of public medical facilities that have diverse, multilingual patient bases. For example, the Queensland Government operates its own interpreting service rather than relying on private companies (Queensland Government, 2018). Similarly, in Japan, where medical tourism is on the rise, the Aichi Prefecture has opened a medical interpreting service to meet the language access needs of hospitals in the prefecture (Nagoya International Center, 2017). In U.S. culture there is a great deal of resistance to turning over additional functions to the government (hence the lack of a national health service), but in some circumstances, such as remote areas with large immigrant populations, such a service might be worth investigating.

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Chapter 2
Certifications for Medical Interpreters: A Comparative Analysis

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ABSTRACT

Four countries offer specialized interpreter certification programs that take into account the needs of the healthcare market: Australia, Canada, United Kingdom, and the United States. This chapter provides an overview, analysis, and comparison of these certification programs by which specialized medical interpreters can demonstrate minimum standards of performance. This chapter reviews several components of five certification schemes: 1) pre-requisites, 2) knowledge areas, 3) skills areas, 4) language combinations, and 5) certification maintenance. The comparisons reveal similar approaches to interpreter certification with a few significant variations. These common elements form the basis for a substantive international equivalence and comparability. At a closer look, each scheme reveals different solutions to the shared challenges. This chapter ends with recommendations for any ongoing or future interpreter certification program and for interpreting stakeholders.

INTRODUCTION

Certification for individual professionals, also called accreditation in some countries, is a process by which a certifying agency attests or certifies that an individual is minimally qualified to provide a particular service. Professional certification programs provide a more formal and fair assessment program, using an assessment development process, exam(s) production, administration, and passing grades that meet the validity and reliability requirements of psychometricians. Through a scientific process, the certifying body can be confident to 'certify' to the public that those who have successfully passed this rigorous process are qualified to perform the tasks required.

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In any field, these candidates, after having their pre-requisites approved and passing one or more exam(s), become certified, and are usually listed in a professional registry, accessible to the public to verify such credentials. A training or educational certificate does not constitute certification (Adams, 2009).

Community interpreting, also referred to as public service interpreting, is an umbrella term initially used by conference interpreters to describe this new form of interpreting services outside the conference setting. This includes the specializations of medical/healthcare, legal/court/judiciary, immigration, elections, educational, religious, conflict zone, social services, and more. It is not a specialization per se, but a collection of many different manifestations of interpreting as listed above, that fall outside the conference-interpreting domain. There are many similarities between interpreters in these non-conference settings, when compared with conference interpreting. In the United States, the term community interpreting is not commonly used, as it does not distinguish features between legal, educational, or medical interpreting. There are various unique factors to medical interpreting being highlighted in this publication. This chapter will focus on medical/healthcare interpreter certifications, and will utilize the original term used to define this specialization: medical interpreter and medical interpreting.

BACKGROUND

Terminology Matters

As with any subject, terminology matters. Terminology is simply a common language, nomenclature, classification, or taxonomy designed to be shared among users to ensure that we all understand the concepts as intended by the originator of the message. In the certification and assessment fields, specific terminology is utilized and often confused by laypersons. This is why the author decided to provide a list of the most common terms and definitions related to 'certification' at the end of the chapter, in order to aid the reader in understanding the text. It may be useful for professional groups that are thinking of establishing their own certification programs. Alternate terms are given in italics. Note that the term 'testing' or 'tests' will not be used in this chapter. The purpose of most tests is to assign grades to students. They offer limited diagnostic information to identify areas for improvement. The term assessment is a more comprehensive concept. An assessment may be a test or an exam that is intended to measure a test taker's knowledge, skills, aptitude, or physical ability. While laypersons use the term test and exam interchangeably, 'exam' usually refers to a mid-term or a final exam, whereas 'test' can be given at any point in time to measure knowledge of a learning module, for example. For this reason, the term 'exam' will be used in this chapter (International Encyclopedia of the Social Sciences, 2008).

Professional Advancement and Recognition

Professionalization is the social process by which any trade or occupation transforms itself into a publicly recognized profession. The professions that benefit from the highest recognition are the ones that have gone through all the stages of professionalization and are protected legally through licensure, so that only those that are qualified are allowed to perform. This occurs primarily in activities that, when performed by unqualified individuals, may put the public at risk. This is typically called an occupational closure, closing the profession to entry from outsiders, amateurs, and the unqualified (Waddington, 1990).

Professionals invest time in their education and training, inclusion in professional associations, and continuing education, in order to remain abreast of the trends and changes in professional norms and practice (Arocha, 1997). Those that do not have a certification program basically have no way to prove their competency and qualification to do the job in question. In some sectors, such as the healthcare sector, these individuals have to be assessed by different employers, which can be quite cumbersome for the individual, since a different employer rarely accepts one exam from one employer as proof of competency.

The activity of interpreting between languages has existed ever since there were peoples that needed to communicate across different languages. Its professionalization process has been a long process that has spanned history and varies significantly from country to country. Wadensjö explains the actions taken by various interpreting stakeholders in professionalization efforts:

People working with interpreting in various spheres of society and various parts of the world are now involved in a process of professionalization. This implies a range of individual and collective efforts, including struggles to achieve a certain special social status, suggestions to define standards of best practice, to control *access to professional knowledge – theoretical and practical skills – and to* control *education and work opportunities. (Wadensjö 2007: 2)*

The references to the term *control*, underlined in the quote by the author, underscore the need to set measurable standards that allow individuals to be identified or singled out as professionals, in contrast to amateurs or unqualified individuals. Wadensjö (2007) describes certain characteristics for professionalization, which include:

1. A Code of Ethics
2. A Standards of Best Practice
3. A consensual definition of role and function
4. A body of theoretical and practical knowledge
5. Formal training programs
6. A system of licensure, registration, or certification
7. An interpreting industry
8. A professional body that is representative of practicing interpreters
9. An established governmental and/or institutional interpreting policy

One of these is certification (6). It is interesting to note that Tseng's professionalization characteristics does not include certification (Tseng, 1992), despite the fact that it is only characteristic or marker that establishes those that are qualified and unqualified for professional practice. In the interpreting field, general interpreting certification programs have existed in different countries. In others, specialized interpreting certification programs have arisen, mostly in court interpreting. In the last decade, interpreting certification programs in the medical interpreting specialization have arisen, and merit further discussion.

Certification helps employers and end-users of a service distinguish those in the workforce that meet the minimal requirements of competency. While universities, training organizations and employers can and do assess those they teach or hire, they are not experts at developing assessments, and may have biases related to pass rates that affect their own credibility as educators or employers. Those organizations that offer certification programs are referred to as the certification body. These certification bodies provide a neutral and impartial third-party evaluation, and certify that their process is sufficient to

ascertain a competent level of activity. It is important to note that this chapter speaks of certification as the process for individuals, and accreditation, as a process for organizations. Some countries, such as New Zealand and South Africa, use the term accreditation for individuals and certification for organizations. Australia just changed their nomenclature from accreditation to certification, although the name of the certifying body contains the term accreditation. This chapter will focus on specialized interpreter certification for healthcare.

FOCUS OF THE CHAPTER

Certification of Medical Interpreters

The certifying bodies that do provide specialized certification state that it improves healthcare outcomes by providing a system that identifies those that are qualified to interpret at a minimally competent level that ensures no risk of hindering patient safety (Arocha & Joyce, 2013), through errors and omissions. They elevate the standards of quality of medical interpreting by providing a certification process that is specific to the medical sector. Interpreters gain recognition, inclusivity with other interpreters who are certified, and distinguish themselves from unqualified bilingual individuals (Angelelli & Jacobson, 2009).

This chapter provides a comparative analysis of five interpreting certification programs. Details of the certification programs were obtained from information gathered from certifying bodies' websites, from standards related to certification and research literature. Three programs are community interpreting certification bodies with medical certification specialist pathways, and two of them were designed completely as medical interpreting specialist certification schemes. The three community interpreting certification programs that will be analyzed are: 1) The Institute of Linguists Educational Trust (https://www.ciol.org.uk/dpsi), in the United Kingdom, 2) The National Accreditation Authority for Translators and Interpreters (https://www.naati.com.au/), in Australia, and 3) Ontario Council on Community Interpreting (http://www.occi.ca/) in Canada. The two medical interpreting certifications to be reviewed include 4) The National Board of Certification for Medical Interpreters (http://www.certifiedmedicalinterpreters.org) and 5) The Commission for the Certification of Healthcare Interpreters (www.cchicertification.org). All five interpreter certification programs will be reviewed and analyzed by the following criteria: a) pre-requisites, b) knowledge areas, c) skills areas, d) language combinations, and e) certification maintenance. Exam design and administration will not be analyzed. This comparative analysis will be followed by recommendations and a discussion of the possible future trends in certification programs for specialist interpreters.

Overview of Each Certification Program

Certification programs may be housed in a variety of organizational structures. Some are related to professional associations, whereas others are freestanding non-profits. The programs that were identified for this chapter offer interpreter certification programs that are designed specifically for those interpreters working in the healthcare setting (The California Endowment, 2006).

- **Institute of Linguists Educational Trust**: The Institute of Linguists Educational Trust (IoLET), is an associated charity of the Chartered Institute of Linguistics (CIOL), which serves the interests

of professional linguists in the United Kingdom. In the UK, community interpreting is referred to as public service interpreting. The Diploma in Public Service Interpreting (DPSI) has been available since 1989, and is a qualification for those who work, or would like to work, in one of these areas: 1) Law: courts, solicitors, immigration, 2) Healthcare: hospitals, clinics, GP practices, and 3) Local Government: housing, social work, education. The Diploma in Public Service Interpreting examination is set within the four public service contexts of English Law, Scottish Law, Health and Local Government. Candidates must stipulate when registering in which of these options they wish to be examined. The credential provided for those who have passed the written and oral exams is Diploma in Public Service Interpreting (DPSI). IoLET has been administrating exams for several years now. For more information about IoLET, see https://www.ciol.org.uk/dpsi.

- **National Accreditation Authority for Translators and Interpreters**: The National Accreditation Authority for Translators and Interpreters (NAATI) is a company that is jointly owned by the nine governments of Australia, governed by a Board of Directors, who is appointed by the owners. Their mission, as outlined in the NAATI Constitution, is to set and maintain high national standards in translating and interpreting to enable the existence of a pool of accredited translators and interpreters responsive to the changing needs and demography of the Australian community. NAATI services are available through any of their offices located across Australia. Accreditation is an acknowledgement that an individual has demonstrated the ability to meet the professional standards required by the translation and interpreting industry. NAATI assesses translation and interpreting professionals against these standards so that English-speaking and non-English speaking Australians can interact effectively with each other, particularly when accessing medical, government and other services. Their core focus is issuing accreditations for practitioners who wish to work as translators and interpreters in Australia. NAATI offers five interpreter certifications: the 1) Certified Conference Interpreter, 2) Certified Specialist Interpreter – Health of Legal, 3) Certified Interpreter, 4) Certified Provisional Interpreter, and 5) Recognized Practicing Interpreter. Only the Certified Specialist Interpreter (CSI) credential will be reviewed for the purposes of this chapter. It seems this specialized component of the assessment scheme has been established, but it is uncertain if the administration of the specialized exam(s) component is running at the time of this publication. For more information on NAATI, see https://www.naati.com.au.
- **Ontario Council on Community Interpreting**: The Ontario Council on Community Interpreting (OCCI) was established in 2016 in Canada. The mission of the Ontario Council on Community Interpreting is to be the body that oversees and regulates the accreditation of interpreters working in the community and public service sectors in Ontario. OCCI brings together four key stakeholder groups: Interpreters, Consumer, Trainers and Testers, and Interpreting Service Providers. Professional community interpreters need an accreditation that is recognized and marketable across the province and, eventually, the country. The title of OCCI credential is Accredited Community Interpreter (ACI) for interpreters working in the legal, healthcare, social services, education, and private sectors. There is no designation listed for the specialist credential. It seems this specialized exam(s) scheme has been established, but it is uncertain if the administration of the specialized exam(s) is running at the time of this publication. For more information on OCCI, see www.occi.ca.
- **National Board of Certification for Medical Interpreters**: The National Board of Certification for Medical Interpreters (NBCMI) started administering certification exams in 2009 in the United States. The mission of the NBCMI (also referred to as the National Board) is to foster improved

healthcare outcomes, patient safety and patient/provider communication, by elevating the standards for and quality of medical interpreting through a nationally recognized and accredited certification developed by medical interpreters for medical interpreters. Its purpose includes: 1) To develop, organize, oversee and promote a national medical interpreter certification program in all languages 2) To promote patients and providers working with credentialed medical interpreters who have met minimal national standards to provide accurate and safe interpretation, and 3) To ensure credibility of national certification by striving to comply with national accreditation standards including transparency, inclusion, and access. The National Board was established as an independent special division of the International Medical Interpreters Association (IMIA), to oversee the national medical interpreter certification program. The National Board, as a division of the IMIA has 501(c) 3 non-profit corporation status. The credential given to those who pass the written and oral exams is Certified Medical Interpreter (CMI). No credentials are given for those who only pass the written exam. For more information on the National Board, please see www.certifiedmedicalinterpreters.org.

- **The Commission for Certification of Healthcare Interpreters**: The Commission for Certification of Healthcare Interpreters (CCHI) started administering certification exams in 2010 in the United States. Its primary goal is to provide a process that will enhance the profession of healthcare interpreting and in turn benefit the communities that are in need of healthcare interpreters. CCHI has brought together the necessary stakeholders through a non-profit organization whose main mission is to develop and administer a national, valid, credible, vendor-neutral certification program for healthcare interpreters. CCHI has researched and built its program based on data from the field that reflects the knowledge, skills, performance and expectations for healthcare interpreting. CCHI offers an independent, national, comprehensive certification program to medical interpreters of all languages. Our CoreCHI™ and CHI™-Spanish certifications are accredited by NCCA; these are the only accredited interpreter certifications in the U.S. CCHI is dedicated to supporting professional healthcare interpreters who value the power of education and certification. The credential given to those who pass the written and oral exams is Certified Healthcare Interpreter (CHI). CCHI does grant another credential for those who only pass the English written exam and it is called CoreCHI. CCHI has 501(c) 6 non-profit corporation status. For more information on CCHI, please see www.cchicertification.org.

Prerequisites

Certification prerequisites are specific steps that must be completed before a candidate is able to sit for the certification exam(s). Not all certification programs require prerequisites, although it is a sound way to eliminate applicants that will not stand a chance at passing the exam(s) components of the certification program. Table 1 lists the prerequisites of all five certification schemes in a side-by-side comparison. Every certification scheme that is being reviewed for this chapter has incorporated prerequisites in their programs. It is not uncommon for certification programs not to have any prerequisites. However, they fulfill a role in ensuring that all professionals have certain skills that may be necessary for the job at hand. Nonetheless, some certification bodies do not want to create barriers for practitioners; they are especially concerned with those that work in minority languages.

Age prerequisites may be more important for activities that are not advisable to be performed by a minor, and in medical interpreting more so, due to the emotional and critical, possibly traumatic situ-

Table 1. Prerequisites

	IoLET	NAATI	OCCI	NBCMI	CCHI
General Education	NA	Bachelor's degree or higher	NA	High School or more	High School or more
Interpreter education	NA		Post-secondary interpreter training -Certificate of completion of the 180 hr Language Interpreting Training Program (LITP) or Glendon Graduate Diploma in General Interpreting (GDGI)	Minimum of 40 hours of medical interpreting training	Minimum of 40 hours of healthcare interpreting training
Language proficiency in English	NA	Yes –several exams are accepted.	Yes–IELTS, IBT TOEFL or MAG Accreditation	Yes – several exams are accepted. Bachelor or approved oral exams accepted.	Yes – several exams are accepted. Bachelor or approved oral exams accepted.
Language Proficiency in other language	NA	Yes, but does not specify exams or other pathways	No	Yes – Bachelor or approved oral exams accepted.	Yes – Bachelor or approved oral exams accepted.
Intercultural Competency Exam	No	Yes	No	No	No
Ethical Competency Exam	No	Yes	No	No	No
Age	19 years	NA	NA	18 years	18 years
Professional Experience	NA	NA	250 hours documented medical interpreting experience	All applications verified prior to undergoing exams	By audit method
Other Pre-requisite pathways	NA	Holds NAATI Certified Interpreter credential; and evidence of 3 years' work experience; and Completed professional development activities		NA	NA
Prerequisites verification	NA	NA	NA	All applicants verified prior to undergoing exams	By audit method
Membership in an association	Membership in Institute of Linguists Educational Trust (IoLET)	No	Membership in a professional association of interpreters in North America*	No	No

*(Association of Professional Language Interpreters (APLI), Association of Translators and Interpreters of Ontario (ATIO), American Translators Association (ATA), and the International Medical Interpreters Association (IMIA).

ations that occur in this environment. Studies show that the practice of relying on minors to transmit information to their parents was and still is common practice in places where medical interpreting is not professionalized (Agency for Healthcare Research and Quality, 2012). Three of the five-certification bodies have an age prerequisite to sit for their exams.

Language proficiency prerequisites ensure that the individuals sitting for the exam have a relatively fair chance of being truly bilingual. There is a common misconception in the lay community that any bilingual individual can interpret between two languages. However, a high level of language proficiency is required in order to provide accurate interpreting services (Ferguson, 2008). Bilingualism also comes in many forms, and rarely equates to a high level proficiency in both languages. When no proof of language proficiency were required in both working languages, individuals with lower levels of language proficiency are able to undertake the exams, skewing and lowering the passing rates. Interpreter certifications assess interpreting skills, and not the proficiency of languages. Those monitoring the exams will not be able to ascertain if a low passing grade was skewed, as these are two different skillsets. Of the five-certification bodies, OCCI is the only one that does not require a specific level of language proficiency in the other language, only in English.

Which certification bodies quantify or recognize experience? It is interesting to point out that OCCI requires 250 documented hours of experience. There is always the question of how one is to acquire that experience without the proof of competency. This only works when certification is not a requirement to practice, but can become a barrier if the organization one is approaching does require it as a quality measure. It also may work if trainees are sought out by organizations, but this is an issue in healthcare due to patient safety. Practicums typically have preceptor supervision for this reason. An unqualified interpreter must not be allowed to interpret unsupervised by a qualified interpreter. Experience has also been used as an alternative pathway for certification. NAATI is the only organization that has an alternative pathway, for those that have passed general interpreter certification. These candidates can provide three years of documented specialized experience. Some non-healthcare interpreting certification programs in other countries provide for an educational pathway, where one's diploma in a Translation and Interpreting Program can be accepted in lieu of a performance exam. However, these are for general interpreting certifications. Due to the ramifications of unqualified interpretation in healthcare, and how it may impact patient safety, it seems that specialized experience without specialized qualification may put patients at risk. Patient safety concerns require healthcare organizations to rely heavily on performance exams for all healthcare related occupations and professions, to the point where all the professionals working with patients are credentialed, except the medical interpreter. Whereas one organization uses experience as a prerequisite, another is using it to credential interpreters. The author would maintain that experience denotes familiarity with the practice, but not competence.

Prerequisite exams, also called screening exams, are not uncommon in certification. However, only one of the five-certification bodies analyzed requires candidates to take a pre-qualifying exam. NAATI requires a separate ethical exam and intercultural exam before undergoing the interpretation exam; other certification programs include these topics as modules in a written or oral exam. Requiring multiple exams in a certification process only makes the process more cumbersome for the candidates.

With regards to general education, only NAATI requires a bachelor's degree. This puts into question whether the other certifications, which only require a High School, degree recognize medical interpreting as a technical occupation or as a legitimate professional practice that requires the vocabulary of a post-secondary education (Arocha, 1997). One solution to this dilemma would be for a certification program to require a 'bachelor's degree or equivalent,' creating specific provisions for minority languages that

may not have enough candidates with bachelor's degrees. Most salary surveys conducted in the United States state that the majority of interpreters have a bachelor's degree. A low educational requirement brands the activity as an occupation and not as a post-secondary level profession. OCCI also does not have any requirement for general education. Some certification bodies do not have any prerequisite at all, but it is unclear how a certifying body can ascertain that an applicant has a sufficiently sophisticated vocabulary to interpret in all registers without such a requirement (Arocha, 1997). This may also affect certificants' inability to access pay grades that do require a specific level of general education.

Only OCCI and IoLET require membership in a national association. While this is not uncommon in various certification programs run by professional associations as the certifying body, it is a frowned upon practice. There are programs, which accredit certification programs that disapprove this practice. The International Standards Organization (ISO) Standard: ISO 17024, for example, explicitly lists a restriction to this practice for certifying bodies that wish to be ISO 17024 certified/accredited (International Standards Organization, 2012). This may be because a professional association or certifying entity may create a self-serving benefit by requiring annual membership, which provides separate benefits, in order to, approve or maintain one's certification, another paid service. It is also a threat to impartiality, a strong tenet in a fair certification program. If a professional is to be trusted by the public, not only competence is necessary, but ethical integrity as well. Continuous affiliation to a professional association may be the only way to guarantee ethical integrity, in the absence of an ethical disciplinary process by the certification body.

Last, one must realize that not all prerequisites are verified. Three of the programs did not specify whether or not every prerequisite is verified, the National Board states on its website that it does review for proof every prerequisite prior to authorizing the candidate to move to the next step. CCHI, on the other hand, according to their website, utilizes the audit method, meaning that they verify only a small portion of the application prerequisites. One who does not meet the prerequisites would lose their credential, if audited only. So how does the public know which certificants meets the prerequisites and which don't? Regardless, the national certification accrediting organization in the United States, the NCCA, does accept this auditing method. The NCCA is a division of the Institute of Credentialing Excellence (see www.credentialingexcellence.org). However, this is not accepted practice by the International Standards Organization, according to their standard ISO-17024 (International Standards Organization, 2012). The author maintains that the auditing method for the verification of compliance with prerequisites is not a valid or credible process. It is also not fair to some certificants who meet the process to have colleagues who have the same credential yet do not meet the same prerequisites.

Knowledge Areas

What are the knowledge areas that medical interpreters need to know to provide safe interpretation that guarantees patient safety? Knowledge and skills are usually assessed differently. Therefore, most interpreting certification exams have a written knowledge-based exam, followed with an oral skills/performance-based exam. Subject matter experts (SMEs) identify the knowledge areas necessary, in conjunction with a subsequent job analysis and reviews of job descriptions. The job analysis gathers quantitative data from a statistically significant number of practitioners. Once the knowledge areas are identified, the certifying programs divide the knowledge exam into modules, with a certain number of questions related to each knowledge area. Table 2 lists all the knowledge areas that are mentioned on the certification bodies' websites, to offer a side-by-side comparison. Some certification bodies do not give

details of their lists the knowledge content of the exams of each certification program. In these cases, Not Available, or NA is listed.

It is interesting to note that some certifying bodies, such as NBCMI and CCHI, give more detail about their exam structure, which is helpful for candidates to prepare for the exam. The weight given to each module is also important, as it showcases what components are more important for the candidate to pass. Exams can require a minimal score per component or a minimal score for the entire exam. This chapter does not analyze the administration, scoring, or rating of the exams, but focuses on the certification scheme. It is noteworthy to mention that neither patient safety nor client education is mentioned as topics to be assessed. These are very relevant knowledge areas that all professional medical interpreters should have and could be tested on.

OCCI does not give much information about its exams. This makes it difficult and cumbersome for candidates to prepare. Perhaps it is due to the fact that it is still developing the specialization exams. It seems that the medical terminology component is satisfied with the successful completion of a Medical Terminology Course of a minimum of 30 hours. Having a separate requirement for terminology seems to be a good solution to avoid attempting to assess terminology in an interpreting knowledge exam, providing more time for the candidate to focus on demonstrating other areas of knowledge needed to practice as a medical interpreter. However, can 30 hours of training provide enough knowledge to pass the exam? NBCMI gives the greatest weight to medical terminology knowledge. They are not assessing the candidate's ability to translate or interpret medical terminology, but the understanding of such terminology, as an interpreter cannot interpret what he/she cannot understand. The NBCMI Job Analysis data collection instrument asked questions about the knowledge areas and skills required in various areas of medical specialties. By virtue of the design of the instrument asking questions about competency in each specialty, specialized terminology was identified in those specialties. This points to the significance of the

Table 2. Knowledge areas

	IoLET	NAATI	OCCI	NBCMI	CCHI
Medical Terminology	NA	NA	Successful completion of a minimum 30-hr Medical Terminology Course	Yes (38%)	Yes (22-25%)
Medical Specialties	Yes	NA	NA	Yes (23%)	NA
Role and Ethics	Ethics only	Separate pre-requisite exam	NA	Yes (15%)	Yes (10-12%)
Cultural Competence	Yes	Separate pre-requisite exam	NA	Yes (3%)	Yes (3-6%)
Standards of Practice	NA	NA	NA	Yes (5%)	Yes (10-12%)
Legislation & Regulations	NA	NA	NA	Yes (3%)	NA
Managing the Interpreting Encounter	NA	NA	NA	NA	Yes (30-35%)
Medical Procedures	Yes	NA	NA	NA	NA
Interacting with Other Healthcare Professionals	NA	NA	NA	NA	Yes (20-24%)

instrument design with regards to the data it generates. It is also interesting to note that IoLET assesses medical procedures and specialties, which may be their interpretation of 'terminology.' It is unclear if the other certifying bodies include procedures in their medical terminology or specialties components. The more detail a certifying body can provide in their public information, the more transparent and fair it will be to the candidate. Ideally a certification scheme would include medical abbreviations, anatomy, symptoms, procedures, and specialties within the medical terminology component of the exam.

NAATI assesses cultural competence and role and ethics separately in a prerequisites exam that must be passed before undergoing the specialized exams. Cultural competence is a different skillset to interpreting, translation, roles and ethics. The author believes that all these skills are required for competent medical interpreting, and therefore must become part of the specialized exams. Cultural competency is an important knowledge and skillset for medical interpreters, and all but OCCI have this as a component. Two exams (written and oral) seem to be enough for a candidate to have to undergo, so long as different skills and knowledge areas are tested separately and scored separately.

While standards of practice are very important to a profession, many countries do not have a specific standard of practice for medical interpreters. However, there is an international standard for medical interpreters that any country can use as an international baseline. The IMIA Standards of Practice (International Medical Interpreters Association, 2007) is an international standard, and is translated into five languages. It sets the parameters and tasks for the specialization in a much more defined manner than a code of ethics does for example. The ISO Standard for Healthcare Interpreting, ISO-21998 is near completion at the time of this publication and can also be used as a standard to be tested against. In the absence of testing standards, certificants would only be certified to know the ethical guidelines, but not the practice guidelines. This is because the code of ethics explains the general rules to practice by, whereas the standards of practice explain how the practitioner performs their duties. Only NBCMI and CCHI list standards of practice as an exam knowledge area, and this may be due to the fact that the United States has the most standards of practice of any country. The UK, Canada, and Australia also have a strong community interpreting training and assessment framework, whereas medical interpreting is just emerging as a separate specialization in its own right. While Canada has a community standard of practice, it does not cover specific practices specific to the unique dilemmas and tasks of medical interpreters.

Legislation and Regulations are only included in the NBCMI and CCHI exams. It is important for these certification bodies for medical interpreters to know the legislation and regulations related to their practice. Client education and advocacy for one's profession is often an important component of a profession. Perhaps other certifying bodies may consider this a knowledge area to add into their certification schemes.

CCHI is the only certifying body that lists these two skills: Managing the interpreting encounter (30-35%), and interacting with other healthcare professionals (20-24%), totaling (50-59%) of the written exam, which is significant. These may have been considered subsets of the Role and Ethics component or the Standards of Practice component in the other exams, but it is a different topic for CCHI. These differences in classification make it difficult to compare certifications. Having said this, it is noteworthy to mention that Role and Ethics need not be classified together, as these are two different knowledge areas and must be tested and scored separately. Listing the Standards of Practice as a knowledge area stipulates that the candidate must know the guidelines of 'how' to practice. These are indeed important documents of practice. It seems that while NAATI and OCCI do not give much detail about their knowledge areas, IoLET does list all the medical subareas within 1) procedures, 2) primary care, 3)

acute care, and 4) other, where it lists other knowledge areas to be assessed, such as complementary medicine, palliative care, victims of violence, etc. As stated before, the more detail a certification body can provide all stakeholders, the better. When comparing NBCMI and CCHI specifically, one can note that the NBCMI knowledge exam gives greater weight to the medical knowledge areas (61%), whereas CCHI focuses on the non-medical practitioner knowledge areas (77-78%). This may be useful information to an applicant who may have to decide between one or another certification program. It also showcases the different approaches to the professional makeup of a medical interpreter.

Skills Areas

Since the interpreting profession involves the very technical skills of interpreting, most interpreting exams in the world, whether general or specialized, include a skills exam component that is separate from the written component (Hlavac, 2013). In reviewing five certification programs, there are only four performance areas that are assessed by all certification bodies, which can also be seen as two performance areas in both language pair directions. Table 3 lists all the skills areas listed by the certification bodies on their respective websites.

The first skillset tested is consecutive interpreting, into and from the language other than English (LOTE). Consecutive interpreting is the most required skillset for medical interpreters, simply by virtue of the fact that it is their core skill, and mode most utilized in dialogic interpreting for spoken languages. Bidirectional consecutive interpreting is the key skill in medical communicative events, and therefore all the certification bodies include this skillset. Since interpreting is a language-specific skillset, it is important that the assessment procedure and tool also assess this skill in a realistic authentic manner;

Table 3. Skills areas

Skills	IoLET	NAAT	OCCI	NBCMI	CCHI
Consecutive into service language	Yes	Yes	Yes	Yes	Yes
Consecutive into other language	Yes	Yes	Yes	Yes	Yes
Long consecutive - monologue	NA	Yes	NA	NA	NA
Sight translation into service language	Yes	Yes	Yes	Yes	Yes
Sight translation into other language	Yes	Yes	Yes	Yes	Yes
Simultaneous interpreting into service language	No	Yes	No	No	Yes
Simultaneous interpreting into other language	No	Yes	No	No	Yes
Translation into service language	Yes	No	No	No	Yes
Translation into other language	Yes	No	No	No	Yes

utilizing language-specific role-plays in the healthcare environment that mimic the authentic interpreting demands of the task at hand.

The second skillset is sight translation into and from the LOTE. IoLET evaluates the largest number of skillsets, whereas NBCMI evaluates the least. In psychometric assessments, when there is a holistic pass score, the fewer the skills/knowledge areas are assessed, the greater the validity of the exam. The reason for this is that the results of the assessment have to reflect the skills or knowledge areas assessed. If there are too many areas, the only way to remedy this is to apply a modular grading system, where each skillset is assessed within a separate module, which guarantees that the candidate has to pass each assessment module, and hence pass the skillset assessed. NBCMI and CCHI do not do this, as they provide for a holistic minimum score, versus modular minimum scores that need to be passed. NAATI provides for a modular system that requires candidates to pass each skillset separately. It is not clear if NAATI candidates can later take only the modules they did not pass or if they have to take the entire exam again. IoLET nor OCCI provide information about whether the test design is modular or not.

While simultaneous interpreting is not the most frequent mode of interpretation in healthcare for spoken language interpreters (it is for signed language interpreters), it is not only needed, but it is required in many specific healthcare scenarios in order to ensure accurate communication. IoLET, OCCI and NBCMI do not assess interpreters in the simultaneous mode. This is a very significant limitation of their certification program, as it means that an interpreter may become certified and yet not have demonstrated his/her ability and performance in this important mode of interpreting. While the lower frequency of the skill may be identified in the profession's job analysis, another parameter in psychometrics is the relevance or importance of the skill for professional practice. While the frequency is low, the importance or relevance of the skill is very high when a patient or provider can't pause. Certain situations require this specific mode of interpreting in healthcare. Long consecutive is rarely needed in healthcare interpreting, and that may explain why only NAATI evaluates this performance skill.

Translation is a different skillset from interpreting. Translation requires training for translation, whereas interpreting requires training for interpreting. While many interpreters are asked to translate documents, some interpreters are qualified to do so while others are not. Likewise, some translators are qualified to interpret, while others are not. Only IoLET and CCHI assess for translation in the skills exam component of their certification program. It is noteworthy to mention that CCHI assesses the translation skillset using a multiple answer section, which puts into question the format, validity and reliability of this part of the exam. Going back to the argument of authenticity, how is one to provide proof of a translation competency by answering questions? One would assume that the best way to assess the ability to translate from one language into another would be to do exactly that, to translate from one language into another. The author maintains that translation may not be included in an interpreting exam, as interpreting may not be included a translation exam. Validity refers to whether an exam measures what it is intended to measure, and adding different skills with a global score doesn't allow for these skills to be distinguished as separate skills. Testing translation in an interpreting exam lowers the validity of that exam. Furthermore, healthcare organizations may be misled to believe these certificants are qualified to translate at all levels, when the level or amount of testing in that skill is not sufficient to determine competency to a legal standard in that specific skill.

Languages Combinations Assessed

Language proficiency in at least two languages is a primary skillset that precedes any ability to interpret. Most certification programs are language specific and therefore it is important for applicants to know which language combinations are available for assessment. This is perhaps one of the factors that complicate any certification process that has to work in different languages. All certification programs require English proficiency at determined levels, either through secondary education or via specifically listed exams and minimal scores. Several national and international exams, such as IELTS or TOEFL, are accepted. The only certification program that does not specify any requirement for the English language is IoLET. It is interesting to note that the Tasmanian government lists the languages that NAATI offers (Tasmanian Government Department of Premier and Cabinet, 2017). Table 4 lists the language combinations offered by the five-certification schemes. Since English is the language of service in the four countries surveyed (Except Canada, where it is English and French), these lists revolve around the other Languages Other Than English (LOTE) assessed.

The certification schemes from the UK, Canada, and Australia are the ones providing certification in the largest number of languages. NAATI has a set of languages that are available only if there are enough certificants in that language. This is a reasonable strategy that enables the certification body to be scalable according to need, and also not to waste resources in languages for which there is not enough demand. It is a practical solution to the problem of setting up services for languages for which there is very little demand. In contrast to these long lists of language-specific exams, the certification schemes from the United States are the ones providing certification in the least amount of languages. The Spanish language accounts for 77% of the linguistic demand for medical interpreting (Cabrera, 2017) in the United States. However, there are cities in the United States with a much broader array of interpreters in other languages need to protect themselves from a liability perspective with regards to all patients, and their commitment to patient safety is equal to all patients. One of the difficulties cited by these organizations is that developing a psychometric-based exam is very costly and not viable for a language that will have very little demand for certification.

In order to strengthen the credibility of these certifications, it is important to consider including more languages. The threat, however, is that the certifications currently only exist for interpreters who cater to the over-supplied languages. This could be viewed as a mechanism to keep other interpreters out or hinder those interpreters from getting jobs, ultimately creating an elitist mentality. (Nimdzi, 2018)

For interpreters wishing to become certified in languages for which oral exams do not exist, CCHI decided to grant candidates a different credential, called CoreCHI, for those that pass the written exam, which is given in English and assesses knowledge areas only. This is in contrast to their CHI credential, given to candidates who pass both the written and oral exams. While this addresses the need of interpreters to have a credential, it does not address the need of healthcare organizations to have interpreters that are certifiably competent in these languages. In fact, seeing interpreters with an alternative credential may confuse employers that could consider a credential without proven competency a deceitful practice at worst, or a confusing practice, at best. CCHI plans to develop oral English into English exams for these candidates in the future (Certification Commission for Healthcare Interpreting, 2018). The author believes that, while this may assess the interpreting cognitive skills, it does not assess the skills in the language context, which means that renditions other than English will not be able to be rated, only the back translation of such renditions. Grammatical mistakes in the other language or other paralinguistic aspects of interpreting will be lost. The National Board has chosen not to grant any credential to a

Table 4. Languages other than English (LOTE) assessed

IoLET	NAATI	OCCI	NBCMI	CCHI
Albanian	Arabic	Albanian	Spanish	Spanish
Amharic	Auslan	Amharic	Cantonese	Russian
Arabic (MSA)	Bangla	Arabic	Korean	Arabic
Armenian E	Bosnian	Armenian	Mandarin	
Armenian W	Cantonese	Assyrian	Russian	
Bengali	Croatian	Bengali	Vietnamese	
Bengali (Sylheti)	Dari	Bosnian		
Bulgarian	Finnish	Bulgarian		
Cantonese	French	Burmese		
Croatian	German	Cambodian		
Czech	Greek	Cantonese		
Dari	Hindi	Creole		
Estonian	Hungarian	Czech		
Farsi	Indonesian	Dari		
French	Italian	Dinka		
German	Japanese	Gujarati		
Greek	Macedonian	Hebrew		
Gujarati	Mandarin	Hindi		
Hindi	Persian	Hungarian		
Hungarian	Portuguese	Indonesian		
Italian	Punjabi	Italian		
Jamaican	Romanian	Japanese		
Japanese	Russian	Karen		
Korean	Serbian	Kmer		
Kurdish (Sorani)	Spanish	Kinyarwanda		
Latvian	Tamil	Korean		
Lithuanian	Turkish	Kurdish-Bahdini		
Macedonian	Urdu	Kurdish-Sorani		
Mandarin	Vietnamese	Laotian		
Panjabi		Lingala		
Pashto	Other languages by request (if there are sufficient candidates):	Macedonian		
Polish		Mandarin		
Portuguese (Brazilian)	Albanian	Nepali		
Portuguese (European)	Amharic	Nuer		
Romanian	Bulgarian	Oromo		
Russian	Burmese	Pashto		

continued on following page

Table 4. Continued

IoLET	NAATI	OCCI	NBCMI	CCHI
Serbian	Dutch	Polish		
Slovak	Filipino	Portuguese		
Slovene	Khmer	Punjabi-Gurumukhi		
Somali	Korean	Punjabi-Persoarabic		
Spanish	Lao	Romanian		
Swahili	Malay	Russian		
Tamil	Maltese	Serb/Croatian		
Thai	Polish	Sinhala		
Tigrinya	Samoan	Slovak		
Turkish	Sinhalese	Somali		
Ukrainian	Somali	Spanish		
Urdu	Thai	Swahili		
Urdu (Mirpuri)	Tongan	Tagalog		
Vietnamese		Tamil		
		Thai		
		Tigrinya		
		Turkish		
		Twi		
		Ukrainian		
		Urdu		
		Vietnamese		

candidate that has not passed the knowledge (written) and skills (oral) exams and is duly certified to be minimally competent to practice in a skills-based profession. The National Board states it is developing more language-specific oral exams. This showcases two different approaches in the United States. It may be worthy to note that in the United States, there is a third certification body, the Registry for the Deaf, which assesses general interpreting for sign language separately. It does not have a specialized certification exam for the healthcare sector, and therefore was not included in this chapter. Their certification program is currently undergoing a complete review to upgrade to a psychometric-based exam process.

The only country of the four that assesses Australian signed language, or Auslan, is Australia. The other countries only assess spoken language interpreters. If interpreting is interpreting in any language, wouldn't it be more equitable if all interpreters underwent the same certification program in their country of practice? In the United States this is not so due to the fact that the Registry for Interpreters for the Deaf (RID) has their own generalist certification program since the 1970s. However, it is not specialized certification. Countries that do not have a certification program yet may wish to consider an alliance between the sign language interpreter association and the spoken language interpreter association in order to develop one certification for interpreters.

It is important to note that minority languages, also called languages of lesser diffusion, or rare languages are rarely included, due to the difficulties in finding qualified individuals who are proficient in

those languages. If it is hard to find those that speak the language, it is much harder to find interpreter educators, trainers, or raters in those minority languages. However, it does seem that some countries are doing a better job than the United States in addressing their linguistic diversity. Much can be learned from these efforts so that all patients are served in a manner that protects equitable health services. Since these five certification bodies test with English as the service language, perhaps reciprocity of credentials could assist interpreters in the United States who wish to get credentialed in languages that are available in the UK, Canada, or Australia, if their certification schemes are willing to assess individuals outside their countries. It seems that NAATI already assesses interpreters outside Australia, as does NBCMI, as it is the only certification scheme that already has remote written and oral exam capabilities.

Certification Maintenance

Most certification schemes include a certification maintenance component, also called recertification. While historically initial professional certifications were valid for life with no expiration date, soon professions realized that practitioners may stop practicing for five or ten years and lose their knowledge and skills, putting the public at risk. Just as one has to renew one's driver's license to prove that one is still able to drive, certification programs have developed certification maintenance components to assure that the practitioner is competent to maintain the certification credential. None of the five certifying bodies require re-examination, so long as the certificant does not let their certification expire. They have other requirements, which are listed on Table 5. As with all aspects of certification, the scheme has to walk a fine line so that it can be rigorous where it needs to be yet not cumbersome towards certificants where it does not. As with any decision made, the certification bodies had to think whether or not they are helping or hindering the certificant to prove they are worthy to remain as a credentialed professional.

Most certification maintenance programs in all professions require some form of continuing education. This is the only way that the certification body can be assured that the certificant remains abreast of their professional developments, including new healthcare procedures, terminology, new paradigms of practice, and other areas, for example. CCHI has specific time range requirements of spacing the

Table 5. Certification maintenance

	IoLET	NAATI	OCCI	NBCMI	CCHI
Continuing Education	NA	Continuous professional development (PD) 40 points per year)	NA	3.0 Continuing Education Units (CEU) in five years (equivalent of 30 hours)	32 Continuing Education (CE) every four years (16 CEs in the first two years and 16 CEs in the second two years)
Ongoing work requirement	NA	Evidence of ongoing work practice (40 assignments per year	NA	No	Certificants must document 40 hours of work experience (20 in the first 2 years, and 20 in the second 2 years)
Ethical and professional conduct requirement	NA	Ongoing certification will be dependent on ethical and professional conduct by the practitioner	NA	Ongoing certification will be dependent on ethical and professional conduct by the practitioner	Ongoing certification will be dependent on ethical and professional conduct by the practitioner
Exam requirement	NA	NA	NA	NA	NA

educational activities evenly across that time frame of four years. The NBCMI only requires 30 hours of contact education within five years. A certificant may take all of the educational activity in whichever manner they choose within the five years timeframe, so long as all 3.0 CEUs are done within that time frame. NAATI has a yearly requirement of 40 hours, which may be cumbersome for certificants.

It is interesting to note that, as of January 30, 2018, CCHI accepts non-instructional activities as continuing education. These may include, for example, professional engagement, in the form of association membership in a professional association, with each year awarding one CE point. Another category of professional engagement includes volunteering, with 1 point being allotted per year, with a maximum of 4 points. Leadership board positions award the certificant 4 points per year, whereas a professional award is worth 2 points per award, and both of these engagement categories also have a 4 point cap. Research publications will earn the certificant 2 points, or half if one is a co-author. This points to an interesting development that gives certificants more ways to fulfill their certification maintenance requirements, while also incentivizing professional engagement. The only possible negative effect is that one may achieve the necessary points without engaging in any educational activity, but they have a provision for only a certain number of CEs being non-educational. Perhaps it would be advisable to ensure that at least half of the points were obtained via educational activities. While CCHI provides the most options, making it less cumbersome for the certificant, on the other had it requires that points be earned in specific time frames, and that can be cumbersome for a certificant who may not be able to spread the requirements so easily among the years. Ideally a certification body allows for the most varied parameters of educational or professional development, with the least amount of requirements in terms of timing, and with the longest time period possible. Certificants should not have to prove they are qualified on a frequent basis, as these educational activities have to be done outside working hours. Those schemes which are too cumbersome to the certificant may risk losing certificants who simply are not able to recertify due to life conditions.

Many certification bodies reserve the right to take disciplinary action against certificants that do not abide by the code of ethics or professional conduct of the profession. These prohibited actions and behaviors are usually listed in the candidate's handbook as forbearance. The disciplinary action is a serious matter, so it is important for the certification body to have a disciplinary policy that lists how to file a complaint, the process of evaluating violations, sanctions, an appeal process, and a process for reinstatement. It is important for a professional body not only to ascertain who is qualified to hold a professional credential, but also who is worthy to the values and behaviors of that profession, for the good of the public.

IoLET and OCCI do not have any recertification requirements.

It is important for the certifying bodies to be more explicit in their websites whether a candidate will ever have to retake the exam portion of the certification process if they let their active credential expire. Whereas two of the certification schemes do state that they have a grace period (CCHI and NBCMI) the others do not explain whether or not the applicant will have to retake the exams.

Limitations of Comparative Analysis

This comparative analysis focused mainly on the certification schemes that exist in the countries with certain common characteristics, such as a high immigration level, where English is the official or one of the official languages, and where medical interpreting is more developed as a specialization. This does not reflect the situation or level of professionalization in most countries where neither community

interpreting nor medical interpreting is highly professionalized. The lack of certification in a country does not mean that there are not other forms of professionalization in medical interpreting taking place. There are countries such as the Netherlands, Israel, Belgium, Switzerland, Japan, and others who have been advancing this specialization significantly. Therefore, the lack of certification does not equate to the lack of professionalization. It is an important step towards the professionalization of each interpreter specialization. This chapter did not compare governance or operational characteristics, such as the administration of exams, rating, or costs, for example. This chapter also compared two specialist programs (CCHI and NBCMI) with three more generalist programs that allow the candidate to opt into a specialist pathway that may or not include an exam. In the case of OCCI, candidates need to provide proof of competency in healthcare via the satisfactory completion of a specialist-interpreting course and a minimum 30-hour terminology course. The fact that some of the programs are not yet completely operational, such as OCCI and NAATI's specialist pathways, also leads to questions of whether the programs will make changes in the near future before or after launching these specialist pathways. Certification schemes are living organisms that may adapt and change at any time. Developing a psychometrically sound certification scheme is costly and time-consuming. However, it is the best alternative to provide individuals with a reliable, valid, and fair system of entry to the profession. It is also the best way to provide the public with some form of assurance that the users of the services are protected from harm (patients) or liability (providers). These five certification programs have demonstrated that while none of them are perfect, they are doing a fairly decent job at guaranteeing the public in their countries that they can rely on their certification to certify whether someone is minimally competent or not to practice. We know this because four of the schemes have been certifying interpreters for over a decade, and two of them have had their Spanish certification process (NBCMI and CCHI) accredited by NCCA. CCHI also accredited its CoreCHI credential. NBCMI chose to discontinue maintenance of accreditation as the accreditation was based on its current process and administration.

SOLUTIONS AND RECOMMENDATIONS

This chapter has examined the availability of medical interpreter certification programs in four countries: Australia, Canada, the United Kingdom, and the United States. The analysis discusses certification within a professionalization process, and how certification distinguishes those that are minimally qualified to practice from amateurs or unqualified individuals. This is particularly important in healthcare, due to the ramifications of errors and omissions in the provision of healthcare services. Therefore, it seems that in part, the medical interpreting specialization has developed certification programs to ensure patient safety (Arocha, Joyce, 2013).

Several components of these certification programs were compared, specifically: 1) prerequisites, 2) knowledge areas 3) skills areas 4) language combinations, and 5) certification maintenance. By studying and analyzing their differences, interpreting stakeholders may gain important information in order to improve the existing programs. The analysis provides framework options for those that are considering developing a specialist certification scheme.

For Certification Initiatives

1. Certification programs are stronger if they are based on psychometric standards of practice (, 2005). Psychometric professionals designed two of the five programs (CCHI and NBCMI).
2. Certification programs may consider adopting psychometric standards to ensure validity and reliability or exams. This is generally a requirement for becoming accredited by certification body accreditation organizations. It also increases the credibility of the program to the general public.
3. The degree to which certification is adopted and expanded will engender higher quality interpreting services in the healthcare sector, protecting providers and patients from unqualified interpreters who may put the provider's liability or the patient's health at risk.
4. Due to the increasingly diverse patient population in many countries, certification programs need to ensure that all languages are certifiable.
5. Certification schemes need to ensure that their exams assess and rate what they are supposed to assess, in an authentic setting, requiring the candidate to utilize that skillset in a manner that is language-specific, and context-specific (healthcare).
6. Certification schemes need to include enough assessment material in one knowledge or skill in order to ascertain if the candidate is truly competent in that knowledge or skill. For example, a few multiple-choice questions will not ascertain translation competency. Likewise, ten terminology questions will not suffice to assess medical terminology knowledge.
7. Certification bodies may consider aligning themselves into a consortium of interpreting certification bodies, in order to exchange ideas at a minimum, and to consider a reciprocity scheme at a maximum. Interpreter certification reciprocity can be a complicated topic on a political level, but it can avoid much replication of effort and resources. In order for interpreters who are certified in a language pair by one certification body in one country to be able to become certified by another certification program through such a program would be ideal from the standpoint of the certificant. This is a pervasive problem for all credentialed professionals in all professions. With supranational remote interpreting increasing, how will employers ascertain the competency of their interpreters?
8. Some certification programs have different categories of certification. CCHI grants candidates for which there is no oral exam a CoreCHI credential after passing the written English-only knowledge exam, without a skills exam. NAATI grants several separate types of certifications, such as Certified Interpreter, Certified Specialist Interpreter, and Recognized Practicing Interpreter. In both cases, it seems that they are creating a strata of interpreter categories that could be detrimental to the branding of the profession. Some interpreters may feel less qualified than others, and some employers may be confused with different designations and not know that a "Certified Interpreter" or a "CoreCHI interpreter, or a Recognized Practicing Interpreter" may simply not be as qualified to interpret in the healthcare setting as their colleagues who are "fully" certified to practice in that specialized healthcare environment.

Since the ultimate purpose of certification is to protect the public, it seems that it is incumbent on certification bodies to develop exams for all the languages and provide patients with the same qualification of interpreters. If there are no interpreters that qualify in a language, that is something that a patient and provider need to know up front, and providing lower than minimal competency qualifications may simply not do the trick and may be considered more confusing or deceptive than helpful. Ultimately, if someone practices interpreting but has not been assessed for minimal oral interpreting competency, that

individual should not be given any credential or be called a medical or healthcare interpreter. Perhaps certification bodies may have a system of classifying language assistants in such languages, but utilizing the term "interpreting" for anyone who interprets only institutionalizes the biggest problem we have in the field, the issue of identifying who is and who is not competent to interpret for a patient and provider in varied and specialized healthcare setting situations. The other problem with creating categories of interpreters is that it creates an incentive for employers to pay less to the less qualified individuals and that can lead to the practice of *not* certifying in certain languages to keep the cost down. This has occurred in the US Court interpreter arena, where counties and administrative offices prefer to call the "qualified" or "recognized" interpreters to the "certified" ones, for financial reasons.

For Other Stakeholders

1. Most educational programs focus on conference interpreting, which provides sporadic work at best and only in conference rich cities and UN languages. It is no secret that there are greater work opportunities in other specializations, such as legal interpreting or medical interpreting. University-based interpreter educational programs are advised to develop specialized courses within their conference interpreting degrees, and/or dedicated programs for these specializations so that interpreting graduates are better prepared to work in these very specialized settings.
2. While there are many university-based certificate programs for medical interpreting, there are still many for-profit corporations training interpreters in an inadequate amount of time. Short forty-hour courses simply are not sufficient to train an individual in all the competencies needed. The Canadian Community Standards of Practice (HIN, 2007) states in Annex A that whereas trainers are not able to train the interpreters on intercultural issues sufficiently in their 180-hour flagship community interpreting Language Interpreting Training Program (LITP) program. This curriculum was adopted in many colleges and is required for OCCI certification. As the specialization further professionalizes, it may seem inevitable that more in-depth university-based programs will be needed in to increase the presence of better educated interpreters. While initiating these programs in minority languages is challenging, language-neutral programs and online-based programs have been very successful in educating a greater diversity of future medical interpreters.
3. There is a possibility that supra-national certification bodies may arise which assumes authority in this specialization, considering that two of the governing bodies (NBCMI and NAATI) already assess candidates in different countries. There is also the possibility in the future that certifying bodies in North America will forge alliances or some form of collaboration in order to increase standardization of certification, increase efficiencies and diminish replication of work. Medical interpreting services have been crossing national boundaries for quite some time now, with interpreters in Canada, Australia, South American countries, and other parts of the world providing remote interpreting services to consumers in the United States, and in other directions, much as in the European Union, which already has developed supra-national interpreting standards for conference interpreters. The International Standards Organization (ISO) standards for interpreting are requirement standards, which means that in the future it is very probable that interpreter service providers, whether individuals or organizations, may wish to become accredited according to the ISO Standards for Healthcare Interpreting 21998, (in development as of 2018), once it is published.
4. Accreditation of certification bodies may become more popular. NBCMI was the first certifying body to become accredited by the National Commission of Certifying Bodies (NCCA), a division of

Credentialing Excellence. Others have followed suit in the United States. CCHI came next, and since then other translation and interpreting certifying bodies are working on revamping their certification schemes, namely the American Translators Association (ATA), and the Registry of Interpreters for the Deaf (RID) in the United States. NAATI just underwent a complete overhaul, which added the healthcare specialist pathway, confirming the need for specialist certifications. The significance of these accreditation standards for certifying bodies is that they regulate or control not so much an individual's minimal level of competence, but it regulates the procedures and practices that are used to certify individual practitioners. All certifying body accreditation schemes require certification processes to be fair, impartial, valid, and reliable, without undue hardships. For example, they regulate that all certification bodies need to have an appeals process. The International Standards Organization has its own standard called Conformity assessment – General requirements for bodies operating certification of persons (International Standards Organization, 2012). It is unlikely, yet unclear if any translation or interpreting certification program has been accredited by ISO.

5. Interpreters who work in the healthcare sector would benefit from advocating for their non-profit professional association to develop specialized certification programs that meet the demands of the healthcare organizations and companies that hire them. Where there are no specialized professional associations, interpreters can lobby the general interpreting association to develop a generalist certification program with specialization pathways, as NAATI, IoLET and OCCI have done. The greatest difficulty lies in the fact that many countries have a cultural or legal preference for the government to certify individuals, versus non-profit organizations. Another is that most interpreting and translation associations are not experts in psychometric-level testing, so it requires the hiring and working with high-level scientists in a process that is costly and time consuming. Last, many interpreting and translation associations are generalist focused, and may believe that they need to develop some general translation or interpreting certifying process before they can address any specialist certification program. This is not necessarily true, as perhaps an easier path is to develop a specialist certification scheme that caters to a specialized sector.
6. Interpreters work in a large variety of languages. Patient language diversity is growing in almost every country due to increases of refugee or asylum seekers, in addition to the increased immigration patterns in the countries surveyed in this chapter. In the United States, for example, as one would expect, the percentage of individuals speaking only English at home has steadily fallen in recent decades, from 89.1% in 1980 to 79.7% in 2010, while the share speaking a language other than English rose from 11% to 20.3% (Rumbaut & Massey, 2013). Certification programs that only assess in a few languages may not be fully serving the needs of their consumers, or end users. They must find ways to assess or guarantee competency in a larger variety of languages (Nimdzi, 2018).
7. Certification bodies may benefit from improving testing technologies in order to make testing more accessible and reliable (Haug, 2015). Haug's study included 32 participants in an online survey on new sign language testing technologies. The top benefits relate to access and reliability. Computer-based testing allows for the candidate to listen to the role-plays in the exact same manner as another candidate. Variations of delivery are diminished. These include accents, moods, and other environmental and interpersonal factors that may affect the performance of a candidate. Computer-based testing sometimes provides automated results immediately after the exam is completed, saving human resources and time in knowledge based rating. Computer-based testing will record the responses in the system, and archive it to the candidate, minimizing errors that could occur in manual recordings. Last, two raters in different locations can easily review and rate an

anonymous recording when the recording is cloud-based. Cloud-based archiving works best for virtual organizations that have applicants across a given country. Access to exam sites is a common problem in individual certification programs. Online proctored testing ensures the security of the exams and prevents cheating at the same level as on-site proctoring. It is interesting to note that of the certification programs analyzed in this chapter, only NBCMI uses online proctored testing. It allows for interpreters who live in rural areas, far from testing centers, to undergo the written and oral exams in this manner. Certification bodies may incur higher initial costs, and a technical learning curve. However ultimately, using testing technology increases access, reliability, and validity of the process.

FUTURE RESEARCH DIRECTIONS

There is much more research to be done on interpreter certification. This chapter only presented a comparison of the general schema of each certification body. Future research is needed to explore best practices, in terms of certification process and testing administration, or the development and revision of exams. More research is also needed with respect to passing scores and other areas that research has merely scratched the surface. This may be due to the fact that there are very few interpreter certification exams available in most countries, and a discussion of these issues requires the inclusion of certification practices and norms that are not widely available to the interpreting community. Most importantly, with the increased availability of certificants, researchers will be able to compare the performance of certified interpreters against non-certified interpreters, to see if indeed certification makes a difference in performance. Are certificants earning more? What are the benefits of certification, according to practitioners? Furthermore, studies have not yet been done on current grievance processes for certification, recertification, or the scoring of exams. Interpreting certification is a field that has more research related to court interpreting than other specializations of interpreting. Furthermore, court-interpreting certification is usually administered by the court system, an employer of interpreters. How do we assure the independence of a third-party certification body that is not involved in the education or hiring of interpreters? Research should also be done on the factors that entice and deter practicing interpreters to get certified. Research may in the future also study the employer's perspective, looking into what enables or deters an employer from requiring certification for hire. Likewise, healthcare organizations who hire interpreters directly should be questioned as to why some require certification for sign language interpreters and not spoken language interpreters. It would be very useful to have a study that just looks at the prerequisites and how it affects all stakeholder groups. Last, the issue of minority languages is a complex one, and a study that looks at how certification bodies are handling this question is very needed.

CONCLUSION

Despite the limitations of this comparative analysis and the need for further research and study of other components of certification programs, the aim of this chapter was to expose readers to the main components in certification schemes as applied to specifically specialist interpreters, such as medical interpreters working in various specialized healthcare settings. The chapter accentuates the complexity of setting up a certification scheme, and its various main components. It is important to note that the majority of

countries have no verification process for the competency of an interpreter, especially non-UN language interpreters, which have engendered a common situation of calling the "interpreter" whoever attempts to relate information back and forth between two languages. This is especially seen in the settings that need the most qualified interpreters, which involve the very specialized legal and medical settings, where miscommunication may cost someone their asylum, their liberty, their health, or ultimately their life. It is imperative that professional associations around the world mobilize to do something about this. While governments are slow to act and have a myriad of equally if not more critical issues to handle, it seems that professional associations may consider tackling the public's need to know who is and who is not qualified. Who is more qualified to determine this other than the qualified professionals themselves? Going back to the development of a profession, the author maintains that certification is a key component to the efforts to professionalize any activity. If other sectors do not recognized the importance of the interpreting task and role, then it is up to the professional sector of interpreters to do it themselves. Hopefully this chapter serves as a possible roadmap on the most important issues to consider in developing a specialist interpreting certification program.

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KEY TERMS AND DEFINITIONS

Appeals process: process by which an applicant, candidate or certificant may request the certification body to re-examine or reconsider any decision

Applicant: person who submits an application to be admitted into the certification process

Assessment: refers to the process of determining a person's competence for a particular type of employment

Candidate: person who has fulfilled specific parts of the certification process, such as pre-requisites or one of more required steps, but has not yet finished such process

Certificant: person who has fulfilled all the requirements to receive a certification credential (Credentialed professional)

Certification body: an organization or division of a non-profit organization that administers certification, having the authority to make all the decisions for a certification program

Certification maintenance: the post-certification requirements in order to maintain the credential provided by the certifying program (Recertification)

Certification program: a process, with several components, that offers an independent assessment of the required knowledge and skills for the minimally competent performance of a professional role (Accreditation program)

Certification scheme: the design and organization of all the components of a certification program

Competence: the knowledge, attitudes, and skills required of a particular role or activity

Credential: the official document and acronym issued by the certifying body that attests to the certificant receiving the certification credential

Exam: the testing component of a certification program that tests the knowledge and/or skills

Examiner: qualified person who administers an exam

Fairness: refers to providing equal unbiased opportunity to each candidate in the process (*equity, parity*)

Grace period: additional time given to certificants, beginning from the date of expiration to allow certificants additional time to recertify

Grandfathering: a pathway designed for those who were trained or tested prior to a certification program

Inter-rater reliability: the degree of agreement among raters (Inter-rater concordance)

Job analysis: the first step of a psychometric assessment of gathering and analyzing information about the content and the human requirements for a specific professional role in the setting(s) in which it is performed (Task analysis)

Pathways: refers to alternative ways to achieve the certification credential
Preceptor: a qualified person who monitors a candidate during a practicum.
Proctor: qualified person who monitors candidates during an exam
Rater: qualified person who scores an exam
Reliability: the consistency of exam administration and scoring
Psychometrics: standard and scientific method used to assess and measure suitability for a role
Psychometric assessment: assessment that uses psychometric standards and scientific methods used to measure suitability for a role
Qualifications: demonstrated education, training, work experience, or credentials
Subject matter expert (SME): qualified practitioner who is an expert in a particular area or topic
Validity: refers to an exam's results' accuracy, that it measures what they are intended to measure
Verification: act of examining evidential proof of accuracy or truth

Chapter 3
Distressful Situations, Non-Supportive Work Climate, Threats to Professional and Private Integrity:
Healthcare Interpreting in Sweden

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ABSTRACT

This chapter describes situations of distress and the working climate of healthcare interpreters in Sweden. A questionnaire focused on distressful situations was administered to interpreters with experience in healthcare interpreting. The results indicated that distress in healthcare interpreting could be traced back to ethically and emotionally challenging interpreting situations and working conditions, and a lack of respect for the interpreters' work. An interview study using Grounded Theory showed that interpreters' main concern was the threat to professional and private integrity. Despite the fact that in general the interpreting profession in Sweden may seem professionalized, interpreters struggle with dilemmas connected to less professionalized activities. Our study was conducted in Sweden, but we argue that the results can be generalized to other countries. Although differently organized in different countries, health care interpreters experience similar dilemmas. Equal access to equitable care can be effectively hindered by language barriers.

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INTRODUCTION

Healthcare interpreters face many distressing situations. These may include anything from delivering a difficult message or dealing with sorrow and anger, to handling challenging terminology. Research has shown that interpreters often find it difficult to convey certain messages, such as those related to a serious illness. Interpreters may experience difficulty balancing their own feelings of compassion, while being neutral at the same time (e.g. Jungner et al., 2015; Lor, 2012; Butow et al., 2010; Splevins et al., 2010; Hsieh 2008). Previous research also points to the lack of support structures or debriefing for interpreters, which in turn leads to vicarious trauma and burn-out (Lai & Mulayim, 2015; Bontempo & Malcolm, 2012; Splevins et al., 2010).

For the study reported in this chapter we assumed that healthcare interpreters handle emotional distress in the interpreter mediated event. Such distress may differ depending on the specific healthcare sector and from country to country, as working conditions for interpreters and their organizations vary. Research on emotional distress and the role of the healthcare interpreter has been conducted on a larger scale in Australia, South Africa and the United States (Penn & Watermeyer, 2018; Hsieh, 2016). These countries differ in terms of conditions for interpreters and interpreted languages. They also differ from Sweden (our country of study) in that respect. There are differences in terms of users of the interpreting services, for example. In South Africa, the users of interpreting services are often indigenous speakers of official languages, but not the language of the institution in question. In the US, Spanish is the most common language and South America the most common geographical background of users of interpreting services. Australia has large geographical distances. Two groups, immigrants and indigenous language speakers, require interpreting services. The interpreters' task can sometimes be more challenging in countries with large immigrant groups. There are newly arrived refugees who may have experienced trauma. Interpreters in countries with indigenous populations face difficulties related to heritage, culture or accessibility. Other differences may stem from the interpreters' working conditions, how the interpreting services are organized, whether interpreters are staff or independent and whether or not they have been trained.

Healthcare interpreters in any country may come face to face with emotionally challenging situations. Situations can be challenging in different ways. Stress, conflict, cultural background, difficult stories or difficult messages may all contribute to challenging work. Distress can originate in the interpreter, the participants, or even the surrounding system.

The research project on healthcare interpreting in Sweden relies on two different studies with two different methodological approaches, one questionnaire study and one interview study. The overall aim of the two studies presented in this chapter was to explore Swedish healthcare interpreters' experiences of distressing situations in interpreter-mediated encounters in the healthcare context in Sweden: how common these situations are; how the interpreters deal with them, and; what type of support they felt they needed.

The first study, which also laid the ground for the second study, was a questionnaire-based survey of healthcare interpreters' perception of moral distress and handling of difficult situations in healthcare interpreting. Study one was explorative and was based on the following three initial research questions:

1. How distressing (intensity) are different situations that may occur for healthcare interpreters?
2. How frequent are these situations?
3. How ethically supportive are healthcare interpreters' working environments?

The second study was based on interviews with interpreters who expressed their interest in participating in interviews in the first study. The study was performed using Grounded Theory as theory and tools for analysis. The two research questions were:

1. What is the main concern of interpreters when experiencing distressing situations in the interpreted event?
2. How do they deal with the main concern and what support do they need to deal with it?

The objective of this chapter is to shed light on how Swedish healthcare interpreters perceive their work situation, by presenting the combined results of the two studies in the project.

BACKGROUND

Interpreting in Sweden

The study reported in this chapter was conducted in Sweden. Sweden has a heterogenous immigrant population (Statistics Sweden, 2018). Some of the major immigrant groups have come from the Nordic countries, Iraq, Syria, Iran, Afghanistan, Poland, Former Yugoslavia, Somalia, Germany, Turkey, Thailand and Chile. Sweden has experienced regular immigration since the Second World War (WWII). From WWII until the 1970's the immigration was predominantly a work force immigration from countries like Finland, countries in southern Europe, and the former-Yugoslavia. Although refugees immigrated before the 1970's, in the early 1970's, immigration became more refugee-focused. Since then, Sweden has welcomed immigrants from all parts of the world. Like many other European countries, Sweden experienced a dramatic increase in immigration in 2015 (Statistics Sweden, 2018). The immigration came to an almost complete halt in the beginning of 2016, yet the interpreting industry suffered, more than normal. Sweden experienced a lack of qualified interpreters during peak periods.

Sweden has a fairly well-regulated interpreting market. Most interpreters are freelance interpreters who work for interpreting agencies. These agencies are subject to public procurement for the whole welfare and law enforcement sector. The non-Swedish speaker's right to an interpreter in encounters with public services has been enshrined in the Swedish Administrative Procedure Act since 1986. The right was further strengthened in the last version (SFS 2017:900). Article 13 of the 2017 formulation of the Act states that: The public service shall call an interpreter and translate written documents to allow a person who does not speak Swedish to defend their rights. The former version read should call an interpreter if necessary (SFS 1986:223).

Sweden has a state authority also who is responsible for regulating interpreters (Kammarkollegiet (The Legal, Financial and Administrative Services Agency) www.kammarkollegiet.se). Interpreters become authorized based on a written test about the Swedish public service and welfare system. They are also subjected to a test in Swedish language and grammar and a thorough terminology test. Successful candidates take an oral examination with different role-play scenarios. Interpreters are evaluated based on their interpreting skills as well as their understanding of good practice in the profession. Similar testing is done in Norway (e.g. Sagli, 2015) and Australia (Hlavac, 2013). The first level of authorization is a general authorization. Several interpreting situations are tested, including those involving social services, healthcare and legal interpreting. Both the oral and the written tests are based on such situations. Inter-

preters who have passed the general authorization can then choose to specialize in healthcare or legal interpreting and pass a specialized authorization test in these areas. There are about 1,100 authorized interpreters in Sweden, who operate in 37 languages. This figure should be compared to the rough estimate that there are more than 4,000 active interpreters in 170 languages in Sweden (Almqvist, 2016).

Sweden offers training courses for public service interpreting both at post-secondary school level (folk-high schools) and university level. The so-called folk-high schools are common in the Nordic countries (Finland, Sweden, Norway and Denmark) and northern Europe (Germany, Austria and Switzerland). Folk-high schools typically do not grant academic degrees, although they may teach typically academic topics such as languages or science. They are often publicly funded and based on the Danish philosopher Grundtvig's pedagogical ideas on education as universal and common (Frímansson, 2006).

Sweden has a number of folk-high schools offering interpreting courses as post-secondary, adult education courses. The Swedish National Agency for Higher Vocational Education determines the content of these interpreting courses. It is a four-month course comprising 545 hours of teaching on different subjects. Healthcare interpreting is taught for 120 hours. Candidates must have a high-school degree and often their language skills are tested before entry. The Swedish National Agency for Higher Vocational Education determines and monitors the requirements for passing the course. Students who pass the final tests are entitled to be registered by Kammarkollegiet (see above).

Sweden has one university program for public service interpreting. The program is run at the Institute for Interpreting and Translation Studies at Stockholm University. The program consists of two semesters at BA-level. The university authorities set the curriculum which has been developed by active interpreters together with researchers in the field of interpreting (Almqvist, 2016; Tiselius and Wadensjö, 2016). To be eligible, students must have a high-school degree and pass a screening test in their two working languages. Interpreting in all types of contexts is taught; interpreting in social services, in healthcare, in migration settings and in legal settings. The program also looks at interpreting techniques and ethics in interpreting. Healthcare interpreting is taught for one-and-a-half term.

The professionalization of an occupation consists of several processes where the occupation acquires characteristics such as a systematic theory surrounding it, professional authorities regulating and training it, and a professional culture and code of ethics (cf. Abbot, 1988). From a perspective of professionalization, it could be argued that the Swedish interpreting profession shows many indicators of being reasonably professionalized and quite well organized. Swedish interpreters have access to training and they can obtain an authorization as proof of their knowledge. Swedish law regulates the use of interpreters and there is research on interpreting. The market for interpreting is regulated by a public call for tenders.

Healthcare Interpreting

Healthcare interpreting is well researched both in Translation studies as well as Healthcare studies. Interpreting in healthcare can cover any type of situation from emotionally uncomplicated sessions with a physiotherapist to end-of-life consultations in pediatric healthcare. In many contexts, healthcare interpreters have little to no training. They may also not be properly remunerated. Healthcare interpreters have a huge responsibility for rendering a correct message. Patient lives rely on correct translation of symptoms or instructions for the administration of drugs. For an international overview of healthcare interpreting see Roat and Crezee (2015).

Studies on interpreting in healthcare have covered many different aspects of healthcare interpreting, including how it is organized in different countries (Lundin et al., 2018; Penn & Watermeyer, 2018;

Benjamin et al., 2016; Angelelli, 2004), the relative cost of the use (or not) of interpreters (Bischoff & Denhaerynck, 2010; Flores, 2005), and the interpreters' role in the interpreter-mediated event (Leanza, 2017; Souza, 2016; Krystallidou, 2016; Hadziabdic et al., 2014; Hsieh & Kramer, 2012).

When it comes to the interpreter's task and role in healthcare interpreting, and how interpreters handle culture in interpreting, authors such as Wadensjö (1998), Pöchhacker (2008) and Skaaden (2013) argue that the interpreter's task is to render and coordinate other people's utterances. Wadensjö and Skaaden both argue that this does not mean the interpreters should be seen as a language conduit. Instead they can be seen as participants in the interaction co-constructing the message. They carry the bilingual conversation without "owning" it, in the words of Jungner et al. (2018). Research has found that interpreters are also informing or clarifying cultural issues (e.g. Angelelli, 2004; Rosenberg et al., 2008; Hsieh, 2016; Souza, 2016). There has been an increasing trend to recommend cultural mediation along with language mediation.

In terms of distress in the interpreter-mediated event, conclusions from studies focusing on how interpreters deal with distress in healthcare interpreting, show that interpreters need more support and more training to handle distressing situations (Lai & Mulayim 2015; Bontempo & Malcolm 2012; Splevins et al., 2010, Hsieh, 2008). In many studies, suggestions given to improve the interpreters' situation include mentoring, help with stress management and professional development of, for example, new medical terminology, and how to be supportive towards the patient (Butow et al. 2010). Finally, studies focusing on the users or clients of interpreting have shown that they too need training on how to effectively make use of interpreters, both in terms of cultural awareness as well as cultural competence. Also, when it comes to learning how to work with interpreters, clients need to be educated (e.g. Jungner et al., 2015; Butow et al., 2010).

MAIN FOCUS OF THE CHAPTER: HEALTHCARE INTERPRETING IN SWEDEN

The working conditions for healthcare interpreters in Sweden have not systematically been studied to our knowledge, although the interview study by Norström et al. (2012) also included interpreter with experiences from working in healthcare. Just like other types of public service interpreting in Sweden, healthcare interpreting is regulated through a public call for tenders by the local or regional governments. Freelance interpreters are then called to work through the agency which won the tender. They work either on site or over the phone to assist healthcare personnel in their encounters. Healthcare personnel in need of an interpreter have access to a call-center. They have to book an interpreter some time before the session in question (1-14 days depending on the language combination). Some languages are also offered on-call over the phone. In some rare cases, the interpreting agencies provide interpreters permanently on-site.

When healthcare interpreters are called to a consultation, they rarely have more information than time, language combination, clinic and sometimes age and gender. There are multiple reasons for this, but the ones most commonly cited are that the background about the patient or the encounter is either not given by the healthcare personnel or lost in the booking process.

As stated above, interpreters with an interpreting education also have some education and training in healthcare interpreting included in their education. Not all interpreters that are active in the market in Sweden have received training, however. Most Swedish healthcare personnel have not received training on how to work with interpreters. It is not included in the general education for physicians or nurses. There are merely occasional one-off short training courses.

Given the Swedish interpreting occupation and its level of professionalization, we assumed that we could also expect Swedish healthcare interpreters to have access to other support structures through their networks or workplaces, that are similar to other healthcare professions, like nurses or physicians for example.

When we started the study, we speculated that the experience of Swedish interpreters may differ from other countries with a less regulated or less professionalized interpreting sector, when it comes to handling emotionally difficult situations. In light of all of the above, we assumed that the general working conditions for Swedish healthcare interpreters ought to be fairly good, although indications both from our own experience and Norström et al. (2012), although for other types of interpreters, indicated the opposite. If our assumption based on the mechanics of professionalization were true, then the working conditions of Swedish healthcare interpreters should not be creating distressful situations for interpreters.

MATERIALS AND METHODS

This chapter reports on the results from two exploratory studies. The first one is based on a questionnaire and the second one is based on interviews with interpreters. Both the questionnaire and the interview study dealt with distressful situations in the interpreted event, and healthcare interpreters' access to support structures.

Materials and Methods of the Questionnaire Study

A cross-sectional survey was conducted using a study-specific questionnaire, which was distributed to interpreters who had some experience in healthcare interpreting. The questionnaire was distributed both on paper and via the internet.

Sampling and Participants

Interpreters working for the three major interpreting agencies in Sweden were invited to complete the questionnaire. They got information about the questionnaire through the agencies' newsletters. Students at the public service interpreting program at Stockholm University were also invited to participate in the questionnaire study via their teachers. Inclusion criteria included having had experience in healthcare interpreting. Participants were informed about the study at the beginning of the questionnaire. They were considered to have given informed consent once they submitted their completed questionnaire. The questionnaire was answered by 190 interpreters.

Of the 190 respondents who participated, 102 (54%) were women and 87 (46%) were men. One respondent did not state their gender. One respondent did not respond to the questions about experience of healthcare interpreting and two respondents stated they had no experience of healthcare interpreting. These three respondents were therefore excluded from further analysis. Answers from 187 respondents were therefore analyzed. Thirty different languages were represented, and 60 respondents said they had interpreted between more than two languages. The most common language was Arabic (n=69).

Thirty-nine interpreters (21%) had state authorization. Six of these had a specialization in healthcare and eleven had a legal specialization. Twelve (6%) reported that they had no interpreter training at all. Two of those reporting they had no training had been working more than 10 years, two for more than

one year and eight for less than one year. Eighty-two respondents (44%) had taken the full interpreting program at folk-high school (equivalent to four months' full-time course, see above). Twenty-nine respondents (15%) had taken the university program (two semesters full-time). There were also other types of interpreter courses represented, such as single courses at folk-high school (n=45), courses offered by the employment agency (n=8), and internal agency courses (n=12).

The respondents were generally experienced interpreters, with 58% of them having more than 5 years of experience, and 28% between 1 and 4 years of experience. Fourteen percent had less than one year of experience. Seventy-nine percent reported doing healthcare interpreting assignments several times per month or more. All respondents had experience of on-site interpreting, and only eight had no experience in telephone interpreting.

Data Collection

The questionnaire was developed from two questionnaires used in healthcare sciences. The first one, the moral distress scale (MDS), is a scale created to measure moral distress (Corley et al., 2001). The scale has to do with the distress experienced when having to act in a certain way due to institutional constraints that goes against the individual's moral or ethical convictions. The scale includes both frequency (how often the situation arises), and the perceived intensity (level of disturbance) of the situation. The answers are given on a Likert scale. The MDS have been revised (MDS-R) and this version has been translated and adapted to Swedish healthcare (Sandeberg et al., 2017). The other instrument which served as base for the present questionnaire was the Hospital Ethical Climate Survey (HECS) developed by Olson (1998). The HECS was developed to evaluate the ethical climate at workplaces in healthcare. The HECS has been shortened (HECS-S) and, translated and adapted to Swedish healthcare (Pergert et al., 2018). Statements about different aspects of the workplace that influence the ability to identify and deal with ethical issues are provided, for example "in my workplace nurses and physicians trust each other". A Likert scale is used to indicate how consistent the statements are perceived to be with the situation at one's own workplace.

The two questionnaires served as basis for the questionnaire in our study. The statements deemed applicable to interpreters in healthcare were singled out and used in the study-specific questionnaire. The objective was to investigate the levels of distress for healthcare interpreters and interpreters' perception of ethical and supportive climate in their work environment. Examples of statements used for the questionnaire include "rendering a difficult message to a patient/relative, for instance that the patient is seriously ill" from MDS-R and "healthcare personnel supports me in handling challenging situations" from the HECS-S. Furthermore, questions unique to interpreting were added, e.g. "I get enough information about the assignment to be able to prepare".

The questionnaire was then tested through a focus group interview with interpreting teachers (n=8). After the focus group interview the questionnaire was reworked and discussed by the authors of this chapter and then piloted on public service interpreting students (n = 27) (Hägglund, 2017). The final questionnaire comprised 9 background questions, 15 questions about distressful situations (based on the Swedish MDS-R), 10 questions about ethically supportive structures for interpreters (based on the Swedish HECS-S), and one open question. Each of the closed questions had Likert-type scale answers. For the 15 questions on distressful situations participants were first asked to rate the intensity of a distressful situation, i.e. how disturbing the participant found the situation. Then they had to rate the frequency of the situation, i.e. how often this type of situations would occur. The 15 questions about

distressful situations covered interpreting difficult messages; interpreting messages which possibly are opposed to the patients' culture; not being able to intervene due to code of ethics; handling healthcare personnel's or patients' discontent or anger; and interpreting in situations where the other participants does not know how to use an interpreter. The last ten questions about support covered how much support participants perceived that they get from contractors, healthcare personnel or even patients, as well as support structures they would like to have.

Data Analysis

The questionnaire data were analyzed using descriptive statistics with a focus on frequency distributions, mean values and significance. A composite distress score for each of the 15 items about distressful situations was calculated, that is, intensity and frequency was multiplied (range 0–16). All statistical analyses were performed using IBM® SPSS® Statistics Version 25.

Materials and Methods of the Interview Study

In this qualitative study, in-depth interviews were conducted with healthcare interpreters (n = 9) about distressful situations and the interpreters working climate. The participants in the in-depth interviews were invited to participate through the questionnaire in the first study.

Sampling and Participants

The participants were recruited via the questionnaire study. At the end of the questionnaire respondents were invited to participate in an interview about interpreting in healthcare, and 22 volunteered to be interviewed. Of the 22 volunteers nine participated in in-depth interviews, interviews were held until theoretical saturation was reached. Due to geographical distance two were interviewed over the phone. The participants received movie tickets for participating.

Of the interviewed interpreters three were women and six were men. They all had some type of interpreter training. Several had taken specialized courses on healthcare interpreting. Languages represented were Arabic, Aramaic, Dari, English, Farsi, Nepali, Russian, Somali, Spanish and Tigrinya. Four interpreters were freelancers, four were employed as telephone interpreters and one was employed at a healthcare center. They had between 2 and 40 years of experience. The freelancers worked for several different interpreting agencies.

The interviewer (EH) is both a trained and professional psychiatrist and a trained and professional interpreter. None of the participants were colleagues or friends with the interviewer. Six of them did not know that the interviewer had a background in interpreting. Three were distant acquaintances and knew that the interviewer was also an interpreter.

Data Collection

The in-depth interviews were performed using an interview guide based partly on the questionnaire answers from the pilot. They were also based on triggers which asked the interpreters to describe distressful situations in the healthcare sector when they had interpreted. Two interviews took place via telephone,

five at Stockholm University and two at an interpreting agency where the interviewees worked as telephone interpreters.

The nine individual semi-structured interviews lasted between 20 and 60 minutes. The interviews started with general questions about the interpreter's background and interpreter education. As the interview went on and trust was established, the interviewer took up more difficult issues such as difficult interpreting situations or contexts. Open questions were formulated around six main themes, and follow-up questions were used to encourage further explanations and examples in the conversation. The interviews were recorded in all cases except one. Immediately after the interview, it was transcribed and field notes were written for further analysis. Data analysis of the field notes was performed in-between interviews to enable theoretical sampling, and to establish theoretical saturation. Emerging categories could be further explored in the following interviews, in accordance with the method (Glaser, 1998).

Analysis Method

The data from the in-depth interviews were analyzed using grounded theory as method for analysis (Glaser 1998). The transcribed interviews were read by all three authors and in a process of open coding; quotes were tagged and coded line by line until a core emerged. Using the constant comparative method, codes were grouped into categories and when the core had emerged, selective coding was done to delimit the coding to categories related to the core (Glaser, 1998).

Memos were written during the coding process about the categories and their properties. Possible relationships between the categories were also discussed by the three authors and memos were kept of the discussions. During the coding phase, the three authors met on three different occasions to compare codes and discuss what the data was actually about, what categories the codes and incidents were indicating, what the main concern of the participants was, and how codes and categories were related to each other.

Possible core categories were also discussed at a grounded theory seminar with other grounded theory researchers. The memos about categories were sorted and theoretical coding was conducted to integrate the categories (see Figure 5). The authors established saturation of the core and its related categories when different incidents kept indicating the same categories (Glaser, 1998).

ETHICAL ISSUES

Ethical approval for the project was obtained from the Regional Ethical Review Board in Stockholm [2017/2212-31]. Respondents to the questionnaire study were given written information before completing the questionnaire and submitting the questionnaire was considered giving informed consent. Participants in the interviews were given written and oral information and signed informed consent before the start of the interview.

RESULTS

Results from the Questionnaire Study - Distress

In this section, we report on the result from the distress questionnaire (questions based on the MDS-R, described above). When it comes to the intensity and frequency of distress in different situations, respondents report that some situations, such as delivering a message about a child's serious illness, have high intensity i.e. perceived as very disturbing, but low in frequency. Others, such as healthcare personnel have expectations on the interpreters which are not reconcilable with ethical guidelines, have high frequency, but is not very disturbing (low intensity). One could argue that the most interesting situations in terms of how interpreters handle distressful situations are those statements which are both perceived as very disturbing (high in intensity) and perceived as occurring often (high in frequency), such as interpreting for patients with experience of violence, trauma, torture, rape, execution.

Figure 1 shows the composite distress score of intensity and frequency of distressing situations by interpreting experience longer or shorter than 5 years. In Figure 1, we see that there are three situations where there is a significant difference between experienced and inexperienced interpreters, namely to deliver a difficult message to the patient; to tell a parent that their child has a serious disease; and to handle a patient who has been unfairly treated and where the interpreter cannot intervene due to ethical guidelines. In the two first cases, the situations get higher distress scores from experienced interpreters. The last case was given higher distress score by inexperienced interpreters. Although, the other differences seen in the figure are not significant, we can also see that situations where the healthcare personnel or patient direct their discontent towards the interpreter, or when the interpreter has to interpret contexts for which they feel they are not competent, are perceived as more distressing by inexperienced interpreters than by experienced ones.

Figure 2 shows the same statements but now by education. The differences between the groups are less clear, and no differences are significant. Delivering a difficult message to the patient remains a task reported as more distressful by the two groups with longer training. The situation of seeing the patient not understanding the message and not being able to act due to ethical guidelines seems to be reported as more distressful for participants with longer education. It should be stressed that the length of education does not correlate to the length of experience. Interpreters with longer experience do not necessarily have longer training.

Table 1 shows the ranking of distressing situations by interpreter experience. The two groups have the same three items at the top, namely, the patient has not understood the message and the interpreter is unable to act due to ethical guidelines; the user/client does not understand how to work with an interpreter, and; interpreting for someone who has suffered torture, rape, war, executions.

Table 2 shows the intensity, frequency and total distress score for all interpreters by experience. All groups reported higher levels of intensity than frequency for the distressing situations. The mean value of intensity scores for all participants was 2.04 (maximum possible score 4.0). There is a difference (although not significant) between the results for the two levels of experience. The frequency scores for interpreters with longer experience were higher than for the inexperienced interpreters.

*Figure 1. Composite distress score of different situations by experience (p<0.05 *, p<0.01 **, p<0.001 ***)*

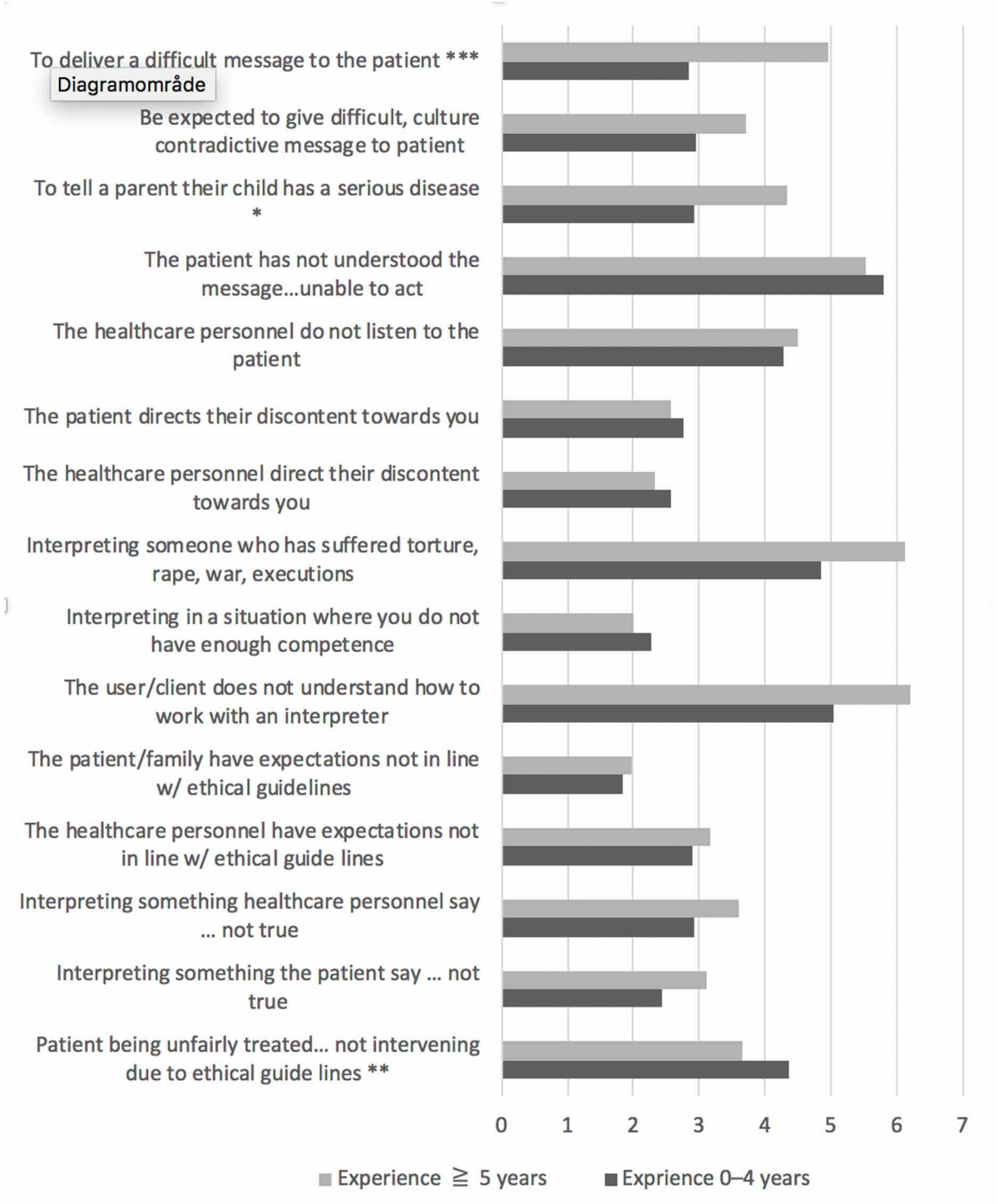


*Figure 2. Composite distress score of different situations by education (p<0.05 *, p<0.01 **, p<0.001 ***)*

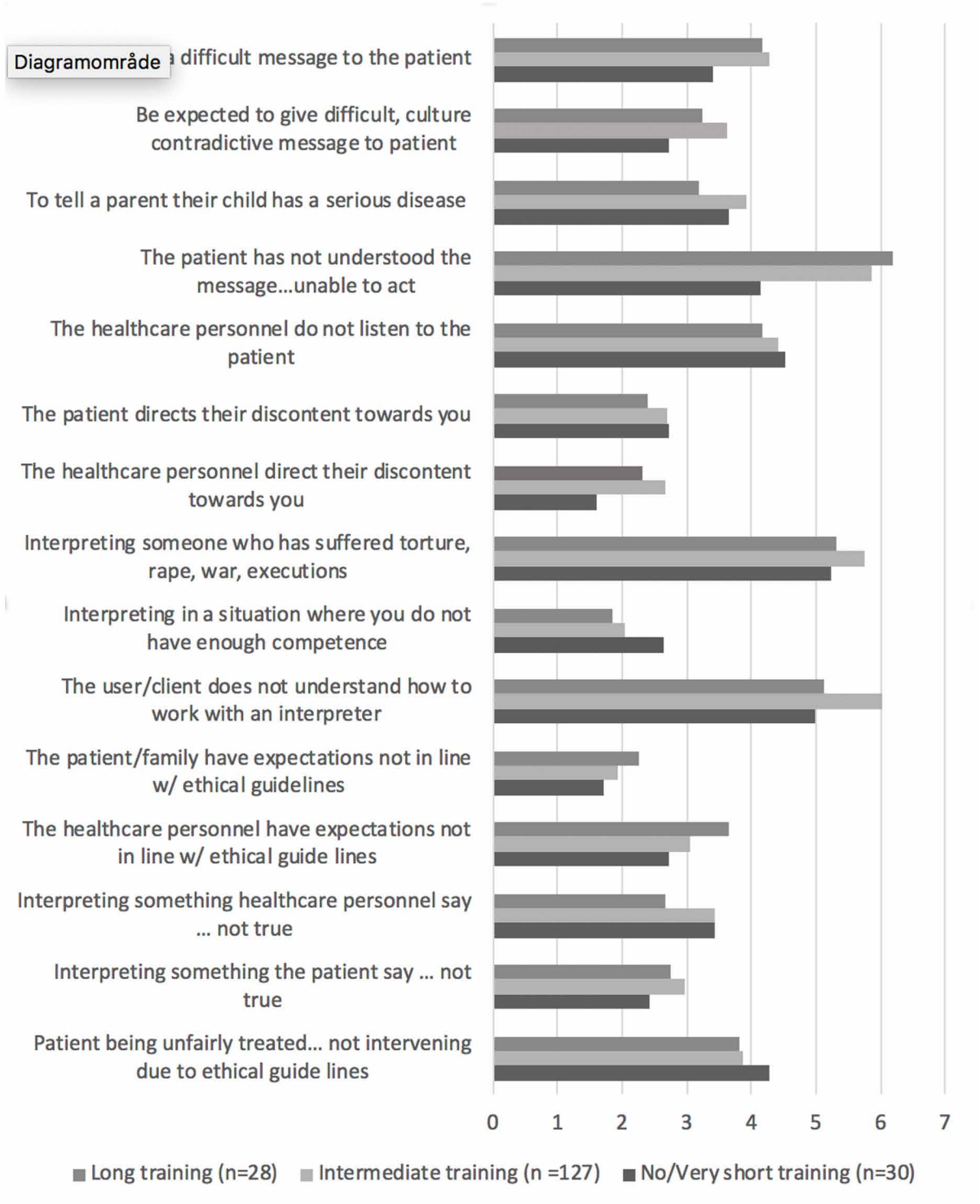


Table 1. Ranking of distressing situations by interpreter experience

Distressing Situations	Experience 0–4 Years		Experience ≧ 5 Years	
	Score	Rank	Score	Rank
Patient has not understood the message unable to act due to ethical guidelines	5,79	1	5,53	3
The user/client does not understand how to work with an interpreter	5,03	2	6,22	1
Interpreting someone who has suffered torture, rape, war, executions	4,85	3	6,12	2
Patient being unfairly treated cannot intervene due to ethical guidelines	4,37	4	3,66	8
The healthcare personnel do not listen to the patient	4,27	5	4,51	5
Be expected to give difficult, culture contradictive message to patient	2,96	6	3,7	7
Interpreting what healthcare personnel say which you think is not true	2,93	7	3,61	9
To tell a parent their child has a serious disease	2,93	8	4,34	6
The healthcare personnel have expectations not in line w/ ethical guidelines	2,91	9	3,16	10
To deliver a difficult message to the patient	2,85	10	4,95	4
The patient directs their discontent towards you	2,77	11	2,56	12
The healthcare personnel direct their discontent towards you	2,56	12	2,34	13
Interpreting something the patient say which you think is not true	2,43	13	3,12	11
Interpreting in a situation where you do not have enough competence	2,28	14	1,99	14
The patient/family have expectations not in line w/ ethical guidelines	1,85	15	1,98	15

Results From the Questionnaire – Ethical Climate and Support

The questionnaire also contained questions about the ethically supportive work climate. Questions were based on the HECS-S questionnaire. On a scale from 1 (never) to 5 (often) interpreters rated different statements about their working climate and conditions. In this section, we report the results from these questions.

Figure 3 shows the frequencies of interpreters' perception of the support they get from their work environment. If the two lowest scores (1 and 2) are put together, then, as can be seen from Figure 3, interpreters experience that they get little support from the interpreting agency (64.5%), healthcare personnel

Table 2. Intensity, frequency and total distress scores in the entire group (overall) and by experience

Category	Overall n=185	Experience 0–4 Years (n=76)	Experience □ 5 Years (n=109)
Intensity, mean (SD)	2,04 (0,99)	1,97 (0,96)	2,06 (0,86)
Intensity, median (range)	2,07 (0–4)	1,97 (0–4)	2,06 (0–4)
Frequency, mean (SD)	1,50 (0,66)	1,38 (0,71)	1,55 (0,63)
Frequency, median (rage)	1,43 (0–4)	1,35 (0–4)	1,5 (0–4)
Total score, mean (SD)	54,12 (36,60)	49,46 (37,6)	57,40 (35,81)
Total score, median (range)	49,50 (0–186)	43,00 (0–186)	51,00 (0–182)

SD: standard deviation

(75.1%), or patients (90.3%). Furthermore, 65.8% feel they don't get enough information to prepare for assignments. However, 69.9% of the interpreters do not feel that they have to take on assignments where they don't feel qualified, for economic reasons.

Figure 4 shows the interpreters' responses, from 1 (not important at all) to 5 (very important), to different statements about the type of support they feel would help them handle distress. Collapsing the two highest scores (4 and 5) shows that 60.8% of the interpreters would like more education and 60.6% would like to get more support. Furthermore, 77.9% of the interpreters think that the users of interpreting should get more information about using interpreters. A majority of the interpreters also think that it is important both that the interpreting agency provides more information about the specific assignment (80%), and that the healthcare personnel give more information to the interpreters before the assignment (77.8%).

The questionnaire also had one open question, which invited participants to give suggestions which would facilitate the interpreter's work. Sixty-eight interpreters answered the open question, and fifty of the suggestions were related to the interpreters' working conditions, for example "[I would] like to get more information about the nature of the assignment and not just the name of the authority or the clinic", "Telephone interpreting is much more demanding", " [I would] like the interpreting user not to diminish me and my role as interpreter", "[I would] like them to respect the timing of the assignment".

Results From the Interview Study

The following section summarizes our results of the analysis of the data from the interviews using grounded theory. Figure 5 is an overview of our results. In grounded theory, a main concern is generated, and the core category explains how participants deal with the main concern using several approaches. The main concern and the core category are placed within a context, and in our case the context is "healthcare interpreting". Below, we explain the different concepts in Figure 5 from our data.

Figure 3. Interpreters' perceptions of ethical and supportive work climates.

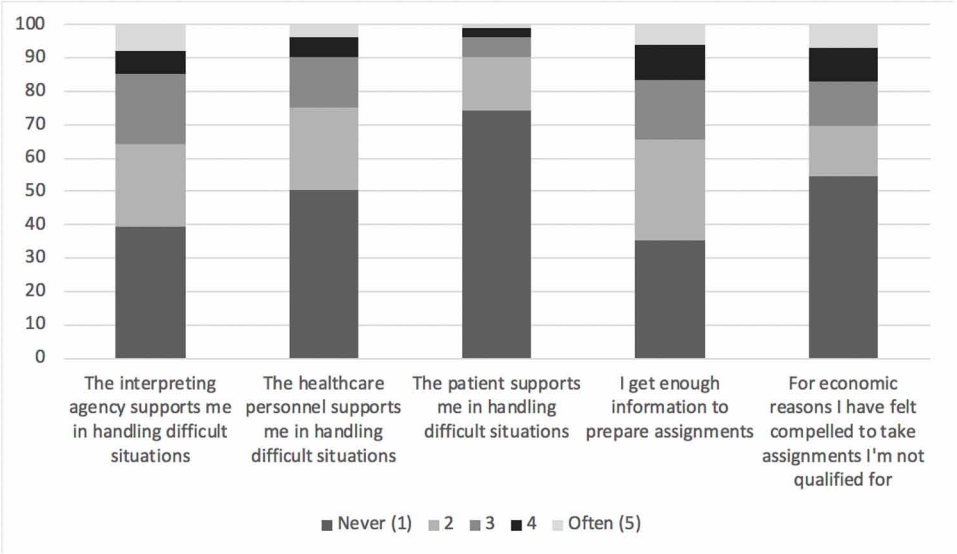


Figure 4. Interpreters' attitudes to different types of support to handle distress.

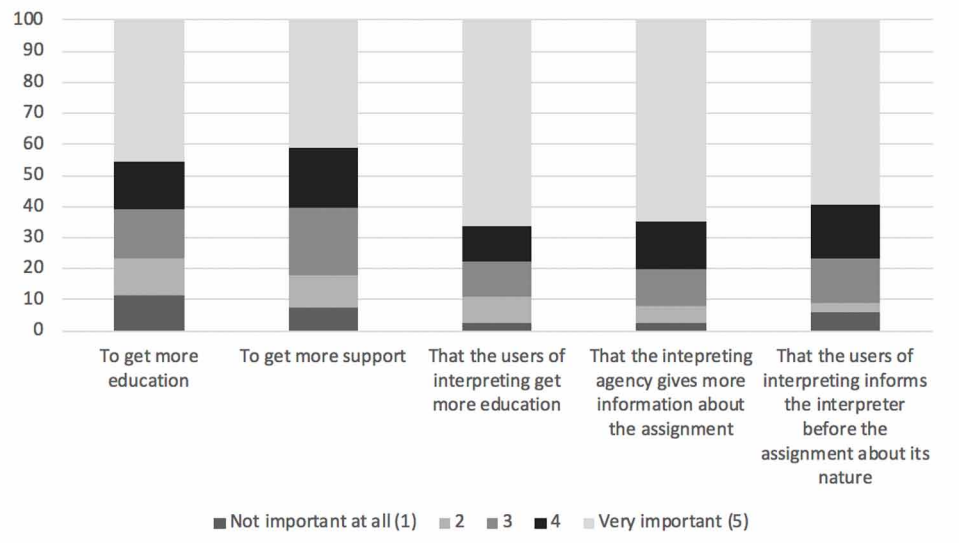
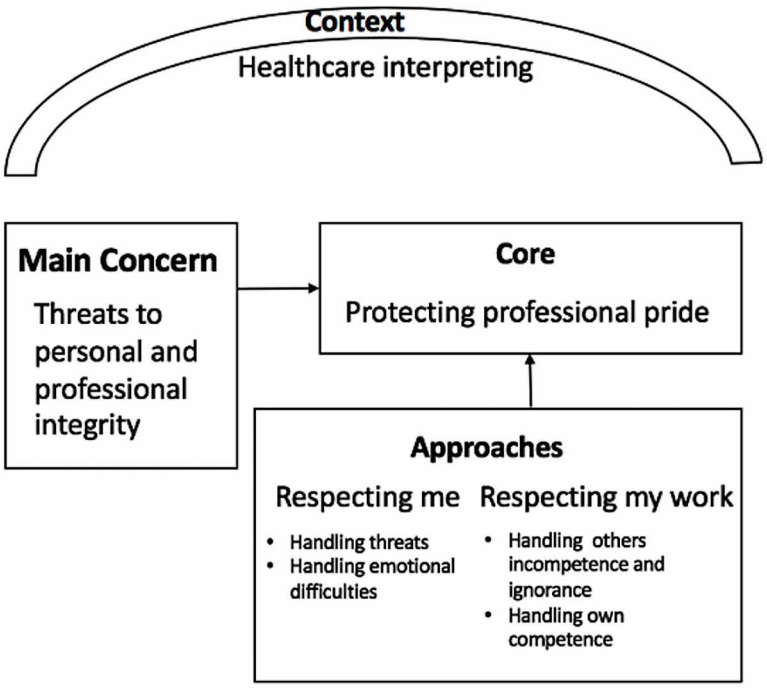


Figure 5. The conceptual model (after Glaser1978) for explaining the theory about threats to (interpreters) personal and professional integrity



Context: Healthcare Interpreting

As we have seen above in the results from the questionnaire, interpreting in healthcare involves many delicate or distressful situations. These situations can potentially involve interpreting other's trauma, interpreting difficult messages, but also difficulties of understanding both terminology as well as participants' different accents, dialects and languages. Many interpreters are freelancers working for an interpreting agency, which means that they come into the clinic, hospital or healthcare center for the interpreted event only. They are not part of the healthcare team. All of them share the same language as the allophone patient. Many also share the same ethnical or national background. Most interpreters are careful so as not to become an ethnical ally for the patients although this also represents an ethical distress for them. Unclear professional or personal identity leads to interpreters often feeling under-valued, misunderstood and even threatened. Threats occur both as covert "When they lie, they always blame the interpreter. It's always the interpreter who is the black sheep", and overt "Where are you [to a telephone interpreter], I will come and fuck both you and your mother. You speak against me". When it comes to emotional difficulties, the interpreters have many examples of distress, or as this interpreter sums up "We are humans, we're not made of stone. Children who are vulnerable, women who get raped, beaten and things like that […] We are living it, we are like actors, so we get very affected by the situation that a human being is being treated like that".

Interpreters also experience that few of their clients understand their profession, and the conditions for their work. They have to explain conditions for interpreting, like that healthcare personnel and patient should talk directly to each other, or that the interpreter use the first person "I" when they interpret, or that they prefer to be seated in a triangle for eye-contact and easy monitoring of the conversation.

Interpreters also struggle to read the room in telephone interpreting as they do not have visual access to the room. They sometimes encounter healthcare personnel who do not tell them how many other persons are present in the room or who they are. The interpreters also say that when they give these explanations, their clients can get upset that the interpreter "wants to decide" or "takes over". They also have to handle the fact that their need for time management is not respected. This means that interpreters are both booked and cancelled with very short notice, and that such changes are not reflected in remuneration or even understanding for any inconveniences that might occur for the interpreter, such as having travelled far for an assignment. In order to handle both work-related and emotional threats to their personal and professional integrity, healthcare interpreters go to great lengths to increase their own competence. They often pay for their training courses themselves.

Main Concern: Threat to Personal and Professional Integrity

The main concern for interpreters working in this environment in terms of the threat to personal and professional integrity stems from the fact that they are neither part of the healthcare personnel nor an ally to the patient. They are often met with lack of understanding and respect for their profession. Healthcare personnel often do not understand how to work with interpreters, and when the interpreters try to inform them, the healthcare personnel are offended. Patients do not understand the role of the interpreters and may expect them to be an advocate. Or, they may not trust the interpreter for different reasons or even threaten the interpreter.

Core: Protecting Professional Pride

The core category, that is, how the interpreters continuously deal with their main concern of professional pride, was to maintain integrity and professional pride and included two approaches or strategies to carry out the core. In our case the approaches are 'respecting me' and 'respecting my work'. Our interpreter-participants took great pride in their work, saying "I'm often proud of my interpreting". They strived to be correct, well-educated and respecting the interpreting code of conduct. "I have taken many courses. Since the nineties, I have been educating myself, the language is like a sea". As we shall see, education is a condition for the interpreters in this context in order to protect their professional pride.

Respecting Me

Respecting me, which should be understood as respecting my professional interpreter persona, includes consequences for the interpreters to uphold to maintain respect when personal and professional integrity is limited or threatened. We divided these into consequences related directly to emotional difficulties and difficulties related to external conditions. Respecting me includes 'handling threats´ as well as ´handling emotional difficulties´.

Handling Threats

The interpreters have to handle threats including handling both pronounced threats and covert threats in relation to the work situation. In order to handle threats from the patient to the interpreter, the interpreter for instance point out that the interpreter is only the messenger. They would for instance tell the patient and doctor "I'm only the interpreter" and thereby indicate that as interpreter they are merely passing on a message. Those who work in a call center also report that they use the call center as a protective environment. This means that they are not present physically with the patient, so they cannot be identified and threatened. They can hit the mute button "I turn the sound off!" and get a break between calls. "I tell the team leader that I need air".

Handling Emotional Difficulties

To handle emotional difficulties, interpreters report that they talk with colleagues, although some believe it does not always help. The interpreters were also setting limits, such as conditions they need in order to interpret. "I have to set limits, and do it immediately, because I have to know I can continue to interpret for this patient". They were also developing self-help strategies, including staying with the doctor to let the patient leave alone, taking courses, taking a time out (one interpreter even stopped working for several years), seeking counselling privately or even just getting tougher with age and experience.

Respecting My Work and My Competence

Another approach to protect professional pride is to raise awareness about the difficulties in interpreting and the conditions around interpreting. They would also work on increasing their own competencies and knowledge. Such actions show their desire to manage competence, both that of others and their own,

in different contexts. Respecting my work and my competence includes handling other's incompetence and ignorance, and handling own competence.

Handling Other's Incompetence and Ignorance

Interpreters talk about the conditions for interpreting. Certain conditions may annoy the other participants in the interpreting setting. "From time to time I remind them to speak directly to each other and doctors often can't handle it, they get annoyed." Handling other people's incompetence also has to do with saving (the other person's) face, by discretely correcting or checking things. "If they say something really strange, I may pretend I didn't hear and ask for clarification".

In terms of handing the conditions imposed by others, they may choose to hide the fact that they work for several agencies. "I sometimes work for a different agency, although it's considered disloyal". Handling conditions can also mean cutting a client short because the call center booking was only made for one hour and the next call is already in line. "But I have to hang up. It's the supervision, they check everything, and if the next interpreting start at ten, then it's difficult, I have to hang up". Interpreters also report being forced to do telephone interpreting as "payment for on-site interpreting is so low and they rarely pay for traveling there."

Handling Own Competence

Most interpreters in the interview study had taken many training courses. They had taken responsibility for their competence, and were taking courses both in interpreting and "also took courses for my own interest, not really related to interpreting, but to learn more [about healthcare]". It was important for them to be professional and knowledgeable, when they meet their clients. They would get training even if it meant that they sacrificed their weekends or would spend money on expensive training. From time to time they needed to bracket their knowledge to some extent: "it's very frustrating when I have to sit there silent and not use my background knowledge [as the interpreter should be neutral and impartial]".

DISCUSSION

The purpose of this study was to investigate distressing situations for healthcare interpreters in Sweden, and to gain knowledge about healthcare interpreters' main concerns and how they address them. We investigated the interpreters' experiences using both questionnaires and in-depth interviews with a grounded theory approach. Using the questionnaire, we investigated the intensity, frequency and total distress score of different situations. The study was explorative but we aimed to investigate how distressing different situations that may occur for interpreters in the healthcare sector are, how frequently these situations occur, and how ethically supportive the interpreters' working environments are.

Our results from the questionnaire showed that interpreters with longer experience ($\geq$ 5 years) get significantly higher distress scores for delivering difficult messages to patients, and also for telling a parent their child has a serious disease (Figure 1 above). Experience interpreters also give higher distress score to interpret for victims of torture, rape, war or executions, and to handle users who do not understand how to work with interpreters, although this difference was not significant. The fact that experienced interpreters score this higher may be due to the fact that they do this type of interpreting more

often than inexperienced interpreters, and thereby the composite distress score is higher for this group. It may also be due to the so-called crescendo effect (Epstein and Hamric 2009). The crescendo effect is a combination of an increase in moral distress and the increase in so called moral residue, which is the lingering effect after morally problematic situations. Epstein and Hamric (2009) described the crescendo effect among healthcare personnel as how moral distress and moral residue builds up due to repeated experiences of moral distress. If healthcare interpreters with long experience find these situations more distressing it could be the effect of repeatedly having to deal with morally problematic situations and the build-up of moral residue.

Our results also showed fewer clear differences with regard to education (Figure 2), which we interpret as due to the fact that the interpreter education in Sweden is so diverse. Some very experienced interpreters had no education, while other interpreters in the data had longer education and short experience. The recent Swedish public inquiry into the state of the interpreting profession in Sweden also supports this data (SOU 2018:83).

When we ranked the distress scores given for different situations for the two groups (inexperienced and experienced interpreters) (Table 1) we found that they rank distressing situations more or less similarly. The three situations ranked the most distressing were when the patient had not understood the message and interpreters felt unable to act due to ethical guidelines, when they had to work with users who do not understand how to work with an interpreter, and interpreting for victims of torture, rape, war and executions. That interpreters find it distressing not to be able to act as they find themselves gagged by ethical guidelines is supported by findings from many other authors (e.g. Souza 2016; Hsieh and Kramer 2012; Angelelli 2004). These finding are often also used as an argument to let interpreters advocate for the patients. We believe, along the argument of Granhagen Jungner et al. (2018), that this result points to the fact that the interpreters often do not understand the concept of their discretionary power (Skaaden 2013), often due to lack of training, and that this leads to unnecessary feelings of frustrations and limitations due to ethical guidelines. It may also, of course, mean that the ethical guidelines are poorly formulated.

Finally, the results about the ethically supportive climate showed that an overwhelming majority of participants felt they did not receive support from interpreting agencies and healthcare personnel, which confirms the conclusions of Norström et al. (2012). Interpreters are freelancers, yet they regularly work for the same interpreting agency as some kind of quasi-employee. It is therefore surprising that they don't feel they are getting this support. The healthcare personnel are not their employers, but they often work together with healthcare personnel in professional teams around a patient. It is troubling that they are not included in different support structures there.

All participants also stressed (despite their generally, fairly high levels of education), the need for more education, more support and also more education of users of interpreting as well as the need for more information about their assignments. These may be considered natural and desired in any work environment, and pointed out already by Tebble in 2003.

As stated above, we noticed in the open questions in the questionnaire that many of the open answers were linked to working conditions. With this in mind, we continue to the interview study, which would investigate the main concern of interpreters when experiencing distressing situations in the interpreted event, and how they would deal with this main concern.

We found that the interpreters' main concern was threats to personal and professional integrity. The core variable here was to protect professional pride. As described above, interpreters used several different strategies to do this, but these strategies could be boiled down to the approaches respecting me and respecting my work. We have described the situations for interpreters in Sweden in our background.

Sweden is a country with a fairly regulated and professionalized interpreting market, so it was quite disheartening that this was found to be the main concern.

Another disheartening finding is the amount of distress related to working conditions, although Norström et al. (2012) had similar results for another Swedish interpreter population. When we started collecting data, we assumed that distress for interpreters in healthcare would revolve around interpreted encounters generating distress. We also thought this would connect to the limited opportunities for debriefing, support or counselling.

Handling distress of interpreted encounters also came up during the interviews. Interpreters recounted stories about having to seek counseling privately or taking professional time-out. They also described how they developed self-help strategies. This is described above in the strategy handling emotional difficulties. This only came up as one of the many codes supporting the main concern. We were surprised that these codes did not seem to be the most important part of the main concern. As reported under the strategy Handling threats and Handling other's incompetence and ignorance, for some of the interpreters, other situations related to a non-ethically supportive work climate, for instance how they had to deal with interpreting agencies considering them disloyal, or getting threats from patients, or having to handle time conditions imposed by others, were equally distressing for them. They described these in the answers to the open question.

The interviewed interpreters said that it is not distressing to interpret a delicate or difficult situation, when the healthcare personnel know how to use interpreters. They also talked about developing their own debriefing strategies for handling the distress in the interpreted situation. One interpreter talked about participating in the interview of our study as debriefing and others that they took courses to debrief. None of our participants had seen the counselor available through the interpreting agency, reasons given for this was that the support was not developed to be easily accessible, and one interpreter even suspected they would lose their assignments if they tried.

Moral distress is thus an issue for healthcare interpreters, as is moral residue and the crescendo effect. Interpreters also feel they lack an ethically supportive environment.

STUDY LIMITATIONS

Results may be skewed as all participants were recruited on voluntary basis through interpreting agencies. We did not reach interpreters who were not naturally, regularly in contact with agencies, or interpreters who were less interested in discussing their work environment or work situation.

Participants in the project were only hearing allophone language interpreters, other aspects may come up from hearing or deaf sign language interpreters.

The participating interpreters may also have felt that they had to be loyal to the agency when they filled out the questionnaire or participated in the interviews.

Furthermore, the study only covers Sweden, and although the study confirms result from studies from the US, more countries need to be studied.

FUTURE RESEARCH DIRECTIONS

Interpreting in healthcare contains both comprehensive dilemmas which can be found in any healthcare context, and very country specific dilemmas. Although healthcare interpreting is well researched in some aspects, there is a need to explore the situation in more countries and also specific areas of healthcare (pediatrics, geriatrics, oncology and so forth) as well as interpreting for different healthcare professions and different types of patients (e.g. indigenous language speakers or signers, allophone language speakers or signers). Research in healthcare interpreting would also benefit from validated common survey instruments, most questionnaires, just as ours, are study specific which limits the possibility of comparison between clinics, professions, specializations, regions or countries. A validated instrument would also promote larger studies giving a fuller understanding.

