Section 1.

Ethical Principles for Healthcare Interpreters

These Standards of Practice reflect CHIA's view of the healthcare interpreter as one of the three parties involved in the ***therapeutic*** relationship between patient and provider. As such, the interpreter shares the ***healthcare team***'s common interest in supporting the patient's health and well-being. Thus, the Ethical Principles and many of their applications (as detailed in the Performance Measures) are quite consistent with the values and principles of other professions in the healthcare field.

These principles will support the healthcare interpreting profession in setting guidelines for professional and ethical conduct and to increase interpreting quality. This will also enhance the trust vested in interpreters by healthcare professionals and LEP patients. Each ethical principle is equally important and reflects a different aspect of the complex interpreting task. While they are numbered here for easy reference, no one principle should take precedence over any other.

In the daily course of their work, healthcare interpreters will likely face situations where some ethical principles will seem to collide with one another, thus creating confusion about an appropriate course of action. Interpreters will then be called upon to exercise their professional judgment to address such ethical dilemmas.

In dealing with ethical dilemmas, the interpreter must remember that their actions need to be aligned with the ultimate goal of supporting the patient's health and well-being. It may not always be possible to support the patient/provider relationship if that relationship is impeding (or getting in the way of) the patient's access to quality healthcare services.

At the end of Section 1, we have developed a 6-step process for ethical decision-making to help guide interpreters faced with conflicting ethics. An example of how this ethical decision-making process could be applied appears in Appendix B.

Ethical Principle 1. Confidentiality

Interpreters treat all information learned during the interpreting as confidential.

Performance Measures

Interpreters maintain confidentiality by acting to:

a. Advise all parties that they will respect the confidentiality of the patient/provider interaction, and, when applicable, to explain to the patient what "confidentiality" means in the healthcare setting.

b. Advise all parties in the interpreting ***session*** to refrain from saying anything they do not wish to be interpreted.

c. Decline to convey to providers any information about the patient gained in a community context (more likely to occur in linguistic communities that are demographically small).

Note: In cases where interpreters are privy to information regarding suicidal/homicidal intent, child/senior abuse, or domestic violence, interpreters act on the moral, if not legal, obligation to transmit such

information to the provider, in keeping with institutional policies, interpreting standards of practice and code of ethics, and the law.

d. Decline to convey to patient any personal information about the provider.

Ethical Principle 2. Impartiality

Interpreters are aware of the need to identify any potential or actual conflicts of interest, as well as any personal judgments, values, beliefs or opinions that may lead to preferential behavior or bias affecting the quality and accuracy of the interpreting performance.

Performance Measures

Interpreters maintain impartiality by attempting to:

a. Demonstrate no preferential behavior or bias towards or against either party involved in the interpreting.

b. Allow the parties to speak for themselves and to refrain from giving advice or counsel, or taking sides.

c. Respect the right of the parties in a conversation to disagree with each other, and to continue interpreting without becoming drawn into the disagreement.

d. Refrain from interjecting personal opinions, beliefs or biases into the patient/provider exchange even when interpreters disagree with the message, or perceive it as wrong, untruthful, or immoral.

e. Avoid exhibiting non-verbal body language or facial expressions (e.g., eye-rolling, shoulder-shrugging, or any display of shock or disgust) that convey bias and lack of impartiality.

f. Disclose personal ties between the patient and the interpreter to the healthcare professional. Consider withdrawing and requesting substitution by another interpreter when personal ties cause discomfort or embarrassment, leading patients to avoid speaking freely.

g. Request permission to withdraw if it is perceived that pursuing the interpreting session would cause undue mental or emotional distress to the interpreter, due to personal trauma or experiences, thus impeding the interpreting task.

   Note: In cases where there is no alternative interpreter, interpreters will give thorough consideration to the situation and act responsibly, in a manner respectful of both self and others.

Ethical Principle 3. Respect for Individuals and their Communities

Interpreters strive to support mutually respectful relationships between all three parties in the interaction (patient, provider and interpreter), while supporting the health and well being of the patient as the highest priority of all healthcare professionals.