Observational studies or reach out studies aiming healthcare interpreters who do not come forward voluntarily is also needed. The general understanding of healthcare interpreting is based on the interpreters who volunteer to participate which creates a bias of that understanding.

Implementation studies can also contribute to the understanding and hopefully improvement of healthcare interpreting. An implementation study takes the starting point in the needs identified, for instance in this study, and implement tools to improve specific situations or contexts. The focus of the study (e.g. working conditions, handling distress) is measured before and after the implementation phase.

CONCLUSION

Healthcare interpreters, as do healthcare personnel, work in a context where many encounters may be potentially distressing. Looking at regulation and work organization of Swedish healthcare interpreters, they would seem to work in a fairly well regulated and professionalized occupation. No previous studies in Sweden have taken a general approach to investigating healthcare interpreters, their potential distress, and ethically supportive work environments.

Our results showcase distress and the main concern in distressing situations for healthcare interpreters in Sweden, but can be generalized to other countries as the distressing situations are global. We pointed out at the beginning of our chapter that since Swedish interpreters are part of a professionalized occupation, one could assume they had access to support structures. As the research has demonstrated support structures are lacking, interpreters are left to their own devices for obtaining support. We also showed that working conditions for Swedish healthcare interpreters contribute to interpreters' distress, and the interpreters develop strategies to handle threats due to working conditions.

Our chapter looked at healthcare interpreters in Sweden only, but it can serve as an example for studying the healthcare interpreting profession in other countries. Rules and regulations, and working conditions, differ greatly from country to country, even within the European Union, for example. Systematic and research-based evidence of the deficiencies of support and work climate of healthcare interpreters contribute to improve the conditions for interpreters and as a result of that the equal access to equitable care for allophone patients, which is legislated in many countries, but effectively hindered by language barriers.

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KEY TERMS AND DEFINITIONS

Allophone: Canadian term for a person who does not speak either English (anglophone) of French (francophone), used in this text for a person speaking a non-indigenous minority language, a language other than the majority language of the institution in question.

Discretionary Power: Term coined by legal philosopher Ronald Dworking, further developed for decision making in professional work by Social Scientist Anders Molander, and introduced in interpreting by Hanne Skaaden (see reference list). Discretionary power is the professional autonomy that an individual who is practicing a profession governed by rules and guidelines such as interpreting has in order to exercise their own professional judgment.

Ethically Supportive Work Climate: A work climate which is defined by both a high social capital (i.e. mutual understanding, shared aims, and unifying members of social networks and communities) as well as support for the individual to feel confident and supported in making ethically or morally difficult decisions.

Healthcare Interpreting: This text uses healthcare interpreting rather than medical interpreting as interpreters in Sweden interpret for all types of healthcare professions, rather than being limited to the medical encounter with a physician or a nurse.

Moral Distress: Term used in healthcare and nursing, introduced by Andrew Jameton, which describes the emotional state that arises from situations when someone feels that the ethically correct action is hindered by institutional constrains or provisions. The situation may create a moral and ethical dilemma where the person feels powerless.

Questionnaire: The questionnaire is the actual instrument, preferably developed and tested for validity and reliability, consisting of several questions or items and distributed to a population which one would like to investigate for some reasons. The questionnaire in this project measures attitudes rather than exact instances of a specific phenomenon.

Survey: The survey is a more comprehensive approach to a field, a survey can comprise several instruments for data collection such as questionnaires, register-studies and/or interviews.

Chapter 4
An Overview of Medical Interpreting in Brazil

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ABSTRACT

Among the settings where there is a need for interpreting services, healthcare contexts require special attention, given the complex nature of medical practice, which consequently imposes different challenges to interpreters. In Brazil, the language barriers faced by patients who do not speak Portuguese are handled mostly by volunteers without any specific training. This article gives an overview of the current demands for interpreters in medical settings in the country and the need for analysis and actions aimed at the development of a professional field to ensure access to health services in the country for linguistic minorities by qualified interpreters. There is a need for public policies to recognize the demand and elaborate linguistic access tools. There is an urgent need to include this specialization among interpreting studies agendas, in the Brazilian context, to include interpreting for healthcare.

INTRODUCTION

In its broadest sense, medicine aims at restoring and maintaining health. Equal access to health and medical services is a fundamental human right, established in Article 25 of the Universal Declaration of Human Rights. The practice of medicine and the success of its goal depend primarily on the patient-provider relationship, or the therapeutic rapport. In turn, many studies have found that the quality of patient-provider communication is one of the essential conditions affecting satisfaction in clinical interactions and that it sustains the goals of medical practice (Ong, Haes, Hoos & Lammes, 1995; Gomes, Caprara, Landim & Vasconcelos, 2012; Stewart, 1995).

The guiding questions of this article stem from those two presuppositions: full and equal access to health and communication quality in the provider-patient relationship. As such, are patients who cannot communicate in Portuguese - Brazil's official language - being neglected with regard to their right to full and equal access to health because of the language barrier? Who are these patients?

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To answer this question, first we must look more closely at the patients who might be caught in this problem. In the context of an internationalized world and the new dimensions of migration flow, numerous foreigners migrate to Brazil; refugees, border residents, and international tourists are increasingly dependent upon education, legal, social assistance, and health services outside their own social, cultural, and linguistic contexts. In addition, Brazilian citizens who do not speak Portuguese also depend on such services - for example, Deaf persons and indigenous peoples. Among the basic services needed, health care stands out because of the complex nature of medical practice, which increases exponentially when there is a language barrier.

In other countries, including the United States, the problem of equal access to health for patients who do not speak English has been addressed through legal cases and practical actions that began in the 1970s and launched a professional field for healthcare interpreters. Yet in Brazil, aside from a few exceptions, such as with services for the deaf and hard of hearing, there is little debate about language barriers in general or in the medical field. This lack of awareness calls for reflection on social rights in this and other interlinguistic spaces. Aside from a few cutting-edge institutions that have departments devoted to caring for foreign patients, as in most countries, the vast majority of hospitals in Brazil do not offer formal interpreting services. Such gap leads us to seek answers to other guiding questions: In hospital settings, who provides interpreting services for non-Portuguese speakers, and how is it done? To what extent are interpreter training programs in Brazil addressing the issue and including it in practical and theoretical courses? And what are the requisites for training qualified interpreters to work in healthcare settings and launch an institutionalized and recognized professional field in the country? This chapter seeks to answer, as much as possible, the guiding questions outlined above. It stems primarily from the author's graduate research project at the Federal University of Santa Catarina, Brazil, carried out from 2009 to 2011. The Master's thesis, focused on assessing the country's language access situation in the medical field, especially as compared to other countries where awareness of the problem and action to solve it are more prevalent. In addition to an extensive literature review, the author conducted a series of interviews with hospital administrators and medical staff, individuals who were acting as interpreters, and patients who speak non-Portuguese languages. She also analyzed existing university-based and private training courses for language professionals. Until this groundbreaking research, the topic had not been studied in Brazil. Because of the lack of systematized demographic and institutional data in the country, the author assessed current practice by analyzing information shared by health facilities in Brazilian and US media outlets and by healthcare representatives she interviewed (Queiroz, 2011).

BACKGROUND

Community Interpreting

In some countries, healthcare or medical interpreting is categorized as a subgroup of community interpreting; other community interpreting contexts include education, law, and social services. In other countries medical interpreting developed as a stand-alone specialization, and was not grouped with all other non-conference interpreting categories. Additional terms used to define community interpreting that occur at an intrasocial level (Pöchhacker, 2004) include social, cultural, contact, and public service interpreting (Queiroz, 2011). Studies on this topic tend to converge around the analyses of community interpreting characteristics and to what extent these settings are different from conference interpreting

contexts. In summary, community interpreting was a term used to describe dialogic interpreting, as opposed to mostly unidirectional conference interpreting. The fundamental differences are related to context, interpreting mode, social status of the participants involved in the dialogue, and purpose of the encounter (Roberts, 2000b; Pöchhacker, 2010).

Community interpreting is nothing new, and it has been a common practice to mediate a wide range of human negotiation for centuries (Roberts, 1994; Pöchhacker, 2004, 2010). In recent history, the need to transcend communication barriers between individuals from distinct cultural and language groups surged mainly because of migration patterns around the world that marked the 20th century. Interlinguistic and intercultural negotiations intensified not only in the political-diplomatic sphere but also in daily life, where a wide swath of individuals started using the services in the new globalized world. In this cross-cultural and cross-linguistic context, providing qualified interpreting services is usually seen as a means of ensuring language access for individuals who are not fluent in a country's dominant language, therefore allowing them to receive necessary services.

Community interpreting started to gain more space in Interpreting Studies in the 1980s, when the field shifted its focus to new analyses, namely those related to context, the content being interpreted, the purpose of the interaction, and the other parties involved in the encounter, looking beyond just the interpreter. Until then scholars had been particularly interested in interpreters' cognitive processes, especially those of conference interpreters. Research on dialogue-based encounters mediated by interpreters emerged due to new social needs sparked by an expanded immigrant influx in developing countries and an increase in the recognition of the rights of minority language speakers, who were having difficulty accessing public services and fighting for their rights (Pöchhacker, 2004; Wadensjö, 1992).

That said, two decades later it is still not clear to what extent the research developed in the field of Translation Studies has undergone changes to its key issues with regard to globalization and the linguistic phenomena derived from it. Even though it was included in more recent surveys of the field (see Williams & Chesterman, 2002), community interpreting was not a widespread research topic in translation or interpreting in Brazil for a long time. Concern regarding the risks involved with ad hoc interpreting have ushered in, albeit slowly, a body of research focused on pedagogical and political questions, aiming to form a professional field of community interpreting (Queiroz, 2011; de Pedro, 2010; Origuela, 2014). This issue has also been somewhat marginally addressed at academic events and was the focus of some discussions at different symposia in 2013, organized by the Brazilian Association of Translation Researchers (ABRAPT), and of the First Brazilian Symposium on Interpreting (SIMBI) in 2013.

Educational and legal interpreting are further developed in Brazil, especially for encounters taking place between Portuguese and Brazilian Sign Language speakers. The prominence of this language pair is in no small part because of Federal Law no. 10,436 and decree 5,626/2005, which allow users of Brazilian Sign Language (called *Libras*) to access public services through translation and interpreting services (Law no. 10,436, 2002). This law, enacted in 2002, has been instrumental in the development and funding of initiatives to ensure language access for Brazilians who speak Libras. A similar law for spoken language speakers who do not speak Portuguese would surely encourage greater progress in this area.

Another growing demand comes from foreign students enrolled in the Brazilian educational system. According to the school census carried out by the Brazilian government's National Institute of Educational Studies and Research (INEP), between 2008 and 2016 there were a total of 73 thousand immigrant students from a wide variety of nationalities in public schools alone. Among them are over four thousand Bolivians, 1,200 Japanese, about 550 Angolans, and 540 Haitians. Brazilian legislation establishes the right for foreigners to access education in the same manner that Brazilian children and adolescents do,

as established in articles 5 and 6 of Brazil's Federal Constitution, articles 53 to 55 of the Children and Adolescents Statute, articles 2 and 3 of the Guidelines and Fundamentals of National Education Law, and articles 3 and 4 of the Migration Law. In addition, articles 43 and 44 of the Refugees Law ensure that the absence of documentation cannot impede access to education.

Access to communication is not just a challenge for students who need to adapt to a new language and the socio-cultural configurations at school, but also for parents who end up distancing themselves from their child's academic life. However, there is no sign that teaching institutions in Brazil engage any professional interpreting or translation services as tools to ensure full educational access to these students and their parents.

Except for a few publications (Novaes Néto, 2011; Nordin, 2018; Queiroz, 2012), the problems experienced by non-Portuguese speakers in Brazil who need legal interpreters have not yet been addressed by Interpreting and Translation Studies scholars in Brazil. The language barrier in these settings is mostly mediated by state-certified legal translation-trained interpreters registered with the judiciary department. Since 1943, national regulations have been in place for these professionals, who must undertake and pass a multi-layered selection process under the auspices of state commercial registries. Such registries have no connection with professional translation or interpreting training and assessment and no objective or explicit affiliation with Brazilian professional associations in the field. Openings for state-certification are limited to a few spoken languages, and to date there have been none for Libras interpreters. However, in some states there are legal interpreters registered with various judiciary offices. According to a presentation delivered by Jaqueline Nordin at the 2013 SIMBI and entitled "Best practices manual for legal interpreters" (Nordin, 2013), non-qualified interpreters work more frequently in the state and federal courts than state-certified ones. According to her, the reason seems to the low remuneration in courts, which amounts to less than 150 Brazilian reais (equivalent to less than $50 USD) for a 3-hour shift and which is often paid with a delay of as much as two years. Nordin stated that bilinguals are often automatically entitled "legal interpreters" and registered with the state judiciary offices, but that they are not following international standards. Such "interpreters" are categorized as experts and follow a pay scale regulated by the judiciary that is not attractive to state-certified translator-interpreters, who earn according to higher pay scales set by the state commercial registries. Nordin produced a manual based on her presentation and it is used in all federal courts in the city of Guarulhos, São Paulo, with the goal of establishing the ethical principles and behaviors for the profession. This manual was further developed into a book (Nordin, 2018).

MAIN FOCUS OF THE CHAPTER

There is a real demand for healthcare interpreting in Brazil. Progress has been slow mostly because of the lack of political and institutional initiatives for supporting practices to reduce the negative impact caused by cultural and linguistic barriers. There is also a lack of theoretical and methodological reflections on this issue, and the lack of a wide range of training programs in general interpreting, much less in specialized healthcare interpreting.

Many healthcare facilities in Brazil have seen a growing number of patients who do not speak Portuguese. However, language access for such patients is haphazard and improvised, and the complexity of patient-provider interactions and the health risks involved in poor communication are ignored. As suggested by a book edited by Whaley (2000), provider-patient encounters are quite complex when it

comes to communicating and understanding illness, and such complexity increases if there are language barriers. Practices and studies in other countries have proven that qualified interpreters minimize the risks associated with multilingual medical encounters and ensure effective treatment.

HEALTHCARE INTERPRETING

Healthcare interpreters mediate communication between healthcare patients and providers (doctors, nurses, technicians, psychologists, administrators, etc.) who do not speak the same language. The dialogue in these interactions can be quite emotional, depending on the nature of the problem. Patients tend to speak in a more subjective manner and use less formal and less technical terminology to describe the reasons for their visit. Providers, on the other hand, tend to use more objective, formal, and especially technical utterances to perform diagnoses and outline treatment. These interactions take place in clinical departments (doctor's offices, exam rooms, operating rooms, etc.) and administrative settings (triage, registration, social services, financial services, etc.). For this reason, the quality of healthcare interpreting depends on interpreters who are versed of the wide variety of medical settings and who have 1) technical skills (linguistic proficiency, knowledge of medical terminology, communication flow management, particularly complex for mental health encounters, skills with regards to positioning and physical space arranging, use of technological tools to be able to provide remote interpreting services through the phone or video, etc.); 2) social, political, and administrative skills (knowledge of the various medical departments and specialties and knowledge of the administrative and legal factors of this setting that determine medical practice particular to the country(ies) where they work; and 3) cultural knowledge (medical, health, illness, and treatment concepts with which each party in the encounter is familiar). Interpreters who work in the healthcare field must also be prepared to deal with a wide range of emotional and risky environments, and therefore also need self-assessment and self-care skills (Queiroz, 2011).

This skill set represents the elements of effective interpreting services that value not just accuracy with regard to verbal and non-verbal information, but also careful treatment of ethical and conduct dilemmas among the parties involved. For patients, professional interpreting services should provide them unrestricted access to information regarding their health, the institutions treating them, the institutions' care procedures, and the medical care team responsible for their treatment. Thus, patients can make informed and balanced decisions and their autonomy is respected within the encounter, enabling them to share their concerns and questions and to create the necessary rapport between them and their providers (Bowen, 2000; Ku & Flores, 2006; Ertl & Pöllabauer, 2010; Schillinger & Chen, 2004; Joint Commission, 2010). For healthcare providers, professional interpreting services enables precise access to complaints regarding patient concerns, which facilitates the diagnosis and treatment processes.

Knowing, understanding, and practicing the skills outlined above is the main differentiating factor between professional interpreting services and those done in an ad hoc manner, generally by bilingual hospital employees, friends and family members (including children), or by volunteer interpreters with no training in healthcare interpreting. Several studies have sounded the alarm regarding the potential problems generated by using untrained interpreters (Schlemmer & Mash, 2006; Angelelli, 2004(a), 2004(b); Bischoff, 2003; Flores et al., 2003; Ertl & Pöllabauer, 2010; Pöchhacker & Kadric, 1999). Reported experiences highlight how the lack of certain skills can become a real challenge for interpreters because it often places them on the outer fringes of their role.

The role of healthcare interpreters, that is, their purpose in the encounter, is a central and controversial theme in studies developed in this field. Much of the debate centers on the degree of involvement by the interpreter, along a continuum that varies from the interpreter as a linguistic decoder who interferes only minimally with subjective information, and the interpreter as a mediator between individuals who also have different social roles. It's important to consider questions of contextual order related to cultural, administrative, and legislative circumstances, especially because there is little room for negotiation with the latter two. For example, in the United States and Canada, the interpreter's role tends to be much clearer and less flexible with regards to his/her relationship to the patient because of a series of laws that guarantee confidentiality of patients' medical information and limit the roles of healthcare providers.

This theme of the interpreter's role in healthcare must be treated carefully and take into consideration known concepts because it generates heated debate in Translation and Interpreting Studies, especially with regard to neutrality and visibility (see Metzger, 1999; Angelelli, 2004(a), 2004(b); Rudvin, 2003; Anderson, 2007; Pöchhacker, 2004; Leanza, 2008). This paper will not focus on the level of neutrality or visibility of interpreters, but instead highlight the potential risks of ad hoc interpreting for all parties involved in the encounter and especially for the patient. As stated by Avery (2001), "…the health care interpreter role involves a complex set of skills and expectations practiced within a setting that is socially, culturally, and politically complex at both an interpersonal and institutional level" (p. 11).

Healthcare Interpreting Demand and Status in Brazil: A Comparison to the United States

In Brazil, as well as in other countries, the demand for healthcare interpreters has intensified especially because of the influx of labor migrant workers and refugees and the inclusion policies for minority groups (Niska, 2005; Bancroft, 2005). In some countries healthcare interpreting is already well established as a profession: Austria, Germany, Norway, United Kingdom, Ireland, Australia, United States, Canada, and South Africa are some examples (Bischoff & Hudelson, 2010). In others, like Brazil and other South American countries, the practice is seen simply as assistance generated by a need for communication.

A significant part of the demand comes from foreigners from various places who go to Brazil in search of asylum or work and who seek care at public hospitals and cannot pay for private interpreters. The recent migratory wave in Brazil includes individuals from Bolivia, Peru, Paraguay, Argentina, Syria, Haiti, Korea, and China. Currently there are about one million foreigners living legally in Brazil. However, many other foreigners are present unlawfully because they do not fit any of the legalization options available in the country. One example of the inclusion policies is Amnesty Act no. 11,961, enacted in 2009, and which provisionally regulated about 50 thousand foreigners who had been living irregularly in Brazil and who qualified according to the prerequisites proposed in the law. According to data from the Ministry of Justice, the law aims at ensuring the freedom to circulate in national territory, access to remunerated work, education, public health, and justice. In 2017, Migration Act no. 13,445 replaced the Foreigner Statute, which had been in place since 1980. Among the principles and guarantees to migrants outlined in Article 4 of this law is the right to access public health services and social assistance. There are also some municipal efforts to regulate immigration status. One example of this is São Paulo Municipal Act no. 16,478, enacted in 2016. Among the priorities actions for this law is implementing free access to healthcare.

In the last 20 years, Brazil has been a popular destination for many refugees. According to the National Committee of Refugees (ACNUR) report, "Refugees in Numbers", up until the end of 2017 Brazil had

officially accounted for a total of 10,145 refugees from several countries, while only 5,134 of them continue to be actively registered with the Federal Police, the entity that registers, monitors, and maintains records on foreigners. Of these, 52% live in São Paulo, 17% in Rio de Janeiro, and 8% in Paraná. Syrians represent 35% of the official refugee population in Brazil. ACNUR also reports that 2017 was the year with the highest number of requests for refugee status recognition: 33,866 in total. Over half of these requests, or 17,865, were from Venezuelans. Cubans accounted for 2,373 requests, Haitians for 2,362, and Angolans for 2,036. The states with the highest numbers of requests are Roraima (15,955), São Paulo (9,591), and Amazonas (2,864), according to data from the Federal Police. Refugee status temporarily regulates the residency of a requester in Brazil, ensuring the right to access public health services.

In addition to the influx of refugees, foreign patients seeking medical care cross the border from various countries on a daily basis (Giovanella, 2007). These individuals count on friends or hospital employees with some knowledge of their language to help them seek medical treatment. They also use body language and gestures to help them access healthcare services. A few hospitals are investing in language classes for their employees as an attempt to mitigate the problem (Queiroz, 2011).

Another demand comes from international tourists. According to the Ministry of Tourism, Brazil received over 6.5 million foreign tourists in 2017. One type of tourism that has been gaining ground in other countries as well as Brazil is medical tourism (Ministry of Tourism, 2010). This type of tourism directly increases the number of patients seeking care in Brazilian hospitals who do not speak Portuguese. Because of the high quality and low cost of its medical care, Brazil has joined the rank of some of the most sought out countries for treatment and surgery by foreigners. The Heart Hospital, in São Paulo, says it receives over 350 foreigners every year. The Samaritan Hospital in Rio cares for approximately 800 foreigners annually. In 2017, Hospital Sírio-Libanês said it saw its foreign patient population grow by 68% in the previous three years. According to ANAHP (Brazil's Association of Private Hospitals), oncological, cardiac, orthopedic, neurological, and cosmetic surgeries are the most sought out specialties. The highest numbers of foreign patients in Brazil come from the United States, Angola, Paraguay, and France.

The Brazilian media has noticed this increase in foreign patients at Brazilian hospitals. In 2006, *Veja* magazine, a widely circulated weekly, published an article by Ruth Costas entitled *Scalpel Tourism*, which stated that over 30 thousand tourists had come to Brazil that year for medical treatment. The number was double if one included tourists who combine conventional vacation travel with healthcare services. The same magazine reported in 2010 that the number increased to fifty thousand in the city of São Paulo alone for the year 2009. A 2018 article, published by a large daily newspaper with national circulation, *Folha de São Paulo*, highlighted the increase in foreign patients at São Paulo hospitals. Albert Einstein Hospital, for example, sees about 4,800 foreign patients every year. Most of them are from Latin America, North America, and Angola.

In addition, many leading hospitals are starting to track and hire staff based on language knowledge. The staff members can be doctors, nurses, and other medical professionals. These employees are then asked to act as dual-role interpreters, even though they are not trained as interpreters. In São Paulo, Hospital Alemão Oswaldo Cruz, for example, has tracked which of its nurses speak English and/or German. The demand for these languages is higher in specialties such as urology, gastrointestinal surgery, and orthopedics, according to a hospital administrator.

As part of the author's Master's research project, a survey regarding language needs was administered in 2010 to hospital staff at the University Hospital Professor Polydoro Ernani de São Thiago, in the southern state of Santa Catarina. The answers illustrate a complete lack of knowledge regarding the

risks involved in encounters with language and cultural barriers. Employees stated that when a friend or family member is not available to interpret for a patient, a colleague with some language skills is called. In response to the question, "How do you diagnose a patient with whom you cannot communicate because of a language barrier?" frequent answers included "I pray it'll work," "I can recognize the symptoms just from looking at the patient," and "I use gestures to take care of the patient." A hospital representative stated there is no type of specific training or procedure when caring for LPP patients; in other words, there is no official protocol for employees to follow on what to do in the event of a multilingual encounter. On patient registration forms there is no space for entering a patient's mother tongue or preferred language of care. In fact, this lack of language identification is true for the entire country; no hospitals ever inquire about a patient's language.

As one can surmise from the examples above, none of these institutions make reference to the need for professional interpreters. The responsibility for mediating communication is transferred to other professionals who are experts in their fields but who often lack the necessary interpreting skills. Despite the legal processes for immigrant and refugee access to Brazil and the mention of the right to access healthcare services, financial resources and clear rules about language access are needed for legislation to be fully enforced. In other words, the laws exist on paper but there are no means or guidance for implementing them, such as funding, definitions of what it means to be proficient in a language, required training in interpreter skills and roles, etc. Such gap precludes the possibility of trained interpreters and therefore appropriate oral and written assistance through qualified interpreters; as a result, LPP individuals have less chances of understanding their rights and responsibilities as patients, and are therefore less capable of achieving social and financial autonomy.

Even though many insist on a monolingual tradition, Brazil's multilingual reality has gained visibility during the last decades, especially through social movements that address issues like culture, ethnicity, regionalism, and border sub-culture. There are ten countries bordering Brazil, all of which are Spanish-speaking, with the exception of French Guiana, Guyana, and Suriname. That said, until 2010 there was no question in the national census survey regarding language, a fact which highlights the lack of understanding for the need to map the country's languages and illustrates a lack of attention regarding linguistic issues and the need for equal access policies for LPP individuals. Furthermore, the question about language focused on indigenous languages and Libras. According to the 2010 Census, among the non-Portuguese speaking Brazilians there are 897 thousand indigenous people from 305 different ethnic groups and who speak 274 different languages, as well as nearly 10 million Deaf and hard of hearing individuals.

The law is not very clear when it comes to healthcare access for indigenous peoples. In 2005, the Ministry of Health created a program entitled Indian-Friendly Hospital that established admission criteria when caring for indigenous people, including the right to have an accompanying guest. Even though some studies consider this "companion" to be an interpreter, there is no indication as to the professional status of such person. Projeto Xingú, which has worked in partnership with the Paulista School of Medicine for over 50 years to provide healthcare services to indigenous people, stated that one of the project's biggest obstacles is the language barrier between providers and indigenous people; its team members also said that such barrier is minimal when there is an interpreter during the encounter.

Despite the loud demands from Deaf patients in Brazil, there still are not any systematized official data on the number of deaf Libras users in the country. Brazil's Deaf citizens can rely on Federal Law no. 10,436/2002 and Decree 5626/2005, which guarantees interpreting services, and specifically mentions healthcare services. However, at the moment, Deaf patients still depend on poorly trained or untrained

interpreters, however well-intentioned and dedicated these might be. Accounts from people acting as Portuguese-Libras interpreters highlight several issues: lack of terminology in Libras, which for the most part not include the wide range of medical terms that are used in a patient-provider encounter; lack of knowledge regarding human anatomy and physiology and medical procedures; inexperience of providers with regard to working with interpreters; difficulty referencing speakers (use of first or third person); turn-taking in conversation; interpreter positioning during different types of medical encounters; among many others (Queiroz & Weininger, 2013). One interpreter said that there are many stories of Deaf patients receiving wrong diagnoses during sessions interpreted by family members. Even though the laws are clear about working with interpreters when communicating with Libras users to access healthcare services, the law does not outline any suggestions for raising financial resources to hire interpreters as employees at healthcare facilities. Many studies that include interviews with Deaf patients mention the lack of hospital-based interpreters. Even though it has been 13 years since the decree regulating Libras in the country was enacted, many hospitals are still not ready to care for patients who communicate in sign language.

Training for Healthcare Interpreters in Brazil: Current Status and Recommendations

Despite the fact that Brazilian laws and policies have established that immigrants and Deaf citizens have the right to access social services, there are very few means that ensure communication access for these individuals, such as the availability of professional interpreters qualified to work in intrasocial settings. Because of this problem, in order to structure a recognized professional field, professional associations must be involved, research in the area must be developed, and curricula for interpreter training must be created. Therefore, we will now take a look at the extent of involvement and progress by academic institutions and professional translation and interpreting associations in the country.

In terms of undergraduate and graduate Translation Studies programs in Brazil, the number of classes that address theoretical and practical aspects of translation is much larger than those that address interpreting. Of the classes on interpreting, the vast majority focuses on simultaneous conference interpreting, especially for English-Portuguese. None of the course curricula analyzed for the author's master's thesis mention any type of theoretical or practical aspects of healthcare interpreting. More recently, however, the bachelor's degree in Language and Libras offered at the Federal University of Santa Catarina (UFSC) and other universities, which aims to train Libras translators and interpreters, revised its curriculum to include topics on intrasocial interpreting settings. Healthcare and legal settings are addressed in classes such as Interpreting Studies and discussed in activities in classes such as Interpreting Practice (Rodrigues & Santos, 2018). In São Paulo, University Nove de Julho has a Portuguese-English translation and interpreting program, and it recently included class on community interpreting.

In more recent developments, non-academia-based programs have emerged for interpreter training in community settings. Associação Alumni, a private entity founded in 1955 that provides training in English as a foreign language and has a long-standing training program for translators and interpreters, is now offering two different modules in healthcare interpreting. The company's website mentions that when completed together, the two modules add up to the requisite training time for individuals to qualify for taking IMIA's certification exams in the US. Interpret2b, an interpreter and translator training program established in 2016, offered the first 40-hour medical interpreter training program in Brazil in 2017. The program's first edition, coordinated by the author and Laura Vaughn Holcomb, was taught by

instructors from different countries, where community interpreting is in varying phases of development. The curriculum included socio-cultural topics in the profession as well as practice in the interpreting modes used in healthcare settings. The instructors were Georganne Weller, a researcher in community interpreting in Mexico; Luciana Carvalho, a psychiatrist at the College of Psychiatry of the University of São Paulo; Liz Essary, who has an MA in Conference Interpreting and teaches medical interpreting at various institutions in the US; Elena Langdon, who has an MA in Translation Studies and teaches at the University of Massachusetts (UMass) Amherst and other institutions across the country; Andrew Clifford, director of the MCI (Master in Conference Interpreting) Program at York University; Izabel Souza, a medical interpreting researcher and consultant in the US; Cristiano Mazzei, director of Online Translator and Interpreter Training at UMass Amherst; Tatiana de Oliveira, a medical interpreting instructor at York University's MCI Program and at Seneca College in Canada; Flávia Lima, medical interpreter and MA candidate at York's MCI Program.

In 2018, Interpret2b offered its first legal interpreting course. This 44-hour course was coordinated by Jaqueline Nordin, and several legal professionals in Brazil and abroad collaborated as faculty. Nordin was the leading instructor and other instructors were Tatiana Raineri, an instructor at the MCI Program at York University; Simone Cristina de Oliveira, a state court judge; Daniel Fontenele, a federal prosecutor; Juliane Rigon Taborda, a public defender in Brazil; Gladys Matthews, NAJIT president and instructor at the MCI Program at York University. Interpret2b will continue to offer both the medical and legal interpreting programs annually. In addition, it might increase the length of these programs and develop continuing education courses.

In Brazil, there are several national entities that represent professional translators and interpreters: Brazilian Association of Translators and Interpreters (ABRATES), National Translators Union (SINTRA), Professional Association of Conference Interpreters (APIC), and Brazilian Federation of Associations for Professional Translators and Interpreters and for Interpreter-Guides of Sign Language (FEBRAPILS). None of these organizations offered any training or certification activities for healthcare interpreters. None of them have a code of conduct and ethics for such setting either. The only code developed in Brazil for spoken language interpreters and translators is SINTRA's, but it is specifically geared toward legal interpreting and is subject to ambiguous and arbitrary interpretation. The code of ethics for sign language translators and interpreters has clearer language, but it would be necessary to adapt it to fit specific settings. The International Medical Interpreters Association (IMIA) has a Brazil Division, but it is currently inactive, and while its standards of practice and code of ethics were translated into Portuguese, they have not been tested or submitted for review in order to be adapted to Brazil's context.

CURRICULAR PERSPECTIVES

In addition to the numerous healthcare-interpreting programs offered in the US, there are programs in Canada, Australia, and a few European countries. In Asian countries, despite the growing demands for healthcare interpreters, there are very few programs (Queiroz, 2011). Aside from the US, most programs are for community interpreting and include a few classes in medical interpreting. Such is the case in the UK, Denmark, Sweden, and Australia. In the US and Canada, some institutions have focused on programs devoted entirely to medical interpreting, but other than a few exceptions, most of the programs do not address the entire range of skills and knowledge areas necessary to master medical interpreting, according to the task analyses undertaken by the two national certification entities for medical interpreting in

the US (CCHI, 2016; PSI, 2010). For example, interpreting techniques in its various modes and the use of technology for remote interpreting and for databases are not included in most programs.

An interesting curricular proposal for training healthcare interpreters emerged from a partnership among universities in Austria, Finland, Germany, and Slovenia during a project developed between 2007 and 2009, entitled MedInt (see Ertl & Pöllabauer, 2010). One of the fundamental goals of this curriculum was to create strategies for increasing awareness among interpreter users (providers and patients) and governmental entities about working with qualified interpreters to help mediate interlinguistic and intercultural medical encounters. In addition, the curriculum was designed to allow for easy adaptation in contexts that went beyond the scope of the project.

Along with some US programs, the MedInt project is an interesting model than can more readily meet the demands of the Brazilian context, especially because it focuses solely on medical interpreting and is adaptable to different audiences. As long as attention is paid to the relevant differences among settings in the Brazilian context, the MedInt project can also be used as base guidelines for curricular proposals in the country, as well as in other Latin American countries. One of the differences from the European context is the sensitivity toward multilingual and multicultural variations, so common in Europe. In Brazil, demographically there are a lot less cultural and linguistic variations, and cultural specificities are subtler, especially with regard to the different Hispanic cultures. Even though the Spanish-speaking countries surrounding Brazil are quite varied, in Brazil people rarely discuss the cultural and linguistic particularities of each one. Another relevant difference is that the MedInt project was created for a context in which healthcare is mostly a public service, without any significant private practice, whereas in Brazil private healthcare services fill the gaps neglected by the public system; such context should be reflected in any program's curriculum.

The MedInt project argues that the implementation success for healthcare interpreting curricula depends mainly on public awareness regarding full access to medical services on behalf of members of linguistic minority groups. For this reason, the various national institutions involved with linguistic, immigration, inclusion, and health policies need to be on board from the beginning. Despite the fact that Brazil does not have any robust legislation regarding linguistic and cultural access, the contextual background provided in the amnesty and Libras laws and the propositions included in the Declaration of Human Rights can be used as tools not just for raising awareness but also for requiring the use of qualified interpreting services.

As noted above, the lack of official data on minority languages in Brazil complicates the ability to create language access laws. For this reason, organizations such as Pastoral Services for Migrants, the National Indian Foundation (FUNAI), the Ministry of Health, the Ministry of Justice, and foreign consulates, among others, bear the responsibility for collecting and organizing updated demographic information through census surveys, so that regional and demographic needs for access to healthcare services by linguistic minorities can be determined. Institutions that offer training programs for translators and interpreters and in health sciences, as well as professional associations in Brazil are potential partners for this awareness-raising phase and can contribute by organizing, promoting, and/or sponsoring research and discussions on the topic. In addition to actual classes or programs in healthcare interpreting, teaching institutions can play a key role in increasing public awareness by including historical and theoretical references to the issue of language access in other classes and programs, so that future allied professionals can contribute to finding solutions that work in Brazil. Nursing, dentistry, allied health, and medical programs, for example, can incorporate notions of language access, cross-cultural issues in communication and healthcare practices, and the differences between untrained and trained interpreters.

From a short-term perspective, it would be interesting for anyone involved in structuring future healthcare interpreting programs to consider how they could benefit different types of groups that are already filling the gaps, such as ad hoc bilingual employees pulled in to interpret and interpreters with experience in other fields. A course focusing on these professionals could meet seasonal and urgent demands, such as those brought on by international sports events that draw dozens of thousands of tourists to Brazil from several countries.

On the other hand, from a long-term perspective, it's important that programs focus on developing curricula that benefit other parties, such as students in language, translation and interpreting, and healthcare programs, and immigrants residing in the country. And since immigrants' educational experience is not always recognized in their new countries of residence, having a degree program in healthcare interpreting could provide a professional pathway for them that benefits from and values their linguistic and cultural expertise.

With regard to linguistic proficiency, which needs to be an admission pre-requisite for healthcare interpreting courses, there are several institutions in Brazil that test for it in a variety of languages (Queiroz, 2011). The ideal fluency level in the source and target languages can be identified through partnerships with language experts.

CURRICULAR GUIDELINES

Curricular guidelines for the author's master's thesis project and this paper are based on the competencies and sub-competencies outlined by the MedInt project as the foundation for healthcare interpreter training. Competencies are defined in the MedInt project as "the combination of aptitudes, behavior, knowledge, and know-how necessary to carry out a given task under given conditions (Pokorn, 2008). Table 1 outlines these competencies, to be learned by interpreting students during a course.

The practical and theoretical knowledge for developing such competencies should be used to develop course content, which needs to be tailored to specific interpreting settings, taking into account the type of demand and the available human, technical, social, and financial resources. Course objectives regarding depth of knowledge and skills (beginner versus advanced, for example) will vary according to course duration and target audience.

CONCLUSION

In Brazil, because of a language barrier, access to healthcare is limited for patients who are Deaf and use Libras, indigenous peoples who do not speak Portuguese, immigrants from around the world, border residents, and international tourists. Since there are no official demographic data on these individuals and their healthcare usage, they depend on government and private institutions to categorize the information and thus legitimize their social needs.

When non-Portuguese-speaking patients need medical care, they must rely on ad hoc interpreting, done mostly by bilingual friends, family, or volunteers, in an improvised fashion (Queiroz, 2011). As international research has shown, there are various risks involved when using non-professional interpreters to mediate healthcare encounters (Nápoles et al., 2010; Flores et al., 2003; Flores, 2006). Such risks include lack of knowledge, misuse, or omission of medical terms, so vital for the success of encounters,

Table 1. Competencies and skills suggested by the MedInt project

Competency	Skills
Interpreting Service Provision	Master different interpreting techniques appropriate for the situation (e.g., consecutive interpreting, sight translation, note-taking, simultaneous interpreting), as necessary; placement and dialogue management (turn-taking); recognize and manage ethical dilemmas and professional role limits; define and negotiate hours and budgets with clients
Linguistic	Understand and use grammatical, lexical, and idiomatic structures in L1 and L2
Intercultural	Recognize different cultural concepts surrounding health, illness, and treatment, or any other cultural aspect that can interfere with the encounter's success.
Technological and information mining	Access technological tools for remote interpreting (video/telephone); actively research medical terms and procedures; organize and manage term bases.
Thematic	Actively research current legislation that oversees medical activity in the country and innovations in medical interpreting both nationally and internationally.

diagnoses, treatments, and therefore the patient's health. Moreover, the lack of skills for dealing with ethical dilemmas or cultural differences, ignorance of policies and healthcare system specifics, and poor notions of self-care all negatively impact the quality of interpreting. Even though Brazil has some inclusion and language access laws, debates about the risk of using ad hoc interpreters in medical encounters and other social contexts are all but non-existing.

The US experience, where professionalization of medical interpreters has rapidly evolved during the last decade, highlights the need to reflect on existing language laws in Brazil and their limited enforcement. It also sheds light on the need to involve professional translation and interpreting associations and to start considering how to professionalize healthcare interpreting in the country, so that patients and providers can rely on qualified, well-paid, and safety-aware interpreters.

Training courses for interpreters in Brazil are almost entirely focused on conference settings and English-Portuguese as a language pair. The one exception found is the undergraduate program in Language and Libras at the Federal University of Santa Catarina, which is currently revising its course components and now includes intrasocial contexts in the Interpreting Studies classes and practicum. In the future, it will become necessary to reflect on the mission and objectives of these courses and evaluate whether students are developing the necessary skills to work in specific settings. For this, research projects in Translation and Interpreting Studies should reframe their theoretical and methodological questions to meet the training demands for interpreters acting in the full range of settings.

Based on MedInt's curricular proposal, this paper concludes that the development of a professional field of healthcare interpreters in Brazil depends on public awareness building through institutional partnerships and on curricular guidelines that can be used to design a range of programs. Such programs need to focus, in part, on developing the skills, knowledge, and competencies to work in medical settings. In the more immediate future, shorter and more focused courses can be developed to meet current and emergency needs. Over time, and with the involvement of professionals in the larger field, more complex and longer courses can be designed. A national certification program could be the following step, but depends first on the creation of programs and on establishing medical interpreting as a profession.

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Section 2
Medical Interpreting Practice

This section describes different activities and issues related to the actual performance of the duties related to the provision of medical interpreting services.

Chapter 5
The Medical Interpreter Mediation Role:
Through the Lens of Therapeutic Communication

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ABSTRACT

While it is claimed that the role of medical interpreters is constantly changing, perhaps it is the understanding of their role that is evolving. The aim of this chapter is to provide an initial exploration of the contextualized issues and challenges related to interpreting therapeutic communication. The qualitative data analysis of nine specialist certified medical interpreters showcase some of the therapeutic factors that influenced their approach and practice. In addition to the interlinguistic and intercultural communicative goals, interpreters utilized their interpersonal, communication, and mediation skills to meet several therapeutic objectives. Interpreters described mediating therapeutic interaction and intervention, playing a therapeutic mediation role in addition to well-known linguistic and cultural mediation roles. Interpreters described their preoccupation and engagement in the therapeutic process, suggesting specialist medical interpreters play an important role in the therapeutic process.

INTRODUCTION

Therapeutic communication, also called health communication, has been researched extensively within the field of communication studies, providing healthcare professionals with clear communicative strategies to enhance their therapeutic aims. Hsieh (2008) was the first researcher to explore how interpreters use communication to manage health and illness. Interpreting is now amply recognized as an interdisciplinary field (Vargas-Urpi, 2011), and the role of the interpreter is a common research theme. Research on the medical interpreters' role(s) has described a multiplicity of roles: monitor and arbiter (Takeda, 2009)

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conduit, clarifier, patient advocate, intercultural mediator (California Healthcare Interpreters Association, 2003), informant, community or cultural representative, and co-diagnostician among others. There is a need to further explore issues surrounding the role and responsibilities of medical interpreters within the contextualized framework of therapeutic communication goals. The qualitative study described in this chapter will showcase what nine practicing medical interpreters have to say about their role in the provision of healthcare services. First, the author will set the scene describing some characteristics of therapeutic communication. Then, data will be presented to showcase how therapeutic communicative goals affect medical interpreting identity and practice. Ultimately, the objective of this chapter is to explore interpreting vis-à-vis the mediation of therapeutic communication.

BACKGROUND

Medical interpreters have been studied, conceptualized and understood primarily based on generalist interpreter norms that are not specific to medical interpreting. Furthermore, as Jacobsen stated (2002), interpreting practice has historically been divided into two separate fields: conference interpreting and community interpreting (i.e. non-conference interpreting). This is still the case, and it is time for these current categorizations to evolve further. Since community interpreting includes several specializations (medical, legal, conflict zone, educational, etc.), some norms and standards for community interpreting simply do not meet or reflect the specialized needs of the healthcare sector.

In healthcare, it has been understood, that the act of interpreting enables healthcare providers to communicate with their patients and vice-versa. However, is there more to interpreting than enabling communication? According to the International Medical Interpreting Association (IMIA) Standards of Practice, initially published in 1996, and republished in 2003 and 2007:

As the dissimilarities between providers' and patients' assumptions increase, literal interpretations become inadequate, even dangerous. In such cases, to convey the intent of the message accurately and completely, the interpreter may have to articulate the hidden assumptions or unstated propositions contained within the discourse.

In addition to properly interpreting or capturing the message of the speaker or signer, the interpreter needs to articulate the *intent* of the message. In order to properly render an accurate interpretation from a functional perspective, not just a linguistic one, not only the content of the message needs to be accurately captured and rendered, but the intent and delivery of such message needs to be accurately captured and delivered as well. Interpreters working in healthcare may need to understand exactly what therapeutic communication is in order to be effective in their practice. This context includes socio-cultural assumptions unique to the provision of healthcare services. Contextual understanding is crucial to replicate the intent of a message. But why does the intent need to be captured? The IMIA implies that without the embedded assumptions, interpreting can be dangerous. Dialogic interpreting involves interaction as well, and interaction is not just how humans communicate with each other, but also how humans relate to each other (Wadensjö, 1998). In healthcare, this relatedness is called *therapeutic rapport*.

THE MAIN TOPIC OF THIS CHAPTER: THERAPEUTIC COMMUNICATION AND THE INTERPRETER ROLE

The healthcare sector is one of the most regulated, in order to protect the public from harm. Healthcare services are bound by very well-established norms, values and beliefs related to the treatment of patients. Accuracy and specialization are of utmost importance in healthcare. Healthcare organizations in the United States prefer interpreters that are not only well-versed in medical terminology, but that are also trained and certified in medical interpreting.

Therapeutic communication, also called health communication, is a subfield of the study of communication. According to the Centers for Disease Control (2004), therapeutic communication is defined as the process of interacting that focuses on advancing the physical and emotional well-being of a patient. Healthcare providers use therapeutic communication techniques to ensure understanding, provide support and, together with the patient, find the best solution or therapeutic plan for the patient's ailment.

In order to describe some characteristics of therapeutic communication, one needs to review certain socio-cultural assumptions common in healthcare in the United States. Healthcare norms, values, and practices are certainly not universal. There are variations, since health culture varies in rural versus urban areas, and operates with diverse participants, with various personal and professional backgrounds, all shaping the unique communicative events that comprise the practice of the medical interpreter. However, Western medicine is quite cohesive. So, it remains to be seen whether the nature of therapeutic communication affects the role of the medical interpreter. This study seeks to explore this issue. What are some of the socio-cultural assumptions embedded in therapeutic communication?

The Pursuit of Equity is a Key Intent in Therapeutic Communication

Equity of rights is a very pervasive cultural belief in the United States. Additionally, the quest for equitable services is an important embedded therapeutic goal because it is a common medical ethical tenet in most countries in the world. In addition, the United Nations Universal Declaration of Human Rights states in Article 25 that 'everyone has the right to a standard of living adequate for the health and well-being of himself and of his family' (United Nations, 1948). The issue of equity is also tied to healthcare disparities. The Institute of Medicine published a seminal work that showcased the disparities of care among different patient populations (Institute of Medicine, 2001), in the United States; since then equity has been a key intent in the provision of healthcare services. The U.S. Department of Health and Human Services developed in 2001, and later revised in 2010, the *National Standards for Culturally and Linguistically Appropriate Services in Healthcare*, also known as the CLAS Standards (U.S. Department of Health and Human Services, 2010), to promote equitable care to all regardless of differences of ethnicity, race, gender, or sexual orientation. This includes provisions for hiring competent medical interpreters. Today it is understood that attention to this matter of health equity doesn't just improve the patient experience, but it also improves national health measures in general. Now this issue is seen as a patient safety issue. Addressing this issue will become a necessity in a world that is becoming ever more multilingual and multicultural. Equitable services do not mean equal services. Equality is providing exactly the same service to everyone. Equity is fairness in every situation, which means adjustments may need to be made. For example, the exact same shoes may be given to every person who needs them; that is equality. However, in order to pursue equity, one would have to provide shoes in the different sizes of the individuals that need them. This is the core principle of equity.

Medical Ethics are Embedded in Therapeutic Communication

Just as equity of service is a medical ethical tenet that affects therapeutic communication, there are other medical ethics that strongly influence therapeutic practice, intent, and communication. These ethical guidelines and norms may have a bearing on the work of medical interpreters (Ozolins, 2014). These typically include: principles of justice (such as equity), beneficence, non-maleficence (do no harm), accountability, fidelity, autonomy (respecting the patient's will), and veracity (saying the truth/not hiding the truth). These ideals characterize therapeutic communication and medical interpreting practice. These principles may need to be incorporated into future iterations of medical interpreting codes of ethics.

Inquiry Process as a Key Methodology for Therapeutic Communication

Therapeutic communication has norms and processes that are taught to healthcare providers in order to be able to diagnose or treat patients. They learn the inquiry method of communication in order to diagnose a patient. This requires certain questions to be asked for a diagnostic process that follows the logic of elimination of possibilities, narrowing them down to a very probable cause or ailment. This inquiry process is used for history taking, diagnosis, and follow up communication. Providers, instead of learning to be active listeners in general, learn to look for key terms, in other words, what information to pay attention to and what to discard as irrelevant. Most communication tends to be in a question-answer format, with close-ended questions, meaning formulating the questions in a way that requires an objective yes or no answer. Providers are taught to then respond to these responses by probing with more close-ended questions. This very specific therapeutic inquiry process of eliminating different scenarios, through a therapeutic line of questioning, helps the provider get to the probable cause or issue at hand. This scientific process of inquiry attempts to eliminate subjective bias. On the other hand, such a strict structure of therapeutic communication may cause the provider to miss peripheral information that may be important to address.

In behavioral health, while the communication is still systematic, the inquiry process is different, where therapists will use open-ended questions to generate a picture of the patients' mind or thought process. As they fish for the cues to diagnose or treat a patient, they will use other learned forms of inquiry, such as active listening, paraphrasing to confirm understanding. This is why therapists are usually seen as better communicators than physicians, because some include the interpreter in the communicative process (Bot, 2003). Interpreters who are not familiar with the structure of therapeutic communication may struggle to understand why providers ask certain questions, or purpose of the messages being transmitted.

Emotional Charge of Therapeutic Communication

There is an emotional component to health communication. Although verbal communication can be delivered with accurate information, there are aspects of emotions and feelings that cannot be captured or expressed entirely verbally. This emotional burden increases with the severity of the complaint, to all parties involved, not just the patient. This means that those communicating with the patient need to consider this effect when delivering or receiving sensitive information. By understanding the process of therapeutic communication and controlling or managing a variety of communication skills, healthcare providers are expected to be able to utilize these empathetic communicative tools (verbal and non-verbal) to give effect to the patient's therapeutic outcomes (Whaley, 2000).

The severity of the health situation may affect all participants' state of mind, which in turn may affect their level of understanding (Norris, 2005). An emergency department interpreter handles one type of emotional charge. Those working in mental health may experience another type of emotional charge (Cornes & Napier, 2005). Interpreting for a rape victim or a domestic abuse victim can be very taxing on all parties, including the interpreter. Concerns for personal safety, or participating in de-escalation efforts, are issues that medical interpreters need to grapple with. It is because of this emotional charge that many interpreters suffer from vicarious trauma, a work hazards common to all professionals working in healthcare (Arocha, 2012). Providers and interpreters also need to be cognizant of how vicarious trauma may affect them due to this emotional charge. Healthcare providers are trained in techniques to help them in this area. Medical interpreters are just now being trained in how to handle vicarious trauma.

The Decision-Making Process in Therapeutic Communication

The therapeutic communicative event typically includes a decision-making component. Even if the therapy that is recommended is going to be performed solely by the physician, the patient still needs to agree to it (Segal, 2007). Other times the proposed treatment may require the continuous participation of the patient until the treatment is finished. In healthcare this is called patient compliance. Different decision-making cultural norms may affect the expectations of the participants. In some cultures, traditionally the provider made the therapeutic decisions and prescribed therapies to be complied with in a very prescriptive manner. Whether the patient complied or not was not the provider's problem or concern. Nowadays, especially in the United States, due to medical errors (Price-Wise, 2015) and to minimize litigation, as well as to respect the autonomy of the patient in patient-centered care, the locust of decision-making has shifted from the provider to the patient. In this model, it is the patient, who, after listening to the providers' suggested therapies in a more descriptive manner, makes the final decision to agree, comply, and therefore be held accountable for the success of the therapy. In this model patients will not be able to say that they didn't know, or that they were uninformed of how their participation in the healing affects health outcomes.

The ethical concept of informed consent has been expanded to reflect the importance of the patient understanding the treatment being recommended, as well as the accountability of participating in the treatment process. Studies have confirmed that clear communication is a key component in the objective to achieve patient compliance, often necessary for healthy outcomes (Segal, 2007). Patients cannot comply with what they do not quite understand. For example, if a patient is not told how important it is to take the antibiotics until the bottle is finished, he or she may stop taking the antibiotics as soon as they feel better. Hence the importance for medical interpreters to ensure understanding as stated in their standards. The IMIA Standards lists the task to ensure that the listener understands as well as to ensure that the interpreter understands the message to be transmitted (IMIA, 2007, pp. 29-30).

Patient–Centered Therapeutic Communication

Another unspoken socio-cultural assumption in healthcare involves patient-centered care. Patient-centered care involves providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values all clinical decisions.

Patient-centered communication evolved to counteract perceived physician paternalism and to prevent malpractice. It involves the preoccupation of putting the patient at the center of care, compliance, and

accountability, shifting it away from the healthcare provider. It is important for the patient to understand that they have a certain level of responsibility for their own health and well-being. Physicians cannot solve all of the patients' problems without their own adherence and participation in the therapeutic process. Ultimately it is the patient that will have to deal with the positive or negative consequences of their medical care. Likewise, without attention to the patient's needs and concerns, important concerns and individualized circumstances may be ignored and lead to neglect or non-compliance. Patients who do not believe or understand their role in the therapeutic process may not see the importance of adhering to the subscribed therapy, placing all of the responsibility of their healing on the provider. Patient-centered care advocates claim this approach ultimately improves patients' clinical outcomes and satisfaction rates by improving the quality of the doctor-patient rapport and the patient compliance needed for such outcomes.

In patient-centered communication, effective care is defined in consultation with, or negotiated with patients, rather than being defined and prescribed by the physician to the patient. This is a newer model of therapeutic communication that requires greater interaction and exchange of ideas and concepts, where the provider and patient form a collaborative team, and where both have equal responsibility for the patient's health outcome; the provider being responsible for diagnosis and recommendations, and the patient being responsible to weigh in all the recommendations and actually decide or not to agree and, if so, adhere to treatment.

Therapeutic Rapport in Therapeutic Communication

This is a very important healthcare concept. Basically, it involves the general understanding in the healthcare sector that the relationship between the provider and the patient affects the therapeutic encounter, the communication, attention, and adherence to the therapeutic plan. Some factors that influence the therapeutic rapport include mutual understanding, trust, and empathy. Medical interpreters are taught that a component of their role is to improve the therapeutic rapport. This means that the interpreter may engage in interventions or behaviors to ensure that the patient and provider understand each other thus creating a positive therapeutic rapport, in the name of the goal of a positive health outcome for the patient.

Health Literacy and Therapeutic Communication

Healthcare providers work hard to learn the very specific terminology that they utilize in their therapeutic communications with patients. However, what good is that specialized terminology if a patient can't grasp the message? Health literacy is a strong movement within the healthcare field in the United States that promotes the simplification of medical language in order for patients to understand and be able to follow through with their part of the therapeutic plan. Whereas this movement is mostly applied to the written form, it is also applied to oral communication. In the past, providers would ask patients if they understood, which would invariably generate a positive response, as human nature may not want to expose doubt. So, providers now use new communicative techniques, such as teach back, to check for understanding. This technique involves asking the listeners to explain what they understood. By requesting patients to paraphrase, providers can have a better grasp of what the patient truly understood.

Patient Safety and Accuracy of Therapeutic Communication

Of all the medical ethical tenets, the first and most important medical ethical tenet comes from the Hippocratic oath of '*First, do no harm'*, (Latin: *Primun non nocere*), one of the earliest expressions of medical ethics in the Western world. This oath prevails over or guides almost every action in the provision of healthcare services. It has gained new importance as the medical concept of patient safety, drawing on the fact that any error in the service of patient care may have a negative health outcome, and should be prevented with safety measures. In order to prevent these misjudgments, all healthcare professionals now, including interpreters, have the responsibility to ensure that accurate communication is taking place among all parties (U.S. Agency for Healthcare Research and Quality, 2015). In interpreter-mediated communicative events, it is hard for the parties involved to know if the other party understands. Therefore, the interpreter shares the burden of ensuring understanding with all parties including themselves. An interpreter cannot interpret what he or she does not understand. How does one ensure one's own understanding? By paraphrasing, or requesting teach back to the signer or speaker, as a practice to ensure the accuracy of the communication among all parties.

In summary, the most prevalent socio-cultural assumptions in therapeutic communication in the United States include equity, health literacy, emotional charge, therapeutic rapport, patient-centered decision-making, and patient-centered care. The question remains as to how these issues affect the role played by medical interpreters. The study attempts to answer this question.

METHODOLOGY

The present research aimed to answer the following question: Is the role of the medical interpreter affected by therapeutic communication, interaction, and intent? The hypothesis is that interpreters are influenced by the nature of therapeutic communication. If yes, how so? Due to the nature of the research, a qualitative study design was selected and self-reporting methodology was utilized. There is great value in obtaining verbal reports. The data can be considered as an accurate representation of the happenings of one's mind as one discusses a task. In introspective analysis, as opposed to protocol analysis, the goal is for participants to express the thoughts that occur to them naturally. Researchers use these data in conjunction with logical theoretical premises to generate hypotheses and to draw conclusions about cognitive processes in practice, in other words, studying what cannot be observed.

In order to reduce potential subconscious bias, participants were recruited for the study by a uniform posting of the study invitation to four community groups on Facebook on November 17, 2018. These Facebook groups were specific to medical interpreting: 1) Healthcare and Medical Interpreters Unite, 2) Medical Interpreters Spanish/English, 3) US Medical Interpreters, and 4) RID Sign Language Healthcare Division. The selective criteria required participants to be 1) at least 21 years of age 2) be trained in medical interpreting, 3) be certified in medical interpreting, and 4) have at least three years of medical interpreting experience. In the United States, most medical interpreters are trained in specialized courses or programs, and national medical interpreter certification has existed since 2009. The age requirement was due to the possible discussion of emotionally charged situations. The practice requirement was needed to ensure interpreters had enough time in the field to form a professional perspective grounded in practice and not just education.

There are two professional groups that practice medical interpreting: 1) specialists and 2) generalists. One cannot be considered a medical interpreting specialist, without substantial *specialized* training, certification, and experienced. Generalists, on the other hand, such as conference or community interpreters, may work in several settings and occasionally practice in a healthcare environment. While these individuals may be trained in medical terminology, or have some level of training in healthcare interpreting, their formation or practice is not specialized in nature. It is difficult to explore a specialized perspective through the eyes of a generalist, just as it is more difficult to explore a generalist perspective by interviewing specialists. The researcher wanted to hear the professional opinions of specialists to further explore this topic as a specialized practice. Thus, the study interviewed specialists and not generalists. These criteria also ensure the data not be skewed by non-specialized professionals, such as community interpreters who may or may not be as cognizant about the therapeutic demands in the field of medical interpreting.

Of the thirty-one interpreters who responded to the posting with interest, nine were able to schedule and undergo interviews within the time frame requested. The criteria were listed in the invitation, and all interpreters met the set criteria. These interviews were scheduled through an online scheduler called Calendly and took place online, mostly through the Facebook Messenger communication application. The study collected data from participants via video-online interviews. The interviews took place between November 26, 2018 and December 14, 2018. One interviewee had to switch from video into audio for technical reasons. The interviews lasted from 38 minutes to 1 hour and 14 minutes. All interviews were conducted in English and all participants worked in the United States. In order to minimize knowledge bias by mentioning the framework of therapeutic communication, the interviews were carried out in a completely open-ended manner, with the researcher asking only one question to start the interview: What are your views on the role of the medical interpreter? This was done in order to see if there were or not any themes related to therapeutic communication that naturally came up in the interpreter role descriptions and explanations. The researcher expanded on this question, seeking more information, using probing or teach back, for the clarification and expansion of the ideas and opinions presented. Interviews were recorded and transcribed. Further analysis of terminology and ideation generated a thematic review of the data to be discussed in the results section.

It is difficult to reduce interpreter bias related to the common theoretical knowledge obtained from their interpreting education. In the United States, interpreters who undergo short 40-60 hour medical interpreting courses, are generally taught four roles: conduit, clarifier, cultural broker, and advocate. They are further taught that their primary role is that of conduit, or vessel of communication. These are also the roles tested on the knowledge exams of the national certification programs. It is to be expected that these roles will come up in the discussion, but the researcher's main purpose was to see if therapeutic ideation was part of the role of the interpreters' thought processes or not. Roles are in and of themselves subjective ideas, making it more difficult to distinguish nuance of opinions. For example, the representation and ideation of the commonly taught primary role of conduit may vary between participants. In the same manner, what is generally understood as the patient advocate role may also vary from participant to participant. Therefore, when the participants mentioned these terms, follow up questions clarified their meaning.

RESULTS AND DISCUSSION

The study data consist of two parts: a) demographic data, and b) interview data. Before the discussion of role(s), it is important to review the demographic data to better understand the participants' backgrounds.

Demographic Data

Demographic data are presented from Table 1 to 10 by: gender, age group, general education, interpreting education, professional background, working environment, working language other than English, employment status, interpreting experience, and certification. The demographic data did not render any surprises other than there were more male interpreters than female interpreters, in a field where female interpreters comprise the majority (Common Sense Advisory, 2010).

As seen by tables 1-11, the demographic data reveals the typical participant as a male medical interpreter, between the age of 25-34, with a bachelor's degree or higher, trained and certified specifically in medical interpreting, working in the Spanish<>English language combination. While Spanish is the most spoken and requested language for interpreting in the United States, sign language comes in second in most states. Two of the nine, or (22%) of participants, work in American Sign Language (ASL), so both signed and spoken languages are represented in the sampling.

Table 1. Gender (N=9)

Male	7
Female	2

Table 2. Age Group (N=9)

18-24	0
25-34	1
35-54	5
55-64	2
65-older	1

Table 3. General education (N=9)

High School	0
Associate Degree	2
Bachelor	2
Masters	4
Doctorate	1

Table 4. Medical interpreting education (N=9)

On the job	1
40 hours	4
1-year certificate	3
Masters in Healthcare interpreting	1

Table 5. Professional background (N=9)

Healthcare related	2
Language related	4
Other	3

Table 6. Work environment (N=9)

Urban	3
Rural	3
Both	3

One of the participants stated that he never called himself a 'freelancer' as he thought the term diminished his relevance as a professional, since his work was not free, preferring to refer to himself as an interpreter 'in private practice.' Four of the nine participants (44%) had studied translation and interpreting as their formative career in college, where the others studied medical interpreting after their college education. One participant had a master's in healthcare interpreting. As far as professional experience, six of the nine participants (67%) had over five years of experience as medical interpreters. The majority of the medical interpreters in the study, or (67%), were employees, and not independent contractors in private practice. One was a dual-role interpreter. Dual-role employment status refers to healthcare

Table 7. Working language other than English (N=9)

Spanish	7
Sign language	2

Table 8. Employment status (N=9)

Employee	5
Private practice	3
Dual-role	1

Table 9. Interpreting experience (N=9)

Under 3 years	0
3 to 5 years	2
Over 5 to 10 years	4
Over 10 to 15 years	1
Over 15 to 20 years	1
Over 20 years	1

Table 10. Certification credential (N=9)

NIC	1
CDI	1
CMI	4
CHI	3

professionals who are trained as medical interpreters due to another language proficiency. Whereas eight interpreters (88%) worked face-to-face, two interpreters (22%) worked in VRI and one worked in both modalities. Results were not compared by demographic variables due to the small sample size.

Interview Data

To avoid confusion for the reader, providers and patients will be referred to as clients, or the primary participants of the interpreted-mediated communicative event. Study participants will be referred to as interpreters. In discussing the interpreter role, it was clear that interpreters did not wish to be typecast into one specific role. Before discussing the role of the interpreter, it was important to ask about their views on the roles of the patient and provider.

The Role of the Patient

In patient-centered care, the patient's role is the most important, so this will be discussed first. What did interpreters have to say about the role of the patient? Interpreters described the patient roles or responsibilities:

Table 11. Modality of service (N=9)

Face to face (F2F)	8
Telephone	0
Video Remote Interpreting (VRI)	2
Both (F2F and VRI)	1

- *I would expect the role of the patient to be one of coming to the session with an open mind, feeling comfortable where he or she is able to express himself/herself in a safe environment, to be able to ask questions, and to be his or her own advocate for his or her care*
- *Well, to communicate his or her symptoms to the medical staff and collaborate with them in wellness and treatment of conditions and hopefully to assist with and comply with the treatment*
- *Their role is to explain whatever is ailing them*
- *The patient's role is to learn, provide information, and receive the services*

The United States is a society that believes in the agency and autonomy of each individual. In such a paradigm the patients need to be active participants in their care plan, as their own advocates, as mentioned by the interpreter. In these explanations, interpreters mention that patients need to interact in a comfortable and safe environment, in order to be able to ask the questions and better advocate for their health. It seems that in addition to communicating their ailments, several participants mention the patients' responsibilities of expression, advocacy, and compliance. This ability to explain their ailment is required in order to obtain a correct diagnosis. There is also mention of the need for the patient to come with an open mind. This comment implies that the patients' state of mind is important. Their role to collaborate and comply with the provider also implies that they need to work with the provider for the desired outcome. One participant saw the patient as a learner, and one may argue that this view may affect the interactions between that interpreter and his patients.

Language minority patient holds linguistic and cultural knowledge at the most deeply personal level. Most importantly, patients are the ultimate experts of their symptoms, regardless of how much detail they remember or how they conceptualize these symptoms. Receiving care requires action, as patients need to initiate the care by coming to a healthcare provider in the first place. They may also already come into the communicative event with some ideas of the best way to handle their situation, based on past experiences with the issue, their own physical experience and knowledge of their own body, and their family history. They come to provide information and also to learn. These are all active verbs, except for one: receive the services, with the patient in a passive role. The need for a comfortable and safe environment may come from the fact that patients bring their own worries, frustrations, fears, and anxiety- an emotional charge to be further discussed- to the communicative event. How he is treated and communicated with may have an effect on that emotional charge, as well as on the patient's satisfaction and compliance.

The Role of the Provider

Providers are the ones who have the most defined role in the conceptualization of healthcare. In this study, healthcare providers or professionals include all of the professionals that interact with patients, such as nurses, MRI techs, therapists, psychiatrists, dentists, etc. Healthcare professionals, especially physicians, have achieved their protected role through education and credentials to diagnose and treat the patient. The provider is the expert in medicine and as such should also be listened to. The provider will certainly know more about the diagnosed condition and its treatment than anyone in the room. Often the provider is perceived not only as a healer, but also as a health educator and advisor. When asked about the role of the healthcare provider, interpreters described the role mostly in relation to 1) their interactions with patients and 2) to their therapeutic goals for the communicative event. The following sample of descriptions showcase a few specific provider responsibilities:

- *To create a relationship with the patient and to be able to understand the patient and get down to the level of the patient*
- *to understand and connect and be able to give the best service and quality care Possible*
- *To be in a collaborative relationship with the patient aimed at accurate diagnosis in prevention and treatment of condition to improve their health*
- *To listen, to analyze, to problem solve, to communicate, to see how they can help the patient with whatever their problem is*
- *To ask the right questions, in order to provide an accurate diagnosis in a timely and professional manner*

Interpreters mentioned several responsibilities of providers. It is important to note that these are the opinions of interpreters on the role of the provider. Further research is needed to see how providers view their role in interpreter-mediated communicative events. Providers are known to *problem solve* and ask questions in order to *diagnose* and treat the patient in a timely and professional manner. However, interpreters point out the importance to *understand*, and ask the right questions and speak about the diagnosis and treatment as helping the patient. According to one interpreter, it is ultimately the responsibility of the provider to *be a collaborative relationship* with the patient. Therapeutic communication is a collaborative endeavor and this is pointed out. This may have an impact on the triadic relationship generated when an interpreter is added to the therapeutic communication. *Understanding the patient* and *connecting* with the patient are also mentioned. Furthermore, one interpreter mentioned that the provider has the responsibility to get down to the level of the patient. This may be important to establish connection and when probed was related to the difference of status and registers between a provider and a patient.

The interviews generated thematic topics that relate to therapeutic communication. Table 12 describes the themes extrapolated from the interview data and the number of times elements of these themes are mentioned when summing up all the interview data. This section will discuss each theme separately.

Ensure Therapeutic Objectives Are Met

When describing their roles, interpreters mentioned therapeutic protocols, goals, and objectives, in addition to interpreting messages accurately. This came with code words such as *patient care, diagnosis, help patients, therapeutic objectives, patient safety, and quality of care*. In explaining the interpreter

Table 12. Thematic topics on the roles medical interpreters play

Thematic Topic	Number of Mentions in Interviews	Number of Interpreters N=9
1. Ensure therapeutic objectives are met	15	9
2. Improve the therapeutic rapport	14	9
3. Align with primary participants	11	9
a) work with providers	13	9
b) work for patients	7	9
4. Address emotional charge	15	7
5. Advocate for patient	9	8
6. Educate clients	8	5

role, they used metaphors such as *providing care* or being a *resource,* stating each professional in the healthcare team, including the interpreter, has a role in the patient's care: *We're there to help and make sure we are there to give the best care we can.* This interpreter conceptualized the therapeutic objective of ensuring that all are there to give the best *care* possible, as intrinsic to his role. An interpreter even described how accuracy might take a back seat to <medical> *care*, implying that his actions were ultimately related to patient outcomes and safety, especially in trauma therapy:

The majority of the time is not really traumatic, but if so, you would have to forego the accuracy to meet the needs of the situation, like background noise, whereas in normal situations the accurate interpretation is important, but the patient getting care is more important… definitely ask for clarification, if it is key information, but not if it is not essential, which I know it is not our role to determine what is important but for the health.

The interpreter admits openly that she actually uses her judgment in what may or not require clarification, implying that perhaps this is not how she was trained. This points to the perennial gap between theory and practice. The rule of transparency, which relates to interpreting all that is stated, including the side conversations, may be more of a goal that can be practiced only in ideal situations, but not in trauma cases. It seems that issues more related to the care for the patient modulates interpreter decision-making. Likewise, the interpreter's decisions will affect the care of the patient (Ferner & Liu, 2009). Does this decision-making process, of whether or not to seek clarification, affect the provider's diagnosis? Let's see a specific case in point described by an interpreter.

Our role doesn't change, only if the provider is not catching that the patient has suicidal tendencies. Well in some ways it might. Even though I'm just being a conduit, then, I have to intervene. I had an oncology or hematology appointment, I can't remember. So it wasn't categorized as mental health, but the patient used a term 'desahuciado' that I had never heard before. I could have interpreted it as feeling bad, but I asked for clarification, stating: 'what does this terminology mean to you'. He kept repeating, "I come to the appointments, they take my blood pressure, but I continue to feel 'desahuciado'. The way he kept describing it, by the time I got done, the guy was feeling 'terminal'. So that's when my antennas captured it. I guess I have to do a bit of an intervention sometimes. I didn't want to probe by asking for teach back, but I told the provider that this meant something other than his life is affected, that he feels hopeless, terminal, and did not want to be around. In that case, I will dig; that's why you <physician> need to let me do my job as the interpreter. You may speak some Spanish, but when something is lost, the provider understands.

The interpreter went on to explain that this was not the first time that she was able to detect the need for mental health services, something that the provider just can't do when they don't speak the language. They can't understand tone, and all the other non-verbal cues, which hold meaning. It seems that therapeutic communication is the primary vehicle for a provider to make a therapeutic recommendation for the patient. Therefore the interpreter's role of digging in or skipping a clarification goes beyond acting as an interlinguistic and intercultural communication mediator. The interpreters showcase the gatekeeper (not seeking clarification) or co-diagnostician (probing for more information) relates to an auxiliary therapeutic role, previously described by (Hsieh, 2006). When she stated *I didn't want to probe by asking for teach back*, I asked why, and the response was that sometimes doctors don't want interpreters to

probe. This provider resistance to intervention is reflected in her statement *the provider needs to let me do my job.* After explaining the issue, *the provider understands*.

This case also reflects on the importance of understanding all parties. This practice conforms to a standard for medical interpreters, stated as: *Ensure that the interpreter understands the message to be transmitted* (IMIA, 2007:30). One term can make all the difference, and she implies that providers need to allow the interpreter to do their interventions to achieve a correct meaning and therefore appropriate interpretation into the target language. When she states: *In that case, I will dig* she is speaking of in the cases where it may have a health consequence. This statement reflects a perspective that the interpreter has a certain amount of knowledge about what types of information may or may not have a health consequence. Further study is needed in this area.

Then there is always the time factor. Therapeutic communication is constrained by a very tight time frame. Timeliness is a quality of care measure. In outpatient healthcare, patients are being scheduled every 15 to 20 minutes for non-behavioral health consults, so time is an important factor. Whereas medical interpreting is performed in the simultaneous and in the consecutive mode, consecutive interpreting requires double the time. It seems that with regards to this environmental demand of time, sign language interpreters have an advantage, since most of their interpreting is performed in the simultaneous mode versus spoken language interpreters, who are more constrained to the consecutive mode. Medical interpreters in this study seem to understand this and will collaborate with the provider to accomplish the therapeutic goal within the time frame given. This seems to be one of the reasons why interpreters have to decide between requesting clarification or not. This is one of the sources of tension between providers and interpreters, as both have to get their work done in the same allotted time. The provider has to share his time with the interpreter, and this may affect the attitude of the provider, to be discussed later. An interpreter describes how timing issues affect their practice and choice to intervene or not:

Sometimes that means not adding anything to the situation, just doing your job, with deaf patients they give an extra 15 minutes, even though it's not consecutive, we need to get the correct information – you need to know what the goals of the environment are; the doctor has a job too, to get in and out. Sometimes they are rushing to get the info of the patient right before the session.

Usually medical appointments do not provide language minority patients with any extra time, so this particular case is not the norm. Even with the extra 15 minutes, the interpreter seems to think it is still rushed by stating the providers are *rushing to get the info*. The time pressure is an environmental demand (Robyn & Pollard, 2001) that affects therapeutic communication. This may require some coordination and teamwork between the provider and the interpreter. It also may pose some challenges such as turf issues between the interpreter and provider. Regardless, the interpreter alludes to the tensions between the 'normative' protocols, and the practical or 'typical' expectations or practice protocols, in healthcare. In sum, the therapeutic objectives and goals seem to be forefront in the interpreters' mind, when discussing the interpreter role.

Enhance the Therapeutic Rapport

The next theme that was most discussed, and related to the first, is the goal to enhance therapeutic rapport, which came up across all interviews. It is important to discuss therapeutic rapport, that is, the closeness in the relationship between the provider and patient. This theme came up as a responsibility or role of

the interpreter. This relationship, also called therapeutic alliance, is understood as the bonding between provider and patient. A certain level of bonding or agreement is required to obtain enough information for an appropriate diagnosis from the provider's side, as well as to obtain agreement and compliance on the therapeutic goals from the patient's side: *We are the linguistic experts, to make the relationship with the patient and the doctor grow, the rapport, to help build that rapport*. One interpreter did start with the communication, stating: *My role mainly is to be able to convey the message. In my own words, I am the subtitle.* This statement was then followed by: *Both the patient and provider communicate as if they spoke the same language.* This explanation reflects the goal of health equity: for the parties to communicate as if there were no language and cultural barriers. This may require more than conveying messages back and forth, as conveying messages is not the same as erasing the communication barrier. Sometimes interpreters gave conflictive renditions.

All of the interpreters interviewed saw helping approximate the provider and patient as part of their role (responsibilities). It is interesting to note that although she labels herself as a conveyer of messages, the task she proceeds to describe is more of a mediation or interactional responsibility. This mediation task is clearly established in the International Medical Interpreters Association Standards of Practice (2007), which states in Standard A-10: *Manage the flow of communication <interactive process> in order to preserve accuracy and completeness, and to build rapport between provider and patient* (IMIA, 2007). There are several additional tasks or standards that support this therapeutic-rapport building: *manage special configuration to maximize ease and directness of communication (A-2), encourage direct communication between provider and patient (A-7), manage the dynamics of the triad (A-11),* and *manage conflict between provider and patient (A-13).* Clearly, according to these standards, there is a strong mediation role in medical interpreting that goes beyond the linguistic act of interpreting.

Here are a few more samples that confirm this preoccupation with building therapeutic rapport through a communicative space of trust and openness:

- *Teams are big at hospitals, and everyone has specific roles. I go back to rise above and give patients the same delivery of language and communication. The clinic I work with, I know the providers, so I know when at this clinic they speak some Spanish to build a relationship at first. Then I jump in. I know exactly when to jump in, there is a small improvement of delivery because all are comfortable.*
- *The interpreter to me is a way for the patient to understand and to be understood. We are the linguistic experts, to make the relationship with the patient and the doctor grow, the rapport, to help build that rapport.*
- *There is a level of trust that goes along with that, it's not me that does it. My work helps them communicate with each other. Also because the physicians realize that we are different people, two styles.*
- *In mental health it's a little more delicate subject, and I will even be more invisible so that the provider can really see what is going on with the patient, by how they speak, not only grammatically and linguistically, but the tone as well. I will be less likely to interfere, of course I will, if there are cultural issues, but it depends on the nature of the appointment. It's hard enough to speak of rape with someone in the room, they need to feel more connected with the provider to open up, I don't want them to feel uncomfortable when we are with them* <patients>.

Multiparty Therapeutic Rapport

Last, in cases where there are more than three participants in the interpreter-mediated communicative event, the role of the interpreter can become more difficult. Interpreters describe some of the additional demands or challenges of their role in facilitating, mediating and nurturing the multiparty therapeutic rapport:

- *This isn't always an easy task. Most of the time it's really good. It's a different approach; the patients know they need me. It's always a very positive interaction, except when we have patients with dementia. Then the family is involved; it's very difficult. Then, when we have bilingual family* <member>, *there is chaos. They think she or he* <the patient> *doesn't need to understand what is happening with the communication.*
- *It's difficult in pediatrics. When the child is a teenager, the kid speaks English. It's easier, but mom needs to know everything, Sometimes, there are times you need to understand so that you can communicate it, I also need to know what mom is saying. I do the whispered simultaneous interpreting, I try but in VRI* <video remote interpreting>, *it is not easy.*

The therapeutic rapport usually involves one provider and one patient, and with the interpreter is called the triad, or referred to as a triadic encounter. When there are more than three participants in the communicative event, the dynamics are different. The provider may develop a stronger bond or rapport with the guardian or with the patient. It depends on the approach of the provider, and also on how patient-centered the care is in the interaction. Regardless, it is impossible to develop a totally equal rapport with both.

Now add the interpreter in the picture. The interpreter describes several times the confusion or *chaos* that ensues when there are more parties in the room. When asked what she meant by chaos, the interpreter stated that they all want to speak at the same time, creating the need to monitor and lead turn taking between all parties, in order to understand, or know a term used four times in a short message. This requires the interpreter to manage the dynamics between the parties, which is not an easy task. This standard to *manage the dynamics of the triad* (IMIA, 2007:32) assumes the typical triadic encounter, when in fact that interpreters sometimes have to manage the dynamics or interactions of all participants of the communicative event, including self. Then he finishes by stating that doing simultaneous in VRI is very difficult in multiparty communicative events. Whereas this is not related to the study, it points to the need for further research in this area, as it relates to environmental demands and working conditions that make it very difficult for the interpreter to interpret accurately.

Alignment of Interpreters with Their Clients

While the interpreter works to improve the therapeutic rapport of the primary participants, it is impossible not to have any rapport with the clients separately. The question remains as to how much alignment or engagement with each participant is appropriate for an interpreter in a therapeutic communicative event. In the healthcare environment, is the interpreter there to provide *interpretation* services for the two parties or is the interpreter there to *facilitate communication* between the two parties? The roles of 'providing interpretation services' and 'facilitating communication' are not the same. Often used interchangeably, the author proposes that these two expressions involve very different roles. There is a

need to explore or differentiate how these roles relate with one another and how they differ from each other. This is the one of the questions that this chapter attempts to answer. In the mediator model, interpreting is just a tool, or one of many tasks or responsibilities for the medical interpreter in facilitating communication, or mutual understanding, by asking for clarifications, or digging in, as one interpreter puts it. In the conduit model, the interpreter is there to interpret between the parties, allowing them to ensure their own understanding and clarify issues directly with each other, without the interference of the interpreter. These are very different ways to conceptualize the work of interpreters and may have an effect on their presentation, practice, professional identity and image.

Work with the Provider

Interpreters had much to say about their relationship with the provider.

- *I need to make sure to help the doctor or clinician do their job.*
- *I'm not a partner nor assistant, we just work together. Well for me because I am paid through the health system, I am part of the team on the medical side. I'm more in alignment with the medical side.*
- *We are being paid by the medical facility, the agency, or the healthcare facility, to respect the medical professional who is paying for the services*
- *I have to say to the provider, you can't say 'you are going to die'. The polite words are not coming in, so I explain that to the doctor, as it is a cultural issue so that they understand…*
- *I am another resource, the person taking the blood; we all have a part, that's how I feel.*
- *They need us to acquire all the information so they can come up with a good diagnosis. They want to understand the patient*
- *There is not just one client*
- *When I'm there, I'm part of the medical team. I feel that they are appreciative of me being there, they couldn't do it without me. My role is at the same level as the doctor, to help the patient. I have a different role, but we are pretty much at the same level.*
- *It depends on staff – on staff I felt part of the team, and the doctors take the time to fill me in on test results before we would go in to explain what was happening, and I didn't get that level of information when I was freelancer,*
- *I asked the tech about something from the notes, and he refused to tell me because of HIPAA, so yeah, he didn't know the role of the interpreter, whether or not we're on staff, but it's more difficult when you are not*
- *I know what I'm doing and the relationship needs to be one of mutual respect where doctors get in and out. They have a schedule, they need to stay on target, so it's important to help them stay on schedule.*
- *I'm blessed to have such a good relationship with the providers I work with. I have an incredible rapport with these people. What really makes it nice is that they see the value in my work, and the physicians ask the nurse to call me, they want me to come back, because he can communicate with this person, they want your work. The doctor can see the difference.*
- *Each time I work with them again the level of comfort increases*

- *As a VRI <video remote interpreter>, I work for 800 healthcare organizations. Something that I have seen is I feel more invisible to them, yet I see myself as part of the team. The invisible part, I'm sorry, I can't…*

The last comment discloses that the relationship with providers as a staff interpreter is more visible, whereas it is more invisible over VRI. When probed about what was meant with 'invisible,' the interpreter stated that the working relationship with the provider is much closer with providers when providing face to face interpreting when compared to video remote interpreting services. Remote interpreting has been shown to depersonalize the service, just as with any other service provided remotely (Liu, 2017)

In all of the other comments, interpreters identify a working relationship that develops over time between an interpreter and provider that inevitably influences the role and boundaries of the interpreter. Miner (2015) investigated the roles, relationships, and responsibilities of providers with interpreters. She found that the role of the provider varied immensely depending on who the interpreter worked with, the setting, and the personalities involved. There were some commonalities among the participants in her study, including the importance of facilitating relationships, creating shared understandings, the ability to communicate quickly and easily with each other, and meeting high expectations, with some expectations considered unusual, when compared to the more traditional role of the community or conference interpreter. When an interpreter states that he will *help them stay on schedule*, this interpreter is acting as a gatekeeper (Davidson, 2000). Some view themselves as a *resource*, whereas others view themselves at the *same level* as the provider.

Work for the Patient

Interpreters invariably have a working relationship with patients. They described the unique psychological challenges that patients face in seeking care. Interpreters described how their work decreased the patients' significant anxiety and vulnerability, not only from the disease, but also related to starting or maintaining a relationship with a healthcare provider. The interpreters described their actions to reduce the patients' anxiety and build trust, even in a very culturally and linguistically discordant relationship. There is a constant tug of maintaining a cordial and professional relationship with the patient, but not at the expense of the patient's relationship with the provider. Studies have shown that building trust and rapport early in a new doctor-patient relationship can provide reassurance to patients (Dang, Westbrook, Nijue, Giordano, 2017).

- *The interpreter to me is a way for the patient to understand and to be understood.*
- *I have a big role and responsibility for the patient's health. I try to make it very clear, what I need. I explain it over and over, interpreting it in different ways. I think it's important to understand that my patients do not understand that they have a choice, If you do this, this is going to happen, if you don't do this this is going to happen, so I try to elaborate: the doctor said this, the side effects may be xyz, etc. so that they see there are consequences either way. I see a patient that doesn't know what to ask, but I can sense in my gut that they want to know, but they don't want to ask, as I reading the hollow look, and I interpret their non-verbal signals.*
- *I need to take care of this patient*
- *I make the patient feel comfortable, that wouldn't normally be possible without my presence*

- *It's a small island so we all know each other. So I will see my patients outside my work, maybe there are ten Deaf people here, and there are only three interpreters in the island, and only me who is Deaf… so the role is I don't talk about it, I keep it separate…take a step back from Deaf community events just to help that not to cause anyone to be uncomfortable… Yesterday I was at OB-GYN and today I'm 'How are you?'*
- *I am not a friend. What they want out of the interpreter is to be on time and don't be my friend, you're not a family member. They don't want that. But some like to feel that they have someone that is their friend. They need to feel comfortable.*
- *You're the middle man don't kill the messenger*
- *This is how I handle a provider that doesn't explain things well. For example, 'Your kidneys are not functioning any more', so I say as the interpreter, 'What does that mean?' because I can see that the patient is clueless, so I make them* <providers> *elaborate. When I see that a patient doesn't know what to ask, and I can sense in my gut that they want to know, but don't want to ask, I read the non-look, the hollow look, and I interpret their non-verbal signals.*

Interpreters discuss their alertness for the non-verbal communication in their work with patients. There is a possibility that those interpreters that focus on the verbal or signed messages, and not the non-verbal communication, may miss the patient's look of not understanding. Others may think that it is not their responsibility to add anything unless the patient decides to actively speak up or sign. Telephone interpreting can capture tone, and hesitation, but it is not able to see the *hollow look*, for example, or other facial or body language. This also puts into question whether or not an interpreter can have equal effectiveness via remote nonvisual communication.

The crux of the matter may be that whereas some interpreters believe it is their obligation to ensure understanding, which is a more visible and participatory approach, others believe that their obligation is to ensure accurate interpretation, and think that they cannot ensure understanding, so why even attempt it? If one is to attempt to clarify for understanding, to what level or depth do you intervene? One participant described how she is a conduit, but gets to the bottom of things when she feels she has to. Another interpreter relayed that as a staff interpreter he had some agency in communicating with patients.

- *At the hospital I left to see another patient, but once I am finished with this delivery, I'll go check on that patient. It's not your responsibility. Often don't know what's happened, I had the luxury to do that as a staff interpreter and the care for that patient improves*
- *Yes, I think staff interpreters have a little more leeway, other care responsibilities that contract interpreters will not have, because they have roles and responsibilities that they have to follow from the hiring institution. There can be huge difference.*

Issues of professional distance and flexibility in approach are put forth, where the interpreters adapt to the interactional needs at hand of each situation. Making the patient *comfortable* or avoiding *discomfort* seem to seep through their renditions, and interestingly it coincides with a responsibility subscribed by the international standard to: *address the 'comfort needs' of the patient in relation to the interpreter with regard to factors such as age, gender, and other potential areas of discomfort* (IMIA, 2007:29). This ties back to the issue of creating a *safe* and trustworthy communicative space for the patient to open up.

Some interpreters aligned more with the provider and others with the patient. This varied with their familiarity with the provider or patient at hand, their own professional approach and their views related

to impartiality and patient advocacy. Some spoke of working *with* the provider, while working *for* the patient. The alignment with the provider was more concerned about

understanding and helping the provider achieve their therapeutic goals of proper diagnosis, patient satisfaction and compliance. Their alignment with the patient was more concerned about easing the patient's discomfort and ensuring their ability to communicate and be understood. This brings us to the discussion to the topic of the emotional charge in therapeutic communication

Addressing the Emotional Charge in Therapeutic Communication

Therapeutic communication is emotionally charged. This theme naturally came up when interpreters described their role:

- *The interpreter takes on a lot of vicarious trauma. I think it's easier for a remote interpreter not to carry so much of that trauma, it's a challenge not to get affected emotionally… if you have a large interpreting community, they* <the interpreters> *have the emotional support, but I don't have that. I have to connect with colleagues virtually. These are people I trust; they know me.*
- *It's hard not to get emotionally involved and have some protocol and come up with ways to be polite and also assertive, with the patient and the provider.*
- *I think the main goal is to be as detached from the messages as possible, that is the most important aspect of the interpreter, to honor and foster the speaker's message as much as the interpreter is able to do*
- *The patients say what makes sense to them, it is not my issue.*
- *Difficult to understand professional distance. I have helped many start their careers and I help them. I see how their perspective is one and as it goes on they start understanding the limitations and the boundaries.*

The emotional charge comes up as it relates to vicarious trauma. Interpreters discuss their need to maintain some *professional distance*, or *detachment* for several reasons. First, it serves to avoid vicarious trauma, and *to not get affected emotionally*. Second, it serves *to honor and foster the speaker's message*. Third, it serves every professional to work within the *limitations and boundaries* of their profession. Maintaining professional distance, and realizing that it is *not my issue* helps, as it is difficult not to get emotionally involved. A certain level of *politeness with assertiveness* is needed. There are definitely soft skills in navigating the interactional aspect of medical interpreting that are part of the role played by interpreters in their work. Other strategies mentioned include seeking support by *connecting with colleagues*. For those interpreters who live within the community they interpret for, this may take the form of virtual connection. This may be an important function of social media interpreter groups that is often overlooked or underutilized. More research is needed in how to avoid and address vicarious trauma.

In behavioral health, interpreters related how their roles played out:

- *There is not a significant difference in mental health, but there is more flexibility in bending some of the standards in place, such as you may be able to switch to third person as appropriate for the encounter.*
- *It also poses its own unique challenges not encountered in other medical settings, such as outside the interpreter role more often, to assist the provider in achieving their goals*

- *The main one is switching to third person, having a conversation with the provider before the session or having the provider asking for the interpreter's opinion due to language barrier. Only the interpreter is able to answer those questions, and in this case the interpreter is permitted to give their own input… but in other encounters, interpreters must never give their own input.*

Interpreters describe some of the changes they make in mental health therapeutic communication. Standards (IMIA, 2017:26) dictate that interpreters: *select the appropriate mode of interpretation (consecutive, simultaneous, sight translation, first or third person).* The need to utilize the third person is a functional one, and the interpreter will gauge the communicative demands of the interaction and decide how to proceed. The use of third person has been demonized as 'unprofessional' by generalists who may not understand the cultural or therapeutic reasons for this. Another interpreter points out that they do in fact give their professional opinions on linguistic and cultural issues that the provider simply cannot capture. May the interpreter be wrong? Yes, but this does not seem to deter interpreters. Insight into a situation is not a diagnosis per se. It is simply the opinion of a colleague engaged in the care of the patient. Nurses and even family members will be asked for their opinions about the state of the patient, and the provider will use all of this information to make a more informed diagnosis of the situation.

Some interpreters described the conduit role boundaries with frustration:

- *As a staff under patient relations, we're told don't engage, let it go but we have to write a report after each encounter.*
- *Now this job is so difficult, we are told just to repeat like a parrot.*
- *I went to a seminar in Atlanta at Children's Hospital and I like the fact a CMI board director spoke about how she was against the rules to be invisible and not being an advocate. I do think that we need to find a way to also convey that. We also need to make sure that we have a way to be part of a team.*
- *As a nurse, you can greet the patient, but as an interpreter I can't, I have supervision, maybe they're recording*
- *I have nobody on top of me as a freelancer, so that's good, but I do my thing or like this morning, it's Friday and the patient was from Puerto Rico making jokes; you want to be part of that as well.*
- *Conduit just means relaying messages back and forth, but I see a conduit as a facilitator who is not just a transfer pigeon*

The invisibility model (interpreters as conduits with little or no professional agency in the interpreted session) seems to be losing ground to a more visible model of active participation (Ozolins, 2016). The interpreter has and utilizes their professional agency to facilitate and mediate language and culture (Liu, 2017b). Interpreters expressed the need to exercise agency to be able to address cultural issues (Arocha, 2016). Most of the research reviewed also showcased medical interpreters as active participants (Angelelli 2004; Bot 2005; Hsieh 2006; Pöchhacker, 1998).

The level of participation may also be affected by the interpreters' approach to practice. In practice professions, most of the work is done through interactions with patients and providers One that is in the middle will go either way, but one that is conservative or liberal may typically participate more or less depending on their individual professional style and approach. There is no right or wrong approach, but one may say that it is safer to strive for the middle way, as extremes tend to cause problems. However, as clearly stated by many interpreters, each situation will call for a nuanced approach.

- *You have a physical, mental, and emotional inside of your person*
- *You have to be very flexible and vary depending on the situation. This is the gray area with CCHI policy* <certification entity> *and varies so much depending on context, as different providers vary in their expectations, patients who want that support, others don't, docs who expect more or less, you're balancing your certification guidelines with the provider and patient.*
- *I need to have a professional relationship with the objective that they are heard and understood and the ability to participate in their care.*
- *I need to be impartial with both*

Patient Advocacy

Patient advocacy came up as a theme in the interpreter role descriptors. It is often referred to as a role, especially in medical interpreter education, and is included in some interpreting standards of practice where it is defined as *actively supporting change in the interest of the patient health or well-being* (CHIA, 2001:45). According to the California Standards of Practice, patient advocacy is a role not to be taken lightly:

Many immigrants may be unfamiliar with U.S. healthcare system services available and their healthcare rights. Individuals with limited English proficiency find it difficult to advocate for their own right to the same level of care as English-speaking patients. Given the backdrop of such disparities, interpreters are often the only individuals in a position to recognize a problem and advocate on behalf of an individual patient.

This statement is followed by a warning: *However, the Patient Advocate role must remain an optional role for each individual healthcare interpreter in light of the high skill level skill required and the potential risk to both patient and interpreter.*

Unfortunately, according to the data, the patient advocacy role is still not well understood even by specialists. Perhaps it is too ambiguous a concept to be useful to the profession. More research is needed in this area. Interpreters shared a variety of opinions about what patient advocacy is and isn't.

- *Sometimes you are not supposed to be an advocate, but then you will make a personal exception. Or you make a comment that is inappropriate for the code* <of ethics> *and other times docs will have higher expectations, like asking us to call them back, or patients will say: Can I call you? Then I'll say: no. Sometimes you can, other times you can't.*
- *You are more or less visible, but they expect you to be a cultural facilitator, a babysitter. An exception would be this: doc did not want to do consecutive; he wanted me to do the history taking. I should have been firm, but the doctor was so difficult. So I did it anyway, it could have gone badly. I just had to make the care happen.*
- *There is a good dynamic shift when you have two deaf people and one doctor, versus two hearing people and one deaf, as the patient is more empowered, because there are two of us and one of them. It is a huge shift of confidence for the patience. I tell the client, it's your decision, you tell the doctor; you tell them how you're feeling. I encourage it; I pull it out of them. I don't think many interpreters do that.*

- *I've always struggled with on the advocacy part. People who are lost and disadvantaged are not in a pleasant situation. People don't understand hard situations, I want to be more of an advocate, but there are many definitions of advocacy. There is a strong case to be made that the patients need advocacy. Even when you read something for them* <sight translation> *or they don't understand the high register, you lower the register.*
- *You have to interpret what is being said, you can't summarize or be a practitioner putting your spin on it, people on the advocacy side will say it's necessary. But you can make that case for other populations; they may not understand where to go next. All are lost, not just LEPs* <Patients with limited English>. *That's why I interpret the advocacy in a conservative way. Wouldn't an English-speaking person or elderly people be confused as well?*
- *I have been and still am little conservative. I don't want the patients to rely on me to give info to the provider. I want it to come from them. I want them to be the person that explains everything. My input could be wrong, the patient could change their mind, who am I to say what the patient wants? It's a fine line, so I like to keep my boundaries*
- *If I see that the family had to wait for two days without food I'll ask for vouchers. I can find the resources and advocate for them, as long as I wasn't the one providing the service. I was able to find out who could help them.*

The last comment discusses how medical interpreters serve as patient navigators. This is a natural extension of their work due to the therapeutic environment they work in. Just as an interpreter may help a patient schedule their next appointment at the front desk of a clinic, serving as a resource within the organization may be required or expected, especially if the interpreter is an interpreter employed by the healthcare organization. For example, medical interpreting standards (IMIA, 2007:37) dictate that the interpreter: ensure that concerns raised during or after an interview are addressed and referred to the appropriate resources. Whereas this is clearly a standard that applies mostly to employed interpreters, even contractors should ensure the patient is able to communicate at the front desk to schedule their follow up appointment discussed in the interpreter-mediated communicative event. The standard to deal with discrimination certainly is not about interpreting but about a peripheral issue that may affect care. The standard further dictates when to do this: a) On occasions where the interpreter feels strongly that either party's behavior is affecting access to or quality of service, or compromising either party's dignity, uses effective strategies to address the situation, b) If the problem persists, knows and uses institutional policies This is patient advocacy.

However, as seen in the discourse referring to patient advocacy, interpreters are all over the place when discussing advocacy. This confirms a lack of understanding within the profession of what patient advocacy is and isn't. Data also reflect a concept that has many meanings and interpretations, as one of the interpreters clearly states when she says there are many definitions of advocacy. Advocacy can generally be understood in two ways. First, more globally, as the support for someone or something, as advocating for access, or care, actively making decisions or taking actions that promotes that cause. Second, it can be understood as acting as a representative of the patient, as in a lawyer representing the client's interests. While one may act in the best interest of the patient, one is not to represent them against the institution unless there is discrimination or a breach of care that needs to be reported. The second conceptualization can become problematic when it is seen as representing the client within the communicative event at the expense of the provider. This would mean a strong partiality for the patient negatively affecting the therapeutic rapport with the provider. Unfortunately, some patients may bring

this expectation to the encounter, and it will behoove the interpreter to explain in the pre-session their primary role is to enable the provider and the patient to communicate. Since the interpreter is there to serve both clients, the advocacy component of their work needs to remain as a support for the therapeutic rapport of the primary parties in order for optimal health outcomes to ensue.

The author contends that all activities that enhance the therapeutic outcome are in some manner part of patient advocacy, according to the definition provided. However, any advocacy needs to always be grounded in the respect and teamwork with the provider, who is the ultimate expert in the therapeutic solution being proposed. Interpreters in the study described patient advocacy as inappropriate intervention or activities outside the scope of the responsibilities of the interpreter, such as the example of history taking. Asking an interpreter to do the history taking is not patient advocacy, yet it was described as such. In that particular example, the interpreter succumbed to the provider's wishes, but explained that her decision was due to her ultimate therapeutic concern to make the care happen. It seems some interpreters may internalize the therapeutic needs, and see their work ultimately as a means to a therapeutic goal, and not limited to their communication mediation role.

Some interpreter comments describe patient advocacy as patient empowerment, which is the most effective way to advocate for the patient to allow patients to speak in their own voice. However, it must be noted that the interpreter actually had to intervene and speak directly to the patient, by having a side conversation with the patient, cajoling the patient to relate the message directly to the provider, in order for this to happen. The interpreter explained that he thought it was important to do this in order to ensure that the therapeutic rapport progressed and developed properly with the provider, and not with the interpreter. Here the interpreter was basically redirecting the patient to develop a rapport with the provider as a way to level the playing field.

Lowering the register is a communicative technique to ensure understanding. Professional and academic groups do not seem to agree on this issue and many have stated that the standard to *maintain the linguistic register and style of the speaker* (IMIA, 2007:24) goes against the standard to *ensure that the listener understands the message* (IMIA, 2007:29). One may extrapolate that whereas the first is the ideal to work from, the second may justify going against the first from a functional perspective. Interpreters are taught to request providers to simplify their language when they sense an educational barrier to communication. However, when the provider is incapable of doing this, the interpreter may need to lower the register for the provider and the patient. In sum, whereas several codes of ethics prescribe maintaining the register of the source language, in practice it is simply not done as it is in (Hsieh, 2006) with the standard of ensuring understanding of all parties.

One participant mentions how she doesn't agree for interpreters to put their spin on the message, which is a valid point, yet not about patient advocacy, but about inaccurate interpretation and lack of professional distance. Another interpreter alludes to the fact that she is more conservative. Interpreters have different approaches, and this is a characteristic of every profession and specialization. There are comments that clearly state the interpreter's conflictive choices and reasons to engage in patient advocacy:

- *As a language conduit and occasionally an advocate, one does have to be very flexible and vary depending on the situation.*
- *For some I take on that advocate role and remind them that 'you said that this was hurting you', I do workers comp cases for these poor people. I will overstep the advocacy role to make sure that what they are saying gets jotted down*

- *I have found myself in situations, where I am an advocate even though you're not supposed to. Why? It depends on the company; they don't want you to get involved. You're supposed to be invisible.*
- *But you have to say something if something is going bad and you will have to intervene, bring it up. Something bad may happen from a medical perspective.*
- *Well, when I go to conferences, there is emphasis not to interfere at all, but I disagree with that role. I have done 20,000 appointments in my life, and if some where the doctor neglects the patient, there can be a really bad consequences, or the doctor prescribes something then the nurse comes and says something opposite to what the doctor said then there is confusion. Or if the patient is not being honest it could be crucial.*
- *It is subjective to some extent, it's a fine line, we try to be as objective as possible, but I don't think we have to disappear,* we are there to facilitate communication, *to ensure that the patient is receiving the same treatment as if they were in their own country.*

Interpreters cannot help but play a role in leveling the field for patients who are considered underserved or with special needs. Their simple presence enables the communicative ability of the patient. This is an inevitable role, sometimes influenced by unrealistic patient expectations of representation, and in other occasions, due to the authentic demand to fill the cultural and linguistic gap. Many see this role as representing the patient's interests. All professionals working in healthcare will be representing the patients' interests. However, it cannot be done at the expense of the provider or the therapeutic rapport between patient and provider. Whereas interpreting agencies and healthcare organizations pay interpreters, medical interpreters have an overriding medically bound ethical obligation to the wellbeing and safety of patient. As well known, power differentials pose a very delicate situation in establishing therapeutic rapport.

None of the interpreters spoke of advocating for the patient in any adversarial manner to the provider. Healthcare providers require the services of an interpreter just as much in order to provide their services at an adequate level of care. While their health may not be at risk, the fact that both participants require these services means that interpreters must not only focus on the patient's needs, but also on the provider's needs. Interpreters will have to cater to both sides as needed, and not necessarily to the same degree. Therefore, from a therapeutic standpoint, patient advocacy simply means engaging in quality patient-centered care, within the framework and flexibility of approach agreed to with the provider. As discussed earlier, the approach and level of participation differs according to many variables, thus black and white prescriptive rules cannot be applied to a practice profession.

Client Education

Medical interpreting is still a field that is not well understood by end-users. Interpreters discussed client education as part of their role as medical interpreters. It is important to note that interpreters were not asked about client education. They were asked about their role as medical interpreters and client education simply came up as a theme when describing their role. More research is needed in this area as these comments only scratch the surface of this topic.

- *It depends who your audience is because often medical personnel may not have a clear idea of what these roles are;*

- *They just see what you are telling the patient, what you are saying.*
- *I don't know that in general people outside of the profession they don't have a clear idea. So for me it's a combination, the role entails doing all of these other things, other than relaying information*
- *When I go to the emergency room or urgent care, I don't have to do my introductions, as they know my work, and how to work with me… it's a beautiful thing to witness*
- *I have spent a lot of time educating them outside of my assignments*
- *I have worked with providers who are used to working with interpreters. As a staff hospital interpreter, it's awesome. They know you; they know the procedure. Well, you're part of the team.*
- *I think an onsite interpreter has greater opportunities to build rapport and have discussions with providers, which is important to educate them on how to work with an interpreter, which is harder to do as a remote or contractor interpreter*

This is an important role for every profession, and interpreting expectations can vary so much that client education is an effective way to set the stage for effective work. As the first interpreter comment states: often, medical personnel may not have a clear idea of what these roles are. One interpreter explains that this is due to the fact that end users can only see what interpreters do, but not necessarily understand. Interpreters describe educating providers outside their assignments. Last, as mentioned previously with the diminished rapport over remote interpreting, it is more difficult to educate providers to work with an interpreter when working remotely or as a contractor interpreter. When asked about why the interpreter believed this, the interpreter simply stated that onsite interpreters worked with providers within and outside the communicative events, discussing cases, and that with a contractor status there is a diminished rapport that deters some interpreters from interacting with the provider in a consultative manner. The interpreter stated, you have to get in and out, without any previous familiarity with the provider or patient you are interacting with. There is no doubt that virtual communication may diminish one's ability to interact fully. However, there are other factors that also influence levels of interaction. More research is needed in this area.

There was no mention of the pre-session in the nine interviews. A pre-session occurs when interpreters explain their role and how the provider and patient can best work with them. The pre-session is the primary vehicle client education. Unless the interpreter has worked with the provider or patient numerous times, a pre-session should occur. The data suggest that perhaps the pre-session is not being practiced regularly as part of the role of the interpreter, even though it is part of their standards of practice (IMIA, 2017).

In mental health therapeutic communication, an interpreter described how her level of interaction with the provider increased due to the provider's consultation needs and receptiveness of the information (Kirmayer, 2014).

When the patient leaves, the provider may ask more questions in trying to get a correct diagnosis. So in order to get to mental health you bring a lot more to that situation.

Common misunderstandings can be avoided by ensuring a pre-session with the parties. In this way each participant's role is clearly defined and the stipulation of the need for the therapeutic rapport to be between the patient and the provider. In behavioral health especially, a positive therapeutic rapport is a significant predictor of a successful outcome (Krupnick, Sotsky, Simmens, 1996).

The qualitative data and discourse analysis of the renditions about the interpreter role went well beyond the conduit role. Interpreters described several perceived responsibilities and tasks that are specific to

medical interpreting and therapeutic communication. These included enhancing the therapeutic rapport, aligning with the primary participants, addressing emotional charge, acting as patient advocates, and providing client education. The perspective that the interpreters are invariably part of this therapeutic process may explain some of the tension between the interpreter and the family member who may wish to limit information and also between the provider and interpreter. Much of this has to do with establishing the domain of each party and not overstepping each other's area of expertise.

THEORETIC ANALYSIS

Academic research has demonstrated that interpreters act in more roles and even face role confusion or overload (Pöchhacker, 1998). This analysis and discussion attempt to look at themes generated through the context of therapeutic communication. There are three theoretical concepts that may be extrapolated from the data: a) therapeutic mediation, b) therapeutic domain, and c) the interpreter as a therapeutic mediator.

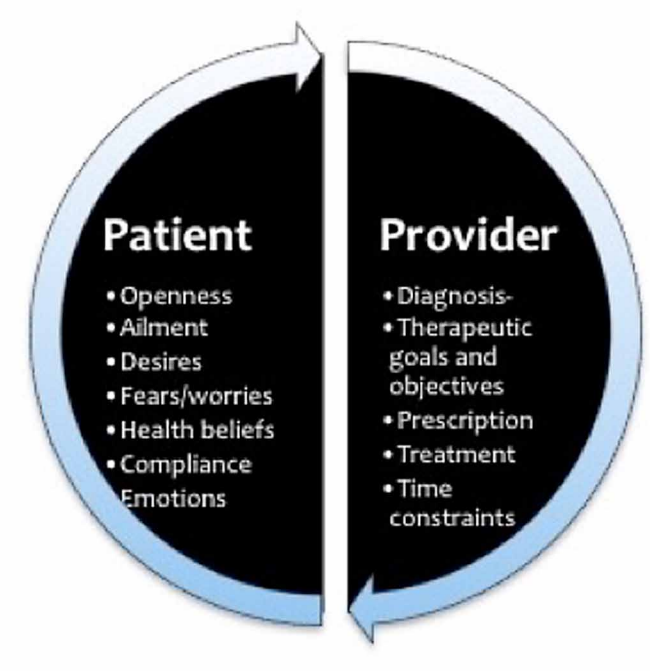
First, what is meant by therapeutic mediation here? Interpreters have described in their communication mediation as a feedback loop of therapeutic issues, problems, ailments, feelings, therapeutic goals, objectives, treatments and directives. There is an understanding that the interpreter facilitates the communication between the primary participants, provider and patient, and as such recognizes and respects the primary players, the patient and the provider. A mediator or facilitator does not have a primary role, but works in the background to allow the main parties to engage in the therapeutic interaction as themselves. However, the data describes more than mediation of communication. Interpreters described internalized responsibilities and roles that seem to be part of the therapeutic process. They requested the language register to be lowered, for example. While this action was communicative, it was also in order to enable equitable care. Ensuring the comfort of the patient, or that trust is established for a positive therapeutic rapport, are all mediation actions to ultimately ensure a positive therapeutic outcome.

Figure 1 shows the therapeutic mediation as part of how the role of medical interpreters is played out according to the data. They demonstrated a significant understanding and maneuvering of the interactional needs of the intercultural and interlinguistic therapeutic encounter that relies on a third party, the interpreter. It is basically the mediation of what is not said or signed. It is the mediation of the interaction between provider and patient.

Interpreters described how their preoccupation with patient safety, their flexibility of approach, dependence on therapeutic goals and constraints, and their attempts to improve the therapeutic rapport, work to safeguard or influence therapeutic outcomes. Figure 1 provides a diagram for this therapeutic mediation work. This interactive cycle between patient and provider evolves as the therapeutic event takes place. It is invariably influenced by the interpreters' ability to mediate or *manage the dynamics of the triad* (IMIA, 2007:32), regardless of their ability to interpret. Therefore, in addition to mediating communication, the effective interpreter will also be able to mediate therapeutic interaction. Ultimately, the data revealed a contextual understanding and contextualized responsibilities and tasks (improving therapeutic rapport, aligning with clients, level of participation, patient advocacy, and client education) that align the interpreter with both parties in order to achieve the desired therapeutic outcomes.

Therapeutic communication is not always collaborative. When the desired outcome of the provider and patient do not match, interpreters need to be alert to it and according to the standards: manage the conflict between provider and patient (IMIA, 2007, p. 34). Does this mean solve the disagreement? No.

Figure 1. Therapeutic mediation



Providers and patients need to solve their own disagreement. What is meant by manage the conflict? According to the standard itself, it means: a) remain calm in stressful situations or when there is conflict, b) acknowledge when there is conflict or tension between provider and patient, c) assist the provider and patient in making conflicts or tensions explicit so that they can work them out between themselves, and d) let the parties speak for themselves and do not take sides in the conflict. Making the conflict or tension explicit requires high level mediation skills that interpreters are simply not being taught, according to the topics being taught in the IMIA Educational Registry, which include over one hundred medical interpreting courses. This issue calls for further study, as mediation skills require more than interpreting messages back and forth.

If one accepts the fact that interpreters mediate therapeutic interaction and as such are providing therapeutic mediation, can medical interpreters be considered therapeutic mediators? Are they being trained for this or simply learning this on the job? Further research is needed in this area. The interpreter is certainly not a therapist. However, the interpreter employs linguistic and cultural knowledge to manage the therapeutic dynamics for specific therapeutic objectives, influencing the therapeutic outcome. Whereas the interpreter is not a doctor, nurse, or psychologist, interpreters are nonetheless utilizing their linguistic, communicative, and mediation skills to provide the best therapeutic care to the patient. The data show that the interpreters are not just therapeutic communication mediators, but in fact acting as therapeutic mediators. They are part of the therapeutic process, enhancing or replenishing the therapeutic dimension that is lost when provider and patient do not share the same language and culture.

Figure 2 shows that interpreters use their interpreting and mediation skills to create a therapeutic rapport that includes a communicative space of trust, safety, with clear therapeutic goals with the objective to ensure a positive health outcome.

The last theoretical framework that may be added here is the reformulation of the medical interpreters' domains of expertise and influence. Some only grant interpreters the linguistic expertise, arguing that the cultural domain may be limited and therefore must be utilized with the utmost care and within clear boundaries to avoid stereotyping or adversely affecting the communicative event. The health or medical domain has been introduced before (Souza, 2016), and is an important contextual domain of medical interpreting. Therapeutic communication interpretation and mediation are but the means of effectively achieving therapeutic goals (information, understanding, consensus, and agreement). This meta-linguistic and meta-cultural view of medical interpreting as therapeutic mediation highlights the importance of the medical in medical interpreting practice. The medical vocabulary and setting are unique, and now it seems by the data that there is also the therapeutic component in the practice of medical interpreting.

Figure 3 shows the domains that influence the interpreters' mediation work. These include the linguistic domain, the cultural domain, and the therapeutic domain. It is important to note that this model does not address which domain is more important, assuming that all are needed, and equally important. Each domain is activated as needed to meet the demand at hand in mediation. Just as the event and the team cannot be separated, these three domains cannot be separated.

FUTURE RESEARCH

Researchers from a wide spectrum of careers have studied medical interpreting. However, as an interdisciplinary field, this specialization is just starting to be better understood. More research needs to be done regarding the interpreter as a limited, yet integral part of the therapeutic process. The intricacies of the

Figure 2. Interpreter as therapeutic mediator

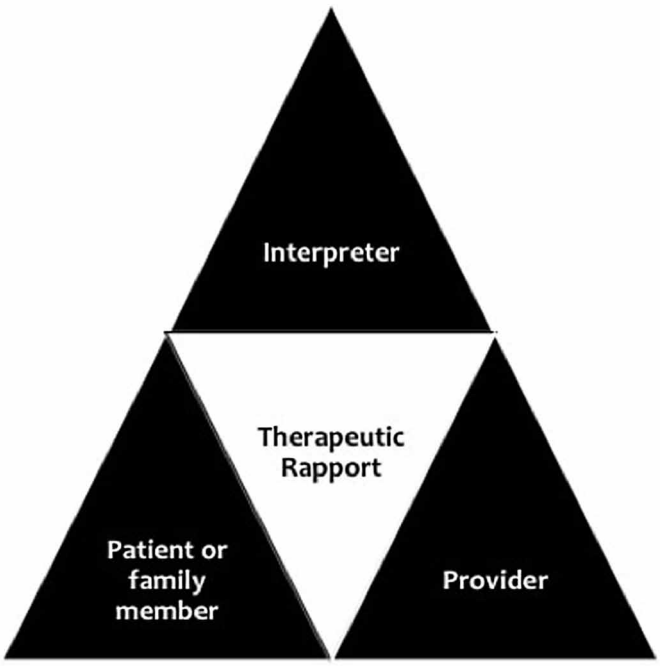
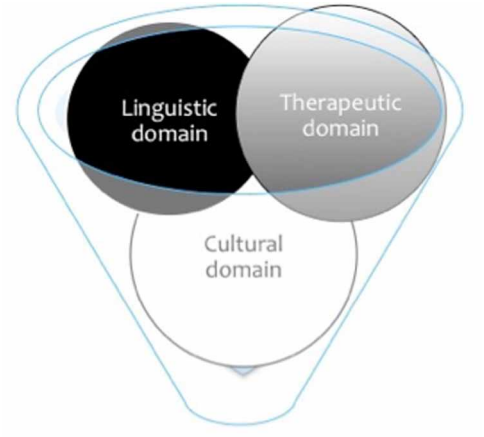


Figure 3. Medical interpreter mediation macro domains



teamwork required between the provider-patient-interpreter triad have been explored, but the interpreter has not been researched as a therapeutic agent. A therapeutic team has traditionally been defined as a group of healthcare professionals that gets together to achieve a specific therapeutic goal, and according to this definition, the interpreter is not part of the team. However, if we broaden this definition to all that have a therapeutic effect on the patient, perhaps one will see the medical interpreter as a therapeutic agent and part of the therapeutic team. The interpreter-mediated communicative event is a therapeutic event and not just a communicative event where individuals interact. The therapeutic interaction, or rapport between all parties and all that ensues from it is in fact what health care is made of. Interpreters spoke of their patients, and the importance of providing accuracy as a form of maintaining the patients' safety. There is also a need to study what therapeutic communication techniques can be applied to medical interpreting practice. Teach back, the technique of asking a speaker or signer to paraphrase what was understood, is one that interpreters have adopted and use in their day-to-day practice. But there are many techniques that may be useful to interpreters as communication mediators. Future research is needed on how medical ethics affects medical interpreters' roles and actions. Whereas ethical decision-making has been studied thoroughly, most of the research reflects the interpreting ethical code as reference, and not the medical one.