Performance Measures

Interpreters demonstrate and promote respect for individuals by seeking to:

a. Treat all parties equally and with dignity and respect, regardless of ethnicity, race, age, color, gender, sexual orientation, religion, nationality, political viewpoint, socioeconomic status, or cultural health beliefs.

b. Recognize that the concept of patient ***autonomy***, including the process for patient informed consent for treatment valued by the healthcare system, may conflict with the world view of many patients and their families from

other cultural backgrounds, and to alert the provider or others (e.g., nurse, social worker, patient-advocate, risk-manager, interpreter supervisor) that such conflicts exist.

c. Recognize the expertise all parties bring into the interaction by refraining from assuming control of the communication, and to provide a full and complete interpreting of all voices in the interaction.

d. Allow for physical privacy, maintaining necessary spatial and visual privacy of the patient while positioning themselves in the interaction.

e. Advise the provider of potential communication barriers due to gender differences between patient and provider, or patient and interpreter.

f. Refrain from influencing patient decisions and healthcare choices (e.g., informed consent, medical procedures, or treatment options).

g. Respond to disrespectful remarks by reminding all parties in the interaction of the ethical principle requiring accurate interpreting for everything that is spoken, including rudeness, and discriminatory remarks and behaviors.

Ethical Principle 4: Professionalism and Integrity

Interpreters conduct themselves in a manner consistent with the professional standards and ethical principles of the healthcare interpreting profession.

Performance Measures

Interpreters demonstrate professionalism and integrity by acting to:

a. Respect the boundaries of the professional role and to avoid becoming personally involved to the extent of compromising the provider-patient therapeutic relationship.

b. Protect the interpreter's own privacy and safety.

c. Avoid personal, political or potentially controversial topics with all parties at all times.

d. Refrain from soliciting or engaging in other business while functioning as the interpreter.

e. Resist creating expectations by either party that the interpreter role cannot fulfill, including functions related to the work of other health professionals, such as taking patient histories, physically moving patients, or assisting the provider in examining the patient, or acting as the patient's counselor.

f. Inform both parties about limitations in interpreting skills and experience when necessary and to consider declining assignments requiring skills beyond the interpreter's level of language proficiency (in either language) and interpreting skill.

g. Dress in appropriate attire in accordance with the setting, environment, and organizational policies.

h. Ensure their professional level of language proficiency (in both languages) and interpreting skills through appropriate and available assessments, testing, accreditation, and certification.

i. Participate in basic training and ongoing professional development through related continuing education activities, such as community college classes, workshops provided by the interpreter's organization, and health seminars.

j. Decline bribes, gratuities, or favors from any party involved in the interpreting in a culturally-sensitive and appropriate way, although small gifts of food from patients and their families may be graciously accepted and shared with other staff, when culturally appropriate.

Ethical Principle 5: Accuracy and Completeness

Interpreters transmit the content, ***spirit*** and cultural context of the original message into the target language, making it possible for patient and provider to communicate effectively.

Performance Measures

Interpreters demonstrate accuracy and completeness by acting to:

a. Convey verbal and non-verbal messages and speaker's tone of voice without changing the meaning of the message.

b. Clarify the meaning of non-verbal expressions and gestures that have a specific or unique meaning within the cultural context of the speaker.

c. Maintain the tone and the message of the speaker even when it includes rudeness and obscenities.

   Note: different cultural understandings and levels of acceptance exist for the usage of obscene expressions and profanities, and we understand the resistance most interpreters have towards uttering such expressions, although interpreters need to honor the ethical principle of "Accuracy and Completeness" by striving to render equivalent expressions).

d. Reveal and to correct interpreting errors as soon as recognized.

e. Clarify meaning and to verify understanding, particularly when there are differences in accent, dialect, ***register*** and culture.

f. Maintain the same level of formal/informal language (register) used by the speaker, or to request permission to adjust this level in order to facilitate understanding when necessary to prevent potential communication breakdown.

g. Notify the parties of any medical terms, vocabulary words, or other expressions which may not have an equivalent either in the English or target languages, thus allowing speakers to give a simplified explanation of the terms, or to assist speakers in doing so.

Ethical Principle 6. Cultural Responsiveness

Interpreters seek to understand how diversity and cultural similarities and differences have a fundamental impact on the healthcare encounter. Interpreters play a critical role in identifying cultural issues and considering how and when to move to a ***cultural clarifier*** role. Developing ***cultural sensitivity*** and ***cultural responsiveness*** is a life-long process that begins with an introspective look at oneself.

CHIA recommends that both providers and interpreters continually participate in ***cultural competency*** training that includes introspection and self-reflection on personal beliefs, values and practice in order to:

- Gain awareness of how one's personal values impact the ability to work within and across cultural groups
- Increase knowledge about similarities and differences between diverse cultural groups
- Develop skills to create, adapt and implement strategies to bridge these cultural differences

Performance Measures

Interpreters demonstrate cultural responsiveness by seeking to:

a. Identify and to monitor personal biases and assumptions that can influence either positive or negative reactions in themselves, without allowing them to impact the interpreting.

b. Recognize and identify when personal values and cultural beliefs among all parties are in conflict.

c. Monitor and to prevent personal reactions and feelings, such as embarrassment or frustration, that interfere with the accuracy of the message, and to recognize such reactions may be a result of their own personal acculturation level, which may be similar to or different from the patient and provider.

d. Identify statements made by providers and patients indicating a lack of understanding regarding health beliefs and practices, and to use applicable strategies suggested in the cultural clarifier role (Section 3. Guidance on Interpreter Roles and Interventions) to prevent potential miscommunication.

e. Seek continually to update their knowledge and understanding of the dynamic cultures of patients, healthcare providers, and the culture of the healthcare system in the United States.

Ethical Decision Making for Healthcare Interpreters

Ethics go beyond morals (right and wrong) to the reasons for the decisions or actions that an individual makes. In healthcare, when we say that someone is ethical, we mean that this person has analyzed his or her reasons for a decision or an action, and that the action is aligned with the ultimate goal of supporting the patient's health and well-being and the patient/provider relationship. It is impossible in some ethical dilemmas to support the patient/provider relationship (i.e. discrimination).

An ethical dilemma occurs when there is confusion about an appropriate course of action. It is important for interpreters in healthcare settings to have a process for making ethical decisions for their actions.

Process for Ethical Decision-making

The healthcare professions have developed processes for addressing ethical dilemmas. The following is one process interpreters may use:

1. Ask questions to determine whether there is a problem.
2. Identify and clearly state the problem, considering the ethical principles that may apply and ranking them in applicability.
3. Clarify personal values as they relate to the problem.
4. Consider alternative actions, including benefits and risks.
5. Decide to carry out the action chosen.
6. Evaluate the outcome and consider what might be done differently next time.

(See Appendix B for an example of how this decision-making process may be applied to help the interpreter make an ethical choice from among a variety of possible actions in an ethical dilemma.)

Ethical dilemmas are common in healthcare settings. Breaking decision-making into a series of logical steps helps interpreters better understand their options and analyze their actions. Healthcare interpreters need to discuss ethical dilemmas and explore ethical decision-making in the context of interpreter training.

Section 2.

Standardized Interpreting Protocols

This standardized interpreting protocol is the framework that guides the interaction between interpreters, patients and providers. In many circumstances, patients and providers are unfamiliar with the functions of an interpreter and do not know how to effectively utilize an interpreter. Protocols allow for patients and providers to understand the role of interpreters, how to proceed, and what to expect from interpreters throughout the encounter. Standardized protocols also enable interpreters to set the stage for a smooth interaction and help them focus on their interpreting task.

While time limitation and the actual context and urgency of any specific interpreting session may require making some modifications, interpreters strive to use the following protocols *before*, *during*, and *following* the encounter.

Protocol 1. Pre-Encounter, Pre-Session, or Pre-Interview

Before the session begins, interpreters establish the basic guidelines to the interpreting encounter by acting to:

a. Provide their name, the language of interpreting, and, if needed, their organizational affiliation.

b. State that they will maintain the confidentiality of the encounter regarding both provider and patient, and to explain to the patient what 'confidentiality' means in the healthcare setting when indicated.

c. Inform the parties of the elements necessary for a smooth interpreted encounter, including:

   1. The requirement for interpreters to interpret everything spoken by either party.

   2. The importance of the patient and provider addressing each other directly.

   3. The need for the parties to pause frequently to allow for interpreting.

   4. The possibility that interpreters may need to intervene for clarification.

d. Ask if the provider needs to brief the interpreter about anything in advance of the upcoming interaction, and to share any concerns the interpreter might have.