LIMITATIONS

The primary limitation is the sample size. The next limitation is that there were only two language combinations, English <>Spanish and English<>ASL. The language combinations in which interpreters practice may affect the role of the interpreter to a greater extent than previously thought.

The caregivers' role is also an important one. Family members or others accompanying the patient have their own role(s) as well, which is mainly as physical or mental support. Even though some interpreters discussed scenarios with caregivers or family members, the study did not ask about their role(s). Further study is needed in this area.

This study did not explore how medical ethics, a component of therapeutic communication, affects the medical interpreting role. Are medical interpreting educational programs teaching medical ethics

to interpreters? It seems that it would be an important subject-matter to include in medical interpreting education.

Another characteristic of health communication that was not adequately discussed is the fast pace of therapeutic communication. One of the greatest disparities in healthcare for patients and providers that require interpreting is the factor of time. The same interaction requires twice the time when interpreted consecutively. This means that if the time of the encounter is pre-set, the provider and patient may find that they have half the time to cover the same amount of communication. How does this affect care of linguistically diverse patients? Does this put pressure on the interpreter not to intervene or to act as a gatekeeper to save time? Can technology develop a system to enhance simultaneous interpreting for spoken language interpreters in healthcare? Research in this area may affect policies related to providing more equitable healthcare to patients requiring spoken language interpretation.

RECOMMENDATIONS

Specialists need to be heard. There is not enough research giving medical interpreters a voice. The codes of ethics and guidelines being given to interpreters seem imposed from more generalist perspectives, such as community interpreting. These seem too restrictive, according to interpreters that were *told* to just relay messages and stay detached. Whereas this may work in a courtroom, it simply does not hold true in an emergency room.

Certified specialists need to move into academic and educational fields, and a certain number of years of practice should be required to teach medical interpreting. Practice professions need to be taught by practitioners. Have you ever seen nursing be taught by someone who is not a certified or registered nurse? Therapeutic communication concepts and the context of healthcare need to be taught in the interpreters' formative years and not as continuing education. These can include: a) counseling theories and practices, b) discourse analysis-based training of discordant speech and ideation, c) role plays in these therapeutic contexts, and d) strategies to maintain role boundaries within an interpreted-mediated behavioral therapeutic communicative event.

Healthcare organizations may consider giving medical interpreters a bigger role in ensuring equity and patient safety, not to mention healthcare access in general. Some in the translation and interpreting field who view the interpreter as a linguist will vehemently oppose this, but if medical interpreters continue to be embraced as a part of the healthcare team, and their own specialist standards are followed, they will continue to play a therapeutic role, an integral part of the therapeutic process that utilizes language as a means to achieve a therapeutic end.

Policymakers may wish to consider adding this understanding to their cultural competency initiatives, to better serve the underserved populations that require interpreting.

Providers need to be better educated on the role of the interpreter as a communication facilitator or mediator, versus a language conduit. Unfortunately, many providers are being taught erroneously that interpreters are linguistic tools, without understanding that they are communication facilitators, facilitators of the therapeutic rapport and of understanding. If they are given the opportunity to do an appropriate pre-session, and the provider discusses the care goals with them, they will be able to work together with the provider and the patient to attain the desired outcomes presented to them.

Unrealistic expectations, such as 'do not to intervene' or 'just interpret word for word' not only limit the interpreter's ability to do their work adequately, but also diminishes the ability of the interpreter to be effective, and the healthcare organization to provide equitable patient-centered care.

There is still great divergence between what is being taught and how interpreters are practicing. The idea that interpreters only intervene when there is a breakdown in communication is simply not what is being practiced. It is time for interpreting to be recognized as a specialized field that is comprised of a 'medical' or therapeutic component, as well as an 'interpreting' component. The medical context is not subservient to the interpreting activity, as the activity is but a means to achieve the contextual 'medical' outcomes.

CONCLUSION

This chapter aimed to answer the following question: Is the role of the medical interpreter affected by therapeutic communication? The data show that certified medical interpreters seemed to be influenced by the nature of therapeutic communication and interaction. Certainly, the data show that interpreters agree that the provider still dominates and controls the medical domain of translating a patients' story into a diagnosis, and determining the best therapeutic course of action. However, this study opens the idea that the interpreter's role goes beyond linguistic and cultural mediation. It also includes a therapeutic mediation component. This mediation component that has more to do with the patient and provider's ability to relate therapeutically, than whether the patient and provider communicate. Two participants can 'communicate' and not 'relate' or 'understand each other' at a deeper level. When no interpreter is required, certainly the patient and provider do not have the benefit of an interpreter to enhance their therapeutic rapport.

So why should interpreter-mediated interactions require the interventions (sometimes seen as interference) of interpreters to enhance this therapeutic rapport? Perhaps the gap and inability to understand, but also to relate with one another, is much greater. The data suggest that there is a certain level of discomfort and distrust in interlinguistic and intercultural relationships. If the role of the interpreter is to close the 'linguistic' and 'cultural' gap between patients, perhaps the reality is that there are other gaps, such as the 'therapeutic' gap that is going to invariably be mediated by the interpreters' simple presence and interaction with the primary participants. Whereas the conduit versus facilitator model dichotomy may not be easily solved, understanding the nature of therapeutic communication as a vehicle for therapeutic interventions may help in the understanding of why practicing certified medical interpreters intervene more than prescribed.

In therapeutic talk, or therapeutic communication, the main goal is to achieve a positive therapeutic outcome. In order to achieve this final outcome, interpreters will engage in a multifaceted range of tasks that go well beyond 'the act of interpreting.' Are interpreters being allowed to serve the healthcare system at the highest level possible? Are hospitals taking advantage of interpreters in their full potential to increase patient satisfaction and patient compliance, as well as reduce liability and risk? Or do they still view interpreters as linguistic conduits? A framework that acknowledges the therapeutic goals of medical interpreters may help explain why medical interpreters practice as they do.

A word of caution: the focus on the therapeutic goals and objectives framework does not attempt to minimize the linguistic work of consecutive or simultaneous interpreting. Nor does it minimize the cultural work of medical interpreters. It simply creates a broader framework for this specialist role,

one of therapeutic facilitator or mediator. This role includes the ability to interpret accurately, but it is not completely defined by this ability. A role paradigm of communication facilitator acknowledges the interpreter as a practice professional with professional goals and objectives that go beyond 'interpreting accurately.' Medical interpreters demonstrate professional agency and decision-making skills that go beyond word choice. The Macro Domain Model acknowledges that the interpreter uses interactive soft skills of mediation and facilitation to navigate these three domains of expertise: linguistic, cultural, and therapeutic. Asking the interpreter to forego any of these domains limits the effectiveness of medical interpreters in closing the therapeutic gap in any specific given situation between a provider and a patient. It also limits drastically the scope of work and the effectiveness for the interpreter to close this gap. Although some may wish to limit the interpreter to a black box interpreter, ultimately within the framework of patient safety, patient-centered care, and equitable health services, the broader *raison d'être* of the interpreter is to play the role of therapeutic mediator to facilitate access to health care. Their interpreting skills are but tools to act as mediators.

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Chapter 6
Investigating Expressions of Pain and Emotion in Authentic Interpreted Medical Consultations:
"But I Am Afraid, You Know, That It Will Get Worse"

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ABSTRACT

This descriptive study, which is based on a PhD research conducted at the University of Zurich and at the Zurich University of Applied Sciences, explores the activity of interpreters. At first sight, the interactions between patients and doctors seem to be fluently and smoothly interpreted. Yet, a closer look at the transcripts of the consultations reveals various conversational difficulties. A striking issue in this data set are the patients' complaints about pain and anxieties which do not always reach the doctors or the nurses, because the interpreters cut out affective parts in their renditions. In such cases, the patients' concerns may simply be lost which prevents doctors or nurses from responding on the emotional level. In other situations, however, the doctors or the nurses miss the opportunity to address the patients' feelings, even if the interpreters convey the patients' concerns to them.

INTRODUCTION

The demographic development leads worldwide to an increasing need of providing interpreting services in institutional settings for participants who do not speak the same language (see e.g. Roat & Crezee, 2015, p. 236). Since the 1990s there is a growing body of research on interpreting in legal, educational, social, and medical settings (see Napier, 2011, p. 123). In Switzerland reference to the need for interpreting

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services is found at the beginning of the 20th century which is rather late in comparison with countries like Australia, Canada or Sweden (see e.g. Faucherre, Weber, Singy, Guex, & Stiefel, 2010). The set-up of interpreting services differs from country to country. "Community Interpreting (CI), or public service interpreting (PSI) as it is also commonly known, is a service that is invariably rooted in the communities and societies that require and provide it. As such it reflects the practices, norms, standards, needs, demands and policies of these communities and societies. CI or PSI, as the double denomination already suggests, comes in many national and geographical variations and is impacted by societal and political forces at local, regional, national and international levels …" (Remael & Carroll, 2015, p. 1). Interpreting in institutional settings is known under even more than these two names. There is an "insistent debate over what the field should be called that is termed 'Public Service Interpreting,' but also 'community interpreting,' 'dialogue interpreting,' 'liaison interpreting,' 'cultural interpreting', 'cultural mediation,' and many other appellations including, simply, 'interpreting'." (Ozolins, 2010, p. 200)

In this chapter, the terms "dialogue interpreting" or "medical interpreting" will be used, as the focus is on the interactional activities and on the specifics of the management of the doctor-patient communication. Dialogue interpreters typically work in the consecutive mode and they attempt to reproduce the utterance of the previous speaker.

This chapter reports on a study using a small data set taken from PhD research based on a larger study. The team of researchers involved in the larger study compiled a corpus of 19 interactions amounting to 14:42 hours of video material. Studies investigating empiricial data are comparatively seldom, as access to authentic data is rather difficult (see e.g. Bot 2005). One of the hardly ever explored topics is the patients' complaints of pain and of anxieties in relation to the interpreters' rendering thereof and to the responses of the doctors or nurses.

The aim of this study is to investigate authentic interpreter-mediated interactions and to gain insight into how interpreters and primary interactants communicate in various medical settings. The primary interactants in three encounters are patients and doctors and in one encounter a patient and a nurse.

The focus of this contribution is on the following questions:

- What is the interpreters' impact on the content of the patients' original utterances and on the emotional intensity of their complaints?
- How do doctors or nurses respond to the renditions of the interpreters?
- What effects do multimodal resources like direction of gaze, manual gestures and head turns have on the course of the interactions?

BACKGROUND

Medical interpreting is studied from various fields such as interpreting science (see among many others Hale, 2007; Menz, 2013; Meyer, 2004; Pöchhacker, 2007), medical sciences (see e.g. Aranguri, Davidson, & Ramirez, 2006; Butow, Brown, Cogar, Tattersall, & Dunn 2002; Fatahi, Hellström, Scott, & Mattsson, 2008; Morina, Maier, & Schmid Mast, 2010), or socio-linguistics (see e.g. Davidson, 2000).

Although interpreting is investigated from various perspectives, the focus in various studies is often on the same questions like "what should an interpreter do, what should s/he not do?", or "should an interpreter be a 'linguistic conduit', a 'bilingual mediator' or a 'cultural broker'"? Indeed, a substantial

part of dialogue interpreting focuses on the interpreter's role and function in the social interaction (see e.g. Angelelli, 2004; Pöchhacker, 2012; Tebble, 2012).

A further recurring topic in the literature on interpreting is the accuracy of the interpreters' renditions. Various researchers established taxonomies and classified renditions (for more information see Napier, 2002; Wadensjö, 1998). Napier developed an omission taxonomy (Napier, 2002, 2015) and Wadensjö (1998) defined types of rendition in relation to the adequate rendering of the original utterance or the deviation from it including the wider context of the interaction.

Based on Conversational Analysis and Multimodal Analysis, multimodal resources like direction of gaze, gestures and head turns are considered crucial in the dynamics of the interactions in more recent studies. These features lead to the question whether an interpreter is a participant of the interaction and responsible for the co-ordination of the communication (see e.g. Bot, 2005; Krystallidou, 2016) or "a neutral person standing slightly apart" (Fatahi et al., 2008, p. 44). In the present study these features will be part of the analysis to provide evidence of nonverbal communication, of the ways in which direction of gaze, gestures and head turns influence the patient's in-/exclusion from the interaction and of the mutual relationship between the interpreter, the patient and the doctor/nurse.

METHODS AND DATA

The PhD research is based on the Swiss research project entitled "Interpreting in medical settings: roles, requirements and responsibilities" which was conducted between 2010 and 2012. This larger project was carried out by an interdisciplinary team of physicians, psychologists and linguists. It consists of three parts: 1) a questionnaire-based survey regarding the role and function of interpreters as perceived by medical experts as well as by interpreters, 2) analysis of 19 interpreted interactions. The dataset collected in three hospitals in Switzerland comprises 14:42 hours of authentic video-recorded doctor-patient consultations. The analysis focussed on the verbal dimension and on the comparison between the original utterances of the patients, of the doctors and of the nurses and the renditions of the interpreters, 3) creation of a multilingual terminology database in Albanian, German and Turkish consisting of 1000 terms (social, medical, psychological terms) with the main focus on pain.

The video-recordings comprise 19 interpreter-mediated consultations involving doctors and nurses, patients and interpreters. The consultations were video-recorded in various departments at the university hospitals in Basel, Zurich and Bern. Ethical approval and patients' written informed consent were obtained prior to the collection of data.

All of the 19 video-recorded consultations were fully transcribed including the Albanian and Turkish utterances which were translated into German. The interactions in the 19 consultations were divided into 3866 segments. One segment consisted of one utterance and its "rendition" (see Laws, Heckscher, Mayo, & Wilson, 2004; Sleptsova et al., 2015). The categories "omission", "reduced rendition", "addition", "change of role", "terminological aspects" were established and rated by linguists and medical experts. The quantitative and qualitative analysis identified "omissions", "additions" and "reduced renditions" amongst the most frequent incidents.

The four consultations discussed in this chapter are taken out of this dataset. They were recorded in the university hospitals in Basel and Zurich. The doctors or nurses are German-speaking, none of them have any command of the patients' languages. The patients are speaking Albanian or Turkish, they have some command of German, as they have been living in Switzerland for some time. They

are all undergoing treatment for various long-term illnesses like diabetes, cardiac problems or cancer. The interpreters have Albanian or Turkish as their first and German as their second language, but they have been living in the German speaking part of Switzerland for several years. All interpreters in the project are so-called professional interpreters in the sense that they are paid by the hospital (see Pöchhacker & Shlesinger, 2005). There are no ad hoc interpreters. The hospitals of Basel and Zurich (among other hospitals in Switzerland) have contracts with Swiss agencies which recruit interpreters for them (cf. Hudelson, Dao, Perron, & Bischoff, 2013, p. 2).[1] The agencies are part of the national community interpreters' association in Switzerland INTERPRET.[2.]After the creation of INTERPRET, a training program leading to a Certificate in Community Interpreting was developed. For the video-recordings in this project the interpreters did not have to be certified, but an experience of three years of medical interpreting was required, and all of them were tested for B2 language levels[3] in German according to the Common European Framework of Reference.

ANALYSIS

When it comes to problems in the understanding, the patients, the doctors or nurses can intervene less easily in interpreter-mediated encounters than in monolingual consultations, because the doctors or nurses do not understand the utterances in the language of the patients. Moreover, it is questionable, whether they perceive alterations of the original statements by the interpreters at all.

The dataset in the project "Interpreting in medical settings: roles, requirements and responsibilites" had shown, that interpreters deviated from the original utterances frequently (see Sleptsova et al., 2015).

For the purpose of this chapter, eight excerpts out of four different authentic interpreted consultations between Albanian or Turkish speaking patients and doctors/nurse are taken from the larger dataset briefly outlined above. These four consultations were recorded in the university hospitals in Basel and Zurich.

The analysis of the data in this chapter is based on the comparison of the primary interactants' utterances and the interpreters' renditions as it was done in the first project described briefly above. In this contribution, instances where the patients' complaints about pain and anxieties are not rendered by the interpreters at all (omissions) or are rendered only partly or reduced in their level of intensity (reduced renditions) are explored. If the patients' concerns and complaints are omitted by the interpreters, they remain of course unanswered, while there could be a response after a reduced rendition.

The two categories are defined as follows:

- **Omission:** Either factual information or emotional expressions about pain and anxieties are left out.
- **Reduced Renditions:** Factual information about pain and/or anxieties are only partly conveyed, and/or the level of emotional intensity is downgraded.

However, the aim of this study is not only an assessment of the source-target-correspondence. The analysis of the eight excerpts is also based on Conversation Analysis and Multimodal Analysis. Numerous authors in the different fields of interpreting research are devoted to the performance of the interpreters, to verbal communication and to role concepts, while only few contributors who pay attention to the methods of Conversation Analysis and multimodal aspects could be named (amongst them Davitti & Pasquandrea, 2017; Davitti & Pasquandrea, 2013; Krystallidou, 2014; Mason, 2012; Pasquandrea,

2011). Drawing on Conversation Analysis the unfolding talk is followed and the communication is seen as a co-constructed sequential process beginning with the patients' or doctors' utterances followed by the interpreters' renditions and by the doctors' or patients' responses. The interplay between all the interactants is explored.

Thanks to the technique of video-recording, multimodal resources are part of this study. The eight excerpts of the four consultations are used not only to examine utterances of patients, doctors or nurse but also to explore non-verbal resources such as direction of gaze, manual gestures, and head turns in order to understand the dynamics of the discourse with the view on the effects of participation. To illustrate the participants' pointing gestures, gaze and body orientation, video stills which are extracted from the video-recordings are included.

The focus is on explicit statements about pain and anxieties, while sharing the other participants' feelings and sensations is not part of the investgation in the present contribution, a perspective explored e.g. by Krystallidou et al. (2017) and Merlini & Gatti (2015). There are a host of different aspects of ways in which patients and medical staff who communicate via an interpreter can be analysed. Therefore, the selection of the excerpts reveals a certain bias. Amongst the issues discussed in this chapter are instances in the consultations where patients express their pain and anxieties explicitely. The focus lies also in the interest to gain insight about what the interpreters choose to convey to the primary interactants in relation to these complaints. Another interesting aspect is how all the interactants (including the interpreters) support their utterances with manual gestures. Particularly important in doctor-patient-communication are the patients' pointing gestures. The focus is on the questions whether interpreters reproduce the patients' pointing gestures or not and whether doctors or the nurse respond to the interpreters' and/or the patients' pointing gestures? In the studies of interpreted encounters the interpreters' renditions of patients' emotional complaints and the response of doctors and nurses as well as the impact of direction of gaze, gestures, or head turns on the discourse are an underresearched issue.

The examples 1 – 4 discussed below are drawn from the wider PhD project investigating aspects of verbal and non-verbal behaviour of the interpreters and the primary interactants.

An overview of the encounters presented is supplied in Box 1.

In the four examples, three doctors, one nurse, four different patients and four different interpreters are involved. The patients are long-term patients reporting the development of their illnesses, their current pain and their anxieties. Three patients speak Turkish (Example 1, 2 and 4), one patient speaks Albanian (Example 3). The Albanian, the German and the Turkish utterances are translated into English by the author. To optimise the readability of the transcriptions, the original utterances are in normal typeface,

Box 1. Overview of the encounters in the examples 1 - 4

Example	Department	Situation	Focus	Languages
1	Internal medicine	Follw-up encounter	Patient's complaint: pain	Turkish - German
2	Oncology	Follw-up encounter	Patient's complaint: pain/ anxiety	Turkish - German
3	Diabetology	Control of blood glucose levels	Patient's complaint: anxiety	Albanian - German
4	Diabetology	Follw-up encounter	Patient's complaint at the closing of the consultation: pain	Turkish - German

the translations and the non-verbal activities are in italics. Moreover, the line(s) of the passages cited is/are indicated by square brackets. The key for the transcription conventions is found in the appendix.

In all of the four encounters three participants are involved: a doctor (D) or a nurse (N), a patient (P) and an interpreter (I). The reason for the selection of the excerpts was based on the topic of pain and anxieties uttered explicitely by the patients.

Example 1

Example 1 is a follow-up consultation in the department of internal medicine. The parties involved are the patient (P), the doctor (D) and the interpreter (I). The doctor speaks German. The patient is Turkish speaking and she has some command of German.

In Example 1 two excerpts are discussed. The focus is on finding the cause of the patient's pain in her leg and on deciding on the adequate treatment.

Excerpt 1.1 "How Is It Going?"

The doctor begins the consultation with an open question to encourage the patient to talk freely about her physical condition: "Wie geht's?" ("How is it going"?)

After the doctor's initial open question "Wie geht es?" ("How is it going?" [12]) the patient answers in German. Obviously, she has some command of German. She understands the question and answers in German: "ee, nit gut, uh, beide krank, viel so alles." ("uh, not good, um both bad, much so all" [12]). What she wants to say exactly, remains rather vague. After this introduction, the doctor is interrupted by an assistant's inquiry. After giving a short answer to the assistant, she turns to the patient again. A verbal pause follows during which the patient looks at the doctor, saying nothing. Instead, the interpreter takes over the next turn: "What was not good? That is what she asked you." [12] - [13]). Contrary to the open question of the doctor, the interpreter foregrounds a negative perspective. She does not refer to the patient's first answer in German, but acts on her own initiative. The patient then reacts in response to the interpreter's intervention and refers only to the pain in her leg and supports her utterance by stroking her left leg from her thigh to the knee without retrieving her more general answer in German ("uh, not good, um both bad, much so all" [12]) from before. The doctor follows the patient's gesture with her eyes (figure 1a). The interpreter does not reproduce the pointing gesture.

The doctor then shifts her gaze to her documents. Doctors have to fulfill several tasks like reading or writing reports, looking for documents, answering questions of assistants or speaking on the telephone while interacting (see e.g. Greatbatch, 2006; Heath, 1984). The interpreter verbalises the patient's repeated pointing gesture: "Uh my left leg hurts so much." [14]) and points with her index finger to the legs of the patient in order to locate the painful area (see Kendon 2004), thus coupling the pointing gesture with her verbal activity (figure 1b).

The patient goes on mentioning her "sleeping" leg and adds that her knees "does things" [14]) without a more distinctly formulated explanation. The interpreter omits this part of the utterance, probably because of overlapping talk. After the withdrawal of her gaze, the doctor starts with a new question (see excerpt 1.2).

The most problematic issues of excerpt 1.1 are the omissions of the symptoms in the interpreter-rendered utterance as well as the additions of the interpreter in which she gives her instructions to the

Table 1a. Excerpt 1

[12]	**30 [02:27.9]**	**31 [02:28.7]**	**32 [02:46.6]**
D [v]	wie gehts?		
D [tr]	*how is it going?*		
D [nv]	((*an assistant knocks at the door and interrupts the interaction with a question; after the interrution she turns her head towards the patient and looks at her*))		
I [v]	Nasılsınız?		Iyi olmayan neyidi?
I [tr]	*how are you?*		*what was not good? that*
P [v]		ee, nit gut du beide krank viel so alles.	
P [tr]		*uh, not good you both ill much so all*	
P [nv]		((*points to back and knee*))	
[13]	..	**33 [02:48.9]**	
I [v]	onu sordu sana.		
I [tr]	*is what she asked you.*		
P [v]		diyorumki bu bacağım çok bu kalçadan ağriyor tah şuraya.	
P [nv]		((*points to hip and knee*))	
P [tr]		*I say this leg hurts so much from the hip till here.*	
[14]	..	**34 [02:54.0]**	
D [v]		mhmh	
D [nv]		((*withdraws her gaze and starts writing*))	
I [v]		uh my left leg hurts so much	
I [nv]		((*points to the leg of the patient*))	
P [v]	kadar zaten dizlerim ağrıyor	çok uyuşup şey yapiyor yani	
P [nv]		((*points to her thigh*))	
P [tr]	*my knees hurt anyway sleeps a lot and does things*		

Figure 1a. The doctor looks at the patient's pointing gestures

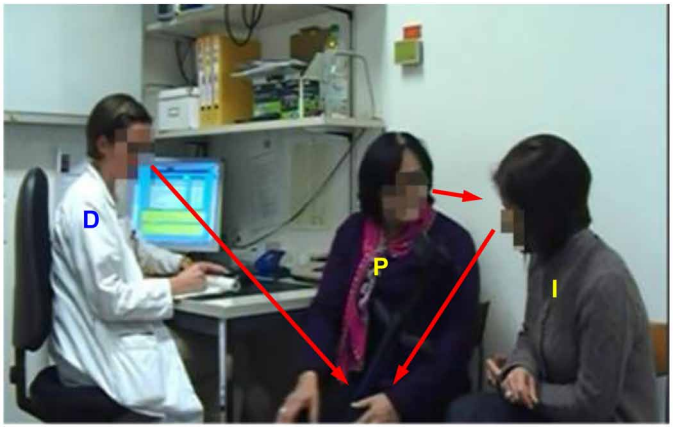


Figure 1b. The doctor shifts her gaze to her documents

patient without interpreting these self-initiated instructions for the doctor. The interpreter acts as an expert. The doctor accepts the interfering of the interpreter and does not question her behaviour.

Excerpt 1.2: "Is This a Pain That Is New?"

After the withdrawal of her gaze, the doctor starts with a new question (see excerpt 1a). The doctor's question "Sind das Schmerzen, die neu sind oder die Sie schon von vorher kennen?" ("Is this a pain that is new or do you know it from before?" [15 - 16]) is formulated clearly as an alternative. She tries to determine what is wrong with the patient. However, the interpreter expands the question ("This pain then is it new or do you know it from before or do you know whether you had it before?" [16 - 18]), so that the second part of the original utterance is in fact repeated. Whether the patient understands the expanded and therefore less comprehensible question is dubious. In any case, she does not respond to the alternatives suggested by the doctor. Instead, she believes the pain in her leg is caused by her temporary paralysis she was suffering from some time back. This assumption is not conveyed to the doctor by the interpreter. Instead, the interpreter acts again on her own initiative by disagreeing and excluding the doctor by speaking Turkish: "No, no, the pain that you describe now" [19]). Because of this omission by the interpreter, the doctor cannot explore the patient's answer. The doctor might realise that the interpreter talks to the patient in Turkish without interpreting for her. Yet she does not intervene and seems to confide in the interpreter. She might not be aware of the fact that the interpreter is acting on her own initiative. The omission might have a negative effect on the outcome of the consultation (see Zendendel, Schouten, van Weert, & van den Putte, 2018).

As seen in this case, omissions (especially in combination with an addition) can lead to "dilution or even censorship." (Setton, 2015, p. 163). The interpreter performs a dominant and an excluding role without the knowledge of the doctor. The doctor seems to trust the competence of the interpreter. Although the patient knows that the interpreter influences her by advising her to change her answer, she apparently trusts the expertise of the interpreter, too, and does not object.

Table 1b. Excerpt 2

[15]	..			**35 [03:04.4]**				**36 [03:09.3]**
D [v]								sind das
D [tr]								*is this a*
[16]	..						**37 [03:14.0]**	
D [v]	schmerzen,die neu sind oder die sie schon von vorher kennen?							
D [tr]	*pain that is new or have you had it before?*							
I [v]							bu ağrılar peki	
I [tr]							*this pain*	
[17]	..							
I [v]	yenimi yoksa daha öncenden biliyormusun yoksa daha öncen biliyormusun bu							
I [tr]	*well is it new or do you know it from before or do you know whether you had*							
[18]	..	**38 [03:18.2]**						
I [v]	ağrılar varmydi?							
I [tr]	*it before?*							
P [v]		ya zaten dizlerim bu felcden dolayı ağriyor belim.						
P [nv]		((*points to knee and back*))						
P [tr]		*well my knee my back hurt because of the paralysis*						
[19]	..	**39 [03:23.7]**				**40 [03:25.4]**		
I [v]		yok, yok bu şimdi tarif ettiğin ağri.						
I [tr]		*no, no the pain that you describe now.*						
P [v]						şu yeni.		
P [nv]						*((points again from the back to*		
P [tr]						*this is new.*		
[20]	..	**41 [03:26.6]**	**42 [03:26.2]**	**43 [03:27.6]**	**44 [03:27.8]**			**45 [03:29.9]**
I [v]		This is new.						yes this
P [v]					şöle şurdan şuraya kadar yeni.			
P [nv]	*the knee*))				((*points to the left thigh*))			
P [tr]					*like this from here to there.*			
[21]	..			**46 [03:32.0]**	**47 [03:33.8]**	**48 [03:34.0]**	**49 [03:35.7]**	
I [v]	pain from hip to knee that is new.							

Example 2

Example 2 is a follow-up encounter in the department of oncology. The parties involved are the patient (P), the doctor (D) and the interpreter (I). The patient is Turkish speaking and she has some command of German.

In Example 2 two excerpts are discussed. After surgery and chemotherapy, the breast cancer patient has just started the radiation therapy. She gets aches and pains and emphasises her fear of tumour recurrence.

Excerpt 2.1: "I Feel Aches and Pains"

In excerpt 2a, the doctor starts with the question "Ja, jetzt, wie geht es Ihnen?" ("Well yes how are you now?" [13]). The interpreter transmits the doctor's open question adequately and the patient starts explicitly talking about her pain and her anxieties. After the interpreter has completed her rendition, the patient might have expected a response from the doctor, but the doctor instead just encourages the patient to go on with her narration ("mhm", [15]) without commenting the patient's complaint. She then repeats her utterance and adds the precise chronological structure of the development during the three days until she could do nothing else but see the familiy doctor. By omitting the patient's repeated utterance ("Today I feel aches and pains", [15 - 16]), the interpreter reduces the emotional intensity and shifts the focus to the aspect of the timing. Although the interpreter has at the beginning rendered quite closely that the patient suffers from pain [14 - 15], the doctor also accentuates only the aspect of time, when he makes sure that she suffered from pain three days, before going to see the family doctor [17]. The doctor does not respond to the emotional factor: "Was hat der Hausarzt herausgefunden? ("What did the family doctor find out?" [19]).

The doctor could have responded to the patient's complaint that the interpreter conveyed to him. His focus is only partly due to the interpreter's omission. He avoids responding to the affective part and instead follows the interpreter by foregrounding the aspect of time ("three days") and by inquiring about the results after her visit to the family doctor. After a short interval of a little more than five minutes, the patient repeats her complaint. It may well be that she has not understood, why she got no answer from the doctor. "Trying again" is her only possibility to get the doctor involved.

Excerpt 2.2: "Fear Grips Me …"

Obviously the doctor has up to this moment not been able to persuade the patient that her pain is most probably harmless. The patient therefore repeats her prior concern and clearly states with more intensity than before that she is very ill and concerned because of the pain: "Ee maybe anyway I am a sick person or from somewhere else and now that this wound exists fear grips me at once where does it hurt, I say it comes from here …" [88 - 91]). The patient's complaint might be difficult to understand for the interpreter and challenging to interpret. She struggles to convey to the doctor what the patient has said, because it is not very clear what the patient is saying and not easy to memorise, even though the gist of the patient's utterance can be properly understood.

The patient's verbal deictic "I say it comes from here" [90] coincides with the gestural pointing to her breast.

The interpreter reproduces the gestural pointing, but fails to connect the pointing gesture with the patient's verbal deictic. The interpreter refers to the wound not to the location of the pain. The two ges-

Table 2a. Excerpt 1

[13]	**20 [01:15.0]**	**21 [01:16.3]**	**22 [01:16.6]**	**23 [01:17.7]**	**24 [01:19.7]**
D [v]				ja jetzt wie geht es Ihnen?	
D [tr]				*well yes, how are you now?*	
I [v]					nasılsınız?
I [tr]					*how are*

[14]	**..**	**25 [01:20.7]**	**26 [01:23.2]**
P [v]		iyi iyi değilim ağrı sızılarım çok.	
P [tr]		*I am not well, I feel aches and pains*	
I [v]			I am not well
I[tr]	*you?*		

[15]	**..**	**27 [01:24.7]**	**28 [01:26.4]**	**29 [01:26.4]**	**30 [01:26.6]**	**31 [01:27.1]**	**32 [01:28.4]**
D [v]					mhm		
D [nv]		((*nods*))					
P [v]							bugün çoktur ağrı
P [tr]							*today I feel aches and*
I [v]	I feel aches and pains.						

[16]	..
P [v]	sızılarım çoktur dün evelki gün işte üç gün duramadım.
P [tr]	*pains yesterday and the day before three days I couldn't bear it yesterday.*

[17]	**..**	**33 [01:33.8]**	**34 [01:36.5]**	**35 [01:39.2]**	**36 [01:40.1]**
D[v]				three days	
P [v]		dün ee ev doktoruna gittim			mhm
P [tr]	*I went to the family doctor*				
I [v]			well for three days I have		

[18]	**..**
I [v]	had it the day before yesterday too yes and I could not bear it any longer and that is why I

[19]	**..**	**37 [01:40.9]**	**38 [01:44.8]**	**39 [01:45.4]**	**40 [01:48.0]**
D [v]			m h m h	what did the family doctor find out?	
I [v]	went to the family doctor				

Table 2b. Excerpt 2

[88]	..	**191 [07:06.4]**				
P [v]		ee acaba ordamı zaten ben hasta bir				
P [tr]		*ee maybe anyway I am a sick person or*				
[89]	..					
P [v]	insan başka bir yerdemi şimdi birde bu yara olduğu zaman					
P [tr]	*from somewhere else and now that this wound exists*					
[90]	**192 [07:13.2]**					**193 [07:18.9]**
P [v]	birde korku alıyor hemen bu nere ağrıdığı zaman ben diyorumki burdan					
P [tr]	*fear grips me at once where does it hurt, I say it comes from here*					
P [nv]	((*patient points to the left breast*))					
I [v]						mhmh
[91]	..	**194 [07 :19 .0]**	**195 [07:23.7]**			
P [v]	geliyor yani belki başka bir yerden gelir.					
P [tr]	*maybe it comes from somewhere else.*					
I [v]	well I think it has been so bad now I know		the pain but the last three			
[92]	..	**196 [07:26.7]**	**197 [07:2 7.5]**	**198 [07:27.7]**		
D [v]		viel schlimmer mhmh				
D [tr]		*a lot worse*	mhmh			
I [v]	days the pain was a lot worse so that I		thought it might			
[93]	..	**199 [07:3 2.0]**	**200 [07:3 2.5]**	**201 [07:3 2.6]**	**202 [07:39. 8]**	
D [v]		mhmh			mhmh	
I [v]	come from something else		and if I			
[94]	..					
I [v]	wound I have a wound here and um then I always think it may be that it is					
I [nv]	((*interpreter points to the wound*))					
[95]	..	**203 [07:4 0.3]**	**204 [07:4 1.0]**	**205 [07:41. 5]**		
D [v]			mhm h			
I [v]	something else that the pain comes fom somewhere else				that	
[96]	..	**206 [07:42.9]**		**207 [07:45.6]**		
D [v]		ich würde es mir gerne mal anschauen				
D [tr]		*I would like to have a look at it*				
I [v]	makes me so uneasy.					

Figure 2a. The patient complements her utterance with pointing to her left breast

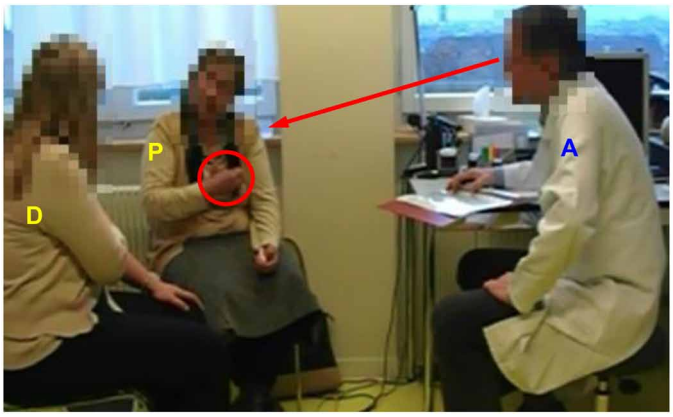


Figure 2b. The interpreter reproduces the gesture

tures look alike, but do not have the same meaning. The doctor perceives the pointing gestures of both the patient and the interpreter (see figures 2a and 2b), but he cannot recognise that the patient's verbal deictic ("here") is omitted, as he does not understand the patient's original utterance. He has no reason to distrust the interpreter's competence.

Instead of interpreting the patient's utterance, the interpreter repeats parts of what the patient had said about her pain's development over three days (see excerpt 2a). Although the doctor is told by the interpreter about the patient's pain-related anxiety and fear, he remains on the factual level that is obviously relevant for him and avoids to address the patient's emotional concern (see e.g. Butow et al., 2002; Lindemann, 2015; Pollak et al., 2007). The patient's pain could possibly signal a medical problem that he might have failed to uncover up to now. So the doctor pays attention to her concern and examines her physically in order to find out the source of the pain. The patient finally achieves her goal in the interaction, but she might still miss his emphatic response.

The doctor is told about the patient's uneasiness by the interpreter, but he hears nothing about her anxiety: "fear grips me" [90] vs. "that makes me uneasy" [95 - 96]. The doctor could respond to the uneasiness, but he does not encourage the patient to talk about the emotional issue. Later in the consulta-

tion (not shown in the excerpts 2.1 and 2.2), the patient tells the doctor that she needs someone to talk to about her worries. Displaying a more engaged attitude towards emotional aspects could have been a move to a positive nature in the doctor-patient communication and satisfy her need to be taken seriously: "Patients … sometimes may have health worries about whose medical status they are not confident. … Given that the exploration of psychosocial factors is central to improved communication and medical care …, it is important for doctors to pay attention to patients' explanations that introduce such factors." (Teas Gill & Maynard, 2006, p. 148).

Example 3

Example 3 is a follow-up encounter in the department of diabetology. The parties involved are the patient (P), the nurse, specialized in diabetic education (N) and the interpreter (I). The patient speaks Albanian and she has some command of German.

In Example 3 two excerpts are discussed. The patient has been told how to monitor the blood glucose level and how to use the results for self-management decision making. But up to now, maximum effectiveness has not been reached. The nurse's aim is to lower the blood glucose level while the patient wants to be reassured that the change of the injection site does not cause various symptoms like for instance the inflammation in the abdomen.

Excerpt 3.1: "She Wants to Tell Something About Her Stomach"

The patient complains about physical troubles in the abdomen that concern her more than her blood glucose level: "But I have been more seriously ill because of the uterus" [47]. The interpreter renders the patient's term "uterus" by "stomach."[4] The interpreter does not consider this statement of the patient as relevant enough for an interpretation, but at least he tells the nurse about his decision not to interpret this statement for her. He also repeats for the benefit of the nurse that the patient's troubles might be an issue at a later stage in the encounter, as he had mentioned to the patient before. The nurse agrees without questioning his behaviour, and the interpreter uses the third person singular when he interprets for the nurse [48] and speaking about the patient behaves as a conversational participant. The nurse sanctions the interpreter's behaviour as a gatekeeper, gives him priority as a speaker and accepts him as a participant who changes the content on his own initiative. The patient's chances of being included in the interaction appear rather restricted. Yet in the next turn [50], the patient "re-launches" her complaint and stresses the change of the various injection sites which might have caused the infection in her abdomen. She talks with an increased intensity and supports her utterances with pointing several times to her arm [52].

The patient's pointing gestures are perceived by both the interpreter and the nurse, but both ignore them. The interpreter does not verbalise the gesture and the nurse does not ask what this repeated pointing could mean.

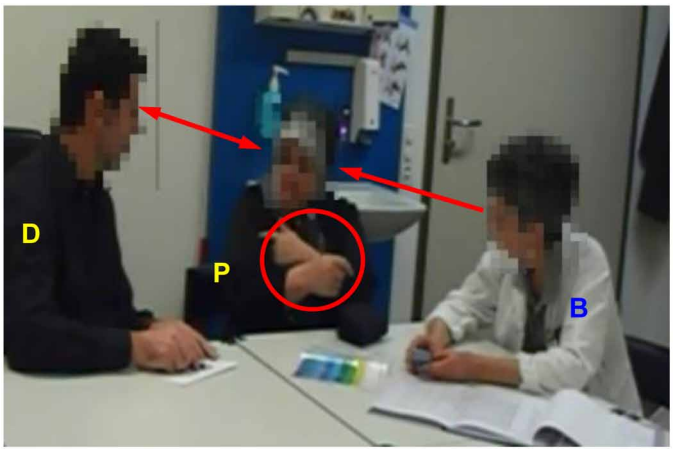
Excerpt 3.1: "But I Am Afraid, You Know, That It Will Get Worse"

There seem to be three different "layers" of conversation going on. The patient and the interpreter talking to each other [98 - 102], the nurse speaking on the phone [102 - 103], and the nurse talking to the interpreter [105 - 106].

Table 3a. Excerpt 1

[47]	..	**98 [03:58.0]**	**99 [03:58.3]**	**100 [03:59.8]**					
P [v]				a ase, ama shum jam kan une pi mitrës e smut.					
P [tr]				*I have been more seriously ill because of my uterus.*					
[48]	..	**101 [04:03.6]**				**102 [04:05.8]**	**103 [04:06.7]**		
P [v]						a po ani			
P [tr]						*a yes ok*			
I [v]		po kjo, noshta vjen masanej.					She wants to tell		
I [tr]		*but maybe this comes later*							
[49]	..	**104 [04:08.5]**							
I[v]	something about the stomach	I said this comes maybe later.							
[50]	..	**105 [04:10.0]**	**106 [04:10.9]**						
N [v]		ja							
N [tr]		*yes*							
P [v]			e une po t'vej tishti e pruna qinato vet k'tu,ama se kam k'						
P[tr]			*as we are here now, I would like to ask you something, I*						
[51]	..								
P [v]	to isilinat ç'tej ma shum mos ma infektu barki,se kam marr shum k'tu,								
P [tr]	*inject insulin, maybe that is why I have an inflammation in my abdomen,*								
[52]	..	**107 [04:20.7]**							
P [v]		se une qera her i kam morr k'tu k'tu k'tu k'tu ene n'kra,							
P [nv]		((*points to injection sites*))							
P [tr]	*because I inject more.*	*before I injected here here here here and into the*							
[53]	..						**108 [04:27.7]**	**109 [04:28.4]**	
P [v]	nuk kom morr veç n'bark.							se tash po i	
P [nv]								((*points to*	
P [tr]	*arm, I did not inject only into the stomach.*							*now I*	
I [v]							mhmh		
[54]	..			**110 [04:31.3]**	**111 [04:31.9]**				
P [v]	shpoj k'to e po marr infektim,				se para di javë un jam				
P [nv]	*her abdomen*))								
P [tr]	*inject here and I get an infection.*				*because two weeks ago*				
I [v]				në n'bark?					
I [tr]				*in the stomach?*					
[55]	..				**112 [04:34.1]**			**113 [04:36.1]**	
P [v]	kën e smur k'tu thot tu kënë e infktu zorrt.								
P [nv]					((*points to the abdomen*))				
P [tr]	*Iwas ill here and they rold me I had an intestinal infection.*								
I [v]								mhmh	

Figure 3. The patient points to the sites of the injections



The patient wants to be reassured that the sites of the injections are not causing the physical problems she is suffering from. The interpreter does not convey the patient's emotional complaint, but interprets what he thinks matters and the nurse cannot respond to the concerns of the patient. After the phone call she seems to take up the preceding turns ("precisely"), but in fact she just follows her medical argumentation from before. The patient and the nurse do not have the same aims in the consultation: the patient needs to be reassured that the modalities of the insulin therapy do not harm her while the nurse wants to optimise the patient's measuring methods.

A hypothesis to be proposed could be that the interpreter omits emotional parts of the patients' utterances, because he is of the opinion that the nurse prefers to concentrate on medical facts rather than to focus on the patients' emotional talk. So he seems to adopt the function of the gatekeeper (Davidson, 2000) and the nurse accepts his conduct, thereby accepting the patient's exclusion.

Example 4

Example 4 is a follow-up consultation in the department of diabetology. The parties involved are the patient (P), the doctor (D) and the interpreter (I). The patient is Turkish speaking but being an experienced insulin user, he understands most diabetes-related issues that the doctor explains in German.

In Example 4 two excerpts are discussed. The focus at the end of the encounter is the patient's question concerning pain in his feet.

Excerpt 4.1: "Do You Have a Last Question?"

The doctor indicates with his question that the consultation has come to an end. The patient seems to know that the doctor will not deal with his worries in the closing minutes, but he asks his question all the same. His complaint reflects the fear of a threatening condition. The doctor is occupied with writing and her head is turned away from the patient. She does not monitor the patient's utterance and does not pay any attention to his gesture which might have suggested to her that the version of the patient does not correspond to the interpreter's rendition. The patient turns to the interpreter and talks to her

Table 3b. E xcerpt 2

[98]	..	**185 [07:59.0]**								
P [v]		edhe përpara jam kan gjat ashtu e s'mut ashti s'po e dijshte se po								
P [tr]		*and I was so ill before, but I don't know, I take the injections*								
[99]	..									
P [v]	i marr gjilponat veç zemra po m'kan, a di çi mos u bona hala ma bet a di									
P [tr]	*but I am afraid, you know, that it will get worse*									
[100]	..	**186 [08:08.6]**	**187 [08:12.0]**	**188 [08:12.2]**	**189 [08:12.3]**					
P [v]	k'tu.	se p'e di sheqeri po m'ben shum posht,e shum bojn e kam								
P [tr]	*here.*	*I know, the sugar is low, very low is the sugar, you can look at it*								
DOLM [v]			po		po, po po po po					
I [tr]			ja		*ja, ja ja ja ja.*					
[101]	..									
P [v]	sheqerin,qera ta kqira me rrall aty, rrall d'onjhere see s'ma blun midja a e									
P [tr]	*there, but seldom sometimes, because the stomach doesn't digest well*									
[102]	..				**190 [08:17.1]**	**191 [08:21.5]**				
N [v]						diabetes berotig X., ich bi imene				
N [tr]						*Diabetic education Ms X speaking, I am in*				
N [nv]						((*speaks on the phone*))				
P [v]	di qi ç'ashtu m'hyp sheqeri									
P [tr]	*You know, then the sugar is high.*									
[103]	..									**192 [08:30.7]**
N [v]	dolmetschgschpröch mit videoufnahme, genau, tschüss.									
N [tr]	*an interpreter-mediated talk that is video recorded, precisely, bye*									
[104]	..									
I [v]	troubles before, too, but now there were more troubles									
[105]	..	**193 [08:36.8]**			**194 [08:38.0]**	**195 [08:43.7]**				
N [v]		mhmh genau.			es ist SO, dass das insuLIN unter					
N [tr]		*mhmh precisely*			*that is right the insulin is injected*					
I [v]	troubles before.									
I [nv]						((*nods*))				
[106]	..									
N [v]	die haut gespritzt wird, das weiss sie ja									
N [tr]	subcutaneously, she knows that									

about his pain and about the doctor who will probably not answer his question. He is pointing to the doctor, showing that he is talking about her. This is a difficult situation for the interpreter. She decides to change this face-threatening utterance completely. The patient has been talking about his pain [344] to the interpreter. The interpreter changes the word "pain" to "little problems". The doctor only turns

Table 4a. Excerpt 1

[343]	**625 [27:36.9]**	**626 [27:37.7]**	**627 [27:39.5]**		
D [v]		haben Sie noch eine Frage?			
D [tr]		*do you have a last question?*			
I [v]			sormak istediğiniz birşey varmı?		
I [tr]			*is there something you would like to ask*		
P [v]					hayır
P [tr]					*no*
[344]	**..**		**629 [27:44.9]**		
P [v]	sormak istediğim ne olur		bu ağrıarı soracam diyecek şeker hastalığından		
P [tr]	*what is there I wanted to ask*		*I ask because of this pain she will*		
[345]	**..**		**630 [27:50.7]**	**631 [27:53.9]**	
D [v]				mhmh	
I [v]			he has sort of little problems		
P [v]	ötürü (xxx)				
P [tr]	*say it is because of the sugar disease*				
[346]	**632 [27:54.5]**				
I [v]	and um then she would say it is because of the sugar but asks other doctor who				
[347]	**..**	**633 [28:01.0]**			
D [v]		ja Sie haben ja em probleme mit den em gefässen an			
D [tr]		*yes, you well have um problems with the um vessels at*			
I [v]	operated that.				
[348]	**..**	**634 [28:07.5]**			
D [v]	den Beinen.				
D [v]	*your legs*	.			
I [v]		ayaklarınızda bu şey damarlarında sorununuz var değilmi?			
I [tr]		*you have problems with your feet with your things veins, haven't you?*			
[349]	**635 [28:10.4]**	**636 [28:10.7]**	**637 [28:11.9]**		
D [v]		und da waren Sie auf der Angiologie.			
D [tr]		*and then you were at the angiology.*			
P [v]	ja ja		ayakta onlar mesala şuraya kadar		
P [nv]		((*pointing to his foot*))			
P [tr]	*yes, yes*		*my foot for example here*		

her head and looks to the interpreter when she hears the word "problems" [345]. She responds to the fact of the problems the patient has with the vessels.

In addition, the interpreter has a terminological problem, as she does not know the word "vessel" and she does not have the medical knowledge either to work "top-down" and for instance to paraphrase the term. However, she signals her word finding process to the patient by asking him: "You have problems with your feet with your things veins, haven't you?" [348]. The patient accepts her first choice and starts talking about the pain in his feet.

The interpreter performs a role that goes by far beyond that of an interpreter. The doctor is not aware of the interpreter's conduct.

As the interpreter changes the content, the patient's gesture looses the original meaning. The interpreter gesticulates with no communicational function, instead the gesture can be seen in the context of her word finding process as she is producing her own content (see figure 4b).

This sort of gesture is called "Butterworth gesture" after Brian Butterworth (Butterworth & Hadar, 1989), a gesture that is quite common in this dataset.

Excerpt 4.2: "When Walking for Instance I Have a Pain as if I Walked on Sand"

The patient tries again to draw the doctor's attention to his pain.

Figure 4a. Patient points to the doctor who concentrates on writing the report

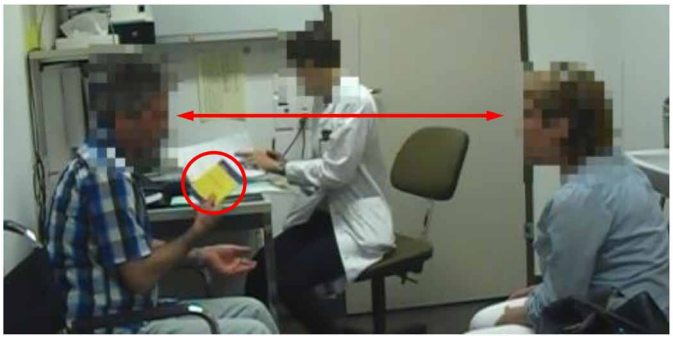


Figure 4b. The interpreter does not reproduce the patient's gesture

The patient is concerned with a disturbing pain in his feet that he mentions only at the closing segment of the encounter. The interpreter passes the information on: "when he walks he feels pain anyway" [352], but omits the metaphor. It is difficult to say, whether the interpreter downgrades the complaint intentionally. It may be that she does not quite know what the patient means by "walking on sand" so that the omission is rather the consequence of a cognitive problem. But she downgrades the patient's next utterance: "Mine is bad, it burns, I am in great pain, it destroys me." [358 - 359] to "Well, he is in such great pain and somehow so warm and quite hot at his foot." [359 - 360]. The doctor might have responded to the patient's complaint, if the interpreter had rendered the intensity in the patient's utterance more adequately. But this is by no means certain, she clearly wants to end this consultation and avoids to take up the emotional part when she refers for the second time to his visit to the angiology that she recommends (Hofer, Eggler, Kleinberger, & Morina, 2017).

CONCLUSION

The present chapter reports on findings that emerged from the analysis of eight selected excerpts.

Overall, the empirical data disagree strongly with the idea that interpreters are acting according to certain concepts of a role like "linguistic conduit", a "bilingual mediator" or a "cultural broker" in mind.

Although the interpreters convey much of what is said by the primary interactants, they provide ample evidence in their renditions by deviating from the original utterances in different ways. In the examples 1 – 4 the frequency of omissions and reduced renditions is clearly shown. Most problems are identified in the interpreters' renditions of the patients' utterances to the doctors or to the nurse. There are different reasons for the interpreters' behaviour that can be identified. Incomplete renditions can be caused by overlappings as in example 1 (see table 1a) (see also Pöllabauer, 2015, p. 212), by the lack of the interpreters' medical knowledge and terminology as in the examples 3.1 and 4.1 (see e.g. Albl-Mikasa, Glatz, Hofer, & Sleptsova, 2015; Dubslaff & Martinsen, 2005; Hofer, Eggler, Sleptsova, & Langewitz, 2015) or by their acting as participants in the interaction and going beyond the role of an interpreter by deciding as gatekeepers which information should be transmitted from one interactant to the other and which is hold back as is seen above all in example 1 and 3 (see Davidson, 2000; Hale, 2007, p. 44). In any case it is questionable, whether alterations of the original utterances are perceived at all by the primary interactants.

Frequently the omissions and the reduced renditions concern instances where patients focus on pain and anxieties. As regards to the processing of the patients' complaints, two patterns are identified: The interpreters omit the patients' complaints of pain or anxieties entirely, as is shown above all in the examples 2 and 3. Therefore, the doctor and the nurse do not hear anything about the patients' concerns and state of mind, they have to refer to what they hear from the interpreters. As the examples show, the omissions go unnoticed or at least uncommented by the doctors or the nurse. In view of the frequency of omissions and of reduced renditions, there seems to be a conscious decision to some extent (see Napier 2002), possibly based on the interpreters' awareness of the doctors' and nurse's reluctance to address issues of pain and anxieties in the sense of gatekeeping (see Davidson, 2000). A milder form of omission that occurs in these eight excerpts is the reduced rendition when the interpreters relay only parts of the patients' complaints about physical pain or anxieties and/or downgrade the relevance or the intensity of the patients'emotional utterances: In the instances of downgrading, the doctors or the nurse could, in fact, respond to the patients' concern. It is one of the striking results in this study that neither the doctors nor

Table 4b. Excerpt 2

[351]	..	**642 [28:19 .6]**	**643 [28:20.3]**
P [v]			yürürken mesela kumda yürür gibi ağrı yapıyor.
P [tr]			*when walking for instance I have a pain, as if I walked*
[352]	..	**644 [28:21 .9]**	**645 [28:23.2]**
I [v]			and when he walks he feels pain anyway.
P [tr]	*on sand.*		
[353]	**646 [28:24.9]**	**647 [28:25.5]**	
D [v]	genau wann waren Sie das		
D [tr]	*Exactly when did you*		

[358]	..	**655 [28:43.8]**	
P [v]		(xxx) benimki acayip böyle yanıyor	
P [tr]		*mine is bad, it burns, I am in great pain,*	
[359]	..	**656 [28:47.2]**	**657 [28: 49.5]**
I [v]		well he is in such great pain and somehow	
P [v]	sızlıyo mahv etti beni		
P [tr]	*it destroys me*		
[360]	..	**658 [28:54.8]**	
D [v]		ja (.) also es kann	
D [tr]		*Yes (.) well it may*	
I [v]	so warm and quite hot at his foot.		
[361]	..		
D [v]	zum teil sicher durch die Zuckererkrankung und durch das probLEM mit		
D [tr]	*partly be because of the sugar disease and because of the*		
[362]	..	**659 [29:01.4]**	
D [v]	den gefässen	Sie sind ja deswegen (.) auf der angiologie (.) in	
D [tr]	*problem with the vessels. That is why (.) you are treated at the*		
[363]	..	**660 [29:05.6]**	
D [v]	behandlung.		
D [tr]	*angiology*).		
I [v]		şekerle bi alakası olabilir ama ayaklarınızda başka sorun olabilir.	
I [tr]		*it may be related to the sugar but it may also be*	
[364]		**661 [29:10.8] (32)**	
I [tr]	*another problem with your feet.*		

the nurse as a rule respond to the emotional parts, even if the interpreters' rendition would enable them to do so. One might argue that the doctors or the nurse might pay less attention to the patients' emotional state due to fact that the affective parts of the discourse are not interpreted adequately. However, a comparison with monolingual interactions shows that doctors tend to dwell more on the medical facts (see Fiehler, 2005; Gülich & Lindemann, 2010; Lindemann, 2015; Pollak et al., 2007; Ruusuvuori, 2007; ten Have, 1990) than to respond to affective statements of their patients. On the basis of the data in the current contribution, it can be assumed that experts as well as interpreters avoid responding to patients' emotional talk on pain and anxieties. The data reveal that omissions and reduced renditions are clearly detrimental to the patients' intentions.

In face-to-face communication all the participants transmit meaning also by their multimodal resources. Both verbal aspects and bodily resources of the primary interactants and of the interpreters are a relevant factor in doctor-patient communication. The video-recordings of face-to-face communication shed light on how the participants employ multimodal resources to clarify their verbal activities. Gestures, directions of gaze and head turns are especially relevant features in doctor-patient communication (see e.g. Norris, 2004; Stukenbrock, 2008). In the excerpts discussed above, pointing gestures represent an integral part in the patients' utterances. By pointing to aching parts of their body patients clarify the sites of their pain in all of the four examples and thus contribute to minimizing the conversational difficulties. In the excerpts discussed above, three patterns of the interpreters' reaction can be observed: Pointing gestures of the interpreter are helping to bridge the linguistic gap as shown in figures 2a and 2b. Yet the data also show that the interpreters reproduce the patients' gestures only vaguely, even if the gestures of the patient are repeated, thus showing the significance of the complaint: The interpreter in example 1 just points to the thigh of the patients (see figure 1b) without really reproducing the gestures, but then transmits the patient's repeated pointing gesture by also verbalising it. In another situation, the data show that an interpreter avoids reproducing the patient's gestures, even when the gestures support crucial messages. For instance, in example 3, the patient points several times to her arm in a highly emotional part of the encounter. Both the interpreter and the nurse are looking at the patient pointing to the sites of injections (see figure 3a). Yet the interpreter does not reproduce the gesture nor does he verbalise it and the nurse does not refer to the patient's repeated pointing either. The nurse seems to rely more on the interpreter than on the patient, and the patient's complaint remains unanswered.

To conclude, patients in interpreter-mediated consultations have more difficulties in raising concerns than patients who speak the same language as the experts (see Rivadeneyra, Elderkin-Thompson, Silver, & Waitzkin, 2000), if parts of the patients' utterances are omitted or reduced in their intensity (see Butow et al., 2011). As a consequence, the patients are excluded from parts of the conversation and probably do not realise, why the doctors do not address their complaints. In none of the four consultations are the patients in the position to shift the focus of the conversation to their pain or to their anxieties, neither through repeated statements or questions nor through gestures. The doctors and the nurse seem to rely more on the interpreters than on the patients, and seem to give priority to interpreters as speakers without being able to monitor the adequacy of the interpreters' renditions. A result that corresponds with Pasquandrea's study (see Pasquandrea, 2012).

The findings of this study suggest that more data be collected in various language pairs. Empirically based research projects are needed to further investigate the patterns of participants' verbal and non-verbal communication as well as the in-/exclusion of the patients in the interactions. The empirical data are valuable material to illustrate the practice of interpreters as well as of doctors and nurses and should be used in future joint training programmes for medical interpreters and for medical staff.

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ENDNOTES

1 For the University hospital in Basel, interpreters are provided by "HEKS Linguadukt", available online: http://www.heks.ch/de/schweiz/regionalstelle-beiderbasel/linguadukt-basel/details/, For the University hospital in Zurich, interpreters are provided by "Medios", available online: www.stadt-zuerich.ch/aoz/de/index/integration/medios.html

2 https://www.inter-pret.ch/de/home-1.html

3 The definition of B2 according to The Common European Framework of Reference (http://www.coe.int/t/dg4/linguistic/source/framework_en.pdf, accessed on 28 February 2019) describes the B2 level of foreign language proficiency as follows: "Can understand the main ideas of complex text on both concrete and abstract topics, including technical discussions in his/her field of specialisation. Can interact with a degree of fluency and spontaneity that makes regular interaction with native speakers quite possible without strain for either party. Can produce clear, detailed text on a wide range of subjects and explain a viewpoint on a topical issue giving the advantages and disadvantages of various options." (p.24).

4 This terminological problem was identified by Naser Morina (University Hospital of Zurich). He believes that it is not a cultural but a lexical or an auditive problem, as "stomach" in Albanian is "mitja". The Albanian word for "Gebärmutter" is "mitrës"and sounds similar to "mitja". The translator who wants to stay anonymous shares this perception.

APPENDIX

Transcript Notations

(.) = pause for less than 0:2 seconds
[v] = verbal utterance
[tr] = translated from Albanian or Turkish into German
[nv] = non-verbal communication
((text)) = description of non-verbal activity
(xxx) = incomprehensible words
(….) = to shorten the transcript, some parts within a transcript are omitted. The passages in question are indicated by ellipsis marks

The description of non-verbal activities as well as the translation of the German and Turkish utterances into English appear in italics. The German utterances as well as the German versions of the Albanian and the Turkish utterances were translated into English by the author of the article.

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Chapter 7
Cultural Differences in Interpreter-Mediated Medical Encounters in Complex Humanitarian Settings:
The Case of Emergency ONG Onlus

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ABSTRACT

Interpreters and mediators working in complex humanitarian settings are faced with new challenges, both linguistic and non-linguistic. As part of on-going research, this chapter reports on cultural differences in interpreting major variables in interpreter-mediated medical encounters in complex humanitarian scenarios. The author will address the importance of cultural issues in humanitarian interpreting, based on the assumption that differences in culture can be a serious barrier to effective humanitarian communication. The author focuses on the interpreters and cultural mediators working for the Italian NGO Emergency ONG Onlus, which provides medical assistance to migrant communities in Southern Italy at its Castel Volturno clinic. The aim is to highlight the importance of a shared culture between interpreters/mediators and their clients and adequately deal with existing cultural differences in order to enact a so-called "cultural compromise" between migrant patients and health professionals with the goal to facilitate prevention, health promotion and education, and treatment.

INTRODUCTION

The cultural turn in translation studies, which started in the 1980s, contributed to a shift in the focus from language mediation to cultural mediation and helped see translation and interpreting as culturally and socially embedded practices. The role of the interpreter as a cultural agent is now widely acknowl-

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edged among scholars (Roy, 2002; Angelelli, 2004; Wadensjö, 1998). As early as 1999, Mikkelson had already clearly described the importance for interpreters of all modes and contexts to be aware of cultural differences:

It is almost universally acknowledged that interpreters working in medical and social service settings need to be acutely aware of cultural differences (hence the term "cultural interpreter" that is so prevalent in Canada), although there is widespread disagreement about what they should do with that knowledge (Carr et al., 1997). Court interpreters are also expected to take culture into account, although they are much more restricted in their ability to educate their clients about cultural differences (Gonzalez et al., 1991). What many of these interpreters may not recognise is that conference interpreters, too, consider themselves not just linguistic, but also cultural intermediaries. Seleskovitch (1978a, 1978b) and Seleskovitch and Lederer (1984) have written extensively about the link between language and culture. Perhaps Jones (1998, p. 4) sums it up best when he says that "in all of their work, (conference) interpreters must bridge the cultural and conceptual gaps separating the participants in a meeting."

Scholars who argue that interpreters need to be culturally knowledgeable, as suggested by Mikkelson (1999), view them as cultural mediators. Because cultural differences between communicating parties may lead to conflicts, interpreters as cultural mediators are expected to resolve said potential conflicts and facilitate communication. This view corresponds to Pöchhacker's (2008) view of contractual mediation, which "refers to mediation intended as resolution of (intercultural) conflicts, i.e. as the facilitation of cross-cultural understanding and communication beyond language demarcation" (Baraldi, 2014). This applies particularly to dialogue interpreting, specifically medical interpreting, in complex humanitarian emergencies in which awareness of cultural differences can help bridge the gap between the individuals interpreted for.

This chapter reports on cultural differences as major variables for the interpreters and mediators who work in complex humanitarian emergencies, specifically in the medical field. It addresses the importance of understanding cultural differences in interpreter-mediated medical encounters in humanitarian settings based on the assumption that differences in culture may represent serious barriers to overcome in a complex humanitarian scenario. The chapter anticipates the results of a qualitative study that will be carried out in the form of ethnography with the cultural mediators working for the Italian NGO Emergency ONG Onlus, which provides medical assistance to migrant communities in Southern Italy at its Castel Volturno clinic.

The objective of this study is to highlight the importance of a shared culture between the mediator and the client to help overcome said barriers. The focus will be on cultural mediation and the role of medical interpreters in humanitarian settings, specifically within the framework of the medical NGO Emergency in the Castel Volturno clinic of the organisation in Southern Italy. The focus will furthermore be on the extent to which cultural mediation is more effective; interpreters coming from the source culture of the clients are more trusted and recognized, due to the cultural background shared by the cultural mediators and their clients. It is worth pointing out that the study has one limitation: as of the writing of this chapter only preliminary conversations were held with the cultural mediators working at the Castel Volturno clinic of Emergency. Said conversations stressed the need for a stronger focus on culture and cultural mediators, however this trend needs to be confirmed by the future analysis on the field. The actual ethnographic observation of the interpreting and mediation activity performed by the cultural mediators working for Emergency in the Castel Volturno clinic of the organisation will be

carried out at a future stage, hence the reason why there is not much evidence about the outcomes of the mediation at this stage.

BACKGROUND

Setting the Stage: Complex Humanitarian Emergencies

According to Keely et al. (2001), complex humanitarian emergencies can be described as situations in which a civilian population is displaced from their homes by war or conflict, and one can witness a deterioration of living conditions and there is often a significant increase in mortality, either in the short or long-term.

Complex humanitarian emergencies are defining elements of today's geopolitical scene, which is characterized by globalization and large migration flows. They have grown exponentially as Europe is facing its greatest migration wave since the end of World War II (OECD Migration Policy Debates, 2015). Data, as recent as the OECD International Migration Outlook, 2018, the statistics released by the Study and Research Centre of the Italian Caritas (IDOS 2017), the figures released by international organizations like the UNCHR and the IOM (IOM World Migration Report 2018), as well as the 2018 Archives on Migrations of the Italian Statistical Office (ISTAT, 2018), show a rapid surge of migratory pressure at the Southern borders of the European Union in recent years.

In Italy, the phenomenon described above is particularly worth analysing, as increasingly large flows of migrants and refugees requiring humanitarian and medical assistance have reached the country in the last few years from various countries in Africa, and especially since the Arab Spring and conflicts in Syria and other African regions. Italy has coped with the situation through a network of *ad hoc* centres at Italian ports, first- and second-level reception centres for asylum seekers, accommodation and repatriation centres, as well as territorial commissions for the granting of international protection at the local prefectures and NGOs. The situation is likely to be exacerbated by a series of hard-line measures, which have been recently introduced by the Italian government to abolish key forms of protection for migrants, which make it more difficult for them to be protected. Italy's new immigration-security decree, which has been recently converted into law by the Italian Parliament, has suspended the asylum process for so-called "socially dangerous" migrants and abolished humanitarian protection, thereby increasing the number of illegal immigrants and resulting in the risk for many foreigners to be expelled.

In the rapidly evolving geopolitical scene, the role that is played by humanitarian organizations and NGOs is paramount in Italy as well. According to Tesseur (2018), "NGOs exercise various important roles in today's globalised society: as global workplaces in the new information- and knowledge-based economy (Castells, 2000); as organisations that seek to influence global political decisions; and as providers of humanitarian and development assistance. They have expanded both their scope and range of activities over the past few decades, and many NGOs work across linguistic and national borders. In addition, a number of these organisations provide assistance to refugees, asylum seekers, and local communities in emergency and crisis situations." In Italy, several humanitarian organizations and NGOs provide aid, medical assistance, and support to non-accompanied minors, and are furthermore active in search and rescue operations at sea. By doing so, humanitarian organizations and NGOs have provided valuable help and carried out activities that straddle the lines between various sectors: asylum procedures, refugee conflict scenarios, conflict related settings, health and support to migrants, and legal settings.

Interpreting for NGOs in Complex Humanitarian Emergencies: Medical Humanitarian Interpreting?

As a consequence of the situation briefly sketched above, everyday interaction across languages in complex humanitarian emergencies has become more visible and necessary than ever. This new scenario has had an impact on the work of interpreters and cultural/intercultural mediators working for Italian organizations that are called upon to face new situations and challenges, both linguistic and non-linguistic, all of which deserve consideration. To communicate with their users, NGOs and humanitarian organizations often resort to interpreters and cultural mediators (Kherbiche, 2009; Moser-Mercer, Delgado Luchner, & Kherbiche, 2013), who not only interpret for them, e.g. in triadic settings, but also advise and help refugees and migrants claim and negotiate their rights in the hosting country (Taronna, 2016), notably in dyadic scenarios. According to Tesseur (2018), "speakers from a wide range of languages come together, and providing language mediation often forms part of NGOs' day-to-day work. In other words, translation and interpreting are keys to the functioning of these organisations, as they negotiate and interact between actors from a wide variety of cultural and linguistic backgrounds in the work they conduct."

In Translation and Interpreting Studies, extensive research has been devoted to the analysis of the relationship between migration and translation from historical, ethnographic, and sociolinguistic perspectives (Inghilleri, 2017), the crucial role played by translation as a form of intercultural communication in migrant contexts (Cronin, 2000), and the link between identity and language in our global society (Cronin, 2006). The relationship between translation, travel, and migration was also the subject of investigation (Polezzi, 2006), as were the ways in which language practices emerging from migration (and migrant writing) can be linked to translation, thus raising questions of identity, role, power, and agency (Polezzi, 2012a, 2012b). Furthermore, there is currently a growing interest in the role of interpreters in conflicts (Inghilleri, 2008, 2010; Ruiz Rosendo & Persaud, 2016) and complex conflict-related scenarios, also as a result of migrations, such as asylum procedures (Blommaert, 2001; Pöllabauer, 2004).

The resulting picture is extremely complex, because it shows that language and mediation needs arise in a number of settings: conflict scenarios in areas torn by wars and conflict-related scenarios in areas that may be far from conflicts, but which are a consequence of wars. Conflict-related scenarios might, in turn, be found in various areas of public and non-public service: medical, legal, administrative, police, or oftentimes at the intersection of these domains, which all fall within the general realm of community interpreting.

The study of interpreter-mediated medical encounters in complex humanitarian emergencies is another area of investigation worth analysing. According to Wadensjö (1998), interpreters activate different listening modes and adopt different roles in pronouncing a given utterance depending on the aim of the interaction and the tasks they have to perform. Interpreting is, as such, a socially embedded practice, and it is very much so in complex emergency situations. Research on dialogue interpreting in the medical domain has been the subject of interdisciplinary investigation for a few decades. It has focused on interpreter-mediated interactions in various healthcare or legal settings, with studies in these fields receiving growing attention, both from a socio-anthropological viewpoint (Baraldi, Barbieri, & Giarelli, 2008), and in the field of Translation and Interpreting Studies. Several studies have focused on public service interpreting and analysed data-driven interpreter-mediated medical encounters. They have been centred on sequences of participants' turns at talk in healthcare services (Angelelli, 2004; Baraldi & Gavioli, 2007; Davidson, 2000), the role of medical interpreters and the interpreters' agency (Angelelli, 2004; Amato, 2011) and the importance of mediation, which concerns both language and culture

(Pöchhacker, 2008). Recent research has confirmed that the cultural work of medical interpreters is as important as the linguistic one and highlighted that supporting intercultural mediation is essential for healthcare organisations to provide culturally competent care to migrants (Souza, 2016). Scant literature exists on medical interpreting in the context of complex humanitarian emergencies, where the activity of the language intermediaries who work for humanitarian organizations and NGOs appears to be more complex. This activity goes beyond their mere interpretation tasks and should be further nuanced depending on the specificities of the organization and the field it operates in.

The tasks faced by language intermediaries working for humanitarian organizations and NGOs are not limited to a "mere" interpreting activity or to cultural transfer responsibilities, but they are made more complicated by a complex set of variables, which are sometimes out of control, e.g. situations of human suffering and traumatic experiences, vulnerability, mistrust, feelings of alienation and disempowerment, violations of human rights and refugee laws, and the increasingly protracted emergency nature of today's humanitarian contexts. Other aspects add to the complexity of the work of medical interpreters and mediators working in humanitarian settings: cultural differences, empathy, use of vehicular languages such as English or French by participants in the encounter, (lack of) training, etc.

The issue of culture is worth analysing in this context. Interpreters and cultural mediators carry out several tasks and take on different roles. As Rudvin and Tomassini (2008) put it, "in this model of the mediator as a "bridging figure," s/he is given a great deal of responsibility—his/her mandate is not only to help the interlocutors avoid misunderstandings and anticipate areas of conflict, but also to construct, no less, a shared basis or cultural-cognitive platform between the interlocutors by facilitating comprehension and reciprocal understanding/agreement." The cultural mediators who work for Emergency ONG Onlus operate in much more complex and broader settings than the medical one. They do not carry out only and "simply" medical interpreting in dialogue settings. They also provide social and health guidance to the migrant users applying for help. For the purposes of this paper, the author, therefore, maintains that the dialogue interpreting and mediation activity performed by the cultural mediators working for Emergency in its Italian clinics, specifically in Castel Volturno, should be considered as a form of "humanitarian interpreting" (HI), as defined by Delgado and Kherbiche (2018):

The term "humanitarian interpreting" describes interpreting practices that fall within the legal framework of International Humanitarian Law (IHL) and International Refugee Law and aim to enable humanitarian organizations to communicate with public authorities and protected individuals / beneficiaries, in order to allow the latter to access their rights. Humanitarian interpreters are members of the humanitarian field (aid providers, beneficiaries or both), who work in contexts characterized by human suffering, vulnerability and stark power asymmetries.

Although humanitarian interpreters may also find themselves working in the medical field, the cultural mediators hired by Emergency do not perform only medical interpreting; they take on various roles and perform tasks that are at the intersection between health mediation, humanitarian aid provision, and social service provision. The interactions they mediate are more varied than the encounters occurring in institutionalised medical settings. As this chapter will show, these language intermediaries operate with a much broader mandate than only acting in interpreter-mediated medical encounters. Furthermore, their status as aid workers is confirmed by the Emergency's bylaws, in which the organisation explicitly indicates that its activities should be contextualized within the legal framework of International Humanitarian Law (IHL), including the 1949 Geneva Conventions and the 1954 Hague Convention. Further

reference legislation for the NGO is the International Human Rights Law (IHRL), including the 1948 International Declaration of Human Rights and 1951 Refugee Convention. In carrying out its activities, Emergency also draws inspiration from Article 32 of the Italian Constitution, which states that "The [Italian] Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent. […]." Emergency therefore considers the right to health as a human right and has this principle underpin all its actions, including the ones performed by its cultural mediators.

Humanitarian interpreting, according to Delgado and Kherbiche (2018), is thus a suitable overarching definition and reference framework for the interpreter-mediated medical encounters carried out by the cultural mediators who work for Emergency. As further detailed below, their activity includes "mere" medical interpreting and language mediation in medical settings, as well as social and health orientation for migrants and is carried out in both dyadic and triadic settings, thus allowing that language intermediaries working for Emergency are considered to be actual aid workers.

Interpreters as Cultural Mediators

As highlighted in the previous section, interpreters and cultural mediators who work in community settings take on different roles when they deal with participants from disparate cultural backgrounds based on the context and the social and cultural values where the interpreter operates. This applies to interpreters working for NGOs in complex humanitarian emergencies, as well. The work by Roy (2002) proposes a classification of the roles assigned to interpreters as discussed in interpreting literature, and suggests that interpreters can either serve as helpers, conduits, communication-facilitators, or bilingual/bicultural specialists. In a later study, Leanza (2005a) identifies two additional roles for community interpreters in paediatrics, i.e. the role of welcomers and the role of family support.

The role as bilingual/bicultural specialists is particularly relevant for the purposes of this chapter. The cultural turn in translation studies, which began in the 1980s, contributed to shifting the focus from language mediation to cultural mediation and helped see translation and interpreting as culturally and socially embedded practices. Since then, it has become widely acknowledged among scholars that interpreters need to have knowledge of the cultures of the languages they work with and that they "must be sensitive to the fact that they are communicating across cultures as well as across languages" (Roy, 2002). Mikkelson (1999) highlights the need for language intermediaries to be culturally knowledgeable, as "interpreters who work in community settings with participants from disparate cultural backgrounds may confront difficulties conveying the source message into the target message accurately due to cross-cultural differences" (Hale, 2017).

Studies on public service interpreting have highlighted that mediation concerns both language and culture (Pöchhacker 2008). As Wadensjö (1998) puts it, interpreters "cannot avoid functioning as intercultural mediators" (p. 75), as interpreting makes it possible to identify non-linguistic features and differences between people, such as differences in worldview (p. 277). In his analysis, Baraldi (2018) shows that "the mediator actively contributes to the social construction of migrants' problems and to the enhancement of possible solutions thereof by extending institutional support, showing active listening, and reducing the risk of conflicts," and lays emphasis on "the meaning of culture and intercultural mediation in these interactions." According to Pöchhacker (2008), three analytical dimensions can be used to look at interpreting as mediation: linguistic/cultural mediation, cognitive mediation, and contractual mediation. Following Pöchhacker's classification, linguistic/cultural mediation is basically a synonym

for interpreting; cognitive mediation helps interpreters express their subjectivity of interpreters, with the concept rejecting the "translation machine metaphor" (Hale, 2007) of interpreting; contractual mediation involves facilitation of communication and conflict management to facilitate cultural understanding and help to resolve (intercultural) conflicts. According to Pöchhacker, there should be a clear distinction between the first two dimensions of cognitive and linguistic/cultural mediation, on the one hand, and the dimension of contractual mediation, on the other, in order to clearly distinguish between interpreters and contractual or cultural/intercultural mediators. In Pöchhacker's view, this distinction helps avoid cultural mediators being preferred to professional interpreters in certain systems and institutions (e.g. in the Italian healthcare system), because they are considered more competent in managing intercultural relations and conflicts. As Rudvin and Tomassini (2008) point out, in the provision of healthcare services "the issue of role is even more interesting and dynamic in Italy compared to many other countries because of the prominence of the so-called *"mediatore culturale/interculturale"* (inter/cultural mediator), the *"mediatore linguistico"* (language mediator), and the *"mediatore linguistico-culturale"* (linguistic-cultural mediator)" over the role of the interpreter.

The prominence of the cultural mediator over the interpreter has a twofold consequence. Firstly, it creates general confusion and lack of clarity about the terms used in Italy. The Italian Turco-Napolitano law number 17 of 1998 itself uses the Italian terms *interprete, mediatore culturale, mediatore interculturale,* and *mediatore linguistico* (i.e. interpreter, cultural mediator, intercultural mediator, and language mediator) as synonyms without making a clear and accurate distinction, thereby highlighting "the existence of a multifarious, hybrid nomenclature [...] this spectrum simply reflects the complexity of role-definitions and definitions of the profession/discipline across sectors" (Rudvin & Tomassini, 2008). Secondly, it shows the need for interpreters as cultural mediators to possess cultural competence to deal with the numerous cross-cultural differences that can be observed between the host society and the patient's culture in the health sector.

For the purposes of this study, it may be useful to refer to the widely cited and commonly-agreed-upon definition of cultural competence by Cross et al. (1989), who described cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or profession to work effectively in cross-cultural situations." Cultural competence in the sense of Cross et al. (1989) can therefore help overcome the cross-cultural differences in communication and provide for effective treatment in interpreter-mediated medical encounters, as shown by Leanza et al. (2005).

Cross-cultural differences might affect the communication process and seriously hamper understanding, diagnosis, and treatment. To overcome said differences, interpreters who serve as cultural mediators and conveyors of culture are needed. Garzone and Rudvin (2003) give examples of the cross-cultural differences in the healthcare sector: how, and the extent to which patients should be informed about their illnesses, the degree to which the family should be involved in informing the patient, and the decisions taken; how to manage delicate or taboo issues; organ transplants and blood transfusions, which are considered unethical in certain cultures; use and perception of pills and medication; expressions to refer to one's body, with images and metaphors changing from culture to culture. According to Garzone and Rudvin (2003), all these aspects must be kept in mind by both interpreter and service provider. While the importance for interpreters to recognize cultural differences in interpreting is widely acknowledged, it is not clear how the "bicultural specialists" in Roy's sense (2002) should respond to these issues during the interpreting (Wang, 2017). Furthermore, there is no consistent approach to resolving potential cross-cultural misunderstandings. (Hale, 2017).

CULTURAL DIFFERENCES IN INTERPRETER-MEDIATED ENCOUNTERS

Contextualizing the Issue: Emergency ONG Onlus in Castel Volturno Clinic

The independent humanitarian non-governmental organization Emergency, which was set up in 1994 to provide free medical and surgical treatment to civilian victims of war, landmines, and poverty in war-torn scenarios outside Italy, has been running its *Programma Italia* since 2006. This programme consists of a series of humanitarian projects aimed at responding to particular situations of emergency or natural disasters, as well as providing free healthcare and social and health-related guidance services. Within the framework of its Italian activities, Emergency has been present in Castel Volturno, Caserta, in Southern Italy with a mobile unit since 2013, and a clinic since 2015. At Castel Volturno, migrants and other vulnerable population groups receive free basic healthcare with the help of the association's cultural mediators. Castel Volturno is one of the areas with the highest numbers of migrants in Italy and is characterized by urban degradation accompanied by the strong presence of organized crime. According to a report by the International Institute for Migration (IOM), it is estimated that foreigners represent a third of the resident population. The patients treated at the Castel Volturno clinic are mostly men employed in construction and agriculture, often in conditions of heavy exploitation, conditions, which are a direct consequence of the unhealthy living conditions that these people experience. The pathologies treated range from skin and respiratory tract infections, musculo-skeletal problems, as well as hypertension problems due to incorrect nutrition and a poor perception of the problem. Another category of patients treated in Castel Volturno consists of commercial sex workers, primarily of Nigerian origin. In the Caserta area, information and disease prevention activities targeted to this group of migrants is carried out with the aim of facilitating the access of sex workers to health services and to increase awareness of sexually-transmitted diseases and behaviours to prevent future risk (translation by the author, Emergency website).

Although Emergency is a medical association originally set up to provide free medical care in war-torn areas, the author argues that its activities, especially within the context of its *Programma Italia*, are to be framed in the general context of humanitarian aid provision. The language mediation activity performed by its cultural mediators should therefore be considered humanitarian interpreting according to Delgado Luchner and Kherbiche (2018).

For the purposes of this chapter, the language professionals hired by Emergency within the context of its *Programma Italia* and, more specifically, in Castel Volturno, are referred to as *mediatori culturali*, i.e. cultural mediators. This phrase is namely the one used by Emergency to refer to its language professionals and indicated in the job announcements for such positions, and it furthermore highlights the greater importance the mediators attach to their role of cultural brokers compared to their language mediation activity. It is worth mentioning that all the medical interpreters working for Emergency are staff members. The organization hires interpreters who should speak Italian and at least two other languages (English, French, Arabic, Romanian, Chinese, among others) and have prior experience in the healthcare sector or in dealing with migrants. In addition to interpreting, they have many tasks to perform. These include welcoming patients and/or recipients of healthcare and social orientation services, providing language and cultural mediation in filling in medical records, as well as before and during the medical examination with the organization's medical staff, providing social orientation services to migrants, accompanying patients to hospitals and helping them with hospitalization procedures, taking care of a number of administrative or logistical aspects, if needed, and providing other healthcare services, if required.

Early Communications with Emergency's Cultural Mediators at Castel Volturno

This chapter anticipates the views of the four cultural mediators working in the Castel Volturno clinic of Emergency. The author had the chance to interact with these workers within the framework of ongoing preparations for future ethnographic research on the humanitarian interpreting activity they carry out at the clinic of the association, where Emergency staff provides, free of charge, medical assistance and social and health orientation to local migrant communities and services at the outpatient clinic. As already pointed out, one limitation of this study was that as of the writing of this chapter only preliminary conversations were held with the cultural mediators working at the Castel Volturno clinic of Emergency. Said conversations already pointed to the need for a stronger focus on culture and cultural mediators, however they only show a trend to be confirmed by the future analysis on the field. The actual ethnographic observation of their mediation activity will be carried out at a future stage, hence the reason why there is not much evidence about the outcomes of the mediation at this stage.

The personal communications with the mediators took place by e-mail or over the phone, and the information was obtained between July and November 2018. The opinions were not collected through structured or semi-structured questionnaires, as the latter are still being developed as part of the broader ethnographic observation and qualitative analysis on the field. It is worth acknowledging that this is probably the main limitation of the study at the present stage, as the chapter presents the cultural mediators' first-hand opinions on cultural differences in the medical encounters where they are called upon to mediate and not the results of a whole research project. To this date, the latter is currently on going and its research design is presently being finalized. This limitation notwithstanding, in her communications with the four cultural mediators in Castel Volturno, the author had the opportunity to enquire about the following issues and to ask the following questions:

Questions and Issues Raised with Emergency Cultural Mediators at Castel Volturno

- **Sociodemographic Questions:**
  - Name
  - Nationality
  - Gender
  - Mother tongue
  - Education and training
  - Previous work experience
- **Questions Related to the Interpreting/Mediation Activity:**
  - Formal education and training as an interpreter and/or cultural mediator
  - Previous working experience as an interpreter and/or cultural mediator (e.g. NGOs, public sector, international organizations, etc.)
  - Languages used for the interpreting/mediation activity (in both dyadic and triadic settings)
  - Information about the interpreting/mediation setting (both dyadic and triadic)
  - Information about cultural aspects in interpreting/mediation (their relevance for the mediator and reasons why they are/are not relevant)
  - Information about, and examples of, aspects and factors that facilitate/hamper mediation (e.g. being of the same gender of the migrant, coming from the same country, sharing the

same cultural background or religion, having the same perception of one's body or health, adopting the same approach to treatment, etc.)
- Information about past experiences of effective/ineffective interpreting/mediation, and related motivations
- Main difficulties encountered in the interpreting/mediation activity
- Rules to respect when interpreting/mediating (e.g. code of ethics, in-house rules of the NGOs, etc.)
- Opinion about whether mediation should be conceived as a purely linguistic or mainly cultural activity and the reasons why. Related question whether the mediator sees herself/himself as a language mediator or as a cultural mediator and the reasons why
- Opinion about whether emergency is a humanitarian organization providing various kinds of support and aid, and only medical support. Related question whether the mediator sees herself/himself as a humanitarian or aid worker in broader terms

The issues and questions were raised and asked in all personal communications with the four cultural mediators working in the Castel Volturno clinic. However, not all the cultural mediators answered all the questions or expressed their views on all the issues raised. This was due to the informal nature of the exchange, which occurred with the cultural mediators, and which took place within the framework of on-going preparations for the future ethnography and qualitative study on the field.

Participants

As of November 2018, four cultural mediators are working at the Castel Volturno clinic: two Italian males, one Nigerian female mediator, and one Romanian female mediator. Their ages range between 40 and 49. All the mediators have different backgrounds and qualifications in areas other than language mediation or translation/interpreting (political science, economics, cultural heritage), with the Nigerian and Romanian mediators having received a formal qualification in cultural mediation (900-hour course in intercultural mediation). However, all of the workers had worked as cultural mediators for NGOs (MSF and Save the Children, local NGOs), the public sector (local health companies, prisons, etc.) or international organizations. The languages mastered by the four Emergency mediators were Italian, English, French, Romanian, and a number of Nigerian languages (Esan, Bini, as well as Pidgin English). For the purposes of this chapter, the language professionals working in Castel Volturno will be referred to as M1, M2, M3, and M4. M1 works as a cultural mediator and is the coordinator of the Castel Volturno clinic; he is male and of Italian nationality. M2 is the other male cultural mediator of Italian nationality. M3 is a female cultural mediator and is of Romanian nationality. M4 is the Nigerian female mediator; she has only recently been recruited to serve as a cultural mediator in Castel Volturno; however, mediators of Nigerian nationality have always been present at the clinic.

Tasks and Responsibilities

The cultural mediators working for Emergency in Castel Volturno carry out language and cultural mediation activities in triadic settings, e.g. supporting Emergency doctors and nurses during examinations, assisting migrants during external medical consultations or examinations, accompanying migrants to information and counselling centres, or to hospital emergency wards, dealing with administrative issues

on behalf of patients for the issuing of documents allowing migrants access to the National Health Service. They also provide social and health orientation to migrant patients in dyadic settings, taking care of their registration at the clinic, informing them about their rights, helping them access National Health Service services, and giving them basic health and social information. Based on the wide range of tasks they carry out and the roles they take on, the author maintains that the activities of mediation and social and health orientation carried out by the cultural mediators working for Emergency in Castel Volturno falls within the definition of humanitarian interpreting according to Delgado and Kherbiche (2018).

Early Conversations With Emergency Cultural Mediators: The Importance of an Intercultural Approach

Cities are getting bigger and bigger, mobile phones multiply, more access roads have transformed some formerly remote places, and T-shirts of international sportsmen are seen in remote places, but still cultural traditions continue to shape people's beliefs about disease, what care they seek, how they respond to illness, and what remedies, practices, or foods they will resort to in order to regain health. In many places, an adversary or a malign spiritual force may be thought to be responsible for an illness, while some individuals themselves are thought, rightly or wrongly, to have brought the illness on themselves. In each instance, the remedy and the action will differ according to local beliefs. Whatever your role in the health team, get to grips with the local culture and try to understand it; do not dismiss practices that do not promote health, but work with local leaders to change them (Principles of Medicine in Africa, 2013).

Early conversations with the cultural mediators working at the Castel Volturno clinic, where the study was conducted, and the personal communications exchanged, highlight a number of points: the importance of having a strong focus on culture, the role that cultural differences between migrant patients and Emergency health professionals might play on the language mediation activity, with the related difficulties interpreters might have to face to ensure an effective transfer of meaning, and ultimately the close correlation between the ability to successfully mediate between different cultures on the one hand, and the effectiveness of care and compliance with treatment on the other.

Specifically, the exchange of information with M1, the coordinator of the Castel Volturno clinic, clearly showed the need to focus on the mediators' cultural competence and the need for them to share the culture of their clients on the other. According to M1, "We are more effective if we share the culture of the migrant patient" (translation by the author, July 2018, personal communication). All cultural mediators also point to the need to adequately deal with existing cultural differences to guarantee effective care, compliance with treatment, and proper transfer of basic health and social information to migrants. Based on the information received, the author's assumption is that cultural differences are better overcome when mediation is carried out by a language professional with a shared cultural background.

A number of studies from sociology and medical anthropology provided evidence for the author's assumption and showed that migrant patients have an intimate, sometimes pantheistic, and definitely spiritual view of medicine and healthcare. Culture and corporeity have always been closely related and deeply intertwined. The way individuals perceive their body depends upon the different cultural perspectives and the mind frames they use to conceptualize their body and its functions. According to Quaranta and Ricca (2012),

Having deep knowledge of the patients' mentality and the codes of meaning they associate with their own personal way of interpreting the relation between their body and the treatment they receive is paramount if one wants to enable effective health treatment strategies and methods. Being aware of foreign patients' cultural frames of reference can help establish a correct doctor-to-patient relation, as well as avoid misunderstandings, mistakes in interpretation, and conflicting goals between health professionals and patients, which could turn out to have tragic consequences (pp. 57-58, translation by the author).

The aim of a much-needed intercultural approach in the medical field in general, and in interpreter-mediated encounters in particular, is to put into place systems through which our cultural patterns can be adequately translated into the patterns of individuals from different cultural backgrounds, and *vice versa*. Knowing how a patient perceives certain parts and functions of his/her body, and what her/his concept of disease is, can help integrate foreign patients' cultural patterns into Western health practices and narratives and help avoid descriptions and information that might potentially lead them to reject treatment or totally abandon it, with the ultimate goal of promoting health care, treatment, and prevention.

This approach has been at the very foundation of Emergency's policies in the recruitment process of its cultural mediators. A recent job profile for cultural mediator, which subsequently led to the selection and hiring of the Nigerian mediator who currently works in Castel Volturno, listed a number of requirements that the potential candidate was expected to possess. Among them was the fact that the "the candidate should be of Nigerian nationality, which is considered to be necessary to better understand the socio-cultural context of the project and provide for more targeted and effective mediation" (translation by the author from the Emergency website). This was confirmed by M2, who, when asked to express his view on the issue, replied that being aware of and sharing the culture of the migrant client is necessary to

[…] be better able to inform the patient of the need for treatment or prevention, which might be considered of secondary importance in his/her culture compared, for example, to a religious rite, or even counterproductive (e.g. the use of contraception, as these are believed to prevent pregnancy even after they are no longer taken) (personal communication, November 2018, translation by the author).

Cultural competence thus appears to be of the utmost importance and should be a defining element of the language professionals working in the humanitarian settings of medical organizations like Emergency. To this end, the definition of cultural competence by Cross et al. (1989) serves as a useful reference. Culturally competent mediators are needed to implement what Quaranta and Ricca (2012) define as "intercultural medicine." They use this phrase to refer to the set of linguistic and practical processes aimed at promoting the adoption of clinical protocols and a positive approach to treatment for migrants. Intercultural medicine presupposes that a given health treatment is planned, conducted, and communicated with the use of language and cultural mediation that can coordinate and establish a common ground with the system of values and beliefs of patients. Only in this way is it possible to facilitate prevention and therapeutic prophylaxis and establish the necessary collaboration between health professionals and migrant patients so that the latter understands the treatment, are willing to accept it, and do not refuse it. This kind of approach might have very practical consequences, first and foremost in terms of trust and compliance to treatment. This is well confirmed by M2:

[…] Language comprehension is definitely necessary; however, it is the ability to mediate between cultures […] that can contribute to establish a relation based on trust and help the patient understand that treatment is needed (personal communication, November 2018, translation by the author).

The same opinion is shared by M4. When asked if a shared cultural background is important in mediation, the Nigerian mediator states that

[…] Knowing and sharing the culture of the migrant patient can be a good foundation to establish a relationship with him/her based on mutual trust (personal communication, November 2018, translation by the author).

M4 goes on to highlight the aspects, which, in her view, can facilitate effective mediation. In this respect, she states that

[…] Coming from the same country or geographical area and knowing the language of the migrant user plays a major role in mediation, also because each… ethnic group has its own body language, which might be completely different from that of another ethnic group. Being of the same gender of the migrant sometimes favours mediation, but this depends on person to person (personal communication, November 2018, translation by the author).

In this view, the language professionals confirm that all forms and models of mediation pursue one ultimate goal, i.e. to contribute to building society and establishing relations open to and based on loyalty, mutual trust, and the common good (Pattarin, 2009).

Cultural Differences in Interpreter-Mediated Encounters

Do we know how we translate? Do we even know what we translate? If we could answer these questions in technical terms we should be on the way to the formulation of a new and comprehensive general theory of language and firmer foundations of philosophy. [Firth, 1956, quoted in Hahn, 1973]

The awareness and perception of one's own diseases and body vary considerably in space and among cultures all over the world. This conception was well expressed by Quaranta and Ricca (2012) when they highlighted the cultural value of existence:

[…] The way an individual is ill and the reason why s/he is ill are subject to interpretation and constructs of social and personal imagination. Existence is a cultural phenomenon and the body of the ill person speaks its own dialect (translation by the author).

Quaranta and Ricca (2012) therefore advocate the need for intercultural medicine, which is capable of making cultures and diseases communicate. Cultural traditions and practices permeate the way in which we interact and have a strong influence on interpreter-mediated encounters. Starting from this premise, culturally competent interpreters serving as cultural mediators are needed to "identify cultural differences as differences in worldviews" (Wadensjö, 1998) and adjust migrants' utterances to the agenda of the medical consultation through translation (Davidson, 2000).

Cultural differences in interpreter-mediated medical encounters and the difficulties interpreters must face to ensure an effective transfer of meaning emerge from the early conversations already exchanged with the interpreters and cultural mediators of the NGO where the study is being conducted. The exchange of information with the cultural mediators working in Castel Volturno reports migrant patients who are, most of the time, reluctant to see doctors for fear of prejudice. Health services are not sought because many women are uncomfortable even discussing the topic. Some patients are especially reluctant to seek health care when the services are provided by male health workers. They fear they will become the subject of rumours or stigma if they see a male gynaecologist. Reluctance is sometimes overcome, only however, if migrants have been informed before of the limits they should not overstep:

M1: Migrant patients are being referred to the NGO clinic through their friends, acquaintances, or pass-parole. For this reason, their relationship with the health professionals is already pre-structured. When I say pre-structured, I mean that migrant patients have already been informed, by those referring them to us, of the type of relation they are likely to establish with the health professional. They already know that they will receive conventional medical treatment, so they are aware of the boundaries of what they can get and of what they can ask for or tell us. Much depends on our health professionals' propensity to listen to them and on their social and relational skills. In other words, it is up to our health professionals and cultural mediators to have a broader perspective and look beyond the simple perception of illness of the migrant patients. In Castel Volturno, we acknowledge, day after day, the existence of a "parallel" universe of care (personal communication, July 2018, translation by the author).

The parallel universe of care M1 refers to, and which is often accounted for by the other mediators, shows that migrants arrive at the clinic with a perception of their illness or condition that is not of a physiological nature, but rather of a spiritual one. As Coppo (2007) puts it, "If, in order to describe the distribution and causes of diseases among various populations and the remedies they most frequently resort to, we were to also use their categories and prevention and treatment systems, we would find some nice surprises. Not only because the most widespread remedy in the world, as Tobie Nathan likes to say, would not be aspirin, but rather chicken, given the large number of these animals that are sacrificed every day on the altar of health, or rather used as ingredients for protection remedies and treatments (…), but also because the most frequent causes of diseases, accidents, and deaths are no longer malaria or infectious diseases, but rather spells, witchcraft, and the evil eye" (translation by the author). As a confirmation of this, M1 states:

The people we treat at the clinic have spiritual and cultural beliefs, which strongly influence their perception of illness and treatment. Most of our patients, who are originally from Nigeria or Ghana, have a perception of their disease or condition, which is of a spiritual nature. They are convinced that their being ill is the consequence of a problem they have with the after world or of a lack of harmony between the world of the living and the world of their ancestors. What causes the disease is not inside the individual and his/her body, but it is rather something external to it. The reason for the disease is linked to several non-conventional causes, like Juju, i.e. the spiritual belief system that incorporates objects, such as amulets and spells, used in religious practice as part of witchcraft in Western Africa. Or it is due to the person's relation with the spiritual husband, the possession of the Mami Wata spirits in women, and Obanjie spirits in children (personal communication, July 2018, translation by the author).

From the point of view of a Western approach to treatment and care, one can talk about the lack of realism that migrant patients often show. According to Taliani and Vacchiano (2006), "[the migrant patients'] cultural views, in which patients refer to the *Invisible* (in its various manifestations, i.e. possession, witchcraft, return to ancestral entities, presence of spirits), constitute epistemological challenges that are still unresolved" (translation by the author). Forms of translation capable of mediating between cultural differences and, ultimately, guaranteeing effective treatment are therefore needed in interpreter-mediated medical encounters, as "when faced with complex languages full of [culturally embedded] metaphors and symptoms based on another symbolic logic, in their daily practice [cultural mediators] opt for solutions that tend to repeat consolidated strategies and select what information should be kept (because it is deemed meaningful) and what information should be rejected, as it is deemed to express superstition, beliefs, and prejudice" (Taliani & Vacchiano, 2006).

According to M1, the migrant patients asking to be treated at the Castel Volturno clinic have preconceptions about the conventional, Western-type medical care they receive at the clinic and are fully aware of, and sceptical towards, what they perceive as limitations of the care they can get. Sometimes they react to their existential uncertainty as "being or feeling ill," and by trusting the opinions of their migrant fellows with whom they have a shared culture. Hence, the diffidence and reluctance towards Emergency health professionals and cultural mediators, is often encountered among patients, and the tendency on their part is to accept health advice coming only from their community. M1 gives a number of examples of this:

We once had a patient, a woman, whom we had visited before and who came back to our clinic to be treated after repeated miscarriages. Her mother, who was still living in Nigeria, had told her that the reason for these miscarriages was a huge worm she had in her womb. Every time the worm killed the foetus and caused her severe menstrual pain. Her mother had convinced her to take traditional medication to kill the worm. We had informed the patient that she had a huge myoma, which was the actual cause of the miscarriages and which needed to be removed, but in spite of that, she was convinced of what her mother told her. On several occasions you have patients who take the abortion pill Cytotec too often, even if they have been informed of the related counter indications, or do not take it at all because someone in their community convinces them that they then might have problems in getting pregnant afterwards. On one occasion, we had a patient who followed the advice of an acquaintance of hers and fled hospital the day before the removal of a huge fibroma that was as big as her womb – the same patient then came back to the hospital with extremely low haemoglobin. There are several "native" doctors in Castel Volturno. Last year, several patients from Ghana came to our clinic and talked of a Ghanaian doctor who would treat patients in his house with a special magic machine that could detect the health problem of the patient at the organ level. Until last year, there was also a midwife who would help women have their abortion at home; in the meantime, the midwife has apparently moved to Bologna. And there are also several Ghanaian and Nigerian traditional drugs around (personal communication, July 2018, translation by the author).

The cultural mediators in Castel Volturno all identify a widespread lack of realism among migrant patients, if one looks at the situation from the point of view of the Western approach to treatment and care. The patients they assist generally show a tendency to treat their health problems through religion or rituals. All Emergency cultural mediators have to mediate for migrant patients with complex religious/

spiritual clinical situations, who assert that a belief in divine intervention prevents them from accepting medication or results in them refusing blood transfusions, for example. According to M1,

Patients try to protect themselves through prayers or rituals. Last year, we had a patient who suffered from severe hypertension and eventually died due to a brain aneurysm. According to the pastor of the church the woman went to, she had suffered from attacks by evil spirits and died because her little daughter, who was still living in Nigeria, turned out to be a witch. Most migrant patients attend Pentecostal or charismatic churches. Pentecostalism is one of the most surprising and even worrying movements of our time and is experiencing a rapid growth in Africa, South America, and Asia. It is based on a close link between healing and religion. Pentecostal pastors make their followers call them prophets; they are seen as healers who can solve various types of health problems ranging from HIV to infertility (personal communication, July 2018, translation by the author).

Cultural differences are also seen in the knowledge and practices that belong to the migrant patient's culture of origin and which are potentially risky for his/her health. Also, on this, M1 offers a number of examples:

[Some women] are used to washing their babies as soon as they return home, because they believe that otherwise s/he will stink for the rest of her/his life. Other women massage the infant vagina with hot towels to prevent its growth, as genital mutilations are forbidden in Italy. In other cases, there is a widespread practice to rinse the mouth of babies with gin or brandy to disinfect it, thus causing severe mouth and throat irritations in the infant. Other women, again, get pregnant to test their fertility and the fertility of their partner in view of a future marriage, to then have an abortion immediately afterwards. And I could add many more examples to these (personal communication, July 2018, translation by the author).

When there is an impasse or the inability to convey a message to a patient because of religious issues or different cultural approaches to health and treatment in a complex humanitarian scenario, it is wise for cultural mediators to know and acknowledge a different view of healthcare and culturally mediate between that view and our Western-style medical approach to medicine. Awareness of the patients' culture and the cultural differences as a possible obstacle to mediation thus becomes paramount. Equally important are, therefore, all the attempts to adopt mediation strategies aimed at incorporating the culture of the other into the Western-style medical approach of doing medicine. According to M1:

Let us be clear: I am not saying that we should treat diabetes in the clinic with magic or prayers. I am just saying that, when faced with practices that are harmful for the health of our patients or result in poor compliance to treatment, especially in chronic patients, we should ask ourselves some questions: What should we do, with what they tell us and with what we observe? How can we make sure that [patients] receive indications for prevention and treatment that they actually follow, without depriving them of a world that they find reassuring? How can we contribute to changing the behaviours of a population when it comes to treatment by focusing on different systems of thought? In an attempt to reach a so-called "cultural compromise," can we start thinking about mediation techniques and communication strategies in the field of primary and secondary prevention, as well as health promotion and education? Let me give you a simple example: one of the reasons why drugs are not taken correctly by some patients might be due to the lack of rituals in prescribing medication. For migrant patients, it is not enough to know

that the active principle of a drug is effective; to believe it is effective they should be given the explanation that taking it at a given time of the day, e.g. after meals, is not only correct from a pharmacological viewpoint, but it is also associated with a precise ritual meaning (personal communication, July 2018, translation by the author).

Successful mediation relies on the awareness of the cultural background of the migrant patient and of the cultural differences between the host and the migrant culture, as well as on the implementation of mediation strategies that take said differences adequately into account. Hence the belief, extreme as it may appear, which was expressed by the language intermediaries in Castel Volturno that only cultural mediators coming from the same area and speaking the same language of the migrant patient can be successful language intermediaries. This is due to the fact that cultural barriers are difficult obstacles to overcome, which might seriously hinder communication, if they are not adequately dealt with. As M4 and M1, respectively, put it,

Mediation is a cultural activity, although language is the bridge that can help us convey the message (personal communication, November 2018, translation by the author).

Cultural diversity can be a barrier if the migrant patient does not identify you as someone who is capable of understanding certain cultural aspects that are related to the fact that you both come from the same country. If that is not the case, these cultural aspects are not even communicated by the patient to the mediator […]. Although I have a long experience with the migrant community in this area, who comes from Western African countries, especially Ghana and Nigeria, I personally find it difficult to define myself a cultural mediator: and that is because I do not speak […] twi, binì, essan, igbo, etc., and because I always realize that, in spite of my experience, some of my interpretations are always simplistic and the result of preconceived ideas. Our migrant clients find it difficult to tell me what they tell my Nigerian colleague. And, not because she is more competent or capable than me, but simply because she is Nigerian. If compared with an Italian colleague, I might be viewed as a cultural mediator, given the experience I have. But all of this experience disappears if I compare myself to a Nigerian, Ghanaian, or Senegalese colleague […]. As far as I'm concerned, the foreign mediator who speaks the mother tongue of the patient cannot be replaced by an Italian mediator (personal communication, November 2018, translation by the author).

Given the difficulty of coping with differences in culture during the interpreter-mediated encounter, the cultural mediators highlight the importance of a shared culture to better overcome said difficulties and guarantee successful communication. The ability to look beyond patients' perception of their malaise and suffering thus depends on the propensity of both mediators and health professionals to listen to them and establish emphatic relations with them, in the awareness that cultural differences might pose a problem to communication and, thus, impair the effectiveness of treatment within the wider framework of humanitarian aid provision. Cultural mediation *per se* can thus be viewed as a form of humanitarian aid provision. As a matter of fact, when asked if they see themselves as aid workers, M1, M3, and M4 all answered affirmatively. M2 gave an affirmative answer, too, and added that

Yes, [I partly see myself as an aid worker], because a patient's health problems are linked to his or her human and humanitarian situation, e.g. to the trip from his or her country of origin, the way in which

s/he was welcomed in the host country, and the living conditions s/he is in at the moment. Plus, the exercise of the right to health for a person is linked to the social and administrative situation (having a permit to stay, tax code, or residence in the host country), which is also very much related to the patient's personal history (personal communication, November 2018, translation by the author).

The ultimate goal of mediation is to contribute to effective prevention and care and treatment by helping migrant patients exercise their right to health. With this objective in mind, which frames the language used in mediation and the cultural intermediaries within the broader context of humanitarian aid provision, cultural differences should be properly acknowledged and taken into account to reach the so-called "cultural compromise" mentioned by M1.

CONCLUSION

This chapter was not an attempt at redefining medical interpreting. Its aim was to stress the importance of culture when interpreting for patients with different health concepts and views in a specific humanitarian setting where medical interpreting takes place, i.e. the context of a clinic run by an NGO that provides healthcare services. The preliminary analysis presented in this chapter will have to be confirmed by the ethnographic observations on the field.

This chapter was a first attempt at accounting for the cultural differences encountered by the cultural mediators working at the Castel Volturno clinic of Emergency. In drafting this first report of on-going qualitative research on the field, the author has attempted to provide first-hand impressions of the organization's mediators on the cultural differences they are likely to face in the medical encounters in which they operate, as well as on the importance of mediating between different cultures, well before different languages, in the complex humanitarian scenarios offered by an Italian medical NGO. This first limitation notwithstanding, i.e. the preliminary nature of the account provided (see section on the early communications with Emergency's cultural mediators at Castel Volturno), it clearly emerged from the exchange with the language intermediaries that differences in cultures can be serious barriers to effective humanitarian communications. Mediators with a shared cultural background are more trusted by migrant patients and can therefore contribute to more effective communication. Cultural differences can be better overcome by mediators who are familiar with the culture of the migrant patients, and are preferred to mediators who do not share the same cultural background of the patients.

A more detailed qualitative analysis carried out in the form of an ethnography based on a more detailed and comprehensive research design, and possibly a larger sample of participating mediators, can provide more insights on the importance of culture in such settings. Furthermore, the specificities of the context in which the cultural mediators working at the Castel Volturno clinic operate, warrant a more critical and detailed engagement with their roles, tasks, and challenges, and requires further investigation into issues such as ethics (Ozolins, 2014), neutrality, confidentiality, and impartiality.

The interpreters and language mediators working in humanitarian settings are the first to be/become aware of the cultural differences briefly outlined in this chapter. In the complex humanitarian settings where they are called upon to operate, they should be able to identify the cultural elements that might hinder communications and adopt proper coping and communication strategies, techniques, and attitudes to ensure a smooth transfer of meaning between the migrant patients and the health professionals. Differences in cultures should be adequately dealt with by interpreters and mediators in order for them

to help facilitate a so-called "cultural compromise" between the migrant patients and the health professionals. Said cultural compromise, achieved through the mediation of language intermediaries who are aware of the cultural differences between their two clients, can help prevent practices that are harmful for the patient's health or poor compliance with treatment, especially with chronically ill patients. If adequately pursued, this cultural compromise can facilitate the provision of therapy or prevention, so that these are complied with, without keeping the beneficiaries of the treatment away from that world that is most reassuring and comforting for them. It can ultimately enable health professionals to reach a population with a different system of thought when it comes to prevention, health promotion, education, and ultimately treatment. In doing this, it is definitely fundamental to achieving the human right to health for everyone, with special attention to groups in vulnerable situations.

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KEY TERMS AND DEFINITIONS

Cultural Competence: A set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals that enable that system, agency, or profession to work effectively in cross-cultural situations.

Cultural Differences: Differences in terms of the complex web of cultural representations relating to various types of regularities or themes (e.g. orientations to life and belief, values and principles, perceptions of role relationships, including rights and obligations associated with them, various norms and conventions of communication, and institutions), which can be encountered in interpreter-mediated medical settings.

Complex Humanitarian Emergency: A situation in which a civilian population is displaced from their homes by war or conflict, and one can witness a deterioration of living conditions and sometimes a significant increase in mortality, either in the short or long-term.

Cultural Mediator: The language intermediary, hired by Emergency ONG Onlus, who is called upon to provide language and cultural mediation between Emergency health professionals and migrant patients in triadic settings, and provide social and cultural orientation to migrant patients in dyadic encounters.

Emergency Ong Onlus: A humanitarian NGO with operations in Afghanistan, the Central African Republic, Iraq, Italy, Sierra Leone, Sudan, and Uganda that provides free medical treatment to victims of war, poverty, and landmines.

Humanitarian Communication: Communication facilitated by interpreters and cultural mediators in complex humanitarian emergencies, which occurs at the intersection between health mediation, humanitarian aid provision, and social service provision.

Humanitarian Interpreting: Interpreting practices that fall within the legal framework of International Humanitarian Law (IHL) and International Refugee Law that are aimed at enabling humanitarian organizations to communicate with public authorities and protected individuals/beneficiaries in order to allow the latter to access their rights.

Intercultural mediation: The act of interpreting both language and culture, bridging and mediating between two persons with different cultural backgrounds.

Chapter 8
In-Between:
An Exploration of Visibility in Healthcare Interpreting

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ABSTRACT

This chapter uses an exploratory study that examines the experiences of American Sign Language-English interpreters who provide all or a substantial part of their service in the healthcare context to discuss the notion of visibility. The visibility or invisibility of the interpreter is intertwined with discussion and research on role, conduct, and the tensions that exist between the framing of the interpreter as community member and the framing of the interpreter as professional. The exploratory study analyzes nine in-depth interviews to reveal the complexity that exists in-between. The in-between spaces are times when the interpreter is not actively engaged in interpreting and times when she is faced with the choice to remain visible or not. In these moments in-between, the construct of the interpreter as a conduit collides with that of interpreter as community partner. The findings reveal a complex set of challenges that have significant impact on interpreters' responses and actions.

INTRODUCTION

For the majority of English-speaking Americans seeking healthcare, an appointment with medical professionals typically proceeds as follows. The patient arrives at a medical facility. She gives her name to the receptionist at the front desk and takes a seat in the waiting room. After a period of time, her name is called, and she follows a nurse into an examination room. She engages in conversation with the nurse about medical history and the reason for the current visit while the nurse takes vitals such as pulse, blood pressure, and temperature. The nurse then leaves, usually with the assurance that a physician will be in soon. The patient then waits for the physician to appear. Once the doctor has joined her, there is extensive conversation about a number of topics with some informal banter included as the discussion proceeds. The patient feels rapport with her physician. She feels heard and well attended to. She leaves

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with an understanding of her health concern and the plan for treatment. With this understanding, the patient complies with the plan; getting prescriptions filled, scheduling necessary appointments, doing as directed by the physician. Having followed the treatment plan, she has a complete recovery with no need for further procedures or appointments. The above scenario assumes the interaction goes as intended by all people involved.