Protocol 2. During the Encounter, Session or Interview

During the session, interpreters facilitate communication to support the patient/provider relationship by acting to:

a. Position themselves to maximize and encourage direct communication between patient and provider.

b. Remind the patient and provider verbally or with gestures to address each other directly, as needed.

c. Use the ***first person*** ("I") as the standard form of interpreting, to enhance

direct patient/provider communication, and to exercise discretion in switching to the "third person" when the first person form causes confusion or is culturally inappropriate for either or both parties.[1]

d. Attend to verbal and nonverbal cues that may indicate the listeners are confused or do not understand, and to check whether clarification is needed.

e. Manage the smooth flow of communication by, for example, pacing the amount of information presented, avoiding side conversations with either party, and preventing parties from speaking simultaneously.

f. Intervene for clarification when interpreters do not understand the terminology or message.

g. Indicate clearly when interpreters are speaking on their own behalf (instead of interpreting the words of either patient or provider) when intervening for any purpose.

h. Consider interrupting the communication process in extreme circumstances to privately discuss with the provider or patient issues of concern to the interpreter that may not be openly discussed within the session (e.g., sensitive matters requiring privacy may arise when multiple family members are present or when a patient's safety is in jeopardy).

Protocol 3. Post-Encounter, Post-Session or Post-Interview

Interpreters provide closure to the interpreted session by taking measures to:

a. Inquire about any questions or concerns the parties may have for each other, and to ensure that the encounter has indeed ended.

b. Provide directions or to accompany the patient to subsequent appointments that day.

c. Facilitate the scheduling of follow-up appointments and to remind the patient or the receptionist to request an interpreter.

d. Document the provision of interpreting services, as required by each organization's policies.

e. Debrief providers or the interpreter's supervisor, when appropriate, about concerns of interpreters or providers arising from the session.

Health & Well-Being of the Interpreter

Following the interpreted session, it is important for interpreters to recognize and address their need to recover from highly emotional and stressful encounters by taking a brief time out or finding resources for emotional support within the boundaries of patient confidentiality.

Interpreters are not machines. The intense work of interpreting in healthcare settings is often stressful. Patients are often frightened, confused, tense or uncertain and may react in negative ways. This may result from frustration at the slow (or quick) pace of the session, difficulty in making themselves understood or in understanding what the provider is saying. Patients may direct their feelings at the provider and sometimes at the interpreter. Providers, on the other hand, may behave in a frustrated manner, appearing to be hurried or critical of the patient, or even of the interpreter. These interactions may cause interpreters to feel uncomfortable, sometimes inadequate, even angry.

Interpreters may find themselves suddenly interpreting emotionally-charged subject matter, such as a diagnosis of a terminal illness, a bad prognosis for an illness or injury, or a death announcement. At other times, interpreters may be

uncertain about the patient's or provider's expectations, while perceiving tension and frustration in the session.

Interpreters may already feel under stress. They may be concerned about making mistakes, working for the first time with a provider or a patient. They could be working with individuals with difficult personalities, calming an agitated or fearful patient, or interpreting complex subject matter and technical terminology. It is critical for interpreters to be aware of their own level of emotional responses to what is happening around them, and to know how to protect their own health and well-being.

CHIA supports the call of the American Society for Testing and Materials (ASTM) '*Guide F2089-01 Standard Guide on Quality Language Interpretation*', in acknowledging that healthcare interpreting is hard work. CHIA recommends that two interpreters work as a team for interactions lasting more than 45 minutes, and, that interpreters be given a 10-15 minute break after working continuously for an hour. After emotional encounters, interpreters need to be able to take a time-out and to seek debriefing, possibly with their supervisor (2000). CHIA also recommends that organizations employing interpreters help protect the health and well-being of their staff by offering workshops. Topics include handling difficult situations, managing conflict and anger, dealing with anxiety, stress and other emotions, and nurturing oneself.