Healthcare outcomes are vastly improved for patients who experience quality communication with their physicians (Collins et al., 2002). This requires the patient and healthcare professional share a language in common. However, in the United States, 21.6% of the U.S. population over the age of 5 is speaking a language other than English at home (U.S Census Bureau, 2017). In the medical context, physicians see an ever-increasing number of patients with whom there is not a shared language, and these patients suffer as a result. Speakers of Languages Other Than English (SOLOTEs), including persons who are deaf and use American Sign Language, experience disparities in healthcare. Such degrading of access to wellness is directly linked to access to communication with healthcare professionals (Smith, 2009).

The use of professional interpreters has shown to greatly improve the healthcare experience for SOLOTE patients (Karliner, Jacobs, Chen, & Mutha, 2007; Bernstein et al., 2002.). The use of interpreter services increases the frequency with which these patients seek care. The improved quality of communication reduces misunderstandings for both patient and physician (Hornberger et al., 1996; Lee, Rosenberg, Sixsmith, Pange, & Abularrge, 1998). The improved quality of communication results in improved accuracy of diagnoses, improved patient compliance with medical directives, improved overall health for the patient (Angelelli & Geist-Martin, 2005; Aranguri, Davidson, & Ramirez, 2006; Davidson, 2000; DeVault, Garden, & Schwartz, 2011; Jacobs, Lauderdale, Meltzer, Shorey Levinson, & Thisted, 2001; Major, 2013) and improved rapport and trust between patient and professional (Jacobs et al., 2001).

Interacting with physicians via an interpreter also has been reported to improved patients' trust of their physicians (Angelleli, 2003; Green et al., 2005; Jacobs et al., 2001). What is not much discussed is that the foundation of the relationship between patient and medical professional may be built on the rapport established between patient and interpreter (Major, 2013). SOLOTEs who use interpreters are more likely to rate their overall experience in the medical encounter as a high-quality experience if they rate the experience with their interpreter the same (Flores, 2005).

SOLOTE or LEP

In the world of healthcare, SOLOTEs are referred to as Limited-English Proficiency patients or LEPs. This label comes from a perspective of inability rather than difference. This perspective can lead to a decrease in empathy for the patient, less effort invested in building rapport and fewer opportunities presented for the patient to participate in medical decision-making (Ferguson & Candib, 2002). The SOLOTE patient as an empowered participant is not as visible to the medical professional as it is for the patient who speaks English.

The medical event for a SOLOTE is therefore often fraught with emotions of frustration and subjugation embedded in an environment rife with power differentials and cultural and linguistic misconceptions (Iezzoni, Davis, Soukup, & O'Day, 2002). Angelelli (2008) noted that interpreters are therefore working at sites "in which there are asymmetrical relations between speakers of more or less dominant social groups" (p. 148). Such circumstances are not unique to the healthcare setting; however, focusing on this particular environment provides a context for the examination of the sociological complexity that exists in interpreted events. The interpreter navigating through the healthcare environment with a patient in a

marginalized position faces many decisions about when, how, to whom, and to what degree she becomes visible as a participating party in the medical encounter.

The data discussed here are part of a larger study on the social organization of healthcare interpreting. The data came from nine in-depth interviews and reveal the complexity that exists in a place that has yet to be investigated fully: that of the in-between. The author uses the phrase in-between to refer to spaces and times when the interpreter is not actively engaged in interpreting, times and sites when she is faced with the choice to remain visible or not. In these moments in-between, the construct of interpreter as conduit collides with that of interpreter as community partner. The findings reveal a complex set of challenges that have significant impact on interpreters' responses and actions.

Making interpreters the center of social inquiry by collecting and analyzing their narratives results in new knowledge about how it is interpreters come to the decisions they do; making them unconsciously, or consciously. Increased consciousness gives interpreters a more informed approach to their choices about what actions to take and to what degree to be visible or invisible.

In this chapter, readers will:

- Learn of the academic discussion of role for interpreters
- Become familiar with the construct of visibility/invisibility that occurs in an interpreter-mediated medical encounter
- Discover the site of the in-between as a sociological place and time where visibility and the complexity decision-making are revealed.

INTERPRETER ROLE AND THE CONSTRUCT OF VISIBILITY

Research on interpreting has moved beyond examining the mechanics of interpreting to look at the work within a social context. If interaction is a social act, then the more recent question has focused on what role the interpreter is to take as the interaction evolves. Research supports that interpreters are active participants at times, inserting themselves into the interaction to control the flow of discourse and the evolving relationship amongst interlocutors (Angelelli, 2003, 2008; Metzger, 1999; Roy, 2000; Wadensjö,1998). However, the idea of interpreter as co-participant (Angelelli, 2003) is often thwarted in the face of the common perception of interpreter-as-tool, a conduit for communication. This perception renders the interpreter invisible as a fellow interlocuter in the interaction.

Goffman (1959) describes social performance as the action, behavior and discourse an individual performs that "incorporates and exemplifies the officially accredited values of the society" (p. 35). In this case, it may be the performance of the professional as detached, as a means to an end, distanced and removed from the social space of the patient is what society values. Training, codes of conduct, and resulting standards of practice promote and work to sustain the interpreter as conduit (Dysart-Gale, 2005). To portray the self as conduit is to choose actions that embody neutrality, objectivity, and distance (Wilcox & Shaffer, 2005); the same characteristics often used to describe the role of "professional." However, the risk of distancing is to appear detached in a highly personal and relational context (Nicodemus, Swabey, & Witter-Merithew, 2011). At the same time, to embody the self as conduit leaves interpreters feeling they have no authority or permission to speak directly to patients or to engage in behaviors that might be perceived as interpersonal involvement; to become visible (Hseih, 2008; McDowell, Messias, & Estrada, 2011). The tension between the actions of the invisible conduit and that of

visible co-participant is heightened when the interpreter is a member of the same linguistic and cultural community as the patient. Angelelli (2008) observed that interpreters "bring with them their deeply held beliefs about power and solidarity" (p. 148). As people working with members of a shared community in a context where SOLOTE patients are often marginalized and subjugated, the interpreters are very aware of the existing power differentials and may feel the need to mitigate these differences. Brissett, Leanza, and Laforest (2013) in their review of qualitative studies of interpreters in the healthcare setting note that power struggles during the interpreted event put the interpreter in the position of choosing between actions that reflect loyalty to the institution or actions that reflect loyalty to the patient as the embodiment of minority status.

To step away from the conduit space and into the space of relational partner is to go against industry expectation. However, to remain entrenched in the enactment of interpreter as instrument of linguistic transmission, the interpreter risks potentially violating rules of common courtesy and the expectations of the patient as community member. Such a violation could erode the relationship-building between the interpreter and patient but also, in a cascade effect, erode the relationship between patient and healthcare provider.

Hsieh (2008) observed that interpreters are often ambivalent about or uncomfortable with agreeing to take actions that could degrade the presentation of self as professional. Brissett et al. (2013) described the conflict as a tension between professional neutrality and commitment to the quality of experience for the patient. The interpreter is actively working to achieve and maintain some sense of balance between the emotional distance that is demanded from the institution and the degree of involvement that may be required to make the patient visible in a context that often disempowers. Add to this the potential social expectations of patients, for example, to engage in conversation at various times while in the medical facility, leaves interpreters feeling conflicted and unsure about what actions to take.

To address the tension and conflict, interpreters find invisible spaces to become visible to the SOLOTE patient. Studies involving spoken language interpreters and behaviors associated with advocacy, found these behaviors often occur in what this author calls the in-between, moments when not actively engaged in interpreting, when the healthcare providers are not present (Angelleli, 2008; Hsieh, 2008). McDowell et al. (2011) discussed how interpreters may remain with patients after medical personnel have left. The interpreters do so in order to offer the patient emotional support. However, these interpreters note how such conduct is counter to standard practices that are a product of institutional and industry policies, revealing societal forces as influences on interpreters' lived experience.

THE INVISIBLE FORCE OF REGULATION – HIPAA'S PRIVACY ACT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is just such an example of a societal force that is having a significant impact on the actions and decisions of all those employed in HIPAA-protected entities. Protected entities include insurance plans, healthcare clearinghouses, providers "of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business." (U.S. Department of Health and Human Services; National Institute of Health, 2007) and finally, business associates who may have reason to have access to Patient Health Information (PHI). If interpreters are not actual employees of the hospital, they fall into this category of business associ-

ate. Whether an employee or a business associate, the interpreter is expected to comply with HIPAA, particularly the Privacy Rule.

The privacy rule is designed to regulate the use and disclosure of patient information so that the patient's privacy is maintained while still allowing for the use of PHI as needed in order for the patient to obtain quality care. Patient information includes demographic data that relates to the patient's medical history, present care, and future plans (U.S. Department of Health and Human Services; Office of Civil Rights, 2013). The rule also protects the use of all data that could identify the patient such as name, address, or birth date. Violations of HIPAA's privacy rule results in hefty penalties that come in the form of fines that quickly add up to hundreds of thousands of dollars (HIPAA Journal, 2015). The interpreter working in the current HIPAA regulated environment is viewed as a potential violator as is anyone who works inside a HIPAA protected entity.

THE COMPLEXITY OF THE IN-BETWEEN

Context of the Study

This study examined the experiences of American Sign Language-English interpreters who provide all or a substantial part of their service in the healthcare context. In conducting the interviews with participants, a particular construct came to light, that of what the author calls the in-between. The in-between refers to moments when the interpreter is not actively interpreting; when medical personnel have stepped away or have yet to arrive. In spaces in-between, notions of interpreter as conduit collide with that of interpreter as community partner when the activity of interpreting is suspended. The lived experiences of the interpreters in this study uncover the unexplored presence of various conflicting demands that permeate these moments that lack the structure the active interpreted interaction provides.

In the in-between, the deaf patient stands before the interpreter; a visible embodiment of the deaf community-at-large. This community and its people present a paradox. The American Deaf community has a distinct language and culture that differs from that of mainstream culture. However, like many minority communities in the United States, the deaf community is embedded in the larger context of the majority culture (Lane, 1995). The deaf person experiences constant tensions between the differing values and expectations embedded in their community versus those imbedded in the majority culture (Ladd, 2003). The common understanding as promoted by the Deaf Community and as taught or told to interpreters is that the American Deaf Community is rooted in collectivism (Ladd, 2003; Lane, Hoffmeister, & Bahan, 1996; Longwood, 2014; Mindess, 2014). Therefore, an interpreter leaving the room and not sharing the in-between could be seen as an act against the collective. Yet, the American Deaf Community is also embedded within the larger majority culture whose members often embrace individuality. Therefore, in any given moment, the interpreter must work to ascertain from what center the deaf person is acting; that of the autonomous individual or that of a member of a larger collective. Clues to the deaf patient's position on partnering in the healthcare context may be elusive, causing the interpreters to feel conflicted as they struggle to ascertain the patient expectation. In this context, it may appear that the best course of action is the simple act of leaving, however, as the results show, for the participants in this study, the choice was far from simple.

Interpreting in the medical context means working with people who are often at their most vulnerable; sick or hurt and surrounded by people who do not know their language or their culture. The situation

becomes even more charged when the interpreter is a Child of a Deaf Adult (CODA). Nadine is 54 years old and has been interpreting professionally for 32 years. During her interview, she talked about times when her deaf parents told stories of their experiences with healthcare providers. When asked why she chose to interpret in the medical context, she replied:

They have to understand what's going on…. Otherwise all of their power goes to the doctor….to whoever is making the decision.

She has witnessed for herself, as both an interpreter and a daughter of deaf parents, the imbalance of power between a patient and health professional that is further complicated when that patient is deaf. She sees her work as a way to safeguard them from the forces that place them in a subordinate position, disempowering them as the decision-makers in the process.

Jena is a Spanish-English interpreter who has been working in the medical context for 5 years. She is not a native speaker of Spanish and is Caucasian. She is not of the same community as the patients she works with, however, many of her interpreting colleagues are of the same language and cultural base as the patients they serve. Jena observes that her colleagues act in ways that are like the safeguard Nadine describes:

There are a lot of spoken language interpreters who have had the practice for many years of being essentially the community interpreter, giving explanations, spending time alone with the patients, kind of being more of an interface with that patient and society or that patient and the medical system.

The interpreters Jena describes are highly visible to the patient, working with the patient to navigate the system. However, this work is invisible to the healthcare professionals who are not present in these moments in-between. For the medical personnel, the interpreters may behave in a way that fits the conduit frame in contrast to their behavior behind the scenes, for the interpreter is being called to respond to the expectations of the medical institution and interpreting industry, both of which expect the interpreter to maintain the distance discussed earlier in this chapter.

Speaking specifically to the institutional and industry anxiety surrounding the need to comply with HIPAA's privacy rule, Nadine observes:

the (medical) profession has made it so that the nursing staff, the medical staff... [are] all so afraid.

Nadine seems to feel that there is institutional confusion about what can and cannot be shared and with whom. This confusion and uncertainty create rules that are attempts to govern those working with patients in a way that avoids the slightest chance of HIPAA privacy rule violation. In this environment, the interpreter is encouraged to be more invisible and conduit-like than ever before. Faced with a patient seeking a health partner, the interpreter faces a complex decision in the spaces in-between.

Methodology

The design of the study implemented a qualitative approach designed to collect personal narratives. Interviews were semi-structured, making use of an interview guide (see Table 2). The guide had a number of both open-ended and closed questions, with opportunities for the interviewer to add or delete

questions in order to foster deeper discussion and exploration of what came up naturally in the course of the conversation. The order in which the questions were raised was informed by the responses of the interpreter and new topics were introduced if found relevant. Each interview lasted approximately 90 minutes. Interpreters were asked to talk through their actions from the moment they arrived at a medical assignment to the moment they left. They were asked to describe moments they experienced as successful and moments that proved less than satisfying. The context was limited to medical encounters within hospitals and associated clinics, excluding private practices. Audio files were sent out to a professional transcription service. Transcripts were then reviewed by the author, comparing them to the original audiotapes. Analysis of the transcripts involved coding for traces of the institution and social forces found in the discourse that were coming to bear during the medical encounter as revealed in the interpreters' narratives. Quotes were reviewed by several of the interviewed participants. Analysis of the narratives shows a commonality of experience among the people interviewed.

Participants

The qualitative method of network/snowball sampling (Hale & Napier, 2013) was selected to identify potential candidates. Ultimately nine interpreters were interviewed. The interpreters held one or more national certificates. Professional interpreters of both spoken and signed languages are granted certification having successfully completed knowledge and performance exams. Jena holds certification as a Spanish English healthcare interpreter with CCHI, the Certification Commission for Healthcare Interpreters. The ASL/English interpreters hold certifications granted by the National Registry of Interpreters for the Deaf, Inc. Four interpreters were of deaf parentage. They self-identified as CODA (Child of Deaf Adult). The remaining five interpreters were not indigenous members of the minority community with whom they work (deaf and Spanish-speaking). There were eight women and one man. All but one of the participants were American Sign Language-English interpreters. One Spanish-English interpreter was also interviewed. Her narrative was included as part of the data set as her experiences paralleled that of the other participants. (See Table 1 for more details).

Data Analysis

The data consisted of the audio recordings of the interviews and the resulting transcripts. Each recording was sent out to a professional transcription service. Upon return of the transcripts, the author reviewed each transcript, comparing it to the audio recording for accuracy. Sections from each transcript that shared a common experience were then bundled together, removing the connection to a particular participant. The data analysis used an open coding system to discover patterns (Charmaz, 2014; Hammersley & Atkinson, 2007) of said common experience. It was from this coding that the ambiguity of the in-between came to light. Any quotation selected from a data bundle was compared to individual transcripts so that the quotation could be ascribed to the correct participant. The quotations that were used in the reporting of the study was verified by a second comparison with the audiotape and, in some cases, sent to the participant for additional verification. Some participants did not wish to provide additional verification, as the audio recording was deemed sufficient. Participants were also assigned pseudonyms to protect their privacy. The design study, results, and report were reviewed by two academic scholars in the field.

Table 1. Table of participant demographics

	WORK	Age	Years in the profession	Certificates held	ID	Race	Gender	% of work in healthcare
#1 "Beth"	In person	44	23 yrs	CI/CT	hearing	Caucasian	F	3/wk
#2 "Endekorte"	in person	61	37 yrs	CSC/OIC:C	hearing	Caucasian	F	25%
#5 "Gladys"	In person	30	3 yrs	NIC-A	hearing	Caucasian	F	25%
#8 "Nadine"	in person	54	32 yrs	CSC, CI/CT	Coda	Caucasian	F	0-20%
#3 "Minerva"	VRI	48	28 yrs	CI/CT	Coda	Caucasian	F	40-45%
#7 "James"	VRI	47	29 yrs	CI/CT, NIC	hearing	Caucasian	M	bulk of the wrk
#4 "Lucy"	VRI	31	14 yrs	NIC	Coda	Caucasian	F	manager/75% of 20%
#9 "Alexis"	VRI	40	18 yrs	CI/CT	Coda	Caucasian	F	evening/wkend
#6 "Jena"	Sp/Eng both	35	5 yrs	CHI	hearing	Caucasian	F	100%

American Sign Language/English Interpreters

Age range 30 - 61 — Average age 44 years
Years of experience 3 yrs - 37 yrs — Average years of experience 23 years
8 nationally certified
4 'hearing' 4 Coda
4 VRI/both 4 in-person
8 Caucasian
7 females 1 male

In Situ: Commonality of Lived Experience

The interpreters describe three physical places that create the in-between: the waiting room, the clinical examination room, and the in-patient hospital room. Permeating all three spaces to varying degrees is what will be referred to here as the Leave the Room (LtR) practice. The interpreters described the practice in basically the same terms; anyone who is not a member of the medical healthcare staff **must leave the presence of the patient** unless accompanied by said member of the medical healthcare staff. Some of the interpreters said it was hospital policy while others said it was practice dictated by the interpreting agency for which they worked. The practice was presented to the interpreters verbally, in email, in contracts or in employee handbooks. Regardless of its roots or medium of presentation, the practice embodies an expectation of specific actions that prove to be a source of tension as the interpreters grappled with what to do: stay or leave.

"Please Wait Here… Your Name will be Called in a Minute"

None the interpreters interviewed described putting the LtR practice to use in the waiting room. Instead, they saw the time waiting to be called into the appointment as an opportunity. Most times the interpreter talked about walking into the facility with little to no information about the nature of the appointment and about to work with a deaf patient they had never met. This 1:1 time in the waiting room then served a function. For the interpreters of deaf parentage (CODAs), the conversation with the deaf patient allowed for a few precious minutes to establish connection as members of the same community. The other inter-

Table 2. Interpreters in healthcare – interview guide

Demographic Information: Age: _____ Certification: _____ Length of Time Interpreting: _____ Length of Time Interpreting in healthcare: _____ Race: _____ I identify as: Deaf Hearing Hard of Hearing 1. What portion of your practice would you say is in medical settings? 2. Do you work in medical settings: • In-person, remotely, both. • And do you do both equally or do you spend a larger part of your time doing one over the other? 3. What drew you to do medical interpreting? 4. What is the process you go through to get assignments in a medical setting? 5. How does a day in a healthcare setting go for you? 6. Can you tell me about a day in a healthcare setting that you would describe as a good day? 7. What supports a good day of work in medical settings? 8. Tell me about a time when it was a bad day in a medical setting. 9. What may have made things go wrong? 10. What strategies do you put into use that are most likely to lead to the feeling that things went well? Can you give me some examples from your experience? 11. Are there times those strategies don't work? Can you give me some examples from your experience? 12. What do you find the most challenging about interpreting in healthcare? 13. What kinds of problems do you encounter? 14. How do you prioritize expectations? 15. Tell me about the treatment you get from • Nurses/staff? • Medical professionals? • The deaf patient? 16. Tell me about what you think others' expectations are of you: • Nurses/staff? • Medical professionals? • The deaf patient? 17. Has there been a time when you felt a conflict of expectations between you and the medical personnel and the deaf patient? Tell me about that. 18. Is there anything else you would like to tell about that I may not have addressed?

preters used the conversation to create a sense of shared linguistic compatibility between themselves and the patient. Either way, the interpreters were focused on connecting with the deaf patient in some way.

It may be that the LtR expectation holds less force in this space that straddles the outside world and the medical world. Whatever the reason, interpreters did not appear conflicted with being visible to the patient as a conversational partner. The only point of tension in this space came about when the interpreters were assessing to what degree the deaf patient wished to engage. Gladys, an interpreter with 3 years' experience working in the medical context, said:

I follow their lead as to even where I sit. If I know them and they say 'How are you? How is life?' blah, blah, blah. I will sit near to them and chat with them if that's how they initiate it. If they are more 'Hey, yeah, I see you.' and they go back to their magazine, I give them their space.

Gladys' comment captures the process of deciding how visible to be in this initial entry space. The interpreter is faced with determining if the patient sees the interpreter's role as more conduit-like and less visible or sees the working dynamic as more allied or interdependent and likely more visible.

"The Doctor Will Be With You Shortly"

Eventually, a patient's name is called and it's time to leave the waiting room. The interpreter walks with the patient back to the examination room accompanied by a nurse who typically takes vitals (i.e., blood pressure, weight, temperature), asks some preliminary questions and checks on medical history and then leaves.

Compared to the waiting room, the is more pressure to comply with the LtR practice in these moments when medical personnel exit. The expectation of compliance with LtR also combined with a common fear voiced by several participants. Beth who interprets in medical settings 3 out of 5 working days a week summarized the concern:

I typically don't wait in the room with them because that opens all kind of cans of worms.

[The deaf patient] starts and tells me, "okay, I am here today because of this and this and this. I have got to remember to tell the doctor that my medicine changed." and they are telling it all to me. Then the doctor walks into the room and they are like "okay, tell them what I said."

Rather than be put in the awkward position of knowing medical information that the patient may withhold or ask to have conveyed second-hand, several of the interpreters interviewed opted to leave the room. Given this possibility, they were willing and, at times, even eager to comply with the practice so as not to be privy to more medical or personal information than feels appropriate or sensible. This response seems to conflict with the efforts made to form some kind of connection with the patient in the waiting room. However, additional time and conversation with the patient may pull the interpreter too far into the social world of the patient and too far away from the spheres of the institutional and industry expectations. There was a safeguarding against appearing more the companion than the professional. To put the lid on the can of worms, the interpreter may opt to leave this space in-between.

Choosing to Leave

The possibility of being told intimate details of various types seems to persuade the interpreters to take actions that create distance at the risk of potentially violating the social expectation of the deaf patient as community member. Gladys expressed the angst that several interpreters shared when feeling compelled to maintain some distance, a value of the profession. She said:

I always feel torn when I have to kind of lay down that boundary because for, I would say, a good number of deaf people that I have worked with, it's just kind of natural to sit and hangout and talk while you are waiting.

In the moment, Gladys' feelings of ambivalence led her to mediate this possible violation when exiting.

Gladys and the other interpreters interviewed described some of what they do to ease leave-taking and reduce the possible tension departing may create. They engage in mitigating conversation such as stating the wish to respect the patient's privacy, explaining that the appointment will go more quickly if the staff sees the interpreter in the hall or that the interpreter wants to be immediately available for a

quick introduction before the doctor enters the room. They also quoted LtR as policy, saying the hospital, the agency, or "my boss" has a rule that requires leaving the room.

Who Are You?: The Hallway Another Kind of Invisible

The interpreter who chooses to leave the examination room and find a space to be that is not with the patient, steps out into the hallway. When the interpreter is actively interpreting in the examination room with the patient and a member of the medical staff, it is obvious how she fits in the context. However, in the hallway, a space that could be described as an in-between, confusion can reign. Beth described stepping out as follows "There are a lot of places where it's literally so tight quarters…I am squishing myself against the door to make room for people to go by." The physical space is not designed with the interpreter in mind as part of the medical landscape. In a place where there is much coming and going of people and equipment, this extra body causes disruption. An easy solution would be to go wait in a space designated for just that purpose – the waiting room. However, interpreters described the need to stay nearby in case they were needed to interpret. They had seen what happened when the physician appeared and they were not immediately present. More often than not, the physician would proceed, potentially compromising the integrity of the interaction and examination with the patient. Therefore, interpreters often choose to stay right outside the examination room despite the sense of being in the way.

In the hallway, a space in-between, the interpreter becomes an unknown party rendering her identity as an interpreter invisible because she is no longer engaged in the activity that informs that identity. The medical staff seeing someone in street clothes standing near a patient space may categorize that body as social support rather than as an attending professional. As Beth explained it "They think that I am just a friend, or I am the pastor's wife from their church who just comes to help." Gladys speculated as to what the medical staff was thinking: "I don't know if you are a professional or you are a family member or you are a friend. Who are you?" It appears that when the interpreter is not engaged in interpreting, she not only does not fit in the physical landscape but, in addition, is not necessarily part of the medical staff's mental landscape either. The interpreters have developed several strategies for this situation.

Several interpreters interviewed explained that, to proactively address the potential confusion, they wear badges in an effort to be recognized as professionals. Some interpreter service agencies or medical facilities had provided their contract interpreters with a badge. A couple of the interpreters had the badges made. Either way, the badge seemed to assist in sending the message that the interpreter belonged in the space, the context. It became an artifact of belonging. If they were still asked questions, the interpreters engage in a conversation that continued to point to their professional standing, mentioning their national certification issued by Registry of Interpreters for the Deaf (RID), for example. Gladys explained that these efforts conveyed that "I wasn't just some person waiting in the hall. I was another professional; just of a different system." The interpreters relied on the interpreting and medical industry's signs and symbols of professionalism in order to create a sense of commonality with the medical personnel; of being on the same team.

However, as she stands in the hallway, the interpreter may present as a potential breach in compliance with HIPAA. Nadine described such a moment: "I stepped out of the room and (the medical staff) are like, 'Oh but for HIPAA purposes, you can't be out here' because I could overhear." Nadine wished to exit in order to obey the LtR rule as dictated to her by the interpreting service agency for whom she worked. The medical staff did not want her in the hallway and so asked that she step back into the patient's room. The staff assumed that by being in the room, Nadine was out of earshot of any HIPAA-related

information that might have been floating around in the hallway. All parties were attempting to avoid a HIPAA privacy rule violation. In this moment, the medical staff offered to leave the examination room door open as a compromise. Nadine says that after this experience, she adopted the same action sequence as her own safeguard against rule-violation—a constant if invisible threat.

Of course, this notion of the open door creating compliance with the hospital directive easily crumbles under scrutiny. The patient and the interpreter can use a language to which the medical staff has no access and therefore could be carrying on lengthy conversations about medical details that should be HIPAA-protected. In addition, the open door may or may not relieve the interpreter of the paradox of working to build or maintain rapport while avoiding being in that conversation that could lead to being told details that she does not want to be accountable for and that could be in violation of HIPAA. Yet, the open door seems to bring some sense of harmony to all parties involved; the patient, the interpreter and the medical staff. The ambiguity of this in-between space seems to be temporarily alleviated.

Choosing to Stay

So far, the interpreters' stories seem to indicate that the best course of action is to leave. However, the scale used to measure the positive and negative consequences of a given action can tip, the interpreter choosing to stay with the patient and ignoring or even subverting the LtR practice/professional expectation. When a patient asked directly, the interpreters were more likely to remain or when they sensed that the patient was feeling particularly vulnerable. They also sometimes opted to stay with a patient with whom there was a history of solid rapport and of mutual understanding of how to share the in-between without opening the can of worms. However, just as with leaving, there remained a need to mediate the decision to stay.

Just as the interpreters acted strategically when choosing to leave the patient's room, the interpreters were equally strategic when it came to remaining with the patient. Gladys normally complied with LtR practice as expected by the interpreter service agency for whom she worked. However, when a patient asked her to stay, she agreed, responding "Okay, you know what? That's fine with me personally, but just to make everything clear, is it okay if we leave the door open and the nurse and the doctors are right there, is that cool with you?" Gladys created compromise in the same manner as Nadine. In this instance, the open door allowed the medical staff to see into the room and this left Gladys feeling more confident and secure about staying. She made herself visible to the medical staff as a means of proof of compliance with the LtR practice and also stayed visible to the patients as a partner in the medical encounter.

In instances where Nadine has been asked to stay, she takes a different tack.

I usually tell the patient, 'Now you know, I'm not supposed to be in the room, but I will because you want that and I want that too.' …We are bucking the rule. They like that. I say so 'you can't tell the next interpreter.'

What is revealed in this statement is the complexity of the situation. First, Nadine acknowledged that the LtR practice is a rule she is expected to follow: "I'm not supposed to be in the room." Next, she overtly aligned with the patient's request for a partner: "I will because you want that, and I want that too." The alignment was formed in opposition to a system that created the rule. It is unclear if Nadine and the patient were "bucking the rule" that produced by the impersonal medical system or by the interpreting industry, or both. Nadine in her response to the patient acknowledged the outside forces that are

driving a wedge between herself and the patient, forces that subvert the desire to do the relational work that creates and maintains rapport.

In asking that the patient not tell the next interpreter, Nadine appeared to point to an interpreter policing power as an invisible threat present in the decision-making process. Nadine spoke of her concern that her colleagues would get wind of her choice and voice their disapproval. The implication is that her choice to stay could damage her professional standing. How the colleague's poor opinion would eventually damage her work status was not overtly stated, however, she seemed to imply that word could get back to her employer and cause her trouble.

Alexis, a CODA like Nadine, has also opted to stay with a patient at times. She expressed a similar concern about the power her colleagues have over her professional standing: "maybe this gets me in trouble …there are those situations where you are going to stay in a room and then what happens the next time that there is an interpreter and the doctor is like 'But wait a minute, the last interpreter was here before.'" Alexis was clear that there were circumstances that would lead her to violate the LtR practice. However, she implied that the next colleague on-site upon hearing the doctor state that the previous interpreter had stayed would let it be known that Alexis engaged in inappropriate action.

Stay or Leave: The Ripple Effect

What becomes evident in examining the interpreters' narratives is that what appears to be a simple decision to stay or leave has repercussions that resonate well beyond the immediate context. What the interpreters choose to do in the in-between can have long-term impact.

When Beth spoke of her decision-making process about whether to stay or leave, she stated "there are certain people who would take offense if I said, 'oh I am going to go stand outside.' Like, 'Well, who do you think you are? Not even going to stand here, and talk to me?" Beth's comment reflects a concern that her actions will be disrespectful. This concern may be a product of Beth's personal value system and it also may be informed by RID's Professional Code of Conduct (2005), which directly states as one of its tenets "Interpreters demonstrate respect for consumers." (p. 2) going on to explain "Interpreters are expected to honor consumer preferences in selection of interpreters *and interpreter dynamics* …" (p. 4, emphasis added). It could be assumed that the dynamics referred to here are those that exist between the deaf person and the interpreter. In that case, if the deaf person as patient wishes for a partner-like dynamic, the interpreter is expected to comply.

Like Beth, Gladys talked about the conflict she experiences as one directed to comply with the LtR practice and, at the same time, considering her relationship with the deaf community. She expressed the ambivalence that surrounds ascertaining the degree of connection and rapport the deaf patient may desire: "If I am known to sit in with patients and I am very talkative and some deaf patients may be fine with that. Others would hear that and say 'I never want that interpreter in my appointment…'" In other words, the deaf patient may find the interpreter who attempts to engage in conversation as someone seeking to be a companion rather than presenting as a professional provider of a service. Also, in Gladys' comment is a concern that a dissatisfied deaf patient will talk to other members of the community and that could ultimately cause Gladys to lose status. In the past, interpreters were selected, trained up, and vetted by the community (Cokely, 2005). A disgruntled member of the community who had found an interpreter lacking could lead to other deaf people also losing regard for that interpreter and deciding to not use her services. In today's world, deaf people actually have little sway over which interpreters they work with, but the remnants of the community dynamics of old still have some impact on interpreters' actions.

On a more personal level, Gladys did recall one particular instance when a patient asked her to stay. She did as asked: "I really felt like it would be detrimental to our (hers and the Deaf patient's) working relationship for me to say 'No, I can't do that. I am going to be in the hall.'" Yet also like Nadine and Alexis, Gladys expressed anxiety about the opinion of her colleagues: "some interpreters may hear that (I stayed) and say I am not going to recommend that interpreter." Therefore, on the one hand, there is the potential of making a decision that will leave the deaf patient feeling disrespected or abandoned. On the other hand, there is the potential of word of a given decision reaching the ears of fellow colleagues and by association, to the people in power at the interpreter service agency, the source of assignments and revenue for the interpreter. The patient is present as a visible force to be reckoned with but there is considerable force to the invisible power of the LtR practice-as-rule. The rule was authored by those with the power to affect a given interpreter's professional reputation an earning potential. The rule is a strong presence in the interpreters' decision-making.

"Your Doctor Will Be by to See You Sometime Tomorrow Morning."

The last space to be considered here is the in-patient room. Patients are often on their own once admitted into the hospital. The interpreters interviewed said, if all is quiet, they are likely to go wait in the hall. They talked about wanting the patient to rest. Also, they did not want to have too much conversation with the patient that might lead to the dilemma mentioned earlier – that of being told too much. The interpreters had no desire to be held responsible for whatever health information the patient shared that would best be told to the physician by the deaf patient and did not rely on the interpreter's recall of past conversation. In addition, they observed that those who spend hours with a patient increase the risk of being told details that are part of the social world of the patient, which is likely to create the perception for both for the patient and the attending medical personnel of the interpreter as a companion rather than professional. Knowing these risks, the interpreters typically left the room. Again, this put them back in the hallway; however, the experience in this time and space in-between was different than when outside the clinical examination room.

When on an in-patient floor, the interpreter was there for hours. Often, there were other interpreters who had been there for prior shifts providing the interpreting services needed. The repeated exposure meant the medical staff began to recognize the interpreters. This appeared to lead to a shift in perspective of the medical staff compared to that formed in the outpatient setting. In the clinic, the interpreter faced the possibility of being seen as a disruptive outsider. On the in-patient floor, the interpreter appeared to gain insider status. In this case, interpreters sitting in the hallway were less likely to be asked who they are, but now they faced a new challenge.

Beth observed: "A lot of times they have seen me, I think, more as a team member, of helping them with what they are doing." This shift in alignment in the minds of the medical staff led to requests to take a message to the patient, to bring the patient a glass of juice that was requested, to help out. Asking the interpreter to do a task they, the healthcare workers, would typically perform, brought the interpreter into the hospital's known scope of work and onto the medical team.

Several of the interpreters acknowledged that they do, at times, simply do as asked. Reflecting on the time she complied with a request from a healthcare provider, Jena said "if the provider is right there just a few feet away and I know that it's not really like I'm in in the room alone with the patient. Depending on the circumstance I am going to let (the request) go." Rather than refuse the provider's request, Jena entered the patient space without the provider, in violation of the LtR practice. However, she did and

does make sure the provider is within some acceptable distance that seems to sufficiently extends her or his presence into the patient space, perhaps protecting the interpreter from concerns about rule breaking. This sequence of actions echoes the act of opening the door during outpatient visits. Jena admitted that earlier in her career, she was more rigid in her choice of actions. More recently, she has seen a shift in her approach. "Maybe I will do that [task] now, because I have seen how much tension between providers and interpreters really affects the patient experience because it affects how the provider talks to them a few minutes later." Jena sees a direct connection between her own behavior and the rapport between provider and patient, and thus the quality of care the patient may receive. She has developed this insight over time and has realized there are times when the consequences to patient well-being outweigh the potential consequence of breaking the rules.

Breaking the Rules: The Place for Compassion?

There are times on the ward, in the emergency room, or in the clinic, when what might be considered atypical or exceptional choices are made. Lucy, a CODA who has spent many years providing services in the medical context, said: "I think that when you are in the hospital, [sic] That's a very vulnerable place for a patient to be at… I think that that vulnerability makes me make different decisions." Nadine's feelings are similar to Lucy's when talking of her own struggle with saying "no" to deaf elders who asked her to stay. "Especially if they don't really have someone in their family anymore. They are all on their own." She recalled a time when she was asked to remain in the room. "I stayed, ignoring my policy." In this instance, Nadine opted to become visible in the patient's social sphere, displaying behavior more like a member of the community with which she identifies because of her status as a CODA, than would be considered the standard behavior of the "professional."

Alexis recalls the patient who had 2 weeks to live. She opted to stay with the patient as the hours passed: "Yeah, I will sit there and talk to the person. I will have conversations. I will interact with this person, because the rules be damned. You know what I mean? Something just felt right about staying." Another time a deaf family had just received devastating news, news she had to interpret. The medical staff left the room, but Alexis remained. She describes the moment:

I was pseudo participating … just my compassion and my sympathy in the facial expressions or my body language or whatever…that situation there was no question in my mind but stay in this room. You don't need to be so cold and robotic and walk out of the room every time the doctor does.

In this context, she set the institutional and industrial system expectations aside and instead allowed her compassion to quietly fill the *in-between*.

SUMMARY

The spaces-in-between have proven to be complex. The waiting room as a space whose occupants are transitioning from the outside world to the realm of the medical institution, is less fraught than the other spaces, but the interpreter must still give thought to what type of discourse to engage in, if any at all. Can the interpreter get some helpful detail and begin to build connection with the patient without crossing too deeply into the social sphere?

This same concern is present in the examination room as a place of possible in-between. In this space, the tension among institutional, industrial and social spheres becomes more intense. The setting exerts a pull on the interpreters to display "self as professional" versus "self as a community partner." This may result in interpreters leaving the room and entering a space in-between where they become undefined. The interpreters step into the hallway on the in-patient floor as well, waiting outside the patient's room. Here they can become differently defined as a member of the care team. This perspective has its own complications. In addition, in the in-patient space, the interpreter is working with patients who are more seriously ill, vulnerable and alone. This context is the one in which the interpreter is most likely to break the rules of the institutional and industrial systems in favor of showing up as a social being.

All of the interpreters are working diligently to navigate among the social and the institutional and industry-driven expectations, to respond to the push and pull of the different systems present in the in-between. They consider perception and alignment in context, in the moment, as they decide whether to stay or leave, to agree to bring in the orange juice or quote policy.

At least half the interpreters talked of walking a fine line, as if on a tightrope, with the community as social system on the one side and the medical institution and interpreter industry on the other; invisible forces enveloping the decision-making process. The interpreters work to obtain balance as the winds of the ever-changing context sway them from one direction to another. Gladys observed that there are colleagues who simply follow the LtR practice, regardless of the immediate circumstances, however she reflects on the need to perhaps be more responsive in the moment: "I think that our line is constantly being remade…when you are actually on the ground, in the trenches…The lines are very porous." The lines are indeed porous, allowing, to varying degrees, the simultaneous presence of the social, the industrial and the institutional, creating individual moments of context in which the interpreter must act.

It may be said what does it really matter in the long run what the interpreters do with the in-between? Again, as quoted earlier, Jena, the spoken language interpreter said, "I have seen how much tension between providers and interpreters really affects the patient experience because it affects how the provider talks to them a few minutes later." It seems if the interpreter does not give thought to the in-between, there is increased likelihood of exacerbating tension and potentially impacting the quality of care for a patient.

FUTURE RESEARCH DIRECTIONS

The finding of the in-between was the result of an initial study. With the issue revealed, this author continued the exploration for a larger study on the social organization of the work on ASL-English interpreters in healthcare, but there are many possibilities for future research. The informants in the study were American Sign Language-English interpreters with one exception. Exploring the perspectives of spoken language users of minority languages regarding their lived experience as patients in healthcare and of their experience with interpreters in this environment would be beneficial. In addition, it would be interesting to learn if medical staff are aware of the interpreters' techniques used to appear or disappear. Further examination of interpreters' in-between experiences in other settings would enrich the understanding of this complex time and space. Research that would look at decisions around visibility and what impacts decisions about the when and where to be visible would influence the interpreters' ability to consider conscious, value-driven actions based on new knowledge that this research would provide.

CONCLUSION

The tension between maintaining the expected performance of professional-as-conduit and that of fellow community member is one that manifests in every interpreted context. In an environment such as the legal setting, the performance of professional-as-conduit overrules all other options because of the negative consequences to the SOLOTE should any impropriety be suspected such as the interpreter engaging in undue influence with the SOLOTE. Distance is necessary to maintain the integrity of the event. However, in other settings, the decision to remain in the role of professional-as-conduit or to shift to that of communication and community partner is more complex. The interpreter committed to a quality experience for the SOLOTE during an interpreted event may find herself wanting to become more visible as a partner; there to work with, not just for, the minority language user. For the interpreter to choose to be more visible not only as a participant in the discourse but as an advocate aligned with the SOLOTE is risky, controversial, and not always welcome by the SOLOTE or the representative of the institution (Hsieh & Hong, 2010). In addition, regulation, policy, contracts and other texts produced by those in power are describing expected conduct and the consensus appears to be to maintain the role of distanced professional. However, perhaps it is time the definition and expected performance of the "professional" was revisited. The professional interpreter could be one that engages with the SOLOTE to co-construct ways to even the playing field and gain access to the paths of navigation that exist in various social systems. The SOLOTE and interpreter could be granted permission, time, and space to discuss to what degree the interpreter will act as tool or as partner. Professional performance could visibly reflect expertise in responsiveness to the changing dynamics in an interpreted encounter rather than engage in responsiveness only in the in-between. Engagement with those with authority within systems and with SOLOTEs is needed to discuss how to achieve access to the products and services the systems have to offer. SOLOTEs' perspectives on what quality care and service means to them could provide much needed insight into how to effect positive change and empower these minority language users. It may be time for responsive professional performance to come out of the shadows so that all parties involved can discuss and negotiate how to achieve best outcomes for Speakers of Languages Other Than English.

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Section 3
Mental Health Interpreting

This section outlines some of the complexities of the mental health interpreting subspecialty.

Chapter 9
Interpreting in Mental Health, Anything Special?

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ABSTRACT

This article discusses some of the key issues of mental health talk in general, both in attitude as well as in words, and dwells upon the difficulties this can pose for interpreters. Subsequently, ways to deal with these difficulties are given. The issue of empathic stress is touched upon. It is argued that, with general background knowledge of disorders and treatment methods and with support to deal with emotional situations, interpreting in mental healthcare will be a very rewarding type of work. Without such preparation and ongoing support, interpreters may not always be able to join into the therapeutic communication properly, which may harm the progress of the treatment and may also hamper their own feelings of well-being and job satisfaction.

INTRODUCTION

The medical sector is a wide and differentiated field. So, it is probably true that each medical specialisation poses specific challenges to interpreters and has its own specific requirements for them. In this chapter, the focus is on interpreting in mental healthcare which differs from the somatic sector on at least one very important point: complaints can nearly only be expressed in words, next to some additional observation of behaviour. Analyses of various bodily fluids, palpation, testing of reflexes, listening to bodily sounds et cetera are relevant in the somatic realm; in mental healthcare only as far as somatic checks relating to medication are at hand. In mental healthcare there is a strong dependency on words in interaction with the patient for both diagnosis and cure. For interpreters this implies a heavy responsibility. The objective of the chapter is to provide the reader with some background knowledge of the characteristics of mental health talk in general and the specific ways interpreters have to relate to these in order to do a good job and to ensure long lasting job-satisfaction.

Some of the key issues of mental health talk in general; both in attitude as in words will be outlined. After that, the influence of these issues on the attitude of the interpreter is described in some depth and

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the amendments that interpreters may need to make – deviations from most Codes of Conduct – in order to ensure effective communication. Following that, some problems that the words of both therapist and patient may give the interpreter, are outlined in some detail; solutions are discussed. Specific problems, interpersonal and emotional, can arise in mental health talk due to what is called 'empathic stress' and this is discussed as a third aspect. Empathic stress may pose a challenge to the emotional welfare of the interpreter and may affect his proper functioning in the sessions. As far as possible, issues are illustrated on the basis of scientific investigations of interpreter mediated mental health talk or on basis of the authors ample experience with interpreter-mediated mental health talk as a practising psychotherapist working with patients with severe psychiatric disorders and her discussions with interpreters both while working together in actual mental health talk and in training situations.

MAIN FOCUS OF THE CHAPTER

Within the field of mental health care there is much variation in aim, method and style that is impossible to capture in a single chapter. Necessarily, the focus is on the general characteristics and three important aspects of mental health talk.

The Therapeutic Relationship and Therapeutic Interaction

Psychotherapy both refers to a general psychotherapeutic conversation technique and to specific treatment methods.

First and foremost, in both modes, attitude is of utmost importance and there is remarkable agreement amongst the various schools of psychotherapeutic thought about how this attitude should be. The basic characteristics of the attitude of the therapist are: understanding and non-judgmental. The therapist has a positive approach, he conveys empathy, he is authentic and shows a healthy trust in his own treatment methods.

In fact, this psychotherapeutic attitude is seen as the 'common factor' in psychotherapies which, together with the relationship between therapist and patient, has proven to be the most important factor contributing to therapeutic improvement (Wampold, 2010; Wampold & Imel, 2015). Since the early 80's of last century, therapists' qualities as perceived by patients have been given research attention. Rating scales have been developed and the most important factors (does the patient see the therapist as attractive, trustworthy and as an expert) determined (Corrigan & Schmidt, 1983). Evidence is arising that the early (immediate) impression the patient has of the therapist has a significant effect on the outcome of the therapy (the better the impression, the better the outcome) (Reefhuis et al., 2019).

The relationship between therapist and patient is an asymmetric one. The patient talks about his problems and innermost feelings, thoughts and behaviour. The therapist listens and his reactions are directed at understanding the patient and helping him to improve. Sometimes, however, some talk about himself, by the therapist, can be helpful in the therapeutic process. In psychotherapeutic terms this is called call 'self-disclosure' and it may be used as a technique.

Secondly, therapeutic talk focuses on problems that are usually not spoken about frankly and openly in everyday social talk. Therapeutic topics are often connected with feelings of shame, guilt, aggression, jealousy; feelings that one usually finds difficult to admit and speak about.

Thirdly, therapeutic talk deals with feeling, thinking and behaving and focuses on changes that specifically fit this particular patient. Patients will only adhere to new ways of behaving, thinking, feeling, when these new ways feel 'good', are 'fitting' and when they have been actively involved in the process of finding, discovering and experiencing these new ways. This implies that therapists usually do not prescribe (new ways of feeling, thinking and behaving) but negotiate, suggest and in general encourage the patient to actively cooperate in finding these new ways. And sometimes, therapists just listen.

On top of this, the development of the interaction between therapist and patient and the evaluation thereof by the therapist, is a diagnostic tool in itself: it helps the therapist to understand some of psychological and relational problems and the psychodynamics of the patient. The (developing) interaction is also an important constituent part of the patients cure, as a 'corrective emotional experience' (term coined by Alexander & French, 1946). For example, the simple fact that the therapist has a genuine interest in the patient and his problems and listens actively and carefully can be a completely new and healing experience to a patient with a history of neglect and abuse.

Therapeutic Communication: Therapists Interventions and Patients' Utterances

As far as the words are concerned, the focus in this chapter is on general characteristics of psychotherapeutic talk, using mainly the classification of Hill called the Hill Counsellor and Client Verbal Response Modes Category System (Hill, 1986), which is meant to be pan-theoretical. The various psychotherapeutic schools of thought that have developed over the last century each have a specific terminology and a specific way of phrasing interventions of which only some salient features are mentioned.

Therapists phrase their interventions cautiously and meticulously and they listen carefully to the words the patient utters and observe his non- and paraverbal behaviour in order to build the therapeutic relationship, to involve the patient in the treatment and to make sure the treatment becomes a proper corrective emotional experience. Therapists do not only listen to the content of the patients' words, but also to how the patient phrases his utterances and which words he uses. He is also attentive to what the patient does not say.

In the 1980's Hill developed a pan-theoretical categorisation system that could and has been used both for research and for training (Hill, 1986). Very briefly, Hill's categories comprise the following. Therapists encourage the telling of the patient with minimal continuers such as mmm, yes, and go on. Silence is also used as a technique: the therapist listens and does not immediately react to patients' words. Either because he expects more to come, or because the thinks about what to say next or because he just feels some pause is necessary. Therapists give approval and support, they sometimes give information, they may give instructions about the therapeutic process itself or because homework needs to be done (exercises for example in behaviour therapy). They reformulate what patients just said and reflect on what has been expressed. Therapists ask numerous questions, both open and closed. These can be questions into facts or past events, or for feelings felt or they probe for feelings underlying the facts and happenings, or for feelings underlying the expressed feelings or they ask for a reflection on those feelings. They can also give feedback. Self-disclosure and social talk are also part of the toolbox of therapists. From this very brief overview it already becomes clear that there are many categories that are not as easy to understand and to differentiate between. Maybe it suffices to say that therapists' questions are often geared to explore, dig up and understand feelings and thoughts that are hidden under the surface talk about facts and actions and that are often difficult to talk about.

On top of these categories, therapists also shape, at least partly, their attitude in words. They do this, for example, by using phatic communication, i.e. the use of words to build up social contact while it does not add to the content of the conversation. This often takes the form of short introductory statements to an interventions like 'you just said…'. Although those words do not add information to the conversation, they signal reciprocity, they signal 'I heard you' and thus add to the building of rapport.

Many therapeutic schools of thought exist, each with their own treatment methods. Most of them use specific vocabulary to phrase their interventions; often, ordinary words are used in a specific way with a specific meaning.

The reactions of patients to therapists' interventions are, of course, not bound to specific rules belonging to the school of psychotherapy they are treated in. For therapists it is important to know when their patients have a specific language-use that deviates from general norms. For example, are they using words that they have invented themselves, are they incoherent in their talk, speak unusually ungrammatical and so forth. Also, grammatical issues like speaking in a passive or active tense, are important. Does the patient speak about himself as an acting person, or as someone who is passively undergoing ('victim') things that happen (to him)? Does he maybe speak of himself in the third person? Does he use a specific style? Therapeutic listening comes to close 'reading' of what the patient conveys.

Empathic Stress

People who work a lot with other peoples' traumata, like physicians, nurses, psychotherapists and emergency workers, may develop symptoms in response to their patient's suffering. It can make them ill and it can also influence their attitude towards the work they do and the patients they treat: empathic stress.

The stress that their patients are experiencing is sometimes that overwhelming that health providers find it difficult to remain stable and professional. The originally felt empathy and compassion can turn into unproductive reactions and negative feelings and thoughts (such as disbelief, 'they are overdoing their stories') or they may feel their own effort is not enough and may feel helpless facing so much misery and start to do more than they should do like helping with practical issues (over-committed). The phenomenon has been thoroughly investigated for all sorts of health providers (see for example Pearlman & McCann, 1990; Pearlman & Mac Ian, 1995). Specifically, the empathy, necessary to understand the patient, is a risk factor for developing symptoms (Palm et al., 2004) which may not only lead to an unproductive stance in the work these health workers are doing but may also lead to their own burn-out due to secondary traumatisation.

It is not difficult to see that when an interpreter is engaged in the process of therapeutic talk, this will have an impact on the therapeutic relationship and on the interaction which are both shaped in words, but also in all sorts of nonverbal and paraverbal behaviour.

What Does This Mean for the Interpreter Attitude?

A Workgroup

In general, it means that interpreters have to be aware of the fact that in mental healthcare sessions, building, analysing and working with the relationship between therapist and patient is the main constituent part of the cure. This relationship is shaped both with words and with gesture, gaze, posture and paraverbal means. Interpreting in such a situation means that the interpreter becomes part of this relationship – ir-

revocably, whether the interpreter wants this or not. In order to help the treatment, it is important that the interpreter plays a constructive role – supporting the therapeutic attitude.

How should this be done? It is important that the behaviour of therapist, interpreter and patient is well attuned, all for the common goal of a smooth-running session. A theoretical background to this importance of the cooperation between all three participants – therapist, interpreter and patient - comes from the group dynamical work of the British psychiatrist Bion in which he defines the term 'work-group' (Bion,1961). A 'workgroup' is a group of people who work together constructively to achieve a common goal, it implies that they know how to solve problems in the cooperation might they arise. The trio therapist – interpreter - patient should function as a 'workgroup'. According to Bion, the formation of subgroups within such a group, is counter-productive. One person being out of tune may disrupt the working process. When in such a workgroup problems in the cooperation arises, they will be solved openly and effectively. For example, in a workgroup of therapist, interpreter and patient it sometimes happens that a patient does not agree with his therapist or with another professional he has to deal with, or with the interpreter. The patient may be angry with the therapist for example for not granting an extra session or with the co-treating psychiatrist for not prescribing certain medication, or with the interpreter for not 'translating well'. Any of these issues needs to be solved, not by siding with the patient against the person he is angry with – a subgroup would then emerge - but by talking about the issue at hand and encouraging the patient to deal with it. So, the issue about the extra session needs to be talked about with the therapist; the patient has to be encouraged into telling his psychiatrist that he is not happy with the medication he gets and thus finding out if anything can be done about it. And the problem with the interpreter can be talked about in the session with as a starting point: the interpreter tries to interpret faithfully but he might have misunderstood or misheard. How can we solve this? What did you mean to say? And of course, the interpreter has to interpret this discussion to both sides. Siding with the patient may seem helpful at first, the patient feels supported at that moment. But such formation of a subgroup hampers the cooperation within the group patient-interpreter-therapist or within the group of people involved in the treatment of this patient. And the patient does not learn to solve problems that arise in any relationship and that have to be talked about in order to make the relationship long-lasting and sustainable and the workgroup repaired. It means that the interpreter has to know and understand this principle and has to be willing to engage is such a discussion.

In order to be able to function as a workgroup it is necessary that the therapist and interpreter know about each other's 'trade'. The therapist has to understand that he cannot ask the interpreter to function as a 'cultural informant' as that would be way out of the interpreters' job description. He also has to know that 'faithful interpreting' does not mean that the interpreter renders a 100% equivalent of the patients (and the therapists) words. They both have to understand that it is sometimes necessary to meta-communicate about the meaning of words. And interpreters have to know that they sometimes have to step out of their role of neutral and uninvolved participants, in order to support the flow of communication in the session. Being too neutral can hamper feelings of security and thus the free flow of the conversation.

The First Impression

Patients' first or early impression of the therapist is a codeterminant for a positive treatment outcome. It seems safe to extrapolate these finding to the interpreter: a good first impression of the interpreter helps to create an atmosphere in which the patient feels free to talk about sensitive issues. The three most important factors that are used to assess this first impression are: is the therapist seen as attractive,

trustworthy and as an expert. These three factors are measured by asking the patient to rate the therapist on 12 factors: friendly, likeable, sociable, warm, experienced, expert, prepared, skillful, honest, reliable, sincere and trustworthy (Tracey et al 1988). It is wise for interpreters to keep these in mind. Although it is hard to tell how exactly one should manipulate one's behaviour in order to make this good impression, it is good to bear in mind that a favourable score on these factors may help in being experienced as professional and that this helps to create a favourable environment for treatment.

The Therapeutic Attitude and the Interpreter

Sometimes it is necessary for an interpreter to step across the line of non-involvement in order to fit into the therapeutic attitude. For therapists, some social talk and sometimes also self-disclosure, i.e. saying something about oneself (facts, opinions, feelings), is a necessary ingredient to a therapeutic session, to ease the conversation and strengthen the relationship. For interpreters counts the same. The next example shows that trespassing the neutrality-boundary can be helpful.

In a Dutch mental hospital setting, a therapist is working with a young woman from a war torn country. She has been heavily traumatised, she is psychotic and some personality problem is assumed. She feels 'the enemy' is still everywhere around her. The sessions with her are difficult as she mistrusts everyone, but especially her country-people. In the session here described, a female interpreter is involved. The interpreter is of Dutch origin and the therapist knows that. The patient, as expected, is mistrustful and wants to know where the interpreter comes from. The interpreter, professionally, renders this to the therapist and suggests she tells the patient she is Dutch. The therapist agrees, hoping this will diminish patients' distrust of the interpreter. The interpreter tells the patient she is Dutch and studied her language in the Netherlands.

So far so good. Here we see an interpreter who deals professionally with a request to cross a professional boundary. In 2003, I already wrote about this phenomenon (Bot, 2003):

In the psychotherapeutic literature, the difference between boundary transgressions and boundary violations is made (Gutheil & Gabbard 1993). Violations are crossings of the boundaries that are harmful to the patient and his or her treatment, while transgressions are made within the context of ethical and adequate treatment. In psychotherapy, it has become clear that boundary transgressions can be initial steps leading to boundary violations when the therapist has not specifically defined why this transgression can be made in this specific situation (Gutheil & Gabbard, 1993).

The boundary transgression in this case consisted of some self-disclosure that was in this case useful to therapeutic relationship building and meant to do just that by the therapist. Boundary transgressions are OK, but also tricky, as the sequel to the above example shows.

The above situation continues, and suddenly the therapist finds himself listening to an entire discussion in a language he does not understand. Sometime later the interpreter renders this to the therapist. They have been talking about the quality of some specific food that is much better over there than in the Netherlands. The interpreter then tells the patient that she regularly receives parcels with this specific product from friends. This sparkles patients' mistrust again: as the interpreter receives parcels, she must have contacts with the secret service – is my patients' reasoning.

Here we see that, just as Gutheil and Gabbard (1993) warn for, one transgression leads to the next. The therapist knew why the first transgression was useful. The interpreter not trained in the intricacies of therapeutic boundary keeping and the ins-and-outs of this patient's diagnosis and treatment, was not aware of that and, seemingly happy to talk about some common interest, continued far beyond the first useful self-disclosing intervention. Informally, amongst therapists, the golden rule is to 'never volunteer information': answering a question from a patient is one thing, taking initiative in giving information about oneself is quite another. Not only can it give rise to undesired effects, as in the above example, it also directs the attention to oneself – and there it should not be – and turns the therapeutic sessions in a friendly tea-party. Self-disclosure should always be functional: concise, helping the therapy to takes a proper course.

In the above example, the patient addressed the interpreter directly, stemming from strong distrust based on severe traumatisation and a personality problem. A patient addressing the interpreter directly is a phenomenon that happens rather frequently when working with patients with severe mental illnesses specifically when personality problems are involved. In general, personality disorders have to do with problematic ways of making and establishing personal relationships, including problems in recognising, understanding and respecting (social) roles. The division of roles and tasks between therapist, interpreter and the patient him/herself is maybe not recognised and understood, and sometimes not respected. Specifically, with patients with a borderline personality disorder, a split between a good interpreter and a bad therapist - or the other way around is sometimes acted out aloud (Lidberg, 2001). It happens that interpreters get scolded or ridiculed, or praised far beyond reality, just as this happens to therapists. Interpreters have to know how to deal with this professionally. This means: being prepared (knowing that such a thing might happen); reacting calmly and friendly, not taking it personal and reacting offended, or too pleased; rendering the utterance of the patient to the therapist, asking (in words or gesture) the therapist how to deal with it, just as the interpreter did in the first part of the above example.

The patient presented here above was interested in the interpreters' origin. But patients may also ask for interpreters' opinion (about the therapist, about the treatment, about his or her own behaviour and actions et cetera) or help and can be quite persistent in demanding a reaction.

A patient is very angry with his therapist about something the therapist said in the session last week. When entering the therapy room, he is talking to the interpreter. The therapist does not understand, it sounds agitated and angry to her. The interpreter reacts to the patient, it sounds calm and soothing. As soon as they all sit down, the interpreter says something to the patient and renders this immediately: 'I just said to him that he should tell you what he just told me'. The patient still looks angry and fidgets in his chair. The therapist addresses him 'something seems the matter, can you tell me what it is about?' which is rendered by the interpreter.

Here we see an interpreter who takes an active role in the conversation after having been addressed directly just before the sessions start. Instead of refusing to get into contact with the patient (which probably would have increased his anger), the interpreter enters into a dialogue but directs it gently to the therapist – where it should be. Later on, the therapist asked, it turned out the interpreter told the patient 'what you say sounds serious, I think it is best you ask the therapist about what he meant with it'. The interpreter thus validated the feelings of the patient without giving an opinion (it sounds serious, not: it is serious) and without entering into further communication. After this the patient talks about his anger

and frustration and it is discussed further during the session. Talking about the irritation and misunderstanding strengthen the workgroup functions and the therapeutic relationship.

Now, an example of how things can go wrong. Here it shows that the interpreter lacks general knowledge of a therapeutic attitude and the goals and methods of mental healthcare.

A patient with a severe alcohol addiction is in treatment with a psychotherapist. He wants to stop drinking, he makes plans for a better life, start an education, get a job. He manages to abstain for a while, but then meets some of his old drinking-fellows, gets seduced and starts drinking again. As a result he has been truanting from school. The patient feels miserable about it and feels that all is lost now and he thinks that he will probably never manage to stay clean. The interpreter who helps them to communicate shows subtle discomfort during the session (sighs, slight frowns) and she tells the therapist after the session that she feels irritated and embarrassed by this fellow country-man who 'messes up', 'abuses the social services' and in general 'gives us migrants a bad press'. She feels 'the treatment is bound to fail'.

Although this feeling of irritation and embarrassment may be understandable, it is not a therapeutic attitude. The basic therapeutic attitude is being understanding and non-judgmental. And a therapist is empathic, positive, and authentic and has a healthy trust in his own treatment methods. The therapist knows that (a) it is very hard to abstain from an alcohol-addiction, that relapse occurs often and does not mean that 'all is lost' but that a restart needs to be made. In this particular case, he also knows (b) that there have been understandable reasons why the patient started drinking as a way of self-medication, (c) he supports the patient in his wish to improve and (d) has trust that the treatment may help the patient maybe not to abstain completely but at least to get some grip on his drinking behaviour. His attitude of 'understanding' may show in words that express his empathy with what has happened ('what a pity' and such words), he does not get angry nor judgmental but, contrary, gives hope by showing trust in the treatment ('good that you have started treatment here and that you tell me frankly that you relapsed last week, so we can work together in how you can possibly avoid this in the future'). The therapist does not judge the patient as a weak person who does not know how to resist temptation, but feels with the patient (empathy) about the disappointment, and is supportive. He may say something like 'it is hard to stop a habit with such a strong physical addictive power'. So, the therapist may, with the patient, have a negative attitude about this particular behaviour, but he will still be empathic with the patient as a person, struggling to overcome his addiction. Authenticity is maybe the hardest characteristic of therapeutic talk. It may show, in this case, in words that acknowledge the pleasant effect of a little alcohol on feelings of wellbeing. In general, it means that the therapist does really believe in his treatment and genuinely feels empathy with the patient and this will translate itself in non-verbal and paraverbal behaviour.

In this example, patient, therapist and interpreter did not function as a 'workgroup'. The critical and negative attitude of the interpreter showed. This was felt by the therapist, and probably by the patient too (he was not asked about it). It cost the therapist energy to overcome the feeling of being criticised.

In the above example, the interpreter doubted the use of the treatment and this affected the therapist negatively. Therapists are sensitive and do worry about what interpreters may think of them and the treatment they give (Bot 2005). This sometimes intensifies the therapist's own doubts and insecurities. One therapist said that she herself feels sometimes that she can do so little for the asylum seekers she treats, and she worries what the interpreter might think of her work. Therapists usually know that interpreters work with many different therapists and, especially inexperienced ones, fear the interpreter may judge

them negatively. This worry may be imagined, i.e. not felt by the interpreter. But interpreters should be aware that their expressions - verbal, nonverbal, paraverbal - count in all detail.

Summary

In general, it feels as helpful to therapists when interpreters follow their attitude towards the patient (Bot, 2005). They have to blend into the atmosphere of the session at hand. Preferably they shadow the therapist, i.e. they should portray the same attitude albeit in a somewhat softer way. For example, when the therapist laughs about something the patient said, the interpreter will smile. If, in that case, the interpreter would refrain from smiling and keep a 'poker face', this could hurt the patient (and therapist) in their sharing of something pleasant and may even give them the feeling of being ridiculed. 'Neutrality' can be perceived as 'not interested' and could as such form a hindrance to the patient; he may not feel invited to speak openly about his problems.

The therapist pays a lot of attention to shape a therapeutic relationship fitting this particular patient and the most he can hope for from the interpreter is to follow suit. Without feeling a real interest and empathy with the patient one is treating, it is hard, if not impossible, to do this type of work effectively. And the same applies to the interpreter. Without an interest in his clients (both therapist and patient) and the words they utter, he will not be able to blend in properly and to interpret faithfully

What About Interpreter Renditions?

Therapist Interventions and Patient Utterances

There is not much research that systematically focuses on the words and their renditions in interpreter-mediated (mental) health talk. Ever since Wadensjö's seminal work, more attention goes to the coordinating role of the interpreter (Wadensjö, 1998). Some people say, even therapists, that the exact words do not really matter. They emphasise the importance of attitude plus the fact that 'something' is being said. On the other hand, in psychotherapeutic theory and technique, there is an emphasis on the importance of wording experiences, feelings and thoughts (sharing, making them explicit, allowing to reflect); on 'finding new words' for these experiences and feelings and thoughts (giving a different perspective, meaning or to replace 'unrealistic thoughts') and on the importance, for therapists, to listen carefully to exactly how their patients phrase their utterances. The approach followed here is that words and attitude matter both. This is supported by findings of research in psychotherapy that attitude explains part of the therapeutic success, together with a properly explained and systematically carried out therapeutic technique. And technique is shaped in words. Which technique exactly is of less importance (Bot & Schaepkens, 2018). Also, rendering words of the primary speakers is the 'bread and butter' of the interpreter; it is their *raison d'être*.

In the introduction, the Hill Counsellor and Client Verbal Response Modes Category System (Hill, 1986) was mentioned. The author used this system to analyse interpreters renditions in the material collected for her PhD research to assess one of the aspects (therapeutic equivalence) of the equivalence concept that was developed to assess the interpreters' renditions: if the original utterance and its rendition scored in the same Hill category, the rendition was assessed as faithful on this aspect. Several of therapists' interventions were actually a sequence of several categories, glued together in one turn.

A brief overview of the Hill categories and the difficulties in rendering some of these interventions follows here together with some reflection on what would help interpreters to render faithfully.

The first three categories of Hill's system seem simple enough: minimal encourager, silence and approval/support/reassurance. These usually concern short interventions. A minimal encourager is a neutral intervention, the therapist showing the patient that he is following, understanding, it serves mostly as a continuer and often overlaps with the primary speaker. Silence could be a thinking pause, it can serve as a time-out to let emotions either sink in or decrease; it may have an explicit function as time-out when irritation arises and seems to turn into aggression. Approval, support, and reassurance could also serve as a continuer, but is not neutral: it provides emotional support, approval or reinforcement - may imply sympathy or may be meant to alleviate anxiety. Although these three are simple interventions, they serve an important function. They often signal reciprocity (I'm listening; I'm hearing you; still with you), they steer the pace of the session and of emotional involvement, they convey empathy (good; you did well; yes, that is okay). Next to the words, the tone of voice is usually an important factor in its effect.

Very often the interpreter does not render such brief interventions. Often, they occur during the turn of the patient and are clear without translation (mmm, yes). But remarkably, when these kinds of interventions appear in the form of brief phrases, such as yes or good (often placed at the beginning of a much longer intervention) it is also relatively often skipped by the interpreter. Interpreters, so they told in an interview, see this often as unimportant 'fringe'. They seem to see it as phatic communication that does not deserve rendition. Albl-Mikasa and her research team found out that phatic tokens, just as modalisations, and hedges are often not rendered in doctor-patient communication (Albl-Mikasa et al., 2015). Interpreters do not see this as the core of the communication, while it serves an important role in the building of a therapeutic relationship, which is 'core business' and needs to be rendered.

It seems obvious that silence does not need to be interpreted; it is clear as it is. Specifically, when the interpreter works over the phone, it can give rise to misunderstandings. The interpreter does not hear anyone speaking and may think the line is disconnected and intervenes with 'do you still hear me', thus disrupting whatever was going on. Therapists should be aware of this and give some verbal clue to the interpreter that they are silent for a while. Some people find silence, in an on-going session, awkward. Interpreters should make sure they can bear it.

The categories of information giving and instruction do not usually pose many problems. Information, given by the therapist, may be about something external, information that does not concern the therapeutic process as such, but for example explains procedures in the asylum procedure of how to get help to find a house. Information can also be about the therapeutic process itself, explaining theoretical or technical aspects of the therapy. This information can also be helpful to the interpreter, as it explains the rationale of the therapy and as such gives background information that can help the interpreter to shape his renditions. The same applies to the category instruction, which can be a process-directive or advice or homework to be done by the patient. It also serves a double function as it may also help the interpreter to understand the process of the treatment.

In general, interventions that give most problems to interpreters are all sorts of questions and reflections that focus on the exploration of inner feelings or that reflect on expressed or underlying experiences (Bot, 2005). Therapists have the tendency to probe: to ask for feelings and emotions that lie beneath the surface and which may explain why the patient is suffering as he does and/or is so persistent in his problematic behaviour or distress. This often leads to series of questions, each going a step further into finding out what is 'really' the problem. Problems in rendering are sometimes related to questions that are phrased tentatively or differ only in a subtle way from what the patient had just said (Bot 2005). The

interpreter might thus have problems in identifying the question-format or in recognising the difference in phrasing. An example is the following:

A therapist is exploring the feelings of a patient whose leg is amputated and which still gives him a lot of pain. He doesn't want to know the people around him to know he is suffering as he does not want to be pitied by them, that would be 'psychologically heavy' for him.

The therapist then asks 'can you explain why it is psychologically heavy for you when people express compassion?'

Which is rendered as 'can you tell me why you don't talk about it? Maybe because they will feel sorry for you?' (Bot, 2005)

Here we see that the interpreter, apart from rendering in a very loose way, does not translate the step to *why* getting compassion is difficult, but stays with 'getting compassion may be difficult', which is what the patient had just said himself.

Therapists can be taught to help the interpreter by wording their inventions clear and unambiguous. In this case, for example, they could introduce such a question with a short phrase in which they explain that they are going to ask a little further. For example, 'yes, I understand it is heavy for you but I would like to know why is it difficult when people are compassionate with you.' In this way both interpreter and patient are helped to understand the process they are in.

The above problem might have arisen because of ambiguous phrasing of the question by the therapist. However, there might also be another, underlying, problem at stake.

In training sessions (mental health specialisation for interpreters) the author makes use, amongst other training material, of training videos made for therapists. One of these is a training video for schema therapy for borderline patients and one of the episodes used is about a patient in the 'angry child' modus. Immediately after entering the treatment room the patient starts venting his anger, fulminating against the fabulous parking fees he has to pay when seeing his therapist, smashing his car-keys on the table. The therapist listens, does not go into the issue of the parking fees but starts asking what else the patient is angry about. Step by step, always asking 'what else' questions, therapist and patient arrive at fundamental issues between the patient and his father that still make him very, very angry, but also 'sad', 'not seen', over-asked' et cetera.

In these teaching sessions it has appeared that interpreters find this episode, the probing, 'odd' and sometimes 'ridiculous', they do not see 'the point' in those questions; they even become angry, finding the repetitive way of questioning nonsensical. And when interpreters find the interventions of the therapist strange, odd, ridiculous or when they make them angry, they will have some problems in carrying out their task: it will be hard to be empathic towards the therapist, to support his strategy and it probably also interferes with his capability to translate faithfully. If one doesn't understand the purpose of a question, it could be difficult to find the right words to render it. So, the problems found in these renditions may well have to do with a general lack of background knowledge of therapeutic techniques and their underlying principles with the interpreters.

Another issue in the 'questions category' is the difference between open and closed questions. Open questions are used by the therapist to invite a telling, to make the patient give information. But they are also used, more often, to invite the patient to probe his own mind and to come up with underlying feelings, motivations and thought. Most often, the therapist takes the 'not-knowing' stance and puts the patient in the 'expert' role: the patient is the expert, the knowing person, of his inner life. When an open question is rendered as a closed question, the therapist already points into a specific direction, putting him in a more 'knowing' position. And this happened relatively often in Bot's material (2005). The difference with reflections is also a difficult one. A reflection, from the part of the therapist, formally takes the form of a question. But because it reflects something the patient has just said, albeit most often in different words, it also has some element of a statement in it. An example is the following phrase, a reflection on an underlying feeling, from the therapist, directed at the patient: "because you feel in fact, you ask forgiveness, you feel in fact guilty to the fact that father has been in prison?" (Bot, 2005).

Just before this intervention, the patient had said that he asked his father forgiveness and it could be derived from former utterances that this was because father had been imprisoned and the patient thought that this had to do with his actions. 'You feel in fact' is a statement, but the phrase has a rising - question- intonation and is meant for the patient to think for himself whether this could be 'true' or not. Minor changes in the rendition - including a change in intonation profile – could thus change this turn into a statement with a therapist stating that the patient does feel guilty.

Some other categories did not clearly give problems in the interpretation per se, although of course here and there, deviations were found. The category 'self-disclosure' – as in self-disclosure by the therapist - did not give rise to specific interpretation problems. When asked of the interpreter it is a different story - as discussed here above.

Of course, the Hill system is only one way to categorise therapists' interventions and their renditions. Some psychotherapeutic techniques use ordinary words in a special meaning. For example, 'protecting' often gets a negative connotation as it is equated with 'over-protection'. But when the interpreter connects it with 'caring for' (Bot, 2005) it loses this negativity. In motivational conversation techniques, often used to help people overcome their ambivalences in therapy, it is customary that the therapist asks permission to touch a topic. He may say 'you just mentioned your drinking habits, is it alright with you if I ask some more questions about that?' Interpreters find this often a bit weird, specifically when this is done more often in a session. And when they find it weird, do not understand its purpose, they may often 'forget' to render it. So, the pitfalls are numerous and will of course never be covered completely. Even the wise advise 'if in doubt, ask' will not cover all misunderstandings. Sometimes you just do not know that you misunderstood.

Bot (2005) found few changes in therapeutic perspective in patients' turns. The Hill categories for patient turns are not dealt with in this chapter. Illustrated with examples, some general remarks can be made about difficulties specific to mental health, in rendering patients' turns.

In a mental health clinic, a judge interviews a patient in order to assess the justification for a forced admission in the clinic. The patient speaks French. In the Netherlands, judges have to speak Dutch in their official sessions ('Dutch is the language of the court'), a French interpreter is asked for. He works over the phone. The patient is a quiet man, who enters the session with some large dictionaries in his hand, which he puts before himself on the table. During the session he leafs through the books. After the judges first question, he starts a long monologue. After some minutes, the interpreter breaks in. He says: 'I'm very sorry, I can understand the words that are spoken, but I cannot interpret this for you'.

The judge replies in fluent French and says he completely understands the problem of the interpreter - he is not to blame and he thanks the interpreter for his meta-communication.

Here we see a proper way to use meta-communication: some patients speak in such a way that interpretation is impossible. A sequence of random words, maybe loosely connected through alliteration, could probably be translated, if one has enough time, but are nearly impossible to interpret. In those cases, the interpreter should explain the characteristics of patients' talk to the other primary speaker.

The style patients use to phrase their utterances may also pose problems sometimes.

A male patient, quite a rough type, has been working as construction worker before a war started that changed his life completely. He enters therapy, with an interpreter, because of serious anxiety problems. In a session, the interpreter suddenly, before rendering patients' words, turns towards the therapist and says 'he is using such beautiful words, I cannot interpret that properly, but you should know this, it is really poetic.' The therapist acknowledges this to the patient and he tells her that he used to read a lot, but now feels unable to do so because he cannot concentrate. Thus an entire new aspect of a patient's life was uncovered.

Also here the interpreter successfully meta-communicated about patients words which opened up new material in the treatment.

What About Empathetic Stress?

Empathy is a risk factor for the development of symptoms of secondary traumatisation and other stress reactions in care providers. Interpreters also need to be empathic in order to understand the clients they are working for. So, one would expect interpreters to be prone to secondary traumatisation as well. Baistow (2000) did a survey in several European countries and found that half of the respondents sometimes suffered from anxiety or changing moods due to the interpreting work. The fact that interpreters are often not very well paid, adds to their general personal stress levels which is also known as a risk factor for the development of this kind of negative reactions (Baets, 2013). Although these empathic stress reactions may occur in a lot of situations in health care, mental health care might be more burdening than other specialisations. In general, the level of expressed emotion is high in mental health talk. Interpreters have to render their patients' traumatic experiences, preferably in the 'I'-form, which may pose problems when talk is about ugly events (Wallmach, 2002). And when they have gone through traumatic events themselves this could evoke their own memories and feelings of distress. Interpreters, who have been asylum seekers themselves, do sometimes recognise their own experiences in their patients' stories. A sign language interpreter told in an intervision group about the difficulties she had in signing about sexual violence and its graphic nature in sign language.

So, there is reason to assume that interpreters run the risk of developing empathic stress reactions that may interfere with their functioning.

SOLUTIONS AND RECOMMENDATIONS

Unfortunately, in the Netherlands, the country this paper is written from, most interpreters have not been trained specifically for their work in (mental) healthcare, nor are they part of a team. They are being hired per session and have no information about the session beforehand. They usually have a training focussing on their work in the judicial realm in which they have been told to be 'impartial' and 'neutral', fitting with the adversarial system of the court. In therapeutic talk a somewhat different attitude is usually more helpful but as it implies deviating from the neutral stance, this sometimes feels 'risky' for the interpreter. The therapeutic attitude may be called 'neutral' and 'impartial' in the sense that the therapist is non-judgmental about the person of the patient; he may be judgemental of some actions of the patient, though. But more important, the therapist empathises with the patient; he is positive and authentic and the other adjectives mentioned above – and this differs from the neutral and impartial stance. It is not easy to shape such an attitude in coordination with the therapist: it means a continuous alignment between therapist and interpreter.

Interpreter-mediated session in mental healthcare ask for close cooperation between therapist and interpreter. Therapist, patient and interpreter together form the therapeutic relationship, which is necessary to make the treatment successful.

To make this happen, it is necessary that both interpreters and therapists be trained in this type of communication. Interpreters need generic knowledge of mental healthcare (its organisation, basic knowledge of the most important disorders and treatment methods) and skills training in attitude issues in mental health sessions. Therapists need training in the intricacies of interpreter-mediated talk. They should know what they can expect from an interpreter and how they can help the interpreter to blend into the session. They also need to be aware of the importance of chairing the session properly to avoid overlapping speech and too long turns. And they have to be aware of the importance of phrasing their interventions unambiguously, in properly constructed and grammatical sentences – which not only helps the interpreter to render faithfully but also helps to keep focus in therapy.

Finally, in order to keep empathic stress (also called vicarious trauma or secondary trauma) at bay, it is important that interpreters get support through intervision and supervision.

CONCLUSION

This chapter dealt with the question whether there is anything special about interpreting in health care. The answer is 'yes, there is'. Basically, there are five fields that ask for special attention.

Firstly, mental healthcare deviates not a small bit from 'ordinary' talk. Although the set-up of the sessions may not be very formal and may seemingly not follow a specific format, the topic of talk does not follow 'normally accepted' social rules. In mental health sessions patients talk about topics they do not speak about in social interactions because they may feel ashamed or do not want to be judged as 'crazy'. On top of that, therapists do not react to those stories in ordinarily accepted ways: they may be confronting, they 'ask permission to ask a question', they may 'bluntly' ask how the patient feels about the therapeutic relationship, and they may give very personal feedback. Instead of 'covering up' ugly histories, they may probe for all details. These are all things that we usually, in ordinary social talk, refrain from. The unaware and unprepared interpreter may feel awkward in such a situation. Notwith-

standing, there are exceptions; for example, EMDR sessions do follow a strict format with prescribed wording of interventions.

Secondly, in mental health care, the relationship between therapist and patient is of utmost importance in order to create the atmosphere in which change can take place. But is also a diagnostic tool and is used as an instrument of change. The interpreter is part of the process and has to know how to fit into this process. This may include behaviour that does not fit into the, most often, very strictly formulated codes of conducts for interpreters.

Thirdly, in mental healthcare talk can be emotionally burdening for both the therapist and the interpreter. Rendering patients' words about trauma in the first person poses a heavy load. In sessions with asylum seekers and refugees, the stories of the patient may seem very familiar to an interpreter who shares the same asylum seekers background. The stories he has to render - about atrocities, a difficult flight and so on - may be very much like his own history. This can evoke emotional reactions that the interpreter has to deal with.

Fourthly, patients with severe mental disorders, specifically when personality disorders are concerned, may try to drag the interpreter into the conversation, as a conversation partner. Or they may be aggressive, overtly disrespectful or they may praise the interpreter beyond reality. To steer clear, the interpreter needs to know how far he can go in reacting directly; he should not take it personally but at the same time he should give a personal reaction that also fits in with the attitude of the therapist. Being neutral can easily be perceived as too neutral in such circumstances.

Fifthly, the language therapists use is sometimes difficult to understand as he may use words in a different connotation as we are used to; moreover, words that feel like 'fringe' are also of importance and need to be rendered. Patients can tell hard or impossible to understand stories, may use newly coined words and speak haphazardly – forcing the interpreter to meta-communicate with the therapist.

For the unprepared interpreter, who has only had a general training that is usually focussed on interpreting in the judicial realm, interpreting in mental healthcare may be rather difficult. The unprepared interpreter will find various situations in mental healthcare odd, he will not understand therapists interventions and / or patients utterances and will feel awkward when boundary crossings are clearly asked for but feel out of bound for him. Interpreters need to be prepared well for working in mental healthcare sessions: they need to know the background of interventions and have a basic knowledge of the most occurring disorders. And they need skills training to learn how to deal with interpersonal and emotional situations in practice. In order to cope with the mental burden of stories of trauma and other emotionally difficult situations, interpreters need to be embedded in intervision or supervision groups which can help them to stay clear from unproductive reactions.

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Chapter 10
Interpreting for Victims of Violence:
Its Impact on Victims and Interpreters

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ABSTRACT

Victims of violence and interpreters share one trait: they are susceptible to trauma-related sequelae. Direct victims may develop PTSD while interpreters may develop vicarious trauma. This chapter sets out the legal basis for language access in healthcare, noting the important quality dimension added by the ACA. It then reviews the statistics for various forms of violence and presents some of its enormous societal costs. It also highlights the similarity of some of the symptoms observed in persons suffering from vicarious trauma, PTSD and burnout, but notes the difference in the genesis of these three conditions. This is followed by an introduction to trauma-informed approaches in delivering victim services. Finally, it lays the basis for identifying VT symptoms, mentions two online instruments that might be useful in assessing the likelihood of vicarious trauma, and reviews types of self-care techniques for creating a personal self-care plan.

INTRODUCTION

Interpreting for victims of violence is not easy. Human beings at their best are by nature empathetic and can absorb the trauma of those they interpret for. Some cases are more difficult than others, but all take their toll. This chapter will provide some background on the pervasive violence in society that makes it likely that interpreters will be called upon to interpret for victims who have been subjected to a level of violence that may be unfamiliar in their own lives. It is not unexpected that victims of violence may suffer long-term damage from their experience; however, all who encounter victims on their path from the trauma to physical and psychological healing may also suffer from their exposure to the trauma of

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others. The victims suffer primary trauma and those in the helping professions may suffer secondary or vicarious trauma.

This chapter aims to introduce interpreters to the concept of trauma –informed interpreting, which ideally should parallel the trauma-informed services provided to these victims. Finally, this chapter hopes to sensitize interpreters to the indicators of vicarious trauma so that they can address these symptoms and develop a self-care plan to prevent, or at least mitigate, its effects on those who interpret for the victims of violence, enabling them to continue to provide these indispensable language access services.

BACKGROUND

The Right to an Interpreter

The basis for language access to an interpreter in courts, social services and healthcare, as well as in many other programs in the U.S., is found in Title VI of the 1964 Civil Rights Act, which reads:

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 subject to discrimination under any program or activity receiving federal financial assistance. 42 U.S.C. §2000d.

The purpose of the Civil Rights Act was to ensure that no federal monies could be used in support of activities and programs that are discriminatory, and in 2000 President Clinton strengthened Title VI by issuing Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency." Following Clinton's Executive Order [EO] the Civil Rights Division of the United States Department of Justice [USDOJ] issued a Policy Guidance (https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf) setting forth compliance standards that recipients of federal funds must follow in order to ensure that the programs and activities they normally provide in English are also accessible to limited English proficient (LEP) persons and thus do not discriminate on the basis of national origin in violation of title VI of the Civil Rights Act of 1964.

Because many entities operating in the justice, social services, and healthcare fields receive federal funding (e.g., the courts (both criminal and civil), police and sheriffs' departments, corrections, public safety, emergency services, hospitals, health departments, social services agencies, health plans, non-profits, clinics, and even sole practitioners who accept Medicare or Medicaid reimbursements), language access in the courts and healthcare is covered, and all of these entities must comply with their obligations under Title Vi and Executive Order 13166. The coverage net stretches broadly and covered entities also include sub-recipients of government funding and even extend to those who receive donations of surplus property (USDOJ Policy Guidance. 2002, p. 41459).

The USDOJ Policy Guidance (pp. 41459-41460) included a four-factor balancing test to assist in determining a recipient's obligations vis-à-vis LEP individuals. These four factors are:

1. The number or proportion of LEP individuals eligible to be served or likely to be encountered by the program;
2. The frequency with which LEP individuals come in contact with the program;
3. The nature and importance of the program, activity, or service to individuals' lives; and

4. The resources available to the grantee/recipient and costs of providing LEP access.

If there were any doubts whether language access extends to medical care and other services for the victims of violence, the explanatory material to the third factor of the DOJ balancing test makes it clear that victims are covered. Factor 3 notes that a factor to be weighed is the importance of the program, activity, or service to individual's lives and commentary specifically states "More affirmative steps must be taken in programs where the denial or delay of access may have life or death implications…."

Under the DOJ Policy Guidance Document, "Enforcement of Title VI of the Civil Rights Act of 1964," language access can be attained through a variety of means and the recipient of federal funds must weigh what is reasonable under the circumstances to ensure language access. It suggests an appropriate mix of written and oral language assistance to ensure language access. The possibility of meeting obligations under Executive Order 13166 using telephonic and videoconferencing, and commercially available language lines to obtain immediate interpreter services is mentioned on a number of occasions in the Guidance.

Section 1557 of the Affordable Care Act [ACA] (2016) added an important quality dimension to the language access requirements of Title VI and EO 13166; it requires that language access, both oral and written, must be provided by "qualified interpreters" and "qualified translators," rather than by people who are merely "competent." Under § 92.4, Definitions, in the Department of Health and Human Services Final Rule (Federal Register, Vol. 81, No. 96, p. 31468) the term "qualified" means that the interpreter:

1. Adheres to generally accepted interpreter ethics principles, including client confidentiality;
2. has demonstrated proficiency in speaking and understanding both spoken English and at least one other spoken language; and
3. is able to interpret effectively, accurately and impartially, both receptively and expressly, to and from such language(s) and English, using any necessary specialized vocabulary, terminology and phraseology.

Confidentiality

Confidentiality is the red thread that runs through the various codes of ethics that apply to both medical/healthcare interpreters and court interpreters. Confidentiality is the first principle in the National Code of Ethic for Interpreters in Health Care drafted by the National Council on Interpreting in Health Care [NCIHC] (2004). It is reiterated in the NCIHC's National Standards of practice published the following year (2005). Confidentiality was the first Ethical Principle for Healthcare Interpreters published by the California Healthcare Interpreters Association [CHIA] in its document, California Standards for Healthcare Interpreters: Ethical Principles, Protocols, and Guidance on Roes and Intervention (2002).

The Model Code of Professional Responsibility for Interpreters in the Judiciary drafted by the National Center for State Courts [NCSC] and serves as the basis for most of the individual state codes of ethics for interpreters in the US, includes confidentiality (1995). The Federal Courts' Standards for Performance and Professional Responsibility for Contract Court Interpreters the Federal Courts likewise binds its interpreters to protect the confidentiality of all privileged and other confidential information. In addition, interpreting companies and social services agencies may also have their own requirements governing confidentiality.

In healthcare settings the importance of confidentiality is underscored by the role it plays in HIPAA (Health Insurance Portability and Accountability Act of 1996). Patients must have confidence that their personal health information (PHI) and personal identifiable information (PII) remains confidential, because without confidentiality, patients and victims of violence may be reticent to fully share all the information that may be crucial for their legal protection, their access to social services, the diagnosis and treatment of their injuries, and the success of therapy designed to help them overcome their trauma.

HIPAA violations are taken seriously. Fines can be quite severe, and depending upon the circumstances even imprisonment is possible. Consequently, interpreters should take precautions to protect personal health information very seriously. Notes should be shredded and disposed of properly. Only sanitized, de-identified information should be shared in debriefing sessions. PHI should never be discussed in public areas of the hospital, social services agency or other facility. Logging off the computers should be an ingrained habit, whether the computers or other electronic devices are personal or belong to a facility, Cell phones, laptops etc. with PHI information should never be left unsecured. Cars should not be used as a secure storage location.

Ensuring the Quality of Interpreting Services

As a result of Title VI, Executive Order 13166 and Section 1557 of ACA, there is a federal obligation to provide language access services in healthcare. There remained, however, one thing missing from the language access picture. There was no federal government program in place – or planned – for the certification of medical/healthcare interpreters, nor had any federal standards been adopted. The change from "competent" interpreters to "qualified" interpreters gave little guidance as to how an interpreter was to be qualified or how to assess a qualified interpreter's level of skill. This contrasts sharply with the situation in the federal courts, where there has been a rigorous – and much sought – court interpreter certification program on the federal level since the Court Interpreter Act of 1978.

But "nature abhors a vacuum" and two organizations stepped up to fill this void: the International Medical Interpreter Association [IMIA] and the Certification Commission for Healthcare Interpreters [CCHI]. The goal of these two organizations was to develop standards, and ethical guidelines and to create valid, reliable psychometrically sound national certification examinations, which both organizations accomplished.

Codes of Ethics and Standards of Practice

In 1987 the IMIA developed the first Code of Ethics specifically designed for medical interpreters (revised 2006). The Code's 12 tenets are comprehensive and require an ongoing commitment to compliance. The IMIA Code requires that medical or health care interpreters make a commitment to confidentiality, make judicious choices of language and mode of interpreting to ensure accuracy, agree to refrain from accepting assignments that are either beyond their skill level or those that involve relationships that would place impartiality at risk. The IMIA Code of Ethics also requires medical interpreters not to inject personal opinions or advice into the medical encounter, not to engage in interpretations that go beyond the scope of the medical encounter and, when necessary, to exercise professional judgment in making the decision whether or not to engage in patient advocacy or in the clarification of cultural issues. Moreover, the interpreter must endeavor to make such interventions as unobtrusive as possible so as not to interrupt the flow of communication between medical provider and patient. In addition, interpreters

must keep their language and medical terminology up to date, commit to continuing education, stay abreast of developments in professional standards and protocols through ties with relevant professional organizations, and finally, not use their position to obtain benefits from clients.

In 2004 the NCIHC developed its own 9-canon National Code of Ethics for Interpreters in Health Care, which covers much of the same ground: confidentiality, accuracy, impartiality, role boundaries, awareness and understanding of cultural differences, respect for all parties, patient advocacy only after judicious consideration of the situation, continuous improvement of knowledge and skills and commitment to professional and ethical conduct. This was followed by the NCIHC's National Standards of Practice for Interpreters in Health Care.

In 2002 the California Healthcare Interpreting Association (CHIA) published its own set of standards, the California Standards for Healthcare Interpreters: Ethical Principles, Protocols and Guidance on Roles & Intervention, often referred to as the "Chia Standards." This document, created under a grant from the California Endowment, has two features that set it apart from other codes of ethics and standards of practice developed by interpreter organizations.

First, the CHIA standards have a broader focus than the interpreter-centric codes of ethics and standards of practice drafted by the IMIA and the NCIHC. The CHIA Standards specifically mention that they were designed for a number of different target audiences, including healthcare interpreters, bilingual workers, administrators, providers, interpreter trainers, community advocates, legislators and government agencies, foundations, policy-makers, researchers, and others in the academic community.

Second, they were adopted in full by the State of California and went into effect as of January 1, 2009. The legislation states: "The Department will accept plan standards for interpreters [sic] ethics, conduct and confidentiality that adopt and apply, in full, the standards promulgated by California Healthcare Interpreters Association or the National Council on Interpreting in Healthcare or the National Council on Interpreting in Healthcare" (Title 28, California Code of Regulations, Section 1300.67.04 Language Assistance Programs). As of that date all interpreters providing interpreting services to LEP enrollees and beneficiaries covered by commercial plans and insurance in California were required to receive training in interpreting ethics, conduct, and confidentiality as set forth in the standards promulgated by CHIA. (California Health Care Association, California Standards for Healthcare Interpreters: Ethical Principles, Protocols and Guidance on Roles & Intervention, undated)

CHIA's set of six ethical principles cover much of the same ground as the NCIHC and IMIA documents: Confidentiality, Impartiality, Respect for Individuals and their Communities, Professionalism and Integrity, Accuracy and Completeness, and Cultural Responsiveness. What is new, however, is that the protocols implemented by individual health care interpreters are spelled out.

The specific protocols described in detail in the document are usually reserved for dissemination at interpreter trainings, but with CHIA's broader focus it made sense to include them in this document so that the various stakeholders know what to expect. The presentation of the Standardized Interpreting Protocols with the description of everything the interpreter has to consider and what the interpreter is actually responsible for is especially valuable for the various stakeholders to know. This information clearly demonstrates that the interpreter is not merely a conduit, but a person with specific responsibilities.

The ethical decision-making piece should also be enlightening for stakeholders who are not a part of the interpreting profession and not exposed to the dilemmas that may arise during an assignment. The analysis of alternative courses of action with the pros and cons of their variable outcomes highlight the complexity of many of these situations.

VIOLENCE IN SOCIETY

There is no lack of violence in the world today: Endless wars, geographically limited genocides, regimes wreaking havoc on their own citizens, and horrific civilian humanitarian crises seemingly accepted as collateral damage. Closer to home there are sexual assaults, child abuse, mass public shootings, school shootings, workplace shootings, shootings in places of worship, domestic violence, intimate partner violence and dating violence. The statistics are shocking, especially considering the consistent under-reporting of domestic violence and sex crimes in general.

Types of Violent Acts

Sexual Assault/Rape

According to the Rape, Abuse & Incest National Network [RAINN], someone in the United States is sexually assaulted every 98 seconds and every 11 minutes the victim is a child. The total annual number of sexual assault victims age 12 and older is 321,500. The breakdown of annual statistics is sobering: 80,600 inmates were sexually assaulted or raped, 60,000 children were victims of sexual abuse that has been "substantiated or indicated" through evidence, 321,500 members of the general public 12 years or older were sexually assaulted or raped, and 18,900 members of the military experienced unwanted sexual contact. Of the sexual assaults of inmates, 60% were perpetrated by jail or prison staff, and more than 50% of these sexual contacts were non-consensual, not to mention that all sexual contacts with prisoners were illegal. Because sexual violence in the military often goes unreported, it is likely that the real figures are much higher. Overall, 9 out of every 10 victims is female and one out of every 6 American women will have been the victim of a rape or an attempted rape in the course of her lifetime. Approximately 3% of American men, or 1 in 33, will have experienced a rape or an attempted rape in his lifetime. (Rape, Abuse & Incest National Network, 2019).

As RAINN points out, the majority of sexual assaults are not reported to the police. Only 230 out of 1,000 are reported to law enforcement, and of these only 46 result in an arrest, only 9 will be referred to prosecutors, only 5 will lead to a felony conviction and only 4.6 rapists will actually serve time for their crime. RAINN notes that the perpetrators of sexual violence are less likely to be incarcerated than any other type of criminal. By comparison, out of 1,000 robberies 619 will be reported, 167 will be arrested, 37 will be referred to prosecutors, 22 of these cases will result in a felony conviction and 20 will be incarcerated. For assault and battery cases 127 out of 1,000 will be reported to law enforcement and 33 will ultimately be incarcerated.

The one bright spot according to the National Crime Victimization Survey [NCVS], which is conducted annually by the US Bureau of Justice Statistics, appears to be that the rate of sexual violence between 1993 and 2012 has fallen by 63%. This decrease is similar to the decrease in the overall crime rate during that period, though it is worth noting that intimate partner violence fell at a faster rate than violent crime committed by immediate family members and other relatives (Truman & Morgan, 2014).

Domestic Violence

The National Domestic Violence Hotline (n.d.) defines domestic violence as "a pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship."

Domestic violence is sometimes referred to as domestic abuse, but recently intimate partner violence (IPV) has become the preferred designation because the socio-structural framework within which this dynamic occurs is not limited to partners who are married, engaged, or even sharing or having shared a domestic space together. Intimate partner violence is a more inclusive and more accurate term, though the term domestic violence is still widely used.

The dynamic of intimate partner violence is illustrated by the Power and Control Wheel developed in the 1980s by the Domestic Abuse Intervention Project in Duluth, Minnesota. The wheel presents eight tactics by which the abusive partner achieves dominance in situations where there is physical and sexual violence or the threat of using these means to achieve the desired dominance and control. The wheel maybe used with attribution to inform and educate clients, staff, and partners; however, it is copyrighted material and may not be used to support revenue-generating activities without permission. A copy of the wheel can be found on the Domestic Abuse Intervention Programs' website (https://www.theduluthmodel.org/wheels/).

The Duluth Model advocates note that they have made a conscious decision not to make the language of the wheels gender neutral, citing a statistical foundation for their decision, i.e., that men commit 86% to 97% of all criminal assaults and that women are killed in domestic homicides 3.5 time more often than men (https://www.theduluthmodel.org/heels/faqs-about-the-wheels). A brief recap of the 8 tactics presented in the Power and Control Wheel and some concrete examples for each are summarized below: Intimidation (breaking things, destroying the victim's property, abusing pets, displaying weapons); Emotional abuse (belittling, undermining self esteem, name-calling, playing mind games, humiliating, guilt-tripping); Isolation (controlling what the victim does, where they go, who they see and talks to, limiting outside contacts, often justifying this with jealousy); Minimizing, Denying, Blaming (making light of abuse, trivializing the victim's concerns, denying abuse happened, shifting responsibility and blame for the abuse to the victim); Using the Children (make the victim feel guilty about the children, using children to relay messages, threatening to take them away or harm them); Male Privilege (treating the victim like a servant, making all the big decisions, defining both their roles); Economic Abuse (preventing the victim from getting or keeping a job, giving an allowance, making the victim ask for money, not revealing information regarding finances, withholding access to family finances); Coercion and Threats (making and/or carrying out threats to do something to harm the victim or those dear to them, threatening to leave or commit suicide, or to report the victim to the authorities, forcing them to drop charges or to commit illegal acts).

The wheel shows a variety of different kinds of abuse. The most obvious are physical and sexual abuse, but the more subtle forms of emotional abuse are designed to, and do destroy self-esteem, normal ambitions and the ability to act, as well isolating victims from family, friends and colleagues in their normal support groups. Financial abuse is effective way of depriving a partner of autonomy and making them dependent and unable to assert themselves in the relationship.

According to the DV Fact Sheet the National Coalition Against Domestic Violence [NCADV] has assembled, 1 in 4 women and 1 in 9 men suffer severe physical or sexual violence and/or stalking at the hands of an intimate partner. These figures are only estimates considering that only 34% of IPV victims seek some form of medical care (Truman & Morgan, 2014). The consequences of this violent behavior include physical injury, post-traumatic stress disorder, psychological symptoms such as a higher rate of depression and suicidal behavior, use of victim services, and sexually transmitted diseases (NCADV, 2017).

Digital Abuse

Digital abuse is the 21st century way of expressing and implementing old-fashioned power and control tactics such as threats, insults and mockery, but now via digital media, e.g., emails, texts, sexts, tweets, Facebook, etc. Digital abuse can put a very public face on belittling remarks and insults, and adds public shame to what previously was often restricted to the victim and perhaps a small circle of close friends. Stealing or demanding the victim's password so that the abuser can monitor the victim's activities, what they say and whom they share this information with. Body shaming and revenge porn are easily disseminated to a broad audience via the internet (The National Domestic Violence Hotline, n.d.)

Stalking has also gotten a modern update; controlling partners and ex-partners can track their intimate partners much more efficiently with the help of technology: they can monitor cellphone usage, engage in cyber stalking, install spyware on a mate's computer or affix a GPS tracking device to their car (The National Domestic Violence Hotline, n.d.). According to the Bureau of Justice Statistics during a period of 12 months approximately 14 out of every 1,000 adults is a stalking victim; of these approximately 1 in 4 experience some form of cyberstalking (2017).

Dating Violence

Dating violence is another form of intimate partner violence, but between current or former dating couples. The aggression within the relationship can be physical, sexual, psychological or emotional. As in the case of domestic violence, typically one partner uses violence or threats of violence to maintain a position of power and control within the relationship. It is most prevalent in the 15- to 24-year-old age group, which makes up close to half of the reported victimizations. Here, too, young women are much more likely to be victims than young men.

Teen dating violence is grossly underreported. One study found that fewer than 3% of teenage girls and teenage boys in New York City reported teen dating violence to someone like a teacher, counselor or law enforcement, and only 6% reported it to a relative. At the same time the New York City Domestic Violence Hotline estimated that it receives 1,400 calls from teenagers every month (DayOne, n.d.).

It was estimated that nearly 1.5 million high school students suffer physical abuse from a dating partner each year (Centers for Disease Control and Prevention, 2006). A 2018 CDC publication found that 8% of high school students reported having experienced physical violence and 7% had suffered sexual violence from a dating partner in the year prior to the survey (Centers for Disease Control and Prevention, 2018). Perhaps even more shocking is that violent behavior often begins as early as 12 years of age (Rosado, 2000). Moreover, the severity of IPV incidents later in life is often greater when such violent behavior has become established during adolescence (Feld & Strauss, 1989).

One of the most disturbing aspects of dating violence is the effect that it has on those who have experienced it. Victims of violent relationships at this time in life have an increased risk of substance abuse, eating disorders, risky sexual behaviors and domestic violence later in life (Silverman et al., 2001),

Child Sexual Abuse

According to RAINN, 66% of victims under the age of 18 were between 12 and 17 when they were sexually assaulted or raped, and 34% of the victims were under the age of 12. Child sexual abuse is widespread, and every 11 minutes child protective services substantiates or finds evidence for a claim of child sexual

abuse. Shockingly, according to the 2016 Child Maltreatment Survey by the United States Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2018), a parent was the perpetrators in 82% of the child abuse cases in 2016, followed by relatives in 6% of the cases and 5% were ascribed to the unmarried partners of one of the parents. Strangers and siblings accounted for the remaining 5%. There is substantiation or supporting evidence in 88% of the sexual abuse claims that the abuser was male, and in 9% of the cases the perpetrator was female, while it is unknown what gender the remaining 3% represented.

Mass Shootings/School Shootings

It appears that there is no official definition of a mass shooting; however, as the term is used in the media, it refers to "a multiple homicide incident in which four or more victims are murdered with firearms … in the course of one event in one or more locations relatively near one another."(Krouse & Richardson, 2015). Note that the death of the shooter, whether by suicide or not, is not included in the total. A more expansive definition includes events in which the injured might have sustained only gunshot wounds but were not killed. This ad hoc definition does not address how many shooters are involved, but in practical terms the perpetrator is statistically very likely to be a solitary gunman. A special subcategory of shootings is school shootings, which may or may not qualify as a "mass" shooting depending upon the number of victims. School shootings have claimed victims as young as 6- and 7-years-old at Sandy Hook, students at Columbine and Marjory Stoneman Douglas High School and students at schools like Umpqua Community College and the University of Texas. The sheer number of victims in some of these mass shootings is overwhelming, e.g., Las Vegas, 59 dead and 851 insured; Orlando, 50 dead and 53 insured. Sadly, the US is the world's leader in mass shootings.

The Societal Costs of Interpersonal Violence

Because of widespread underreporting even estimating the direct costs of interpersonal violence is a challenging task. When the long-term indirect costs are added to the equation it becomes more so. The World Health Organization (WHO) report, The Economic Dimensions of Interpersonal Violence (2004), has made a laudable attempt, and the figures are mindboggling. In the WHO study interpersonal violence includes child abuse and neglect, intimate partner violence, elder abuse, sexual violence, workplace violence, youth violence and other violent crime. As outlined in the study direct costs include the costs of legal and medical services for the victims, direct perpetrator control costs, policing, incarceration, foster care, private security contracts and the economic benefits to perpetrators. Indirect costs include lost earnings, lost time, and lost productivity, lost investment in human capital, indirect protection costs, life insurance costs, benefits to law enforcement, domestic investment, external investment and tourism, psychological costs and other non-monetary costs. The WHO study points out that the wide variation in the estimation of societal costs is the result of the inclusion or exclusion of these different categories rather than different methodologies of calculating them (WHO, 204, p. 6).

Not surprisingly, a more inclusive enumeration of costs results in higher estimates of total societal costs. The 2004 WHO report cites a study by Caldwell setting a figure of $1 billion as the cost of child abuse in the state of Michigan alone as early as in1992. In that study Caldwell included not only direct medical expenses, protective services and foster care, but also lost tax revenue due to premature death,

special education expenses, psychological and welfare services, preventative services, adult criminality and subsequent incarceration related to child abuse.

Many of these violent acts, such as sexual assault, intimate partner violence and child abuse are under reported. Consequently, it is difficult, if not impossible, to assess the true cost of intimate partner violence, sexual assault and child abuse, not to mention that these figures can never be more than estimates. According to the Institute for Women's Policy Research (n.d.), the costs of IPV encompass the direct costs for medical expenses, lost wages for missed work and even loss of employment, lower lifetime earnings due to diminished educational achievement, debt and poor credit and housing instability.

A randomized telephone survey of 3,333 women revealed that healthcare costs for abused women are 42% higher than for their non-abused peers. Even if the abuse ended 5 or more years in the past, their current medical costs were 19% higher than for women who have suffered no abuse (Institute for Women's Policy Research, 2017, citing Bonomi et al. (2009)). Campbell (2002) confirms more frequent recourse to medical treatment, stating that the injuries, fear and stress resulting from living with intimate partner violence can lead to chronic health problems.

A major issue that makes it difficult to assess the full societal cost of intimate partner violence, sexual assault and stalking is due to the delayed impact these behaviors have upon their victims. Max et al. (2004) estimated that the cost to U.S. society was $5.8 billion, including $4.2 billion for physical violence, $320 million for partner rape, and $342 million in 1995 dollars. Converted to 2017 dollars this would be a total of $9.3 billion. Another study suggests that IPV costs the US economy between $5.8 and $12.6 billion each year, or up to 0.125% of the national gross domestic product (World Health Organization, 2004).

Of course, this financial overview does and cannot take into account the consequences of domestic and sexual violence in human terms. The negative health and monetary effects on abused female partners provide a rough idea of the costs, but the long- and short-term consequences for the children living in homes with intimate partner violence are likely to have a lifelong negative impact that cannot be measured economically. According to the Childhood Domestic Violence(n.d.), 5 million children in the United States witness domestic violence annually, and 40 million adults in the US grew up living with domestic violence. According to this same report, domestic violence in childhood is correlated with learning difficulties, lower IQ scores, deficiencies in visual-motor skills and problems with attention and memory. Children whose exposure to domestic violence is repeated often meet the diagnostic criteria for PTSD. Moreover, children from these homes are physically abused or seriously neglected at a rate 1500% higher than the national average. Children who grew up with DV are 6 times more likely to commit suicide, 50% more likely to abuse drugs and alcohol and 74 times more likely to be violent. These are very sobering statistics, but it is challenging if not impossible to track these trends accurately into adulthood (Truman, 2014).

Summary

The magnitude of the impact on victims of violence, measured in physical, financial, and human terms open the larger discussion of possible policy responses and the types of interventions that may have a preventative or mitigating effect, both on the underlying violent behaviors that result in victimization and on the subsequent responses that can either alleviate the victim's psychic pain, re-traumatize the victim or leave the victim unaffected despite good intentions.

Larger policy decisions go beyond the scope of this paper, but there is one unavoidable fact that emerges from the above review of the prevalence, societal cost and long-term impacts of violence: Based on the foregoing statistics and the estimated crime rate of 20.1 victimizations per 1,000 for U.S. residents 12 years of age or older (Truman & Langton, 2015), it's not a question of whether medical/health care interpreters will be called upon to interpret at encounters with victims of violence, but it is more a question of how often they will interpret for traumatized victims.

MAIN FOCUS OF THE CHAPTER: PREPARING TO INTERPRET FOR VICTIMS OF VIOLENCE

Anticipated Terminology

Victims and survivors of domestic violence present an anticipated set of injuries and symptoms that health care interpreters must be prepared for. Campbell (2002) notes in her Lancet article, women who have been physically and sexually assaulted are more likely to have injuries on the head, face, neck, thorax, breasts and abdomen than women who have been inured in other ways. In the longer term they have increased susceptibility to chronic pain, gastrointestinal and gynecological problems, including sexually transmitted diseases as well as depression and posttraumatic stress disorder.

In addition to indices of lower general health, the 5 aggregated studies cited by Campbell (2002) highlight a host of other substantive areas where significant risks for abused women exist and for which health care interpreters must be prepared. These include: Digestive problems (diarrhea, spastic colon, constipation, nausea); loss of appetite, binge eating, self-induced vomiting; abdominal pain, stomach pain; urinary tract and kidney infection, pain and other problems with urination; vaginal infection (discharge, itching); sexually transmitted disease; AIDS or HIV-1; vaginal bleeding, severe menstrual problems, dysmenorrhea; pelvic pain, genital area pain; fibroids or hysterectomy; headaches, migraines; fainting, passing out; seizures, convulsions; back pain, chronic neck pain; influenza or cold, stuffy or runny nose; hypertension.

In addition to these physical symptoms, Campbell (2002) notes the mental health effects observed in victims of intimate partner violence, the most frequent of which are depression and post-traumatic stress disorder. Other sequelae of intimate partner violence reported by Campbell range from greater suicidal tendencies to higher levels of anxiety, insomnia, and social dysfunction than found in non-abused peers.

Additional specifically violence-related injuries were identified in a Bureau of Justice Statistics special report following a survey of hospital emergency departments (Rand, 1997). According to this report, 34% of people injured in violent acts were treated for bruises or similar injuries, 31% were treated for cuts, stab wounds, or internal injuries, 17% were treated for factures, sprains, dislocations, dental injuries, or other muscular/skeletal injuries, 5% were treated for gunshot injuries, 5% for rapes/other sexual assaults, 4% for concussions or other head injuries, and 5% for other miscellaneous injuries. 92% of these victims of violence were released immediately after treatment while 7% were hospitalized for further treatment.

A Trauma-Informed Approach

With statistics like those cited above, it becomes clear there is a great likelihood that medical interpreters will have to interpret for physically and psychologically injured victims of traumatic events in the course of their work: Consequently, they should become familiar with trauma-informed care.

Harris & Fallot (2001) outlined the basic rules of trauma-informed services: Recognize the trauma and take it into account; avoid triggers and retraumatization whenever possible; support the victims' coping mechanisms; and allow victims to manage their own trauma symptoms so that hey can benefit from treatment and services (cited in Covington, 2008). Because lack of control is so often associated with trauma, a key feature of trauma-informed practice is to return to victims as much control over their lives as possible, and in this way promote recovery and healing.

In its Concept of Trauma and Guidance for a Trauma-Informed Approach, The Substance Abuse and Mental Health Services Administration (SAMHSA) stressed that the entity providing victim services had to be fully committed to and endorse trauma-informed care throughout their entire organization, from clerk to the CEO in order to provide a context that will promote healing Everyone in the organization must have an understanding of trauma, recognize the symptoms in their clients, their clients' families and staff, and integrate this knowledge into the policies, procedures and practices (Substance Abuse and Mental Health Services Administration, 2014).

SAMHSA outlined six key principles that create the foundation upon which to build a trauma-informed care. These principles are:

- Safety
- Trustworthiness and Transparency
- Peer Support
- Collaboration and Mutuality
- Empowerment, Voice and Choice
- Cultural, Historical, and Gender Issues

Interpreters play an indispensable role in implementing the principle of Empowerment, Voice and Choice, because it is the interpreter who gives LEP victims a voice and the ability to relate their account of the traumatizing event or events. Having a voice is the first step toward the empowerment that is necessary for victims to re-take control of their lives and undergo the transformation from victim into survivor.

The interpreter must be prepared for victims of trauma to act in ways that may be distressing to the interpreter. The victim may cry, sob or rock back and forth, or laugh inappropriately even when there is absolutely nothing to laugh about. There might be gaps in their description of what happened since trauma can affect memory. They may fall into a distracted silence and say nothing at all. Basically, traumatized victims are unpredictable and each one is different. The interpreter must be prepared for a wide variation in the responses by victims of trauma. And the interpreter must not be disturbed if there are long periods of silence.

Always show sensitivity and respect for the victim. The danger of retraumatization is very real, so never touch the victim. What was meant as a sympathetic touch might turn out to be a reminder of the assault and could trigger retraumatization. Be sensitive to the victim's need for autonomy. Never give the victim advice or recommend particular service providers. Avoid giving any indications of disapproval.

Familiarity with the Interpreter Codes of Ethics and Standards of Practice is a good foundation for understanding the role of the interpreter and the normal boundaries of that role. Understand when to clarify or advocate if this is necessary.

Always observe the principle of impartiality stressed in the codes of ethics. An interpreter must not come to an assignment with preconceived notions about the victim, how she dressed, why she was where she was in the middle of the night or question her judgment in her choice of mate or companions. Impartiality precludes victim blaming. Because the interpreter must also appear to be non-judgmental, it is important that the interpreter endeavor not to make any gestures or make any faces that night be misinterpreted as disapproval or dissatisfaction. Victims of assault are in a very vulnerable, sensitive moment in their lives and may project their own fear of disapproval onto any expression.

The interpreter must have the self-knowledge to know whether they possess the ability to handle interpreting for certain types of trauma; this is particularly critical for interpreters who have a trauma history of their own. There have been reports of interpreters breaking out in tears and having to be comforted by the victim, and others fleeing the room when the description of the traumatic event was too similar to what they had once experienced (conversation with Cannon Han, September 8, 2016). Needless to say, actions like these could easily trigger re-traumatization.

Finally, it is important in the pre-session to look at the victim directly with a warm and open expression. Make the victim feel supported. Not being believed is one of the things that victims are most distressed by. Although interpreters are not in a position to make statements expressing belief or disbelief, a smile during the pre-session, and a slight nod can make them feel supported. Do not avoid looking at them, since that could be interpreted either as dislike or that the trauma they have suffered is so terrible that the interpreter cannot bear to look at the victim.

What Is Vicarious Trauma?

Very generally, vicarious trauma (VT) has been described as the negative impact that long-term exposure to the trauma of others potentially has on the professionals working with trauma victims. The term vicarious trauma was originally created to describe the effects that trauma work had on psychotherapists, but it has gradually been applied to an ever-widening circle of members of the caring professions, that is, precisely the groups whose empathy and compassion makes them particularly susceptible to its reach.

Recognition that vicarious trauma may impact many occupational groups other than the traditional caring professions has grown considerably over the years. It is now acknowledged that in addition to psychotherapists, doctors, nurses and many other healthcare and medical professionals, vicarious trauma also affects social workers, victim advocates, EMTs, first responders, hospice personnel, 911 operators and workers covering suicide hotlines, clergy, veterinarians, animal welfare workers, police, human rights advocates, disaster relief workers, child abuse investigators, school teachers, judges, attorneys, court staff, journalists – and interpreters.

Definitions: Vicarious Trauma, Post-traumatic Stress Disorder, Burnout

First, it is important to differentiate what vicarious trauma is and what it is not, and what makes it different from phenomena such as PTSD and burnout, which can manifest very similar symptoms. It should be noted, however, that some of the symptoms shared by PTSD and vicarious trauma sufferers are not shared by workers experiencing burnout.

Vicarious Trauma

VT may be referred to using a variety of terms: Compassion fatigue (Figley, 1995), vicarious traumatization (McCann et al., 1990), secondary traumatization, secondary traumatic stress (Figley, 1983, 1995), secondary victimization (Figley, 1982) and secondary stress disorder. All of these terms have one thing in common: They highlight the one critical factor that sets VT off from PTSD and burnout – that is, that vicarious trauma results from indirect exposure to the first-hand accounts of suffering by others, and not from one's own firsthand experience of suffering direct trauma to one's own self or from personally witnessing traumatic events.

Although some authorities believe that compassion fatigue is different than vicarious trauma; that is, compassion fatigue is the numbing of feelings resulting from repeated exposure to the traumas suffered by others, while vicarious trauma refers specifically to a dynamic and profound shift in worldview and outlook on life that is the direct result of their repeated exposure to traumatized through their work as helping professionals (Pearlman & Saakvitne, 1995).

In practice, however, this distinction is frequently blurred, and the terms are often used interchangeably. In order to avoid confusion and focus on the issues relating to the identification of the warning signs of VT and the necessity of making appropriate responses to counteract it, this paper will use the term vicarious trauma throughout.

In addition to the vicarious or secondary nature of vicarious trauma, a second critical element of this phenomenon is that the effect of such indirect exposure to trauma tends to develop a greater impact with repetition over time and is cumulative. Thus, the more someone hears narratives about similar traumatic events, and the longer the exposure to the events suffered by others, the more serious the effects of this exposure are likely to become.

It should also be noted that very often, though certainly not exclusively, vicarious trauma is the result of work-related exposure. This is not to say that family caregivers may not also suffer from vicarious trauma as the result of their demanding, long-term responsibilities for the care of close family members suffering from debilitating physical and mental conditions, and/or the sense of powerlessness arising watching their loved one's slow, inexorable intellectual and/or emotional deterioration, but the day-in and day-out exposure to the traumas of others in the workplace takes its toll.

A third, and critical aspect is that vicarious trauma, if left untended, can result in serious, even disabling, personal impacts on those who are involved in the traumas of others. Self-care is critical in addressing, mitigating and preventing the cumulative effects of vicarious trauma. Techniques to recognize and minimize the impact of the work of caring for others will be presented in the self-care section below.

Post-traumatic Stress Disorder

From the above description of vicarious trauma, it is clear that VT and burnout are conceptually different from post-traumatic stress disorder (PTSD), despite the many similarities in the symptoms resulting from both PTSD and VT. The description of PTSD for a lay audience used by the Veteran's Administration's National Center for PTSD on its website underscores the fact that PTSD is the result of primary, not secondary, trauma: "PTSD is a mental health problem that some people develop after experiencing or witnessing a life-threatening event, like combat, a natural disaster, a car accident, or sexual assault." (Veteran's Administration's National Center for PTSD, 2019).

PTSD was not recognized as a mental disorder until 1980, when the American Psychiatric Association included it in the third edition of the Diagnostic and Statistical Manual of Mental Disorder (DSM-III). The DSM does not recognize vicarious trauma as a disorder.

The enumeration of PTSD symptoms below is not included for diagnostic purposes, but rather to make it possible to compare and contrast them with the warning signs for VT and burnout:

- Intrusive thoughts
- Involuntary memories
- Flashbacks
- Reliving events
- Recurring dreams
- Avoiding reminders (people, places, things, activities, situations, objects)
- Repressing memories of the traumatic event
- Unwillingness to talk about it
- Negative thoughts (negative self-image)
- Loss of trust
- Persistent fears, anger, guilt, shame)
- Loss of interest in previously enjoyed activities
- Numbness
- Sense of detachment
- Estrangement
- Arousal
- Hypervigilance
- Irritability
- Easily startled
- Emotional outbursts
- Reckless behavior
- Self-destructive habits (The American Psychiatric Association website)

Additional symptoms include:

- Feeling of hopelessness
- Depression
- Physiological reactions when reminded of the trauma (sweating, labored breathing, increased heart rate)
- Inability to remember important details about the trauma
- Feeling on edge
- Poor concentration
- Sense of doom
- Difficulty falling or staying asleep
- Inability to experience positive emotions
- Difficulty maintaining close relationships (Mayo Clinic website)

Interestingly, phenomena very similar to PTSD had been reported before the term post-traumatic stress disorder appeared in the literature. The term "shell shock" came into use during World War I to describe a cluster of symptoms similar to many of those exhibited by PTSD sufferers. The terms "combat fatigue," "combat neurosis" or simply "exhaustion" was used during World War II to describe a similar group of symptoms. But PTSD-like symptoms had already appeared in the works of the chroniclers of antiquity when they described the reactions of battle-hardened warriors who presented extreme symptoms such as intrusive thoughts, re-experienced battles, nightmare-like dreams, dissociative behavior, numbing, hyperarousal, self-harm, solace in alcohol in order to sleep, and suicide (Birmes, 2009). We are left to conjecture whether these reactions were written about because they were rare or whether they were more widespread but mentioned sparingly because of the loss of written documents over the millennia.

Burnout

Although some of the symptoms of burnout are similar to the symptoms of both PTSD and vicarious trauma, the three conditions are different. Although burnout may result in insomnia, depression and ultimately a decision to leave a job or the profession, other more extreme symptoms such as re-experienced horror, intrusive thoughts, recurring nightmares, trauma triggers and other more extreme warning signs are absent.

According to the definition of Burnout by Psychology Today, also designed for a lay readership, "Burnout is not simply a result of long hours. The cynicism, depression and lethargy of burnout can occur when a person is not in control of how the job is being carried out… working toward a goal that doesn't resonate, or when a person lacks support" ("Psychology Today", n.d.)

Burnout symptoms include physical and emotional exhaustion, cynicism, detachment, feelings of ineffectiveness and lack of accomplishment. Physical symptoms range from chronic fatigue and insomnia to loss of appetite as well as gastrointestinal problems, headaches, dizziness, fainting and shortness of breath. Burnout is also associated with frequent infections, colds, and flu. As feelings of burnout intensity, mild tension can build up to anxiety that may become so severe that one's ability to function becomes impaired. Similarly, early feelings of sadness may ripen into full-blown depression and bouts of irritation may escalate into anger.

Burnout can also lead to a diminished sense of enjoyment that can pervade other areas of one's life, including relationships with family and friends. This can lead to pessimism, isolation and detachment, feelings of hopelessness, lack of productivity and poor job performance.

To identify whether the underlying cause of the symptoms is burnout or vicarious trauma or compassion fatigue, Figley suggests that the question to ask is: "Do I love my work?" According to Figley, "If the answer is 'no,' it is most likely that you are suffering from burnout. If the answer is 'YES! You are more likely suffering from Compassion Fatigue" (Figley, 2007)

Another distinction noted by Figley is that vicarious trauma or compassion fatigue is usually characterized by a sudden onset of symptoms, whereas the indicia of burnout appear slowly over an extended period of time (Figley, 2007). Moreover, burnout appears to be closely associated with a number of negative workplace related factors unrelated to compassion or empathy. Triggers cited by Maslach include excessive workload, lack of control, absence of suitable rewards, loss of positive connection with coworkers, perceived lack of fairness, and a conflict between values (Maslach et al.1990).

A comparison of burnout, PTSD and VT leads to the question: Why are people, as human beings, affected by vicarious trauma?

Part of what makes people susceptible to vicarious trauma is that humans, at their best, care about others, and precisely those who are most compassionate and most empathetic are the ones who choose to go into the caring professions. Figley put it well: Vicarious trauma is the "cost of caring" (1982).

However, empathy that succumbs to vicarious trauma should never be regarded as a personal weakness. Instead, it is important to recognize the inherent risk to all members of all the helping professions so that these professionals can be made aware of this danger. At the same time, it is critical that prevention and mitigation measures are introduced to minimize the "cost of caring."

INTERPRETERS AND VICARIOUS TRAUMA

Although the recognition of interpreters' rightful place in the group of professionals susceptible to vicarious trauma came relatively late, it is now fully accepted in the interpreter community. These days there is scarcely a conference for interpreters that does not address this important issue (e.g., American Translators Association 2010, 2012, 2013 and 2015, Interpret America 2013, Oregon Society of Translators and Interpreters 2014, National Association of Interpreters and Translators 2015,). Moreover, training programs designed specifically for interpreters who work with victims of domestic violence, sexual assault, human trafficking and torture, invariably include modules on vicarious trauma and self-care (e.g., curricula developed by the Asian Pacific Institute on Gender Based Violence, National Center for State Courts and Ayuda, among others).

Because of the nature of the work that interpreters perform, their services are indispensable to comply with the mandate to provide language access to limited English proficient clients and patients if the service provider does not speak the patient's/client's language. This means that interpreters will be called for assignments involving crisis interventions, vehicle accidents, crime scenes and child abuse and neglect investigations. They will be working with domestic violence advocates and human rights attorneys. They will be in court interpreting for trials involving shocking abuse, assault and murder. They will interpret descriptions of torture and death in asylum cases and at holding facilities where asylum seekers and other immigrants are detained. They will interpret for medical appointments of all kinds, in doctors' offices, in emergency rooms, for rape kit examinations. They will interpret for routine medical appointments and medical emergencies. They will interpret both good news and bad news on a regular basis, for joyful couples as well as for bereaved parents and for the terminally ill in hospices.

FACTORS INCREASING THE LIKELIHOOD OF VICARIOUS TRAUMA

Because of situational aspects, medical and trauma services interpreters, like the medical personnel and caregivers they interpret for, are at risk of vicarious trauma. There are, however, a number of factors unique to interpreting that make interpreting in victim services, medical contexts and criminal cases particularly intense for interpreters.

Psycholinguistic Factors

Interpreting in the First Person

In order to ensure that the victim or patient receives the same full and undivided attention from the caregiver, advocate or service provider that an English-speaking victim or patient would receive, interpreters are directed to intrude as little as possible into the interpreted encounter. Thus to ensure that the caregiver or service provider speaks directly to the patient and not to the interpreter, interpreters are taught to use direct speech rather than indirect or reported speech; that is, the interpreter is instructed to use the first person when the limited English speakers they are interpreting for refer to themselves using the first person.

This means that the interpreter repeats the words of that person as if these traumatic events had happened to or been perpetrated against the interpreter. "And then he punched me in the face with his fist. I could hear the bone in my nose break and the blood ran down and dripped off my chin" "No one did anything to stop the attack. They just stood there and watched. I drifted in and out of consciousness – coming to only when the pain became even worse and then I'd drift off again."

Using the first person directs the attention where it should be – on the victim or patient. It does not take the focus off the victim or patient, or remove the victim from the conversation as it would in the "ask-her-tell-her" model so often used by untrained ad hoc interpreters and caregivers unaccustomed to working with interpreters. However, from the interpreter's perspective repeating – and adopting – the narrative as one's own in the first person intensifies its impact on the interpreter – and makes the interpreter more susceptible to vicarious trauma. .

It is true that there are circumstances under which interpreters may be justified in switching into the third person, for example, to distance themselves from an event when the subject matter of the victim's narrative becomes too horrific (e.g., describing the details of torture or a gang rape). Nonetheless, in the normal course of their work interpreters will primarily interpret in the first person.

Repetition

Naturally the emotional nature of the messages conveyed has a strong impact, as it would on any listener, but the interpreter is in a unique position not shared by anyone else at these encounters. The interpreter must listen attentively, try to remember every detail of the message, process all this information from the original language into a second language and then repeat the processed message in that second language. Next the interpreter must listen intently to the response to that message, once again remember it in detail, process that response from the second language unto the first and then repeat that message in the first language.

This means that the interpreter has significantly greater exposure to these statements than anyone else in the room because the interpreter must respond to the original message in a variety of ways, i.e., listening intently, endeavoring not to omit critical details, actively processing the entire message into another language and finally delivering the processed message in that other language. The result is that the interpreting process transforms the encounter into a far more active, intense and internalized experience for the interpreter than for anyone who just listens and responds to the narrative.

For a deeper understanding of all the linguistic and cognitive processes that an interpreter performs in transferring a message from one language into another see Pöchhacker's review of the work by other

scholars in analyzing and representing the complexities of the multitude of the mental processes the interpreter draws upon when performing the interpreting act. In particular, he discusses Gerver and Moser-Mercer in the 1970s and Cokely in the early 1990s and Paradis in 2000 (Pöchhacker, 2016).

Visualization

Another factor that further exacerbates the impact of interpreting the statements of the victims of domestic violence, sexual assault and other forms of physical abuse is that interpreters are taught to use visualization as a mnemonic aid, especially to improve short-term memory in consecutive interpreting. See, e.g., (Mikkelson, 1993, Roberts, 2014), among others. Recommendations to visualize events and their chronology as a memory aid abound online in curricula for training programs, in serious scientific articles and rehashed in informal blogs.

Systemic Factors

In addition to the various psycholinguistic considerations, there are also certain structural systemic factors that underplay or even ignore the likelihood that vicarious trauma may become a serious problem for interpreters in general, but especially for those working in the medical and victim services fields.

As mentioned above, although there is now wide recognition in interpreter community that vicarious trauma is a potential problem for interpreters, this is not always the case with those who hire and/or work with interpreters. There are several reasons for this:

Unfamiliarity with Interpreting and the Interpreter's Role

The failure to recognize that interpreters are susceptible to the same risk of vicarious trauma as others in the caring professions might be due, in part, to the perception – and misunderstanding – of the interpreter's role as an unbiased and neutral conduit who merely repeats the words of others. This perception is erroneous for at least two reasons.

First, it fails to take into account the active, dynamic cognitive processes used by interpreters in rendering a message from one language into another. Many outside the interpreting profession are unaware of the processes involved in interpreting, i.e., listening far more intently than is customary in daily life, the performance of the multiple active mental processes required to understand, remember, actively recreate and deliver the original message in another language.

Second, the view of the interpreter's role of the interpreter's role as a mere neutral conduit discounts the natural human empathy and compassion that is aroused when witnessing the suffering and trauma of others.

Structural Factors in the Workplace

The failure to appreciate the risk of vicarious trauma for interpreters can, in part, also be attributed to the fact that many, if not the statistical majority, of medical and trauma services interpreters are freelancers who work in many different languages and at many different facilities. This means that an interpreter supervisor may see individual interpreters infrequently and might not be aware how often a particular freelancer is actually exposed to difficult situations, suffering patients and traumatized victims.

Independent Contractor Status

Freelance status also means that medical facilities, victims' services and translation and interpreting agencies may not routinely provide independent contractors with the in-service training events relating to vicarious trauma and self-care that they make available to their staff. This could be due to long-standing, well-meaning policies of not imposing any non-compensated obligations upon their freelance interpreters, or it could be the result of a conscious decision to avoid taking any steps that could be construed as transforming their independent contractors into employees. Either way, however, it means that freelance interpreters often do not benefit from the in-service trainings that their colleagues with staff positions enjoy.

Lack of a Natural Support Group

In addition, because freelancers often work in a variety of settings and facilities, they may not have the opportunity to develop a professional support group the way that is possible for staff interpreters who see each other every day (or at least frequently), building relationships with each other during coffee breaks and lunchtime. The likelihood of building such relationships is further diminished by having to rush off to the next appointment, which may even be at another facility. For the freelancers who come and go on erratic schedules this can result in a feeling of not being fully connected to their colleagues, leading to a sense of workplace isolation that increases the likelihood of both burnout and vicarious trauma.

The Constraint of Confidentiality

Finally, the duty to maintain confidentiality that is a pillar of virtually all codes of interpreter conduct may also inhibit interpreters from discussing assignments, situations and ethical conundrums that are particularly troubling. Informal debriefing with colleagues as well as formal procedures organized by an employer are recognized as having real therapeutic value for the persons debriefed, but here, too, independent contractor status may preclude the inclusion of the freelance interpreter's participation in employer-supported debriefing sessions. Debriefing will be discussed in greater detail below.

Remote Interpreting

It has been suggested that 911 telephone interpreters who work remotely with no face-to-face experience with the people they are interpreting for are less likely to suffer from vicarious trauma since they are completely removed from the presence of the traumatized victims or patients and they are not exposed to any visual images. Without access to a peer-reviewed study, it is hard to draw any valid conclusions, but anecdotal reports suggest otherwise (conversations with participants in the Vicarious Trauma Workshop, Interpret America, 2013). It appears that interpreters taking these calls often imagine violence, trauma and injuries that are at least as serious and sometimes far worse that the actual situation. Interpreters who interpret for 911 calls also report that they are haunted by their sense of powerlessness as they stay on the line while events unfold at a distance, sometimes with virtually no hope of immediate help or intervention from any source.

Recognizing the Signs of Vicarious Trauma

The first step in addressing the problem must be sensitizing those who are at risk to the signs that might suggest that vicarious trauma might be lurking in the wings.

There are myriad warning symptoms. Some of the signs are purely physical, while others are mental, and others reflect directly the change in one's worldview that is a marker of VT.

Saakvitne and Pearlman analyze their set of symptoms and break them down into three basic categories of warning signs: physical, behavioral and psychological/emotional. (Saakvitne and Pearlman, 1996). Another way to classify these symptoms is by where they manifest themselves, e.g., in the workplace or in one's personal life (Rainville, 2016), but for practical self-assessment purposes, the list below should prove helpful without analyzing and categorizing the kind of symptom.

- Absenteeism
- Addiction
- Aggression
- Agitation
- Apathy
- Anger
- Anxiety
- Burnout
- Cynicism
- Defensiveness
- Depression
- Difficulty Concentrating
- Difficulty Separating Work from Personal Life
- Dissociative experiences
- Easily Startled
- Emotional numbness
- Exaggerated startle response
- Exhaustion
- Feeling Overwhelmed
- Headaches
- Insomnia
- Intrusive thoughts
- Irritability
- Lack of Energy
- Loss of Empathy
- Loss of Hope
- Mistrust
- Moodiness
- Nightmares
- Physical illness
- Sadness
- Self-doubt

- Sense of Futility
- Social distance
- Spiritual Emptiness
- Substance Abuse
- Trauma Imagery
- Withdrawal

For those who may wish to have a more official confirmation of their own intuitive assessment of whether, based on the symptoms listed above, they may be suffering from VT, there are free online resources available. They will be discussed below under Self-Care.

Some More Susceptible to VT: Predisposing Factors

Although not every individual who experiences secondary exposure to traumatic events will develop the indicia of vicarious trauma, research has shown that certain factors predispose some people to suffer from VT. Those with trauma history are especially vulnerable, since hearing about the traumas suffered by others may trigger memories of their own trauma and may even cause intense flashbacks. This is particularly true for those who have suffered abuse and trauma in their childhood. (Berwin et al., 2000). Individuals who have a past history of mental problems are also more likely to be affected by vicarious trauma (Figley, 1995, Levin & Greisberg, 2003).

Two other factors that were identified in a study undertaken with therapists. These factors were having less experience at the job and the lack of supervision (Pearlman & Mac Ian, 1995). Neither of these factors should be surprising. For those therapists new to the field there will be many new situations requiring analysis and fresh decision-making, which will increase their level of stress. Moreover, they will not yet have had the opportunity to develop coping mechanisms. In addition, the impact of work with trauma victims might not have been stressed - or even discussed – during their training. Lack of supervision will be a risk factor for all those who are independent contractors, but it seems especially relevant to interpreters since so many are freelance.

Other significant predictors of vicarious trauma are professional isolation and the lack of a social support group. Here, too, freelancers who work at multiple locations and especially in the lesser used languages are much more likely to be in this position than those who are staff and likely to have the support of others in their workplace who have similar concerns and professional experiences.

Another factor that has been identified as contributing to the likelihood of vicarious trauma is working beyond one's skill level or outside of their realm of expertise (Crezee et al., 2015). It is not surprising that either of these would increase the interpreter's stress level.

Finally, those subject to significant stress in other aspects of their own lives are more susceptible. For measuring this too, there is an online tool to measure overall life stress that will be presented below under self-care

Negative Impact of Vicarious Trauma

Because vicarious trauma can have serious negative effects on many aspects of an interpreter's life (personal health, general behavior, interpersonal relationships in and out of the workplace, job performance, relationships with colleagues, family and friends, changed personal values and beliefs – and

lack of compassion), it is imperative for interpreters to have a self-care plan. Studies with mental health professionals have shown that VT may have a negative long-term effect on their ability to perform their professional duties effectively. Experience from the wide range of other fields suggests that it is likely that is true for all professionals who consistently work with trauma victims.

Self-Care

As mentioned above, interpreters and professional translation and interpreting organizations are very aware of the danger of vicarious trauma and the importance of self-care.

Identifying a Potential Problem

Self-care starts with self-assessment, and here is where many interpreters may stumble. Anderson (2011) points out that the interpreter's commitment to a code of ethics that emphasizes neutrality and impartiality may make it more likely for an interpreter to underestimate the effect that the fraught subject matter they interpret may have upon them. Because they perceive themselves as neutral and impartial rather than empathetically engaged, interpreters may have an inherent tendency to downplay or dismiss the impact of their exposure to the traumas of others, resulting in their failure to recognize VT, even in the presence of the symptoms and behaviors enumerated above.

For those who may wish to have a more formal confirmation of their own intuitive assessment of susceptibility to the long list of symptoms listed above, there are free diagnostic resources available online.

One such instrument is the Professional Quality of Life Scale (ProQOL-5). The most recent version of the ProQOL-5 can be accessed from the ProQOL website (www://https:/proquol.org using the ProQOL Measure & Tool tab). This version of the assessment tool replaces the earlier Compassion Satisfaction and Fatigue Test (CSFT), the Compassion Fatigue Test (CFT) and the Compassion Fatigue Self-Test originally created by Figley in 1995, and then continued by B.H. Stamm. At 30 items, the new ProQOL-5 is less than half the length of those older 66-item tests, but is regarded as more predictive and more psychometrically sound.

Two major changes to the test are worthy of note. First, the ProQOL-5 now measures "Compassion Satisfaction" as well as "Compassion Fatigue." Second, the test was renamed. The ProQOL Manual explains the reasoning for changing the name of the test when it was last revised. The new name was intended to de-emphasize any association with negative outcomes that seemed to affect only some practitioners of the helping professions. At the same time, a decision was made to shift the focus to broader professional quality of life aspects that affect everyone, because it was thought that this broader focus might also be more conducive to the promotion of more positive systemic changes being introduced in the workplace as well as to helping to de-stigmatize vicarious trauma as a condition, albeit one not included in the DSM-5 or any of its predecessors.

ProQOL and the versions that preceded it have been freely accessible for no charge since their first iteration in 1995 provided that full attribution is given and the instrument itself is not modified in any way other than changing the word "helper" to "social worker," "advocate," "nurse," etc. to fit the professional group that is under examination. From the start the ProQOL's developers have demonstrated their long-term commitment to keeping the test free for those who might need it. Although ownership of the ProQOL was transferred to the Center for Victims of Torture (CVT) in 2017, the CVT also recognizes

the importance of the test's accessibility to all who work with trauma victims and states on its website that the ProQOL will remain free and available to all despite the recent change in ownership.

The ProQOL has been used widely in projects in more than 30 countries and the ProQOL versions 5 and IV are currently available in 25 languages (Arabic, Brazilian Portuguese, Chinese, Chinese – Simplified, Danish, Dutch, Farsi/Persian, Filipino, Finnish, French, German, Greek, Hebrew, Italian, Japanese, Khmer, Korean, Nepali, Norwegian, Polish, Portuguese, Russian, Spanish, Swedish, Turkish). The ProQOL website continues to seek translations into additional languages.

As noted above, high levels of life stress increase susceptibility to vicarious trauma. Thus, when making a self-assessment it may also be helpful to check one's levels of overall life stress. The Holmes and Rahe Scale, designed by two psychiatrists in 1967 to measure the correlation of stress level with illness, was developed from more than 5,000 responses by patients who had been selected on the basis of their medical records. Each patient was given a list of 43 life events and asked to mark off those they had experienced in the preceding 12 months. Each event was assigned a weight based on the estimated magnitude of the stress such an event would normally generate. Scores ranged from a high of 100 points for the "death of a spouse" down to "vacation" at 13 points and "minor violation of law" for 11 points at the very bottom of the scale. The study confirmed that the greater the stress level, the more likely an individual was likely to have succumbed to illness. The Holmes and Rahe Scale is also online at https://www.mindtools.com/pages/article/newTCS_82.htm and is free of charge.

The risk of vicarious trauma is real and widely recognized, but nonetheless there is some good news: Figley deems the condition as highly treatable through the development and application of a self-care plan. This ability to overcome vicarious trauma is reiterated by Gentry (2002), citing Pearlman and Saakvitne (1995).

It is clear that self-care in a general sense has captured the interest of a broad swath of the public in recent years. There are informal blogs and podcasts devoted to self-care. The New York Times even ran an article in its Style section on the individual and often highly idiosyncratic self-care habits practiced by a selection of NYT employees. Home and hearth magazines like Good Housekeeping recently featured an online presentation of 30 mini articles on de-stressing ideas to be used in everyday self-care, and even Martha Stewart declared "2019: The Year of Self-Care."

There is, however, a world of difference between consciously-focused therapeutic self-care designed to combat the toxic legacy of ignored vicarious trauma and compassion fatigue and the routine self-care featured in the popular press, which is often predicated upon seeking out rejuvenating experiences and the purchase of comforting, even indulgent, items intended to keep busy people centered and provide a much needed sense of balance in their lives.

The American Heritage Dictionary, defines self-care as:

The act of engaging in activities or behaviors that help one achieve or maintain good physical or mental health, especially to mitigate the effects of stress or trauma (American Heritage Dictionary, 2019).

This definition encompasses the popular definition of self-care that emerges from the myriad articles appearing in the popular press, that is, self-care as an action to promote feelings of well-being, very often through goods and experiences, but it also includes therapeutic self-care as an act of self-protection against trauma.

Duty of Self-Care

Therapeutic self-care for interpreters providing language access to LEP victims of violence has little to do with self-indulgence; therapeutic self-care is a necessity in order to maintain the ability to work effectively for the good of LEP traumatized victims and suffering patients.

Researchers Pearlman and Saakvitne (1995) pointed out that trauma counselors, and by extension other professionals working with victims of violence and other traumas, must maintain their mental balance, not out of egotism, but in order to continue to serve their clients best by performing to a high professional standard. The familiar inflight passenger safety announcement crystalizes the wisdom of their imperative: "In the event of a loss of cabin pressure, an oxygen mask will drop down automatically… If you are traveling with a child or someone who needs assistance, secure your own mask first, then help others."

Pearlman and Saakvitne (1995) highlight an important issue: Interpreters who fail to take care of themselves first, might ultimately be unable to help those others at all.

Figley reported a correlation between compassion fatigue and ethical violations by mental health professionals (Figley, 2007). Similarly, Sartor (2016) and also Bell and Robinson (2013) noted that vicarious trauma affects the decision-making judgment of mental health counselors, particularly in their analysis of potential ethical dilemmas and grey areas involving client-counselor boundaries and confidentiality, both of which are crucial areas for interpreters in general and for medical and trauma services interpreters in particular. Other studies have found that untreated VT not only impairs judgment, but can also have a negative impact on memory and concentration (Levin & Greisberg, 2003; Jaffe et al., 2003)), both indispensable for interpreter performance.

The correlation between vicarious trauma and ethical violations reported by Figley, Sartor, and Bell & Robinson are concerning and certainly constitute an impediment to performance. Although neither the NCIHC Code of Ethics for Interpreters in Health Care nor the NCIHC Standards of Practice mention eliminating impediments to performance as the state court interpreter codes do, these concerns are covered under the topic of Professionalism in both NCIHC documents. The stated objective of the NCIHC Standard of Professionalism is "To uphold the public's trust in the interpreting profession." The concept of professionalism is fine-tuned in the eight subsections, numbers 19-26 that follow; subsection 23 states broadly "The interpreter is accountable for professional performance." Thus, there is a duty of self-care.

Pearlman and Saakvitne (1995) identified four areas important to the prevention of secondary traumatization and vicarious trauma. 1) professional strategies relating to workload and accessible supervision; 2) organizational strategies, such as release time and safe physical space; 3) personal strategies including personal limits and committing to self-care activities and 4) general coping strategies, such as self-nurturing and seeking connection.

Medical interpreters, particularly freelance interpreters, are likely to have a limited ability to exert control over the professional/management and institutional aspects of the job; consequently the focus here will be on the areas where individual interpreters are able to take charge of creating a personal self-care plan and developing good general coping strategies. What does self-care include?

The Foundation: Good Physical Health

The basis for all self-care is a commitment to a healthy lifestyle. This means:

- Regular meals
- Good nutrition
- Adequate hydration
- Sufficient sleep
- Adequate exercise
- Regular medical and dental care
- Creative pastimes unrelated to work
- Regular social activities
- Spiritual practices

Self-Care Techniques

Other specific self-care recommendations are more closely related to the identified risks arising through the interpreter's exposure to the narratives of violence and trauma they interpret. These include:

- Debriefing
- Decompressing
- Maintaining boundaries
- Relaxing
- Exercising
- Building a support system

Debriefing

The American Heritage Dictionary definition of the verb "debrief" reflects the two main, generally understood meanings of the word:

1. To interview (a government agent, for example) at the end of an assignment, especially to obtain intelligence or to provide instructions regarding information that should be kept secret.
2. To meet with (one who has undergone a traumatic or stressful experience), especially for therapeutic or diagnostic purposes.

The term debriefing is a military concept, as reflected in the first definition above. There are different types of debriefings designed to meet specific needs, e.g., military debriefings, educational effectiveness debriefings, psychological debriefings and critical incident debriefings. Some are highly structured; others are more informal.

Although studies suggest that debriefing is not an effective tool in the prevention of PTSD when used with subjects directly exposed to trauma and can even be harmful, it appears that debriefing with sufferers of secondary trauma serves a valuable purpose. According to Gentry (2002) it is important to share/dilute the images and stories that first responders and others have been exposed to. The domestic violence and criminal attorneys who were the subjects for Levin and Greisberg's research on vicarious trauma in attorneys cited the "lack of a regular forum to discuss and ventilate their own feelings" as a problem (Levin and Greisberg, 2003). Knodel's study of sign language interpreters established that debriefing was the coping mechanism of choice for her respondents, 80% of whom selected it from the list

distributed to them (Knodel, 2018). The perceived value of debriefing among sign language interpreters had already been established by Wessling and Shaw (2014) in their research on interpreted Video Relay Service (VRS), where debriefing was the most frequent coping strategy mentioned in response to their open-ended questions.

Although the studies show that interpreters recognize the value of debriefing even in the broadest and most informal sense of the word, many feel conflicted as to the permissibility of debriefing due to the duty of confidentiality imposed upon them by their codes of ethics (Knodel, 2018; Dean and Pollard, 2001). However, confidentiality should not be used as a disincentive to debriefing. Both the confidentiality required by HIPAA and by the codes can be respected through circumspect editing/sanitizing/censoring of the information shared with others in a debriefing. Names, places, diagnoses, and identifiable situations must be stripped from the narrative information that would reveal or identify the persons or situation.

The situation is exacerbated for interpreters who are not staff with opportunities to debrief with supervisors or colleagues as well as for those who work in small tightly knit communities where even vague details might make it easy to deduce identities based on very little information. In such situations special care must be taken, and debriefing in the form of journaling might be the best option, though here too, confidentiality must be maintained and no personally identifiable information should ever be included.

Decompressing

Interpreting negative diagnoses or narratives of the traumas of others creates tension. Because an interpreter must remain focused during an appointment, the options for decompression during an assignment are limited. This means that it is all the more important to be able to do so afterwards. Depending upon the workplace, there might be a quiet corner for a staff interpreter or others to retreat to, but that is not a given. Freelancers might that their car is their refuge and the place to take deep, conscious breaths and listen to music on the way home.

Another decompression aid might be to create a personal "calming kit" to keep in the car or one's purse for use after especially challenging assignments. Calming kits are often recommended by family therapists to help children manage anxiety, overwhelming feelings and difficult behaviors, but there is no reason not to turn to the same principle for decompressing after a grueling assignment. It is essential that a calming kit contain items that are meaningful and comforting to the interpreter who will use the kit. It is equally important that these items appeal to all five senses: Smell, taste, touch, sight and hearing. Appealing to the senses is important to help interpreters transition from the disturbing material they have just interpreted to being fully and consciously present in this post-exposure moment.

What would be included in a calming kit is highly individual, and the following suggestions are just that – only suggestions to inspire, not to prescribe.

- **For Smell:** A favorite fragrance, an essential oil or a spice from the kitchen.
- **For Taste:** A hard candy, a crisp apple, chocolate.
- **For Touch:** A smooth pebble, a stress ball, a soft pillow, paper to crush or tear to shreds, something with a soothing texture like satin or velvet
- For Sight: A photo of one's family, a loved one, a place associated with positive memories, a calming landscape
- **For Sound:** Favorite music, a CD of soothing nature sounds

Setting Boundaries

Because level of exposure to trauma-related content is the most reliable predictor of vicarious trauma, it is important for interpreters not to bring their work home with them. Often an end-of-the-work-day ritual is what helps interpreters draw a clear line between work and their non-work life. This can be as mundane as switching the cell phone to night mode or journaling the day's particularly difficult moments just before leaving work. The calming kit might be another way to establish clear a boundary between the work with traumatized populations and the rest of one's life.

Many interpreters have small but meaningful rituals to symbolize crossing this boundary, e.g., removing one's watch or a symbolic bracelet at the end of the work day, pulling a cheery brightly colored scarf from the glove compartment and putting it on, meeting friends to socialize after work, showering the day away and putting on fresh clothes upon arriving home. Others leave trauma content behind by immersing themselves in the world of an audiobook as they make the trip home. Every interpreter is different, so their transition rituals will vary widely, but the important thing is to make a clear demarcation between work life and personal life.

Relaxing

Relaxing covers a wide range of activities, ranging from yoga, meditation and practicing mindfulness to hobbies requiring fine motor control and meticulous attention to detail, which might be relaxing for some, but perhaps even stressful for others. Deep breathing, stretching, massage, Tai Chi, sessions in a sensory deprivation tank are other possibilities. Read, paint, garden, stargaze, pet the cat, go bird watching. Exercising can clear the mind and make it easier to fall asleep. Go to the dog park and chat with the other dog owners. There is value in stepping back from the week's work, disengaging and going on mini vacations and spiritual retreats. The Internet is filled with lists of activities that promote relaxation and mindfulness: Walking in nature, reading, journaling, spending time in deep thought. There is no shortage of options.

Maintaining a Support System

The value of a positive support system cannot be underestimated. It is important to have colleagues with whom to debrief, discuss professional issues, decompress and simply vent. Isolation is not only one of the signs of vicarious trauma but it is also a factor that exacerbates it. The lack of a process to build a support group is felt especially by those whose workplace culture does not promote this. This was pointed out by responses in the study with domestic violence attorneys mentioned above (Levin & Greisberg, 2003). Freelance interpreters working in multiple offices and institutions are in a similar or even more isolated situation since they have to create their own professional support systems. Professional organizations represent one natural group where freelancers can find colleagues with similar work experiences, problems, interests and understanding of confidentiality.

Creating a Self-Care Plan

The risk of vicarious trauma demonstrates how important it is to commit to a personal self-care plan. Ideally, a self-care plan should be balanced and take the psychological, the physical, the social and the

spiritual aspects into account. For a self-care plan to be successful, there must be follow through. This means that the plan must be creative and appealing enough to sustain. It also means that the plan must be realistic and not so overly ambitious that it is soon abandoned. A carefully designed self-care plan is what will make it possible to continue to pursue a satisfying profession in such a way that is possible for victims and patients to participate actively and fully in their own health decisions.

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Chapter 11
Interpreting and the Mental Status Exam

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ABSTRACT

The necessity of engaging qualified interpreters to work in partnership with mental health clinicians when serving patients with a limited English proficiency (LEP) is gaining widespread support. Numerous research studies have documented improved patient health and satisfaction outcomes in this regard. Psychiatric practice often involves complexities of thought, language, and communication that clinicians and interpreters must appreciate. One such topic is engaging LEP patients in the mental status examination (MSE). This chapter describes the nature of the MSE, challenges when interpreting for the MSE, strategies for handling such challenges, and approaches for effective collaboration between interpreters and mental health clinicians regarding the MSE and cross-linguistic mental health care more broadly. The current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena also are discussed.

INTRODUCTION

There is growing evidence that individuals with limited English proficiency (LEP) experience obstacles to safe and high-quality healthcare (Wu & Rawal, 2017). Language barriers between patients and medical clinicians are common, and are associated with poorer quality of care, misdiagnosis, medical errors, and lower patient satisfaction (Flores, 2005; Divi, Koss, Schmaltz, Loeb, 2007; Ku & Flores, 2005; Ngo-Metzger et al., 2007; Woloshin, Schwartz, Katz, Welch, 1997). Language assistance provided by qualified interpreters has been shown to increase healthcare utilization as well as improve clinical outcomes and patient satisfaction (Flores, 2005; Jacobs, Shepard, Suaya, & Stone, 2004; Karliner, Jacobs, Chen, & Mutha, 2007). Generally LEP patients view the availability and quality of interpreting services as crucial;

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the use of interpreters and the perceived quality of interpreters' translations are strongly associated with the quality of care overall (Baker, Hayes, & Fortier, 1998; Dang et al., 2010; Green et al., 2005; Kline, Acosta, Austin, & Johnson, 1980; Kuo & Fagan, 1999; Lee, Batal, Maselli, & Kutner, 2002; Moreno & Morales, 2010; Ngo-Metzger et al., 2007).

Many oversight bodies recommend that healthcare clinicians working with LEP patients engage the services of professional interpreters to safeguard quality of care, patient safety, informed consent, and appropriate patient participation in healthcare decisions (Joint Commission, 2009; Registry of Interpreters for the Deaf (RID, 2007a). The use of interpreting services also is gaining advocacy within healthcare systems (Sleptsova, Hofer, Morina, & Langewitz, 2014). An interpreter provides an important linguistic and cultural link between the patient, clinician, and the healthcare system itself.

The use of qualified interpreters early in the sequence of *mental health* service interventions also is associated with better clinical practice and has been shown to be more cost-effective in light of the potential fiscal consequences of inadequate diagnosis and poor referral decisions (Bischoff et al., 2003). As healthcare systems develop and increasingly adopt policies regarding LEP patients and interpreters, it is important that interpreters and clinicians alike understand key issues in psychiatric practice that impact the nature and quality of interpreting work, such as how clinical interviews are optimally mediated by interpreters, including the mental status examination (MSE). The remainder of this chapter describes the MSE (and its variants), common challenges when interpreting for the MSE, tips for managing such challenges, strategies for effective collaboration with medical clinicians, and concludes with information regarding the current state of scholarship in the field of mental health interpreting and training opportunities for interpreters who seek to improve their knowledge and skills in the mental health arena.

BACKGROUND

What is the Mental Status Exam? The MSE is an important component of many clinical interviews. Its results can inform the patient's history, diagnosis, and treatment plan (Barnhill, 2014). All medical clinicians are trained to do the MSE, but it is most often used by clinicians in the mental health field. Its frequent use and value are comparable to taking a patient's vital signs in other fields of medicine. So why does this matter for interpreters? A patient's preferred language and culture must be taken into account when conducting and interpreting the results of the MSE. Linguistically and culturally, the patient must be able to understand the MSE questions and communicate their answers, while the clinician must be able to interpret the patient's responses in light of potential linguistic and cultural differences between clinician and patient (Pollard, 1998a; Norris, Clark & Shipley, 2016). Interpreters play a crucial role in ensuring that these linguistic and cultural elements are accurately conveyed and considered in this important phase of a patient's clinical assessment and care.

The MSE can be thought of as a broad cross-sectional assessment of a patient's cognitive and emotional state and capacities. While the MSE most frequently is conducted with patients being served in mental health settings, MSEs also may be conducted in primary care and other medical settings – whenever a patient's cognitive and emotional state and capacities are in question or simply must be documented. The MSE will most certainly be conducted during a mental health clinician's first contact with a patient and may be repeated frequently with the same patient, particularly in emergency or inpatient psychiatric settings. The interaction that comprises the MSE can vary considerably in length – being briefer when the MSE is repeated with a patient whose previous MSE results already have been documented or when

a clinician has little question that a patient's basic cognitive and emotional state are intact and unremarkable. An effective MSE can provide crucial data for immediate diagnostic and treatment decisions and inform more longitudinal mental health perspectives (Barnhill, 2014).

The assessment of mental status begins the moment the clinician meets the patient – at least it has begun in the *thought world* (Dean & Pollard, 2013) of the clinician. While some aspects of the MSE may include specific questions posed to the patient, for the most part, MSE data is gathered through observation and seemingly casual conversation, where the clinician is attuned to listening for key MSE information as the patient relays their story or answers broad questions (Robinson, 2008).

Though at times seemingly informal, the MSE nevertheless is a multifaceted clinical tool that involves a set of standardized observations and inquiries that reveal information regarding multiple domains: sensorium and cognitive functions, perception, thinking, feeling, and behavior (Robinson, 2008). Table 1, based, in part, on Robinson (2008), lists specific topic areas that are assessed under each of these domains. Almost always, a clinician's formal MSE documentation will address each of the topics listed, via the data gathered through observation, informal dialogue, and formal questions.

While clinicians will document most or all of the above topics in the patient's medical record after conducting the MSE, to an untrained observer (including many interpreters) the interview that yields MSE data may not appear to be an "examination" at all. If open-ended questions do not yield some of the desired MSE data, the clinician will usually ask more specific questions that focus on key MSE topics. Sometimes, patients will be asked to respond to specific MSE-related questions (e.g., "What is today's

Table 1. Domains and topics assessed via the mental status exam

Domain	Topics Assessed
Sensorium & Cognitive Functions	• Level of consciousness • Attention • Concentration • Orientation to person, place, date, and situation • Memory (short and long-term) • Fund of knowledge • Intelligence • Capacity for abstract thinking • Reality testing
Perceptual Anomalies	• Hallucinations • Delusions • Illusions • Depersonalization or derealization
Thought and Language	• Quality of speech • Thought content • Thought form • Suicidal and/or homicidal ideation • Insight • Judgment
Emotional Status	• Affect (shorter-term emotional states) • Mood (longer-term emotional states)
Behavior	• Appearance (e.g., hygiene) • Posture and gait • Motor activity • Degree of openness regarding the interview • Attitude toward the examiner

date?") or perform certain tasks (e.g., copy a drawing or follow a written command). (More on this topic in the next section.) Some clinicians use MSE checklists to gather key data in a more structured manner.

MAIN FOCUS OF THE CHAPTER: INTERPRETING FOR AN MSE

Assuming that interpreters are familiar with the complications and nuances of working in a bilingual-bicultural environment and working in mental health settings in particular (Pollard, 1998a; Tribe & Lane, 2009; RID, 2007c, Vernon & Miller, 2001), interpreting for the MSE when it is conducted in a conversational manner should not be particularly difficult. Of course, any time a translation challenge or relevant cultural issue arises, one should inform or educate the clinician about that challenge or issue. Asking a clinician to rephrase a question that was difficult to translate or explaining why a translation is difficult or noting how a question or topic bears particular cultural relevance are common choices an interpreter might make in such situations. But bear in mind each of the topics presented in Table 1 since the clinician will desire specific data regarding them.

For example, communication regarding, emotions, mood, unusual thoughts or sensory experiences, are particularly important to convey because they are not easily observed. Also not easily recognized by the clinician will be relevant characteristics of *how* the LEP individual is communicating. Is their speech (or sign language) unusually fast or slow or odd in other ways (see the section on "dysfluency" below)? Are the thoughts expressed by the patient (e.g., communications with the spirit world) possibly considered unusual in the clinician's culture but common in the patient's culture? Anticipating these important possibilities before they arise is the best preparation for interpreting during the MSE.

Specific Questions and Procedures Sometimes Used During the MSE

Beyond what may appear to be typical conversation about a patient's emotions, life difficulties, etc., there are many specific questions and procedures that may come up during the MSE. Each of these questions or procedures relates to one or more of the topics listed in Table 1. Interpreters should be prepared to encounter these questions and procedures, some of which may seem unfamiliar or strange. Some patients express surprise or even annoyance that these questions or tasks are asked of them, especially when they feel that the clinician is digressing from addressing the concerns that brought them to the facility. It is usually sufficient for the interpreter (or better yet, the clinician) to explain that these questions or tasks are presented "to everyone" or otherwise convey that, in mental health settings, these questions or tasks are common.

Regarding the topic of orientation, clinicians may ask the patient to state who they are, where they are, the day and date, or even ask questions that should involve common knowledge such as who the president of the United States is.

Regarding attention and concentration, clinicians may ask patients to do arithmetic problems in their head (not on paper) such as a task known as *serial 7s* (Teng, 2018). Here, a patient is usually asked to subtract 7 from 100 (the correct answer is 93) but then continue subtracting by 7s (e.g., 93 – 7 = 86, 86 – 7 = 79, etc.) for a short while. Another common technique is to ask the patient to spell a familiar word backwards. Often, the clinician will choose the word "world" (where the correct answer would be d-l-r-o-w). However, if one has translated the word "world" into the patient's preferred language (e.g., "mundo" in Spanish), the task would be problematic or not make sense at all unless the clinician was

informed that the word "world" was changed to another word via the translation. In the video accompanying *Mental Health Interpreting: A Mentored Curriculum* (Pollard, 1998a), a Spanish language interpreter encounters this problem and asks the clinician if he wants the patient to spell *world* or *mundo* backwards.

Regarding short-term memory, clinicians may ask patients to remember a short list of words, then recall them perhaps 20 minutes later. In some cases, when a patient has difficulty recalling one or more of the words, the clinician may give them a hint (e.g., "It was a color.") or even offer multiple choices (e.g., "Was it red, blue, or green?")

Other procedures are intended to investigate the patient's language functioning. One such strategy is asking the patient to comply with a sequence of verbal commands (spoken or written) beginning with one-step commands (e.g., "Close your eyes") and progressing to more complex commands with multiple steps (e.g., "Point to the ceiling, then point to the door, and then to the main source of light in this room"). Another technique may involve asking a patient to read aloud from a paragraph or from a list of single words. Patients may be asked to spontaneously generate a written sentence. When these language-based MSE tasks are administered, especially involving reading or writing, LEP patients may not be able to respond or respond inappropriately which could be mistaken for symptoms of cognitive impairment. Interpreters should immediately discuss with the clinician any potential challenges in assessing patients using these language-based techniques, including how translation of spoken instructions (or responses) might affect the results.

Other MSE tasks may involve writing, drawing, or other motor functions. Patients are sometimes asked to copy a drawing that is shown to them, using another piece of paper. These drawings are usually geometric figures such as two oblong hexagons that intersect. Sometimes, patients are asked to perform an imaginary motor function such as threading a needle. A common procedure is to ask patients to draw a clock (that is, an analog clock face, not a digital clock) and set the hands of the clock at "ten past eleven". This specific wording, in English, is critical to the task; saying "ten minutes past eleven o-clock" would disrupt the information the clinician is looking for. This part of the clock drawing command presents translation difficulties in many languages and the clinician should be informed of this.

Finally, in assessing abstract reasoning, it is common for clinicians to ask patients to explain the meaning of a proverb. English language proverbs such as "people who live in glass houses shouldn't throw stones" or "a rolling stone gathers no moss" might be presented. Here, the clinician is looking for an abstract versus a concrete explanation of the proverb's meaning. While some LEP individuals may be familiar with the proverb(s) presented or be able to figure out an abstract explanation even if they are not familiar with the proverb, it is typical for LEP individuals to be unfamiliar with proverbs in a language in which they are not fluent. Again, clinicians should be alerted to this problem if a proverb inquiry is made during the MSE.

Other Potential Complications When Interpreting for the MSE

The Bilingual, Bicultural Environment and Fund of Information

Interpreters know that, frequently, differences between two languages cannot easily be bridged, especially in a word-for-word way. Unfortunately, clinicians who are monolingual may not understand this and erroneously presume that whatever is said in one language can be mapped, in a direct fashion, to words that have similar meaning in the other language. Dean and Pollard (2005) offer useful guidance to read-

ers who do not fully understand the nature of interpreting work which sometimes requires translation strategies that are unknown, even unexpected, by monolinguals.

Interpreters also make translation and behavioral decisions based on cultural and contextual variables in the service environment, as well as their own experiences as members of an LEP community (since most interpreters' first language is the non-English language with which they were raised). Interpreters are usually the only person in the room who truly understand the bilingual, bicultural factors at play. This information could directly impact a clinician's ability to achieve the objectives of a MSE and/or other evaluation and treatment goals and must be openly discussed (Raval, 2003). Differentiating between bilingual, bicultural factors that are truly relevant to the situation from those that may reflect the interpreter's own personal themes, biases and assumptions – especially in mental health settings – is a valuable outcome of such frank discussions (Tribe & Lane, 2009).

LEP individuals may be immigrants, refugees, or deaf persons who have had difficulty acquiring a spoken/written language such as English (which is common in the deaf population). One consequence of limited proficiency in a majority culture's language, or less familiarity with that culture itself (as is often the case with immigrants and refugees) is a lower "fund of information" (Pollard, 1998b) regarding the country or culture in which they now live, regardless of one's intelligence or educational attainment. Fund of information deficits are the result of multiple factors that impede access to information in the majority language (e.g., radio, television, magazines, overheard conversations, etc.). When LEP or deaf patients "don't know things" that a clinician assumes are common knowledge, errors in MSE conclusions can result. Deficits in fund of information also can hinder a patient's understanding of, and cooperation with evaluation and treatment in mental health and other medical settings. Gathering information about communication and learning history in both family and school contexts can help to differentiate between fund of information gaps, limited intellect, and mental health symptoms.

Dysfluency

It is not unusual in psychiatric settings to encounter patients whose primary language is not fluent or even proficient (i.e., their language is "dysfluent"). Certain mental illnesses and neurological conditions can interfere with individuals' thought processes, language abilities, or both. For example, psychotic illnesses, mania, strokes, dementia, drug or alcohol intoxication, and certain developmental disorders all may cause language dysfluency symptoms. Dysfluency generally takes one of three forms: (1) a general lack of language proficiency that significantly impairs communication with the individual or (2) specific, disruptive errors in language use that are atypical of average users of that language, but which do not significantly impair communication, or (3) language articulation problems that are not suggestive of a thought disorder per se (e.g., slurred speech). All of these forms of dysfluency are important to notice and convey to clinicians – the interpreter is typically the only person in the room who has the ability to notice such language problems.

Since virtually all (hearing) persons are proficient, if not fluent, in their preferred language, even seemingly minor dysfluent language events *might* be indicative of important psychiatric or neurological impairments. For this reason, mental health clinicians are taught to attend to even the subtlest of language dysfluency events. Andreasen (1980) describes no fewer than 20 specific types of language dysfluency that may be observed in psychiatric settings, giving examples of each type (as manifested by native English speakers with psychiatric disorders).

Here is an example of obvious, general dysfluency, directly quoted from a native English-speaking patient with schizophrenia who was responding to a psychiatric interview captured on film in a training video series for mental health clinicians (Wohl & Csernansky, 1994):

Well there the before on the clock, that's the 6, 7, 8, 9, 10, 11, 12, 1, 2, 3. They go by those numbers of the clock. And when you do the 25 after that's the after side of the clock. We go by the 1, 2, 3, 4 and 5 of the clock and the 5 you go right left to 7 number on the clock is the 5 number. You go right left to that number. That's what the 25 is. If you don't do something they tell you to do and Jesus makes the shotgun sound and then phone rang not to answer the phone or the doorbell.

This language sample is so disturbed that it would be nearly impossible to translate accurately. There is simply not enough logic or structure in the patient's language to convey sufficient meaning to the interpreter to allow her/him to form a coherent translation into the target language. (In the interpreting field, we denote that interpreters are receiving an utterance in one language, the "source language," and translating it into another language, the "target language"[1]). Dysfluent language of this severity is most certainly evidence of significant psychiatric or neurological impairment. If the interpreter translated only those parts of this utterance that she/he understood, in effect, "cleaning up" the language sample and failing to convey to the clinician the severe dysfluency that was otherwise evident, critical diagnostic information would be hidden from the clinician's awareness. The key here is to note that the patient's language, in large part, is not coherent. An interpreter's assumption of, or search for meaning in this language sample would be both fruitless and counter-productive. Below, we will address what an interpreter still can do to be helpful to the clinician, even when confronted with such severe language dysfluency.

Here is a different language sample demonstrating a much *less* severe degree of dysfluency that is nevertheless significant enough to have diagnostic relevance. It is also a direct quotation from a native English-speaking patient from the same diagnostic interview film series cited above. She is discussing the death of her mother. This patient was filmed during the manic phase of bipolar illness.

She had cancer of the spinal cord when I was 11-years-old and they had to take out her back, eight inches of her back out to kill the cancerous tumor. So that means she was paralyzed from her breast down for 21 years of her life. She died the age of the year I was born, '61. I believe everything has a purpose under heaven…I believe that's the time that God wrote down she is going to die before she hit her 62nd birthday. She was going to die and be my guardian angel at 61 of the year I was born.

Notice this patient's unusual phrasing involving numbers as well as her reference to her mother being paralyzed from "the breast down." Other portions of this interview revealed that the patient expressed a great deal of sexualized ideation. Native English speakers might say that a person was paralyzed from the "neck" down, the "waist" down, etc., but not the "breast" down. The several odd references to numbers in this language sample are even more noticeable. The severity of language dysfluency is subtler than in the earlier language sample and does not impair understanding as severely. Yet, even these language anomalies are diagnostically relevant. Again, ignoring such language anomalies or "cleaning up" the language in one's translation would hide important diagnostic information from the clinician.

While encountering language dysfluency is one of the most challenging aspects of interpreting in mental health settings, it is also one of the most important – where the interpreter's response to this challenge typically holds diagnostic and/or treatment significance. Most interpreters who work in com-

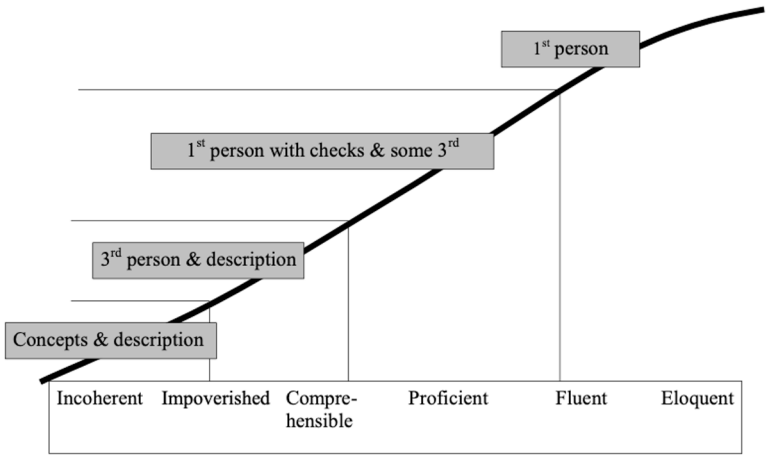
munity settings have not encountered language dysfluency associated with psychiatric or neurological disorders, but it is not unusual to encounter in mental health settings. Despite the challenges involved, there are still helpful ways the interpreter can respond.

Again, the first rule is to not "clean up" dysfluent language or otherwise speculate what the patient "probably means" and then provide the clinician with a fluent, coherent (and misleading) target language translation. While a verbatim translation may not be possible when a patient's language is seriously dysfluent, interpreters still have options.

Figure 1 below portrays different options interpreters have when encountering dysfluent language. At the base of the figure is a scale of language dysfluency where fluent or even eloquent language is depicted on the right end of the scale. When language is of good quality, as depicted here, interpreters will normally translate in the first person and have little difficulty. Remember, here we are referring to the patient's preferred or best language. While most individuals are fluent in their preferred language some patients with psychiatric or neurological disorders are not. Thus, fluency (and logic) should never be presumed when interpreting in a mental health setting.

The middle portion of the scale is meant to depict language that is somewhat poorer in quality, such as proficient (but not fluent) language or language that is comprehensible (i.e., generally understandable, for the most part) but not even proficient in quality. Here, an interpreter will usually translate in the first person, when the language is good enough to allow this, but will often need to ask the patient to repeat or clarify what they said. Another option in this range of language dysfluency is to switch from first person translation to "third person" translation (e.g., "He was describing a physical fight he had with a friend, but it is not clear if this happened recently or long ago or which person punched which person first"). While a third person translation does not provide the clinician with the exact detail that the interpreter might desire, it still provides the "gist" of the language sample and further alerts the clinician that the interpreter is having difficulty translating the patient's language, therefore making the clinician aware that there is probably a degree of dysfluency being manifested by the patient. If the clinician truly cares about the unclear content, she/he can interrupt and ask the patient to clarify. But, more likely, the clinician may want to know (later) from the interpreter the nature of the translation difficulty she/he observed

Figure 1. Translation options when confronted with language dysfluency



when the switch to third person took place. Such information may well reveal the type of dysfluency the patient was manifesting (Andreasen, 1980).

At the left end of the scale at the bottom of Figure 1, are the terms "MLS" (meaning "minimally language skilled"), where very little of the patient's language is clear and/or logical and "incoherent," where virtually none of what the patient is communicating is understandable. Again, this certainly can happen when patients have severe psychiatric or neurological impairment, but interpreters still can be tremendously helpful in such situations. As shown in Figure 1, while first person translation in such situations is likely impossible, there might be segments of the patient's language that are sufficiently understandable for a third person translation. But even when that is not possible, interpreters can still *describe* what they are observing in the patient's language. Such description can be extremely helpful to clinicians who are trained in identifying different forms of language dysfluency.

For example, there is a dysfluency symptom known as "clanging" in which patients are drawn to the structure of the language they are using and not the logic of what they are attempting to say. With hearing patients who "clang" they may put together a sentence with words that rhyme or begin with the same sound but, together, the sentence does not make sense. Deaf patients who clang also are drawn to the structure of sign language (and lose sight of the logic of their communication) by putting together a sentence that uses several signs involving the same handshape but, again, which do not make sense as a complete utterance. Since clinicians working with interpreters will not recognize rhyming, sign language handshapes, etc., the only way they might suspect that a patient might be clanging is for the interpreter to inform them that these types of phenomena are occurring.

While clanging is only one example of the many language dysfluency symptoms one might encounter, two key points remain – interpreters should always explain to the clinician (either in the moment or afterward, as the situation warrants) unusual language events that they observe and, second, never insert clarity or logic in a patient's language utterances when such clarity or logic is weak or absent. Failure in either regard "hides" potentially crucial diagnostic and/or treatment information from the clinician that may well impede or curtail the treatment that the dysfluent patient deserves.

Interpreter-Clinician Partnership in Mental Health Interpreting

When interpreters and clinicians work together in providing access to care for patients whose first language is not English, there are multiple benefits for all, especially patients. The following section offers considerations in developing a collaborative relationship and environment for the interpreting of MSEs, others psychiatric interviews, and medical appointments generally.

Like other venues of interdisciplinary teamwork, in medical contexts, preparation helps clinicians and interpreters work together most effectively. Interpreters should be recognized as fellow "practice professionals" (Dean & Pollard, 2013, 2018) on the service team. Familiarizing oneself with local interpreting agencies, national interpreter organizations and their codes of ethics or professional conduct, and specific guidelines for working with interpreters in medical and mental health settings can be very useful (Tribe & Morrissey, 2004). Written guidelines and contracts about interpreters in medical settings can include specifics regarding confidentiality, roles and responsibilities, and other professional and ethical issues (Sills, 1997). Introducing interpreters to key hospital or office staff, inviting their participation in continuing education lectures or courses and relevant meetings helps integrate interpreters with the broader medical team and environment (Tribe & Sanders, 2003). Clinicians could also provide a dictionary of medical terms available for interpreters to consult (Tribe & Morrissey, 2003).

Hiring qualified interpreters who have experience, training, and are comfortable in mental health and/or medical settings is valuable for many reasons, but is especially important when initial diagnostic (e.g., MSE) and treatment planning decisions are being made. Determining the client's preferred language, including dialect, and finding an appropriate interpreter with a background in both the patient's preferred language and mental health work is often a challenge that can be streamlined when interpreter referral agencies and clinicians work together. If possible, interpreters and patients should be matched for gender, age and religion, particularly if this is relevant to the meeting or consultation (e.g., in cases of sexual assault or intimate partner violence) (Patel, 2003; Nijad, 2003). If multiple appointments are anticipated and the patient and interpreters agree, then the same interpreter should be requested for ongoing appointments whenever possible. When that is not possible, interpreters should be encouraged to pass along key information about the assignment (e.g., key names and relationships that are discussed, important facts that have been established, etc.) to new interpreters who will be involved so that continuity of communication can be maximized between the clinician(s) and multiple interpreters.

Interpreted appointments almost always take more time than appointments where clinicians and patients speak the same language and schedules should be planned to accommodate that extra time. A 10-15 minute "pre-session" before the appointment begins, in order to explain the purpose of the meeting and clarify any technical concepts, vocabulary or jargon, cultural issues, and nonverbal communication norms that may arise should take place whenever possible. If using technical vocabulary or procedures other than discussion is anticipated, familiarizing the interpreter with these terms or procedures beforehand can allow for smoother communication during the appointment (Tribe & Morrissey, 2004). Even planning the physical arrangement of the environment, so that it is conducive to a three-way conversation is helpful (Tribe & Morrissey, 2004).

The value in taking the time to prepare in advance for interpreter-clinician collaborations cannot be overstated. Beyond the interpreters and clinicians themselves, interpreter service agencies, office managers, and human resources personnel also can be helpful in this preparatory stage.

If pre-appointment preparation is done well, this maximizes the likelihood that the clinician and interpreter can concentrate effectively on their respective duties during the appointment itself. Ultimately, when the appointment begins, the clinician, interpreter, and patient should all feel comfortable; it should be obvious to the patient that these fellow practice professionals "know what they're doing." Leading off with an open discussion, where all involved acknowledge that interpreted conversations present unique challenges is fundamental (Tribe & Morrissey, 2004). This can be achieved by first clarifying the interpreter's professional role and addressing confidentiality boundaries (Tribe & Sanders, 2003).

Being mindful of pacing and turn-taking is especially important when working with interpreters. They cannot interpret for more than one person speaking at a time and, as noted, words or concepts in one language do not always have exact equivalents in another language, sometimes requiring extra time for an effective bilingual, bicultural translation. Clinicians and interpreters should not discuss anything in front of the patient that is not intended for the patient to understand. That is, all communication conducted in the patient's presence should be translated. If issues arise which require private discussion between the interpreter and clinician, the interpreter can explain this to the patient and a break can be taken so that the interpreter and clinician can confer or, better yet, these things can be discussed in private before or after the meeting (Razban, 2003; Baylav, 2003). Particularly in mental health settings, it also is advised that interpreters not be alone with the patient/family without the clinician present (e.g., in a waiting room) to maximize confidentiality and professional boundary-keeping.

The collaboration between clinicians and interpreters should continue after the appointment as well. The appointment experience is often rich with communication dynamics, curiosities, and ideas for feedback that can be discussed during a short debriefing session. Any translation, cross-cultural or other challenges the interpreter noticed should be shared with the clinician. Debriefing on how well the clinician and interpreter worked together as a team is another important topic which may involve questions or even constructive criticism regarding their working partnership. Discussing arrangements for future communications and appointments also can occur at this point. This "post-session" is a wonderful opportunity for these practice professionals to share information and resources that may help one-another continue to develop their skills in bilingual, bicultural mental health work.

Continuing Education and Mental Health Interpreting

The lack of well-regulated training for interpreters is an issue in many countries (Dean & Pollard, 2001; Tribe & Sanders, 2003; Hwa-Froelich & Westby, 2003). Interpreter qualifications, training, and other professional and even legal requirements vary widely (Tribe & Morrissey, 2003). The effectiveness of interpreter preparedness and on-the-job judgement, whether regarding translation, behavioral, or ethical decisions depend a great deal on their familiarity with the setting in which they are working (Dean & Pollard, 2013). Unfortunately, interpreters often function or are trained as "generalists" – as if their bilingualism and cross-cultural knowledge prepares them to work with equal effectiveness in any setting. This is quite inaccurate. Medical and mental health settings, legal settings, and educational settings, especially post-secondary ones, present particular challenges regarding the requisite knowledge, vocabulary, and experience to perform competently as an interpreter (Pollard, 1998a, RID 2007a, 2007b, 2007c).

An interpreter's role is complex and demanding. Their work requires a variety of skills, including knowledge of specialist terminology, ability to reflect on meaning, memory skills and the ability to convey accurately the meaning of the content expressed (Tribe & Morrissey, 2003). Interpreters benefit greatly from continuing education, support, and supervision (Dean & Pollard, 2009, 2013). Interpreters who work in mental health settings also may need supervision and consultation resources around matters such as therapeutic boundaries, confidentiality, therapeutic practice, and the consequences of communicating traumatic material (e.g., vicarious trauma). Interpreter organizations should consider how to incorporate mentoring, consultation, and supervision into continuing education programs for all interpreters, especially those working in mental health and medical specialties.

Two organizations have created certification processes for medical interpreters: the Certification Commission for Healthcare Interpreters (CCHI) and the International Medical Interpreters Association (IMIA). The CCHI exam assesses healthcare terminology, interactions with other healthcare professionals, interpreting encounters, and cultural responsiveness and includes consecutive and simultaneous interpretation in addition to sight translations. The IMIA Certified Medical Interpreter status is available for Spanish and nearly 30 other languages and requires successful completion of written and oral exams (VanderWielen, 2014).

The United States presents a mix of state legislation and individual organization policies regarding medical interpreting. Even though the above two national organizations provide certification processes for medical interpreters, various state certification programs also exist. Pollard (1998a) developed a popular mental health interpreting training curriculum conducive to various interpreter training environments (e.g., small group, large group, individual, etc.) Other notable resources for mental health interpreter training include the Alabama Department of Mental Health's Mental Health Interpreter Training (MHIT)

program, the CATIE Center's mental health interpreter training program at St. Catherine's University, Cambridge College's Mental Health Interpreter Certificate program, the Cross Cultural Communication Institute (CCCI) Mental Health Interpreter Certificate, the University of Minnesota's Interpreting in Refugee Mental Health Settings training, a program run by the National Latino Behavioral Health Association (NLBHA), and the National Asian American Pacific Islander Mental Health Association (NAAPIMHA) Mental Health Interpreter Training Program (MHITP). In 1978, the U.S. Congress passed the Federal Court Interpreters Act, mandating that the U.S. courts establish a program to facilitate the use of certified and otherwise qualified interpreters in judicial proceedings instituted by the United States (VanderWielen, 2014).

CONCLUSION

The presence of qualified interpreters in mental health settings is gaining popularity. The benefits to patient access and satisfaction in healthcare, diagnosis, and treatment are many. The MSE is a central component of assessment in mental health settings that is used to examine and document various aspects of a patient's cognitive and emotional functioning. Some elements that impact interpreting for the MSE lie in the assessment techniques utilized by clinicians and some in the challenges that LEP patients may present (e.g., dysfluency, fund of information gaps). A collaborative and open relationship between clinicians and interpreters is the key to conducting a proficient MSE and bridging the gaps between the clinician, patient, and interpreter. Utilizing cooperative guidelines helps to organize interpreter and clinician roles and responsibilities before, during and after interpreter-mediated appointments. Supporting the progress of mental health interpreter training and certification programs is essential to promoting the vital role of interpreters in mental health care.

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ENDNOTE

[1] In the interpreting field, we denote that interpreters are receiving an utterance in one language (the "source language") and translating it into another language (the "target language")

Chapter 12
The Mental Health Interpreter:
The "Third Space" Between Transference and Counter-Transference

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ABSTRACT

This chapter aims to provide an interpretation of the role of the mental health interpreter, using the concept of "third space" taken from the field of cultural translation and the psychoanalytical concept of transference/counter-transference. Such interpretation provides a unique and novel analysis of the work of the mental health interpreter through the perspective of the "third space", thus enabling a broader view of the interpreter's role in the therapeutic session. The authors' insights are based on a reflective journal written by the first author while working as an interpreter during a parental training in a public mental health clinic in Israel. By reviewing the different roles, powerplays, and challenges in this third space, the authors will suggest some practical recommendation regarding the training and supervision of mental health interpreters, allowing them to serve as competent and ethical mediators between the patient and the therapist.

INTRODUCTION

The literature on interpreters in public services (including mental health interpreting) has long been recognized the interpreter-mediated session as an interaction (Wadensjö, 1992) in which not only the main parties have distinct voices (e.g. "the Voice of Medicine" and "the Voice of the Life-world", as Mishler [1984] refers to them) but also the interpreter. Brisset and colleagues (2014) have found that collaboration with a competent interpreter helps the healthcare provider to better listen and understand the patient's lifeworld (Leanza, Bolvin & Rosenberg, 2013). Such examination of the interpreter's dynamics in public service settings challenges "the myth of the uninvolved interpreter" (Bot, 2003) and assumes

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a more present, active and involved role for her (Hseih, and Nicodemus, 2015). The dynamics in the triadic encounter are even more significant in mental health settings, as will be further elaborated later on.

This paper aims at analyzing the work of the mental health interpreter from a new perspective – that of the "third space", thus enabling a broader view of the interpreter's role in such settings. The authors base their insights on a reflective journal written by the first author while working as an interpreter during a parental training in a public mental health clinic in Israel. She interpreted between Hebrew and Italian throughout 20 sessions that took place between January and August 2016. With the background of a mental health worker and a trained interpreter, her observations refer to the linguistic, cultural and psychological aspects of the interpreted session.

BACKGROUND

Language, Interpreting and Health

The importance of the mother tongue in psychotherapy is extensively discussed in the literature (Amati-Mehler, Argentieri & Canestri 1990, Santiago-Rivera & Altarriba, 2002). The centrality of words in psychoanalytic psychotherapy is crucial as a pathway to analysts' and patients' access to the content and effect of pathogenic unconscious, fantasy, memory and complexes and contribute to an effective therapy.

A meta-analysis of 76 studies found that therapies offered in the patient's mother tongue were twice more effective than therapies offered in English (Griner & Smith, 2006), with more effectiveness being measured when the therapy included culturally adapted measures. In the macro level, patients who are not proficient in the country's primary language may encounter barriers to the use of mental health services (Sentell, Shumway, & Snowden, 2007), as well as higher rates of treatment dropout, recurrent and longer hospitalizations, poor adherence to medication and treatment recommendations, lower client satisfaction. Naturally, all these barriers may contribute to health disparities among fragile populations.

When patient-therapists language concordance is not possible, the session should be mediated through an interpreter (Brisset et al., 2014). Based on understanding of the importance of language in psychotherapy, some therapeutic models, e.g. the Cultural Consultation Service (CCS) in Canada, suggests considering the social, cultural and political context of the patient's behavior and symptoms, to provide better diagnosis, assessment and treatment plan (Kirmeyer et al., 2003). In such cases, cultural mediators (sometimes referred to as cultural 'brokers') eliminate not only the language gaps, but become go-betweens who sensitize clinical practitioners to patients' belief systems and encourage patients to "trust" the institutional system. According to Miklavcic and Leblanc (2014) who studied the Canadian CCS mentioned above, cultural brokers can help in assimilating the immigrant's point of view to the healthcare system and broader society, by offering a more inclusive two-way exchange of the other's perspective.

Since the triangular encounter of the therapist-patient- interpreter requires specific expertise and preparation, many providers often lack the appropriate training to effectively use interpreters during therapy. For example, a survey among mental health providers in Montreal, Canada, revealed that even when linguistic resources such as interpreters were available, many providers were not aware to issues like the dynamics in the triadic encounter, the possible roles of the interpreter, and key elements for a successful interpreter-mediated intervention (p. 1245).

The Complexity of Mental Health Interpreting

Interpreting in mental health settings requires special knowledge, awareness and skills. Interpreters in mental health have a responsibility for the co-construction of meaning, which is one of the basic and most important process acquiring within a therapeutic encounter (Leanza, Bolvin, and Rosenberg, 2013). The interpreter's choices, even on the renditions of small, allegedly non-informational utterances, may either exclude or marginalize the principal participants. Successful mediation, on the other hand, may help building an emotional rapport (Farini, 2013).

In addition to general linguistic and interpreting skills, the mental health interpreter should be able to identify meta-linguistic issues, such as unusual linguistic choices or unique forms of languages, that may be important for an accurate diagnosis and treatment (Registry of Interpreters for the Deaf, 2000; Santiago-Rivera & Altarriba, 2002). Mental health interpreters should also be aware of extra-linguistic factors, such as the nature of the session (for example, an intake interview) and the setting (i.e., the combination of concrete and subjective elements in the psychotherapy framework that are set up to provide continuity, consistency and containment). For example, the length of therapeutic sessions may affect the ability of the interpreter to keep focused.

Another important element is the interpersonal dynamics in the room (Hlavac, 2017). Interpreters must be able to cope with silence, anger, tears and mistrust. Moreover, their feelings that things are not going according to their own common sense regarding the nature of the conversation and patient-therapist dynamics, may leave the interpreters confused and frustrated. Anderson (2012), a mental health interpreter, accurately phrased the effects of these emotions: "When the interpreter silently questions the course of therapy, subtle emotional overtones may be disruptive to the therapeutic relationship. […] Their innate responses can add some emotional nuances to the interaction that were unintended by the therapist, and eventually to subtly degrade the quality of trust and rapport between therapist and client". That said, the interpreters' performances have interpersonal and clinical consequences on the shifting boundaries of task, identities, and relationships in therapist-patient interactions (Hseih & Nicodemus, 2015)

Despite the fact that interpreters can be emotionally affected by their mere presence and involvement in therapeutic sessions, studies addressing issues of emotions in interpreter-mediated encounters are few and quite limited (Hseih & Nicodemus, 2015). Similar cultural background or past experiences may evoke significant emotional impact (Miller et al., 2005; Tribe & Morrissey, 2004), as well as the fact that the interpreter usually speaks in the first person. On the other hand, studies have shown that such exposures could also lead to substantial personal growth among the interpreters (Hseih & Nicodemus, 2015; Splevins et al., 2010). In any case, most interpreters do not receive supervision[1] or support, and may be at risk of developing secondary or vicarious trauma (Splevins et al., 2010).

The following chapter is aimed to shed light over the need of therapists and interpreters to identify and acknowledge such emotional impact, and be prepared to handle its implication, both for the success of the therapy and the interpreter's emotional well-being and his/her proper professional conduct.

THEORETICAL FRAMEWORK

The Third Space no. 1: The Cultural Translation Perspective

Almost all aspects discussed so far regarding the interpreter's position in the consulting room are generally framed as "problematic", often used to highlight the difficulties that this service presents to all involved parties. However, the authors would like to suggest a different view of the role of the interpreter in mental health settings, which points out, next to the difficulties and "traps" it creates and faces, the potential added value that his/her presence can bring to the table of successful therapy. To this end, the authors will rely upon the sociolinguistic concept of "third space" articulated within the theory of cultural translation by the scholars Homi Bhabha (Bhabha, 1994) and Judith Butler (Butler, 2012).

Bhabha is one of the pioneers of post-colonial studies of literary criticism. In his thinking, identity is shaped by a complex and uninterrupted negotiation that finds its most fertile ground in hybrid and intermediate spaces. The latter, better known as "third space", is the theater of cultural translation (Buden et al., 2009), a platform to the development of identity and the creation of cultures. Engaging into the relationship with the other means to take the risk of his unconscious, of the displacement of the point of view, to identify with the untranslatable (Bhabha, 2016). In such a condition of liminality and paradoxes, people are constantly in motion, engaging in dialectical processes and exchanges: "It is in this space that the authors will find those words with which we can speak of ourselves and others" (Bhabha, 2006, p. 157).

In the wake of Bhabha's thought on cultural translation, Judith Butler (Butler, 2012), a comparative literature researcher who specializes in moral philosophy and gender studies, identifies the place of the meeting with the other as the third space, which forms the basis of the ethical relationship par excellence: "a relation to alterity […] as constitutive of identity" (Butler, 2012). In other words, translation is not merely the interpretation that a translator performs on a literary or social script; rather, the translation itself – and particularly its encounter with otherness – becomes a model for ethical and political action (Bermann, 2014). The very title of Butler's book, *Parting Ways* (Butler, 2012), alludes to a constant transformative and translational movement, and is in a perpetual duality between belonging and detachment, which she "solves" by suggesting the uncertainty of ambivalence as a guarantee of ethics. Only then, in the ethical encounter that implies a continuous transition between worlds and in the departure from the origin, religious, spiritual, and cultural content can be reworked and translated into renewed and relevant ethical resources for the here and now. Furthermore, Butler's ethical responsibility implies listening to often "remote and foreign" human voices (Butler, 2013, p. XII), and to the abandonment of certainties to the unknown: "Translation cannot be a simple assimilation of what is foreign into what is familiar; it must be an opening to the unfamiliar, a dispossession from prior ground, and even a willingness to cede ground to what is not immediately knowable within established epistemological fields" (Butler, 2012, p. 12). Thus, Butler's account on cultural translation concerned with cultural differences echoes Bhabha's, as both are seeing the introduction of foreign elements into another culture as potentially conjuring something 'new' out of the encounter between two competing 'languages' (Lloyd, 2007, p. 153).

Bahadir (2004) addresses the post-colonial ethos in order to deal with the cultural, social, political and professional identity of public services interpreter: "Interpreters, too, are engaged in a borderline activity, producing other cultures against the background of their own cultures, and creating a new space, a third culture, 'something like culture's 'in-between', as Bhabha would put it." (Bahadir, 2004, p. 816). In the globalization era, when profiles are multiple and easily subjected to hybridization, Bahadir stresses the

need of resistance to the fascination of the one-dimensional dehumanizing ideal of the interpreter as an invisible, transparent, neutral and objective agent. This expectation of being impartial and factual clashes with her being a third party in between, "steadily moving from involvement to detachment, and back" (Bahadir, 2004, p. 807). In performing this back and forth act that recalls Butler's fluctuating dynamic, the interpreter should be self-critical and self-reflecting, sufficiently aware of his/her own culture and of the fact "that seeing, reading, writing (i.e., translating) the other culture to mine means incorporating it into 'my world' in order to make it comprehensible and thus, 'digestible'" (Bahadir, 2004, p. 807).

Bahadir encourages interpreters to focus on freedom, responsibility and visibility as vital elements for professional ethics for interpreters experts in intercultural communication. Hence, in addition to the bag of "duties" implicated in his/her job, the interpreter working in the consulting room has many powers that still need to be identified. As Levinas put it, the interpreter plays the role of both a witness and a judge (Levinas, 1961), acting as a moral authority over therapist and patient. Paradoxically, it is a passive, mirror-like power, as the interpreter will not actively purge the contents of the dialogues; instead, his/her presence pushes the parties towards greater ethical and critical content.

This aspect of the third space, then, refers to the negotiation and mediation functions the interpreter's role entails. By acting as an influential author of tension between ethics and justice, a bit like a tennis court's net, the presence of the interpreter can stimulate both interlocutors in the consulting room to pass over only those contents that are sufficiently "high" to go above the net. The interpreter, who is serving as a "host" during the session, much like a referee, can act as a witness to the truth, an impartial judge and ethical guarantor of intimate exchanges.

The Third Space no. 2: The Psychoanalytical Perspective

Since the therapist in the presented case study operated in a psychodynamic psychotherapy framework, the interpreter's experience will be conceptualized using the notion of transference/countertransference, that is central to psychoanalysis theory and practice (Racker, 1968; Searles, 1978; Laplanche, 1988). The concept of the third space is also a prominent part of the psychoanalytical discourse, viewing the analytic session as a third space (Winnicott, 1971), which is the place transference and countertransference take place.

As first conceptualized by Freud (Freud, 1895), one of the conditions that makes analysis possible is the establishment of a two-way relationship, called 'transference' and 'counter-transference', between patient and therapist. This is a living relationship, in which there are constant movements and changes (Joseph, 1985). As Joseph noted, "everything of importance in the patient psychic's organization based on his early and habitual ways of functioning, his fantasies, impulses, defenses and conflicts, will be lived in some way in the transference (Joseph, 1985).

Notably, the concept of transference has undergone significant changes and developments since Freud, through the contributions of analysts like Winnicott (Winnicott, 1956), Kohut (Kohut, 1968) and others (Mitchell 1988). Nonetheless, contemporary therapists still agree that much of the therapy's potential depends on the ability to work with transference and counter-transference (Nissim Momigliano, 1984).

Having examined the theories mentioned above, one can assume that the differential between those psychoanalytical transference flows is actually the third space of cultural translation. In the presented case study, there is a guest in this third field: the interpreter. In this triadic exchange, the interpreter sits between therapist and patient so that they maintain visual contact with each of the participants throughout the session. In order to guarantee an easy flow, the interpreter has the responsibility of delivering the

contents from one side to the other with great precision and sensitivity, as well as to fulfill his/her task paying attention to all the details.

Although one could say that the translation process is fundamentally mechanical and immediate, it almost always involves an interpreter's choices, which rely on his/her linguistic and cultural background, as well as her personal experience. Thus, it is reasonable to assume that the sentence translated to the recipient will not be identical to the one offered by the originating interlocutor, especially in circumstances where the emotional burden is considerable. In that case, the interpreter is at risk of being entangled in the transferential relationship, which may push him/her to modify the text, even unconsciously.

In order to explain this possible implication of transference on the translation process and product, the concept of 'lateral translocation' should be introduced. Initially discussed in the context of group psychotherapy (Yalom, 1975), lateral translocation describes the way that transference within the group is always in movement[2] (Baranger & Baranger, 2011), and becomes possible engines of development and transformation for all participants. Besides the main patient-therapist transference, a part of the projections is directed towards the other participants who make up the relationship with the therapist. The therapeutic alliance in the group retains the participants in a joint care project, where they perceive reciprocal feelings of closeness and solidarity. Despite the differences between group dynamics and an interpreted intervention, the mental health interpreter, too, is involved in the therapeutic alliance (Chiappano & Ferruta, 2012). Therefore, it may be assumed that interpreter is not immune to the development of such transfer and empathy experiences towards other members.

CASE STUDY: INTERPRETING IN MENTAL HEALTH

Israel is home for about 8 million people, shared by diverse linguistic and cultural communities. The largest linguistic group is Hebrew, seconded by Arabic and Russian. In total, there are about 30 languages spoken (or signed) in Israel – by either native minorities, Jewish immigrants, work migrants and asylum seekers – mainly from African countries (Ethnologue, 2018).

Despite this linguistic diversity, training of interpreters in mental health services is extremely limited. A directive from 2011 by the Ministry of Health requires all healthcare institutions to provide culturally and linguistically competent services (Ministry of Health, 2011). Although the ministry offers telephone interpreting services for medical institutions, these are mainly used in general hospitals, as well as in primary and secondary care. Since 2013, initiatives by the NGO – the Jerusalem Intercultural Center, in cooperation with mental health centers, have started offering focused medical interpreting skills training for bilingual workers of the hospitals. However, these initiatives did not last long; apart from these local initiatives, no special training was offered to interpreters in mental health. In fact, most requests for interpreting services in this area were addressed on an ad-hoc basis.

This was the case in the current therapy, too, since Italian is a very marginal language in the country[3]. In January 2016, the first author was offered to interpret in a series of parent training sessions, for Italian – Israeli parents of a 12-year old girl. The author was never specifically trained to provide interpreting services in the mental health field. However, since she has the background of both translation (Ph.D. studies at an Israeli university) and mental health, she felt as she could take this assignment, and allow the family the access to mental health services.

The parent training took place in a Children's and Adolescents' Clinic, which is part of the Public Mental Health Service in one of Israel's largest cities. The sessions took place once a week, besides

Jewish holidays and a few cancellations made by the patient herself. The insights described here were documented in a reflective journal written by the first author, in which she wrote down mostly personal impressions and feelings after each session. All personal details, including the child's name and the location of the therapy, have been changed here to prevent identification.

The individual therapy of Rebecca and the parental training were initiated by Rebecca's school. The family immigrated to Israel from Italy when Rebecca was 10. She presented adaptation and learning difficulties, partly due to language barriers and partly to emotional challenges of different nature linked in some measure to tensions at home. A report issued by the school discussed the possibility of domestic physical violence. Therefore, Rebecca was placed under an individual therapeutic program first, and then in peer group therapy, while both parents were invited in parallel weekly training sessions. While Rebecca was able to master Hebrew well enough in order to undergo therapy, her parents, who had difficulty with the language, had to use an interpreter. It should be noted that is no formal arrangement for Italian-Hebrew medical (or other) interpreters. However, due to the Ministry of Health's directive regarding language accessibility to health services (2011), the relevant function in the mental health system made an effort to find an interpreter to take part in the therapeutic sessions.

Except for the first meeting, which both parents attended, only the mother participated in the remainder of the sessions. As a result, the parental training phase was, for the most part, a series of individual therapeutic session with the mother. Thus, there were three participants in the room: the psychologist, Rebecca's mother (herein referred to as "the patient") and the first author, serving as the interpreter (hereafter "the interpreter"). The intake sessions have been conducted by a male psychologist, but after a couple of sessions, he was replaced by a female psychologist. The therapy was never formally ended, but rather abruptly stopped, due to some financial difficulties of the parents.

The descriptions and reflections reported in the first author's reflective journal were analyzed to understand her role as an interpreter, her involvement and the dynamics in the room, all in light of the "third space" concept.

DISCUSSION

The Interpreter as an Agent in the Cultural Third Space

The interpreter, as a guest in the consulting room, must be transparent enough to avoid disturbing the intimacy of the therapeutic encounter and patient's sensitivity, while also able to provide the therapist with all the necessary information. This double chore requires facilitating verbal and nonverbal communication, as well as mediating concepts and cultural practices, as warranted by the circumstance.

The family, consisting of the father, mother, and their two children, came from a large Jewish community in Italy, and whose members belonged to different social spheres and economic classes, as in the case in most Jewish communities in Central and Northern Italy. Having immigrated for Zionist and religious reasons, once in Israel, this family was faced with a number of social acceptance difficulties, especially in terms of employment, with resulting financial challenges.

Awareness by the interpreter of intercultural gaps, such as different systems of values, roles of family members, taboos, authorities and educational systems, is likely to be an added value. Therefore, interpreters, especially in community settings, are sometimes acting as "cultural interpreters" or "cultural mediators" (Albertini & Capitani, 2010). In our case study, this cultural mediation was manifested in a

number of ways. First, when the interpreter had the impression that the translation was not able to communicate all the subtle details and feelings, she felt the need to add some more information in order to make the therapist aware of the gap.

In order for the therapist to understand the social context, the interpreter was often elaborating on the social structure gaps, as well as the dynamics within the Jewish community in Italy. These features included, among other things, a difficulty to openly discuss some issues with other community members, feelings of shame due to economic difficulties and some miscommunication between the more and the less affluent community members. These dynamics may have led to feelings of isolation and loneliness, in a community that is a minority in Italy. Another cultural issue that had to be clarified, in the opinion of the interpreter, are family dynamics (e.g., family roles and everyday dining habits), as well as discourse patterns in typical Jewish families.

Such difficulties and frustrations would have likely impacted the domestic environment. It is important to point out that in Italy, even today, and certainly as it pertains to older generations, the possibility of using "moderate physical violence" against children as an educational and corrective method is still socially tolerated. The Italian law does not explicitly establish whether it is lawful to slap one's own children (Codice penale, Articolo 571 - Article 571 c.p. -Abuse of the Means of Correction or Discipline), as the jurisprudence has not yet been established in a secure and predictable manner. Thus, where the border between legal correction and abuse appears blurred, the law prefers to leave it to each individual case. This attitude is also a significant cultural gap that the therapist had to be made aware of by the interpreter.

Another cultural aspect that should not be underestimated is the respect for privacy and confidentiality of information. At the beginning of the therapy, the psychologist took care of introducing the interpreter to the patients, while emphasizing that her presence will not in any way undermine the secrecy and confidentiality of the sessions. However, the risk that the interpreter may, even involuntarily, establish family connections through the local community network was high. As the Jewish-Italian community is so small, the interpreter in our case actually knew the patient's employers, and it just so happened that she ran into them at a circumcision party at the end of therapy. Anticipating that this could happen, the interpreter consulted with the psychologist before taking part in the event, agreeing to keep as much physical distance and discretion as possible, as not to embarrass or making the patient uncomfortable.

Indirect cultural mediation was also performed outside the therapy room. One of the psychologists initiated a debriefing meeting with the parents and the interpreter present, after the first session. During this conversation, the parents had quarreled in Italian. The therapist noticed that the interpreter found herself in a very complicated situation, having too much power in her hands that she did not know how to use ethically. Thus, he suggested to talk things over with the interpreter after the session, so she could express her personal impressions and any relevant information that would help him understand the situation or the patient. The therapist listened attentively, though it was not officially defined as supervision. At some point, the second psychologist started to join these meetings, bringing this kind of open-hearted conversation to an end. From that moment on, the therapists-interpreter conversations became very concrete and informative, mainly focusing on language gaps. This type of events raises an ethical question: is confidentiality limited only to people outside the therapy, or also referring to the relationships between different members within the room? This area is considered a kind of a grey zone, indicating the need for more explicit roles to regulate the interpreter's work, and protect not only the therapist but also the interpreter – who do not enjoy the same legal, professional and ethical protection as psychotherapists get.

When no fixed rules regarding the supervision of interpreters exist, certain dynamics are being left to the discretion of the subjects involved. The interpreter, in this case, found it very useful to exchange information with one of the therapists after the sessions, during which she provided the latter with some clarification on the family background. These short conversations helped her, in return, to better her understanding of certain attitudes and responses. However, while the first psychologist in charge of the family always made himself available to accept short feedback from her, the second therapist was hastier and less available.

The biggest challenge for the interpreter was to find a way to be active in the communication while letting the patient and therapist remain the main actors. In order for this latter condition to occur – to act as a supervisor in transparency and professionalism – the interpreter must be able to manage production and awareness of the emotional content she conveys, so as not to become too entangled nor empathic, risking, in both cases, an involuntarily manipulation of the content she is supposed to deliver. This brings us to the discussion regarding the development of transference and counter-transference by the interpreter herself.

The Interpreter's Transference Within the Psychoanalytical Third Space

Acting in the third space of the intersection between the transference and counter-transference, or in the differential between the "flows" coming from both the therapist and the patient, the interpreter is exposed to the risk of excessive identification, rescue fantasies or, at least, of developing over-empathy toward the patient. Thus, it is crucial that the interpreter be placed in the condition of managing her involvement and emotional burden in the session. Otherwise, she might develop lateral transfers or extreme empathy that could compromise the "sterility" of the therapeutic setting.

Following Joseph's advice stating that "everything of importance in the patient's psychic's organization […] his fantasies, impulses, defenses and conflicts will be lived out in some way in the transference" (Joseph, 1985), the first author's reflections (taken from her private journal written during that time) shows she did cope with complex fantasies, impulses, defenses and conflicts while interpreting the therapy. The risk of identification presented itself in different ways. For example, the patient spoke of an "unresolved relationship with the absent maternal component" and, like the interpreter, "had gone to a non-Jewish school where she had been the victim of episodes of anti-Semitism that influenced her choice to emigrate to Israel", as the interpreter recalled thinking during the session. These common childhood experiences in the same motherland have challenged the first author in terms of identification, and, using the first-person while interpreting, made it even stronger. Notably, the risk of identification tends to be more evident when the patient and interpreter belong to small communities.

Another thought that crossed the interpreter's mind was related to the family's financial situation: "The patient was also living in a condition of financial deprivation, akin to the circumstances in which one of my close acquaintances was living as a result of bankruptcy procedures". Personally exposed to some financial difficulties of Italian friends recently immigrated to Israel, the interpreter had a hard time separating her personal experience from her professional ones, resulting in greater empathy toward the patient. At the same time, other notes demonstrated the sensitive subject of wishing to have a closer alliance with the therapist, risking a situation of "inferiority" and isolation of the patient:

"In addition, within what is already an asymmetrical dynamic, i.e., the therapeutic encounter, the fact that I perceived greater intellectual and social affinity with the therapist could have caused an implicit alliance between the latter and me…".

The interpreter's personal experience undergoing psychoanalysis seemed to show up and "disturb" the course of the interpreting. After one of the sessions, she wrote to herself: "By chance, the patient had the same name as my personal analyst. I wonder how it could affect fantasies of inversion of roles, where I to identify myself with the therapist, or worse, going above her." Other notes show that situations when the therapist answered differently from what the interpreter would have imaginably done were a constant cause of frustration for her.

These examples demonstrate the effect of the mediating role on the interpreter, such as feelings of over-identification, anger, and empathy, alongside the willingness to bridge the language and cultural gaps, even when this is not necessarily required. The strong influences of the transference and counter-transference on the interpreter, just like those experienced by the therapist, require great awareness and self-control, in order to avoid taking professionally inappropriate decisions.

CONCLUSION AND CLINICAL IMPLICATIONS

Based the concept of 'third space' elaborated in cultural translation by Bhabha (1994) and Butler (2012), the authors suggest looking at the interpreter in the consulting room as a special guest acting in the third hybrid and liminal space, which is placed in the intersection produced by the transference and counter-transference between patient and therapist. In doing so, the interpreter could provide a significant contribution to the therapeutic process. However, for this to happen, it is crucial that the interpreter will be able to manage his/her own involvement and emotional burden in the session. Otherwise, lateral transfers or excessive empathy might compromise the quality of the interpreting, thus "contaminating" the content and the triadic dynamic of the session.

Such delicate complexities emphasize the need for tailored supervision for interpreters, "built-in" in his/her professional work routine, incorporating both classic therapist training and interpreting studies theories. An effective clinical supervision should address the multiple aspects of emotions expressed by the patient and provider, and the culturally, linguistically and professionally appropriate ways to handle them (Hseih and Nicodemus, 2015). Moreover, it could help the interpreter to manage the personal emotional burden, allowing him/her to not only provide an impartial service as possible but also to better develop greater awareness, self-criticism and self-reflection in the therapeutic situation. These were stressed by Bahadir as essential skills of the interpreter, improving him/her to function as a linguistic and cultural broker in the session.

Reviewing the set of dynamics within the third space, it is also suggested that interpreters would receive the appropriate tools to make a judgment in situations of moral dilemmas resulting from their space in the room, as well as from the triadic relationship. The interpreter might – consciously or unconsciously – make interpreting-related decisions that will affect the therapy. This ability, to decide whether to deliver a message, or even slightly change it (even though a different tone of voice, or the addition of physical gesture) carries with it tremendous powers. Thus, interpreters must be aware of the powers they hold and their possible implications on each of the participants (including themselves) and the therapy as a whole.

FUTURE RESEARCH DIRECTIONS

As the acknowledgment of the interpreter's involvement in the emotional aspects of psychotherapy is relatively new, many questions and arguments raised earlier require further research. Here are some issues directly stemming from the current analysis: what is the potential influence on the interpreter in other therapeutic frameworks, such that are not based on working with transference/counter-transference? To what extent should the interpreter be informed on the patient-provider dynamics in the room? On the one hand, such knowledge will help him/her be more aware, and be able to transmit faithfully even the slightest nuances. On the other hand, such a background may "contaminate" the translation or hamper her neutrality. Such issues should hopefully be explored in future studies, contributing to our understanding of the interpreter's place and role in mental health settings.

LIMITATIONS

This chapter is based on the experiences during a therapeutic process of a single family, by a specific interpreter. The emotional responses of the interpreter described above may have been influenced by the therapist's choice of therapeutic framework. The insights and model proposed here should be further examined in various types of therapies, involving interpreters from diverse personal and professional backgrounds.

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ENDNOTES

1 The term "supervision" in this context refers to conversations between professionals, aimed at enhancing one of the professionals' effectiveness at work (Dean, Pollard, & English, 2004).

2 Baranger and Baranger (2011) introduced the concept of a bi-personal field to describe the dynamic process of analysis, the location of the projections and cross introjections and counter-identifications between analyst and patient.

3 According to recently published data, the Italian community in Israel is composed of approximately 15,000 people, most of whom probably have proficiency in Hebrew (Della Pergola, 2014).

Section 4
Medical Interpreting Education

This section identifies some interesting new approaches to medical interpreting education, as specialized training gains traction worldwide.

Chapter 13
Mode Switching in Medical Interpreting and Ramifications on Interpreters' Training

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ABSTRACT

Mode switching is a frequent practice in healthcare interpreting, but has received very little attention. This research aims to bridge the aforementioned gap by investigating the instances of mode switching in interpreter-mediated healthcare encounters and the implications of this practice (or lack thereof) in managing effectively the administration of patients' care. To achieve this aim, the investigator created an online survey intended for trained healthcare interpreters alone. Seventy-five responses were collected over a period of three months (May to July 2019) and analyzed using a mixed methods approach. The objective was to demonstrate how interpreters envisage mode switching from the perspective of the training they received, the applicability of switching in relation to the nature of assignments that call for such shift in modes, the differences in mode switching between spoken and sign language, the institutional or other constraints (such as time limitations, number of participants, power differential among interactants) that call for or hamper mode switching, etc. The collected answers reveal a discrepancy between training and practice as well as between prescriptive requirements and reality in the field of healthcare interpreting. The respondents' comments allow the investigator to make key training recommendations.

INTRODUCTION

Knowledge, management, and use of all modes of interpreting are crucial elements in the administration of interpreting services in the healthcare sector as well as in planning and delivering training programs to both new and seasoned interpreters. This chapter draws on the experience of medical interpreters' self-reported working practices and on that of the author, in her capacity as a seasoned interpreter and instructor of healthcare interpreting at the Master's level. The main focus of the analysis presented here-

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after is to reflect on the modes of interpreting commonly used during interpreter-mediated encounters in healthcare, on the basis of the nature of each encounter, the needs of the clients, and the actual skills of the interpreters.

The discussion sheds light on various aspects of an often-neglected facet of healthcare interpreting, namely the interpreters' ability to use all modes of interpreting required by communicative instances or the modes interpreters' were trained in, and/or to select the most appropriate ones, depending on the circumstances. It is also the author's intention to delve into and reflect upon the instances of mode switching as implemented by interpreters and the decision-making process behind each instance of switching from one interpreting mode to another. The interpreters' ability to switch modes is examined in relation to the training they have received. Mode switching will also be discussed from the perspective of future planning of skill development training programs for healthcare interpreters at the college and university level, as well as the ones to be run by professional associations or organizations.

For the purposes of this investigation, data were collected via a web-based questionnaire specifically designed to allow interpreters to reflect on their practices and share them with the researcher. The questionnaire was distributed online and was made available to both spoken and sign language interpreters working in the field of healthcare. Although the scope of the target audience (i.e. interpreters) was originally intended to be international, the questionnaire was distributed mainly across Europe and North America via postings to national and international professional associations and fora commonly used by practicing interpreters. In the following section, the author presents the methodology behind conceiving, structuring, and wording the questionnaire as well as the way data were collected and subsequently analyzed.

Using a mixed methodology for analyzing quantitative data, the investigator aims at offering her own interpretation on ways of (a) identifying possible discrepancies between current language mediation needs in the various healthcare settings and actual interpreting practice; (b) discussing interpreters' competence on the job vis-à-vis nominal and/or minimal demands of the profession as reflected in the Codes of Practice and Conduct of the various Healthcare Interpreters' Associations, professional/regulatory bodies and undergraduate/graduate curricula in healthcare interpreting; and, finally, (c) proposing measures in the form of recommendations to be taken into consideration by various stakeholders when they plan and/or update training programs and curricula for healthcare interpreters, thus translating teaching objectives into educational policies.

METHODOLOGY

As mentioned previously, this chapter is the result of a mixed methods research, insofar as elements of qualitative and quantitative research approaches are used to confirm (or disproof) a hypothesis. Answers to this hypothesis aspire to further our understanding of a specific area of interpreting practices in healthcare settings and to corroborate these findings with similar conclusions in corresponding areas of research (Johnson et al., 2007, p. 123).

The research presented herein has a starting point or original hypothesis and a specific purpose. Both elements fall under the Primary Dimension category of a mixed methods analysis, namely a set of characteristics that constitute a priority during the design phase of any research (Schoonenboom & Johnson, 2017, pp. 108-109). As far as the hypothesis is concerned, the researcher used her personal experience as an interpreter in the healthcare sector and as an instructor of healthcare interpreting to put

to the test an assumption according to which healthcare interpreters tend to refrain from using certain modes of interpreting or shy away from them, whenever possible, for reasons that may be attributed to a variety of factors, such as training (formal or professional), spoken vs. sign language interpretation, number of years of experience, institutional constraints, interpreters' mental and physical capacities and limitations, only to name a few.

The purpose for seeking to confirm or disproof the said hypothesis is to investigate the impact mode switching practices or lack thereof may have on the final product of the interpretation, that is, communicating the meaning and intent of what is said in the context of an interpreter-mediated medical encounter as clearly, as unobtrusively, and as unambiguously as possible. Qualitative analysis of raw data collected via the questionnaire would allow the investigator to correlate her findings with research conducted in the area of common interpreting practices so as to understand how the latter may impact the actual administration of care seen both from the point of view of the well-being of the patient as well as from the standpoint of the 'do no harm' adage by which physicians must legally and ethically abide. The investigator's intention is neither to demonize interpreters for and through their practices nor to attribute a disproportionate (overinflated) value to the notion of 'inadequacy in skills' in interpreting. Instead, the ultimate goal is to use the findings of this research as a springboard for advancing our understanding of how interpreters actually work in the real world and for conceiving and implementing effective policies with respect to training on various interpreting modes at various stages of one's interpreting career. The latter would allow us to educate, all stakeholders of the importance of effective and appropriate mode switching to enhance communication by ensuring accuracy and completeness in spoken and sign healthcare interpreting.

The hypothesis and purpose of investigation stated above fulfill most of the criteria set out in Green's classification when describing the importance of the use of mixed methods approaches in designing research. In our case, interpretation of the analysis of collected data will be used for development purposes, namely "[the] use of results from one method to help develop or inform [another] method, where development is broadly construed to include sampling […] as well as measurement decisions" (Green et al., 1989, p. 259). The said development cannot materialize without satisfying the pre-requisite for complementarity. Since every research is based on models and theories used before, it is only plausible that any interpretation of the results of this survey be elaborated by, illustrated with, and clarified via results produced via the implementation of other methods and theories. This will allow us to verify tested models, and expand or modify them by using the new findings.

It is commonly accepted that mixed methods increase credibility of research because the combination of qualitative and quantitative principles enhances the integrity of findings (cf. Bryman's 2006 scheme of rationales for combining qualitative and quantitative research). This is a highly desirable goal in academic research, especially in social sciences, where quantitative data are mined and explored because they "provide an account of structures in social life." (Bryman, 2006, p. 129). However, the interpretative process, namely any attempt to produce results by translating quantitative data through qualitative management schemata, runs the risk of being viewed as subjective. With respect to quantitative data analysis, it is argued that:

a common belief amongst social scientists is that a definitive, objective view of social reality does not exist. For example, some quantitative researchers claim that qualitative accounts cannot be held straightforwardly to represent the social world, thus different researchers may interpreter the same data somewhat differently (Burnard et al., 2008, p. 431).

Subjectivity is often viewed as a thread to the validity of survey results, thus questioning the investigator's motives and credibility. It is the author's belief that what may be labelled as subjective interpretation of social life, social reality, and/or social practices is merely an effect, one that can be mitigated by the process of cross-verification of data collection for investigatory purposes. One way to achieve this is by means of carefully choosing the questions submitted to the attention of the respondents, in other words the way questionnaires are structured, worded, and presented to participants. The following section offers a detailed explanation of the rationale behind the type of questionnaire devised for the purposes of this analysis and the nature of its questions. As in all surveys, this one is not free of shortcomings. Despite flaws, the researcher firmly believes in the plurality of interpretations as means for advancing knowledge and for producing more than one possible outcomes and/or solutions to theoretical questions and practical problems.

Creating the Study's Questionnaire: Basic Considerations

The questionnaire used in this study was designed by using a simplified version of the sequential model. In a sequential design, the two main components of the study, namely the qualitative and the quantitative component, do not occur simultaneously. Instead, one precedes the other and their order may alternate depending on the aim and objectives of the study. In our case, questions were conceived, structured, and ordered in such way as to allow for sets of data to be analyzed as the survey progressed. This would result in using interval findings to support the original hypothesis and/or accommodating for alternative hypotheses to emerge along the way.

This type of survey was deemed more appropriate than the alternative of implementing a concurrent design. Several reasons could account for this choice. Firstly, it was not possible to specify or predict in advance the size of the sample. Secondly, in the case of questionnaires such as the one used for the purposes of this study, where participant responses are somewhat predictable and controlled (cf. forced-choice questions), it would be easier to apply a methodological approach to data analysis that would neither be classified as strictly deductive nor as strictly inductive. Additionally, a sequential design would facilitate an ongoing collection of data (over a period of three months), which, in turn, would translate into constantly improving the size and quality of sampling as well as the analytical process and methods. Thirdly, due to time, budget, and personnel constraints, a sequentially designed survey would require less effort on the part of the researcher and would yield results faster.

Undeniably, there are limitations to using a sequential model approach to data collection and analysis. The sequential model decreases the researcher's chances of validating the data by taking into consideration variations between sets of samples or by going back to the respondents and seeking their approval as well as their understanding or interpretation of the results. In that respect, generalizability from findings is rather limited, unless the sample is substantially big to allow for a better representation of the targeted population (category of respondents). Moreover, it is claimed that surveys based on a set of questions offering pre-determined answers may be rather inflexible thus producing biased results/findings "as the coding framework has been decided in advance, which can severally limit theme and theory development" (Burnard et al. 2008, p. 429). It is, therefore, argued that an inductive approach to a theoretical hypothesis—such as in-person recorded interviews where participants would be free to express their opinion on the issues presented to them—would be more suitable for social science surveys, especially when the investigation is about a phenomenon for which very little if any is known to the investigator(s).

After having considered all possible advantages and disadvantages associated with the aforementioned design model and the selected data analysis approach, the investigator made sure that minimal requirements were satisfied to ensure reliability of data and validity of findings. This included narrowing the target audience (the respondents) by implementing selection criteria so as to minimize random answers susceptible to increase dispersion of data values beyond the expected value (mean). For instance, when asked whether they switch modes, interpreters would have to answer by 'Yes' or 'No'. The veracity of their answer would then be tested in a series of subsequent questions, whereby participants would have to state the frequency of mode switching, the instances of switching, etc. The lower the standard deviation in the latter set of questions, the higher the consistency in the participants' responses during the first set of questions (i.e. Do you switch modes when interpreting in healthcare settings?) and, by extension, the higher the validity of the data. Consequently, invalid responses due to inconsistency between answers provided at the probing and verification stages of the survey were reduced via the insertion of questions seeking validation of answers provided in previous question sets. Those were theme-related questions, which would allow the researcher to verify whether respondents were consistent in their responses throughout the questionnaire. Discrepancies in answers would be taken into account and would be tagged with a specific code to be analyzed at the interpretation phase.

In order to counter limitations generated by the finite number of answers to choose from in the questionnaire, since the latter comprised mainly predetermined sets of answers for each question, it was decided to present participants with a mixed questionnaire format consisting of closed as well as open-ended questions. Thanks to a mixed questionnaire, responders would, on the one hand, be able to expand the answer(s) chosen from a list of choices (more than one plausible answer by question was possible); on the other hand, they could opt for a different answer than the ones available should the choices provided be deemed unsatisfactory. Moreover, necessary provisions were made for cloze-type questions to bear different formats, ranging from dichotomous questions (Yes or No answers), importance questions (very important to least important), Likert scale questions (to access frequency of occurrence oscillating between the values of never and always), to rating scale questions (very good to very bad) so as to express degrees of preferences, etc. Once again, the rationale behind all this was to reduce the effect produced by 'leading questions', which run the risk of generating results just for the sake of proving the original hypothesis even if this should not have been the case.

Another issue that weighed considerably during the inception phase of the questionnaire was the wording used in it. In the investigator's mind, questions had to be clear, unambiguous, and interpreted by all respondents in the manner envisaged by the researcher (Fox et al 2003: 170). Clarity of questions is of paramount importance in surveys administered online, because respondents do not necessarily have immediate or unlimited access to the investigator. In other words, the researcher is not always available when respondents are in doubt of the meaning of any given question or when they need to voice their objections or concerns *vis-à-vis* the items of the questionnaire. This can also apply in cases where the researcher is clearly identified in the survey and offers contact information.

For clarity purposes, the denotative aspect of the questions included in a survey should be highly emphasized in web-based questionnaires, where willing respondents expect taking a survey to be a straightforward process, one that would not take too much of their time. The higher the transparency of the questions the more likely it is for a participant to fully engage in the process and, most importantly, to complete the questionnaire. Complete questionnaires increase validity of collected data and credibility of their interpretation. Moreover, wording that is neutral and innocuous enough to accommodate for all demographic, social, and cultural aspects of the respondents—from gender and age, ethnicity and

spoken *vs*. working languages, professional specialization and status to institutional relations and power differential, etc.—is more positively viewed by potential respondents. Finally, ease in taking the survey increases the probability of its dissemination by word of mouth. If respondents are satisfied with the survey and find it relatively easy to complete, they are more likely to recommend it to fellow professionals thus increasing the number of potential participants. For this to happen, participants need to be able to understand the benefits of the survey and to identify with the aims and objectives set therein.

To ensure the highest degree of question readability and transparency, wording and order of appearance of questions were modified several times to reflect suggestions provided by a small group of respondents (3 in total). This group comprised fellow researchers who are also professional interpreters specializing in the healthcare sector. All three members of the set group have experience in conducting questionnaire-based research and their expertise was invaluable in our work. These three colleagues acted as members of a control group. The term "control group" is used in its expanded acceptation, one that is commonly found in surveys conducted in the context of evaluation studies. As Peng and Ziskin (2008) state, evaluation research aims at testing the effect of questionnaire design, item wording or other aspects that relate to data collection. Typically, in evaluation studies, the design used to test questionnaires and their effects is a classical "split-ballot" design or one of its variants. (Lavrakas, 2008, pp. 146-147). In this research, the a-typical, informal control group was given several versions of the same questionnaire either simultaneously or at subsequent stages. In the first case, two versions of the same questionnaire were administered to all members at the same time. The respondents of the control group would be asked, on the one hand, to comment on the efficacy of the questionnaire, the order of questions, and their wording and, on the other hand, provide suggestions for improvement. In the second case, upon implementing the control group's recommendations, improved versions of the questionnaire were subsequently distributed to test its readability, efficacy, and causality of items and procedures presented by way of questions included in the survey.

The visual/interactive nature of the questionnaire is equally important to the success of the survey (Fox et al., 2003, p. 170). Earlier there was mention of the quasi forced-choice format of the questionnaire. As such, the choices provided to the respondents may not satisfy their expectations. It is therefore vital to inform participants, either explicitly or implicitly, of the limitations imposed by forced-choice questionnaires and to compensate the lack of options by open-ended questions whenever possible. Additionally, choosing a user-friendly environment combined with an aesthetically attractive yet practical layout for presenting the survey are elements susceptible to increase responsiveness among participants. With that in mind, we experimented with the paid and unpaid version of a well-known, high frequency visited platform (Survey Monkey) for creating and administrating online surveys and the free version of one of the latter's known competitors. Our goal was to come up with the best visual outcome as well as a user-oriented system. The investigator opted for the unpaid version of kwiksurveys.com, a Europe-based online survey application, for reasons that had to do with presentation and usability of the questionnaire as more setting, management, theme and appearance features were made available to both the investigator and the respondents.

A final note on the selection of participants is necessary. The choice of format of the survey pre-establishes the narrowing of the pool of potential respondents. With a web-based questionnaire, it is presumed that participants have access to the World Wide Web and that they are actively involved in agencies dedicated to the provision of language and/or healthcare services, be them interpreter and translator associations, translation and interpretation agencies, hospitals and other institutions specializing in the provision of care, universities, colleges, etc. It also implies that participants are proficient users

of personal computers, tablets, cell phones as well as the Internet and are quite familiar with discussion fora or other means (i.e. platforms) of sharing information and communicating news pertaining to the healthcare interpreting profession. Nowadays most professional associations and related bodies are in the process of exploiting the all-increasing communication possibilities offered by social media pages in addition to traditional institutional homepages. Interconnectivity of media and platforms, programs and applications amplify public exposure of surveys via multiple/cross-postings, which, in turn, may result in more participants being willing to take a survey. Consequently, what seems restrictive at first glance may actually prove more effective in reaching out to a wider, more diverse community of healthcare interpreters. In the section dedicated to the analysis of data, the author will delve into the restrictions imposed upon her with respect to the population the survey was designed for as well as onto the implications of these restrictions on findings. It suffices to say, however, that concerns voiced in connection with accessibility of future participants to the World Wide Web are nowadays quite irrelevant; interpreters are required to become all the more technologically savvy to be able to perform their work online as well as onsite.

Ethical Issues

The validity of every research is subject to respecting a series of ethical requirements although, as Kennedy suggests, not all ethical aspects have an empirically proven impact on survey quality and respondent compliance (Kennedy, 2008, p. 28). All things considered, it is believed that there is a direct correlation between applying ethical principles in research and ensuring and maintaining credibility of the survey itself and the survey specialist (as a professional) or the researcher. (Lavrakas 2008: xxxvii). It is also commonly accepted among survey research specialists that anonymity, and its correlates, namely confidentiality, informed consent, privacy, etc., should be observed to ensure voluntary participation of respondents and a higher degree of authenticity and accuracy in their responses.

In the survey studies jargon, the semiotic realm of anonymity goes considerably beyond the restrictive definition provided in dictionaries. As Kennedy points out, anonymity is a complex concept that occupies two ends of a wider spectrum. One of the imperatives in surveys, including web-based questionnaires such as the one examined herein, is for each participant to "remain completely unknown to anyone associated with the survey." This can be interpreted in two different ways: first, the researcher may be aware of specific individuals who are either willing to take the survey or who have actually taken the survey, but their responses remain unidentified, in other words the responses cannot be associated with these individuals. Second, the only person who actually knows that s/he participated in the survey is the respondent. Any claim to the contrary can only be arbitrary and unsubstantiated. Anonymity is also a term used during the data collection, processing, and analysis stages. When information is dissociated from identifying characteristics of the respondents (such as age, gender or location) the term anonymity applies. This is also known as de-identification of data.

Applying the principle of anonymity is not uncomplicated or unobstructed. This is all the truer in the case of web-based surveys, which are potentially (and often intentionally) open to anyone. The question is not whether the researcher will require participants to identify themselves by first and/or last name, address or phone number. The real issue is whether platforms, specializing in applications that offer unpaid products/capabilities for creating and administrating surveys implement security requirements and policies to prevent unauthorized access to collected data. In other words, anonymity of users, primarily that of respondents, is dependent upon the privacy policy of the service provider and the researcher's decision to keep the data on the provider's website for as long as s/he deems necessary. Usually, pro-

viders such as Kwiksurveys operate in accordance with national and international laws on privacy and confidentiality of personal and/or other sensitive data and their privacy policy is clearly stated to all parties involved as per standard legal requirements.

Moreover, anonymity of the participants can be an added value to survey participation. Respondents may be more forthcoming to provide information, especially of a sensitive nature, if they are reassured that the latter will not be traced back to them. For example, healthcare interpreters would be less willing to admit lack of skills in simultaneous interpreting had the question referring to this particular skill set was worded in ways which would imply that interpreters who were not trained or were inadequately or insufficiently trained in this mode would fail in their task as professionals. Stigmatization of behaviors (personal or professional) can only be avoided through anonymity.

That is not to say anonymity is flawless. In web-based questionnaires, anonymity may invalidate data collection and interpretation as multiple responses may be attributed to a single respondent. Nowadays, invalidation of data due to duplicate/multiple entries by the same anonymous respondent can be (partially) avoided thanks to an identification code given to each respondent during their login. The identifier may include, among other things, the location of the login, the time of the login, the country, state and/or province, and the referral medium (social media pages, professional associations, etc.). As mentioned already, this automated feature is only partially effective: one person may log into the survey several times, using different locations, time zones, periods, etc. It is, however, hypothesized that an attempt to intentionally falsify an academic-oriented survey would require disproportionate effort to actually answering all the questions properly. Real life professionals have hardly the time or the inclination to resort to these kinds of practices.

To further reduce negative effects associated with anonymity or with respondents assuming multiple or fake identities when participating in a survey, the option of collecting some sort of demographic data (such as age or age range, gender, professional/institutional affiliation) would benefit the collection of reliable information. Introducing a series of carefully chosen identifiers helps steering the search from a purely ethnographic approach toward one that considers recommendations for future educational policies as part of its ultimate goal. For this reason, it was decided that personal identifiers that are of significance to the analysis be given by respondents on a strictly voluntary basis. Personal information questions were asked at the very end of the questionnaire so that they would not work as a deterrent. Had this section been inserted at the beginning of the questionnaire, it could have been a disincentive for completing the survey. Personal identifiers were quantified and qualified to provide a clearer understanding of the profile of the respondents, although their scope is limited given that not all participants in the survey filled out the corresponding field.

Confidentiality of data is usually one of the major concerns with survey studies, whether administered online or through one-on-one interviews. In the context of surveys, confidentiality is a term whose definition is broader and more complex than the one provided in dictionaries. Strictly speaking the promise of confidentiality increases the participants' level of confidence that the collected data will not be used to identify the respondents and that the information gathered will not be shared with people or organizations. Such organizations could proceed with either the identification of respondents and/or with penalizing the participants for their responses in the survey's questions or for participating in the survey in the first place.

Kennedy (2008, p. 132) astutely points out that national and international laws on confidentiality and privacy are constantly updated. This complicates privacy requirements for online surveys, which aim at an international pool of respondents for whom different laws may apply. In our case, the survey

was created and administrated in accordance with the General Protection Data Regulation (Regulation EU 2016/697 of the European Parliament and the Council) and participants were formally informed of the protection of collected data. The latter were in no way to be used for purposes beyond the academic scope of the survey (such as advertisement or solicitation).

Analyzing Data: The Choice of Method

Previously in this section it was implied that a primarily forced-close survey would call for a deductive analysis of data, as long as such questionnaires were created with an initial assumption in mind, one that would require validation by data. As a researcher, I find this view quite restrictive for two reasons: first, online questionnaires are not necessarily more biased than surveys conducted through personal interviews. The latter are also based on pre-established questionnaires, which can potentially be biased, and have to be used consistently throughout all interviews and with all participants if results are to be treated as valid. Second, mixed questionnaires, such as the one used in this survey, leave room for personalized commentaries. When analyzing respondents' comments, it would be more appropriate to apply an inductive approach insofar as (a) opinions expressed in relation to the issue or issues raised in each question may give rise to other questions; (b) patterns of repeated ideas may equally arise thus revealing aspects that were not presumed or originally considered by the researcher. Newly emerging viewpoints, in the form of commentaries, could potentially become the basis for new conceptual categories.

This is usually achieved by applying a grounded theory approach (Strauss & Juliet, 1994) in social science. What is actually proposed here is to view a given practice, that of mode switching in interpreting, as an event (or a fact) that occurs or may occur conjunctively and warrants its explanation as the product of human activity, one that is socially generated and, therefore, susceptible to scientific examination (Bhaskar, 2008, p. 46) In the present study, I will consider the reality of interpreting as comprising three different domains, namely the domain of mechanisms and structures, the domain of events and that of experiences. Following Bhaskar's taxonomy, I will be argued that all three domains in the order presented above, that is, the 'real', the 'actual' and the 'empirical': "constitute overlapping domains of reality (idem) that occur independently from one another but are all socially intertwined insofar as experiences, and the facts they ground, are social products; and the conjunctions of events, that, when apprehended in experience provide the empirical grounds for causal laws, are […] social products too" (p. 47).

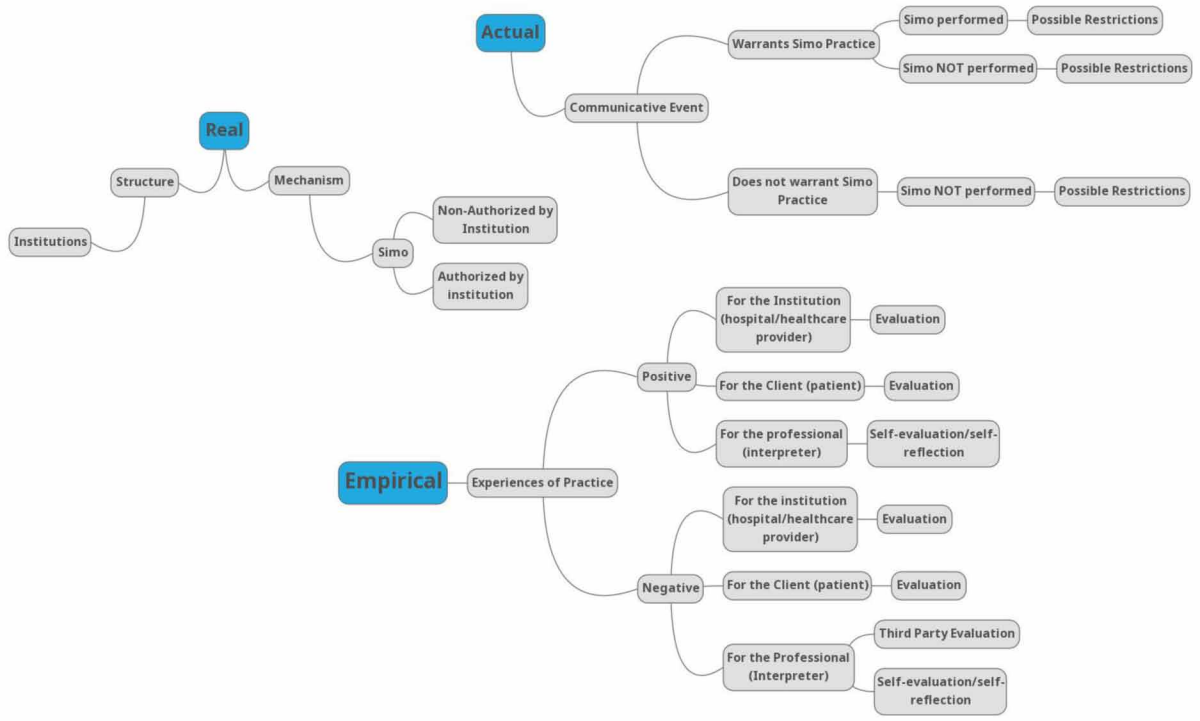
For the purpose of this analysis, the domains of the reality that are about to be investigated are divided as follows: first, the researcher will consider the aspect of reality in interpreting. Interpreting is a real, structured practice governed by a set of rules, or mechanisms, which are created and perpetrated by institutions with a direct say to the said practice. Then, interpreting will be considered from the point of view of what Bhaskar labels the 'actual'. This is, in other words, the sum of events or patterns of events, labelled as communicative events, that warrant interpretation services (spoken or sign) via the presence of an interpreter. Events take place within the structures described above but the presence of the latter does not constrain the nature of realization of each event (e.g. the communicative instance requiring interpreting). The third domain is the domain of the 'empirical', where events are apprehended as experiences by the actors involved (the participants in the communicative event). Events may be perceived differently by the individuals involved in them as events have a different significance for each stakeholder who participates (willingly or unwillingly) with this objective in mind.

To better understand the domains described above in relation to this investigation, it would be useful to consider the following example: simultaneous interpretation is an actual mode of interpreting, one

that is used consistently and almost exclusively in conference interpreting but may also be required in healthcare interpreting, depending on the nature of the encounter, the locus of the event, and the medium used to perform interpretation. In that respect, simultaneous interpretation is institutionally dependent. The activation of this mode is subject to the nature of the communicative event, which may be restricted by conditions that may be attributed to the agent assigned to perform this task/practice, i.e. the interpreter. The experience stemming from this event will be different for each participant in the encounter and will be interpreted through the lenses of individual expectations (assumed, realistic, achieved, etc.). The table below provides an adumbrated representation of the domains of reality as applied in the case of interpreting.

The table above is revealing of the web of relations between the real, the actual and the empirical. If institutions, namely healthcare institutions, prohibit the use of simultaneous interpretation, for reasons that carry meaning and significance to them, such as the type and quality of administration of health services, it is only logical to presume that an interpreter's actual assignment would not involve the use of this particular mode. This would be the case even if the said mode was the most appropriate, from a communicative point of view. The actual, in other words the non-use of the simultaneous mode, is dependent on the real, that is, the institutional restrictions imposed upon the interpreter (with or without legal repercussions). However, this form of dependency does not preclude interpreters from 'breaking the rules', thus performing simultaneous interpreting (possibly with the consent or the encouragement of the healthcare provider or thanks to a certain degree of tolerance on the latter's part) in situations where it is believed that the simultaneous mode would increase efficacy in communication and ensure expediency in the delivery of urgent care. In this case, the actual ceases to depend on the real, because

Figure 1. Domains of reality in healthcare interpreting



transgressing the rules results in creating new conditions for the real to emerge. Restrictions in terms of performing in simultaneous mode or transgression of rules in order to break free from restrictions may produce a variety of experiences that may be as numerous as all possible combinations of stakeholders involved in any given medical encounter.

Reponses collected via the questionnaire help the investigator to determine what the interpreters' perception (empirical aspect) of mode switching is with respect to the reality and actuality of their professional life either as freelancers or as institutional (in-house) interpreters. As mentioned earlier in this chapter, the goal of this research is, on the one hand to reveal as many realities as there are interpreter-mediated actualities and perceptions of the latter from the interpreters, and, on the other hand, to suggest interventions susceptible to alter (improve or adjust) realities and perceptions of the practice for all stakeholders' sake.

Mining the Questionnaire: What the Data Revealed

The questionnaire is comprised of 21 items out of which 19 are cloze questions whereas two are purely open-ended questions. A complete version of the questionnaire is provided in the Appendix at the end of this chapter. Depending on responses given in some preliminary questions, participants might have to answer fewer than 21 items/questions. Ten out of the 21 items are mixed questions, that is, they allow respondents to expand on their answer(s), provide alternative responses or comment on issues that are raised by the question itself.

From a statistical point of view, it is worth mentioning that 75 responses were collected in total. Out of the 75 respondents, 53 completed item 21 of the questionnaire, where they were asked to identify, on a purely voluntary basis, their gender, age, city/town, province or state, country, email address and institutional affiliation or position. None of the components of item 21 were compulsory. As a result, those who answered the said item did not necessarily complete all fields. One should note, however, that in approximately 90% of the above-mentioned cases, respondents completed most fields under item 21. This is quite encouraging because it speaks to the level of trust interpreters experienced *vis-à-vis* the survey and probably in relation to the investigator, who is clearly identifiable by name, function, affiliation and contact information. It is also suggestive of the degree of familiarity interpreters have with online surveys and the use of technology, as well as their trust in online survey tools to protect their personal information. It may also be viewed as an attempt on the part of professional interpreters specializing in the field of healthcare interpreting to reach out to their peers and the academic community to help the latter advance the theoretical underpinnings of the practice. A high percentage of the 53 respondents who wished to be partially identified shared their professional email address. One would assume, rather safely, that those respondents would accept being contacted by the investigator for further information or for receiving the results of the survey to which they contributed. Sharing one's contact information and professional affiliation adds to the credibility of the survey (as was explained earlier). Most importantly, however, it gives face to an otherwise faceless entity and testifies to the respondents' need to prove or assert the credibility of their answers as being provided by real people with a specific status and an actual, expert opinion on matters that pertain to their profession.

As far as the demographics of the respondents are concerned, the sample is predominantly female with 43 out of the 53 respondents who chose to identify themselves as women. Far from being conclusive as to the gender make-up of our corpus (lest we forget that 22 respondents remain unidentified), and by extension of the healthcare interpreting profession as a whole, this result is consistent with findings by

researchers such as Angelelli (2004), Zwischenberger (2011), Pym et al. (2013), Dam & Zethsen (2013), and Gentile (2013), who have concluded that both the translation and the interpreting professions are nowadays female-dominated. More specifically, it is claimed that the number of women who work as interpreters or translators or both overwhelmingly surpasses that of men. In a more recent study, focusing mainly on conference interpreters, Angelelli and Bear stressed that "while issues of gender and sexuality have been broadly and consistently discussed in relation to translation, they remain under-studied in the field of interpreting" (2016, p. 2). One could rather safely suggest that the field of community interpreting and the subfield of healthcare interpreting are even less studied from the perspective of the professionals' gender.

Feminization of the interpreting profession, especially conference interpreting, has been the object of investigation for some years now. Pöchhacker (2016) studied the trend and concluded that the impressive shift in the ratio of women to men interpreters started in the 1950s and 1960s and has continued ever since. More specifically, he calculated that for every three female interpreters there is only one male counterpart. Sociological approaches to studying this phenomenon, as in the case of Baigorri-Jalón (2004), have been used to account for this impressive turn of events, which translated in women making their way into a series of professions, including interpreting. According to Baigorri-Jalón (2004), it is the passage from "marvel to profession" (2004, p. 84) that changed the face of conference interpreting forever. Theorists have argued that professionalization of conference interpreting, and the subsequent shift from male to female domination, is closely associated with the change in interpreting modes, namely the prevalence of simultaneous over consecutive, and the creation of interpreting schools in Europe and elsewhere with women entering interpreting training programs in order to make interpretation a profession from which they could make a living. Oddly enough, there is an ambiguous relation between feminization and professionalization of interpreting, in general, and conference interpreting, in particular. As pointed by Gentile, "the topic of feminization of conference interpreting has been put forward in a few scholarly papers, and there seems to be agreement among interpreting scholars that feminization has taken place in conference interpreting and that it has led to lower status" (2018, p. 23).

The decline of the profession's prestige as a result of more women entering and/or dominating the conference interpreting field (Pöchhacker, 2016, p. 174; Spânu, 2009) reflects a disturbing trend. The reason for professionalizing interpreting subsequently becomes the justification for its current de-professionalization and, by extension, a claim for underestimating the importance of the said profession and for devaluating the work of interpreters, which by nature requires high skills (Spânu, 2009, p. 18). Feminization of the interpreting profession seems to be the prevailing trend in healthcare interpreting as well. However, professionalization of healthcare interpreting, both as a process and as a result, does not follow the same trajectory as conference interpreting. For once, conference interpreting had traditionally viewed community interpreting as having a lesser value and therefore as being of a lesser importance. This view was also supported by more prestigious professions (i.e. doctors) with which healthcare interpreters come into direct contact. For decades, community interpreters had been stigmatized as being less professional if at all compared to their conference counterparts. This can be explained in part by the lack of formal training of community interpreters who offered their services in an *ad hoc* capacity for several decades. Nowadays, lack of training in community interpreting, including healthcare interpreting, is no longer a valid argument. Additionally, as a predominantly female profession, conference interpreting will have a vested interest in promoting and protecting its subfields (healthcare interpreting included), which are equally if not more female-dominated, if the goal is to re-affirm the value of interpreting for the society as a highly-skilled, vitally important service whose delivery must be entrusted with trained

professionals. Finally, community interpreters, in general, and healthcare interpreters, in particular, relied on the professionalization models used by conference interpreters when they first sought recognition of their work, especially during the passage from the status of occupation to that of profession. This may no longer be the case, as healthcare interpreting has made considerable progress in establishing itself as a distinct specialization within the interpreting profession. (cf. Mikkelson, 1996; Adams, 2009; Arocha & Joyce, 2013)

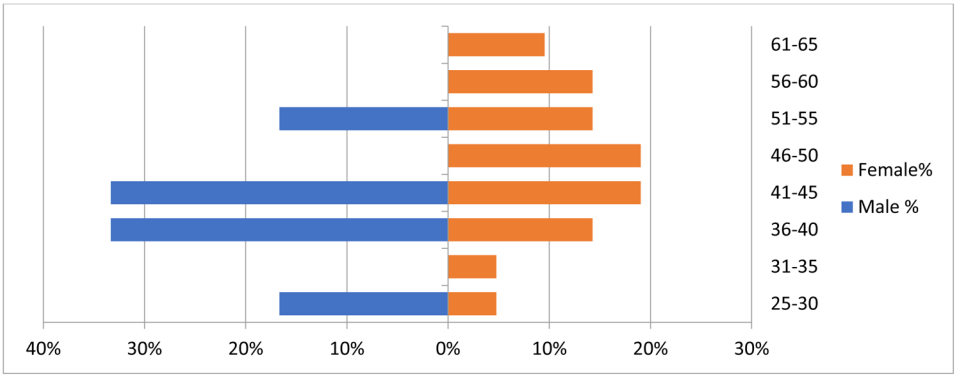
Given that the focus of this chapter is not the feminization process of healthcare interpreting and its sociological repercussions on the field of interpreting in general, it is important to bear in mind that many conference interpreters double as healthcare interpreters in the community and that women are exceedingly more active in healthcare interpreting than men. This basic acknowledgement calls for more research on the gender make-up of the profession as it overlaps with the one found in other professions, which also tend to be female-dominated (nurses, language professionals, etc.).

Age is also an interesting demographic component that needs to be examined in relation to gender and function (or position). As the table below suggests, all male interpreters identified under item 21 are significantly younger than their female colleagues as they belong mostly to the 24-30, 36-40 and 41-45 age groups. Contrary to men respondents, most female interpreters are aged 41 to 50 years old (over 20% of respondents) with over 15% of them working well into their sixties. When comparing status and position *vs*. gender, some interesting facts emerge; they may support the feminization hypothesis of the interpreting field. Specifically, it is suggested that women remain field interpreters for many years, whereas men tend to advance faster and more frequently to managerial positions. Although the results generated by this corpus are not sufficient to confirm such a trend, they are suggestive of what it has been suspected so far, at least in the case of conference interpreting (cf. Pöchhacker, 2015), namely that men tend to seek professional advancement faster than women. Based on our sample, influential positions in the field of interpreting are held by both men and women, but are of a different nature. For example, three of the 53 respondents identified under item 21 occupy a position within the academia. All three are women whose age ranges from 37 to 48 years old. Contrary to academic positions or affiliations, managerial duties are assumed by men and women alike but with men ascending the institutional or corporal ladder at an earlier age. Here is an example that demonstrates this trend: two of the men in our sample identified themselves as supervisors of translation/interpreting services in institutions or governmental organizations and/or head trainers. Their age ranges from 36 to 44 years old. Instead, women who hold key functions in their respective workplaces and/or professional associations are well into their 40s and 50s.

These observations are not intended to create a sexist impression of the field of interpreting; nor is it implied in any way that women lack opportunities for career advancement in the said field. The latter would go contrary to the trend of feminization of the profession, which, inevitably is to be run by women. They simply reflect a reality, whereby women access positions of power and influence almost a decade after their male colleagues. There may be many reasons to account for this delay, the most obvious one being that some women, during the childbearing period, may prioritize family over work thus relegating career advancement expectations and goals to a later time in their professional life.

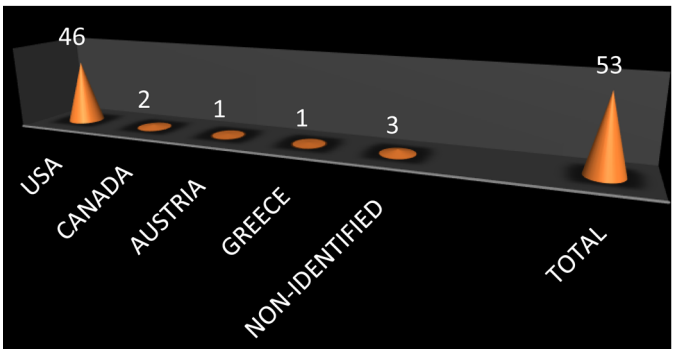
As far as the geographical dispersion of all 53 responses identified under item 21 is concerned, there is an overwhelming presence of North American professionals with 46 respondents coming from the United States and two from Canada. There was one participant from Austria, one respondent from Greece, whereas three out of the 53 respondents opted for not revealing their work/residence location. The dispersion is represented in the chart below.

Figure 2. Women vs. men age distribution



It is not possible to explain the geographical distribution of respondents and the predominance of responses coming from the US as opposed to other parts of the world. The difficulty resides in a variety of factors that come into play in this part of the analysis. Firstly, the chart provided above is based on the self-identification of respondents under item 21 of the questionnaire. If one is to rely on this information alone, one is to conjure that the location provided by 51 out of the 53 individuals who shared their personal data coincides with their place of residence and the area in which they exercise their professional activity. Secondly, these 51 responses correspond to 68% of all respondents to the survey, which means that a considerable percentage of participants, i.e. 32%, are not accounted for geographically by means of self-identification. Thirdly, the geographical locator of the Kwiksurveys platform is a useful tool for locating all 75 participants in the survey to the extent that the results generated by it are compared against personal data provided by the respondents to account for discrepancies in the information given. The scope of this comparative analysis is limited to 51 out of the 75 responses submitted. In other words, in 24 cases the location provided by the Kwiksurveys platform is the login location of the respondent at the time they took the survey online. The login location is not necessarily the place of residence of each participant or the country or region where s/he works as an interpreter. A point in case is a female interpreter who identified herself as being from Luverne Minnesota (MN), but whose login credential located her in the region of Quetzalternango in Guatemala at the time she took the survey.

Figure 3. Geographical dispersion of identified respondents (Total of 53)

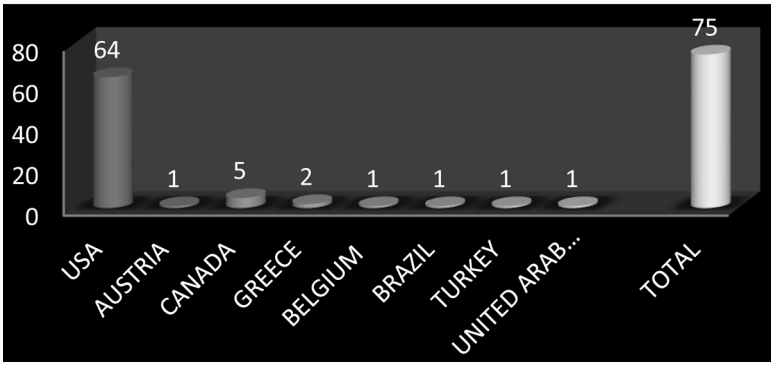


After carefully comparing data generated by the survey platform locator and those provided by the respondents themselves, a slight revision of the geographical distribution of respondents had to be made. The revised data did not in any way modify the investigator's original conclusion, that is, the vast majority of answers came from the Unites States. The chart below provides the final make-up of the respondents' geographical distribution.

As mentioned above, one can only speculate on the predominance of responses coming from North America, especially the US. One plausible explanation is that the healthcare interpreting profession is well established in the States, where major organizations and professional bodies are located. The latter's access to the healthcare interpreters' population is ensured through a variety of communication means that rely heavily on social media for networking and dissemination of vital information. It also extends far beyond the geographical confines of the United States, as these organizations are international to a large extent. As a result, they exert considerable influence all over the world. This is the case of IMIA with its various chapters worldwide. The above-mentioned hypothesis can be partially confirmed by the Kwiksurveys statistics on the various referral means for accessing the survey. It seems that the key referrer for this questionnaire was Facebook, with 49 hits out of 75 responses. Linkedin came in second with 11 referrals. In seven cases it was not possible to identify where respondents got the link to the survey. Finally, five referrals were institutional, in other words information about the survey was disseminated via organizational mailing lists, which cannot be disclosed herein for reasons that pertain to confidentiality and anonymity.

These statistics are not, however, satisfactory in the sense that countries with a long tradition in healthcare interpreting—a tradition which translates, among other things, in considerable research in the corresponding field—are not represented in the survey's demographic and geographical make-up. This is the case of Australia. We believe that lack of responses from our Australian colleagues account for one of the most critical shortcomings of this survey. The breadth and depth of their expertise, in connection with the number of working languages as a result of the country's multi-ethnic/multilingual diversity, would have contributed greatly to furthering our understanding of the conditions of mode switching during interpreter-mediated medical encounters and the intellectual, institutional, and educational requirements and repercussions associated with this practice. In the same vein, scantiness in data from Europe, Asia Minor and Asia are also detrimental to the impact of this survey, especially since the refugee crisis in Europe, as a result of the war in Syria and the turmoil in Middle East, has created new

Figure 4. Geographical dispersion of all respondents (Total of 75)



needs in interpreting, notably in the field of healthcare interpreting along with that of asylum seeking. Countries such as the UK, Belgium, Germany, as well as some of the countries of the Scandinavian peninsula, namely Denmark, Sweden, Norway and Finland, have a long tradition in community interpreting, which translates into a well-developed infrastructure for serving the linguistic needs of their multilingual communities. Their expertise would also be invaluable to this survey as it would allow us to have a greater appreciation of the variety in practices from the point of view of what is real, actual, and empirical in various parts of the world.

Despite the shortcomings listed above, it would be safe to say that the number of valid responses received in the framework of this survey is quite satisfactory (74 out of 75). If our American counterparts were more willing to take the survey, their contribution is greatly welcomed because they represent a body of professionals that is extremely diverse in terms of geography, professional and institutional affiliation, and legal and professional requirements to enter the profession. Inversely, as the analysis of the answers clearly demonstrates, linguistic variety is not represented in this sample: the vast majority of the respondents work mainly from and into English and Spanish.

More precisely, in terms of languages, it would be appropriate to start our analysis by distinguishing between spoken language interpreters and sign language interpreters. Eight out of the 75 participants in the survey (i.e. 10.6%) reported being SL interpreters. Almost 90% of them reported being American Sign Language (ASL) interpreters and classified ASL either as their A or B language. On one occasion, sign language was classified as C language with Spanish and English being identified as A and B respectively. As far as language interpreters go, linguistic variety is not the prevailing pattern of this sample. The table below depicts the most frequently occurring language combinations as reported by the respondents.

The following chart represents the distribution of languages per A, B or C classification as reported by the participants.

A closer look at how respondents understand their language skills in order to classify them under A, B, or C allows us to interpret how language professionals in the healthcare sector understand the concept of working languages as opposed to or in conjunction with languages spoken in general. To achieve this, it is critical to review key documents that provide a definition of what is an A, B or C language in interpreting. This would represent what Bhaskar (2008) names the real in his taxonomy, namely the institutions that set the standards and dictate practices. Then, we need to contrast those documents with the results of the survey as depicted in Tables 2 and 3 above. Historically, conference interpreting has been the one to set the standards for designating the interpreters' working languages. The yardstick for this was the opposition between mother tongue and other languages. Not surprisingly, in the AIIC World website, the traditional definition of working languages prevails. There, language 'A' is labelled as the interpreter's 'mother tongue' or a strict equivalent of it into which all interpreting work, be it in consecutive or simultaneous mode, is performed. An interpreter's 'A' language is also called 'active language', because it is the one to which one instinctively resorts to express complicated ideas in a natural, fluent, and unobstructed way. Consequently, 'B' language is a language "in which the interpreter is perfectly fluent but is not a mother tongue." (AIIC World Website). Practically speaking, an interpreter working into his/her 'B' language, which is also considered an active language, may wish do so from one or several working languages. According to AIIC, interpreters working into their 'B' language may be more comfortable doing this in one mode, preferably the consecutive mode, because the speed is reduced and so is the interpreter's mental workload. This descriptive definition of the working circumstances under which the use of 'B' language is permitted becomes rather prescriptive insofar as it frames the pos-

Table 1. Frequency of language combinations among respondents per A, B or C language classification

Language Combinations	Number	Remarks
I.		
A = English		
B = Spanish	**21**	
C = None		
II.		
A = Spanish		
B = English	**18**	
C = None		
III.		
A = Spanish		C = French (x 2)
B = English	**3**	C = Portuguese (x 1)
C = Other		
IV. V.		
A = English		A = English/B = Arabic/C = None
B = Other	**3**	A = English/B = Russian/C = None
C = Other		A = English/B = Polish/C = German
VI. VII.		
A = English		
B = None	**1**	
C = None		
VIII.		
A = Spanish		A = Spanish/B = Haitian Creole/C = English
B = Other	**1**	
C = Other		
IX.		
A = Spanish		
B = None	**10**	
C = None		
X.		
A = Other		A = Italian/B = German/ C = None
B = Other/None		A = Arabic/B = None/C = None
C = Other/None		A = Greek/B = English/C = None
	6	A = Greek/B = French/C = None
		A = Urdu/B = Punjabi/ C = None
		A = Burmese/B = Chinese/C = Mizo
XI.		
A = None		
B = None	**1**	
C = None		
Total:	**64**	

Table 2. Distribution of languages per A, B, and C language classification

Language	English	Spanish	French	German	Portuguese	Greek	Arabic	Italian	Polish	Burmese	Haitian Creole	Punjabi	Mizo	Urdu
A	x	x	x			x	x	x		x				x
B	x	x		x			x		x		x	x		
C	x		x	x	x								x	

sibilities of the actual. Finally, a 'C' language is the one into which as a self-respected interpreter does not work because there is a discrepancy between the level of understanding (this level is usually close to being perfect) and the level of command (a much less perfect level). For this reason, 'C' language is considered a passive language. It is worth noting that, in the course of their professional life, many conference interpreters strive to turn as many of their passive languages as possible into active languages. This is due to fierce competition in the field.

Let us consider another example. In the *National Standard Guide for Community Interpreting Services*, a reference document for the community interpreting field and its specializations in Canada, the definition of languages deviates only so slightly from the one put forth by AIIC. There are, however, some notable differences, which reflect interpreting requirements and actual practices in the healthcare interpreting field. Firstly, 'A' language is equated with an interpreter's mother tongue, but this equation is labelled as "native proficiency in speaking and listening". The authors of this Standard use the ASTM Standard F2029 on Language Interpreting. According to ASTM, an 'A' language can be used as both source and target language for the purposes of community interpreting. Similarly, 'A' language is considered a primary language in opposition to 'B' and 'C' languages, which are considered active and passive languages respectively. As far as the 'B' language is concerned, the *National Standard Guide for Community Interpreting Services* clearly states that this is "a language other than native in which the interpreter has full functional proficiency in speaking and listening… [therefore] perfect command of the language." As in the case of 'A' language, 'B' can be used as either source or target language (p. 30). Finally, 'C' is the language from which one can only work (source language) without being able to perform inversely. It is equated to "a language other than native in which the interpreter has full functional proficiency in listening." This precludes the use of 'C' language as a target one. Nowhere in this document is it recognized that, in the world of interpreting (healthcare interpreting included), interpreters may have more than one 'A,' 'B,' or 'C' languages.

Those definitions inescapably create a problem with the professionals' own interpretation of working languages. Given that bidirectionality in healthcare interpreting is not optional, a healthcare interpreter cannot count his/her 'C' languages as working languages. To put it simply, a healthcare interpreter who claims having Haitian Creole as a 'C' language, should not be allowed to work into Haitian Creole because the latter is a passive language. This would be the case should we stick to the letter of the definitions provided above. This, however, leads to an absurdity: a healthcare interpreter hired on the basis of having Haitian Creole as part of his/her working languages, should be able to interpret from and into this language with an almost equal fluency in both directions. In other words, the definition of 'C' language in the context of healthcare interpreting needs to be revised if it is to reflect logical expectations for trained healthcare interpreters and their clients.

Putting under the microscope the essence of 'C' language in healthcare interpreting reality and practice helps us reveal the intended meaning behind the respondents' claims *vis-a-vis* their working

languages and how they understand and utilize their linguistic combinations. When practicing healthcare interpreting, there cannot be such a thing as passive language(s). Only active languages are plausible scenarios of practice as a result of the bidirectional nature/exchange of the communicative event. At best, passive languages could be perceived as the ones healthcare interpreters are adding progressively to their linguistic arsenal in order to expand their realm of professional practice and, therefore, generate additional income.

Taking into account that participants in this survey are professional interpreters, it should not come as a surprise that only five in the 64 linguistic combinations generated by the submitted answers state a 'C' language. It is rather safe to presume that, lest the said interpreters are also working as conference interpreters and therefore categorize languages by using conference interpreting-inspired classification or when performing in conference settings alone, their 'C' language corresponds to a working language into which they work less frequently than in their 'A' and 'B' languages. This claim is also corroborated by the fact that, in 10 cases, 'B' and 'C' languages are fields in the questionnaire that went unanswered. This is the case of language combination VII in Table 1 above. One is to hypothesize that, in this particular example, the working pair is assumed to be "Spanish <> American English", since the interpreters in question reside and work in the United States.

This observation has immense repercussions on training for spoken language healthcare interpreters. Working languages and interpreters' education are two aspects that need to be examined from various angles. Departing from our samples of respondents and their linguistic profile, it is important to investigate the educational background of those who took the survey, and more specifically the type of training they received in interpreting, in general, and in healthcare interpreting, in particular. Statistics generated by the answers the respondents submitted in the corresponding section of our survey are quite revealing. The majority of participants, i.e. 60%, have undergone some sort of professional development programs which specialize in medical/healthcare interpreting, followed by 52% of respondents, who stated they have attended seminars specializing in healthcare interpreting. Twenty seven per cent of the respondents have received vocational training in this specialization holding a community college diploma or equivalent in healthcare interpreting. If one is to add these three numbers together, it would come to an aberrant number (139%). However, these statistics are far from being irrational. They should be viewed in relation to other possible answers since respondents were given the option to provide more than one applicable answer. When considered synthetically, the results yield some worth-noting facts, namely that very few interpreters in this sample have a BA or an MA in healthcare interpreting, despite the fact that university programs multiply around the globe and in some areas, such as in North America, have been established for quite a while. In the same vein, medical interpreters with an educational background in linguistics and language-related fields (i.e. Modern Languages, Translation and Interpreting Studies), whether it is at the undergraduate or post-graduate level, represent only a small portion of the sample. It would not be logical to proceed by adding up these percentages because they would lead to a statistical error. Any given person can hold more than one BA degrees, and/or a master and/or Ph.D. degree in one of the fields selected by the investigator, while having taken professional development courses. The most obvious conclusion emerging from this particular segment of data is that the said sample of respondents is made primarily of people who, at best, have a community college diploma and have taken professional development courses and/or attended specialized seminars related to their interpreting practice.

When trying to explain the statistics depicting the educational background of the respondents as well as any action taken to further their professional development via the acquisition of new, skill-related knowledge, it could be argued that healthcare interpreters who actively work in the field and consider

interpreting as a means of making a living, may not be able to afford investing in long-term educational plans (BA or MA studies) that are both costly and time-consuming. Additionally, the value-for-money relationship is also to be taken into consideration, especially if a university degree may not necessarily guarantee higher pay in the healthcare interpreting market. However, given that credentials, such as certification, become progressively a requirement for entering the profession or remaining in it, programs or diplomas that sanction the acquisition and mastery of professional skills and competences in healthcare interpreting are more popular. The main reason for their popularity is that certification courses are intensive and financially more affordable to the vast majority of field interpreters than any undergraduate and/or graduate program, especially in the North American context. Finally, among the respondents, we have identified individuals who have non-linguistic educational backgrounds, but who had decided, at some point in their professional career and for reasons that do not fall within the scope of this survey, to work as healthcare interpreters. These people are more likely to have received some form of vocational training in interpreting, in general, and healthcare interpreting, in particular.

An accurate interpretation of the interpreters' training on the skills and competences that are essential to exercising their profession needs to be correlated with their age and the moment interpreters entered the profession. In other words, data reflecting training trends among the participants in the survey need to be examined from the point of view of years of experience in the field. The latter are suggestive of the entry requirements at the time the subjects started their professional activity as interpreters. As a result, it is not surprising to discover that 31% of the respondents in this sample have been working in the field for more than 10 years, with 12% of respondents working for at least 20 years. The great concentration is to be found in the 5-10 years professional experience cluster (i.e. 35% of all respondents), whereas the number of respondents with less than five years of experience is not to be underestimated, especially in relation to the size of the corpus. The table below represents the 'years of experience' breakdown based on the answers received in the question: How many years have you been working as a medical interpreter?

The table below (Table 4) reveals some interesting trends *vis-a-vis* the level and type of education received in languages, translation and interpretation (conference or community), the age of interpreters and their years of working experience. One could go into great depth in analyzing the data collected herein. Instead some key observations will suffice at this point of the analysis. Firstly, most Ph.D. holders (99%) report having a working experience as healthcare interpreters ranging from 5 to 10 years. Although the age of the respondents in this cluster is not identified, one could presume that they must fall under the 36 to 55 years' old category, especially since this is the average age of most of reported MA holders in the Translation Studies and Interpreting rubric. Secondly, MA holders' working experience seems to vary considerably in terms of years in the practice, with a higher concentration occurring at the 5-10 and 10-20 year categories. One would hypothesize that professionals seeking to expand their knowledge

Table 3. Years of professional experience of healthcare interpreters

Answers	# of Respondents	Percentage
Less than 5	18	24%
5 year up to 10 years	26	35%
10 years up to 20 years	22	29%
20 years or more	9	12%
Total	75	100%

in the field and improve their practical skills, thus increasing their chances as professionals, embark on post-graduate studies that will offer them the professional development and theoretical underpinning necessary to fulfill these goals. One would assume that one makes this time-consuming and financially demanding decision at an age in one's professional life during which adaptations may deem necessary for career re-orientation purposes and/or career advancement. Professionals belonging to these age groups are still susceptible to learning new things and improving existing knowledge and willing to invest time and money in an endeavor that will be cost-efficient.

However, one of the main trends depicted in the table below is that the vast majority of respondents have received professional development courses or a combination of professional development courses coupled with vocational training at the community college level and/or seminars focusing on specific skill sets. This category covers all age groups, with a higher concentration occurring at the 45 to 65 age group. Interestingly enough, most MA and Ph.D. holders do not report having gone through vocational, and/or professional training offered by institutions other than universities. This is not, however, the case of BA holders (translation, interpretation, and languages combined) for whom some sort of vocational training, either as a community college diploma or a professional development certificate, was deemed necessary for entering the profession.

As mentioned previously, Table 4 is rich in information if data are combined in various ways. What is of interest to us is to further our understanding of how mode switching in interpreting relates to the type of education and/or training practitioners received prior to the commencement of their professional activity or during the exercise of their practice. This will allow us to account for mode switching choices made by interpreters, on the basis of their skills received, assimilated and put to practice, and advise future training policies and programs accordingly.

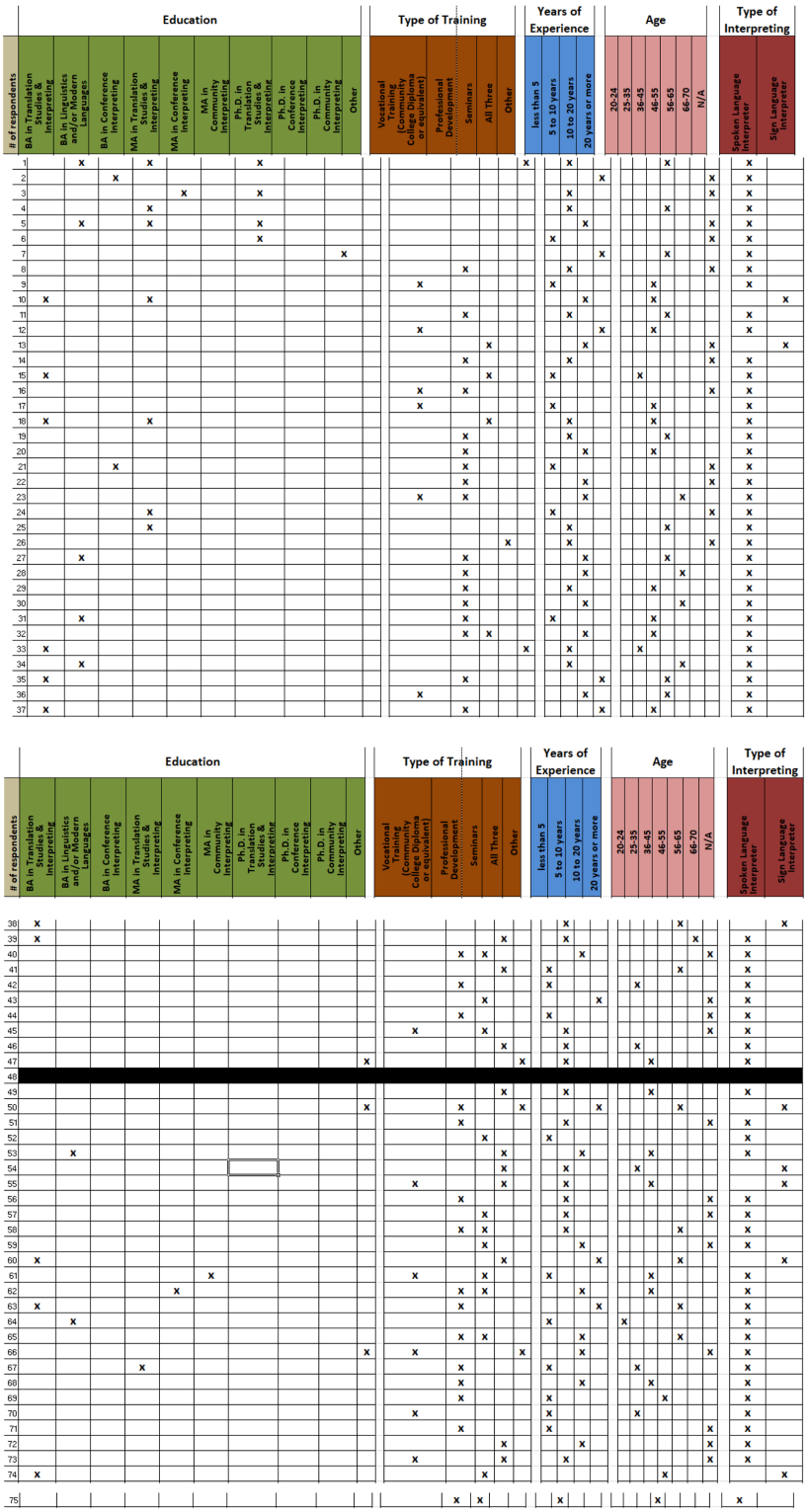
The Case of Mode Switching in Healthcare Interpreting

In order to understand how mode switching occurs in interpreter-mediated healthcare encounters and what its implications are, a preliminary disambiguation of the concept of modes in interpreting is imposed. Pöchhacker (2015), for whom modes are at the center of conceptual distinctions in interpreting, acknowledges the need for disambiguation. If mode is to be broadly understood as the way in which something is done or the shape and/or form of a practice, then modes in interpreting are said to be "generally defined with reference to the *temporal* relationship between the interpretation and the source text" (Wadensjö, 2015, p. 299).

The taxonomic distinction of consecutive *vs*. simultaneous mode of interpreting is one that has been established in the context and for the purposes of conference interpreting, especially since the advent of technology, which revolutionized the practice. However, interpreting modes are related to the modality of languages used in any interpreter-mediated communicative event. By modality of languages in interpreting one is to understand the difference between spoken language and sign language as the production of speech in each of the two modalities and the conditions under which it is produced modify the temporal relation between the source text (to be interpreted) and the target text (the interpreted one).

Pöchhacker (2015) emphasizes the intricacy in associating the concepts of modes and interpreting with one another or dissociating them from one another. If modes are to be considered from the point of view of settings, as in the case of the current study, questions of modality need also to be accounted for especially when, on the one hand, specific types of interpreting seem to favor one mode of interpreting over another, whereas, on the other hand, within a given setting, the element of modality of language

Table 4. Distribution of respondents by type and level of training, age, years of experience and type of interpreting



imposes restrictions upon the type of mode or modes used. To add more to this mix, the question of interpreting settings is not unconnected from the type of interpreting performed. This is particularly salient in the case of community interpreting, which covers a variety of settings where various types (or sub-types) of interpreting take place, namely healthcare interpreting, court interpreting, liaison interpreting, disaster relief interpreting, etc.

According to the most recently accepted nomenclature, community interpreting (as opposed to general interpreting and/or conference interpreting) is considered a type of interpreting whereas healthcare interpreting is treated as a specialization within the community interpreting type. The latter is treated as a broader category, which can only account for some of the numerous characteristics that are specific to healthcare and court interpreting. These characteristics call for a differentiated approach to the various interpreting specializations, both from the educational (training programs) as well as from the statutory/regulatory standpoint (codes of ethics, standards of practice, legal frameworks, etc.). Moreover, consistency in the use of terminology for this study requires that consecutive mode in interpreting be free from restrictions that relate to the duration of speech. In the framework of conference interpreting, consecutive is associated with speeches lasting +/- 6 minutes on average. This is far from being the case in healthcare interpreting, where speech exchanges alternate every few seconds to a couple of minutes at most (with some exceptions applying, notably in the context of sessions dedicated to health education). Contrary to consecutive, simultaneous may take several forms and be performed onsite or remotely, with or without the use of technology. It may last for quite long stretches of time, thus imposing working conditions on healthcare interpreters which often contravene regulatory requirements that bind conference interpreters and the organizers of events where conference interpreting is offered. These requirements comprise, but are not limited to, a minimum number of interpreters per booth, the obligation to take turns every 30 to 45 minutes at most, access to interpreting equipment that fulfill ISO standards, prior access to documents, etc.

Finally, directionality is an additional component which further complicates the concept of mode in interpreting (cf. Dijk et al., 2011). Readers should be reminded that longstanding views on directionality are currently under attack, especially since the traditional definition, originated from the world of conference interpreting, has been made obsolete by factors such as the bidirectional nature of some types of interpreting and their specializations; the restrictions imposed by the element of modality (spoken *vs*. sign language) within the interpreting types which are organically associated with bidirectional interpreting; the linguistic make-up of modern users of languages, especially with respect to the phenomenon of global Englishes in a transcultural world (cf. Pennycook, 2007; Gentile, 2017), just to name a few.

On the back of the information provided above, it is vital that a terminological basis is established for conventional purposes. The latter will allow us to provide a consistent framework for interpreting the results on mode switching as produced by the answers to the questionnaire. The term mode as defined herein takes into consideration recent developments in framing conceptually methods and practices in interpreting studies, as reflected in current research and regulatory documents, such as the upcoming ISO 21998 standard. Consequently, modes of interpreting will be equated with "an established method" of rendering spoken language *x* into spoken language *y* (also known as spoken language interpreting) or spoken language *x*/sign language *x* into sign language *y*/spoken language *y* (aka sign language interpreting). We acknowledge two methods of delivering spoken or sign language, namely the consecutive mode and the simultaneous one. We take for granted that, in an interpreter-mediated healthcare encounter in the various settings of a community (from general hospital clinics and ER departments, to prison hospitals, to doctors' offices, to refugee camps and disaster-stricken areas), consecutive mode is always performed

bidirectionally as opposed to simultaneous interpreting, i.e. the second mode of interpretation, whereby speech delivery is almost always unidirectional, regardless of the direction into which the delivery is made (cf. the issue of A and B language previously discussed in this chapter). This is to be understood in the sense that in sign language as well as in spoken language healthcare interpreting the selection of interpreters is not made on the basis of their A (i.e. native language or a quasi-equivalent of the latter) or B language or on how comfortable interpreters may be in performing simultaneous in their B language. Interpreting assignments are allocated based on the interpreters' language combination(s) and the professionals' availability at the time of the interpretation request. After all, healthcare interpreters are required to perform bidirectionally as this is the nature of the interpreting type and setting.

Sight interpreting was purposefully omitted from this questionnaire partly as a result of its hybrid status in the conceptual framework of modes. In the interpreting studies taxonomy, sight interpreting is classified under interpreting modes. More specifically, it is considered a form of simultaneous interpreting, due to the nature of the mental processing required to transform—in real-time and under conditions of pressure—written text into speech. This mental process is quite similar to the one activated during simultaneous interpreting. Sight interpreting is widely used in interpreter-mediated encounters. Healthcare interpreters would sometimes have to go several hours on end sight-interpreting documents for clients. This occurs most frequently in the mental health sector.

There are several reasons why sight interpreting was not included in this research. Firstly, there seems to be a discrepancy between the actual practice (i.e. the empirical) of sight interpreting in various healthcare settings as reported by interpreters and the prescriptive framework delineating conditions for practicing this mode safely. Codes of Ethics tend to discourage the use of what is more often defined and widely known as 'sight translation' when long and more complicated documents are involved (i.e. the real), especially when these documents were not given to the interpreter prior to the meeting for adequate preparation. Codes of Ethics and other documents written with the intent of setting standards of practice prescribe the occasional use of sight interpreting by limiting the use of this mode to simple documents or documents which do not exceed a single page or a couple of pages at most. This length usually corresponds to an average hospital form or a short medical record. However, it is difficult to establish what constitutes a 'simple' document as opposed to a complicated one, especially if the degree of complexity and/or difficulty is solely defined from the standpoint of the expert's level of understanding and degree of familiarity with relevant documentation (i.e. the healthcare provider's expert knowledge of the corresponding typology/field).

Secondly, as mentioned earlier, sight interpreting is a form of simultaneous interpreting with the point of departure being a written text instead of an oral one. Undoubtedly, it could have been useful to expand the focus of our investigation to sight interpreting given the frequency of its use in the healthcare sector and the burden associated with this practice (cognitive, ethical, and legal) for the interpreter. This is probably one of the second most important shortcomings of this research. It was actually pinpointed by respondent #66 who added the following comment: I believe the focus of the study is only on consecutive and simultaneous mode switching. Sight translations are used a lot in healthcare and we also switch between all 3 modes.

Although we wholeheartedly agree with respondent #66, we believe that collecting data on the frequency of sight interpreting would entail providing a broader framework for investigation in which the interpreter-mediated encounter would go beyond the strictly triadic and/or multiadic exchange to encompass instances where sight interpreting actually takes place, that is, either at the pre or post encounter phase. In this case, communication is no longer or is not exclusively between the patient and

the provider via the interpreter's mediation but, most frequently, between the patient and the interpreter or the interpreter and the healthcare provider with the third party not being present. For this reason, and given the importance of sight interpreting in the healthcare sector, we anticipate a future research which will focus exclusively on this widely under-investigated practice in healthcare. Any research dealing sight interpreting in the healthcare setting should also encompass its ensuing, highly controversial aspect, that of the role boundaries and limits of functions. The utilitarian view of the interpreters' role was discussed by Hsieh and Kramer (2012). In the words of the authors "interpreters are conceptualized as instruments in the process, providing utility without influencing the content or dynamics of provider-patient communication" (2012, p. 158). During interpreter-mediated encounters, the function of sight interpreting may often shift the interpreter's role to that of the provider's proxy thus generating imbalance between the parties and with respect to the encounter's communicative goals.

Thirdly, it would have been more sensible to investigate the interpreters' degree of familiarity with the simultaneous mode (frequency and instances of use, training received, and training required) to establish their level of competence and to back it up with the corresponding proof of evidence where applicable. Training healthcare interpreters in performing sight interpreting without sufficient and/or adequate follow-up training in simultaneous interpreting may result in serious distortions with respect to understanding the importance of this mode and treating it accordingly (the actual). Interpreting pedagogy recommends that sight interpreting is introduced once basic consecutive skills are solidified. Sight interpreting is the springboard for developing its composite skill, namely simultaneous, but in the absence of the latter the former may suffer considerably. In that respect, our research is yet another research that does not contribute to a field "[which] has attracted relatively little research interest" (Pöchhacker, 2015, p. 406). However, an investigation of the interpreters' position *vis-à-vis* sight interpreting in the healthcare context including the challenges they encounter, conflicting expectations, and legal repercussions of errors or omissions during this practice in relation to the patients' well-being would be quite useful for pedagogical as well as regulatory purposes.

A final note on questions 17, 18, and 19 of the questionnaire seem appropriate. They all refer to notetaking, which is not a mode in interpreting, but a 'technique' closely intertwined with the consecutive mode. Note-taking is at the heart of the interpreter-mediated encounter, which is delivered consecutively, and is believed to be a practice exclusively performed in spoken language interpreting. Sign language interpreters are torn on the subject, as will be revealed by their comments on the questions about notetaking. As Ahrens states (2015, pp. 284-285), note-taking is yet another area in interpreting studies to be under-investigated. The challenge with notetaking for interpreters who perform in the healthcare and court sector is the requirement for destroying one's notes after the end of each session. This renders any research on the language, form, technique and extent of notes extremely difficult since confidentiality issues come into play. Any observational type of research also becomes quite difficult as the presence of the researcher during an interpreter-mediated encounter is very difficult to achieve. Research based on real-life, real-time observations would then have to be substituted by simulations in highly controlled, artificially created environments.

Patterns of Mode Switching in Healthcare Interpreters

Via the questionnaire devised we wanted to understand if and how often interpreters switch modes, i.e. when and how they move from consecutive to simultaneous and vice-versa and what are the communicative instances, which call for one or the other at any given time. Questions dedicated to this

segment of the investigation were Questions 5 to 16 (see Appendix for the questionnaire). The collected data are quite suggestive of how interpreters view their practice and utilize their training by turning it into on-the-job competence. Fifty-two per cent of the respondents claim to be using consecutive mode almost exclusively in their everyday interpreting practice in the healthcare setting (81-100% of times). One would presume that this statistical result is consistent with the bidirectional nature of a typical interpreter-mediated medical encounter in spoken language, an encounter that is mainly triadic, i.e. it involves the patient, the healthcare provider, and the interpreter. Only 8% of the respondents (six participants in total) claim that consecutive is only marginally used in their daily professional practice. This number is confirmed by the results yielded in the subsequent question, namely the frequency of use of simultaneous. Eight respondents (or 7% of answers received) use simultaneous at a rate of 81-100%. This number corresponds to the eight sign language interpreters who took the survey. By extension, the six participants who considered consecutive as a marginally used mode in their healthcare interpreting practice must also be sign language interpreters. Answers in Questions 5 and 6 respectively are quite balanced if we were to represent the average frequency of use of both modes. To do so, we only need to add the responses in the 41-60% and 61-80% categories for both consecutive and simultaneous. The results read as follows: average for consecutive 28%; average for simultaneous 33%. This testifies to a satisfactory level of accuracy in respondents' answers. In other words, participants were carefully and consistently providing their answers throughout the questionnaire. The tables below, generated by Kwiksurveys, reflect the statistical trends analyzed above.

As far as mode switching is concerned, 92% of our respondents, or 69 participants, admit switching modes when needed. The remaining 8% (or six respondents) must represent our sign language interpreters. The result is not surprising insofar as the complexity in settings, communicative patterns, number of people involved and particular communicative demands are known to prevail in interpreter-mediated encounters in the healthcare sector, where the one mode-fits-all approach is neither feasible nor effec-

Table 5. Frequency of use of the consecutive mode

Answers	# of Respondents	Percentage
0-20%	6	8%
21-40%	9	12%
41-60%	3	4%
61-80%	18	24%
81-100%	39	52%

Table 6. Frequency of use of the simultaneous mode

Answers	# of Respondents	Percentage
0-20%	38	51%
21-40%	15	20%
41-60%	8	11%
61-80%	9	12%
81-100%	5	7%

tive. Inversely, it is rather interesting to consider that two out of the eight sign language interpreters do not view their modality as being exclusively served by simultaneous.

If mode switching is a reality in the field, the frequency with which interpreters move from consecutive to simultaneous and vice-versa is revelatory of the former's practices as informed by the institutional setting, the nature of the encounter, and their skills and competences at work. The answer dispersion observed with respect to options made available to participants in Question 8 suggests that not all interpreters are used to switching modes. The reasons for it can only be hypothesized at this stage. To that end, we believe that our attention should be drawn to the two extremes in the range of options provided. In other words, we need to consider the relatively high rate of respondents (38% or 26 participants) who report switching modes at a frequency of 0-20%. Given the previous statistics, it is safe to conclude that six of these 26 respondents are sign language interpreters. However, this leaves us with 20 out of the 69 respondents (i.e. almost 14%) of the corpus rarely switching modes. Inversely, the mean distribution of respondents is concentrated at the 21-40% and 41-60% clusters, which represent a total of 37 interpreters (or 53% of the respondents) switching modes at a rate of two to six times out of ten. It would be presumptuous to claim that the above-mentioned average corresponds to mode switching within a single communicative event. For us to reach such a conclusion, we would need to have included a more specific question addressing the issue. Regardless of this, what counts is that more than half of the interpreters from our corpus report switching modes on a regular basis. For someone to be able to claim the said competence, one needs to have developed the corresponding skills.

Based on respondents self-reporting, 57% have received formal training in the simultaneous mode as opposed to 92% who reported having formally been trained to perform consecutive. The difference in the percentage between these two modes should be interpreted in relation to the type of training interpreters have undergone and not as a fact in itself. A key word in Questions 13 and 15 are "formal training", which limits the spectrum of valid answers to the following categories: professional training, vocational training including seminars, and specialized university training (at the undergraduate and postgraduate level) in conference and/or community interpreting. This category should not encompass Ph.D. programs as they sanction academic/theoretical-oriented knowledge, in the form of research, thus excluding the development of practical skills, such as modes of interpreting. Answers received in Questions 13 and 15 confirm that the majority of respondents received professional/vocational training, followed up by workshops and/or skill development seminars (often webinars). This type of training explains the prevalence of consecutive mode as opposed to simultaneous.

The biggest surprise in this survey comes from what seems to be a statistical discrepancy at first glance. This discrepancy emerges as a result of data gathered in Questions 14 and 16. These questions functioned partly as verification (follow-up) questions, partly as explanatory fields to Questions 13 and 15. In the case of simultaneous, 32 respondents reported having received no formal training in this mode. When the 'NO' respondents were asked to explain how they learned to interpret simultaneously (Question 14), there were 43 responses, i.e. 11 more than expected. This difference may be attributed to the possibility of choosing more than one available answer. Curiously enough, of the 43 responses given in this question, 33 are deemed correct as they represent training methods that are actually informal (self-training, on the job training, and other). The 'Other' category represents an interesting reflection of the interpreters' own perception of formal qualifications as opposed to experience gained in the field. Nine responses were received under this category, which produced eight comments, in the corresponding field of the questionnaire. Out of these eight commentaries, one was obviously contrasting the 'NO' answer provided in Question 13 by stating legal interpreting training as an alternative form of training

(informal). Unless the said respondent went through the training but did not successfully complete it to be able to provide proof of competence, legal interpreting training cannot qualify as informal training. All other answers seem to place simultaneous outside the sphere of a skill that can be taught and perfected through education and training. For one respondent, in particular, simultaneous has been a natural ability improved with practice. For another interpreter, simultaneous interpreting is a default mode in her capacity as sign language interpreter. In her commentary about having been trained in this mode, she reported the following:

I learned the concept of simultaneous as the definition of interpreting back in the 70s. So simultaneous has always been what I have striven for. I [..] expressed a preference for simultaneous interpreting (skill-wise) when I began interpreting for medical schools and medical professionals who normally do not want to wait for consecutive – because it changes the professional dynamic of communication with peers… (Participant # 50)

This statement alludes to the fact that choosing one mode over another is often dictated by the expectations of some of the members of the triadic or multiadic communication scheme, even if these expectations may run contrary to the purpose of the communicative event *per se*. In healthcare settings, the ultimate purpose of every medical encounter, either interpreter-mediated or not, is the well-being of the patient. However, conflicting expectations are the result of constraints that need to be taken into account and evaluated accordingly if one is to grasp the extent of complexity of choices interpreters have to make on a daily basis. Interpreting modes and the circumstances under which interpreters choose them—on their own volition or against their better judgment—in order to accommodate the participants' needs in the interaction are part of the hard decisions interpreters make in their daily practice. The comment made by respondent #50 takes us as step further. It provides insight into how an interpreter evaluates the needs of participants in the interaction, under the circumstances, by putting the communication requirements of the patient (i.e. the deaf person in the interaction) first. As suggested by the interpreter's comment, she is taking a clear stand in favor of one party, thus risking to go against the expectations (implied or overtly expressed) of the other party or parties in the encounter, namely the doctors who may be wary of the use of consecutive for their own communicative needs (dynamics), especially among peers.

[…] I do not choose to move into simultaneous interpreting when it will alienate the Deaf person I am working for. If I start in simultaneous and the person understands me – I continue doing that until I need to break an idea into steps for clear comprehension – once that person understands again, I will go back to simultaneous. If the person cannot follow simultaneous interpreting and I NEED to use consecutive (or interactive) in order to know that the information is being followed, I will not EVER go back into simultaneous… that would be counter to what the Deaf participant needs…

(Emphasis in bold is used by the investigator whereas emphasis in upper case is used by the respondent)

This is clearly a mode switching strategy used by the interpreter to avoid alienation of the deaf person (patient) thus empowering the latter in communicative instances where a deaf patient is presumed to be or is actually powerless. It is, therefore, implied that the interpreter is entrusted with the responsibility or feels that it is his/her duty to facilitate, to a large extent, access to information in settings where reasonable accommodations for deaf patients are often lacking, thus re-instating the balance of power among

participants. This is rather consistent with findings by Hommes et al. (2018: 960) in a survey conducted amongst ASL interpreters. In this research authors concluded that despite the 'Americans with Disability Act', and the healthcare professionals' acknowledgement of the importance of the interpreters' role in the healthcare setting, necessary accommodations to render interpreter-mediated medical consultations patient-centered are lagging behind the actual needs of deaf patients and relevant research findings.

If mode switching is to be considered an interpreter's strategy to manage the communication flow and its effectiveness, as is suggested in the case of the SL interpreter of our corpus, one can claim that mode switching is actually a means for advocacy via linguistic mediation when interpreters witness or fear discrimination against the patients. This does not in any case mean that discrimination may always be against the patient. It may very well be that healthcare providers are subject to discriminatory behaviors generated by patients, their family members, and interpreters alike. Finally, SL interpreters in our survey criticize prevalent beliefs in their line of work, namely that modality is the main indicator of switching modes. To use the words of respondent #55:

[…] many people assume ASL **should be simultaneous***, when I find it switching often during many encounters depending on what is being communicated and how the patient is reacting to the information. There are ranges of signing options and topic understanding. (Emphasis in bold is used by the investigator)*

Pre-conceived ideas about modes and modality apply also in spoken language interpreting. The prevalence of consecutive in spoken language, as an interpreters' preferred mode, is clearly indicated in the results of our survey, where 52% of the respondents are claiming using consecutive between 81 and 100 of times and switching modes as often as 0-40% of times (51 out of 74 valid responses). In other words, 74% of the participants in this survey admit switching modes less than half the time they interpreter for healthcare purposes.

With respect to spoken language interpreters, the data collected herein allow the researcher to make the following hypothesis: if encounters require switching from consecutive to simultaneous, then interpreters often have recourse to other strategies such as summarizing information, suspending interpretation to ask for repetition or clarification, take notes, etc. For transparency and accuracy purposes, it is vital to acknowledge that this particular segment of the investigation represents one of the highest rates of standard deviation (i.e. 9.3) found throughout the questionnaire. Question 12 was designed to provide extra information in relation to participants who testified not switching modes during an encounter. The "NO" respondents were asked to specify their alternative strategies to mode switching in a subsequent question. However, answers collected under Question 12 contradict responses received in Questions 7 and 8. This deviation possibly results from that interpreters may be less forthcoming admitting practices that are current in the field but go against professional requirements for promoting 'best' practices.

Inversely, the results that correspond to switching from simultaneous back to consecutive show that the interpreters' primary concern is accuracy and consistency in information, as well as transparency and accountability of speakers. Interpreters state clearly that, once in simultaneous mode, there must be pressing circumstances that would call for going back to interpreting consecutively. Based on the responses received, the circumstances that warrant the shift from simultaneous to consecutive are the following (listed in order of importance and frequency of occurrence):

1. Need for clarification: the information is complex in meaning and/or technical and/or is presented in a complicated way.

2. Issues of fluency: apply to patients who are not fluent either in spoken language or in sign language. In this case, interpreters need to have the entire message delivered to them in the source language before re-encoding it in the target language.
3. Need for longer pauses: all parties have agreed to take turns in speaking but accuracy and consistency in information as well as accountability of speakers require that consecutive interpreting be used even if providers do not like it or deviate from their commitment to take turns.
4. Lack of equipment: healthcare interpreters consider that in the absence of portable equipment for simultaneous interpreting the chances of miscommunication are greater, thus creating barriers to understanding.
5. Confusion in the room: this comment relates to the previous observation. It has to do with the participants' ability to adjust to the simultaneous mode and tolerate the background noise. In other words simultaneous is viewed as a distraction during an interpreter-mediated encounter that is annoying for either the patient or the provider or for all parties involved (the interpreter excluded).

A strikingly interesting comment comes from a female interpreter with over 20 years of experience in the field. This colleague brings up the case of *chuchotage*. Chuchotage, also known as whispered interpreting or whispering, is sometimes treated differently from simultaneous both as a mode as well as from the standpoint of circumstances that may lead to switching back to consecutive. This distinction calls for a brief discussion. According to Diriker (2015: 383), whispering interpreting is a sub-type of simultaneous, which is used for small groups and without simultaneous equipment (bidule). Whispering is the most common form of simultaneous in the healthcare setting, with the interpreter standing beside the party that needs to hear the interpretation of a constant flow of speech produced originally in a language s/he cannot understand. What is interesting about whispering as defined above is that it increases the cognitive load of the interpreter and the challenges associated with this mode. The interpreter is physically near the various speakers, thus making him or her visible to all participants, especially if one is to take into account that interpreter-mediated medical encounters take place in rather small quarters. This proximity influences the role of the interpreter as perceived by the participants in the interaction, who may, at any time, switch to a conversational mode, which, by definition, necessitates the use of the consecutive mode. Simultaneous with equipment in healthcare settings reduces considerably bidirectionality in the communication flow, unless all participants wear the necessary equipment. However, had this been the case, simultaneous would have been virtually impossible, especially since all interactants would be tempted to speak at the same time. When considered from this perspective, our colleague's comment with respect to changing modes from whispering (simultaneous) to consecutive when "my client gets a question, so I have to switch to consecutive" becomes meaningful.

When investigating the occurrence of mode switching with respect to instances/types of communication, it is clear that interpreters turn from consecutive to simultaneous in order to accommodate the following situations (presented in the order of frequency of occurrence):

1. Mental health encounters
2. Hospital encounters (general)
3. Pediatric encounters
4. Other

Before dealing with what the investigator and the respondents consider the most important category, i.e. mental health consultation sessions, it is important to provide some useful explanation with respect to categories 2 to 4 above using the respondents' own comments. The urgency of the medical need often dictates that interpreters use simultaneous to expedite 911 calls, trauma or stroke cases or any other type of medical emergency. Next comes the element of time. It is often reported that healthcare providers are extremely busy and need to breeze in and out a medical consultation in order to get to the next one. It is rarely stated that interpreters are also pressed for time. Respondent #19 reminds us that time constraints apply to doctors and interpreters alike and that they are interconnected.

[I switch to simultaneous] when **both the doctor and myself** *are pressed for time and simultaneous interpretation: 1) ensures no interruption to the speakers' train of thought, and 2) reduces the length of the encounter in ½ [half] as everything doesn't need to be said twice, so to speak, but in real time; this is reserved for pressing situations, i.e. I am booked only for an hour and must begin a different assignment promptly at the neighboring clinic at the end of the hour; the Dr. is running behind and the encounter begins 12 min. to the hour. Rather than 'abandon' the patient who has been waiting patiently for the provider, I maximize the time of their encounter. (Emphasis in bold is used by the investigator)*

Another instance which lends itself to simultaneous is the speed of the speech of one of the parties involved in the encounter. The latter is most often presumed to be a member of the medical team/staff who refuses to take necessary pauses, even when asked by the interpreter, to allow the latter to convey the information in the target language. Interpreters often report cases of uncooperative healthcare providers, a recurring theme which has emerged several times in this survey. Moreover, respondents drew our attention to yet another instance of communication where the use of simultaneous may serve best the purposes of consultation. This is the case of IEP or Individualized Educational Programs for children with disabilities requiring special accommodation to be able to reach the students' educational goals. Among the accommodations to be made are provisions for spoken language interpreters for children who do not speak the language in which formal instruction is offered or sign languages interpreters for deaf kids. Finally, interpreters feel the need to use simultaneous for their patients, when consultations take place at medical teaching facilities. During these instances, patients' medical providers, in their capacity as teachers or medical students and/or residents, provide lengthy explanations to their trainees or engage in a discussion with them about the patients' condition with the latter being present. It is obvious that interpreters take seriously the imperative of 'interpreting everything said', thus empowering patients by allowing them to partake of any information that is directly related to their well-being (respondent #51).

With respect to interpreter-mediated encounters in the mental health sector, Bot (2015: 332-333) summarizes current research as focusing mainly on the interpreters' presence from the point of view of their role, the quality of the translation provided, as well as their position within the therapeutic relationship (cf. Cerci et al., 2018; Leanza et al., 2015, 2012; Brisset et al,. 2012; Cambridge et al., 2012)It seems that this paradigm is still very popular in recent articles dealing with the presence of interpreters in the mental health clinical setting (cf. among others Wand at al. 2019; Chatzidamianos et al, 2019). Conclusions seem to converge in that there are considerable benefits in viewing interpreters as equal partners or co-constructors of the therapeutic process (aka co-therapists) in mental health care.

Interpreters cannot and should not be perceived as a passive and neutral conduit of emotional and highly sensitive information. Interpreters should be equal partners in the triangle of care. This is an appropri-

ate model that builds trust, fosters collaboration and facilitates the development of a structure that can result in appropriate diagnosis and treatment. […] interpreters also need to be supported in their role through clinical supervision. This will safeguard against interpreters becoming emotionally distressed and encourage them to remain working in mental health services. (Chatzidamianos et al. 2019)

However, to the investigator's knowledge, there is little if any research focusing on the impact of the choice of mode to all the parameters identified above as being key to understanding the role and function of the interpreter in mental clinical settings. It seems that in Kennard, Roberts, and Elliot study (2002) whispering, as a preferred mode of interpreting in interpreter-mediated mental health encounters was discussed from the perspective of errors, distortions and omissions. The respondents in this survey confirm the prevalence of simultaneous in mental health without providing additional comments as to the constraints placed upon them by using this mode. Instead they are quite vocal when they insist that providers show mistrust to simultaneous performed for the benefit of the patient, either because they are annoyed by the noise or because they are not used to it, thus suspending their speech in order to initiate the conversational (consecutively supported) mode. It is also possible that healthcare providers be warry of the patients' forming some sort of alliance with the interpreters when simultaneous is used.

MODE SWICHING AND INTERPRETER TRAINING: RECOMMENDATIONS FOR FUTURE EDUCATIONAL POLICIES

Although limited in scope, this survey reveals a discrepancy between the actual, the real and the empirical in mode switching during interpreter-mediated medical encounters. Generalizations would be both dangerous and abusive as findings are based almost exclusively on spoken and sign language interpreters working in medical settings in the United States, thus representing a specific medical culture. There are, however, five superordinate themes that emerge following a critical analysis of the survey results: (a) the interpreters' preference for consecutive over the simultaneous mode by virtue of their training; (b) interpreters favoring consecutive in order to satisfy the conversational mode preferred by healthcare practitioners and patients alike, as this mode is deemed more transparent and therefore less likely to result in the interpreters' allegiance with one or other party; (c) the preference for short consecutives that are less demanding on the note-taking level; (d) the shift to simultaneous for expedience purposes, thus accommodating the provider as well as the interpreter; and, finally (e) the use of the simultaneous mode as a means for dealing with power struggle issues among healthcare providers.

All five themes are connected with training at various levels and degrees. The interpreters of this corpus were openly admitting having received more training in consecutive than in simultaneous (some having received no training in the latter at all). At the same time only half of the interpreters who reported having learnt how to take notes, as part of their training in consecutive, take notes as frequently as 75 to 100% of times. Their comments suggest that notetaking is not for everyone which, in turn, implies that there must be issues with how note-taking was incorporated in the consecutive mode curricula. As mentioned previously, observing healthcare interpreters on the job and collecting evidence of their notes is very difficult to achieve.

Testimonies provided in this survey give us plenty of food for thought in regard to the educational needs of healthcare interpreters and the direction educational policies need to take. As far as consecutive is concerned, it is our understanding that solid note-taking skills would increase interpreters' competence

in dealing with longer stretches of speech in the conversational mode, thus reducing the frequency of interruptions and the need for repetition, the participants' fragmented discourse, and, ultimately, the need to have recourse to the simultaneous mode. This will also increase the fluency in the participants' speech, and will facilitate interaction and exchange of information while establishing a feeling of trust among all interactants. For this to happen, programs at the professional and vocational level need to step up to meet the standards of university programs. Note-taking and conference mode for healthcare interpreters are well established practices with considerable educational as well as theoretical underpinning. Professional organizations seek—and should continue to do so in the future—academic trainers' expertise in providing their members with educational opportunities to update, expand, and improve the corresponding skills. This also translates in the requirement for trained interpreters to belong to and maintain an affiliation status 'in good standing' with interpreters' associations to be able to keep abreast with the latest developments in their field while having access to updating their knowledge and skills periodically. Receiving all benefits (professional, legal or other) associated with such memberships and abiding by the professional, ethical, and educational standards of the profession should be a requirement for all in-house or freelance healthcare interpreters.

Concerning the simultaneous mode, the underlying message from the respondents to the survey is that training is lagging behind regarding the all evolving communicational situations where simultaneous is an inescapable duty to perform. Advances in technology and the advent of new ICT-inspired products change the face of interpreting, by adding new demands upon healthcare interpreters, especially those working with less common languages. Video-remote interpreting (VRI) will soon favor simultaneous mode in bidirectional encounters thus creating hybrid modes in simultaneous, establishing new sets of rules of conduct for interpreters as well as healthcare providers and patients alike. Remote interpretation is not new, and neither is phone interpreting which has been used for decades now and will soon be replaced by the new technologies. Healthcare interpreters will inevitably be faced with the reality of working from offices or their own home, after having invested in the necessary equipment and having adequately trained in these new hybrid modes. Questions have already raised as to the suboptimal conditions of performing interpreting from one's home, without the necessary infrastructural support (soundproof rooms, absence of distractions that may hamper quality of reception, sound and, subsequently, the interpreter's output, etc.). Simultaneous training needs will become more pressing and educational programs will have to adjust to the new reality by moving away from the traditional booth-based training to anticipate new needs and to accommodate the new forms of simultaneous performed remotely.

Educational programs, awareness campaigns and subsequent policies need to take into consideration all interactants in the interpreter-mediated consultation regardless of setting or directionality specificities. The use of mode that better serves the do-no-harm tenet, by which healthcare professionals and interpreters need to abide, is something that needs to be re-negotiated among stakeholders who have a clear vested interest in it. Training interpreters in the various modes of interpreting does not guarantee that these modes will be actively used to benefit the patient. It was suggested time and again in this survey that failure to use the most appropriate mode is, to a large extent, a responsibility shared among the interpreters, the healthcare providers, and the patients. Any training of interpreters should result in subsequent training of the medical personnel who works with interpreters. Given population mobility and migration flows, all healthcare professionals should expect to have to work with interpreters. For this to happen, two basic conditions must be met: first, a much-needed cooperation of the academic world of interpreting and medicine needs to be initiated or expanded. The support of professional associations is a catalyst to the success of this endeavor. Second, researchers need to take an interest in the

cost-investment-outcome effectiveness relationship of studies that focus on mode switching as a means for understanding actual interpreting practices at the community level, in general, and the healthcare sector, in particular. In other words, data are required to demonstrate the interconnection of appropriate mode switching to factors such as expedience in the administration of care, reduction in the occurrence of medical errors due to interpreters' performance (omissions or misunderstandings), and possible advantages in investing time and money to educate healthcare professionals into effectively negotiating conditions of mode switching with their therapeutic communication partners, namely the interpreters.

LIMITATIONS AND FUTURE RESEARCH DIRECTIONS

In previous sections of this chapter, the shortcomings of the research were discussed in detail. These shortcomings are primarily the result of the following: (a) the limited number of respondents to the survey; (b) their geographical dispersion, which is limited to North America, but should have included huge interpreting markets such as Asia; (c) testimonies from healthcare interpreters in Australia and in the Scandinavian countries, with long tradition in the sub-field; (d) the absence of variety in terms of working language combinations, as well as (e) the nature of the questionnaire, which favored cloze type questions instead of open-ended ones. Regardless of these limitations, it is the investigators belief that the primary goal of this study was met. However, findings need to be corroborated by further research in the area of mode switching.

Inspired by the conclusions presented in this chapter and the respondents' comments and suggestions, we identify three major areas that call for immediate investigation. The first relates to interpreter-mediated encounters in the mental health sector as this is a field in medicine where the role of the interpreter clearly is viewed as that of the co-constructor of the therapeutic process. By focusing on modes and means to implementing mode switching for the patient and the provider, as efficiently and as unobtrusively as possible, any future research can offer valuable insight into how effective training and proper collaboration protocols may increase positive therapeutic outcomes in mental health.

The second area is sight interpreting. The reason why sight interpreting was not included in this study has been explained extensively. Its importance in the healthcare setting is as big as if not bigger than consecutive and simultaneous together. If one is to consider sight interpreting skills as the consecration of an interpreter's training in consecutive as well as the springboard for acquiring solid skills in simultaneous, investigating the instances under which interpreters are asked to sight interpret for patients, the quality of sight interpretation, and the latter's effectiveness *vis-à-vis* the goal of this exercise (i.e. share information with the patient and collect vital data or receive consent from the latter) are legitimate goals to launch observational research projects to trace good as well as bad practices, identify institutional constraints, detect behavioral patterns, etc. Emphasis needs to be given to the time and place sight interpreting occurs within the medical encounter, as it often takes place beyond the triadic or multiadic interaction: it is considered as an extended part of the communicative event. The rules that apply in this case should also be examined in relation to the setting, the modality, and the power differential among interactants so as to account for all possible legal and ethical implications beyond the obvious ones (breach of confidentiality, accusations of lack of impartiality and issues pertaining to informed consent before signing sight-interpreted documentation).

Finally, the third area of investigation refers to the all-evolving nature of simultaneous interpreting in the healthcare setting. It is clear that the latter moves from its traditional whispered form to new hybrid

modes generated by the revolutionary changes introduced by technology. Medical interpreters should not underestimate the speed with which changes are entering the field and their swiping effect. In her capacity as seasoned healthcare interpreter, the researcher firmly believes that the multi-faceted nature of healthcare interpreting has made medical interpreters more flexible and more susceptible to change. With that in mind, necessary adjustments still need to be made, especially with respect to training interpreters in the new hybrid modes. Research in this area can anticipate the direction of trends and offer valuable suggestions on training and on how interpreters should best adapt to the working conditions that are about to emerge.

CONCLUSION

Mode switching in healthcare interpreting is by far an underestimated component of the interpreters' skills and competences and, consequently, an under-investigated area in the field of interpreting studies. The current study, although limited in scope and therefore unable to allow for possibilities of theorizing upon its results, has revealed some interesting facts. These facts confirm the investigator's original hypotheses, which are based, on intuition, professional knowledge and personal experience of the field, and the expertise acquired as healthcare interpreting instructor at the MA level of a university program specializing in conference interpreting (offered in the North American context).

It was shown that interpreters operating in the various healthcare sub-settings select the use of modes of interpreting for reasons that do not always comply with the objective of fulfilling the communication needs of their patients. Despite that, interpreters' primary concern still remains the well-being of patients. Respondents were able to give us a glimpse of the alternative practices they devise in order to counter the effect of involuntary mode switching or the mechanisms they use so as to impose the mode that, in their mind and based on their expert opinion, serves best the communicative event.

It was equally demonstrated that interpreters in the field alternate less frequently than one would expect or than actually needed between consecutive and simultaneous. There are two main reasons that account for this: the first pertains mainly to lack of adequate or sufficient training, whereas the second has to do with lack of confidence in the interpreters' ability to perform in simultaneously mode, possibly as a result of insufficient training. These two reasons were implied in comments but never clearly stated in the participants' commentaries or responses.

Moreover, basic differences between spoken language and sign language interpreting were highlighted with respect to pre-conceived ideas *vis-à-vis* the usefulness and applicability of each mode and the by-default mode for each modality. More importantly, however, respondents used various indirect ways to alert the investigator to the need to review concepts such as A, B and C language if one is to fully grasp the complete spectrum of the role of healthcare interpreters, their daily practice, their availability in connection with their working languages, and the demand for a variety of languages in the market. This demand may vary in connection with the interpreters' geographical/physical location, etc.

Finally, it is obvious that more research is required in the areas indicated in the section above as interpreters, regardless of their age, level of training in healthcare interpreting or years of experience in the field, show that they are open to embrace new ideas and to receive more targeted training to improve skills and corresponding practices. Their participation in this study is testimony to how interpreters feel about opening up the profession to research that would translate into best professional practices.

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APPENDIX

Mode Switching in Healthcare Interpreting: Questionnaire

This study is exploring what trained medical interpreters have to say about the use of different modes of interpreting in healthcare

1. Are you a trained interpreter?

    a. Yes
    b. No

If your answer is NO, please do not proceed with this questionnaire. This study is for trained interpreters only. Should you answer no, I thank you for your interest and kindly ask you to pass this survey along to other trained interpreters.

2. How many years have you been working as a medical interpreter?
    a. Less than 5
    b. 5 years up to 10 years
    c. 10 years up to 20 years
    d. 20 years or more
3. What type of training did you receive in order to work as an interpreter?
    a. BA in Translation and Interpreting Studies
    b. BA in Modern Languages
    c. MA in Translation and Interpreting Studies
    d. BA in Conference Interpreting
    e. MA in Conference Interpreting
    f. MA in Community or Healthcare Interpreting
    g. Ph.D. in Community or Healthcare Interpreting
    h. Ph.D. in Translation and/or Interpreting Studies
    i. Vocational Training (Community College Diploma or equivalent)
    j. Professional development program with specialization in medical/healthcare interpreting
    k. Seminars specializing in Healthcare Interpreting (organized by professional associations, agencies, colleges and schools, hospitals, departments and/or national, regional or local authorities, such as the Ministry of Health of your country, etc.)
    l. None
    m. Other (Please Specify)
4. What were the languages in which you were trained to interpreter and/or to speak? (List all that apply in the order of A, B and C languages)
    a. A language:
    b. B language:
    c. C language:
5. How often do you work in consecutive mode?

   a. 81-100%
   b. 61-80%
   c. 41-60%
   d. 21-40%
   e. 0-20%
6. How often do you work in simultaneous mode?
   a. 81-100%
   b. 61-80%
   c. 41-60%
   d. 21-40%
   e. 0-20%
7. Do you ever switch modes of interpreting during a specific communicative event? (If your answer is NO, go directly to question 12)
   a. Yes
   b. No
8. If your answer in Q7 is YES, how often to you switch modes?
   a. 81-100%
   b. 61-80%
   c. 41-60%
   d. 21-40%
   e. 0-20%
9. During what type of assignment do you switch modes? (More than one answer may apply)
   a. In hospital encounters
   b. In pediatric consultations
   c. During mental health sessions
   d. When only one person in the communicative event requires interpretation
   e. When more than three interactants are present in the communicative event
10. When do you switch from consecutive to simultaneous? (More than one answer may apply)
   a. When the patient or the health-care provider starts talking too fast and won't stop
   b. When the healthcare provider is giving a long explanation without stopping, namely when there is no dialogue between the parties, just an explanation of facts
   c. When the parents of a child patient need interpreting for the conversation that is taking place between the pediatric patient and the healthcare provider, provided that the patient and the provider share a common language that is not shared by the provider and the parents of the pediatric patient
   d. When an adult patient speaks the language of the institution/country with the healthcare provider whereas the family member(s) present during the communicative event speak(s) a different language than that of the institution/country and need(s) to know what is being said about the patient's health condition
   e. When I am in a group meeting and am interpreting for an individual who does not speak the language that is being spoken by all participants in the interaction
   f. Other (Specify below)
   g. Other (Please Specify)

11. When do you switch from simultaneous to consecutive?
    a. When there are up to 4 people in total who participate in the communicative event (interpreter included)
    b. When all parties have agreed to speak in turns and to wait for the interpreter to interpret before speaking again or taking turns
    c. When asked by one of the parties involved in the communicative event to do so
    d. When I believe that it is more appropriate for the purpose of the encounter so as to ensure accuracy and completeness of information, transparency and accountability of the speakers
    e. Other (specify below)
    f. Other (Please Specify)
12. If your answer in Q7 is NO, how do you interpret for a patient and/or a healthcare provider who will not pause or who speaks too fast?
    a. I summarize the information
    b. I do the best I can under the circumstances
    c. I don't interpret or I suspend interpretation. Then I ask for repetition. I politely ask the interactants to pause so that Ihave time to interpret
    d. Other (Specify below)
    e. Other (Please Specify)
13. If you perform simultaneous during a communicative healthcare event, have you received formal training in this mode?
    a. Yes
    b. No
14. If your answer in Q13 is NO, how did you learn simultaneous?
    a. Informally (Specify in the space below)
    b. On the job
    c. I am self-trained (I took programs online, such as tutorials, or used specialized software and other applications to learn at home)
    d. Other (Specify below)
    e. Other (Please Specify)
15. If you perform consecutive during a communicative healthcare event, have you received formal training in this mode?
    a. Yes
    b. No
16. If your answer in Q15 is NO, how did you learn consecutive?
    a. Informally (Specify in the space below)
    b. On the job
    c. I am self-trained (I took programs online, such as tutorials, or studied specialized books)
    d. Other (Specify below)
17. If your answer is Q15 is YES, were you also trained in notetaking?
    a. Yes
    b. No
18. If your answer in Q17 is YES, how often do you take notes?
    a. Always (100%)

b. Usually (90-75%)
c. Often (more than 50% but less than 75%)
d. Rarely (less than 10%)
e. Sometimes (less than 50% and more than 10%)
f. Never

19. If your answer in Q17 is NO, do you take notes anyway?
    a. Yes
    b. No
20. Is anything about mode switching that you would like to mention/add for the benefit of this study?

Thank you very much for participating in this survey and for answering our questions. Your answers provide our research with relevant information to advance the knowledge about the specialization of healthcare interpreting. Rest assured that your personal data will remain confidential and will not be used for advertising or solicitation purposes.

It would be useful for us to know a little bit about you. Your profile will allow us to add a demographic component to our research. Should you wish to partake in the results of this survey, kindly fill out the fields provided below.

Please note that this filed is optional.

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Chapter 14
Competence-Oriented Task-Based Learning Approach to Medical Dual-Role Interpreter Training

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ABSTRACT

With the developing complexity of international communication and the development of hospitals, diversified interpreting demands, such as interpreting for conferences held by hospitals and for visiting delegations from overseas healthcare institutions, have emerged in the medical field, other than interpreting in the clinical setting. Instead of engaging a professional interpreter temporarily, many hospitals are more inclined to invite their own staff to interpret, for many reasons. The core issue is to empower the medical staff with interpreting competence. This chapter examines a case study closely to summarize and share the teaching experience for training conference-level dual-role interpreters in the medical field. The research then proposes the competence-oriented task-based learning approach and examines its effectiveness.

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INTRODUCTION

In the medical field, medical knowledge, technology, technique, and medical education are undergoing rapid changes. Building a culturally and linguistically competent healthcare system is essential to improve healthcare quality and reduce racial and ethnic health disparities in culturally diversified countries (Anderson et al. 2003). However, with further development, diversified interpreting demands have emerged in the medical field, other than interpreting in the clinical setting. In order to cope with the developing complexity of international communication and the development of hospitals, dual-role interpreters need to interpret for events hospitals organize, such as conferences, academic exchanges, and visiting of delegations, especially when working in a leading hospital. For the same reason as in a clinical scenario, these hospitals need conference-level qualified dual-role interpreters who are familiar with the local language and culture, and more importantly, the medical system they serve, including the hospital's development, vision, and know-how. Another reason is that the chances of interpreting would promote communication between medical personnel and their international counterparts. It also enhances a hospital's linguistic and cultural competences as a whole in the long term.

In this context, the First Affiliated Hospital of Sun Yat-sen University and the International Medical Translators and Interpreters Association conducted three sessions of dual-role interpreter training from August 2017 to March 2018. The purpose of this joint effort was to empower some of their excellent medical personnel proficient in English with conference-level interpreting competence. The short-term objective was to facilitate the hospital's international communication, especially for the conference on medical education to be held in the hospital. The long-term objective was to upgrade their international medical services in the near future vis-à-vis the fast-growing Chinese demand. The series of training reflected the need for higher level dual-role interpreter education and training in the healthcare sector. A high standard training is a way not only to enhance competences at the individual and team level, but also for organizations to gain competitive advantages (Noe, Clarke, & Klein, 2014).

The three sessions of training were designed for the purposes of the hospital's development, with the difficulty elevated. The first session was a 24-hour training, focused on interpreting theories, training methods (retelling, summarizing, paraphrasing, and shadowing), consecutive interpreting skills, note-taking, sight translation, and role play in medical scenarios (i.e., delegation visiting, escort interpreting, and speech). The second was a 30-hour course that aimed at empowering the medical personnel with simultaneous interpreting competences for the coming international conference on medical education. The third session, an 18-hour online course, continued to reinforce the learning outcomes from the second and prepared for the conference by interpreting and translating real-world materials. The teaching team comprised two professors, who were specialized in interpreting teaching and practice, and two teaching assistants.

This is action research aiming at establishing a teaching approach which is appropriate for dual-role interpreter training for the mentioned purposes. Using the second session as an example, this chapter also examines the case closely to summarize and share the teaching experience. There are three research questions:

1. How to design intraorganizational dual-role interpreter training?
2. What are the competences required for conference-level dual-role interpreters?
3. What kind of teaching method to develop to help the learners to acquire these competences? What effect has been achieved?

BACKGROUND

Traditionally, the aim of interpreter education was to train professional interpreters (Gile, 2009). However, as international exchanges and work-based needs become more complex, medical professionals possessing a mastery of a foreign language need to work as dual-role interpreters when needed. In the medical field, multilingual staff is often asked to provide interpreting services (e.g., physician-patient communication). Multilingual healthcare providers positively affect the satisfaction of patients limited to English proficiency, quality of care, and outcomes (Flores, 2005). Meyer, Bührig, Kliche, and Pawlack (2010) examined the collected medical dialogues. Their conclusions found that multilingual medical staff are familiar with the local language, culture, background, and medical care system, and are fully aware of the pragmatic and medical intentions of the doctors working in the same hospital. Therefore, they have the ability to interpret for non-English speakers or patients with limited English proficiency, which has only become more common with the increasing number of such patients. Moreno, Otero-Sabogal, and Newman (2007) find that "bilingual staff is often used to interpret, without any assessment of their skills" (p. 331). They then document dual-role language testing and discover insufficient language ability of the dual-role interpreters. Elderkin-Thompson, Silver, and Waitzkin (2001) suggest that "nurse-interpreters would be provided with interpretive training on how to minimize errors" (1356). Ngo-Metzger et al. (2007) point out that training is important to improve interpersonal care and satisfaction for both professional medical interpreters and bilingual healthcare providers. Previous research on dual-role interpreters focused mainly on clinical scenarios. Though research has emphasized the importance of sufficient training for dual-role interpreters, few articles are devoted to this topic.

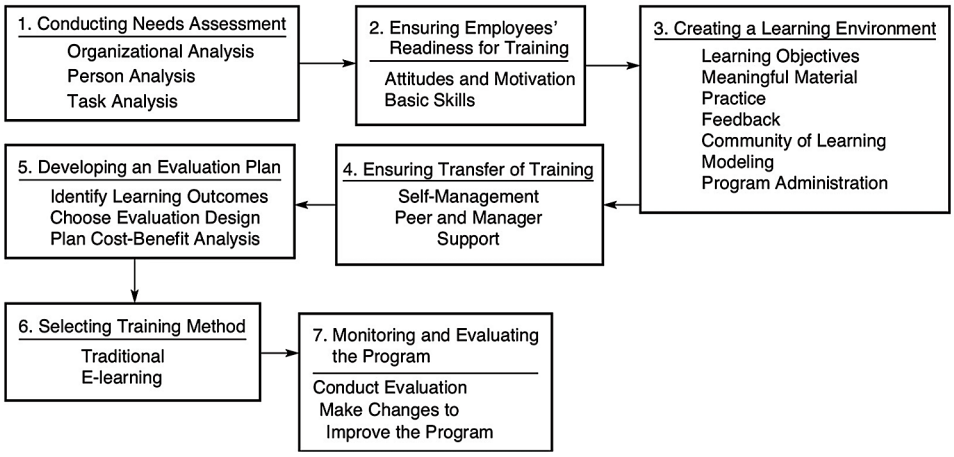
Guided by Noe's (2016) "training design process" model (p. 11) of focusing on the objectives and goals of the training and combining interpreting teaching theories, foreign language teaching theory, and andragogy with the practices of interpreting, this research first expounds the theoretical and practical basis for constructing a competence framework for medical dual-role interpreters, explaining the importance of tasks in interpreter training, and then seeks to propose a competence-oriented task-based learning (TBL) approach to medical dual-role interpreter training. This approach is expected to be effective in guiding learners toward the acquisition of the necessary competences for international medical education conferences.

TRAINING DESIGN

The training design is primarily based on Noe's (2016) model of training design process, which this author developed according to the instructional system design [1] for staff training and development (Figure 1). The training design process is a systematic approach for developing a training program in seven steps. This section will briefly introduce the authors' training design based on steps 1 to 5 of the model, which is crucial for determining the teaching method of the sixth step. The last step is to conduct the evaluation (please refer to the section *Results and Discussion*) of the program.

Before determining the method and officially beginning training, the trainers and other stakeholders often collaboratively conduct a needs assessment to ensure learners' readiness for learning, create a learning environment, and develop an evaluation plan, in order to achieve the training objectives and maximize learning outcomes.

Figure 1. Training design process (Noe, 2016, p. 11)



The short-term objective for the hospital is to train its own medical staff to provide interpreting services for its own international medical education conference. The long-term objective is to build a linguistically and culturally competent healthcare system in a comprehensive way, including the enhancement of the medical staff's English language proficiency for communicating with international patients, translation (used as a hypernym for both translation and interpretation) competence, and skills for international academic exchanges, all to meet the increasing needs of internationalization of the hospital. For the medical staff, the primary objective is to acquire new skills for personal and hospital development.

According to the authors' pretraining survey—an assessment of knowledge, skills, and attitude (KSAs)—the learners (25 in total), including surgeons, physicians, and hospital administrators, were selected by the hospital for their good mastery of English, interest in medical education, and willingness to learn interpretation. They held a positive attitude towards the training and were motivated by their interest in new knowledge, career advancement, improvement in competence, and other extrinsic reasons. Five of the learners finished the first session of training[2]. Fifteen of them had accumulated interpreting and translation experience when participating in international conferences and conducting research. Thus, they possessed the required language proficiency, knowledge, skills, and positive attitude to receive the training to provide interpreting service within an intensive period. With the guidance of experienced teachers and teaching assistants and the substantial support the hospital provided, the learners' progress in the program was expected to have some success.

The teaching team identified the short-term objective or phase objective: Training medical staff to provide interpreting service for the conference to be held in three months. The leadership of the hospital was fully supportive, allowing all of the learners to ask for leave during the training period. Thus, an ideal learning environment for the training was established.

In order to ensure the transfer of learning, the teaching team grouped the learners. A teaching assistant, who was experienced in translation and interpreting teaching and research (i.e., the first author of this chapter) was responsible for monitoring their learning and the progress of the program. Based on the KSA's assessment and a pretest including English-Chinese sight interpreting and Chinese-English translation of paragraphs both on the topic of medical education, the learners the teaching team selected

were found to be qualified to receive the training and able to transfer what they learned from the training into actual situations.

The learning objective for the second session was to empower the learners to provide interpreting service for the coming conference. According to the arrangement of the hospital, several of the excellent learners would be selected to do simultaneous interpreting, including Chinese-English and English-Chinese simultaneous interpreting with text and whispering.

Following Noe's training design process (2016), after identifying and completing the above five steps, the training method could be selected. The following part of this chapter will focus on the construction of the appropriate teaching method for medical dual-role interpreters' training.

THE RATIONALE FOR PROPOSING AND APPLYING A COMPETENCE-ORIENTED TASK-BASED LEARNING APPROACH

In this part, the authors first identify the competence framework for dual-role interpreters and discuss the rationale for TBL in interpreter training, and then propose a competence-oriented TBL approach for medical dual-role interpreter training.

Competence Framework for Medical Dual-Role Interpreters

In translator and interpreter's education, researchers have carefully examined and conducted empirical studies on translator and interpreter's competence and developed models and frameworks (Beeby et al., 2011; Binhua, 2007; Kiraly & Hofmann, 2016; EMT Expert Group, 2009; PACTE, 2008; Pöchhacker & Liu, 2014). However, little research has focused on dual-role interpreter competence composition. Based on EMT's (2017) framework and the composition of interpreting teaching Yang (2005) proposed, this chapter will analyze the competence needed for the dual-role-interpreters-to-be in this training.

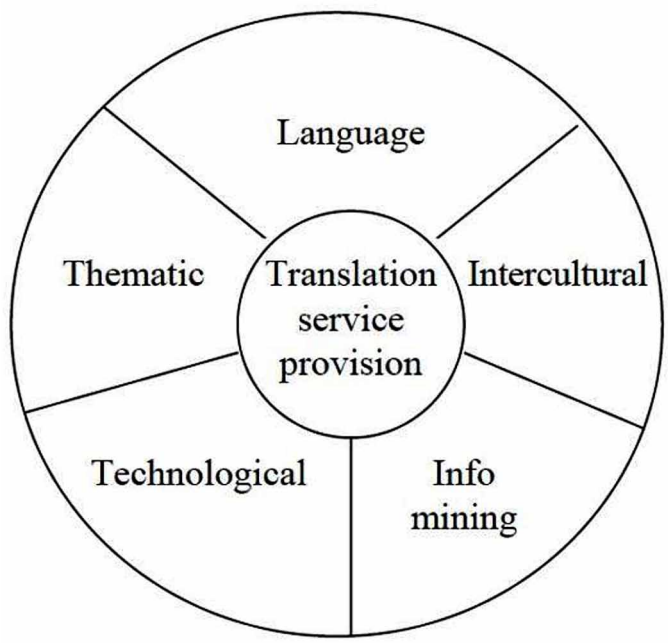
EMT Translation Competence Framework: From 2009 to 2017

The EMT Expert Group (2009) formulated *Competences for Professional Translators, Experts in Multilingual and Multimedia Communication*, known as the Wheel of Competence (see Figure 2). It has become the primary translation competence framework of the European Union (EU). The translator and interpreter education model of the EU has been an important reference for universities and institutions who provide translation and interpreting courses worldwide, including those in Asian countries.

The general framework is based on the EU's multilingual language environment, and economic and social development. The proposed competency framework applies to language professions, or translations in a broad sense, including different types of interpreters (EMT Expert Group, 2009).

With the development of economy, science and technology, especially artificial intelligence, the deepening of the globalization process, and the changes and challenges of the language industry, as well as European higher education, EMT revised the translation capability framework in 2017 (see Figure 3). The competence framework has used four key terms since the 2008 *European Qualifications Framework*, namely skills, competence, knowledge, and learning outcomes. The formation of the *European Qualifications Framework* relies on the change of the European labor market and the internal trend on

Figure 2. Wheel of Competence (EMT Expert Group, 2009)



lifelong learning. Therefore, the main purpose of the EMT 2017 competence framework is to enhance graduates' employability and incorporate lifelong learning concepts.

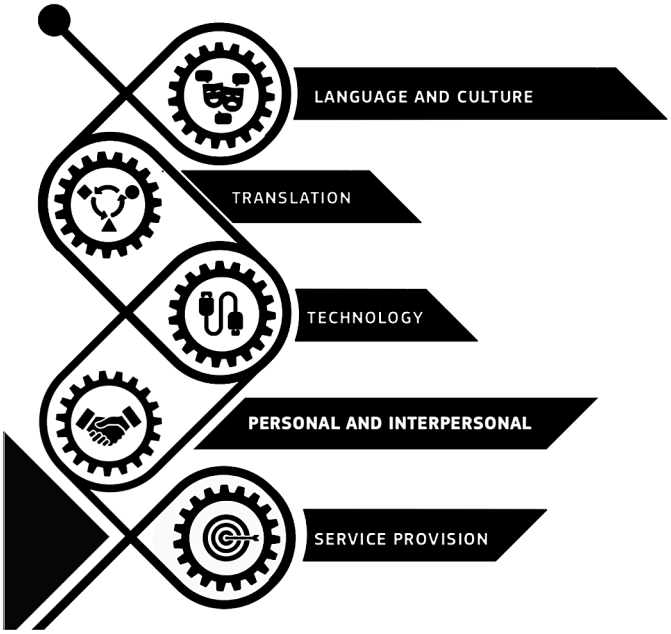
The 2017 framework clearly states that the purpose is not to propose a framework that encompasses all competence, skills, and attitudes that all graduates possess, such as the absence of theoretical knowledge and research capabilities. It is about establishing a general framework that describes the competences and specific skills that graduates should have. Moreover, the expert group recommends that translator and interpreter training programs can propose the competence framework applicable to specific areas and expand the scope of existing competence, skills, and knowledge.

The aim of this training was not to foster professional interpreters, but to empower the medical staff with required competences to provide simultaneous interpreting services for the coming conference. Therefore, importance rests on differentiating the dual-role interpreter competences from those consolidating and enhancing the employability of undergraduate and graduate students majoring in translation and interpreting. The dual-role-interpreters-to-be would deal with the interpreting of the speeches, lectures, and seminars on medical education during the conference. The key issue is to identify the competences these professionals need to acquire.

Competences for Dual-Role Interpreters

Interpreting teaching and medical education share the same goals to help the learners acquire knowledge, skills, and positive attitude to produce satisfactory learning outcomes. As Yang (2005, pp. 17-20) proposed, interpreting teaching is composed of three elements, namely language, knowledge, and technique (see Figure 4). This chapter extends Yang's composition (2005) to include a fourth element: attitude,

Figure 3. EMT Translation Competences framework (EMT Expert Group, 2017)

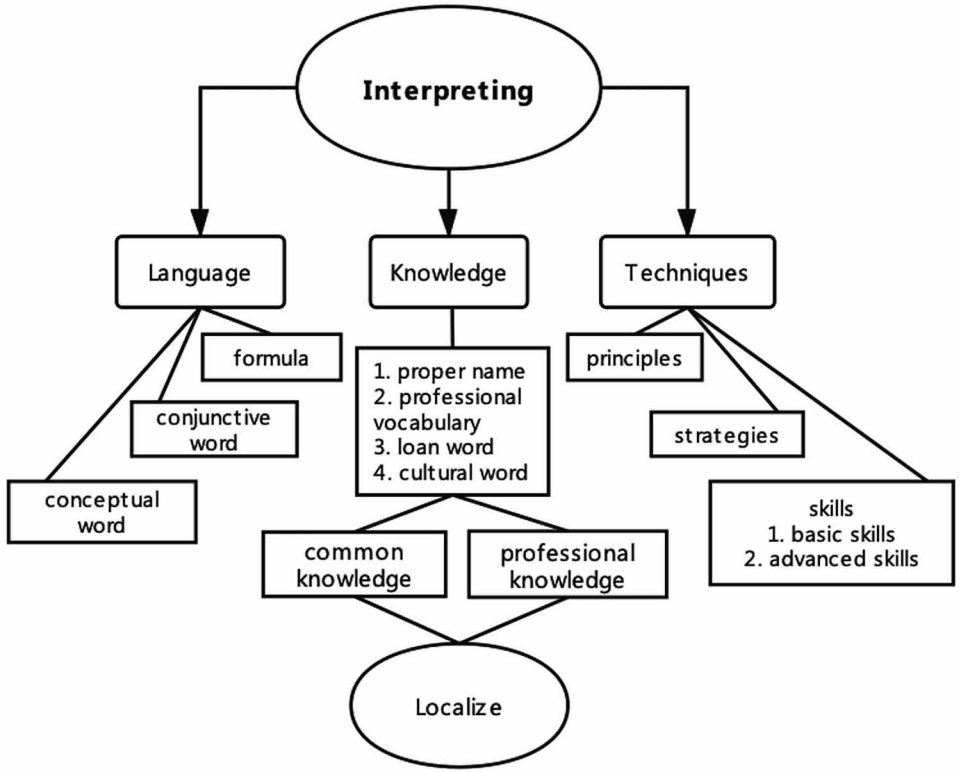


since dual-role interpreters require this competence outside of language, knowledge, and techniques. The following also explains the four elements in the context of the training session.

- Technique: It is the primary goal of the training. "'Language' and 'knowledge' constitute the content of interpreting, which is organized by technique" (Yang, 2005, p. 17). Traditionally, linguistic competence plays a pivotal role in interpreting competences. In this training, however, English proficiency is the primary condition for them to be selected to attend the training. On the part of knowledge, since all learners receive medical education as soon as they enter their universities, they are familiar with the system. Therefore, the priority for teaching is "technique," which bridges their "language" and "knowledge." Techniques include principles, strategies, and skills of interpreting.
- Language: The language the learners should learn include formula, conjunctive words, and conceptual words, which are collectively referred to as frequently-used vocabulary and phrases or formulaic sequences. They help interpreters expand their linguistic repertoire, polish their delivery, and enhance the effectiveness and efficiency of both learning and teaching. Research (Boers, Eyckmans, Kappel, Stengers, & Demecheleer, 2006) shows that formulaic sequences can be a useful contribution to improving learners' language proficiency.

Similar to formulaic sequence, an apparent correlation exists between the prefabricated chunks, which "can be easily retrieved and used without the need to compose them online through word selection and grammatical sequencing" (Tremblay & Baayen, 2011, p. 152), and the learners' language proficiency. An empirical study by Meng (2017) shows that, with sufficient lexical chunks prefabricated in their long-term memory, the interpreters will acquire a thorough understanding of the subject matter, thus

Figure 4. The composition of interpreting teaching based on Yang (2005)



gradually forming a better cognition of the knowledge in a specific area, which will finally help promote their competence in actual interpreting situations. He also pointed out that prefabricated lexical chunks "cannot work satisfactorily without the input of other knowledge, such as grammar, culture, and professional expertise" (p. 121).

As Gile (2005) emphasized, "when the trainees' mastery of the working language is insufficient, …intensive language training should be conducted in parallel with training in interpreting techniques properly" (p. 144). In this training, the function of input of multimodal materials on medical education is dual: One is to help the learners construct their knowledge system on medical education, and the other is to expose the learners to the working language they should master.

- Knowledge: It includes interpretation knowledge, language knowledge, and thematic knowledge. Interpretation knowledge refers to learners' metacognition of the application of certain strategies, principles, and training methods. Language knowledge consists of proper nouns, proper names, professional vocabulary, loan words, and cultural words (Yang, 2005). Thematic knowledge refers in particular to knowledge such as theories, pedagogies, important authors, and the world's development of medical education in this training session. It equips learners with the discursive ability to interpret and solve interpreting problems in a systematic and holistic view. Interpretation knowledge and language knowledge are closely related to "technique" and "language," and interactive with thematic knowledge.

- Attitude: Based on the characteristics of adult learning and interpreter competence framework, the learners must develop their interpreter awareness through training, in order to achieve learner autonomy.

As Knowles (1984) postulated, adult learning theory has five assumptions:

1. Self-concept moves one towards a self-directed learner.
2. A learner's experience becomes an increasing resource for learning.
3. A learner's readiness to learn becomes increasingly oriented to the development of one's social roles.
4. Adult learners change to the immediate application of knowledge, and, accordingly, one's orientation toward learning shifts from subject-centeredness to problem-centeredness.
5. The motivation of adult learners is internal.

In this training, the learners are interested in interpreting, self-directed, motivated by both intrinsic and extrinsic reasons, and ready to learn. Therefore, the teachers' task is to teach and facilitate their learning through demonstrating, instructing, scaffolding, supporting, and building the learning environment, in order to help learners construct their interpreter awareness, strengthen their positive attitude towards learning, and achieve learner's autonomy.

Technique, language, knowledge, and attitude form the four pillars of the competence framework of medical dual-role interpreter in this training. The four core competences are interrelated with one another. As Kiraly (2014) proposed for translator education, interpreter training can also "be seen as a dynamic, interactive process based on learner empowerment" (p. 17). The acquisition of interpreter competence is the way to learner empowerment. Integrating the goals of medical education and interpreting teaching, extracting their shared aspects and indispensable parts, as well as modifying the contents specifically for the training, the teaching focus should lie on technique, language, knowledge, and attitude.

Task-Based Learning in Interpreter Training

TBL usually means an approach focusing on the use of authentic language to complete meaningful tasks, in order to achieve learning outcomes in a particular domain. TBL has been used as a regular method in foreign language teaching and learning (Ellis, 2003; Leaver & Willis, 2004; Thomas & Reinders, 2010), since Willis (1996) outlined a framework for task-based language learning. It is also an effective and efficient educational strategy for delivering medical education (Harden, Crosby, Davis, Howie, & Struthers, 2000). Inoue and Candlin (2015) applied the TBL approach to translator education and proved its effectiveness.

In this chapter, drawing on Inoue and Candlin's (2015) definition, TBL in dual-role interpreter training refers to a particular teaching approach in which tasks simulate authentic situation, replicate professional requirements, and pedagogically sequenced requirements to scaffold specific interpreter competences acquisition.

There are two reasons to utilize TBL in the training. First, Gile (2005) identifies interpreting exercises as the main pillar of training in which the exercise materials are lectures and tutorials in different fields such as economics, international institutions, and environment, which can be regarded as the application of TBL to interpreter training. The training itself can be regarded as an amplified preparation process

before interpreting, which was also a significant task for dual-role interpreters. Second, the task-based approach offers many advantages. It allows for simulating situations relating to the real world and performing authentic tasks through which it provides a continuous chain of activities for learners to learn by doing (Albir, 2007).

Littlewood (2004) defines "task" as a continuum from form-focused to meaning-focused, in which the latter translates to authentic communication. As Inoue and Candlin (2015) concluded, tasks in TBL are characterized by their holistic nature and interconnectedness. However, the tasks themselves are not the objectives of learning, but they are meant to expose learners to a simulated setting or provide context for them to develop relevant competences, which ensures the learning outcomes are achieved (Harden, Uudlaw, Ker, & Mitchell, 1996). Therefore, it is not necessarily TBL, if the tasks are not deliberately designed from a holistic perspective, interconnected with each other, and linked with learning objectives. It is also not enough to be a task-based approach, if a task does not simulate real-life situations or learners do not reflect after finishing one task or the whole process in a metacognitive way.

Combined with the training objectives and adopting a holistic view, the teaching team determined the task types according to the actual conference agenda. The tasks include shadowing of lectures, speeches, and videos, long/short consecutive interpreting with/without notes, simultaneous interpreting with/without text/transcript/PowerPoint, the preparation before, and cooperation during interpreting. Since the key objective of the training is to help the learner acquire the competence to do simultaneous interpreting mostly with text, the teaching team used much of the training hours to practice simultaneous interpreting with text and sight translation.

In order to choose specific materials after identifying the task types, the authors extend the concept of interpreter preparation, since the training can be seen as a systematic preparation process for the coming conference[3]. "Preparation before interpretation" includes all the necessary material, background knowledge, language resources, and psychological preparations that an interpreter must perform before interpreting service. Liu Heping (2007) emphasizes:

Linguistic knowledge is essential to interpreting, but cognitive competence is even more so, because more than language conversion, interpreting involves cognitive processes of analysis, comprehension, memory retrieval, and verbal rendition, and preparation can provide necessary information for these cognitive tasks. (p. 73)

Scholars (Gile, 1998; Liu, 2007) have conducted experimental studies and examined the influence of preparation on the quality of interpreting in which the former has a positive effect on the latter. It is essential for interpreters to know well the theme and its development, keynote speakers, and the theoretical framework of the lecture before providing interpreting service, which is also the process of making a reasonable prediction when preparing for the conference.

The materials selected for the tasks were all authentic, including the prominent organizations of the scenario, background of the keynote speakers, their research, public speeches, interviews or lectures, the development of medical education around the world, theories, and teaching methods on medical education, all in the form of videos, PowerPoints or academic papers. These tasks simulated the real conference situation in a holistic way and interconnected with each other.

In this way, the learners can practice interpreting skills, become familiar with the backgrounds of the conference, and learn the language which is frequently used, both in English and Chinese, in a medical education scenario simultaneously. The teaching team also adapted some wordings and expressions in the materials when it was necessary to practice frequently used formulaic sequences, necessary interpreting skills, and discourses on medical education.

Competence-Oriented TBL Approach

The competences for dual-role interpreters are different from those needed in professional interpreter education. A dual-role interpreter in this context did not need to manage the customer relationship and complicated technology (except for searching information online). Besides, interpersonal skill overlapped with the competence which was required for being a qualified medical staff and which they could deal with very well after the teachers' explanation. The purpose of the tasks was to empower them to acquire the necessary competences, which have been identified as technique, knowledge, language, and attitude. Therefore, the approach was task-based and competence-oriented.

From the social-constructivist approach, the fundamental principles for translator education Kiraly (2014, pp. 34-50) proposed can also be applied to interpreter training: Multiple realities and multiple perspectives, appropriation, the zone of proximal development (ZPD), situated learning, viability, scaffolding, sociocognitive apprenticeship and transformation, and the acquisition of interpreter competence.

In this training, by using authentic materials in each task in a simulated way, the learners were actively involved in almost authentic and experiential learning. In this process, the teachers provided exemplary interpreting, corrected and discussed the learners' mistakes with them, and inspired the learners to find problems and corresponding solutions. The scaffolds were gradually withdrawn as they became dispensable. The learners could also gain support after class from the teaching assistants as they needed. Though working and interpreting in pairs, the learners acquire knowledge from their peer learners and the teachers could also acquire knowledge from them and the medical staff, especially when the discussions involved medical knowledge.

The ZPD[4] means "the situation-bound 'virtual domain' in which appropriation and consequent development occur" (as cited in Kiraly, 2014, p. 40). The teaching team selected the materials and ordered the tasks according to the learning objectives and the learners' level. The difficulty of the task materials was then elevated as the learners progressed.

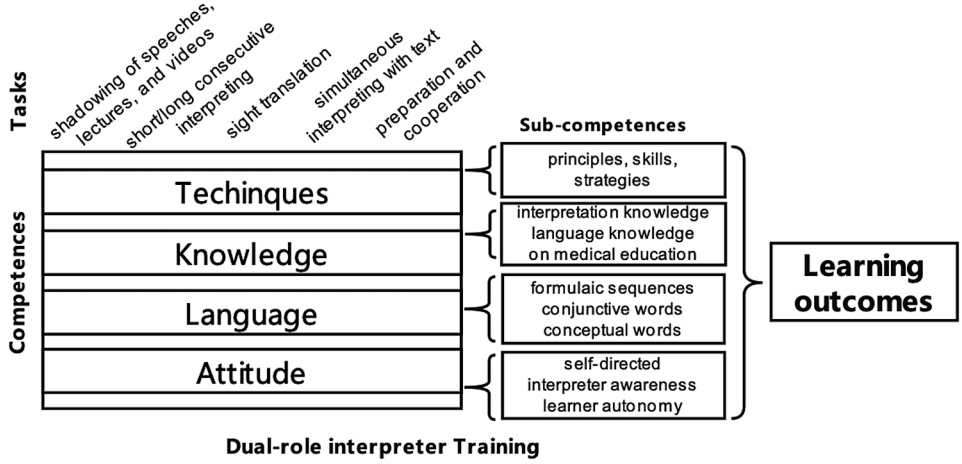
Figure 5 shows the competences running through the tasks, along with the subcompetences of each.

The tasks to help acquire those competences are: The shadowing of speeches, lectures, and videos; short consecutive interpretation; sight translation; long consecutive interpretation; simultaneous interpretation with/without text; preparation and cooperation. The tasks are all themed on medical education.

The learners learned relevant competences in each task: To acquire knowledge on medical education during the preparation for a lecture, practice interpreting skills during actual interpreting, learn formulaic language while comparing their own translation with the teacher's, and enhance their awareness of self-directed learning when summarizing and reflecting their performances. Each competence is stressed in different degrees in every task. In the same way, the subcompetences of each competence were considered and related to medical education conference interpreting in different tasks. The framework aims to allow the learners to acquire interpreter competences and achieve interaction and integration of competences through different tasks.

All tasks were designed to enhance the learning outcomes in different degrees. During the early stage, a text was sometimes practiced many times in the form of different tasks. For example, the teacher played a video of speech with text, and asked the learners to shadow first, and then did sight translation. The last step was simultaneous interpreting with and/or without text. After the in-depth interpreting training, the teacher facilitated the learners in reflecting on the skills and strategies they just adopted, problems encountered, and corresponding solutions.

Figure 5. Framework of competence-orientated TBL



The series of tasks has four purposes. The first is to allow students to experience different forms of interpreting. The second is to master the language recourses of related topics. The third is to use the same example to learn how to adjust the use of interpreting techniques. The fourth is to control the difficulty of the task, in order to build confidence for the learners with their comprehension of the original text increased. With the expansion of the learners' ZPD and their increased familiarity with the materials, the teacher asked them to interpret with or without text and then listen to their recordings to do reflection in order to raise their awareness of the factors involved in interpreting process, and further strengthen their metacognition.

Schraw (2001) describes two aspects of metacognition, knowledge of cognition, and regulation of cognition, and argues that metacognitive knowledge is teachable. He further describes four instructional strategies for promoting the construction and acquisition of metacognitive awareness: "Promoting general awareness of the importance of metacognition, improving knowledge of cognition, improving regulation of cognition, and fostering environments that promote metacognitive awareness" (p. 118). Interpreter's awareness is the metacognition of interpreter competences, which may include awareness of one's identity and professionalism as an interpreter, linguistic awareness, "good understanding of cultural sensitivity and awareness" (Lubrano di Ciccone, Brown, Gueguen, Bylund, & Kissane, 2009, p.28), awareness of identifying and solving problems, and avoiding pitfalls, which are not entirely unteachable.

From a constructivist viewpoint and regarding the acquisition of interpreter competences as a dynamic and interactive process, the teacher's role is usually as counselor and consultant in TBL that emphasizes "shift in teacher and student roles" (Inoue & Candlin, 2015, p. 62). In this training, however, the teacher must scaffold knowledge and techniques actively in the first classes, in order to reduce the learners' anxiety, and then play the part of facilitator, consultant, and expert gradually in the rest of the course, in order to promote the learners' self-directed learning. In this way, the learners can construct their knowledge system of interpreting and learning strategy through assimilation and accommodation by interacting with the teachers and their peers.

As interpreting activity emphasizes the quality of output, in competence-oriented TBL, the teaching team not only valued the learning process, but also attached importance to the quality of the learners' output and expound the standards of interpreting, though its multiple realities were recognized. Thus,

in this training, the teachers and learners worked together to use their own knowledge background and experience to correct the learners' output in each interpreting task to ensure its quality.

Therefore, competence-oriented TBL in dual-role interpreter training not only emphasizes the learning process and competence acquisition, but also attaches importance to learning outcomes. The teacher plays the roles of instructor, facilitator, consultant, and expert in different learning stages, in order to gradually empower the learners to acquire autonomy to continue their own learning.

RESULTS AND DISCUSSION

According to Noe (2016), training evaluation is the process of gathering information about training outcomes to evaluate if training is effective. The effectiveness of the competence-orientated TBL can be primarily evaluated from the perspectives of the learners, the teaching team, and the organization: the hospital.

Learners' Perspective

In this section, the authors employ the triangulation method to evaluate the training by using a pre and posttraining comparison, expert grading, and a questionnaire.

By comparing the results of the two checkpoints of the training, one on admission and another at the end of the training, the teaching team found that the learners achieve obvious progress in terms of logic and fluency of output, the application of interpreting techniques, the accuracy of terms and proper names, the use of formulaic sequences, the reduction of frequency of pauses, fillers, repetitions, backtracking, and discourse markers. The progress can be seen in Learner A's case (Table 1).

The Flesch-Kincaid reading ease, which is used to measure the readability of text, of the whole passages of the pretest and the posttest are 47.9 and 38.5[9]. Both of them fall under "college level," meaning "difficult to read," with the latter more difficult than the former. In contrast to the translation of pretest, Learner A has made progress regarding delivery, which consists of the numbers of fillers, increased words, pauses, errors, redundancy, discourse markers, and backtrackings. The target text and source text ratio[10] for the two excerpts are 2.43 and 2.21, which means the delivery of the subject is more concise within the same length of time after training.

By considering the four dimensions for evaluating interpreting quality, namely fidelity, target language quality, delivery, and logic of sentences, one teacher gave 80 and 85 out of 100, respectively, for the entire translations of the two checkpoints for Learner A.

The questionnaire results also provide a snapshot of all the learners (n=21) concerning their satisfaction degree with the training and progress in KSAs. The questionnaire (Table 2) used a Likert 6-point scale, with the most dissatisfied (the least satisfactory) being 1 point and the most satisfactory 6 points. All of the questions received a mean score of over 5 out of 6. These results suggest that the learners were satisfied with the training regarding the theoretical part explicating the previous studies for practicing interpreting (Q1), the practice materials selected (Q2), the training of interpreting techniques (Q3), and the interpreting tasks designed (Q4 and Q5). The answers showed that the learners confirmed their progress in the mastery of knowledge on medical education (Q14) and interpretation (Q15), interpreting techniques (Q16), and attitude (Q17). They gave high praise to the trainers (Q6-Q11) for their expertise, teaching method, and responsiveness to their questions.

Table 1. Comparison[5] between the excerpts from the pretest and the posttest on sight translation[6] of Learner A

Items	Pretest: Sight Translation (E to C)	Posttest: Sight Translation (E to C)
The originals	What is problem-based learning? Problem-based learning, or PBL, is a pedagogical practice employed in many medical schools. While there are numerous variants of the technique, the approach includes a professor's presentation of an applied problem to a small group of students who engage in discussion over several sessions. A tutor usually provides supportive guidance for the students. The discussions of the problem are structured to enable students to create conceptual models to explain the problem presented in the case.[7] (79 words)	Simulation is a teaching technique. It is useful in learning and practice in many different disciplines. It replaces and simulates real experiences in the form of guided situations and experiences. They are often immersive and amplified to ensure accurate and specific learning in a fully interactive way. Simulation-based training tools, techniques, and strategies are used to design structured learning experiences. They are also used as a tool to measure whether the teamwork and competencies of the learners achieve specific learning goals.[8] (81 words)
The translations	什么是基于问题的学习?基于问题的学习也称为PBL,是一种广泛地[I]应用于多个嗯[F][P]教学院校[E]的教学方法。这种方法呢[F]有许多不同的亚类[E]。通常我们看到的形式是由一名教师向一小组的[RD]学生提出一个应用性的问题,然后组织学生进行分场次的几场[B]的[RD]讨论。通常呢[F]有导师来向学生提供一个[RD]支持性的这样子[F]一个[RD]指导。[P]问题的讨论过程呢[F]是结构化的,这样子[D]使得学生可以建立一个[RD]概念的[RD]一个[RD]模型,来[P]呃[F]理解这个[F]病例当中提出的问题。(192 words)	模拟是一种教学技术。在非常多的领域都是广泛应用,非常的有用。它的要点就是[P]有一种[RD]有准备的[E]高度模拟的仿真的[B]这样一种[RD]场景或者经验来代替真实的情况。因此它能够放大[P]训练过程当中的准确性以及特定的训练[P]目的。基于模拟的训练工具、技术还有策略,被广泛的用来设置结构化的学习场景。它[RD]作为一种工具,模拟可以用来评估团队合作或者学习者的胜任力,特别是在具有具体的学习目标的情况下。(179 words)
Overview of problems	Fillers[F]=7 Increased words[I]=1 Pauses[P]=3 Errors[E]=2 Redundancy[R]=6 Discourse markers[D]=2 Backtracking[B]=1	Fillers[F]=0 Increased words[I]=0 Pauses[P]=3 Errors[E]=1 Redundancy[R]=3 Discourse markers[D]=0 Backtracking[B]=1

The types of interpreting services that the learners could provide after training were investigated in the last question of the questionnaire (Table 3). The result shows that sight translation, simultaneous interpreting with text, and consecutive interpreting are the top three services the learners were confident to provide, matching the hours they spent in the in-class practice. It matches the actual situation that no one could do simultaneous interpreting without text, given the practical challenges it brings and the focus of the training being simultaneous interpreting without text.

The investigation showed the specific services the learners were confident of providing with the pre-condition that they must be fully prepared. The answers of the learners vary from each other, allowing the hospital to schedule different tasks according to each individual's competence and wishes.

The above results have significant implications for the effectiveness of the competence-oriented task-based approach.

Trainers' Perspective

Through the observation of the teaching team, composing of two teachers and two teaching assistants, the learners made noticeable progress concerning understanding, expression, application of interpreting techniques, knowledge repertoire, quality of their interpreting, and metacognition of identifying and solving problems.

Table 2. Questionnaire for course evaluation

No.	Questionnaire Items	Mean
To what degree are you satisfied with the following aspects?		
1	The explanation of the theories on interpreting training.	5.43
2	The interpreting materials used in training.	5.71
3	The training of interpreting techniques.	5.67
4	The interpreting tasks.	5.52
5	The logical connection of the tasks.	5.38
6	Professor A in terms of her expertise.	5.81
7	Professor A in terms of her teaching method.	5.71
8	Professor A in terms of responding to my questions.	5.71
9	Professor B in terms of her expertise.	5.90
10	Professor B in terms of her teaching method.	5.90
11	Professor B in terms of responding to my questions.	5.86
To what degree do you agree with the following statements?		
12	The textbook composed by the teaching team is helpful for me.	5.52
13	The teaching assistants are helpful for me.	5.62
14	The training has deepened my knowledge of medical education.	5.76
15	I have learned the basic knowledge on interpreting.	5.86
16	I have learned interpreting techniques.	5.86
17	I will enhance what I have learned after the training.	5.76
18	I am satisfied with the training as a whole.	5.86
19	I would like to attend similar a training in the future.	5.86

Table 3. The types of interpreting services the learners could provide

Questionnaire Item	Choices	Times Selected
I am confident to provide the following interpreting services after preparation. (You can select more than one answer)	Simultaneous interpreting with text	10
	Whispering	8
	Simultaneous interpreting without text	0
	Interpreting of emcee script	4
	Interpreting for visiting delegations	8
	Consecutive interpreting	10
	Sight translation	15
	I temporarily cannot provide interpreting service	2
	Others (please specify): I can do English to Chinese interpreting after preparation but not vice versa.	1

Organizational Perspective

By interviewing the organizers from the hospital, the authors learned that the management of the hospital was satisfied with the training and appraised the teaching approach as "targeted and effective". The series training has been incorporated into the hospital personnel training and development program, which is of great significance for the internalization of the hospital.

Outcomes of the Training Sessions

The training program consisted of three sessions. Some of the learners participated in all of them, and some participated in two. It usually takes a period for learning outcomes to emerge gradually after training. Though the leading case in this chapter is the second session, it is more persuasive to consider all the three as a whole, when examining the learning outcomes.

Five learners had provided interpreting service in the medical education conference in March 2018[11]. Over the next few months, one learner interpreted consecutively for the lecture on reducing healthcare-associated infection held in the hospital. She also could translate for her department when needed. Another learner was selected for the interpreter team of the Annual Meeting of Chinese Pathologists, frequently made up of eight to nine medical professionals from different hospitals and competent in simultaneous interpreting. She provided simultaneous interpreting solely twice for the 2018 meeting, each lasting 30 to 40 minutes. All of the above learners earned high recognition from both speakers and audience.

Evidence shows that, after training, several learners successively provided interpreting and translation services for the hospital and even for a national organization. The language service capability in the hospital was significantly enhanced. The training outcomes are still increasing. Moreover, it is observed that the demand for a conference-level qualified dual-role interpreter is by no means unique.

FUTURE RESEARCH DIRECTIONS

This research has revealed the fact that in the medical field certain situations require a high level of qualification for interpreting other than between physicians and patients on a daily basis. More research is needed including the roles that medical dual-role interpreters play, their functions for hospital development, and how they complement professional medical interpreters. It is also worth exploring the situations where the competence-oriented task-based approach for medical interpreter training is applicable. They would add to previous understanding of dual-role interpreter as well as interpreter training in the medical field, as a whole.

CONCLUSION AND PEDAGOGICAL IMPLICATIONS

As Mackintosh (1999) claimed, "interpreters are made not born" (p. 67) and, based on the training experience and findings above, it can be safely concluded that dual-role interpreters for specific purposes can be made through proper training, using a competence-oriented TBL approach. Also, they can actually benefit from their background, professionalism, and related knowledge system, which equip them with competitive advantages in interpretation in a specific field.

Using the medical dual-role interpreter training as a case study, this chapter proposes the competence-orientated task-based approach. From the perspective of the learners, the teaching team, and the hospital, and according to the learners' performance in the posttest, the learning outcome phases have been achieved and the approach is considered useful.

In this training, the learning objective (i.e., training medical staff to provide interpreting services for the international medical education conference), combined with organizational and individual needs, is the axis running through the entire process of the training and has become the dominant factor in training design, selection of materials, and establishment of teaching methods. In the competence-orientated TBL approach, the learners' learning is task-based and competence-oriented to achieve growth in knowledge, skills, and attitudes which are firmly related to medical education interpreting.

However, one prerequisite worth emphasizing is that the teaching approach is applied to intensive training with clear goals and themes, and is supported by the organization, in which the learners are professionals with good English proficiency.

Based on the teaching experience and action research, this study offers an integrated approach combining competence-based learning and TBL for dual-role interpreter training. It provides an exciting opportunity to advance knowledge of establishing an innovative teaching method. The authors hope that this study will contribute to a deeper understanding of cross-disciplinary interpreter education. The readers should bear in mind that the study is based on a case study, so the competence-oriented TBL needs to be applied in more scenarios, in order to be adjusted and improved.

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KEY TERMS AND DEFINITIONS

Competence for Dual-Role Interpreters: Composed of interpreting techniques, proficiency in at least two languages, knowledge framework, and positive attitude towards providing interpreting services for his/her organization and towards continuous learning.

Competence-oriented Task-Based Learning Approach: An approach for intensive interpreter training. It aims to empower learners with interpreter competence through interrelated and integrated interpreting tasks.

Interpreting Techniques: Explicit knowledge and tacit knowledge of interpreting, including principles, strategies, and skills of interpreting.

Knowledge Framework for Dual-Role Interpreter: A knowledge framework that includes interpretation knowledge, language knowledge, and thematic knowledge, all of which interact with each other. Among them, thematic knowledge is closely related to a medical dual-role interpreter's background and the needs of hospital development.

Medical Dual-Role Interpreter: A medical professional proficient in two languages and who works as an interpreter for his/her hospital when needed.

Preparation Before Interpreting: All the necessary materials, including background knowledge, language resources, and psychological preparations that an interpreter must perform before providing interpreting services.

Triangulation Method for Training Evaluation: A two-layer method for evaluating training. The first layer focuses on the post-training performance of learners by using pre- and post-test comparisons, expert grading and questionnaires. The second layer emphasizes the actual effect of the training by collecting views from multiple perspectives and observing emerging learning outcomes over a long period.

Training Design Process: A systematic approach to developing a training program. The approach also includes a training evaluation.

ENDNOTES

1 Instructional system design or instructional design is "a technology which incorporates known and verified learning strategies into instructional experiences which make the acquisition of knowledge and skill more efficient, effective, and appealing" (Merrill, Drake, Lacy, Pratt, & Group, 1996, p. 6).

2 The attendance of previous training is not a prerequisite, but an advantage.

3 The learners had not yet obtained the real materials which were used for the medical education conference, when they attended this session of training.

4 Originally developed by Vygotsky (1896–1934) during the last ten years of his life (Yasnitsky, 2018).

5 In Table 1, all of the problems in the translations concerning delivery are underlined and tagged.

6 In this session, a simultaneous interpreting test was also conducted by the end of the course. Since the learners were not able to complete a pretest of SI, the teaching team did not carry it out. Therefore, in this chapter, the authors used sight translation as pre- and posttest comparison.

7 This paragraph is adapted from: www.asbmb.org/asbmbtoday/asbmbtoday_article.aspx?id=48713

8 This paragraph is adapted from: elearningindustry.com/medical-simulation-role-learning

9 Text intended for readership by the general public usually aims for a Reading Ease score of around 60, with a higher score representing easier readability. Please see: readable.io/blog/the-flesch-reading-ease-and-flesch-kincaid-grade-level/

10 Calculation method: Dividing the number of Chinese characters by the number of English words.

[11] After this training session, 12 of the learners were grouped into three levels: five as "highly recommended", three as "recommended", and four "potential candidates", by the teaching team based on the comprehensive performance in terms of their KSAs, and the recommendations were submitted to the hospital.

Chapter 15
Facilitating Legitimate Peripheral Participation for Student Sign Language Interpreters in Medical Settings

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ABSTRACT

The chapter explores student interpreters' learning of medical interpreting within a situated learning context that necessarily includes senior interpreters, senior healthcare practitioners, and deaf community members. Learning within this community of practice exposes students to the multimodal nature of sign-language interpreter-mediated interaction, including co-speech and no-speech gestures, linguistic and non-linguistic communicative actions, and the use of environmental tools and the situated use of language and interaction. Situated learning within the clinical-skills lab enables legitimate peripheral participation that closely emulates the authentic interpreting task. Data from roleplays based on a clinical-skills lab are analysed and examples are identified to show that student interpreters are driven by notions of language, rather than communication fidelity. The multimodal nature of the interaction within the situated learning environment facilitates the students' exposure to and learning of situationally driven interpreting choices.

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INTRODUCTION

In this chapter, the authors explore the professional development function of roleplays that take place in clinical-skills labs with hearing clinicians, student sign-language interpreters and deaf patients. The roleplays occur in the semester before students engage in practicum/internships within public service/community settings (semester five in a six-semester BA). Within their university, the authors work with a senior nurse practitioner to base roleplays within the nursing clinical-skills lab used to train student nurses and other healthcare professionals, to more closely resemble the experience of interpreting in a real-world clinical setting. They also work with key members of the local deaf community to ensure their participation in the roleplays. Experienced interpreters, i.e. the senior lecturers, run the roleplays and discuss in debriefing sessions involving all stakeholders the decisions the student interpreters make, demonstrating ways of managing language and interaction (Roy, 2000; Wadensjö, 1998). The engagement of these participants is representative of the medical 'community of practice' (Lave & Wenger, 1991) of which the sign-language interpreting students will become a part, i.e. the professionals and deaf people with whom they will work when undertaking medical interpreting assignments.

The participation of the experienced interpreters, the non-signing nurse and the deaf community member facilitates legitimate peripheral participation (LPP) (Lave & Wenger, 1991) in a medical interpreting 'community of practice' for the student interpreters. LPP is the process by which the students start to undertake some of the tasks expected of an interpreter (i.e. preparation, interpretation and interaction decisions) with those involved in the community of practice, i.e. master interpreters, master health practitioners and patients, in an environmentally authentic setting.

The topics covered within the roleplays are either based upon the health experiences of the deaf participants, to expose students to authentic responses of deaf patients receiving care for conditions they have experienced; or on common medical conditions that give rise to consultations in primary healthcare, for which interpreters will be expected to interpret, and which might be novel for the deaf participants. Emulating the patient's reactions to novel situations also facilitates deaf participants asking genuine questions. The widely reported limited access of deaf people to health information (SignHealth, 2014) supports exposing students in this setting to the type of questions that deaf community members may well ask.

This analysis focuses on the multimodal nature of the interaction between the nurse and the deaf patient, i.e. the linguistic and gestural communicative actions used in speech, sign and manual gestures (Kusters, 2017). By engaging with a community of practice, the roleplays allow the student interpreters to see the lived practice of being a nurse, including the natural use of co-speech and no-speech gestures to deliver treatment. It also facilitates the student interpreters witnessing the lived experience of deaf people, viewing linguistic and non-linguistic communicative actions within the healthcare setting to understand how they engage with a health practitioner.

The student interpreters must understand that when interpreting, several strategies are available to them. Linguistically, the student can 'tell' the participants what was said; linguistically encode via depicting language (Dudis, 2011) what is being shown; or interactionally point to the language or gestures of the participants to draw the interlocutor's attention to communicative behaviours being used. This telling, showing and pointing (Stone, 2019) must also be supplemented by 'doing nothing', i.e. letting the nurse and the patient interact directly so that clinical rapport is established, with the nurse taking clinical responsibility for the patient.

BACKGROUND

Many healthcare appointments involve the need for physical examination and/or patient disclosures of a personal or intimate nature. This is one of the difficulties of offering student interpreters opportunities to undertake real-life medical interpreting assignments, even during practicum/internships. Also, the quality of interpretation can have a significant impact on the clinician's ability to make a diagnosis (Paananen & Majlesi, 2018), build a rapport with the patient (Labun, 1999) and subsequently offer appropriate treatment. Allowing a student/apprentice interpreter, who has not yet finished training and is not yet covered by any professional indemnity insurance or registered with an appropriate professional body, to undertake such an assignment would be unethical and potentially unsafe. For these reasons, student interpreters undertake roleplay scenarios in order to have some experience of interpreting in domains in which they will work.

Traditionally these roleplays may take place within a classroom setting, with parts (e.g. doctor, nurse, dentist, patient) played by fellow students or tutors. However, this strategy has some drawbacks. Firstly, if the roleplay participants all know both the spoken and the signed languages being interpreted, no one is actually reliant upon the interpretation, and consequently their reactions cannot be guaranteed to be authentic. Responses given within these interactions among the participants are as likely to be responses to the original language as they are to the rendition the student interpreter provides.

Secondly, participants in a roleplay in this context also have other relationships (i.e. those of tutor and student). The risk is participants will move in and out of the roles of tutor or student and roleplay characters making the interaction less authentic (Wadensjö, 2014). This switching of footing (Goffman, 1979) is less likely to happen if the roles are not played by tutors/students and the setting is not the classroom, but rather somewhere much more like the physical environment in which the scenario generally takes place.

Thirdly, roleplays allow students the opportunity to develop some 'emotional intelligence' (Bradford, 2017, p. 3). The creation of a more authentic experience allows students to do so with the appropriate stakeholders, rather than in the context of participants with other footings, and in the context of a simulated medical environment rather than a classroom.

Situated Learning

Situated learning is a social-practice theory. Lave & Wenger (1991) describe situated learning as a bridge, between a view according to which cognitive processes (and thus learning) are primary and a view according to which social practice is the primary, generative phenomenon, and learning is one of its characteristics' (p. 34). They make a clear distinction between intentional instruction and the incidental learning that can take place when activity is situated in a real-world authentic context.

For situated learning to occur, a necessary element is co-participation between those who seek to acquire knowledge and skills in a particular area, and those who are 'masters' or experts in this field. These parties interact with each other in a 'community of practice' (e.g. a medical interpreting community of practice that includes healthcare professionals, patients and interpreters), and learning takes place as a result of this interaction. Therefore, the learning is not taking place in an individual student's mind but is a co-participative experience. The senior nurse practitioner who took part in the roleplays described that experience when interviewed, and previously reported (Hughes, Bown and Green, 2018, p.157), saying:

I've learnt so much about listening and just simple things like the length of consultation and the time and the patience, the non-verbal skills and the space, and the consent issues.

Key in a situated learning context is that 'learning', rather than 'teaching', takes the central focus. The suggestion that students/novices can see exemplars of practice from masters or more advanced apprentices implies that modelling of preparation, interaction, interpreting and professional decision making occurs. The deaf participant in the roleplay was also interviewed (Hughes, Bown and Green, 2018, p.157), and sees this as valuable because:

The activities undertaken in the clinical skills lab were based around some of the more common illnesses/conditions like: diabetes, blood pressure, a GP consultation, a physio appointment etc. Doing those kinds of common appointments now, helps the students envisage ways to cope when they encounter these same appointments in real life.

Lave & Wenger (1991) found that the most interesting aspects of apprenticeship, where this type of knowledge transfer takes place, could be categorised and analysed under a framework that they call 'legitimate peripheral participation' (LPP).

Legitimate Peripheral Participation

LPP is a lens through which to examine the way the learning takes place. It is important to examine the definition of legitimacy in applying this framework. 'Legitimate' relates to 'ways of belonging', and in this context, legitimacy means that the students must engage in parts of the 'real' job, rather than undertaking tasks that, at best, model decontextualized language tasks. That means the tasks that master interpreters undertake and model for the students are then also partially undertaken by the novice interpreters—e.g. they can begin to undertake preparation for an interpreting assignment, do some co-interpreting alongside a master interpreter, or provide support within an interpreting team. This requires members of the community of practice to be present, and in the example here, these are the master interpreters, master nurses and deaf community members.

Situating the medical roleplays in a clinical-skills lab, students will experience some of the real-world aspects of medical interpreting, such as the impact of the space available, the sights and smells of a hospital/healthcare environment and the various medical equipment that surrounds them, contextualising participation in a way that is not possible in a traditional classroom setting. Student interpreters have the opportunity to understand the ways a clinical situation requires them to work and the impact of the environment on the interpreter-mediated event.

This added level of authenticity exposes student interpreters to some of the factors they must consider in addition to the language work of their interpreting. For example, in a roleplay set in a physiotherapy appointment, students must navigate the difficulties posed by the nurse requiring a sign language user to lie face down on a physiotherapy couch, thereby obscuring sight lines and affecting the ability of the interpreter to impart instructions without taking further action (more on this example below).

It is crucial to note that within this theoretical approach, peripheral participation within LPP is a move toward full participation, as opposed to a move toward central participation (Lave & Wenger, 1991). In this context, peripheral has the sense of partial participation, with a goal of enabling full participation. Novice interpreters undertake tasks that are legitimately part of the interpreting assignment but may not

undertake the whole of the assignment at this point, if that is outside their current capacity—i.e. they participate partially and not fully in the interpreting task.

Lave & Wenger (1991) demonstrate this notion of partial or peripheral participation in their analysis of the apprenticeship journey of novice tailors who work with master tailors to develop their skills, and who move from cutting the cloth according to the pattern templates (a relatively simple but legitimate part of the tailoring process) to later undertaking some of the sewing elements of the task requiring more experience. This scaffolds their learning and allows them to practically participate in the whole process alongside the master tailors, moving in stages from peripheral to full participation. In this way, peripherality can be perceived as a positive notion, as a gateway to the tailoring community of practice.

In the same way, the novice interpreters involved in the simulated medical interpreting assignments participate in the medical interpreting community of practice and gain an 'opening' of this gateway. This also facilitates professional development by expecting students/apprentices to participate fully as professionals in the parts of the professional practice in which they engage.

In terms of participation, the authors are clear that apprenticeship is not just observation; peripherality can be both an empowering and disempowering position, depending upon relations of power in any particular situation (Lave & Wenger, 1991). For example, preventing one from moving toward full participation is disempowering. The novice/student must have the opportunity to undertake real tasks or parts of real tasks within the learning environment and move toward undertaking the role of the interpreter in its entirety (which can happen in practicum/internships, in Semester Six of this BA program). The move toward full participation is additionally fostered by debriefing and critical reflective practice after each medical interpreting roleplay, also expected of sign language interpreter professions in the UK. Debriefing and critical reflection aim to foster an empowering frame that continues to move student/apprentice interpreters toward full participation.

Multimodality

With respect to communication and interpreter-mediated interaction, to date much of the focus of the immediate interpreting work has been on the language work of interpreters, without considering the multimodal nature of communication. When people talk, they also use co-speech gestures, no-speech gestures and tools while talking (Clark, 2016). This talk as action (Wadensjö, 1998) and talk while acting creates the context for the language used, contributes to the meaning of the language in context and can sometimes make interpreting redundant for deaf sign language users who have a visual sensory orientation (Bahan, 2008) or for hearing non-signing participants who understand a transparent sign that functions as a communicative gesture. In this sense, interpreters must consider not just the spoken or sign language used (two modes of communication) but also gestures such as eye gaze, pointing and gestural actions that include depiction (i.e. further modes and repertoires of communication). This is recognised as part of the interpreter's work in some medical interpreting standards where the 'linguistic and extra-linguistic aspects of communication' (International Medical Interpreters Association, IMIA, 2007 p. 12) must be considered with respect to the therapeutic relationship between patient and healthcare provider.

Similarly, when considering manual gestures, although the manual elements of transparent signs have greater linguistic complexity in sign languages, they may be borrowed from communicative gestures widely used within a regional or national context, and thus function as an iconic gestures (Kusters, 2017). Equally, some seemingly transparent gestures are comprehensible for sign language users in more nuanced ways than for non-signers viewing this manual activity as communicative gestures (Sutton-Spence &

Boyes-Braem, 2013). These can need interpretation rather than leaving hearing non-signers to infer the fuller meanings present in sign-language users' gestural use of signs. As such, the communicative motivation of the moment must be considered within the context of the medical environment, to enable better direct dyadic (between healthcare provider and patient) or interpreter-mediated triadic communication.

By ensuring the students' exposure to situated learning and engaging in peripheral participation, the communicative interactions of the participants emulate real-world settings. Furthermore, the students can see that deaf people are sophisticated communicators and used to communicating with hearing non-signers. Even with an interpreter present, many deaf people in the UK will try to ensure they have some rapport with the hearing person who is providing them with a service, such as healthcare. Similarly, some non-signing service providers will try to establish a rapport with their service users irrespective of the presence of an interpreter. These communicative motivations manifest in the roleplays as the members of the community of practice ensure that the students have exposure to the multiple communicative semiotic repertoires present in the healthcare setting.

Student Development From Clinical Roleplays

Following is the presentation of the data on students engaged in medical interpreting roleplays within a clinical-skills lab. The students are final-year British Sign Language (BSL)/English 'hearing' interpreting students (in Semester Five of six) who have professional fluency (CEFR C1) (Council of Europe, 2018) in BSL and English (typically native English speakers with some heritage BSL users). Previously in the classroom, they have studied consecutive interpreting for a year (Semesters Three and Four) within local government and social-service contexts. In their final year in the BA program (Semesters Five and Six). the focus is on simultaneous interpreting covering a variety of public-service settings, to prepare students to be generic interpreters when they graduate, as required by the professional accreditation body (the National Register of Communication Professionals working with Deaf and Deafblind people, the NRCPD). In the second semester of this final year (Semester Six), the students undertake their practicum, which enables further transitioning into full participation, ready for work as a professional interpreter upon graduation.

Prior to interpreting within the clinical-skills lab, the students have two weeks of discussion on interpreting in medical settings. These discussions include reviewing the literature on medical interpreting; reviewing their language glossaries for medical terminology in both working languages; undertaking a situational analysis using demand-control schema (Dean & Pollard, 2011; 2001) as their framework; considering the National Council on Interpreting in Health Care paper (NCIHC, 2003) on the physical positioning of interpreters within medical settings for optimal access for deaf sign language users; interpreting medical monologues in BSL and English into English and BSL respectively. All these tasks are designed to ensure their readiness for the roleplays. Even so, when students find themselves within the clinical lab, the novelty of the environment poses challenges as described below.

In the clinical-skills lab, the nurse practitioner and deaf community member are involved each roleplay with one of the student interpreters. The student/apprentice interpreters who are not involved in the roleplay observe the interpreter-mediated event, as does the master interpreter. The roleplays are video recorded (as are many nurse-training events in the clinical-skills lab) for analysis and reflection. After the interpreter-mediated event, each participant is given an opportunity to reflect and provide feedback, as are the observing student interpreters and master interpreter.

Issues, Controversies, Problems

The involvement of the medical interpreting community of practice within the clinical-skills lab ensures that the talk, co- and no-speech gestures, and use of tools simulate real-world practices within an 'authentic' medical appointment. The students experience the talk of nurses from a nurse and the use of tools (termed 'realia' by Crezee, 2015), such as the blood-pressure cuff, oxygen mask and physiotherapy table, as a nurse would use them. They witness the ways a deaf patient would interact with them, the amount of space available to professionals within the hospital and clinical settings, the interaction of the nurse with the patient while engaging in tool use and diagnostic and medical procedures. This shifts the focus away from 'talk as text' to talk as action and talk while acting.

The following examples from the data, which exemplify four different types of multimodal interactive learning points achieved within the situated learning environment:

- Transparent situational information (the presence of an oxygen mask);
- Transparent use of sign/gesture;
- Transparent use of co-speech gesture with tool use (the blood-pressure cuff); and
- Semi-transparent use of sign/gesture with tool use (lying on a physio couch).

Each of these scenarios demonstrates an added layer of complexity that would not be present outside of a real medical encounter or a situated learning experience. The data is the video-recorded situated-learning roleplays that students undertake during Semester Five in the clinical-skills lab, with examples to draw the readers' attention to the benefits of exposing students to simulated interpreting as part of LPP, moving toward full professional practice. Each scenario, and the co-participatory learning that each situation facilitated, are now presented.

Oxygen Mask—Tools as a Barrier

In the post-operative recovery roleplay, the deaf patient is lying down on her side with a drip fixed to her at the elbow (non-intravenously, but to simulate an intravenous drip) and is wearing a pulsometer on her index finger to monitor oxygen flow (see Figure 1). The nurse is attempting observations of her recovering patient and the student interpreter is accompanying the nurse. As the nurse begins her observations, she briefs the student interpreter about the patient's current state and explains that the patient is just coming around after a successful operation, all manifesting as a zero rendition (Wadensjö, 1998) by the student interpreter.

Whilst the nurse is talking, the deaf patient starts to show signs of regaining consciousness and appears to be trying to remove her oxygen mask from her face, something that the nurse will have witnessed on countless occasions. The nurse is non-reactive because this is expected behaviour and exhibits what happens within the community of practice to the peripherally participating student interpreter and to the observing student interpreters.

The interpreter is faced with several cognitive demands vying for his attention in this moment. The deaf patient makes eye contact with the student interpreter, points to the mask and signs the sign WHAT? The nurse is talking to him as is the patient (albeit in different modalities, thus exhibiting the complexity of needing to manage bimodal linguistic interaction), but he is not interpreting either original (zero renditions). The patient is obviously disorientated and distressed, and then seems to be maintaining eye

contact with the interpreter, 'asking' for some explanation of her current situation. Here gaze is used in lieu of a manual gesture as an attention-getting strategy and is not noticed or understood by the nurse as the beginning of communication and a floor-taking strategy in BSL.

The deaf patient initially generates two types of ambiguity. Firstly, the utterance WHAT? could mean 'What is the mask for?' or 'What is going on?' or 'What the hell?'. Secondly, the deaf patient is directing her gaze at the student interpreter, which could be understood as directing the question to the interpreter rather than the nurse. However, this is an interpreter-mediated encounter and within this context are choices about footing (Goffman, 1979), such as conveyor of information, i.e. animator, rather than principal and author in this moment (Wadensjö, 1998). The interpreter must decide how this question will be uttered and potentially make known to the nurse that the deaf patient is wanting to better understand her situation.

The student interpreter's response to these conflicting demands seems to focus on alleviating the deaf patient's distress. Despite the nurse being able to see that the patient is attempting to remove the oxygen mask, the interpreter feels it necessary to point this out, and even goes so far as to suggest that the nurse should replace it, whilst reaching toward the mask with his hand, as though to touch it (Figure 2). This kind of activity does not fall within the remit of the interpreter, who is there to facilitate communication; the interpreter is not a trained healthcare practitioner and neither qualified nor insured to use or adjust medical equipment. Within this situated learning environment, the student finds himself not only authoring statements, i.e. engaging in non-renditions (Wadensjö, 1998), but also engaging in attempting to author actions, i.e. removing or replacing an oxygen mask.

Figure 1. Deaf patient on the bed with drip

Figure 2. Beginning patient observations

The situated learning environment allows the student interpreter to engage in actions that he would not have anticipated and places him in a context where he undertakes certain actions that fall outside of the responsibility of the professional interpreter within the healthcare setting. Critically reflecting in the debrief, the student said this was 'because Kirsty was acting as though she had just had an operation … I was trying to have a discussion to get her out of the pain'; and because that 'side of my personality was like "it'll be all right, it'll be all right"'. His motivations are to be a problem solver and to ensure that the deaf patient's needs are addressed. However, he is not mindful of the footing of the ratified participants in this interaction, nor of ratified actions in which he can legitimately engage in this setting. The situated LPP therefore presents a co-participatory learning opportunity for him and all the other students who are observing the roleplay, which a classroom setting would not have afforded.

Communicative motivations for these actions are worth noting. The presence of the oxygen mask does restrict the linguistic features of the BSL the student interpreter can perceive, reducing the linguistic signal and increasing the 'noise'. English mouthings (Sutton-Spence & Woll, 1999) form part of the linguistic signal in BSL, and one of the student's motivations for wishing the removal of the oxygen mask is to ensure the BSL original is fully perceivable before rendition, since the medical tool acts as a barrier to comprehension. This experience of realia as a barrier is only realised because of the clinical setting. Additionally, the patient is lying on her side and has restricted movement, which changes the nature of the BSL produced and the phonetic realisation of the language, also potentially acting as a barrier to comprehension for the student interpreter. Finally, the simulation by the deaf patient of the disorientation caused by the anaesthesia is novel to the student interpreter, and the different factors that contribute to making comprehension more difficult overwhelm him. His motivation is to ensure the deaf patient is treated well. This culminates in a series of actions: the inchoate attempt to remove the mask; then attempting to draw the nurse's attention to the mask; and the continual overlapping of the nurse's talk with interpretations of the experience of pain uttered by the deaf patient, none of which is novel to the nurse.

By having members of the community of practice participating in this interpreter-mediated event, the student experiences LPP and the requirement to make decisions in the situation about language and interaction management. The student also experiences a 'constellation of demands' (Dean & Pollard, 2011), where the main demand may be accompanied by other concurrent demands, something that cannot be authentically replicated in a classroom scenario. This occurrence of demands in clusters leads to the 'it depends' response of instructors to students' questions about appropriate action to take, should a particular demand arise. In a situated learning context like that of the roleplays in the clinical-skills lab, to answer such questions in a contextually appropriate way, instructors can draw attention to the demand constellations.

Class discussions about the roleplays led to broader discussions on the role of interpreter-generated utterances (i.e. non-renditions) (Wadensjö, 1998) designed to ensure the nurse understood the deaf person's expectations of having access to information, and the interpreter's difficulty in understanding the language because of an impoverished linguistic signal. There was also discussion about the need to draw upon the nurse's experience of typical post-operative patient behaviour (i.e. asking the nurse if this is normal behaviour as a patient comes round); and better understanding of situational pressures that might create the desire to engage in actions that could have negative consequences (i.e. asking if the equipment can be adjusted).

Drink Gesture—Sign as Functional Communicative 'Gesture'

In this consultation, the nurse talks about the necessity for the patient to take Fybogel. As she says 'it's really, really important that you take that Fybogel', the nurse uses a co-speech 'drink' gesture (as seen in Figure 3 below) and explains that Fybogel is orange flavoured. The interpreter interprets that Fybogel is a tablet that is orange flavoured. When the deaf patient then starts to ask the question about how the medication is to be ingested, she uses the iconic sign DRINK (as seen in Figure 4 below), asking whether it is in liquid form or tablet form. Before the interpreter can render this into English, the nurse (having understood the DRINK sign as a transparent communicative gesture) answers, 'yeah, it's a drink'. Slightly after this response, the interpreter still interprets the deaf person's utterance as 'so do you drink it or…?', which is obviously redundant at this point, as the nurse has already answered the question. The nurse then repeats 'it's a drink' three more times.

As mentioned above, deaf signers and hearing non-signers will often try to develop rapport, well described by Kusters (2017) in the context of deaf-hearing interactions between shoppers and shopkeepers in India. In an interpreter-mediated environment in a healthcare setting, much of this interaction is mediated by the positioning of the interpreter in relation to the healthcare practitioner. Figures 3 and 4 show that the positioning is not conducive to the deaf patient seeing the co-speech gesture that disambiguates the English phrase 'take'; nor does it appear to be conducive for the interpreter to see the disambiguating co-speech gesture so that she can accurately render 'taking' (Fybogel) in the target language (Stone, 2010). Finally, the positioning is such that the deaf patient cannot realise that the nurse has responded to her signing before hearing an interpretation. This is information not perceived by the deaf patient, and in the interests of communicative fidelity, the interpreter would need to let the deaf patient know this has happened for the deaf patient to be aware of it.

One issue is that students have a heightened sense of being faithful to the linguistic message, understanding this to mean that all of the language content of an interaction should be rendered to ensure the completeness of the message. Students often use expanded rather than reduced or zero renditions, as

Figure 3. Nurse uses 'drink' gesture

the novice interpreters begin undertaking the language work without sufficient pragmatic enrichment to render the linguistic content and the inferences made. Figure 3 shows that co-speech gesture also plays a role in communicative interaction (as does pro sign gesture, where a gesture replaces a sign). Often, depicting gestures can be mapped onto depicting signs so that an accurate (isomorphic) depicting utterance can be rendered into sign language. For this to occur, interpreters must pay attention to both linguistic and non-linguistic cues in the environment.

The linguistically bimodal nature of the interaction also means that there is information unknown to each participant, potentially only being heard, seen or witnessed by the interpreter. In the post-operative roleplay above, the nurse did not know that the gaze of the patient was an implicit question in BSL. In this scenario, the nurse responded directly to the deaf patient, but the deaf patient remains unaware of that this has taken place. Being exposed to authentic 'direct' communicative interaction via situated learning, the student interpreters have the opportunity to experience these naturally occurring moments

Figure 4. Deaf patient uses the sign DRINK

of signs being understood as communicative gestures (and vice-versa). It also enables students to consider an appropriate response in the context of repeating information that has already been understood by one or both parties.

In this roleplay, the nurse does not sign BSL (or any other sign language), and having minimal experience interacting with deaf people, she instinctively engages in a co-speech gesture and also responds instinctively to a sign that she recognises (at least as a presented action gesture) and understands it communicatively in this context. In a classroom setting, where a member of the teaching staff may play the role of the healthcare professional, everything said in BSL is understood, and so they cannot 'manufacture' these moments easily in a simulated assignment. Similarly, there is a risk that teaching staff's co-speech gestures are informed by their knowledge of BSL, so these do not represent the types of co-speech and no-speech gestures in which non-signers engage. In this context, the community of practice enables this authentic interaction to occur and to facilitate co-participatory learning moments during the interpreter-mediated event and in the debrief.

One of the points raised in post-roleplay class discussion was that repeating a question perceived to have been answered might mean that a nurse would draw an inaccurate inference regarding the attentiveness of the deaf patient within the clinical appointment, and that could be detrimental to building rapport between nurse and patient. The student interpreter could have decided to inform the deaf patient that the nurse understood the sign DRINK and responded; although an interpreter-generated utterance, it is faithful to the broader context of the communication event. This information can change the dynamic between nurse and patient, in that it is then clear to the deaf patient that the nurse is paying attention and even paying attention to the signs being used. The cultural value of BSL use in the Deaf community is high, and non-deaf people are often seen as allies if they are understood to be making the effort to communicate directly. This demonstrates that being attentive to the multimodal nature of the interaction can facilitate greater rapport building within the clinical setting.

One final point, which is more of a structural issue, is that repeating the question also adds time to the interpreter-mediated clinical appointment, within a medical system (in the UK) that allocates limited time to each appointment. Adding time to the appointment is not the most efficacious way of interpreting and might mean that further issues cannot be discussed, due to time constraints—also something of which the nurse practitioner is aware, and noted above. Debriefing with the students and discussing these issues within the context of situated learning not only gives them sensitivity to the moment (as discussed above) but also enables the discussion of systemic considerations beyond the scope of the immediate interpreter-mediated event (Stone, 2018).

Arm Gesture—Blood Pressure

In the nurse consultation roleplay, the nurse is going to take the patient's blood pressure; having put the cuff in place, she wants the patient to turn her arm over to a palm-up orientation. In order to achieve this, the nurse gives a visual demonstration with her own arm while talking (a co-speech gestural depiction). At this point, the deaf patient's eye gaze is still trained on the nurse, having just watched her put the cuff on her arm. She sees the nurse turn her arm and starts to turn her own to the correct orientation as shown in Figures 5. and 6.

In this context, the student is aware that the eye gaze of the deaf patient is on the nurse and the nurse's gestural depiction. The deaf patient has watched the cuff and watched the nurse turn her arm, and throughout this period the interpreter has not rendered the speech co-occurring with the gesture. This

Figure 5. Blood-pressure cuff being placed

zero rendition moves away from the typical decision made by student interpreters. Here the realia enables the students to see how nurse and deaf patient interact and the need to allow the deaf patient to watch the nurse and the blood-pressure cuff being placed on her arm. The interpreter experiences the eye gaze of the deaf patient and its role in coordinating interaction, including when renditions can or cannot occur.

The interpreter then raises her arm and holds it in what is known as neutral space in sign language linguistics. This draws the deaf patient's eye away from the nurse and toward the interpreter. Taking the floor, the interpreter then repeats the presented action as a BSL depiction (a reduced rendition), as the deaf patient watches and then repeats (and confirms) what she has been instructed to do and has already done. In this instance, it may be that a zero rendition by the interpreter would have been the optimum, as the patient could have maintained eye contact with the nurse for a little longer and this interaction would have contributed to the building of rapport between them. Even so, the coordination of the rendition according to the eye gaze of the deaf patient is successful.

In the debrief, a discussion ensued around the interpreter's need to consider how to flex processing time at points where language has 'a tangible purpose' (Bradford, 2017). The student must prioritise instructions such as this one or a request to 'roll up a sleeve' or perform some other action to allow an examination to take place, and the rendition is structured accordingly. The post-roleplay class discussion focused on whether the rendition was needed, even in a reduced form. If the deaf patient, informed by

Figure 6. Deaf patient rotates her arm

the gestural depiction of the nurse, undertakes the action the nurse requires, then a zero rendition, i.e. doing nothing, does still appear to be faithful to the communication goals and successful interaction.

Physiotherapy and Spatial Positioning

The physiotherapy roleplay required a student interpreter to interpret a consultation and subsequent examination by a physiotherapist. This included an examination of the patient's back, which took place with the patient lying face down on the physiotherapy couch. This would normally mean cushioning the patient's face within the breathing hole to look at the floor. For a hearing patient, communication can continue as normal whilst this examination takes place, as they hear the spoken utterances of the physiotherapist and a spoken-language interpreter. However, for a deaf patient, lying face down means that the deaf patient is looking at the floor and not able to see the interpreter, which restricts communication. It is impractical to suggest that the interpreter lie on the floor (although a technological solution to this could occur with a video camera and a screen placed on the floor). In this instance, the physiotherapist and the patient agreed that a hand signal would be used to indicate that the patient was in pain when the thoracic region was palpated.

The video footage shows that the first indication of pain is given in response to the physiotherapist palpating the thoracic region. The deaf patient raises her hand and lowers it within two seconds. The nurse indicates that she has seen this gesture with a thumbs-up gesture in response. The deaf patient's head is slightly raised, so she sees the nurse's gesture and in this moment it functions communicatively. The interpreter does not intervene (although this is principally the result of not being positioned to be seen by the deaf patient), the consequence of which is that direct communication occurs between health professional and patient, which is a desirable outcome.

Eight seconds later, the patient again indicates pain by raising and lowering the hand within two seconds. This is also met with a thumbs-up response from the nurse. Shortly afterward, another two-second raising of the hand occurs, although this is not acknowledged by the nurse. This same pattern continues twice more before (at 02:49) the deaf person raises her hand and keeps it raised for 11 seconds,

Figure 7. Student interpreter positioning

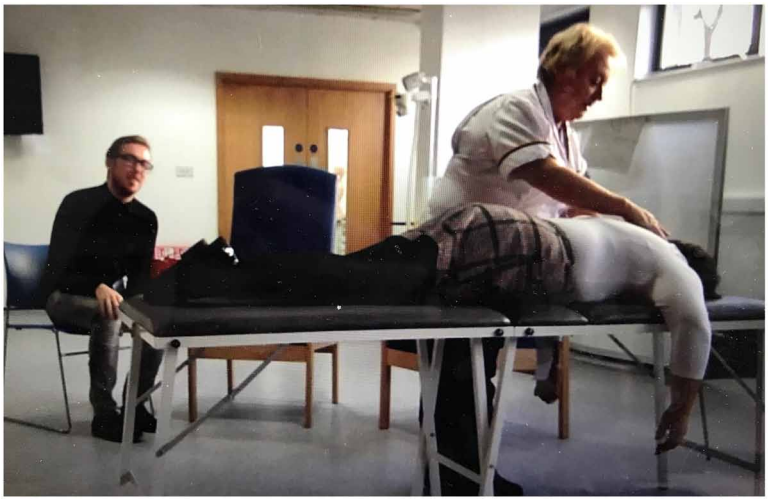

Figure 8. Optimum positioning agreed

and visibly motions with the hand in the raised position in a way that indicates greater intensity of pain. Arguably, this gesture is more easily understood by a sign language user where lengthened duration of a sign can often function as an intensifier. The nurse, whilst seemingly recognising that pain is present, is not aware that there has been a change in its intensity. This demonstrates that although the gesture is communicative, here there is a role for interpreter mediation; however, during this 11-second period, the student interpreter is not looking at the deaf patient.

The student interpreter faces the issue that seemingly no language interaction is occurring, and so there is no commensurate requirement of fidelity to the message. Nonetheless, communication, albeit gestural and at first glance possibly more sophisticated in nature than communicative pro-speech gestures between two non-signers, requires the student to see beyond the language work of an interpreter and better understand the information that the nurse may not well understand. If we consider communicative fidelity to include gestural interaction, then the interpreter has a role in ensuring that effective communication has occurred.

In the debrief for this session and in the subsequent student self-analysis of this footage, this incident was recognised as a learning opportunity that indicated the importance of not relying on the nurse to fully understand gestures that may have a linguistic component (in this case, indicating intensity of pain). The student interpreter came to understand that in such an appointment, physical positioning in the space is key (NCIHC, 2003). This also highlights that in teaching, greater attention can be given to better understanding the spatial practises of deaf people (see Kusters, 2009). The student needed to retain sight of the deaf patients' hands in order to comment upon the level of pain being experienced, and allow the physiotherapist to make a fully informed diagnosis. Learning such as this is only possible in a situated learning environment where the healthcare professional is reliant upon the interpretation, and it is possible to recreate the physical environment of a physiotherapy appointment (see Figures 7 and 8).

The student interpreters, master interpreters, nurse and patient were all then able to discuss the resolution to this issue and determine the positioning that would have been optimum for enabling the interpreter to fully relay the information about the level of pain the deaf patient experienced. As the deaf patient said:

It provides an unbelievably valuable experience for the students and I have really enjoyed myself! I am delighted that this session has taken place and I really hope there will be more sessions like this in the future. It really will help the students develop in readiness for their life as a working interpreter.

This legitimate peripheral participation facilitated learning for the whole class. Students were able to see the impact upon others that their behaviour within an assignment can have during examination (Baker & Maier, 2011; Krystallidou et al., 2018) and to see talk in action where the context of talk and gesture has the potential to influence the outcome of a medical appointment.

CONCLUSION

The examples above show instances when the realia of the authentic clinical setting cause student interpreters to become overwhelmed by the choices available to them. Within the situated learning environment while engaging in LPP, the student interpreters will then either:

- Undertake actions not within their remit within the clinical setting; or
- Pay attention to the languaging of the interlocutors but not to other multimodal resources used in the environment, which are also information resources.

The situated learning environment enables the student interpreters to "understand challenges better, prepare more efficiently and assess their skills and the effort required to progress better" (Chouc & Condé, 2016, p. 100). The reflections within this setting from the deaf patient, senior nurse practitioner and fellow student/apprentice interpreters also better contextualise the post-roleplay discussions within a community of practice.

In the examples above, one of the main benefits of situating the roleplays within a clinical environment is exposing the students to the constellation of demands (Dean & Pollard, 2011) in the medical interpreting setting. By having realia present in the setting, all parties (patient, nurse and student interpreters) can safely understand the influence of these tools and equipment on the reactions and decisions of the

interpreter. It also calls into question some of the assumptions that each party has regarding interpreter mediation within medical settings.

In the examples above, patients learn about the positioning of interpreters and its influence on direct interaction. The nurses learn about positioning, transparent and opaque gestures of deaf patients and the foreignness of the environment for apprentice interpreters, as well as the impact interpretation can have on the length of time a consultation may take. The interpreters learn that the work of an interpreter extends well beyond the language work in the event and understand that decision making is contextually bound.

The success of using the clinical-skills lab for LPP is that it enables better engagement in a community of practice. The environmentally authentic setting draws out behaviours from the nurse, patient and master interpreters that highlight the multimodal nature of the interaction for the novice interpreters. The post-roleplay debriefs with the nurse, the deaf patient and the master interpreter draw the novice interpreters' attention to their successful use of telling, showing, pointing and 'doing nothing', and when these things could be used to greater effect to enable spontaneous rapport to develop between the nurse and deaf patient.

LIMITATIONS

The chapter focuses on four cases drawn from the data recorded during the teaching of medical interpreting within a sign language interpreter-education program in the UK, based at a university that also has a large nursing degree program. The dataset is small, and a further systematic data-collection exercise could lead to a better understanding of the frequency of the occurrences of each of the phenomena described. However, the level of description does draw attention to important aspects of medical interpreting which situated learning provides and that classroom-based roleplays cannot emulate.

It is important to recognise that such situated learning experiences are only possible given the availability of the appropriate resources—in this case, the use of the University's purpose-built clinical-skills lab and the time of the registered senior nurse practitioner, a senior lecturer at the University, and of the deaf participant from the local Deaf community. It is not cost effective to offer these situated learning opportunities for every class. Therefore, it is imperative that the design of such activities be well thought through in terms of offering as much practical participation to each student as possible, by scaffolding the learning with appropriate activities prior to the session taking place and offering the opportunity for post-session reflection.

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Chapter 16
Sight Translation:
Best Practices in Healthcare and in Training

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ABSTRACT

In this chapter, we will provide updated knowledge in the discussion of how to define sight translation. Furthermore, we will present a discussion of best practices in sight translation in a health care context, not only related to the process of sight translating, but also to challenges regarding the listener's accessibility to sight translated texts. Furthermore, we will present our curriculum for sight translation at Oslo Metropolitan University and explain the rationale behind it based on theoretical knowledge from extant translation studies and the theories of semiotics and multimodality. We will argue that sight translation needs to be treated as a unique interpreting method that requires special training, and we will conclude with suggestions for further research.

INTRODUCTION

Sight translation, also known as prima vista, refers to the process of interpreting a document from writing into speech. Together with consecutive and simultaneous interpreting, sight translation is one of the basic interpreting methods—in which the interpreter is provided with a written text and is expected to instantly and smoothly deliver the translation of its contents at a speed appropriate for natural oral production (Čeňková, 2010, p. 320). Sight translation occurs in both oral and signed interpreting. In this chapter, the focus is on oral interpreting.

During sight translation, the interpreter reads a written document silently in the source language and renders its contents orally in the target language. Thus, the process involves a transformation from the written to the spoken mode. Relying on both written and spoken discourse, sight translation is a complex

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task that involves many competences—e.g., reading, text-analytic, communicative, public speaking, coordination of speech and translation—in addition to the written and oral competences in the two languages used. According to Stansfield (2008), the involvement of both written and oral language makes sight translation the most challenging interpreting method, especially because written language usually involves the use of more complex sentences than spoken language.

Gonzalez, Vasquez, and Mikkelson (1991) describe sight translation as an art:

Like accomplished musicians who play an apparently effortless version of a piece they have never laid eyes on, interpreters are actually drawing upon years of training and experience to perform this feat. The end product should be both faithful to the original text and pleasing to the ear (that is, in free-flowing, natural sounding language) (p. 401).

Interpreters in the health services often come across documents that they are expected to sight translate, mostly for the patients but also for health care personnel. The types of these documents can be very diverse. There are journal entries, resolutions, medical histories, forms the patient must fill out, notice letters, or information leaflets that the interpreter has to interpret for the patients or for health care personnel. In other words, a substantial amount of interpreting occurs from the written to the spoken mode in the field of health care. Typically, the interpreter interprets an information leaflet for a patient into the patient's language. The leaflet may, for example, contain information about an operation that the patient is going to have or information about a diagnosis that the patient has received. In other cases, the interpreter has to interpret the languages the other way around. For example, the interpreter may be expected to interpret a foreign medical journal from the patient's language to the language of health care personnel.

In extant literature, as well as in practice, interpreting is widely construed as the action of overcoming barriers between two languages in spoken discourse. However, sight translation is a form of interpreting that relies on both written and spoken discourse and does not fit into this classification. Nevertheless, sight translation is commonly used in interpreter-mediated communication in public services, including health care, as demonstrated by the examples above. The interpreters in public services in Norway report that they sight translate on an almost daily basis (Felberg, 2015; Nilsen & Monsrud, 2015) in various locations and contexts, such as hospitals, doctor consultations, courts, asylum interviews, schools, child welfare situations, and other social service contexts.

In the literature, there is no agreement about the definition of sight translation, and, thus, it still remains a debatable issue. Nevertheless, the most challenging and distinct feature of sight translation is the shift from the written to the spoken mode, which in addition to linguistic challenges in the written—spoken language continuum, includes mediation of mode-specific resources into another mode. This chapter presents the argument for the following definition: Sight translation is an interpreting method that involves a shift from the written to the spoken mode. This is called interpreting because the target text is mostly presented orally and because sight translation in the public sector is discussed as part of an interpreting assignment. In the public sector, sight translation occurs within the field of interpreting and not within translation, and the task is performed by interpreters.

Sight translation is not only an interpreting method but also a pedagogical tool (e.g., Song, 2010). Traditionally, sight translation has been treated as a pedagogical tool used to develop second-language skills or translation skills or to prepare for other methods of interpreting—it has not received the sufficient attention it deserves as the widespread communicative practice that it has become (Čeňková, 2010,

2015; Chen, 2015; Li, 2014). How sight translation is integrated into training and education, as both a pedagogical tool and an interpreting method, varies significantly, but researchers argue that, since it is a widespread practice, sight translation should be taught independently in interpreter training (Changmin, 2001; Ersozlu, 2005; Sampaio, 2007). This is a view that is supported in this chapter.

In extant research, the process of sight translation is mainly scrutinised in terms of language transfer, and it is not known how, for example, the many production problems related to the method actually affect a listener, since the research is mainly monologist (Vargas-Urpi, 2019). Analyses of sight-translated texts are usually performed on written transcripts, and the mediation of one mode into another—e.g., in this case, of writing into speech—is rarely examined as an independent effort (c.f. Gile's effort model in Gile, 2009). The mode shift is rather understood as inherent in the other efforts (reading, translating, producing speech). The modal challenges are not only related to the interpreters' work; they also affect interactions. In the discussion of how to define sight translation based on a review of previous studies, the latest research on this topic is included. Findings from recent research are also presented, which are based on interviews with interpreters who are experienced in sight translation within the health care services. Sight translation, it is argued, needs to be treated as a unique interpreting method that requires special training.

Furthermore, it is also argued that interpreters do not need special courses for performing interpreting tasks in the sphere of health services. The method is the same across the public sector—what varies are the settings and the texts that are being interpreted. Hence, the courses on sight translation must include exercises and training that are related to the particular types of texts that are found in the various environments of the different spheres of the public sector. The students must learn about the types of texts that they will be expected to interpret in hospitals, during doctor consultations, in police interviews, through the telephone, in multiparty meetings, etc.

This chapter highlights the shift in the mode and the reading effort in sight translation by presenting the theoretical aspects related to these important factors in interpreting from writing to speech, and it explains how the concepts from these theoretical perspectives are used with students during their interpreting studies. Furthermore, a discussion of sight translation best practices in a health care context is presented here based on the knowledge obtained from extant research and the authors' own experience as teachers of sight translation at the Oslo Metropolitan University, in addition to interviews with health care interpreters. The best practices can be developed only through systematic training that is based on updated knowledge and on the understanding of an interpreter as an engaged actor who solves the problems of translatability and mutual understanding in situated social interactions. Consequently, issues are discussed not only in relation to the process of sight translation but also to the challenges regarding the listener's accessibility to sight-translated texts. Furthermore, the curriculum for sight translation at Oslo Metropolitan University is presented, and the rationale behind it is explained based on the theoretical knowledge of the semiotics and multimodality theories, as well as reading, since sight translation also requires highly developed reading skills. The students are provided with various training tasks during the course, which is based on 15 European Credit Transfer System credits (European Commission). This chapter demonstrates the close connection between theoretical knowledge and practical exercises, such as reading tasks, self-evaluations in a language laboratory, interpreting with peer feedback, role-playing and reflections in groups.

This chapter is structured as follows. First, an update of the knowledge in the discussion of how to define sight translation is provided, particularly with respect to sight translation in public services, including health services. Second, we present some results from interviews with interpreters in health

services. Third, the Oslo Metropolitan University sight translation course is presented with a particular focus on multimodality and reading skills. At the end of the chapter, some concluding comments regarding suggestions for further research are presented.

DEFINING SIGHT TRANSLATION

Sight translation involves the transposition of a message written in one language into a message delivered orally in another language (Lambert, 2004, p. 298). There is, however, no agreement among scholars concerning the definition of sight translation, as underlined by Krapivkina in 2018:

Thus, we can conclude that the status of sight translation is rather controversial. There is no uniform definition of the concept of sight translation in applied linguistics studies. Sight translation is considered either as a mode of interpreting or translation or as a separate type of intercultural activity. As a result, the role of sight translation in teaching practice is ambiguous as well (Krapivkina, 2015; Stansfield, 2008, p. 696).

The term sight translation can refer to different types of activities, depending on the conditions under which the sight translation is performed. One can make a distinction between sight translation with and without preparation of the text, called "unstressful sight translation" and "stressful sight translation," respectively (Lambert, 2004, p. 298). The most typical type of sight translation that is used in health care is stressful sight translation. Adding to the stress is the unpredictability of the health care field. The interpreter may one day sight translate for a patient who is taking part in a stroke programme at a health rehabilitation centre. The assignment the next day may take place during a birth or even during a birth with complications.

The literature on sight translation also distinguishes between sight translation and sight interpreting (Lambert, 2004), where sight interpreting refers to simultaneous interpreting with text (Pöchhacker, 2004, p. 19). According to Čeňková (2015), transcripts or reports on the bases of police and asylum interviews are part of the sight translation practice, where the interpreter also interprets during the interview. Consequently, the interpreter may then be regarded as one of the "co-authors" of the written text because it is their translation that is the basis for the transcript or report (Felberg, 2015). This practice is sometimes referred to as "back translation", rooted in the idea that these reports are literal transcripts of the interpreter´s rendition. However, Spitz and Hlavac (2017) argue that it is more precise to consider the method a variant of sight translation because the report/transcript must be understood as a new text, sometimes also sight translated by a different interpreter. In health care, the interpreters sight-translate transcripts and reports in a similar manner, after consultations, psychological assessments on the bases of interviews or reports following medical investigations.

Sight translation relates to both literate and oral discourse. Thus, sight translation can be defined as a specific type of written translation, as well as a type of oral interpretation. An ongoing discussion regarding the definition of sight translation focuses on whether sight translation should be considered a part of the interpreting or the translating discipline. Should sight translation be defined by taking the written source text as the interpreter's starting point or should the definition start with the spoken target text? The source-oriented approach, in which the interpreter is expected to produce a text that sounds as if it is read in the target language, demands that the interpreter can produce "written-like" text orally and

under time constraints Time for planning is one of the distinct differences in how writing and speech is produced (Chafe & Danielewicz, 1987); consequently, the source-oriented approach is hardly achievable. The target-oriented approach, on the other hand, expects the interpreter to deliver a text that is adjusted for listening purposes. This chapter argues that the latter is the most fruitful starting point for defining sight translation. Since a text is translated into spoken form, the recipient of the text is a listener, and the interpreter's performance must, therefore, try not to be "written like" but rather "listener friendly." It is important for the listener to be able to understand and to follow the text when deprived of the reader's privilege of seeing and reading the text. It is the interpreter's responsibility to render the text orally in such a manner that makes it possible for the listener to follow and understand the content of the text easily. Furthermore, the change from the written to the spoken mode is as central to sight translation as is the translation from one language to another, as one of the authors here further argues (Havnen, 2019). The shift in mode should therefore be reflected in the definition of sight translation, as well as in interpreter training. Hence, this chapter also contends that an essential part of the sight translation curriculum must be devoted to managing the shift in mode in different settings, such as multiparty meetings, face-to-face interactions and remote interpreting via phone or video conferences. In a face-to-face interaction, the interpreter can exploit other resources to transfer cohesion (gestures, gaze), whereas phone interpreting may require the use of prosody and/or explications.

Categorising sight translation as belonging to either the field of translation or interpreting might be a dead end. In her article on written-to-signed-language translation, Wurm (2014) tries to deconstruct the translation and interpretation prototypes. She connects the discussion about categorising this practice as translating or interpreting to the dichotomy between orality and literacy and to the "great divide" between speech and writing. Wurm argues that these categorisations do not address the complexity of the translating and interpreting practices, nor do they address the needs of modern communication (Wurm, 2014, p. 251). She contends that such a categorical division into dominant practices marginalises the "between practices" as "hybrids." She reasons that this might ultimately harm the research on translation studies, because it only covers the "prototypes" that do not represent practical reality (p. 253). She chooses to use the phrase, "written-to-signed-language-translation," when referring to the mediation and translation process in order to include the variety of textual combinations and to highlight the mode shift and process. A similar strategy is used by Oslo Metropolitan University when naming the sight translation course, "Interpreting from writing to speech."

The question of defining a phenomenon, in this case a translation or interpreting method, is always related to what the definition is needed for and why it is needed. To the discussion of definition, the purposes of the sight translation could therefore be added—whether sight translation is an exercise, a tool or a communicative practice. Sight translation can be used as a tool for more efficient translations that are supported by speech recognition technology and with the possibility of revision (Dragsted, Hansen, Vandaele, & Bastin, 2009). In this case, sight translation demands different strategies than interpreting during a dialogue for an actual listener; again, this situation also varies, depending on whether or not the listener is visible or the translation is recorded (Biela-Wolonciej, 2015). A recorded sight translation gives the listener some of the same privileges as those possessed by the reader (the possibility to control the speed and to repeat some sequences), so it is clear that the possibilities for interaction with the text should influence the choices and the focus in the translation process. Chen (2015) refers to sight translation as a multipurpose translation skill and indicates that it is necessary, as Li (2014) and Moser-Mercer (1995) also highlight, to be clear about which type or variation of sight translation one is referring to

since the different variations demand differing sets of skills and approaches depending on the situation and the purpose of the activity.

This chapter is concerned with sight translation during interpreting assignments in health care consultations, as well as sight translation in other public service spheres. Sight translation is therefore defined as an interpreting method that involves a shift from the written to the spoken mode. Thus, this method is named "interpreting from writing to speech", like the course at Oslo Metropolitan University that is mainly intended for students interpreting in the public sector.

KNOWLEDGE ABOUT INTERPRETING FROM WRITING TO SPEECH

Weber (1990, p. 50) states that sight translation requires rapid analysis of text; rapid conversion of information from one language to another, while avoiding word-for-word translation; and public speaking skills. Mikkelson and Willis (1993) state that sight translation should sound as if the interpreter is reading a document in the target language, which implies a smooth delivery devoid of hesitations and pauses.

Intuitively, one might think that a visual text may be a facilitating factor in interpreting from writing to speech, but Frash and Maksyutina (2008, as cited in Krapivkina, 2018, p. 696) claim that the visual anchorage is a hindrance rather than a facilitating factor as the text distracts the interpreters from focusing on meaning rather than words, so that the mere visual presence of this type of text causes risk of interference (Gile, 2009; Li, 2014; Sherve, Lacruz, & Angelone, 2011; Song, 2010). Frash and Maksyutina may be right in their claim but, according to some studies, this could also be explained as a problem for beginner interpreters—and not so much for those who are trained in interpreting from writing to speech and who, consequently, have highly developed reading skills, as trained interpreters perform better (Lee, Vandaele, & Bastin, 2012; Moser-Mercer, 1995).The reason why the authors here think that visual text can be more problematic for beginners in interpreting from writing to speech is that the same problem is seen when they train interpreters in simultaneous interpreting—they initially focus on words rather than on meaning, so that the training for simultaneous interpreting must involve a shift in focus from words to meaning or rather from words to larger chunks of text. Therefore, the authors here believe that the sight translation interpreters need to be trained to shift focus from words to meaning in the same manner as in simultaneous interpreting. The interpreter needs to be able to read the source text while interpreting to the other language. In order to produce smooth speech, the interpreter has to read ahead to identify the key words and units of translation while planning target-language expressions at the same time (Agrifoglio, 2004, p. 54). The interpreter has to extract enough information from the source text to reformulate it into meaningful units in the target language. The obvious answer to the question of what specific skills are required for interpreting from writing to speech, as opposed to interpreting, is in general reading skills.

The results of the studies conducted by Agrifoglio (2004) and Ivars (2009) show that sight translation is a complex and unique technique that places cognitive demands on the interpreter that are by no means less rigorous than those of simultaneous and consecutive interpreting. Sight translation is a complex task that involves many competences, e.g., reading, text-analytic, communicative, public speaking (Krapivkina, 2018), coordination of speech and translation (Wadensjö, 1998), and written and oral competences in the two languages used in each translation process. However, traditionally, sight translation is usually not a part of the interpreter-study curricula as a method in its own right (Sampaio, 2007). Furthermore, the dialogue-interpreter training mainly focuses on the way in which the interpreter manages and maintains

the verbal interactions between the primary participants, although it seems to overlook the importance of specific non-verbal aspects inherent in mediated interactions (Krystallidou, 2014). In addition, the verbal and non-verbal aspects of interpreting seem to be treated separately to a large extent (Galvano & Rodriguez, 2015). However, recent research with a multimodal focus studies how people communicate using combinations from the full repertoire of meaning-making resources, which are referred to as 'semiotic resources', as well as the effects of these uses (Felberg & Nilsen, 2017; Kress, 2010).

While writing this chapter, the authors also noticed that there is still a considerable research gap in the literature on interpreting from writing to speech. In particular, the research gap concerning the shift from the written to the spoken mode, with focus on the interpreters' choices and interaction with the interlocutors and on the listeners' perception and understanding, needs to be addressed. These issues are not connected to the well documented linguistic challenges, rather properties of the modal shift. There is a need for more knowledge about the best practices, in addition to further theoretical discussions related to these practices. With respect to future research, studies that research texts that are interpreted from writing to speech in health care and elsewhere are encouraged in order to develop the discussion on the translatability of these texts. In addition, there is a need for further discussion on sight translation when one of the two languages involved is a sign language (Cardinaletti, 2012).

INTERPRETING FROM WRITING TO SPEECH IN HEALTH CARE AND OTHER PUBLIC SERVICES

Interpreters traditionally interpret spoken discourse, a practice that is also reflected in the Code of Ethics that guides interpreters in Norway. According to this Norwegian Code of Ethics, interpreters shall render what is being said, without changing, adding, or omitting anything. Thus, interpreting from writing to speech—or what is written—is not included in the Code of Ethics.

Interpreting in health and other public sectors is, however, not only conducted by interpreters with training and education in the interpreting field. Unqualified interpreters present a serious obstacle to communication in the public sector in Norway, a situation that is challenging for both professionals and their clients (see, for example, IMDI, 2007; Nilsen, 2001, 2005, 2011). A 2012 report on interpreting at the university hospitals in Oslo (Linnestad & Buzungu, 2012) demonstrates that only approximately 10% of interpreting assignments are performed by a person with an appropriate interpreting competence. This report played an important role in the establishment of an internally organised interpreter-provider for the hospitals in Oslo, a measure that was taken in 2014 to improve the quality of interpreting. The aim of the interpreter-provider is to always use the best-qualified interpreters available, and their implementation has reversed the numbers from 2012 and increased the quality of interpreting services rapidly. According to the interpreter-providers' own statistics at the university hospitals in Oslo, 90% of their assignments are now conducted by qualified interpreters (Brandvold & Olssøn, 2018). The situation in other parts of the country, however, seems to have remained the same, with very low interpreting quality (IMDI, 2018).

It is also known that reading skills among interpreters vary significantly and that many of the interpreters in Norway lack sufficient reading skills, which represents a barrier for interpreters' performance and for the development of interpreting from writing to speech techniques (Nilsen & Monsrud, 2015). There is, thus, not only a need for training interpreters for interpreting in health care and other public sectors but also a specific need for training them in interpreting from writing to speech with a special focus on reading. This is most likely also the case in other countries.

The quality of interpreting from writing to speech, however, is not only a question of the interpreters' qualifications. It is also a question of the communicative goal of the text and of the text itself. The guidelines of the National Council on Interpreting in Health Care in the United States (2009, p. 6) highlight the importance of providing patients with information in a format that they are able to understand. This important point relates to the fact that some texts are not suitable for interpreting from writing to speech due to, for example, their information density. Based on interviews with interpreters in Norwegian hospitals, a description of these documents is provided below, along with the challenges that they represent. The interpreters also identified whether they believe that the patients understand the contents of these documents. The interpreters were not certain of this and expressed concerns about the quality of their own work due to insufficient preparation time and time pressure disturbing their performance. The texts that are unsuitable for interpreting from writing to speech are meant to be read and reread; they are not produced for listening and are, thus, not appropriate for interpreting from writing to speech. However, not accepting a task to interpret from writing to speech during an assignment on the basis of the text not being suitable for listening may be unreasonable in a given situation. Nevertheless, if accepting a task, the challenges must be made transparent for all parties in order for the interpreter to be able to compensate for the method's limitations. Both health care personnel and patients must be made aware of this method's limitations, which means that they must gain an understanding of the fact that the content of a text may be difficult to grasp or remember if presented orally. Ideally, the interpreter and the patient should be given extra time and other tools to secure their communication.

This chapter argues that interpreting from writing to speech needs to be treated as a unique interpreting method that requires special training. Furthermore, it is a method that is used across numerous sectors. It is argued that the method itself does not differ according to a specific domain of the public sector. From the perspective of the interpreting method, interpreting from writing to speech in health care is the same as in other public services. What differs between the sectors are the types of documents that are interpreted from writing to speech and how the interactions are organised. This is, however, a claim that should be further discussed based on cross-sectional research and knowledge about best practices.

INTERVIEWS WITH INTERPRETERS IN HEALTH SERVICES

Now that interpreting from writing to speech has been defined, described, and discussed in a general manner, this chapter turns to interpreting from writing to speech in the sphere of health services. To learn more about this topic, a small study was set up in the fall of 2018. In this study, focus group interviews (Frey & Fontana, 1991) are conducted with eight interpreters who are actively interpreting within the public sector in Norway, including the health services sphere, in order to obtain knowledge about their experiences with interpreting from writing to speech in health care.

The interpreters were recruited through the Norwegian Interpreters Organization by mail and through the social media platforms that are used by interpreters in Norway. The languages represented amongst the interviewed interpreters include Arabic, Kurdish, English, Polish, Russian, Serbian, and Spanish. All of the interpreters had formal training with at least 30 ECTS in interpreting. They all also had at least 200 hours of interpreting experience in the public sector, including the health service sphere. Furthermore, five of the eight interpreters had also participated in the course "Interpreting from writing to speech" at the Oslo Metropolitan University (15 ECTS).

In the interviews, the interpreters claim that interpreting from writing to speech in the health care sphere does not occur as often as, for example, in legal settings, where it is a part of almost every assignment, but that they also use this interpreting method in health care quite often. Four of the interpreters interviewed report that they often interpret from writing to speech and four report that they sometimes interpret from writing to speech, although it was not possible to establish exactly how often during the interviews. The interpreters also underline that interpreting from writing to speech in legal settings is more predictable, since they do it more often and are, consequently, more familiar with the different genres of the documents and their variation in the legal settings is not as broad as in the health sector. At the structural level, the interpreters wish for more information prior to beginning work on assignments in health care and think it is a good idea to have access to a digital document bank, with all the non-sensitive, standardized documents that are used in the different health settings, e.g., psychiatry, rehabilitation, hospital, doctors' office, etc. The digital document bank could, for example, include texts such as information leaflets, brochures, and diagnostic schemas.

The results from the interviews are consistent with the experiences the students refer to during interpreter training which is presented later in the chapter. In the following subsections, more details from the findings are presented under headings that are related to the questions discussed with the interpreters during the focus group interviews.

Document Types Interpreted from Writing to Speech in Health Care

During the interviews, the interpreters reported on different kinds of documents. The documents that the interpreters interpret from Norwegian writing to target language speech can be divided into three types:

1. Brochures, instructions, and information materials. The information materials include, for example, instructions on how to prepare for or to follow up surgery. Another example is the written information about how to follow up with medication, for example, the wording on a medicine bottle or a prescription.
2. Forms. There are different kinds of forms that the patients must fill in.
3. Various referrals, reports, and evaluations after investigations, examinations, and test results.

The documents interpreted to Norwegian are usually test-results from examinations or procedures performed abroad (CT, MRI) or documentation on previous medical history detailing innate or chronical medical conditions. The latter are typically written documents that the foreign language speaker is familiar with and must be interpreted to the medical practitioner for their use.

The interpreters are very concerned about careful interpreting that does not distort the content of the text. Since some of the information the texts contain might not be familiar to the interpreter, there are occasions on which the interpreter discusses, for example, what certain abbreviations might refer to with the health care personnel or the patients.

Challenges Related to Interpreting from Writing to Speech in Health Care

When encountering interpreting from writing to speech in health care settings, the interpreters report that they had never been prepared or provided with information about interpreting from writing to speech beforehand. Thus, in the health care settings in Norway, it seems that interpreting from writing to speech

is an implied part of the interpreting task and is not considered a method that has specific challenges, thus requiring special training and preparation. The interpreters all highlight that being able to prepare for interpreting from writing to speech would improve the quality of their interpretation and probably also save time.

The interpreters provide suggestions on how to improve the practice of interpreting from writing to speech. When ordering an interpreter, the interpreter could, for example, receive information about the relevant standard documents related to the assignment. This would give the interpreter time to look through documents prior to beginning work on the assignment, which would also improve the quality of interpreting. One of the interpreters reports that she was once given time to prepare, when she was interpreting in a situation testing dementia, and she explains that this is a situation in which the patient's language use plays an important role in the diagnosis. Otherwise, the interpreters seem to agree that best practice is difficult to standardize in guidelines, as each situation has its own particularities and needs to be dealt with in cooperation with all the involved parties.

Some of the interpreters report an uneasiness when interpreting information material from writing to speech. The reason for this is that the information material is usually linguistically accessible and does not represent special difficulties but the information is meant to be read, reread, and taken home on many occasions—the information should last and serve as a reference point, but when it is interpreted into speech only the information is not retrievable. The interpreters consider it a better practice to make written translations for this type of material. Another aspect of reading the information material or other comprehensive documents is that hospitals and doctors are pressured on time. The interpreters describe these situations as challenging in more ways: they feel that they need to be efficient and speed up but that there is no time to read through the text beforehand, both of which affect the quality of the interpretation, so that they ultimately question whether this delivers secure communication and whether the patient is able to follow the interpreting from writing to speech. In this vein, the interpreters also report that they usually explain the limitations of this method to both the health personnel and the patients. Although the interpreters express these challenges as pressure on the interpreter's role, it can be understood as a modal challenge that intersect with the role; the interpreter understands that the interpreting method has cognitive limitations, not for the interpreter, but for the listener. According to the Code of Ethics this is not the interpreter's responsibility, however by taking upon such task, the responsibility becomes a "stowaway". This also links to the next issue of change in the interactional pattern that occurs because of the mode shift.

One of the other concerns the interpreters express through the interviews relates to the responsibility attached to the communication in this sphere. Previous research on interpreting from writing to speech in asylum interviews, also reports on the changes in the patterns of engagement between the communicating parties (Felberg, 2015). The interpreters in Felberg's study voice concerns related to the interpreter's role and their interaction with the public service employees. Through the act of handing over a written document to be interpreted from writing to speech, the public service employee usually effectively withdraws from the institutional dialogue. Thus, they also seem to hand over to the interpreter some of their responsibility in this public service encounter. The written document indirectly communicates the public service employee's message and the constellation changes from the initial three communication participants to two communication participants plus a document. The document becomes the foreground of the encounter and influences it. At the same time, according to the interpreters, the public service employees sometimes exclude themselves from the interaction because they have difficulty following what is being interpreted (Felberg, 2015). In this particular setting, the report, which is usually several

pages in length, is interpreted from writing to speech at the end of the day, and the interpreters express concern about the listeners' lack of attention that often results in them not reacting to—for the interpreter—obvious mistakes. The interpreters also express similar concern about communication, when interpreting from writing to speech in health care, with respect to attention and inclusion—from both parties in the interaction.

Forms

According to the interviewed interpreters, the practice for filling in forms varies. Some health care workers sit with the patients and assist in the process of filling out of forms so that the interpreter can ask questions when a patient is unsure about a point in the form. This is considered a better practice than a situation in which a health care worker leaves a patient with an interpreter so that he or she can do something else.

Sometimes the interpreter is asked to interpret forms in the waiting room. The interpreters agreed that this is not an ideal situation. When in the waiting room, other people can hear what the interpreter and patient are talking about. This threatens patient privacy because it is never certain who understands which language in a waiting room. Other times, the patient and the interpreter are provided with a private room but without the health care worker—the interpreter must then encourage the patient to ask questions at a later stage. This is not seen as a great problem, although the situation creates more pressure for the interpreter's role and responsibility.

One interpreter stated that she does not consider filling in the forms for the patient to be the interpreter's responsibility and usually refuses to do so. There is a discussion on whether interpreting writing to speech or speech to writing is the responsibility of an interpreter. Interpreters seem able to accept such tasks and to usually find ways not to get involved beyond what they can justify within the frames of the Code of Ethics—which means considering how much responsibility to take and assessing the document, the time available and their own competences. For the sake of understanding, when sitting alone with the patients, the interpreters express greater responsibility for the texts and explain that they tend to ensure their interpretation by using, for example, more variants of a word or expression when interpreting from writing to speech without the health care personnel present in the situation. In a multimodal perspective, the pressure on the role seems to be perceived as bigger the more verbalisation is necessary from the source to the target; a form to be filled in is often complex in its layout and has less verbal content and more graphic resources. This requires verbal explication that interpreters consider as on the verge of their responsibility.

In the interviews, the diagnoses forms in psychological and psychiatric investigations were mentioned specifically because these forms include many detailed nuances that are related to emotions. It can be particularly challenging to find these nuances in another language on the spot. Vocabulary related to expressions for happiness could, for example, be any of the following: cheerful, happy, lively, in high spirits, merry, vibrant, thrilled, enthusiastic, energetic, overjoyed, fine, glad, pleased, satisfied, etc. The interpreters say that this vocabulary needs to be prepared beforehand, since these linguistic nuances are particularly important in diagnostic work. The nuances that are at an appropriate level for these forms are particularly difficult to find under time constraints. Since these forms are standard diagnostic tools, they could be made accessible to the interpreters beforehand.

Only one interpreter stated that she had interpreted from writing to speech on the phone for an assignment in health care. In this case, she received the form beforehand. Interpreting from writing to speech

does not, therefore, seem to occur remotely often—but, as reported by one interpreter, interpreters need to be prepared for this possibility. Consequently, it is probably a good idea for interpreters to ask ahead of time whether an assignment includes interpreting from writing to speech and, if it does, to ask for the document(s) beforehand so that the assignment can be properly prepared.

Reports and Evaluations

When talking about reports and evaluations, the interpreters seemed to agree that they are challenging, not so much in terms of length, although that can also be an issue, but more with respect to the complexity related to their information density, sentence construction and terminology. These are expert statements, and the interpreters prefer either to be prepared or to be assisted with explanations from the person responsible for the document, who can present it and explain things when necessary. In health care settings, it is hard to anticipate what to expect before an assignment due to the fact that health care is a very broad category.

Interpreter Training

When asked about interpreter training, the interpreters were of the opinion that training should include general knowledge about interpreting written texts and that a method, not a specific public sector domain, should be the starting point of training. This does not mean that the interviewed interpreters claimed that they do not need domain-specific knowledge about health care and legal settings, for example, but it indicates that the focus should be on how to conduct the interpreting from writing to speech with different texts in various situations. The interpreters stated that the method they use is the same, regardless of whether it is used during a police interview or a doctor consultation. What varies are the text genres and the situations in which they are interpreted. An important difference regarding situations is the number of involved participants. Interpreting for only two persons, a nurse and a patient or a police officer and a suspect, for instance, is easier than interpreting in situations with many participants. Furthermore, in hospitals, the interpreters sometimes meet with many participants, as they do in court rooms. Typically, these are interdisciplinary meetings in which a patient's diagnosis or treatment is discussed. In addition, the interpreters noted that, from their perspective, the line between the different public sectors is not that clear. Medical records and psychological evaluations are oftentimes read in court, and in the interpreter-mediated court proceedings, these documents are interpreted from writing to speech. The main differences between interpreting in health care versus other settings are the pressures of time and the lack of task preparation possibilities. Furthermore, the interpreters stated that the texts in health care are usually shorter than those in court, but that they are also more unpredictable due to the numerous diagnoses patients may have.

The interpreters noted that interpreting training should also include strategies on how to argue for better working conditions. In some situations, the interpreters said that they find it hard to reject a text that they think is not suitable for interpreting from writing to speech. These are texts that are so complex that the demand on the listener is too high. It is a waste of time to interpret these texts, and they may represent a danger for the patient's health because the interpreters believe that they are impossible to grasp in an oral form. They are meant to be studied and reread. When expected to interpret such texts, interpreters related that they sometimes compromise their own standards in order to satisfy the expecta-

tions of health care personnel. They want to appear qualified and able to handle challenges and, on some occasions, have a fear of losing face.

For the training of interpreters, the interviewed interpreters also underlined the importance of practicing using current texts from different public sectors. For health care, it is important that the training includes, for example, the different types of documents that they talk about in the interviews.

Interpreters choose how to mediate on the basis of the communicative goal of the text in context and by relying on their text-analytical skills and their interpreting skills. When interpreting from speech to speech, the interpreter relies on non-verbal resources such as prosody and facial expressions. When mediating a written text, the interpreter relies on the textual resources such as punctuation and layout. Working with texts on the bases of semiotic resources and multimodality in interaction offers the interpreters a theoretical framework to justify what would otherwise possibly be considered adding, changing or omitting text. This knowledge supports the interpreter when choosing which semiotic resources to rely on in a particular setting through a quick analysis of the situation and by choosing a solution that both supports communicative goals and respects the Code of Ethics.

TEACHING INTERPRETING FROM WRITING TO SPEECH

At Oslo Metropolitan University, a bachelor's programme in Public Sector Interpreting is offered, the courses for which the authors of this chapter have participated in developing. This programme includes an introduction to interpreting in the public sector and focuses on consecutive interpreting (30 ECTS), interpreting from writing to speech (15 ECTS), the interpreter's communicative competence (15 ECTS), the history of translation studies (15 ECTS), interpreting monologues, memory, and note taking (30 ECTS), simultaneous interpreting (15 ECTS), the cultural aspects of interpreting (15 ECTS), remote interpreting (15 ECTS), interpreting in complex meetings (15 ECTS) and a bachelor's thesis (15 ECTS).

The students in the programme come from a variety of backgrounds. A typical group of interpreting students includes a mix of students from different immigrant communities and from Norway's majority population group, as well as the students from varied educational backgrounds. These students have also had varying private and professional experiences with interpreting (Tiselius, 2015, p. 1). Most of our students work as interpreters when studying. Prior to being admitted to the programme, the students' language skills in both languages are tested. During the BA programme, the students are responsible for developing their language competences individually and in groups.

The BA programme is experience based and centred on online activities and three two- or three-day seminars per university semester. The programme is offered in four languages at the time. The students' shared ground is the Norwegian language and the Norwegian public sector. Relevant Norwegian texts from the various sectors are used as the common starting point. The BA programme in Interpreting in the Public Sector at Oslo Metropolitan University draws on many theoretical perspectives. Recently, multimodal theory and social semiotics are shown to provide useful concepts for the discussion of the linguistic details in the interpreter students' interpreting performances. It is also understood, in line with the research on literacy, that the existing knowledge of discourse, genre, and stylistic variations improves comprehension while reading.

The course "Interpreting from writing to speech" provides the students with practical skills and theoretical knowledge related to interpreting from writing to speech in various situations. One of its main areas focuses on developing reading skills and text analytical skills. Theoretical knowledge includes

the perspectives from social semiotics and multimodality. Parallel with the course on communicative competences related to different aspects of interpreting, such as speech act theory, multimodal theory, social semiotics, and genre theory, the course on interpreting from writing to speech is in the second year of the bachelor programme.

The "Interpreting from writing to speech" curriculum, which includes various course content forms such as tests, lectures, and exercises, is based on the latest research, as well as on what the course authors believe are the best practices in interpreting from writing to speech. The assumption of best practice is built on knowledge from other scientific fields, e.g., semiotics and multimodality, as well as on the authors' own experiences as interpreter trainers and interpreters in public-sector services. The curriculum includes exercises taken from the health care domain, as a part of the public sector arena.

An important part of the course "Interpreting from writing to speech" is reading. The students are specifically taught about reading and are introduced to theories about reading, as it is the belief of the authors that students need to understand what reading, as a complex skill, is in order to improve it. In the following sections, the multimodal theory is briefly presented prior to some theoretical aspects of reading to which the students are introduced.

Multimodal Theory

When interpreting from writing to speech, an activity in which the two modes of writing and speech meet, the application of a multimodal approach seems logical and is in line with the turn to multimodal approaches to communication and interpreting in general. In particular, a multimodal approach proposes that meaning is constructed by using combinations of semiotic resources. Therefore, the students are introduced to the concept of modes and semiotic resources used in sight translation, both in written and spoken text, as well as to how a document, as an artefact, can function semiotically. These concepts provide students with the language that is needed to talk in detail about what they are doing when they are interpreting. Why is the interpreted text good and adequate? The answer is often that the interpreting student is able to find an appropriate combination of semiotic resources in the target language. The students discuss these semiotic resources amongst themselves in groups. The authors believe that these discussions are important because they raise the students' metalinguistic awareness and make them better able to monitor their own interpreting, to learn from their performances, and, if necessary, to argue their choices.

The multimodal perspective we apply builds on the perspective of Halliday's social functional linguistics (SFL) regarding how languages fulfil three meta functions in communication—representative, interactional and ideological meanings. Kress and Van Leeuven (1996) develop this perspective to account for other modes that explore other meaning-making semiotic resources in addition to language. This multimodal theory promotes an understanding of how different semiotic resources work together, not only as supplements to language but also through separate modes of communication, thus completing communicative actions (Norris, 2004). The semiotic resources include, for example, embodied (gestures, gaze), visual (images, layout, print) and aural (voice, prosody) resources, depending on the domain of representation. As a method of analysis, social semiotics focuses on analysing and describing the semiotic resources exploited in different contexts and on developing ways that show how these are organised to create meaning together. The intermingling of modes and languages, as well as the mere presence of the document in sight translation, creates a complex interactional ecology (Davitti & Pasquandrea, 2017). What is evident in transcription, for example, is that writing cannot capture all the semiotic features in

speech and that annotations need to be done on prosodic features in order for meaning not to be lost (Chakhachiro, 2016).The same is the case when writing is mediated into speech; the mode shift demands exploitation of other semiotic resources.

Labelling writing and speech under "language" disguises the differences between the two modes (Kress, 2010; Scollon & Scollon, 2009). Writing and speech differ in production, exploitation of semiotic resources, and perception. Writing is spatially displayed through graphics on paper, screen, or other media. Readers can usually address a written text by shaping it according to their own interests (Kress, 2010). This means that readers can skip parts of the text and read it recursively and/or several times. In speech, in face-to-face interactions, language is exploited together with sound, prosody, gestures, facial expressions, gaze, proximity and space (Kress, 2010).

More specifically, since writing and speech differ in what they involve (reading vs. listening) as well as in which cohesive resources are exploited and how, the modal shift in interpreting from writing to speech might affect perception and, thus, understanding and participation in interactions. In written texts, the layout is a cohesive resource and establishes balance in the text, while in spoken texts the rhythm has a similar function. Van Leeuwen (2005, p. 181) argues that perception of both balance and rhythm are biologically given and vital human interactions that link to the perception of coherence. The difference between cohesion and coherence is that the cohesion is in the text while coherence is affected also by the perceiver's competence and knowledge. Cohesion in itself does not necessarily create coherence, although cohesion is considered important in texts. Not only the mode shift but also the necessary shift in interpreting from writing to speech and from one language to another involves the risk of disturbing textual cohesion. A recent study (Havnen, forthcoming) shows that interpreter competence, as well as text characteristics, influence cohesion in texts that are interpreted from writing to speech. Interpreting from writing to speech is particularly vulnerable to verbal and grammatical interference (Agrifoglio, 2004; Akbari, 2017; Shreve, Angelone, & Lacruz, 2010).

When interpreting from writing to speech, the level of interaction between the listener and the interpreter influences the listener's ability to understand the text. Interpreters report that this interaction is important. While interpreting from writing to speech, they maintain eye contact with the listener and try to adapt the speed and pauses to the listener. This interactional perspective is important in all kinds of interpreting but is of particular importance in interpreting from writing to speech because of the differences between the written and oral texts, as well as the change in the interactional pattern from a triadic to a more dyadic exchange in which the documents 'speak' through interpreters.

Reading in Interpreting from Writing to Speech

One of the first challenges that many students face during training programmes are their reading skills. The ability to assess documents and interpret them from writing to speech as an interpreter requires highly developed reading abilities. Results from previous research in Norway show that 70% of the interpreters tested did not have sufficient skills in one central component of reading, namely, decoding; that there is vast variation in skills; and that decoding speeds vary according to the interpreters' linguistic backgrounds (Nilsen & Monsrud, 2015). The results of the tests of the interpreters' reading skills conducted are a strong indication of the specific need for training in reading skills amongst many public sector interpreters. Also, the testing performed at the beginning of the 'Interpreting from Writing to Speech' course the authors teach, suggests that many of the interpreter students are surprisingly slow at reading. In addition to slow readers, there are many students who have studied at the university level

and have read a significant amount. Even these students, with much prior reading experience, expressed that they benefitted from the introduction of strategic reading skills and from learning how to activate prior knowledge, locate key words, predict texts, visualise, summarise, etc. When focusing on reading, some of them reported that they also started reading more in their other languages while applying the acquired strategies and analytical tools.

Hence, what are the sufficient and insufficient reading skills in this context? It is obvious that a student interpreter must be able to read at some level, but how well must a student interpreter be able to read in order to benefit from the interpreting from writing to speech exercises? How well must a student interpreter be able to read in order to learn how to interpret from writing to speech fluently? In an earlier article (Nilsen & Monsrud, 2015), one of the authors of this chapter argues that the student interpreters should aim to have highly automated reading skills because only by possessing such skills can an interpreter concentrate fully on interpreting from writing to speech without being hindered by difficulties relating to decoding or understanding a text.

Exercises and Training

Some of the exercises that are used for training interpreting from writing to speech are similar to those suggested for conference interpreters—reformulation and making summaries (Weber, 1990; Ersouzlo, 2005; Krapivkina, 2018). Other exercises are developed to cover the interactional aspects of interpreting from writing to speech and focus on the listener's perspective. As also suggested by Vargas-Upi (2019, p. 12), the students are trained using role-play situations in which they are provided with a specific task and a clear context. When taking part in role-plays, the students discover not only linguistic issues but also the works of gaze, positioning, handling of the documents, etc., and how these extra linguistic features come into play in the process of interpreting from writing to speech. The role-plays are also ideal opportunities for the students to learn from each other. In these role-plays, the students interpret texts for each other and set the roles up as realistically as possible. For example, a role-play scenario may create the following situation: a health consultation with a doctor in which the interpreter has to interpret a medical record or an information leaflet before an operation. In addition to role-plays, the students are also trained in the language lab so that they can evaluate their own performances through transcriptions, analyses and repeated listening.

Other practical exercises include text analyses, reading aloud in both languages and interpreting written texts from both languages. These are done for the purpose of self-evaluation (language lab) and/or reflection, peer evaluation, reflective discussions and discussions in groups. The Oslo Metropolitan university training of public sector interpreters does not include language courses, and presupposes high linguistic skills in both languages when students are admitted. The linguistic skills in both languages are tested before admission. We do not have teachers in the languages offered, thus both peer work in language groups and individual work with texts in the other language is expected. The tasks are developed, and the focus of the analyses/discussions is described—in one interpreting task with peers, the students are asked to, for example, evaluate prosody and fluency, or contact and coordination, or grammar and interference, and so on. It is important to have faculty lead these discussions, as the students can very easily end up discussing terminology—which is, of course, also important when that is the task. While listening to somebody else or to themselves reading aloud or interpreting, the students experience what it is like to be a listener, the goal being to increase sensitivity towards their own production. When interviewing the interpreters for the purpose of this chapter, an interpreter who is both a translator and

an interpreter reported that this course was an eye-opener for her; it taught her to attend to the needs of listeners and suggested that her background as a translator gave her a tendency to be more source-oriented when interpreting written texts.

During the course, the students are exposed to a large variety of texts and are assigned reading on three different levels according to the results of a reading test. They get reading tasks and try out different reading strategies for various analytic purposes. They also learn strategic reading for the purpose of interpreting—e.g., how to read ahead, how to maintain and get a quick overview of the text by moving their sight left and right of the middle, etc.

The students also engage in discussions on ethical dilemmas and responsibility in interactions. They explore how to use theoretical knowledge to explain their need for time to read a text or to obtain a text in advance. They also explore how to suggest other methods if they are not competent to interpret certain text, or if it is not advisable to use interpreting from writing to speech as a method based on the text complexity, length or use of media, or if not appropriate for the communicative purpose. At the end of the course, the students' reading skills and the skills for interpreting from writing to speech are tested.

Text Analyses and Exploring Semiotic Resources

As part of the reading program, the students are encouraged not only to read but also to analyse the text from different perspectives. They learn to explore how semiotic resources are exploited to create meaning with regards to genre, linguistic features, layout, images, and illustrations. These texts represent interpersonal, representative, and ideological meanings. By focusing on these aspects, the students are asked how the written resources at hand can be represented in speech. This is explored, through a dialogical approach: how the modes have different affordances and limitations and how communication is affected by the interpreting method. The issues that are focused on do not only relate to the process of interpreting from writing to speech but also to the challenges experienced with respect to the listener's accessibility to texts that are interpreted from writing to speech, as well as the interpreter's evaluations of the text's suitability for interpreting from writing to speech.

Understanding how language works, both through written and spoken modes and together with other modes, is important in order for interpreters to be able to identify and convey meaning. An overall understanding of how a mode affects communication in general is also at the centre of the authors' practical teaching. The course, therefore, theorises and discusses the shift from writing to speech. What does the interpreter have to convey from the written text into speech to make the text comprehensible in the spoken mode and how can it be done? What are the available strategies that can be justified while still respecting the Code of Ethics by not adding to or deducting from any of the text's content? The multimodal theory offers a framework of understanding that verbalising does not necessarily mean adding anything to the text and that some resources, which are necessary in the written text, might not be needed to express the equivalent meaning in the spoken text and vice versa.

Interpreting from writing to speech is, of course, not strictly related to writing in the sense that writing only includes letters, words, and sentences. Written documents often also include other semiotic resources, such as bullet points, space, logos, etc. An example of this is interpreting headlines in a document, for example, a headline that says "Health." An adequate rendition of this headline in speech could be "The next passage is about health." In other words, information is not only found in the text itself but also in its structure, which may consequently also need to be interpreted from writing to speech.

In a recent study that one of the authors of this chapter conducted at Oslo Metropolitan University, how interpreters render written semiotic resources is examined (Felberg & Nilsen, 2017). The participants in the experiment had not yet taken the sight translation course, and the findings from the study have influenced the course curriculum. One finding from this study is that the interpreters interpret written semiotic resources in different ways; the text they interpreted into speech contained elements, such as quotation marks and different types of bulleted lists, that contribute to meaning-making. Interpreter 1 in this study used the words "Quote; end of quote", while the other two interpreters used their hands to gesture quotation marks. Interpreter 2 used one hand, while Interpreter 3 used both hands. None of the interpreters said "citing" or reformulated "said that…", which are also possible choices but might be perceived as adding since it is not verbally expressed. From a multimodal perspective, though, this would not be considered adding, rather "doing the same" in another mode. Another element that is often found in official documents are bullet points. When it came to rendering bullet points/lists, Interpreters 2 and 3 used their fingers to simulate counting. Interpreter 2 used this strategy consistently, while Interpreter 3 used it on one occasion only, and Interpreter 1 did not use gestures. Her hands were occupied holding the document. She indicated lists by the tone of her voice and pauses. Again, there is a reluctance to verbalise, but the need for expressing meaning potential still remains. The interpreters proved to be quite creative in how they exploited the available resources, but they were often not conscious of their strategies (Feldberg & Nilsen, 2017).

The theoretical knowledge and concepts that were introduced to the students were not only related to analysing the source texts but also to how interpreters can mediate semiotic resources in their renditions, as well as exploit resources such as the written document, body posture and gaze in an interactional manner (Felberg & Nilsen, 2017). In sum, the goal is to strengthen the student interpreter's professional and strategic competence in the various settings in which they interpret and to understand the potentials and limitations of the interpreting method.

SOLUTIONS AND RECOMMENDATIONS

Based on the knowledge that is presented in this chapter, sight translation is better described under the term interpreting from writing to speech, because this method involves a shift from the written to the oral mode. This shift is the most salient feature of the method. Furthermore, the term interpreting is preferred to the term translation, because it draws attention to the listener's perspective—and the listener is the one who receives the text in an oral form. The text must be adapted to an oral form, a form that is not only translated but converted from writing to speech.

Of special interest for the inquiry here is whether interpreting from writing to speech in the health care sector differs from interpreting from writing to speech in other domains and, if so, in what manner? It is argued that interpreting from writing to speech in the health sector in Norway does not differ from that in the other public sectors. In other words, the interpreting method is the same and whether it is the preferable method in a particular situation must be evaluated for each specific case—on the bases of the text, the interpreter's competence, and the communicative goal. What does differ between the sectors, however, are the type of documents that are subject to interpreting from writing to speech and the translatability of these documents. Thus, a general course in interpreting from writing to speech is recommended – a course that includes texts from various contexts in the public sector.

FUTURE RESEARCH DIRECTIONS

Further investigation of the exploitation of the semiotic resources in the process of interpreting is recommended. In particular, more research is needed that relates to how interpreters combine their semiotic resources to construct their renditions and to whether the meaning of the text is preserved. There is also a need for more research to take the perspective of the listener and to examine how well the interpreting functions for the listener. There is also a need to explore how interpreting from writing to speech affects communication, with the shifting of focus between the spoken interaction and the written artefact, and some responsibility moved from one primary part to the interpreter. The strategies that the interpreter adopts to balance this position within the framework of the professional Code of Ethics is also worth investigating.

CONCLUSION

In this chapter, updated knowledge on interpreting from writing to speech is presented. This knowledge is based on international research and on the authors' own general knowledge about the practices within the public sector in Norway and, in particular, within its health services sphere. By presenting the current practices in Norway, the authors hope to encourage their colleagues to share the practices in other countries so that collaborative learning can take place, and that, perhaps, even some cross-national studies can be conducted. The practices are certain to vary much from country to country.

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KEY TERMS AND DEFINITIONS

Interpreting From Writing to Speech: One of the basic interpreting methods used in Public sectors.

Modes: Modes refer to a set of socially and culturally shaped resources for making meaning. Examples of modes include writing and speech.

Multimodality: Multimodality provides a framework for the analysis of visual, aural, embodied, and spatial aspects of communication, and the relationships between these modes.

Public Service Interpreting: Public service interpreting enables national and regional authorities to communicate with persons with a migrant and/or refugee background who do not speak or understand the national language(s) (sufficiently well), in order to screen their status as (potential) asylum seekers or to allow them to have access to public services such as health care, municipal and police services. (European Commission).

Sight Translation: Sight translation is an interpreting method that involves a shift from the written to the spoken mode.

Social Semiotics: As a method of analysis, social semiotics focuses on analysing and describing the semiotic resources exploited in different contexts and on developing ways that show how these are organised to create meaning together.

Chapter 17
In Through the Looking Glass: The Discord Between Practice and Education

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ABSTRACT

Traditional interpreter education programs were designed for conference interpreting markets. With the introduction of dialogue interpreting, some portion of the educational content was then allotted to public service interpreting and specialized settings became more prominent, programs then added courses to place more attention on specific contexts. In the last decade researchers began to view healthcare interpreting as a specialization of interpreting, and not just interpreting in a different setting. This chapter will review the evolution of the healthcare interpreter's role in the context of alignment between education and workplace reality in Canada. The results of this review demonstrate that the work expectations of healthcare interpreters do not align with delineations of the interpreter as a language conduit nor with current educational programs and recommends a more robust and situated pedagogical schema that includes ongoing and deliberate continuing education as an interim measure to mitigate tensions between student and practitioner, theory and practice.

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INTRODUCTION

The role of the interpreter in healthcare settings has been in a constant state of evolution from the moment of its ad-hoc advent to current day. The establishment of designated titles (healthcare interpreter, medical interpreter, etc.), ensuing standards of practice and certification programs existing in some countries have not prevented this ongoing transformation. This is not to say that the role is lacking robust qualifications, clearly defined duties or expected performance outcomes, instead that continual states of ambiguity and redefinitions of practice and purpose have resulted in a distorted mirror image of the original, and where the role is experienced "through the looking glass." Interpreters who work in healthcare settings regularly face challenges, often unanticipated, that cause a dissonance between role definition and situational pull that brings into question the presentation of their role. Traditional interpreter education programs designed for the conference interpreter in mind, and a linear conduit model of message transmission, require assessment and transformation if they are to equip the interpreter to work in healthcare settings. For example, the demand for collaborative intermediation or the need for intervention is a common occurrence in healthcare settings (Angelelli, 2004b, Bischoff, Kurth, & Henley, 2012, Leanz, 2005, Katan, 2012). All interpreter-mediated settings have their dynamics and challenges. Intercultural and interpersonal communication are amplified in medical settings, as a result of factors that influence the encounter and that are not often found in other interpreter-involved settings, or at least not found to the same level of intensity. The context of healthcare interpreting may quickly transform what interpreters were taught in class to little more than guidelines for best-case scenarios. These ambiguous spaces, while the concern of ongoing research, also leave the role open to subjective revisionism, facilitating a definition or redefinition of the function of the interpreter's role to a host of characters.

While advances have taken place in recent years with five certification schemas worldwide, and an upcoming ISO standard on Interpreting in Healthcare Settings (ISO TC37/SC5), along with several other standards of practice that touch upon specialized settings, there is still a very large chasm between these significant improvements and educational programs for interpreters, where the focus is still primarily on teaching the most basic interpreting skills and terminology, and have not expanded to other core competencies (Tryuk, 2015, Albl-Mikasa, Glatz, Hofer, & Sleptsova, 2015). Moreover, the fundamental conceptualization of the healthcare interpreter still models that of language conduit engaged in the act of linear message transmission. This is evidenced by the current interpreter education courses that "tend to be structured around modes of interpreting (consecutive – only sometimes dialogue – then simultaneous) where the ultimate aim is becoming proficient in conference interpreting. There is little room on these programs for variety in kinds of professional interpreting" (Kelly, 2017, p.28). This lack of alignment between classroom content and real-world requirements, along with a lack of consensus on role and purpose has resulted in a myriad of interpreter education programs that span the range from 40-hour community-based training to undergraduate programs that provide modules on interpreting in healthcare settings within their Translation and Interpreting programs. In many cases, programs that continue to perpetuate the traditional archetype of the interpreter, seem more like ad-hoc responses to the practice needs of interpreters in healthcare settings, rather than an authentic and deliberate approach to the role. Fundamentally, it's because such methods continue to ignore the underlying need for a paradigmatic shift in pedagogy in relation to the specialized setting of healthcare interpreting.

This chapter will address how the primary role of the interpreter as a communication facilitator has deviated from a strict adherence to the conduit model in healthcare settings, and the implications of this transformation for interpreter education. The chapter will also explore how the application of the role in such settings is determined by a progression of factors and conditions that contextualize the communication process as well as the relationships between the participants. Finally, this chapter examines how the current pedagogical framework lacks critical real-life underpinnings for interpreting in the specialized setting of healthcare. It concludes by recommending the implementation of a multipronged schema for both the interim and long-term timeline. This chapter is limited to Canadian experience.

BACKGROUND

Interpreting services at the community level in Canada gained prominence in the mid 1970's, following the demographic changes evidenced in the previous decades, when immigration not only increased in numbers but also in diversity as a direct result of major changes to Canada's immigration legislation. Traditionally immigrant populations had origins in the British Isles, Western Europe and the U.S, however, legislative changes to the Canada's immigration policies opened up opportunities to populations from an increasingly diverse list of source countries from the Caribbean, the Americas, all regions of Africa, Asia, the Middle East, Oceania and other regions (Statistics Canada, 2016). This diversification of source countries led to a cultural and linguistic heterogenous population and subsequently challenges to both the provision and accessibility of public services.

In the beginning, if there ever were a formal 'beginning', those that acted as the linguistic bridge for newcomers were often bilingual volunteers that were both formally assembled under the auspices of a community or immigrant services agency, or simply provided assistance informally through a network of friends of community members. There were no commonly stated expectations as to how the work was done, what the role was before, during or after a session, nor were there any ethical standards of practice articulated. Additionally, there were no mechanisms in place that validated competencies of the volunteers, and any training available was typically workshop-based, orientation style instruction. This informal, ad hoc, and completely unregulated practice in language access for minority language speakers was the norm for many years, however, advances have been seen, primarily in the major urban areas, such as Toronto, Montreal, Winnipeg, Vancouver, and other regions. An emerging awareness of the important work done by these 'interpreters' in the community began and along with it, debates on what an interpreter in public service contexts was meant to undertake. Initially the narratives positioned the work of the interpreter in the community as distinct from that done in courts or at the conference level, speculating on the impact that specialized settings lay on the role. In the US, there were similar patterns, and as Downing and Helms Tillery wrote in 1992:

Community interpreting is a specialty in itself, apart from courtroom or conference interpreting. Com-munity interpreters handle the tasks of interpreting in a variety of community situations. including police and (non-courtroom) legal encounters, schools (parent-teacher conferences), public safety, employment interviews, and community agency services, as well as health and mental health

care settings. In this country [US] in particular, individuals with few or no qualifications beyond their ability to speak the languages in question have often been called upon to serve in the role of interpreter in these community settings. These 'lay interpreters' are often workers pulled away from other jobs when needed, or friends and relatives, including minor children of the client. (p. 9)

Across the land, this role of bridging the language gap was alternately designated as either a language conduit, a formal and disengaged language assistant, to cultural navigator, a more involved cultural facilitator and helper that provided support to both the clients and service providers. A variety of initiatives and projects began to emerge to examine the community interpreting landscape and how to delineate and advance it. These initiatives found ground principally mid 1980's and continued throughout the 1990's when some of the most seminal activities took shape, such as the establishment of the Healthcare Interpretation Network (HIN) in Ontario in 1990, which published the National Standards Guide for Community Interpreting Services, and the founding of Critical Link Canada (now Critical Link International) in 1992. From 1994 – 1996, the Health Care Interpreter Partnership Project, a collaborative initiative funded by a provincial health sciences research grant, brought together community and institutional health care services, language service provers and the post-secondary provider of interpreter training programs and culminated in the very first set of standards for health care interpreters and for professionals working with interpreters (Niels Agger-Gupta, 2001, p. 17).

Canadian Events

- Critical Link Canada (1992)
- Critical Link Conferences – Ottawa (1995), Vancouver (1998) and Montreal (2001)
- The Health Care Interpreter Partnership Project (1996 - 1998)
- The Development and Implementation of the Medical Interpreter Program (Vancouver Community College, BC 1998)
- The Development and Implementation of the Language Interpreter Training Program (LITP) – (Ministry of Citizenship and Immigration, Ontario, 2002)
- The Strengthening Access to Primary Health Care Project (2003 - 2006)
- The National Standards Guide for Community Interpreting Services – Healthcare Interpreter Network (2007)
- The Canadian Coalition on Community Interpreting (2013)
- Certification Exams for Medical Interpreter and Community Interpreter- Canadian Translators, Terminologists and Interpreters Council (2015)

The Canadian Coalition on Community Interpreting was established under the leadership of Canadian Translators, Terminologists and Interpreters Council (CTTIC), with the aim to establish a certification process for community interpreting that paralleled that of court and conference interpreting, which had been in place for some time. In Canada reserved professional title protection for interpreters, translators and terminologist can only be obtained through a certification process overseen by the CTTIC and administered through provincial membership bodies. Canada does not have an official or nationally acknowledged accreditation protocol for individual practitioners.

The Canadian approach to interpreting done at the community level has traditionally been that of a generalist, inclusive of all public service settings, but the increasing attention and volume of work done in the healthcare sector has led to the acknowledgment for a change to the typology of interpreting settings. In 2014, and after years of advocacy on the part of the community interpreting sector, CTTIC established certification exams, for both a Certified Community Interpreter title as well as a Certified Medical Interpreter title, and thereby expanding the list of certified professional titles.

With these important initiatives, along with significant achievements, such as certified title protection and examination processes mentioned above, undeniably critical to the validation of any profession, attained, one could assume that the necessary educational and professional development mechanisms would also fall into place, to complete a professional pathway. However that was not the case, and in Canada the educational opportunities available to interpreters are limited at best, and non-existent in the main.

THE SHIFTING PICTURE OF THE INTERPRETER'S ROLE

Community interpreters are generalists who work across public services, but research has shown that the largest consumer of interpreting services for spoken language is the healthcare sector. The arena of healthcare, in its position as a major consumer of interpreting services, has been paramount in the design of the interpreter's role, and in the ongoing debate and shifting characterization of that function. Ideally, setting should not influence the fundamental identity of a professional role and practice so much so that it exposes it to external dictates, but factors inherent to the arena of healthcare interpreting permit for dispensations that touch upon the fundamental role of interpreter as is defined in current pedagogy and theory.

Since the 1950's, when interpreting was formalized with a professional title designation championed by the Association internationale des interprètes de conférence (AIIC), (Garciá-Beyaert, 2013), changing migration patterns experienced in later decades, shaped a linguistic and cultural diversity now found within and across many nations, promoted the advancement of a new brand of interpreting known as community or public service interpreting.

Initially, community interpreting was an ad-hoc response to these changing linguistic and cultural demographics and one that was "provided informally by family members (including children), friends, and untrained/untested bilingual [institutional] staff" (Roat & Crezee, 2015, p. 228). As it progressed and advanced as a division of interpreting, community interpreting began to draw much attention from scholars interested in understanding this new locus within the profession. Community interpreting adopted many of the central tenets of conference interpreting, given the absence of any other set of guiding principles, however, transposing a set of rules from one end of the interpreting continuum to the other resulted in a decontextualization of the practice by ignoring the realities of the field, neglecting practitioners who were left to face ethical dilemmas without sound guidance, and relinquishing the profession to definitions from external influences (Kalina, 2015, Hseih et al., 2013).

Although the conventional characterization of the interpreter is that of a language conduit, healthcare settings have had a significant influence in the movement to redefine the role, and considerable research has shifted the lens to a broader scope of the interpreter role, one that moves beyond that of message transmission (Angelelli, 2004, Wadensjo, 1998, Bischoff & Hudelson, 2010). Specifically, the healthcare domain has been a catalyst for change and evolution from interpreting as language transmission to interpreting as intercultural and interpersonal communication. It must be acknowledged that interpreting in healthcare settings is not unique in that "all situations in which interpreters facilitate communication are cases of intercultural communication" (Kondo, et al., 1997, p. 153), but nevertheless, the dynamic impact of cultural variables and cultural constructs becomes even more accentuated in healthcare settings, where cross-cultural concepts of health are layered by the emotional and traumatic experienced conditions of illness and wellness. Extensive research that has engaged interpreters as research subjects (Souza, 2016, Angelelli, 2004b) has confirmed that the denotative approach of strict role-boundary maintenance to interpreting has left interpreters to fend for themselves in the field as they "are swung from left to right on the pendulum of the various roles they fill and are required to navigate in many difficult situations with very little support – situations that go well beyond the demands of basic translation" (Brisset, Leanza, & Laforest, 2013, p. 138). And that interpreters working in the field make choices about role that do not always reflect their training, for example, McDowell, Messias, & Estrada (2011) found that "certain practice recommendations (e.g., that interpreters not interact with either party outside the context of the interpreted encounter; that all parties speak only in first person) often were not followed. In fact, these conventions actually were more a source of confusion and caused interruptions rather than facilitating direct communication between providers and clients" (p. 142).

The role of the healthcare interpreter role was dispatched before it was fully formed, and therefore subject to various definitions shaped by the situational context in which the role was placed and the needs of those in the power position. Research has demonstrated that the work that interpreters do can be markedly distinct from that which is defined by pedagogy (Souza, 2016, Brisset et al, 2013) and that interpreters will continue modifying the role according to the context and not theory (Dean & Pollard, 2001). Scholars have presented a typology of the interpreter role that is generated depending on the arrangement of multiple factors such as proximity, cooperative intention, formality, and power relationships, to highlight a few (Pöchhaker, 2004, Kaufert, 1999, Leanza, 2005) and also on the intercultural awareness and competence of both the institution and institutional personnel (Souza, 2016). Angelelli (2004) states that "...difference in perceptions that interpreters have of their roles is of essential importance to both the research and the practice of interpreting…the discovery of how interpreters perceive their role and, in turn, how this perception impacts cross-cultural communication is crucial" (p. 49). In an auto-ethnographical approach, using herself as a case study in the shifting practices of the interpreter role, Spinzi (2015) examined the "similarities and differences between Community/Public Service Interpreter and Cultural and Language Mediator" (p.123). Her conclusions ask the question: who has the right to decide on the role of the interpreter? Is it the practitioners themselves or "should a stricter job description be applied to interpreters working in the community?" (Spinzi, 2015, p. 123). Given the many characters that a language interpreter plays in healthcare settings, and which are assumed of them, conceivably a reconceptualization of the healthcare interpreter role, along with a more robust and situated pedagogical schema, is required.

Current dispatches and applications of the conduit-model seem to cause more friction than facility. And while there may be tentative agreement that a shift in ideology may perhaps be necessary, the reality is that the preparation, education and training for interpreters who work in healthcare settings continues to emulate and propagate an outdated notion of the role. As Angelelli (2004) found, "although codes of ethics and standards of practice rule that interpreters must be neutral, this task may be more easily said than done. It is no simple feat to escape the social processes to which all individuals are continuously exposed" (p.32).

Given this disconnect between training, expectations and the context, interpreters working in healthcare may address any incongruencies that they encounter in ways that may not align with current delineations of the interpreter as a language conduit (Bischoff et al., 2012, Angelelli, 2004b, Karliner, Jacobs, Chen, & Mutha, 2007), nor that work to facilitate and support their work in the field.

INTERPRETING AS INTERCULTURAL COMMUNICATION

As communication facilitators, healthcare interpreters serve a vital role in multicultural and multilingual societies. Moreover, as bilingual and bicultural resources, they connect service providers with service users while navigating cross-cultural issues, non-verbal communication and intercultural communication, and the "connotative meaning" of words (Ting-Toomey and Chung, 2012). While the traditional approach to interpreting, has been grounded in the theory of communication as transmission, where "communication is a process of sending and receiving messages or transferring information from one mind to another" (Craig, 1999, p. 125), the dynamic role of the interpreter in healthcare settings is better understood, and ostensibly more realistically situated, in the theory of communication as a constitutive part of the process, in which meaning is created together and shared (Craig, 1999, Dysart-Gale, 2005, Pöchhacker, 2013). Given the nature of intercultural contexts, where a common ground of understanding and awareness is not always available, and where multiple layers of personal and systems-based values can further complicate communication, linear transmission of message and meaning cannot be assumed. Therefore, the interpreter cannot fixate on one singular role because interpreters do not only translate the words of an interlocutor, "they interact in a peculiar triadic situation, [where] three (or more) people co-present with each other" (Linell, 1997, p. 55). Dysart-Gale (2009) states that the theoretical positioning of the interpreter within the paradigm of communication as transmission is what causes confusion and dissonance. Indeed, the interpreter in healthcare settings is perceived as occupying multiple roles, depending on the perspective and expectation of the healthcare practitioner (Hsieh et al., 2013) or of the institution (Hadziabdic et al., 2015). Acknowledging that interpreting is axiomatically more suitable to the constitutive, meaning-making model of communication permits more relevant models of education, training and professional development, and as Dysart-Gale (2009) states,

this perspective suggests that rather than attempting to subsume the conduit role and the more interactive advocate, clarifier, and cultural broker roles all together under the idealizations of the transmission model, interpreter theorists could articulate the various interactive roles in accordance with more suitable communication models. (p. 100)

The relationship between communicative modelling and interpreting cannot be ignored, "[c]orrelating interpreters' roles and communication characteristics …would give us a better understanding of the complex reality of interpretation and how relational issues affect its impact on patient care and health" (Brisset et al., 2012, 138). Additionally, Brisset et al., (2012) further found that "interpreters are more than communication helpers and Lifeworld representatives of the System: they are witnesses of how our institutions deal with socio-cultural and linguistic diversity" (pp. 138-139). Interpreters fulfill a broad range of functions all in aid of intercultural mediation and communication (Bischoff et al., 2012, Souza, 2016).

Interpreters act as communication facilitators in healthcare settings, folding together all forms of communication, the verbal and the non-verbal, and bridging barriers that are more intuitive than perceptible, to ensure that the intended message as communicated by the speaker is understood. Intercultural communication draws interpreters into a triadic encounter as they begin the process of a "symbolic exchange process whereby individuals from two (or more) different cultural communities attempt to negotiate shared meanings in an interactive situation within an embedded societal system" (Ting-Toomey & Chung, 2012 p. 24). Ting-Toomey and Chung (2012) describe this definition as being imbued with profound concepts of symbolic exchange, interdependent relationships, the simultaneous encoding and decoding that occurs between the sender and receiver, a definition of cultural community and the mutually understood observance of the goal of the encounter. When one considers the enormous task with which the interpreter in a healthcare setting is entrusted, one that involves such a multiplicity of factors and relationships, it becomes much more understandable that the interpreter's role in these encounters takes on a certain fluidity: "The concern with… interpreting in institutional settings strongly suggests the adoption of a wider (meso-)sociological perspective to analyze communication policies and power structures and the resulting constraints on language use in a given social institution" (Pöchhacker, 2013, p.68).

Therefore, interpreting across languages and cultures in a healthcare context is a complicated process of negotiation and shared meaning-making (Wadensjo, 1998, Angelilli, 2004b). Healthcare as a cultural setting is a high context interaction and can be a very confusing space for a communicative interaction that is conducted without clarification or intervention. Given the collaborative environment, which tends to blur the role boundaries among the participants, and the potentially perilous consequences of miscommunication, healthcare interpreters are situated in a very challenging communicative space. Adding to that challenge is the gamut of patients and families with their knapsacks replete with unpredictable educational, socio-economic, geographic, cultural and religious perspectives and incongruent forms of communicating (Angelelli, 2004b, Albl-Mikasa, 2015, Ting-Toomey & Chung, 2012). As Kondo et al., (1997) assert, the role of the healthcare interpreter is complicated at its very essence, because "the interpreter's task…is to help the parties perceive and decode, i.e. understand the meaning of the message that is being sent. What is involved here is a complex, multi-layered, dynamic process through which meaning is exchanged" (p. 153). As human beings in communication, we make choices about the amount of time we choose to spend "contextualizing another person…[a] certain amount of time is always necessary, so that the information that makes up the explicit portions of the message is neither inadequate nor excessive" (Hall, 1976, pp. 92 – 93). The contextualization of the message is not only extended to patients, but also the healthcare system as a benefactor when the additional roles that interpreters assume lead them to act as agents of integration (Albl-Mikasa, 2015, Bischoff, et al., 2012).

Often, it's the doctor who asks for intercultural explanation. In most situations the doctor asks, How [sic] is it in your culture? Then I have to explain our culture. First I ask the patient. When the patient has answered I give my own answer, how it is for me at home. Then the doctor understands the patient's background exactly. (Bischoff, et al., 2012, p. 11)

The body of knowledge that informs communication theory can significantly contribute to the conceptualization of the interpreter as a participant in a constitutive model of communication, (Dysart-Gale, 2005). Moreover, it can form a theoretical framework in which to examine the modified application of the interpreter role in healthcare settings and a means to examine current interpreter studies pedagogy and curriculum development, therefore "the move to translation being considered as an act of communication shaped by the context (often professional) in which it takes place has obvious implications for the design of translation curricula" (Kearns, 2012 p. 21). These extensions, then, of a broader conceptualization of the role of the interpreter in healthcare settings speak to fundamental elements largely lacking in current interpreter education models.

INTERVENTION AS COMMUNICATION FACILITATION

Consequently, and intrinsically, interpreting is an act of intercultural communication (Spencer-Oatey & Xing, 2009, Sakellariou, 2011). Interpreters mediate communication between two or more interlocutors who do not share a common language and by extension, in most cases do not share a common cultural framework or worldview. The disconnect that may occur between the delivery of an intended message and a received message as it filters through the noise of cultural diversity gives rise to the opportunities of demands for intervention as a means of message clarification and verification (Dean & Pollard, 2001). In fact, scholars have expanded on this function of the interpreter by proposing that there are layers to the interpreter's intervention (Katan, 2012). Therefore, both by design and operation, the community interpreter's role includes a characterization of intercultural intervener. Since culture and language are infinitely intertwined, the interpreter is routinely interpreting meaning that is articulated by verbal, culturally contextualized non-verbal communication and paralinguistic vocalizations (Albl-Mikasa, 2015). Interpreters are not only part of a larger, complex network overlapping cultural frameworks, cultural and professional values, and societal expectations, but also subject to influences of intrapersonal culture on decision-making processes when deliberating between standard practice, and intervention. For many interpreters, their role comes with many hats, and they see themselves as occupying more than the singular function of language conduit, leaving them subject to ethical dilemmas when in the field.

Definitions of health and wellness vary across cultures and that cultural can prescribe how one engages with the healthcare system (Schiavo, 2014, p.88). It is not surprising then that the healthcare domain has exerted considerable weight on the changing role of the interpreter. Given the complexity of healthcare and the possible deleterious consequences of poor understanding or miscommunication, interpreters feel the pull to intervene (Albl-Mikasa, 2015, Bischoff, et al., 2012) and to take on broader roles. The conduit model does not allow for an explanation of personal belief systems and cultural values (Kaufert, 1999, Putsch, 1985, Karliner, et al., 2007), factors that have a bearing

on health and health outcomes. As Putsch (1985) succinctly stated, "communication in health care is a complex issue. Language and cultural barriers complicate the situation" (p. 3344). The complications that Putsch speaks to are manifestations of intersecting factors that demand the interpreter to intervene or highlight the control that maintains professional boundaries. Contextualizing communication in the physical environment as well as the conceptual setting of cultural frameworks (Dysart-Gale, 2005, Brämberg & Dahlberg, 2013) means that interpreters act as active participants in the co-construction of meaning. In 1999, Kaufert's ethnographical study of 10 cancer patients, their families and caregivers, along with their Aboriginal language interpreters, demonstrated that in situations such as end-of-life care, where culture emerges so palpably in an interpreter-assisted encounter, the interpreter is often left feeling disempowered and without any resources with which to navigate the situation. This relinquishment of agency is because, ultimately, venue does make a difference: "venue will determine to a large degree the purpose of the communication, the context of the communication, and the consequences of the communication" (Roat & Crezee, 2015, p.243). The dynamics of the intercultural domain become even more accentuated in healthcare settings, where cross-cultural concepts of health are permeated with the often emotional and traumatic circumstances of illness and wellness.

Because interpreting is more than the restatement of words from a source language to a target language – interpreters must first understand and then reframe a conceptual construct: "they have to understand the context of the questions and make a validity claim of the words in their own culture" (Brämberg & Dahlberg, 2013), but must also be sensitive to their own value interference and awareness of non-verbal cues demonstrating Thus, the thrust of interpreting is not in language proficiency, although proficiency is requisite, it is in the application of language in combination with communication skills and intercultural expertise.

NEGOTIATING THE AMBIGUITIES

Interpreters working in healthcare settings, are constrained almost exclusively by their personal definition and commitment to professional ethics, and internalized self-discipline, which makes essential that practitioners become more fluent not only with the external language and definition of ethical frameworks, but how those frameworks may compete or conflict with their own internal values. Healthcare setting are complex situations that have a higher potential for the occurrence of dilemmas because of value-laden context and the interference of multiple factors. More importantly, it is not an overstatement to say that the consequences experienced as a result of a decision or application of the role may be dire, as they are in other crisis situations involving interpreters. Dilemmas that position professional standards and values against one's own personal values, or perhaps even against issues of life and death. More current research from Wu and Rawal (2017) substantiates the concept that the healthcare interpreter's role has "several dimensions that extend(ed) beyond simply bridging the communication gap between patients and healthcare providers" (p. 8).

In the absence of teachings that reflect the reality of the field and that, moreover, are against typology as defined by governing bodies, interpreters "developed elaborate reasoning about four roles that they played in healthcare settings: conduit, advocate, manager, and professional" (Hsieh,

2008, p. 1370). Gustafsson, Norström and Fioretos (2012) demonstrated "that it is almost impossible for the interpreter to avoid the role as a cultural broker. It could well be potentially favorable to closely analyze interpreted meetings on the basis of the concept of the cultural broker, providing tools for understanding the role of the interpreter in a broader social context" (Gustafsson et al., 2012, p. 202).

An interpreter has more than simply a communicative value in society. In healthcare settings, the interpreter is variably an agent for integration or settlement, an organizational support offering insights into cultural models of health and wellness or a navigator, facilitating patients' health care journey and as agents of integration, (Kaufert, 1999, Bischoff, Kurth & Henley, 2012, Souza 2016). Wu and Rawal (2017) found that "interpreters view patient safety as a key component of their work, but have trouble operationalizing their commitment to safety due to the constraints of their roll" (p. 9). The reality, therefore, is that all of these other facets of the interpreter's role are very real and the contextual demand to move beyond role boundaries is a force requiring address. Given the gap between theoretical models and practice realities it is not "surprising that ethics…. have become a central component of research" (Tryuk, 2016, p. 17), as role variations can be construed as ethical transgressions.

Fundamental Gaps in Healthcare Interpreter Education: The Canadian Landscape

Dean and Pollard (2001), have proposed that community interpreting, which includes medical, educational, social, and legal interpreting, is a practice profession, which, much "like medicine, teaching and law enforcement, [does] involve the learning and application of technical skills, but these technical skills are always applied in a dynamic, interactive, social context (i.e., with patients, students and citizens/suspects, respectively)" (p. 136). The ethical guidelines and pedagogical philosophies that inform the student body, are often at conflict with the practicalities of the field (Tryuk, 2015, Yenkimaleki, 2015) resulting in perceived ethical breaches of conduct.

If we accept these propositions, then the manner and material of healthcare interpreter education must not only be revisited, it must also be schematically prepared to integrate self-assessment, and continuing education in an ongoing process of continued competence. Currently, educational opportunities for interpreters in Canada are in general, limited, and in the main, practically nonexistent for those interested in specializing in healthcare interpreting.

Interpreter education dedicated to specialized settings, and excluding conference and sign language interpreting, varies across Canada. At the post-secondary level education for interpreters seeking to work in a community or healthcare-based settings are primarily situated in the continuing education departments at universities and colleges, and are not considered part of the core educational programs. There are two programs that are worth noting in that they either have, or had, successfully endured for many years, and in the case of the latter described below, were impressive in their curricula and instruction.

The program most recognized currently is the Language Interpreter Training Program or (LITP), which offers 180 hours of instruction, organized according into six, 30-hour courses. Initially

developed in 2004-2005 with funding provided by the Ministry of Citizenship and Immigration, Ontario (Sasso, 2006) this program adheres closely to traditional, fundamental interpreting curricula: The six courses are Introduction to Spoken Language Interpreting, Consecutive Interpreting, Sight Translation, Simultaneous Interpreting, Setting Specific Interpreting, Capstone Course Skills Integration. This program is only offered in Ontario.

In British Columbia, historically one of the longest running and most highly regarded program offered had been the Court Interpreter Program (established in 1979), first offered at Langara College and then subsequently at Vancouver Community College (VCC). In addition to the Court Interpreter Program, and as an outcome of the Health Care Interpreter Partnership Project (Sasso, 2006), VCC also began offering a comprehensive program for interpreting in the specialized healthcare setting. The VCC program offered certificate programs in Court Interpreting (350 hours) and Community and Health Care Interpreting (280 hours) that were bilingual in instruction and given in up to 13 languages. Both these programs were closed down in 2012, and although the program made a brief resurgence in a modified form as a 180-hour unilingual program, it existed for two years before it too was discontinued.

There are a few other post-secondary programs that offer courses in interpreting in a combination of settings all within the same course – business, community or legal, but they tend to focus on one or two specific languages or are aimed at the international student market. Over all, and in general terms, educational opportunities for interpreters and translators – once again excluding sign language interpreting – are few and far between. There are currently six universities across Canada offering programs in translation and interpreting, with an emphasis on translation studies in French, English and Spanish, and a majority concentrated in the Ontario region.

Interpreting in healthcare is a component of only one post-secondary degree program – Glendon College's Masters of Conference Interpreting – which offers two, 3-credit courses on interpreting in healthcare plus an additional virtual interpreting in healthcare practicum. This brief scan of interpreter education programs available in Canada demonstrates that while there are programs offered at the institutional level, the content apportioned to the study of healthcare settings is marginal, and conventional in content – and that a traditional model of conference interpreter education prevails.

Given the environment of interpreter education, in the broader frame, the argument to bolster healthcare interpreter education may just be moot, what is there to bolster? Interpreting programs, the education of interpreters in general, is something that has been on a decline in terms of the availability of courses over the last few years in Canada. In 1992, Downing and Tillery optimistically wrote that "at present the survival of the [VCC Court Interpreter] program no longer seems to be in doubt, partly because of heightened public awareness and support" (Downing & Tillery, 1992 p.11) but that was not the case. The program, along with others, did indeed shut down 20 years later. So, what do we do in the light of declining opportunities for interpreter education, where generic programs seem to be most available, while paradoxically the demand for interpreters in healthcare is on the increase? And that a formal certification examination process now exists as a persuasive point for professional validation. We cannot leave the field as it is, to do would not only weaken the efforts taken to date to improve the professional profile of the specialized area of interpreting in healthcare, but would also abandon the practitioner, who continues to perform duties in the ambiguous space between training and practice.

EDUCATING IN PIECES: FILLING THE GAP IN HEALTHCARE INTERPRETER EDUCATION

While it is true that interpreting is interpreting is interpreting, contextualizing the role within diverse settings highlights different aspects of that same role and associated tasks. Although the technical skills required of interpreters, across all contexts, are comparable and foundational, there are situations that require a more unique programming for specialized settings. An essential skill for interpreters working in dynamic settings such as healthcare is the ability to assess factors contributing to the discord between what was taught in the classroom and what is occurring in the reality and acknowledging that the "subsequent lack of pedagogical focus on the significance of the dynamic social context for making interpreting decisions (other than via "it depends" in response to students' inquiries, as we explain below) stifles interpreters' critical thinking abilities when they enter the workforce, not only in terms of ethical decision making, but also in terms of making decisions related to behaviour and language translation" (Dean & Pollard, 200, p. 156)

Healthcare interpreter education has not kept up with the demands of the marketplace place or the realities of working in a highly charged, dynamic setting that is not only imbued with the daily traumas of life and death, but also with the cultural factors that influence interpersonal and intercultural communication and interaction (Spencer-Oately & Xing 2009, Angelelli 2004, Souza, 2016). The shortcoming of interpreter education for healthcare settings has not meant that practitioners are in the field performing their duties as they had been educated to do by the traditional model, but rather that they are making it up as they go along, because the demands for them to do so are much too strong and the setting is much too intimate (Bischoff & Hudelson, 2010, de Souza 2016) for them to ignore it. Souza's (2016) data highlight the conflicts that interpreter practitioners face:

I'm trying to be impartial, so when I am trying to balance my communication I feel I am stepping out of my role of conduit, but that has to utilized because I feel that the communication is challenged and we are in an extreme situation, that it would negatively impact the level of service that the patient is receiving. When it is absolutely necessary when I feel the explanation will make a big difference. (p. 158).

The future of education in healthcare interpreting is dependent on numerous factors that intersect with both marketplace realities and national policies around the utilization of language services and the will behind those policies. Without a reasonable expectation of a living wage, more specialized types of interpreter education will likely not be favoured given program costs, but the demand for interpreters in healthcare will not only continue, it will likely grow. Until healthcare interpreter education is responsive to the practice demands of the field, continuing education and professional self-assessment are critical quality control measures to ensure that practitioners are both supported and empowered to work to the best possible standard.

In her five-year PhD research study, Souza (2016) found 99.56% of the 458 research participants, composed of interpreters working in the healthcare domain, contested the linguistic-only approach to their roles. Souza's (2016), study demonstrates that healthcare interpreters occupy three macro-roles that may all be executed concurrently or in part, including the continuous alertness to cultural

matters, the need to intermediate at times of cultural ambiguity and the concern for the patients' wellness and engagement, and she states "the participants' foremost focus was not on the perfect linguistic interpretation, but on the health of the patient and the medical outcome" (Souza, 2016, p. 290). This reveals how the interpreter's role is not motivated by an external mandate, but that individual practitioners take it upon themselves to pattern the tasks they perform to meet contextual gaps and demands. It could be said that the responsibility of ensuring that such gaps and demands are not left to the interpreter to fulfill falls to the healthcare system and its personnel, but the interactional reality of the interpreter-mediated space creates demands that the bilingual, bicultural interpreter is likely to find problematic.

We must listen to the practitioners and not impose an incongruous pedagogical framework on a profession that is essentially evolving as it is being executed (Souza, 2016, Ratanawongsa et al., 2018). Whereas every interpreter-involved scenario has the possibility of the unknown and unanticipated, an additional constituent in healthcare settings is the outcome equation. The impact of problematic understanding, miscommunication and professional negligence may result in a life or death condition. The stakes are higher and less forgiving. Therefore "a focus on the *local* real-world professional, social and educational contexts in which translation and interpreting take place also offers many keys to training initiatives which we may well miss if we focus our attention solely on international developments in language mediation education" (Kearns, 2012, p. 25).

Adding to the complexity of healthcare interpreting is the move towards remote interpreting, be it via telephone or video. The multiple and supplementary skills required to navigate this landscape is something not currently taught in existing interpreting courses. In Canada there are provincial healthcare systems that have moved primarily to providing interpreting services exclusively via remote platforms – such as the Alberta Health Services (L. Behiel, personal correspondence, July 29, 2019), while other regional bodies are increasing their provision of remote services such as in Ontario and British Columbia (G. Eagan & K. Malli, personal correspondence, July 15, 2019). The other characteristic of healthcare appointments in Canada that lends itself well to the remote and virtual space is that appointment lengths are frequently incompatible with the structured per-hour compensation scales for freelance interpreters. For example, appointments can sometimes take as little as 15 minutes, yet may be charged at a one hour minimum, adding yet another facet for consideration as this can create resistance for utilization of interpreting services based on an apparent cost inefficiency. Efficiencies can be gained when virtual forms of service delivery are employed and utilized, but this must be preceded by educational content that teaches how to work via remote platforms in complex care settings. And that also introduces the need to marry interpreter educational objectives to parallel programs for professionals that work with interpreters.

Healthcare interpreter education, considering only spoken language education in this case, in Canada is largely non-existent (see Table 1), while the need for interpreters in a broadening array of new languages related to migration trends is steadily increasing(G. Eagan, K. Malli, & L. Behiel, personal correspondence, July 29, 20190. In 2016 the Medical Interpreter and Community Interpreter Certification were established through the professional membership bodies as represented by CTTIC, but that has seemed to have had little impact on the uptake of utilizing only certified professionals. An online search of Certified Medical Interpreters in member databases for both the the Society of Interpreters and Translators of BC (STIBC) and the Association of Translators and

Table 1. Post-Secondary Programs – Interpreting and Translation – in Canada

Province	Institution	Program	General/Specialized	Credentials	Hours
British Columbia	Simon Fraser University Continuing Studies Department	Translation and Interpretation	Medical Interpreting – Mandarin/English	Certificate	120
British Columbia	University of British Columbia Extended Learning Department	Introduction to Medical Interpreting	Introductory Workshop	Certificate	7
Ontario	Offered at 6 post- secondary institutions - Conestoga College • Humber College • Mohawk College • Niagara College • St. Clair College • Seneca College	Language Interpreting Training Program (LITP)	General Interpreting	Certificate	180
Ontario	Glendon College – York University	Masters in Conference Interpreting	Conference interpreting, Court Interpreting, Healthcare Interpreting, Translation	**Graduate Diploma OR Master's Degree**	Full Time
Alberta	University of Alberta	Translation Studies		Undergraduate Certificate	
Ontario	Ryerson	Translation	Business - French	Undergraduate Certificate	
Ontario	University of Toronto	Translation Studies	General - Chinese, French, Korean, Portuguese, Spanish	Undergraduate Certificate	
Ontario	University of Ottawa	Translation Studies	General – French, Japanese	Bachelor of Arts	
		Translation Studies		Masters and Doctorate Degrees	
Ontario	York University - Glendon	Translation Studies	General and French and Spanish	Undergraduate Certificate, Master's Degree	
Ontario	University of Waterloo	Translation Studies	General and French and Spanish	Bachelor of Arts, Undergraduate Diploma	
Quebec	McGill University	Translation Studies	General and German, French and Spanish	Bachelor's degree, Undergraduate Diploma, Graduate Diploma, Master's Degree	
Quebec	Concordia	Translation Studies	General and German, French and Spanish	Bachelor's degree, Undergraduate Diploma, Graduate Diploma, Master's Degree	

Interpreters of Ontario (ATIO) yielded zero certified members in the two highest volume languages (Punjabi and Mandarin) at ATIO, and zero Punjabi, and five Certified Mandarin Medical interpreters at STIBC. While professional certification is important, we have not seen the rush to only recruit certified interpreters on the part of Language Service Providers (LSPs) in both provinces. Meanwhile, a consequential discussion is strikingly absent, where and how do interpreters obtain not only the fundamental, but also the forward-thinking education essential for the professionalism and competencies demanded of this work? Intent on a certification status, and without the integration of educational and professional development opportunities, the practice has been left only partially resourced in establishing a comprehensive career ladder in Canada.

TOWARDS A ROBUST EDUCATION MODEL

A educational model for interpreters working in healthcare settings should be premised on what the research has brought to the forefront: that the dynamic and multifaceted work in healthcare settings indicates an alteration in the application of the interpreter role so that it can achieve its primary function, which is that of communication facilitator, by incorporating a more comprehensive definition of communication. Factors that impact the work of the interpreter in complex settings must be taken into account: multiple, and concurrent types of communication, and various impediments, such as the critical nature of healthcare, the involvement of family and multidisciplinary teams, variations in values of health and wellness, and expectations of the system and patient, to name only a few, can hamper the interpreter's work.

In the light of the current state of healthcare interpreter education, the urgency for more robust programs, and the increasing demands of the healthcare sector, a 2-pronged approach is recommended. The first prong builds on existing core courses, by expanding and extending them to include modules as presented in the research conducted by Souza (2012): these are premised on intercultural inventories, control-demand schema and intercultural mediation. Additionally, to include Angelelli's (2006) suggested addressing the "development of skills in at least six different areas: cognitive processing, interpersonal, linguistics, professional, setting-specific, and sociocultural" (p. 25). As can be seen in Table 1, programs and courses with a focus on interpreting and more specifically on interpreting in healthcare settings, have a strong emphasis on medical terminology – anatomy and physiology. Courses that also combine teaching general interpreting foundational skills, such as note-taking, listening, memory, etc., simply add a medical lens to the content. Missing are the core competencies explored and recommended by the recent research, as discussed above.

The second prong is the implementation of a parallel or auxiliary educational course of programs that educate to the competencies required, as established by the body of research knowledge. This can be in the form of professional development opportunities or by way of community-based educational programs. The unifying thread would be that such programs work in concert, based on a standardized foundation of principles. While community-based programs do exist currently, this chapter has not addressed them due to a lack of any commonly accepted curriculum or program standards, which

has resulted in widely variable types of programs. It would be an enormous undertaking to review them all, however it could prove to be a useful exercise in the movement toward the implementation of a universal healthcare interpreter professional and career pathway.

PLANNING FOR THE LONG-TERM BY LOOKING AT THE IMMEDIATE NEEDS

For as long as the education of healthcare interpreters continues to be less than what is desired or required, the gaps in the knowledge and skill acquisition must then be fulfilled by a more rigorous continuing education scheme, as mentioned above, that integrates and augments current programs. This includes community-based solutions that can more readily responsive to the changing educational needs of the field, such as working with interpreter educators located outside of the post-secondary institutions and working more closely with interpreting service providers delivering language services to health care. This approach should also include remote, or online educational opportunities that blend in a virtual classroom and that do not rely solely on self-directed learning. This integrated schema could not only offer specialized modules on new practices within the medical and healthcare fields, such as medical assistance in dying programs, speech-language pathology, but also components that could eventually be included in a core curriculum, once the education of healthcare interpreters in Canada becomes a more thorough program of study.

RECOMMENDATIONS FOR FUTURE STUDIES

Interpreter education is contextualized within a country-specific map of overall translator and interpreter educational opportunities, legislation and policies governing access and utilization of language services, certification and/or accreditation structures and opportunities and the market place. These forces combine to design an overall picture of current ideologies and practices. This would suggest that we have to also keep in mind why robust educational programming is not available in a sector where demand is demonstrably growing. What are the forces at play that cause this inverse relationship to occur? Is it not reasonable to assume that as the demand for specialized interpreting services increases, so to would the educational mechanisms that prepare them for the market also increase in supply? It would seem to be the case that Angelelli's (2016) comment is very much in evidence in Canada, where student-centered programs are practically absent when it comes to languages outside of the official English and French, and as it applies to the specialized area of healthcare interpreting. Instead we have a medley of offerings that either do not connect with the current demands of the field, or that superimpose a healthcare lens on traditional content, all the while the focused outside of the interpreter's realities.

Interpreting entered academia to meet a pragmatic need (rather than as an object of study). Thus, research questions about T&I pedagogy were deferred in order to address the immediate market or professional needs of practitioners. Logistical questions related to the conducting of "training"

took priority over questions that addressed what a well-rounded education of interpreters should look like and how it might account for the different setting in which interpreters work (i.e. community, conference, legal and medical). For example, based on instructors' personal experience and opinions rather than on empirical research many programs that taught interpreting did little more than teach terminology relevant to the field. (Angelelli, 2016, p. 111)

RECOMMENDATIONS

The enquiry that this chapter seeks to address is how to stem the tide of waning educational programs for healthcare interpreters and to utilize increasing demands as leverage for the implementation of robust programs, using a multipronged approach of interim community-based options, while building a future, comprehensive schema. Recommendations to advance this are listed below.

1. **Closer collaborations between community-based training programs and healthcare institutions.** Educators and healthcare institutions have traditionally not intersected in any significant way since the Strengthening Access to Primary Care project (2004 – 2006), and in fact, the experience has been one of increasing gulf between these two entities for the most part. Educators, at the time primarily community-based organizations, have disconnected from healthcare institutions and providers which results in disconnect with what the real work-day world requires of interpreters. For example, an increased reliance on technology requires the integration of this component in educational offerings. It is recommended that cross-sectoral committees re-establish working relationships to better service both the institutional and educational needs. There are models of collaboration – such as the Canadian Coalition for Community Interpreting – which can be resurrected to serve this purpose.
2. **Educate medical and healthcare interpreters to become educators themselves.** A train-the-trainers model would have a two-fold benefit – it would enlighten healthcare professionals to appreciate the function and work of an interpreter, while creating critical allies internal to healthcare institutions. An expanded base of educators, sensitive to both the context of healthcare and the work of language interpreting, would also promote educational offerings both inside and outside of the system.
3. **Create a network of programs and services that can act as a ladder to certification through the implementation of continuing educational opportunities.** This recommendation is probably the one that can most readily be implemented following a more thorough inventory of assets and resources available across the country and connecting them in a deliberate model of educational components. This piecing together of current offerings and courses, programs or workshops can be facilitated by an online platform to provide a pan-Canadian model accessible to all learners.
4. **Utilize online platforms for virtual teaching.** Building on the last recommendation to stitch together available programs and opportunities, this last recommendation strongly urges the educators and practitioners to embrace, implement and fully utilize online learning as the foremost model. In a country like Canada, where the diversity is broad, the geography expansive and

the population low, online resources can make education more accessible and efficient, while closing the geographic and resource gaps. For example, in British Columbia there are small, community-based educational organizations offering unique programs not available in other parts of Canada. Online platforms are the most efficient way to connect need to resources.

As a cautionary note, it is useful to keep in mind that healthcare services are contextually situated within national political, constitutional and historical systems and as such, global programs do not always fit local needs. In fact, they may act to confuse where enforcement is not strong enough to oversee what is being taught or promulgated to interpreters.

LIMITATIONS

This chapter concentrates solely on spoken language interpreting in immigrant and refugee communities in Canada and does not intent to speak on behalf of educational opportunities for sign language.

Because of the distinct contexts of linguistical minority communities in Canada, it would not have been possible to address how to ameliorate situations for all communities. In Language Barriers in Access to Health Care (2001), researcher Sarah Bowen states that "in Canada there are four constituencies who may face barriers to health care due to having a non-official first language:

- First Nations and Inuit communities,
- Newcomers to Canada (immigrants and refugees),
- Deaf persons, and
- Depending on location of residence,
- speakers of official languages (French and English)" (p. 13).

And while barriers to healthcare services may be experienced in very similar ways, the contexts that frame these four constituencies are distinct in their political, historical and legal circumstances (Bowen, 2001), and subsequently the strategies for equity also vary.

This chapter also aimed to explore the gaps in training for healthcare interpreters experienced as a product of what the role demands in real life situations and what the curricula addresses in the classroom. It is this deficit that was the focus of the chapter and it does not intend to state that all interpreter education is lacking in excellence or distinction.

CONCLUSION

The role of the interpreter in healthcare settings has experienced an evolution that has shifted how the role is perceived and applied. The core work of the interpreter, as a communication facilitator, is sustained, but with a more comprehensive understanding of exactly what communication in healthcare is, bringing into play the intercultural elements, such as values, and beliefs around health, wellness, and illness, along with the linguistic diversity, demands a revisit of how the role

is in actual practice. But along with that recognition, is the reality that the educational strata that prepares the practitioner is incomplete at best, and that this first must be augmented, amended and strengthened before the role can have any real agency within the healthcare realm.

It is worthwhile to circle back on the observation that the scarcity of educational opportunities and programs exist not in a declining marketplace, but in a growing sector where interpreters, specifically interpreters in healthcare settings, are in increasing demand. Is not not reasonable equation that an increasing demand should result in more programs to prepare the workforce? What elements are intersecting for this to not be the case? As mentioned previously, an investigation into current practices is a recommended undertaking for any future action: understanding the waning tide of educational programs in the face of waxing demands would make for very informative contribution to the body of work.

In Canada, most broad-range, unilingual instruction available to those seeking to work as interpreters is primarily available via community-based organizations or private agencies. While the quality of these programs is not consistent, they continue to provide educational programs even though they may not conform to standards as set out by the NSGCIS and ISO documents. This is due to a generally unregulated part of the interpreting profession in Canada. A recent, unpublished, survey commissioned by a not-for-profit, public sector ISP servicing language needs for the healthcare sector (K. Malli, personal correspondence, November 25, 2019), demonstrated that 50% of agencies that responded either had no minimum educational requirements when recruiting or onboarding interpreters, 8.3% required a minimum of 15 hours of community-based training, 16.7% required a minimum of 60 hours of community-based training, and 25% required completion of a certificate program from a post-secondary institution. Of the 12 agencies that responded, 3 were non-profit agencies, government based, 3 were non-profit, non-government based, 4 came specifically from the immigrant and refugee service sector, and two represented hospitals or healthcare specifically. While this was a small survey, it did capture the large service providers of interpreting services at the community level in Canada and it illustrates a very significant concern – that even the educational expectations of agencies that are robust in their service delivery infrastructure and scope of services, are minimal at best.

This chapter sought to explore that while fundamental role of the interpreter has been influenced by the work done in healthcare settings, and that impact has resulted in a move away from a strict adherence to the conduit model in healthcare settings, and further, that the demand for interpreters in healthcare in on the rise, the educational setting continues to exhibit a lack of the necessary elements desired in a professional pathway. While limiting its lens to the Canadian landscape, anecdotal information, such as that found in social media, indicates that this is not a uniquely Canadian experience. The urgency is to transform this movement to one that is respectful and reflective of quality service delivery in an area where a lack of knowledge and skill has very real life or death consequences. The institutionalization of a comprehensive educational and career ladder will not take place overnight, but a meaningful practice can be created by acknowledging and piecing together programs that observe international standards in a map of assets and resources and guiding would-be professionals to acquire the necessary educational base they need.

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Chapter 18
A Medical Interpreter Training Program and Signed Language Interpreters' Decision Latitude: Exploring the Impact of Specialized Training

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ABSTRACT

The certificate in healthcare interpreting (CHI) is a medical signed language interpreter training program in the U.S. This qualitative study consisted of focus groups to examine the effect of CHI on graduates' views of their role, responsibilities, and decision latitude. Analysis suggests that CHI may be shifting practitioners from a restrictive conduit model (taking no action when faced with a decision) to a values-based approach. Also outlined are features of the program that contribute to this shift.

INTRODUCTION

This chapter is a report on a qualitative study conducted with focus groups of graduates from Rochester Institute of Technology's (RIT) Certificate in Healthcare Interpreting (CHI) program. This study aimed to examine the impact the CHI program had on their views of their role, responsibilities, and decision latitude. CHI is a nine-month non-credit program comprised of a one-week residency on campus followed by online studies. The program offers continuing education for nationally certified interpreters who already have experience in the healthcare setting but may not yet have any specialized training in that area. Without sufficient training, it is common for signed language interpreters (SLIs) to make decisions based on the conduit or machine metaphor models of interpreting (Dean, 2014; Dean & Pollard, 2011). This default approach to interpreting (Hsieh, 2008) often leads practitioners to take no action or to do nothing when faced with a decision (Dean, 2014). It was of particular interest to the researcher

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to explore and examine how CHI may be changing the ethical discourse for healthcare specialists and potentially negating the use of the of the conduit model.

BACKGROUND

In the United States, the field of signed language interpreting has been continually evolving since the inception of the Registry of Interpreters for the Deaf Inc. (RID) (2015a), in 1964. In the fifty-three years since, seminal disability legislation has vastly increased the demand for services and the field has morphed into a profession. SLIs work in a variety of fields. Common fields for SLIs include: Legal, mental health, video relay service, community, educational, and healthcare (Registry of Interpreters for the Deaf Inc., 2015c). The *Americans with Disabilities Act* and the *Affordable Care Act* have instituted requirements for healthcare providers about the provision of signed language interpreting for persons who are d/Deaf in America (Office for Civil Rights of the U.S. Department of Health & Human Services, 2017a, 2017b)[1]. Accordingly, just about every hospital and healthcare provider in America meets the criteria established in those laws to provide and ensure effective communication for d/Deaf patients.

The requirement to provide effective communication has led to an ever-rising demand for qualified interpreters able to facilitate this in the healthcare setting. According to Mitchell (2005), approximately one million people above the age of five years old are "functionally deaf". In contrast to this demand, very few formalized training programs of any significant length exist to equip SLIs to work in healthcare. To date, four such programs have been identified: Rochester Institute of Technology's (RIT) Certificate in Healthcare Interpreting (CHI) program, RIT's Master of Science in Healthcare Interpreting, St. Catherine University's Healthcare Interpreting program, and Minnesota State's Medical Interpreting Certificate. Many SLIs who find themselves working in healthcare do not have substantial training or credentials in this specialization. Further, even among generalist interpreters who work in a variety of community settings, there is little accord about the role of the SLI.

Roy (1993) provided four metaphors to describe the role of an interpreter: Helpers, conduits, communication-facilitators, and bilingual/bicultural specialists. Two others are the advocate and ally models (Baker-Shenk, 1991). These metaphor models still commonly exist in some form or another within the ethical framework of practitioners. The conduit model persists in the decisions and actions of newer and seasoned practitioners. Spoken and signed language interpreters alike largely prioritize the conduit approach (Dean & Pollard, 2011; Dean & Pollard, 2013; Hsieh, 2008). One major reason for discord in the general population of SLIs is the lack of consistency in interpreter education programs (IEPs). While the RID's webpage lists a total of 121 general programs available at undergraduate and graduate levels (Registry of Interpreters for the Deaf, Inc., 2014), only 18 colleges and universities have achieved accreditation (Commission on Collegiate Interpreter Education, 2015). Without standard accreditation for all programs, it is unlikely that the curriculum or instruction is consistent. Further, the RID offers no medical certification option for SLIs wishing to specialize (Registry of Interpreters for the Deaf Inc., n.d.a). While the spoken language Certification Commission for Healthcare Interpreters (2018) does offer a medical certification to SLIs; this certification does not assess interpreting skills (p. 5). Most hospitals and providers rely on interpreting agencies to supply them with interpreters, and therefore are unable to directly oversee or manage the qualifications of the people who are contracted. Agencies receive very little oversight or quality assurance. Further, no state licensure exists for medical interpreting.

SLIs who work in healthcare come from myriad training backgrounds. Eligibility for the generalist National Interpreter Certification does not require that an SLI graduate from an IEP. Candidates must simply hold a bachelor's degree in any major, or successfully complete the alternative pathway application (Registry of Interpreters for the Deaf Inc., n.d.b). Accordingly, it is reasonable to suggest inconsistency in SLIs' views on their work and how much latitude they believe they have in their decision-making. Nicodemus, Swabey, and Witter-Merithew (2011) posited that IEPs do not adequately prepare graduates to anticipate and evaluate options and potential consequences, or to act with confidence when making decisions. In order to be collaborative members of the healthcare team, interpreters must be prepared to use their decision latitude and believe they are authorized to do so (Nicodemus et al., 2011). Dean and Pollard (2001) hypothesized that, while most professionals enjoy wide decision latitude, the profession of signed language interpreting through education and practice, has codified the importance of not exercising such latitude outside of strict linguistic translation decisions. Robert Karasek (1979) originally coined the term "decision latitude" and defined it as one's decision authority, skill level, or the controls one brings to the demands that arise in their work. Karasek postulated, for a worker to feel satisfied and not overwhelmed with stress in a high demand job, there should be a high correlation between job demands and the discretion permitted to that worker to decide how to meet those demands. For SLIs not appropriately prepared and qualified to work in the healthcare setting, this high correlation is unlikely.

Dean and Pollard (2011) have proffered that "[t]here are numerous historic and current factors that impede interpreters and interpreter instructors from embracing or consistently following a context-based approach to interpreting practice decisions" (p. 10). One factor Dean (2015) contended is the use of role metaphors to guide ethical decisions and behavior. These role metaphors, which likely began as a shortcut to explaining what SLIs do, have been coopted to serve as the standard ethical guidance framework (Dean, 2015; Dean & Pollard, 2018). When defining the ethics of a practice profession, Dean and Pollard (2011) argued that it is the term responsibility, and not role, that is the necessary ethical construct, one which conveys the obligations of the professional. The term responsibility broadens the scope of ethical behavior within which a professional practices, rather than narrowing or constraining it, as the term role implies. In practice, studies have shown that interpreters do often consider and cite contextual factors when engaging in ethical reasoning, especially when performing interpreting activities that do not conform to the conduit role metaphor, such as coordinating turn-taking, providing education and advice related to culture and communication, managing resources, and even addressing the emotional needs of the participants (Clifford 2004; Dean, 2015; Hsieh 2006, 2007; Tate & Turner 2001; Thomas, 2012).

DECISION LATITUDE IN THE HEALTHCARE SETTING

Spoken Language Interpreting

While the study reported in this chapter focused on SLIs, analyses made in this report may be of benefit to all interpreters. Existing literature has repeatedly identified the prevalence of and need to move away from the conduit model of interpreting, especially in the healthcare field. Hsieh (2008) described this model as a method of conceptualizing interpreters as robots who are trained not to speak to participants directly, not to have personal opinions, and not to be emotional even in life or death situations. This work on spoken language interpreting in healthcare specifically addressed how the emphasis on this model often leads interpreters to experience conflict and distress, as it relates to their role and other people's

expectations of this role (Hsieh, 2008). In this particular study Hsieh conducted, interpreters in healthcare identified four roles they tended to play: Conduit, advocate, manager, and professional. By far, they identified the conduit role most frequently and explicitly. They prioritized invisibility in the attempt to foster the development of the provider-patient relationship as primary. Interpreters' training called for invisibility and neutrality in the default conduit role, and this played out in their work.

Rosenberg, Seller, and Leanza (2008) provided a different perspective as to how spoken language interpreters view their roles. Their study compares professional interpreters to family member interpreters. Within these two groups, roles are viewed as: Transferring information, creating a safe environment, cultural mediation, and the maintaining of professional boundaries for professional interpreters; facilitating comprehension, diagnosis, and treatment, and assistance navigating the healthcare system for family members (Rosenberg et al., 2008). While diagnosis and treatment fall outside the scope of a professional interpreter, the other roles that family members identified could be effective and appropriate if the goal of the healthcare environment is to do no harm and to help patients become well. In fact, the authors state: "To obtain the maximum benefit from a professional interpreter, the physician must invite the interpreter to act as an advocate for the patient and a culture broker" (Rosenberg et al., 2008, p. 92). This implies that the interpreter should often work above and beyond the conduit model.

Angelelli (2001) theorized that interpreters tend to subscribe to the belief of invisibility (i.e., conduit) and are subsequently prevented from identifying and appropriately acting upon their complex roles, due to important aspects of their power being obscured. Further, Angelelli's study found that, even while subscribing to the belief that invisibility is optimal, interpreters in the healthcare setting were in fact visible, and that their visibility did have varying levels of impact on the interaction. In more recent work, Angelelli (2004) found that healthcare interpreters do not actually perceive themselves as invisible, which stands in paradox to the conduit model ideal interpreters in general espouse. In this study on the continuum of invisibility, healthcare workers ranked highest, proceeded by court and then conference interpreters. As a result, Angelelli (2004) advocated "[…] the interpreter as a visible powerful individual who has agency in the interaction. As such, the interpreter would be capable of exercising power or solidarity. The interpreter would either maintain the status quo, or alter it" (p. 262). This evidence leads to the question: Why do interpreters espouse invisibility when it has proven to be unrealistic, prevents them from taking responsibility, and can lead to harm of themselves and others?

Power Dynamics

Acknowledging the power the interpreter holds in an interpreted interaction is a critical part of moving away from the conduit model. Baker-Shenk (1991) described power as "the ability to act" when you can make decisions and follow through. She also asserted that in regard to power, there is no "neutral" position. The SLI must acknowledge power, because hearing people have systematically deprived d/Deaf people of power and failure to recognize this unequal footing does not make it cease to exist (Baker-Shenk, 1991). In the healthcare setting, Baker-Shenk conjectured that SLIs stand between the d/Deaf person and their goals, and are often the only person present who has access to both languages and cultures, which bestows great power on the SLI. Baker-Shenk claimed that the conduit model perpetrates basic tendencies of any dominant class or people in the position of power; they deny that they have this power, and deny that it is present and affects every setting and every interaction with the subordinate class. Minges (2016) conducted a survey of SLIs and found that most of the respondents self-identified as allies in their work, specifically for social justice. This suggests that SLIs want to act in a manner that

allows them to equalize any power imbalance, although their training may constrain their ability to do so. In healthcare specifically, a natural power imbalance already occurs between patient and provider. "[M]edical discourse, like other forms of institutional discourses, is also asymmetric with respect to relative power of the conversational participants" (Davidson, 2001, p. 3). This is exacerbated when the patient is d/Deaf and has systematically been deprived of his/her power. When SLIs do not make conscious choices to correct power imbalances, they help maintain the hearing person's greater power and the disempowerment of the d/Deaf person (Baker-Shenk, 1991).

The Persistence of the Conduit Model

Despite the standing evidence against the conduit model and the concept of invisibility for the SLI, these ideals persist (Clifford, 2004; Dean, 2015; Fritsch-Rudser, 1986; Hsieh, 2008; Nicodemus et al., 2011; Roy, 1993). As recently as five years ago, Schofield and Mapson (2014) published a study on dynamics in interpreted interactions in healthcare and still felt the need to make the argument that more than attention to effective language-transfer alone is required for effective interpreted interactions. The authors' data indicated that active collaboration with the healthcare provider before, during, and after appointments by the interpreter is potentially beneficial. This suggests that now clinicians and interpreters alike are beginning to shift away from the notion of the interpreter as an invisible conduit (Schofield & Mapson, 2014).

These continued arguments would not be necessary, if the field had moved beyond the conduit model. Both the conduit model and the term *role* have become generative metaphors in the profession of signed language interpreting because educators, scholars, and practitioners use these metaphors as a basis for their ethical frameworks (Dean, 2015). Dean and Pollard (2011) summed up how the conduit approach is evidenced in the field of signed language interpreting with a question that SLIs commonly consider when they have an ethical dilemma: "What would happen if I were not here?" (p. 10). Clifford (2004) provided a similar question considered by spoken language interpreters: "What would happen if the patient were comfortable speaking English?" (p. 91). The point of these questions is to imagine a scenario in which, in any interaction, both parties could speak the same language and converse without an interpreter. The fallacy (in part) of this exercise for SLIs lies in the actual power imbalance that exists between participants, because at least one of the participants is in fact d/Deaf, is likely not on equal footing, and the interaction does require interpreting (Dean, 2015). When the SLI's undeniable presence calls for some level of direct involvement, making a decision based on how one might answer the above hypothetical questions, may result in a blatant disregard of professional responsibility (Dean & Pollard, 2011). Imagining a situation where the SLI is not needed is not beneficial to deciding how the SLI should conduct himself/herself, because the demands in this alternate imaginary situation would, by its very nature, be quite different and the actual demands that do exist should not be ignored. Using this hypothetical scenario to arrive at a control decision ignores the SLI's responsibilities and is the antithesis of context-based ethical reasoning and professional responsibility.

The Missing Discussion on Responsibilities

What is often missing from the conversation of the SLI's role is the responsibilities that go along with the role. Dean and Pollard (2005, 2011, 2013) discussed how other practice professions, such as in medicine, law, and teaching, closely link these two words and how SLIs have historically failed to include the re-

sponsibility portion, likely due to the predominance of the conduit model where the only responsibilities they hold are their immediate translation choices. The portrayal of the interpreter as invisible despite being central to the cross linguistic/cross cultural communicative event may also imply that interpreters have no responsibility in the outcome of the interaction, even though they in fact can and do impact the outcome significantly (Angelelli, 2001; Metzger, 1999; Napier, 2003). An SLI in the healthcare setting acting in the conduit or machine model may well be ignoring power dynamics and their impact on the interaction. This perpetuation of the status quo can have serious negative consequences. Hsieh (2008) discussed such impacts: "If interpreters do not believe that they should intervene in problematic situations, there might be serious threats to quality and ethical health care services" (p. 1382). Bringing the discourse on ethical decision-making into the frame of the SLI's role and responsibilities can help to move away from the conduit model approach and mitigate the impact of ignoring any power imbalance that exists between participants.

Normative and Descriptive Ethics

Dean and Pollard (2018) claimed that SLIs have failed to correctly apply normative ethics within their field. Beauchamp and Childress (2012) defined normative ethics as what is ethically valuable and ought to be. In essence, these are the prescriptive rules a field or profession follows in the hopes of upholding the values said profession holds dear. Normative ethics can also be either deontological or teleological. Dean (2015) noted that deontological ethics are rule-based, while teleological ethics are goal or value-based. Ethics can be either normative or nonnormative, and the reasons behind why one ought to do something are justified by a variety of moral theories (Dean, 2015). In contrast to normative ethics, descriptive ethics attempts to describe the actual conduct of practitioners, how they reason, and their moral beliefs (Beauchamp & Childress, 2012). When attempting to determine where the generative metaphor of the conduit model fits into this discussion of ethics, arguably it could be considered deontological and both normative and descriptive. SLIs may believe the conduit model is the way they should behave, and they may report that, in actuality they use it as a decision-making guidepost. A deontological model relies primarily on adherence to the rules set forth, without much consideration of the underlying values, or which to uphold when such values conflict. It is when two or more values conflict that ethical deliberation must occur; a practitioner has the responsibility of assigning one goal or principal priority over another when the actions associated with both are incompatible in an attempt to achieve some sort of balance (Beauchamp & Childress, 2012; Dean, 2015).

Decision Latitude

Dean and Pollard (2011) believed that one of the main factors that impedes the instruction of SLIs from embracing a context-based approach to ethical reasoning is the prioritization of invisibility over other values, even though this runs counter to the mentality of a practice profession. The proposed solution to the prevalence of the conduit model is the teleological or outcome-based ethical framework and the demand control schema (DC-S) to apply context-based ethical reasoning. Dean and Pollard's research has demonstrated that instruction in the ethical constructs of DC-S improves critical thinking skills. This leads to enhanced ethical reasoning and greater confidence among both student and working interpreters (Dean & Pollard, 2011).

The ability and discretion to exercise a broad decision latitude may be of importance in healthcare for an SLI. Pollard and Barnett (2009) proposed the term "fund of information deficit" and defined it as "a distinct limitation in one's factual knowledge base in comparison to the general population, despite normal IQ and educational attainment" (p. 182). The authors asserted that, because of deficits in fund of information and other factors, d/Deaf individuals are particularly at risk for low health literacy (Pollard & Barnett, 2009). Factoring together a general fund of information deficit, low health literacy, and the inherent power imbalances of healthcare, all of which can contribute to the daily oppression experienced by d/Deaf people, arguably the use of the conduit model is not ideal for fostering effective communication in the healthcare setting.

In the UK, Thomas (2012) conducted a survey of British SLIs and found that those who had more recently been qualified (between 2008 and 2012) to work were more likely to exercise a wider decision latitude than those who entered the field before that time. The study also uncovered that, on an individual basis, participants tended to consistently respond more liberally or conservatively to all answers. This may suggest that the degree of decision latitude an SLI has and uses varies based on personality and other individual traits. However, the findings that newer practitioners entering the field tended overall to respond more liberally may indicate a shift in the education that SLI students are receiving. It is possible that IEPs in the UK may be shifting away from teaching the conduit model and are better equipping students to justify deviations from the conduit model without invoking the common "stepping out of role" explanation.

Specialization

Within the profession of signed language interpreting, healthcare is a specialization. Normally, to be considered a specialist, certain requirements must be met: Advanced training, specialized skills and knowledge, experience, and unique qualifications to work in the specialized setting (Witter-Merithew & Nicodemus, 2010). A profession's regulation of their specialties must be measured to assure that those regulations recognize and promote advanced knowledge. Witter-Merithew and Nicodemus (2010) recommended assessing the degree of professional autonomy professional practitioners are afforded and exercise as a measurement instrument for this task in the field of signed language interpreting. Interestingly, RID's standard practice paper *Interpreting in Health Care Settings* makes no mention of specialized training recommendations or requirements for healthcare SLIs beyond standard national generalist certification (Registry of Interpreters for the Deaf Inc., 2007). It is a paradox that healthcare interpreting is considered a specialization, when no specialized training or credentials are required. *Interpreting in Health Care Settings* makes no mention of decision latitude or the responsibilities of the healthcare SLI beyond effective communication (Registry of Interpreters for the Deaf Inc., 2007). Further, the type of continuing education opportunities most frequently available to those who choose to specialize are weekend workshops. These are limited in their time and scope, which naturally leads them to focusing primarily on strategies for interpreting content. Workshops do not allow for supportive constructive learning opportunities, ongoing feedback, and the development of necessary specialized skill sets (Dean, 2015).

Professional Development and Interpreting Pedagogy

For new entrants into interpreting who attend and graduate from IEPs, Nicodemus et al. (2011) advocated for the use of problem-based learning, which includes the presentation of a real-life situational problem that requires students to generate possible effective solutions, while considering each resolution's implications and potential outcomes. This learning process, which also includes case study analysis and Dean and Pollard's (2009) observation-supervision, teaches students to find their "voice" and learn how to establish presence. Ultimately, this learning process allows them to engage in their work and decision-making in a transparent and authentic manner (Nicodemus et al., 2011). This approach can help instill context-based ethical decision-making skills in novice SLIs from the beginning of their career. In a survey study, Wilbeck (2017) found that graduates of IEPs identified real-world context-based problems and applications as a method lacking in their training that if present, could lead to greater comprehension for students. Ruiz (2013) proposed that utilizing experiential learning theory with real life problems and dilemmas in the classroom reduces the amount of on-the-job training recent graduates must go through after graduation. When that type of learning does not occur until after graduation from an IEP, it can be detrimental to clients and co-interpreters alike as the recent graduate struggles to learn how to problem solve in real time (Ruiz, 2013).

Several authors have outlined postgraduation options for optimal professional development methodologies in the field of signed language interpreting. Dean and Pollard (2011) identified supervision and reflective learning as key components to the continuing education and professional development of SLIs. These tools help practitioners manage the intrapersonal demands that occur in their professional activities. Supervision and reflective learning help SLIs appreciate and utilize a broader range of controls, such as patience, confidence, and environment-specific knowledge, by learning new control options from their peers (Dean & Pollard, 2011). Cheetham and Chivers (2001) concurred that, for continuing education, reflection is of vital importance. In their study, many participants extolled the virtue of reflection within a structured framework, especially in dialog with other learners. In a survey study, Curtis (2017) identified the following benefits from ongoing DC-S supervision sessions in which SLIs participated: "Enriched learning (formative), increased professional standards and accountability (normative), and support for the wellbeing of the practitioner (restorative)" (p. viii). This research suggests that several issues pertaining to work-related stress, education, and standards and ethics for SLIs can be addressed by the use of professional and structured supervision, and that such supervision should be a credentialing requirement for SLIs (Curtis, 2017).

Updating the Continuing Education Model

Farrell, Bourgeois-Law, Ajjawi, and Regehr (2017) conjectured that single-day learning interactions are difficult for providing effective feedback, because of the need to develop a strong relationship and trust between the participants. The type of supervision discussed above differs from the most common type of continuing education offered to SLIs. "The 'weekend workshop' needs to be replaced with a longer strand of study that provides several sessions focused on a topic with a requisite performance component to be assessed by a qualified instructor, before RID CEUs are awarded" (Witter-Merithew & Johnson, 2004, p. 47). RIT's Certificate in Healthcare Interpreting (CHI), includes case conferencing which is a type of observation-supervision that allows participants to engage in reflective discourse (K. Miraglia, personal communication, October 11, 2017).

The weekend workshop format is convenient in that it allows SLIs to gather together for short periods of time to learn and improve their skills. If a different method is to be implemented that proves more effective and popular, it must address the issue of convenience, which undoubtedly today means incorporating the use of the Internet. From the convenience of their own homes, SLIs can meet and confer with regularity over video conferencing software, online classrooms, and discussion boards. Within the field of continuing education for translators and interpreters, the Internet will continue to be instrumental in providing new forms of learning and teaching (Colina & Angelelli, 2017).

In conjunction with the online platform, Colina and Angelelli (2017) identified task-based learning (TBL) as an effective method in the education of interpreters and translators that results in improvements of overall learner awareness. Through peer interaction, TBL was found to improve numerous areas of students' work including: The ability to identify and address translation challenges, preassignment research skills, source text comprehension, target text production, and interpersonal skills necessary to build sound relationships with clients (Colina & Angelelli, 2017). The online platform and TBL are both tools which are utilized in CHI. These combined tools offer students the chance to engage in learning and development over a longer period of time, with more than one or two meetings, exactly as Witter-Merithew and Johnson (2004) recommended.

Competencies

In 2010, the National Consortium of Interpreter Education Center published the document *ASL/English Medical Interpreter Domains and Competencies*. This organization is no longer in operation due to a loss of funding. As a result, the document has not been reviewed or updated since that time. In many ways, the document takes a deontological approach to prescribing appropriate behavior for an SLI in healthcare. It provides specific examples and many details. In contrast, the National Council on Interpreting in Health Care's *National Standards of Practice for Interpreters in Health Care* is a much briefer document that outlines nine domains, by first stating the guiding principle or value that should be upheld and then providing a few succinct tenets for each principle (Ruschke, Bidar-Sielaff, Beltran Avery, Downing, Green, & Haffner, 2005). This teleological approach, where the domains and competencies are grounded by guiding ethical principles, provides an interpreter with more latitude to make decisions when values conflict and one must be upheld at the expense of another. The International Medical Interpreters Association's *Medical Interpreting Standards of Practice* (1995) does prescribe some appropriate behaviors for an interpreter, but those behaviors extend beyond the straightforward act of facilitating communication between two languages, and only 3 overarching themes and rationale are provided: Interpretation, cultural interface, and ethical behavior. These themes make it evident that the document expects that interpreters are obligated to act as more than what would be appropriate with the conduit model. All three documents outline requirements for professional boundaries, cultural awareness, advocacy, and the actual interpretation act. It may be argued that, while the framework of these documents is quite different, the underlying spirit is similar, since the domains included are often quite alike.

Synthesis and Gaps in Literature

Plenty of evidence exists about the prevalence of the conduit model and its detriments to healthcare (Angelelli, 2004, 2001; Baker-Shenk, 1991; Davidson, 2001; Hsieh, 2008; Rosenberg et al., 2008). An essential piece of the effective SLI puzzle is maintaining a broad decision latitude and behavioral

flexibility. Further, methods for instilling such context-based ethical reasoning skills exist and are even in practice in certain instances (Dean & Pollard, 2011; Thomas, 2012). The theoretical framework undergirding CHI's approach to ethics is the DC-S (Dean & Pollard, 2011). The DC-S framework has been used in numerous IEPs and workshops, and is not unique to CHI (Dean & Pollard, 2012). Prior to the author's study, no evidence was available specifically about how training in longer term specialized healthcare programs has shaped graduates' perceptions of their role and responsibilities or their decision-making skills.

SOLUTIONS AND RECOMMENDATIONS

Methodology

In light of what is known about the restrictive nature of the conduit model, this qualitative study aimed, in particular, at investigating what impact CHI had on graduates of this specialized training program's decision latitude and their understanding of their role and responsibilities. The research questions that guided this study were:

1. How is CHI advancing a diverse group of students' decision-making skills and providing a sense of legitimacy with decision latitude?
2. How does CHI affect or advance SLIs' understanding of their role, responsibilities, and decision latitude?

Online focus groups (group interviews) were held to interview people who had previously completed the program and who self-selected. Demographic data via an online survey was collected from respondents prior to participation in a focus group. Focus groups offer a flexible and social method for collecting a variety of types of evidence, including tacit knowledge and collective views and opinions (Ryan, Gandha, Culberston, & Carlson, 2013).

The Institutional Review Board of RIT's National Technical Institute of the Deaf granted ethics approval for this study. All participants of the study submitted their agreement to the informed consent form presented at the beginning of the demographic survey, before they were able to proceed. The form notified them that their focus group sessions would be recorded and transcribed by contractors, and that reporting of the data would redact any names. The form also explained that redacted transcripts would be shared with CHI's director for other future purposes. At the beginning of each focus group, participants were asked for a commitment of confidentiality not to share names or any identifiable information inside or outside the group. They were also informed that it would be the responsibility of each party to uphold the confidentiality of the group.

Participants

Recruitment requests were sent to graduates of CHI, excepting those who are Certified Deaf Interpreters (CDIs), because their responsibilities and functions are different from those of hearing SLIs. Additionally, the number of CDI graduates from CHI is a very small percentage of the total population. In an effort to reduce the variables present in this study, focus was placed on hearing interpreters and the

kinds of decisions they make when working by themselves. All hearing interpreters accepted into CHI were nationally certified and had some healthcare interpreting experience before entering the program. No other previous healthcare training was required.

By the date of this study, CHI had seven cohorts and approximately 100 graduates (K. Miraglia, personal communication, August 31, 2017). Requests were sent via electronic mail to the addresses the CHI program had on file for graduates and posted in their closed Facebook group to reach any members whose email addresses had changed since they had applied for the program. The initial email included a description of the project and a link to the demographic survey.

Those who responded and completed the initial survey were entered into a database. As part of the survey, participants were asked to select three preferred meeting times. Nineteen respondents completed the survey in its entirety. Of those, 14 participated in focus groups. Participation in the focus groups varied by region and cohort. Approximately 57% indicated that one or more of their degrees was not in the field of signed language interpreting. All participants had an associate's degree or higher; 57% reported that they had increased the amount of work they had performed in healthcare, science and technology, and mental health since completing CHI.

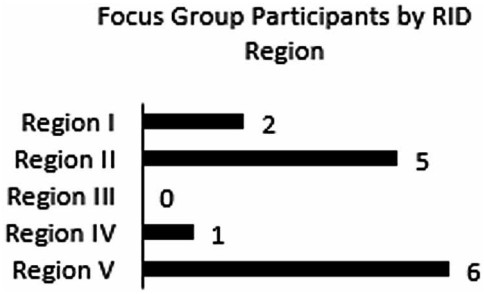
Data Collection

After completing the demographic survey, 14 participants were placed into 4 90-minute sessions. All but one participant was able to join a focus group. In an attempt to gain the opinion of all willing participants, that individual and the author met once the groups were complete. The author provided her with the collective responses gathered, and asked her to agree or disagree and add her own opinion. On average, focus groups contained three participants. The focus group sessions were conducted from what Ryan et al. (2013) referred to as the Type B Social Constructivist Perspective to investigate the "how" and "why" of CHI's impact on graduates' decision latitude. This perspective allowed for "a dynamic social process, where participants explore opinions, beliefs, and understandings […] within a group dynamic through a form of collective sense-making" (Ryan et al., 2013, p. 4). Conducted and recorded via Zoom software, sessions were free flowing. As moderator, the author first provided an introduction reminding participants of the purpose of the study and ground rules for the loosely structured discussion. To guide the process, the author posed a series of open-ended questions to create a group dynamic and social interaction that would reveal both explicit knowledge and what is hidden, but understood, by participants as tacit knowledge (Ryan et al., 2013).

Data Analysis

Focus group sessions were transcribed to facilitate text analysis. The author reviewed all recorded sessions multiple times to become more familiar with the data and for errors in the transcriptions to be corrected. Transcripts were then imported into Dedoose, a qualitative data management platform which allows for coding. As transcripts were reviewed, themes were coded, and patterns emerged. Using the frame of the social constructivist approach to focus groups, utterances and excerpts were tagged for both explicit and tacit knowledge. What the group expressed as tacit knowledge was key for uncovering relevant issues during the analysis process (Ryan et al., 2013). Once all codes had been applied and organized into themes, transcripts were reviewed again through the lens of the knowledge, skills, and attitude (KSA) theoretical framework for assessing the professionalization of signed language interpret-

Figure 1. Focus group participants by RID region



ing used by Witter-Merithew and Johnson (2004). One aspect of the KSA is that professionalization occurs when formal study leads to practitioners who have "a complex set of skills, higher order thinking and decision-making skills, and a body of technical knowledge" not widely held by the general public (Witter-Merithew & Johnson, 2004, p. 23). Also necessary for professional SLIs is the "right" attitude, one that expresses an abiding respect for d/Deaf people, their language and culture, and a commitment

Figure 2. Focus group participants by graduating cohort year

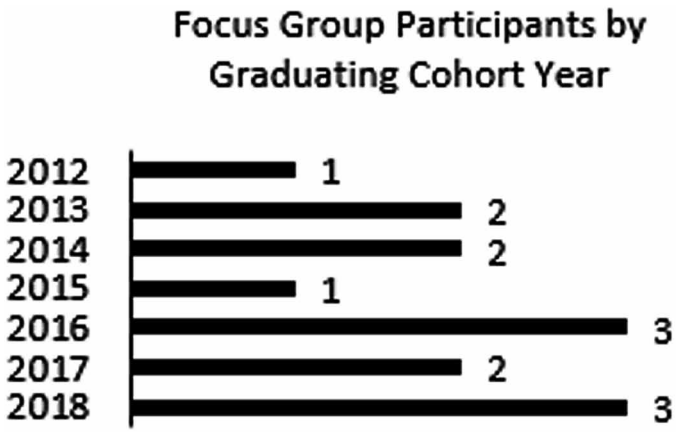


Figure 3. Highest level of education completed

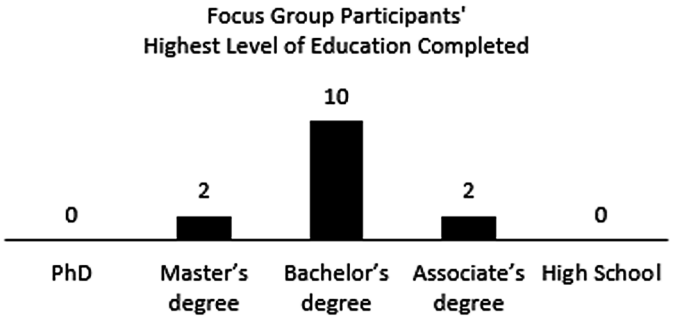
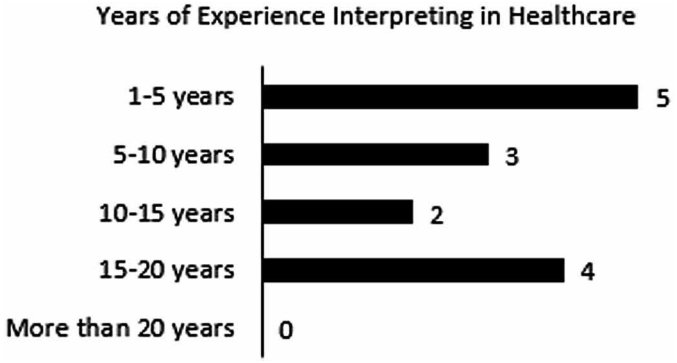


Figure 4. Years of experience interpreting in healthcare



to serving their communal interests (Witter-Merithew & Johnson, 2004). Existing themes were then cross-referenced with KSA to look for the most common co-occurrences.

Results

The major themes that emerged in this study were: appreciating interpreters as practice professionals, specialized education, and values-based decision-making. Within each of these broad themes, multiple subthemes were present. Table 1 shows the frequency of the major themes occurring in the data set. The data are presented first by the major themes, and then analyzed through the lens of the KSA theoretical framework. All numbered subthemes are listed in order of occurrence from the greatest to the least. Non-numbered tables and lists are presented in no particular order. All data (including quotations) presented here emerged from focus group discussions.

Interpreters as Practice Professionals

Interpreters as practice professionals was overwhelmingly the most common theme that emerged. This particular theme is an accumulation of a number of subthemes that directly or indirectly spoke in general to the demeanor and embodiment of a practice profession, and the concept of responsibilities in particular. Participants operationalized the theoretical concept of practice profession in ways that expanded Dean and Pollard's (2005) original explanation. This was illustrated through narratives about SLIs working in relationship with an historically oppressed and marginalized group where consideration of contextual factors is essential, due to the primacy of this relationship. As a practice profession, the discussion and

Table 1. Major themes

Theme	Percentage
Interpreters as practice professionals.	49%
Specialized education.	27%
Values-based decision-making.	24%
Total	100%

acknowledgement of responsibilities is vital. Participants freely and easily identified a number of responsibilities for healthcare interpreters, which are expressly outlined in the "acting within one's purview of expertise" section of "Attitude", but also peppered throughout this report.

Specialized Education

Specialized education was a theme that explicitly spoke to the need and desire participants had to further their education. Participants expressed recognition of the unique demands of healthcare and the necessity of adequately preparing to work in such a setting. This implies that a standard SLI IEP is insufficient to prepare one to work in healthcare, and that specialized training is needed and valued among practitioners. Discussion on this topic focused on what CHI instilled in graduates. Of note is the fact that the Mental Health Interpreter Training (MHIT) program that is held annually in Alabama was mentioned frequently. Robyn Dean and Robert Pollard are faculty members of the MHIT where the DC-S is taught, and major contributors to both CHI and the MHIT directly and through their theoretical work.

Values-Based Decision-Making

The theme of values-based decision-making was another that emerged resulting from the analysis focused on implicit or tacit knowledge. The term was almost never explicitly mentioned. All of these subthemes contribute to the concept of an ethical practitioner and specifically to the teleological approach to decision-making.

Knowledge

See Table 5.

Table 2. Practice professional subthemes

1. Acting within one's purview of expertise.	2. Acting as a member of the team.
3. Acknowledging responsibilities.	4. Sharing information in confidence.
5. Respect and empathy.	6. Role.
7. Awareness of the oppression and power structures d/Deaf people face.	8. Providing education.
9. Consideration of subsequent interpreters.	10. Awareness of the interpreter's impact on communication.

Table 3. Specialized education subthemes

1. Understanding healthcare structure and system.	2. The vulnerability of patients and the gravity or life and death nature of healthcare.
3. Improved confidence.	4. Improved interpreting skills.
5. Working with d/Deaf professionals and CDIs.	6. MHIT.

Table 4. Values-based decision-making subthemes

1. Reflective practice and case conferencing.	2. Prioritizing values.
3. Demand-control schema.	4. Ethical decision-making and critical thinking.
5. The goals and values of the environment.	6. A broadened perspective of the continuum of controls available.

Understanding the Healthcare Structure and System

The overarching knowledge related learning feature of CHI that surfaced was the content that helped participants better understand the healthcare system and structure. One notable feature of training was that participants were able to explicitly outline a significant difference in values for healthcare and mental health. While the general healthcare setting values patient autonomy, mental health often prioritizes patient safety over autonomy. Comprehension of the healthcare system and structure is the building block on which all other themes in this section rely. Tacit understanding of this system was present throughout all discussions and is evidenced repeatedly in other sections of this analysis.

[T]he biggest, simplest example from CHI was that if I go into a room with a patient, [when] the nurse leaves, I'm right behind the nurse leaving. The nurse says "Oh, no, just stay, stay in with the patient. The doctor will be right in." And then, if I just say "Oh, no, I can't. It's unethical," right because that's how we're taught. "That's not my role." Like what does that even mean to the nurse? And so, to use something as simple as "Oh, no, I'm respecting patient privacy, so I'll be waiting in the hall until the doctor comes in." And the nurse is, you know, "Oh!" And I used it, and when I used it, it was just like "Okay. Would you like a chair to sit in the hallway?"

Table 5. Knowledge themes

Understanding the healthcare structure and system.	Acting as a member of the team.
Role.	The goals and values of the environment.
Awareness of the oppression and power structures d/Deaf people face.	

Table 6. Pedagogical content about healthcare structure and system

Goals and values of healthcare.	Medical terminology in English and American Sign Language (ASL).
How the interpreter fits into the healthcare team.	Hierarchy and structure of a healthcare system.
Study and analysis of *ASL/English Medical Interpreter Domains and Competencies*.	Benefits of using healthcare professionals' language and jargon to reduce resistance to interpreter requests and reasoning. Example: Requesting a linguistic specialist when a CDI was needed allowed providers to comprehend the value of bringing one in, since "specialist" is a common term in their lexicon.
d/Deaf Healthcare literacy and fund of information gaps.	

Acting as a Member of the Team

The member of the team concept was expressly and frequently used to describe the work of a healthcare interpreter. The ability of participants to act as members of the team rested on having sufficient knowledge about healthcare. Knowledge about content, terminology, structure, staffing, goals, and values were all identified as the underpinnings for recognizing how an interpreter fits into the team and for acting upon that information. Trainings on this topic resulted in participants feeling more emboldened to work with medical staff as part of the team. Of note was the cognizance that staff interpreters are often garnered the same respect and trust as other staff members and have a heightened level of access and knowledge of the facility, which is not generally the case for freelance interpreters. Those who had practiced in both positions identified that feelings of team membership were diminished in the freelance position. Participants also mentioned the appreciation of the staff when acting as part of the team; how clinicians want things to go smoothly and are often grateful for the support to achieve that.

Examples of decision choices resulting from the "acting as a member of the team" philosophy are:

- Staying in an exam room and explaining the interpreter's reasoning to a patient who did not understand why a certain choice was being made in the effort to maintain transparency in decision-making.
- Making phone calls to nutrition when a patient wants to order food to free up nursing staff.
- Walking into the nurse's station to preconference before meeting a patient.
- In a mental health setting, finding out what the goal of the appointment is and what the provider might want an interpreter to look for linguistically.
- Helping patients navigate the system which requires interpreters being sufficiently familiar with it.

When I talk about my-- what it is that I do, as part of the healthcare team. I don't talk about myself as this lone being anymore. I'm actually a part of that team and I help everyone around me recognize that I am there for them as well, as much for the patients.

[For a neurology patient who is being monitored for linguistic use] I'm going to have to be with the nurse to voice what the person is signing. Well, why can't I just watch and then write down what they sign and say [to the physician] … this is what they signed, and it's the same thing every time and it looks just like it did the last time I saw them three months ago or it looks different than what I saw three months ago. I can do that. I'm a language expert.

Table 7. Member of the team learning features

Codes of conduct for medical interpreters.	*Principles of Biomedical Ethics* (Beauchamp & Childress, 2012).
How to develop a rapport with other professionals to improve outcomes and facilitate the achievement of goals.	How and why to use healthcare terminology and language when speaking to clinicians.
Thought worlds of providers.	Recognizing when education is needed and providing it.
Advocating for one's own health and safety.	Speaking to the staff to provide expert consultation when something out of the ordinary linguistically or culturally is observed with a patient.

Role

The concept of *role* included several constructs. Participants expressed a broadened sense of what could be considered within their role as a result of CHI. Many shared that they no longer use the term *role* when discussing their work, and instead frame things in terms of their responsibilities. The appreciation of the relationship between role and responsibilities was both implicit and explicit. Each group identified numerous responsibilities for healthcare interpreters. This illustrated the tacit understanding participants hold about practice professionals having responsibilities that guide their decisions. Numerous explicit mentions were made about how CHI taught graduates to recognize their responsibilities. DC-S as the framework for decision-making and assessing potential outcomes was brought up frequently. This schema seemed to be the underpinnings of the paradigm shift that participants experienced during CHI.

Much dialogue centered around the conflicting expectations that exist about appropriate behavior for an interpreter. These conflicts were said to stem from both service users and other interpreters. The member of the team construct was something that cooccurred frequently with the term *role*, exemplifying a shift away from the conduit model. Instances where participants chose to act in a manner that would typically be considered on the liberal end of the continuum of ethical and effective control choices (Dean & Pollard, 2005) were tempered with deliberation that, while those choices were right for the particular circumstance, they would not be appropriate in most other circumstances. This implies that participants are cognizant of their responsibility to act judiciously and to consider potential outcomes when making decisions. Acknowledgement was made that the trust of the service users was paramount. Participants also agreed that their primary function was to facilitate communication.

We had a mother who was in labor, a single mom … There was no family members, and traditionally where our role, and I use air quotes, is to, you know, not have an opinion, to be neutral, to sort of have that boundary clear. And the mom was just getting so worked up that the baby wasn't coming out, and you know she's just very, very upset, and I made the decision to just grab her hand … because she was just crying that no one was there for her … we looked at each other, and she was like I'm going to do this. And I … nodded my head and held her hand while she gave birth, and I still stand by my decision. I think that the value of the baby's safety and health and the mother trumps what normally we're supposed to be, you know, more of a neutral party in that situation.

[I]f I stay within my role as interpreter, I'm not going to pick up a knife and start carving on somebody. But … I'm going to come by in line with [the facility's] goals, the goal of the team.

Table 8. Participants' broadened definition of role now includes

Outcome-centered decision-making.	Consulting in third person.
Providing cultural and linguistic clarifications.	Ability to assess what is and is not within their purview of expertise, and act accordingly.
Appropriate behavior for a community interpreter is not necessarily appropriate for healthcare.	Recognition that interpreters who have not gone through CHI often make different choices, and this can affect service users' expectations.
Taking ownership for negative consequences or resulting demands that ensue from their actions.	Engaging in critical thinking.
Providing education.	

I think that's what the CHI program did for me was really expanded my definition of what the role was.

[T]raditionally, we're some type of metaphor, or we're a bridge, we're a conduit, we're a facilitator, we're, you know, I mean, the definition of interpreter has changed so much, right? And we're advocates, and we're allies, and we're this and that. So, with CHI, you know, we're part of the medical team, and we're responsible for effective communication, and that involves everyone, and in order to do that, we have to make decisions instantly and in any given moment, we'll make hundreds of decisions, and each of those decisions, our controls will have resulting demands and consequences.

The Goals and Values of the Environment

Evaluating the goals of the environment, a major feature of the DC-S process was prominent in many discussions. Participants rarely explicitly stated customary healthcare goals but recognized that their decisions should align with the goals of the setting. Examples of interpreters choosing to step in if they were aware of a medication allergy were common, which signifies their implicit recognition of the goal to protect the welfare of patients and safeguard them from harm. Values of the setting were more readily discussed, including one of the core values *justice*. This was most frequently evidenced in acknowledgements of the limited resources available in healthcare and their constant need to prioritize the use of those resources in a manner that the system deems most fair. This played out primarily with the example of the limited amount of time physicians have to spend with each patient and how this influences their interactions. Awareness of the urgency physicians operate under shifted intrapersonal demands participants faced regarding their perceptions of providers, and subsequently changed the control choices they made. Dean and Pollard (2001) defined intrapersonal demands as those physical and emotional factors that only pertain to the interpreter internally. Whereas in the past, participants might have been put off by a provider's attempt to hurry the discourse along, now they identified being able to recognize the underlying reasons for such urgency and expressed understanding.

Since participants learned about the values and goals of the healthcare environment in CHI, they reported they are better able to predict thought worlds (i.e., attitudes and beliefs about the world that is characteristic of a given people, time and place) of providers and patients, and various processes and procedures in healthcare. Having knowledge of these schemas aided participants in feeling more confident, knowing what to expect, and having strategies in place for the myriad demands unique to each setting. Analysis occurred regarding how specific goals may vary by setting. For example, a physician follow-up appointment has a different set of goals than a radiology exam. Understanding why providers make certain choices through the frame of their goals led to an internal response of more balanced alignment with both patients and providers, more sense of agency, and enhanced ability to guide patients through the process.

Participants suggested that, unlike in other settings, such as video relay service, it is imperative that healthcare interpreters comprehend the context of the discourse throughout the process. Understanding a provider's motivation may result in different, more effective translation choices. As part of the team, participants identified that it is their responsibility to help facilitate achieving the goals of the environment. This requires comprehensive appreciation of those goals. An interpreter functioning in this manner facilitates other team members effectively doing their jobs and achieving their goals.

Examples of working towards the goals of the healthcare environment:

- Explaining to staff when something atypical in language or culture is observed and what its implications may be.
- Ensuring future appointments have communication access established.
- Sharing information they are privy to when relevant and necessary.

Jean Rodman's [adjunct lecturer] lecture on the Four Goals. That has probably been the quickest and easiest go to in my brain for helping me just navigate everything that's going on. The four goals are the goal of the message, the members, this meeting, and the moment. So, that's probably one of the biggest tools I think that I use on a daily basis.

Awareness of the Oppression d/Deaf People Face

Participants discussed what they had learned in CHI about the reduced healthcare literacy of the d/Deaf community and their disenfranchised status. Participants recited several anecdotes surrounding oppression of the d/Deaf community in the healthcare setting that they had observed. CHI was not directly identified as having taught participants about this oppression beyond education about fund of information and healthcare literacy disparities. However, it was frequently attributed with providing them with the controls and latitude to identify and remediate disparities when they occur. Participants often cited cultural mediation as the responsibility that called them to address these imbalances.

The primary failure about which participants expressed frustration was facilities that would not provide appropriate accommodations for patients. This centered around either resistance to providing interpreting, or the provision of ineffective interpreting. They cited cost containment as one possible rationale for this occurrence. Lack of sufficient accommodations exacerbates the inherent power imbalance that already exists between patients and providers. Participants noted that in their experiences they recognized a potential social dynamic that had been discussed in CHI. That is, d/Deaf people often perceive healthcare as something that is done to them, rather than something in which they participate. This was tacitly expressed with cases of patients having things done to them that they did not understand and to which they never consented. Since CHI, the participants have recognized that, due to potential disparities, sometimes a patient may want to ask a question or express a concern, but he/she does not have the language, experience, or empowerment to do so.

Examples of observed oppression and deliberate choices participants made to remedy the situation:

- Taking steps with d/Deaf children to get them to actively participate in the process, rather than just deferring to hearing parents.
- Identifying when a healthcare literacy or fund of information gap exists and providing expansions to address it.
- Recognizing how processing time in a group discussion can exclude the d/Deaf person, because they are not given an equal chance to engage, and making this known to all parties, in order to allow time for them to participate in dialogue.
- Explaining to providers that family and guardians of d/Deaf patients often do not know signed language, and this can impact the dynamics of relationships.
- Explaining to providers why writing back and forth may not constitute effective communication.
- Asking the questions that it is clear patients want to ask, but do not explicitly verbalize.

- Earning the trust of patients.

I think it's so hard for the d/Deaf community because they have had to fight for everything that they've ever gotten. So even the health system is adversarial to them because they weren't accepted with open arms … it went from "We're not going to provide you interpreter, we're going to write. And we're going to provide you VRI, even though you don't want it" … they've really never been allowed to have an equal seat at the table. Everything gets done to them. So-- And then we come in and … our goal is to, like that physician, is to get a person better. But yeah, you're dealing with a patient who looks at you as an adversary, you know?

Skills

See Table 9.

The Demand-Control Schema

The DC-S was frequently referred to as the "biggest thing" or "main takeaway" participants garnered from CHI. They were encouraged to process everything through the lens of the DC-S. Since completing CHI, many reported that they had applied this framework in all the settings in which they had worked–not just healthcare–and that the DC-S had completely changed how they practiced. While many participants were previously exposed to this schema, they gained a deeper understanding of it through CHI. This, coupled with the academic demographics of participants, suggests that the level of DC-S pedagogy in many IEPs and workshops is insufficient to fully put the schema into practice. It was through weekly analyses and case conferencing over the course of several months that participants began to develop the skills to quickly identify the demands upon them and envision the potential outcomes of control choices before making a decision and taking responsibility for the results of that decision. Participants appreciated the logical, nonjudgmental way of approaching dilemmas and the language it provided to discuss their work and the rationale for their decisions. This is done in part by removing the interpreter's impressions or judgments from the analysis process and instead just focusing on what is seen and heard.

Mention was made that seasoned interpreters may be more readily able to draw on past experiences to aid in identifying the demands of hypothetical or real scenarios, once given the language, as opposed to newer interpreters who may struggle to recognize demands they have yet to experience. Throughout the focus group sessions, participants demonstrated how they have embraced the DC-S through their explicit word choices.

The ability to identify the demands placed upon them in their work gave participants a sense of agency and the freedom to ask for what they needed. With the DC-S, the common "it depends" phrase

Table 9. Skills themes

The demand-control schema.	Prioritizing values.
Case conferencing and reflective practice.	Ethical decision-making and critical thinking.

Table 10. Features of the DC-S that participants cited frequently

Intrapersonal, environmental, and interpersonal demands.	Spectrum of liberal to conservative controls.
Reflective practice.	Case conferencing.
Preassignment controls, such as preconferencing with the medical team upon arrival.	During assignment controls, such as asking providers to provide a visual representation.
Post assignment controls, including case conferencing.	Values-based decision-making.

in response to what one would do in an ethical dilemma was replaced with a comprehensive analysis of the actual situation or context-based ethical reasoning. It provided a way to deal with the reality of each unique situation, rather than relying on a generalized metaphor model to determine what is or is not within one's role. Participants identified that since CHI, they had made different decision choices than they would have previously in similar situations. They also shared that they felt that the DC-S recognizes that interpreters have a lot going on all at the same time and imbues a sense of respect and professionalism in what they do.

[K]nowing that there is no little interpreting devil or angel on me … was very liberating and maturing and I felt it gave me the adulthood that I've craved in this profession. It gave me autonomy and the sense of maturity that I've felt that would be needed … I think that DC-S grown us up a lot as a profession.

[T]he demand control that was overlaid the entire CHI program, we were encouraged to kind of process things through that schema a lot. And … that's the key significant difference in how I conduct my work pre-CHI and post-CHI, that I've got the tools to talk to colleagues … I have the language to explain some decision-making. And it also helps me have a foundation and have like a sequence to go through before I make a decision to do something in an actual interpreting situation.

Prioritizing Values

When asked whether participants adopt the values of the setting they are working in, they predominantly agreed that they do. This requires an understanding of these values and recognition that at times these values may conflict with each other, or with the standard values of the interpreting profession. This is typically when an interpreter identifies an ethical dilemma. It was assumed that participants were familiar with the values of the SLI profession. Recognition was given that when conflicts arise, the prioritization of certain values over others may create resulting demands that an interpreter is responsible to handle. In order to maintain trust with service users, an interpreter is prudent to be transparent in his/her choices and explain why one value is prioritized over others.

Illustrations of competing values and participants' ability to weigh potential outcomes when upholding one value at the expense of another:

- When the interpreting value of confidentiality conflicts with continuity of care, an interpreter may prioritize the latter by sharing handoff information to a subsequent interpreter.
- Prioritizing do no harm over the value of confidentiality may result in an interpreter disclosing information about medication allergies that would have otherwise been omitted.

Table 11. A comparison of the values explicitly identified for healthcare and signed language interpreting

Healthcare Values	Signed Language Interpreting Values
Patient health. Confidentiality. Justice. Do no harm. Continuity of care. Patient autonomy and informed consent. Safety.	Neutrality. Confidentiality. Unobtrusiveness. Facilitate communication.

- When a discourse requires informed consent, this may trump interpreter neutrality as exemplified by making sure a provider slows down important instructions, requesting providers utilize visual illustrations, halting the process to recommend a CDI, or advising providers to check for comprehension before proceeding.

[B]efore CHI my approach to the code of professional conduct was this very rule-based, you can't do this, you can't do that, and so on and so forth. And now after CHI … I've looked at things from more a value perspective. So, you know, you look through the code of professional conduct and you try to analyze what's the value behind that rule … then again, sometimes those conflict and you have to sort of prioritize.

Case Conferencing and Reflective Practice

Case conferencing, a method of reflective practice in the DC-S and a routine part of the CHI curriculum was lauded for its benefits. Weekly case conferencing sessions were held where students were able to hear fellow classmates discuss complex situations and learn from each other. Presenting students were required to write out a DC-S analysis of a scenario, which enhanced their ability to recognize demands. Participants reported that it afforded them the ability to retroactively review their decisions and analyze what demands resulted in those choices, without judgment. Several participants shared that they have since established relationships with interpreters who had also been through DC-S training, with whom they regularly case conference. This suggests this skill will continue to aid them throughout their careers.

Many participants expressed concerns that, under the predominant understanding of confidentiality among SLIs, case conferencing is still considered a violation. In justification for the need, reference was

Table 12. Benefits of case conferencing

Fostering collegial support, rather than criticism.	Helping practitioners identify the perspectives of all stakeholders in each situation.
Providing an agreed upon framework for analyzing a situation.	Learning from negative outcomes to prevent them in the future by implementing different control choices.
The diversity of experiences and backgrounds in each CHI cohort contributed to an enhanced learning environment.	Reassurance that interpreters in other areas were experiencing similar situations and operating under similar guidelines.
Acquiring novel control options through engaging with colleagues.	

made to other practice professions and their use of case conferencing and supervision. Participants also expressed the human need to talk about one's work experiences in a safe space, and that the expectation that interpreters hold things secret indefinitely is unhealthy and not present with other professions. Beyond the collegial support and camaraderie during CHI, one's cohort often became a network of colleagues who have similar training and with whom to discuss matters. This is especially important due to the isolation that many interpreters experience in their regular work day. Since interpreters generally practice without supervision or colleagues present, case conferencing is an opportunity to commune with other professionals and dialogue issues and concerns.

[W]e're the only profession that I've come across where the concept of keeping something in forever and ever is expected, and that's just not realistic.

I saw and met all these wonderful people with all these different perspectives and thought worlds, if you will, I just felt like I could be a sponge. And I learned so much from everyone. And particularly when you have d/Deaf people mixed in with our group, it was phenomenal, because I would have never thought of a particular situation the way someone who was actually our client would think of it, and who is now not only our client but also now our peer in our profession.

Ethical Decision-Making and Critical Thinking

Much discussion about ethical decision-making centered around the perceived deontological nature of RID's Code of Professional Conduct (CPC). Expectations placed upon them as a result of this may be impeding SLIs from engaging in critical thinking or making choices that they think are appropriate for a given situation. On several occasions, participants mentioned a portion of the CPC that discusses that SLIs should refrain from providing counsel, advice, or personal opinions which restricts agency and prevents critical thinking. Arguments were made that the CPC does call on SLIs to exercise judgment, but ultimately it does not give practitioners the tools to do so. In the participants' view, critical thinking, rather than following a hard and fast set of rules, is necessary to effectively evaluate potential outcomes, before implementing a control choice. They frequently cited reflective practice as a primary tool for evaluating and improving decision-making.

While participants tacitly understood the difference of rules-based vs. outcome-based decision-making, they tended to be unable to recall the terms deontological and teleological without prompting. Possible future and actual past consequences weighed heavily on participants' minds when discussing decision-making, which indicated that they felt the onus to make decisions that are likely to have the best outcomes for the most people. The responsibility participants felt to execute ethical decision-making was evident in their language about moving away from using the term role, when making and justifying decisions and engaging in reflective practice and case conferencing to learn from past negative outcomes, so that they could make different decisions in the future.

[I]f we decide to do nothing, that's still doing something. And so, we make decisions all the time in interpreting, and it's just, you know, on the spectrum of "is it more liberal, is it more conservative?" And so … even to this day, I'm still taking that with me when I go into a medical setting, or actually to be honest, into any setting.

[I]t's kind of a cop out, in my opinion, is if we just say, "oh, that wasn't my role". Like what does that really mean? What are you actually trying to get at? You know, what's the ethical dilemma? What's the competing values? … What are we actually talking about? So, I think the CHI program has challenged me to do that, to dig deeper. It's not just, you know, recounting a story. It's actually reflecting on what I've done and why I've done it.

Attitude

See Table 13.

Improved Confidence

Confidence was a predominant theme throughout focus group discussions. Participants addressed a multitude of ways in which their confidence was improved as a result of CHI.

So, I think … intrapersonally I feel different. So, even if I'm not treated differently, I feel different about my work. … I feel more confident and feel more … a part of the team; I think it varies. So, … even though

Table 13. Attitude themes

Improved confidence.	Acting within one's purview of expertise.
Respect and empathy.	The vulnerability of patients and the gravity or life and death nature of healthcare.

Table 14. Learning features that impacted confidence and resulting internal feelings

Learning Features	Resulting Internal Feelings
Case conferencing.	Connection to colleagues.
Medical content and vocabulary.	Ability to use language familiar to healthcare practitioners to articulate rationale for decisions.
Healthcare system and structure.	Ability to better predict the thought worlds of clinicians.
How the interpreter fits in to the healthcare setting.	• Enabled to show a patient a picture to explain a concept or ask providers to pause for an expansion. • More equally aligned with patients and staff. • A part of the medical team. • Agency or visibility.
Benefits of and how to work with CDIs.	Ability to advocate for patients.
Applying DC-S as decision-making framework.	• More controls available. • Permission to act on the things they identified as needing action rather than remaining passive. • Reconciling the conduit model and "staying within role" with the reality of each situation.
Using third person to consult as an expert.	Feeling like they have more right to ask questions, interject, or clarify.
Mental health setting and content.	Feeling more prepared to work in this setting.

I'm an outsider in that hospital setting, I do still feel like I'm there to serve the patient just as much as the nurse is, just in a totally different way.

I feel more empowered to be more forthright with "This is what I see; this is, let me explain to you what's happening" as opposed to just … I say what's being said and that's it with no explanation. I think I, the empowerment that comes with … I can explain my responsibility, probably that comes from, or for me anyway from having gone through the program.

Acting Within One's Purview of Expertise

While this theme cooccurred most frequently with attitude, it could also be viewed from the frame of knowledge. However, recognizing that what is within an interpreter's purview extends beyond the conduit model and judiciously choosing to take responsibility for those elements does greatly depend on an interpreter's attitude about their practice. Numerous responsibilities were identified as falling within a healthcare interpreter's purview. Transparency and using third person to both report and consult were two associated concepts.

Examples of transparency and use of third person:

- Addressing providers directly to educate or to inform that it appeared a patient may not be comprehending.
- Making suggestions about the best way to achieve effective communication, such as recommending the provider give a visual example to explain a concept.
- Explaining the interpreter's rationale in translation choices and other decisions.

[W]hen I say [to the clinician] "would it be possible for me to talk with you for just a moment … or clarify something?" Sometimes it's respected and … they'll do it, and other times it's not. But prior to CHI, I would never have even considered asking that question. So, I feel like I have a right to be more involved and like I have a right to ask some questions to clarify things.

One illustration of consulting that occurred frequently was the concept of confidentiality being defined as sharing information in confidence. When information is pertinent and relevant, it may be incumbent

Table 15. Responsibilities associated with "acting within one's purview of expertise"

Transparency.	Use of third person to both report and consult.
Visibility.	Act as a guide through the healthcare system.
Facilitate communication.	Language and cultural mediation.
Recognize appropriate need for CDIs and advocate for their use.	Sharing information in confidence.
Manage interpersonal dynamics.	Liaise with all parties.
Providing education.	

upon the interpreter to share what he/she knows, with the expectation that other providers and professionals can be trusted to use it only as it pertains to the goal of the environment.

Let's say I know this person has an allergy to penicillin, somehow it's not been noticed and someone comes in and give him a penicillin shot, that the goal is to do no harm in that situation that [providers] expect me to say, "Hey, wait a minute, let's check if they can have penicillin". Because I talked about this to some local interpreters and they are like, "you can't say that" … So I said, "so you would let them give him penicillin and maybe kill them?" you know? But that's still where some folks are thinking.

The concept of the interpreter's visibility and the need to act as a guide through a system with which patients may not be familiar, and even the responsibility of the interpreter to explain the process were all mentioned multiple times. Participants discussed how as members of the healthcare team, they represent the organization for which they are working. While fund of information was only explicitly mentioned rarely, the need to act as a guide through the system may indicate that participants tacitly understood the potential knowledge gaps that might exist with d/Deaf patients and the interpreter's responsibility to close some of those gaps, whether in a freelance or staff position. Many participants discussed the illusion of interpreters as invisible, and how this construct ignores the reality of their presence and even inhibits their ability to act as a guide.

I also have more conversations with the d/Deaf person than I ever did before about process, sequence of events, in the [emergency room], or even in the college classroom.

So we have these things going in our head, decisions that we make that affect things because we do exist in the room and yet we don't have the-- we supposedly don't have the agency and the self-generativity to exercise that agency. And yet, we're exercising that agency every moment and it is affecting things.

Facilitating communication along with language and cultural mediation were two themes that participants almost seemed to take for granted. There was unanimous agreement that these fell into the purview of the interpreter. In fact, these were identified as an interpreter's area of expertise specifically. Recognition was given to the differences between d/Deaf patients' and hearing providers' thought worlds and the interpreter's responsibility to mediate these differences.

I make it very clear that my level of expertise lies in linguistics; in language and in culture. And I don't go beyond that because I have not had training that lies outside of my area of expertise.

So as far as the responsibility of the interpreter … sharing information with both sides, cultural mediation information but also like, isn't that cultural in the context of like the d/Deaf community operates quite differently than your typical hearing patient, and also on the other side … of that as well, right? … That's one of the responsibilities is to … share information that you're expert in and the knowledge that you have.

Discussion on the imperative nature of cultural mediation in healthcare was exemplified in an excerpt in which the provider was misinterpreting the facial cues of a d/Deaf patient, based on his/her expectations of his/her own culture. Had the interpreter chosen not to step in, it may have resulted in an erroneous

mental health diagnosis. In this regard, one of the participants reported: "In my opinion, this patient is frustrated, not agitated. And it's in my professional opinion, based on what I know about the language and the culture and the way … d/Deaf people communicate".

Recognizing when a CDI was needed and advocating for the use of one was repeatedly mentioned. Participants who had CDIs in their cohort extolled the virtues of being able to learn alongside them and discussed how they felt more confident in requesting and utilizing them in practice. CDIs brought a different perspective to group discussions about decision-making and translation choices. The perception that CDIs have an even broader decision latitude was prevalent and tied to curricula presented during the CHI.

I just see how their kindness shows through in their interpretations. Like they are so much not machine model … CDIs they have this beautiful way of not only working with the language … Those guys are just doing anything they can to make this communication happen.

When I was in CHI … we had actually two CDIs that were in my cohort. And it was awesome. … [T]his person regularly would use real world concepts to explain health care issues. And like the clogging of arteries and having blockages comparing it to a garden hose and how it just doesn't let water through and backs up and just to make sure in the end that the patient fully understood regardless of their level of their understanding health care issues.

Providing education took many forms, including:

- Educating patients about why interpreters make certain choices.
- Educating providers about how interpreters fit into continuity of care and minimum qualifications for interpreting in healthcare.
- Elucidating cultural disparities and healthcare literacy data among d/Deaf people.
- Explaining why interpreters may need access to some confidential data.
- Proactively informing clinicians when their equipment or procedures will impede communication (i.e., placing a pulse oximeter on a finger may making signing difficult).
- Explaining how interpreting provision works.
- Explaining the intradependence of the Deaf community and how those relationships can carry more weight than an expert's opinion.
- Providing rationale about when interpreting is needed and why.

Respect and Empathy

Participants brought up respect and empathy from the perspective of interacting with both patients and providers. When discussing patients, respondents exemplified context-based reasoning again and again. One demand they identified repeatedly was the struggle of balancing respect with compliance of regulations and rules. Participants discussed the context of each situation, rather than referring to specific rules about how to proceed. Decisions about whether to touch or hug a patient depended on if there were contact precautions in place, or whether appropriate personal protective equipment was being worn. Rationale for showing empathy generally centered around scary procedures and diagnoses, and

the appropriateness of showing caring and acknowledging the experiences and feelings a patient may be having, similar to how other providers interact with patients.

The concept of an interpreter's humanity came up repeatedly. Specifically, how interpreters are present in times of crisis or illness for other people. This provides interpreters with an opportunity to respond as one human being would respond to another. Training to consider the context of the situation, rather than adherence to strict unchanging rules, allowed the participants to feel less restricted in how they showed respect and empathy.

[T]hat emphasis of small things like just helping out could make such a difference. If you're just being a human being, that's what you would do with anybody. But previous training would be, "You stay in your role. You're the interpreter and you just" … I looked back at times in my earlier working life where that's what I did because I thought that's what was right. And I felt like the CHI program allowed me to give myself the freedom to go—"now this feels right for doing this right now". And it's a decision that I would make with each person in each situation but then I didn't have to stay in a role that was actually confining.

When respect was brought up regarding interactions with staff and medical professionals, participants identified the major impact their demeanor and willingness to engage could have on the outcome of a situation. Several respondents mentioned incidences prior to CHI, where they felt adversarial towards providers, but the training they completed assisted them in understanding providers' thought worlds and where gaps may exist in their knowledge base. In turn, this allowed them to recognize that everyone is usually trying to provide the best quality service, but may be ignorant of the unique needs of d/Deaf patients and may need some education, which the interpreter is perfectly situated to impart. Taking an active and visible role in the discourse allows the interpreter to lay the foundation of collegial recognition, so that, when consulting is necessary other practitioners are open to it and recognize the interpreter as a member of the team. Respondents also identified that their attitudes and demeanors leave a legacy for subsequent interpreters and that this must be considered as decisions are made.

[K]indness. We just need to remember that. We're going to accomplish more with kindness and respect towards other professionals. And I think that was one of the really big points that I got in the program about how we approach those other [medical professionals] to better help the d/Deaf consumer.

The Vulnerability of Patients and the Gravity or Life and Death Nature of Healthcare

This theme was tacitly and explicitly weaved throughout all the focus groups and justified the necessity for context-based reasoning. As participants provided examples of decisions they had made, they continually harkened back to the unique nature of healthcare and the vulnerability patients experience, which is not generally present in other types of interpreting work. This vulnerability is most readily exemplified in the states of undress that patients may experience and is unique to the nature of the healthcare setting. Anecdotally, the results of inaccurate or incomplete interpretations tended to have much more serious consequences in healthcare, because diagnoses are being given, treatment plans are being decided on, and misinformation has the potential to result in death or diminished quality of life. Subsequently, these life or death situations led participants to make decisions which they would not otherwise make and which

may be considered too liberal in any other context. "[T]he patients are just so much more vulnerable … and that plays into maybe how I will handle something".

Participants provided examples of decision choices they made in consideration of the gravity of the situation:

- Specialized training to understand medical discourse and be able to provide complete and accurate interpretations without relying on the patient's background knowledge to piece context clues together.
- Discussing translation choices and cultural information with clinicians in mental health settings where a person's liberty may be at stake.
- Getting a CDI when decisions have to be made and it appears a patient may not be able to give informed consent.

A gravity to it … it's different than my doing a class on World War II. It's different than my doing something else, it's a medical thing. … [In CHI] it was just broadly felt in the room at all times that this is a big deal, what you're doing here. That's how it felt to me anyway.

FUTURE RESEARCH DIRECTIONS

This study relied on participants' recall and self-reporting for data collection. A possible enhancement to these data would be to perform on-site observations of SLIs who have graduated from CHI while working in the healthcare setting, in order to collect direct data about their decision latitude in practice. Additionally, qualitative studies could be conducted to interview patients or providers about the outcomes they have observed when working with graduates of CHI, when compared to other healthcare SLIs. It would also be informative to conduct similar studies of graduates from the other long-term healthcare interpreting training programs, to be able to compare results from CHI against the impact other programs have had on interpreter's decision latitude.

CONCLUSION

This research study examined the impact CHI had on graduates' views of their role, responsibilities, and decision latitude. Through the use of a demographic survey and 5 focus groups, participants were interviewed in a free-flowing, social manner, in order to elicit reports of any changes they had seen in their work since completing CHI. What emerged were numerous ways their decision latitude had been broadened. Very few responses reflected the type of conduit-based decision-making that is still prevalent in the larger field of signed language interpreting. Instead, participants exhibited context-based decision-making and critical thinking skills when reporting their workplace dilemmas and experiences. When examining the impact of CHI, recognizing interpreters as practice professionals, specialized education, and values-based decision-making were the three major themes identified.

These results suggest that, in fact, training over a longer period of time than the typical weekend workshop, within a curriculum that features supervision, case conferencing, application of the DC-S,

and specialization specific content, can lead to interpreters with improved confidence who are able to identify and act upon their responsibilities, rather than rely on what is or is not *within their role*, when making decisions. This highlights the importance of making these types of continuing education opportunities available for interpreters going forward. Over the 9-month period of CHI, students had so much more opportunity to build collegial relationships and put the skills they were taught into use than would have been available in a short-term workshop setting. Given that these results bolster Curtis' (2017) report on the normative benefits of DC-S supervision and its effect on an interpreter's assurance that they are practicing within a range of standards consistent with their colleagues, the author recommends that interpreting fields (spoken and signed) adopt and promote specialized training programs and credentialing requirements that incorporate these pedagogical features. Interpreters who are more thoroughly trained provide a higher quality of service to the people with whom they work and have more confidence in their decision-making.

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KEY TERMS AND DEFINITIONS

American Sign Language (ASL): Primary signed language used in North America.

Certificate in Healthcare Interpreting (CHI): Rochester Institute of Technology's (RIT) National Technical Institute of the Deaf's (NTID) nine-month non-credit certificate program which is primarily conducted online. The program aims to provide professional development to working SLIs in the specialization of healthcare. At the time of this paper, all graduates of this program had to be certified and have experience interpreting in the healthcare setting in order to qualify to participate.

Context-Based Ethical Reasoning: Critical thinking that involves an ongoing assessment and evaluation of the actual situation at hand. Outcome centered rather than rule based.

Interpreter Education Program (IEP): Generalist associate and bachelor degree programs that prepare students for entry into the field of signed language interpreting. Often include curricula on: American Sign Language, interpreting and translation theory, ethics, linguistics, discourse analysis, as well as general education classes required of any college student.

National Technical Institute of the Deaf (NTID): A college housed at Rochester Institute of Technology that serves Deaf and Hard of Hearing and interpreting students.

Registry of Interpreters for Deaf (RID): RID is the professional organization for signed language interpreters in the United States. They administer and maintain national certifications. Current certifications offered include: National Interpreter Certification (NIC), Certified Deaf Interpreter (CDI), Specialist Certificate: Legal (SC:L). This organization is also responsible for developing and publishing standard practice papers that cover a variety of specializations, including medical interpreting.

Role Metaphors: A series of models that have historically been used to describe and prescribe the work of signed language interpreters in America. Arguably, the most common is the conduit model.

Signed Language Interpreter (SLI): A signed language interpreter who interprets bidirectionally between at least one signed language and another language. The second language is often a spoken language. Most commonly in the United States, SLIs work between American Sign Language and English.

ENDNOTE

[1] Per contemporary practice in the deafness field, the upper case "Deaf" is used in this document when referring broadly to the community of individuals (or the organizations they establish) who use American Sign Language and otherwise manifest a sociocultural affiliation with the values, norms, and practices of the Deaf community and its culture. For some time now, scholars and the Deaf public have used this capitalized term, in ways similar to the capitalized terms Hispanic and Black, for example. The lower case "deaf" is used when making nonspecific reference to individuals with severe to profound hearing loss, without regard to their potential sociolinguistic or cultural affiliation with the Deaf community. The use of d/Deaf is used when referring to both groups.

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