Endnotes

1. The interpreter avoids using third person references, such as "the patient said," or "the doctor asked." However, it may be permissible for an interpreter, in languages based on relational inferences (including some Native American and Asian languages), to interpret asymmetrically. This means the interpreter interprets in the third person as appropriate with the patient but interprets in the first person on the English side of the conversation.


CALIFORNIA HEALTHCARE INTERPRETING ASSOCIATION
CHIA

Section 3.

Guidance on Interpreter Roles and Interventions

The fundamental purpose of healthcare interpreters is to facilitate communication between two parties who do not speak the same language and do not share the same culture. Various barriers to cross-cultural communication exist. These include language differences, language complexity, and differences in cultural norms, in addition to organizational or broader systemic barriers facing LEP patients. This section describes roles and strategies available to interpreters within the healthcare encounter to help the parties address these barriers.

CHIA recognizes that interpreters employed by any particular organization may have other duties and responsibilities associated with their employment outside of the role of interpreting. These duties will vary from organization to organization. They may include acts of customer service (not to be confused with patient advocacy) such as helping patients with directions, escorting patients to different locations, and informing patients of operating hours.

CHIA recommends that healthcare organizations ensure that interpreters are neither asked nor expected to carry out duties for which they are not trained. Examples include asking interpreters to take a patient history (to "speed up" the process), to assist the physician with the physical examination, to transfer

patients from bed to wheelchair, or to conduct patient health education in the place of the provider, based solely on having interpreted the same information in the past.

Bilingual providers or staff members serving as interpreters must clearly communicate that they are present in the encounter wearing an interpreter hat, and not wearing their usual provider hat. Ideally, during the interpreted encounter, bilingual providers or staff focus exclusively on interpreting. They temporarily step away from their usual duties as a nurse, clinician, case manager, medical assistant or other position. They need to alert the parties when they take off their interpreter hat.

Interpreter Roles within the Healthcare Encounter

Healthcare interpreting is a distinct specialty within the interpreting profession. The most frequent roles are those of ***message converter***, ***message clarifier***, ***cultural clarifier***, and ***patient advocate***.[1] These roles are presented in order of increasing complexity and controversy, requiring increasing skill, experience and caution on the part of the interpreter.

The most important consideration when choosing a role is how the interpreter's actions continue to support the primary relationship between patient and provider, in the context of the health and well-being of the patient.

Techniques and strategies for effectively carrying out the different interventions mentioned in this section should be explored in detail and practiced in the context of comprehensive and professional healthcare interpreting training.[2] Without this training, some interpreters may be unable to identify the communication barrier, decide on the appropriate role or feel comfortable using the strategies described in these standards. Interpreters may find the "ethical decision-making process" presented in Section 1 (and the example in Appendix B) helpful for determining the appropriate interpreter role.

Role 1. Message Converter

In the ***message converter*** role interpreters listen to both speakers, observe body language, and convert the meaning of all messages from one language to another, without unnecessary additions, deletions, or changes in meaning.[3] To do so, interpreters must manage the flow of communication between all the parties present. Interpreters need to intervene (verbally or nonverbally) when parties speak too fast or fail to allow the interpreter time to interpret. They also need to manage turn-taking, indicating to individuals speaking at the same time that they will be heard in sequential order or that a party must be allowed to finish speaking.

Role 2. Message Clarifier

Interpreters acting in the ***message clarifier*** role are alert for possible words or concepts that might lead to a misunderstanding. When there is evidence that any of the parties, including the interpreter, may be confused by a word or phrase, interpreters may need to:

a. Interrupt the communication process with a word, comment, or a gesture to the party currently speaking.

b. Alert the parties that the interpreter is seeing signs of confusion from one or more of the parties and identify the confusing word or concept.

c. Request or assist the speaker of a word or concept unfamiliar to the listener or interpreter to restate or describe the unfamiliar word or concept in a simpler way.

d. Explore ways to assist speakers to describe concepts using analogies, or "word pictures" when there are no linguistic equivalents in either language.

In any of the roles, when interpreters begin speaking in their own voice and no longer converting messages of either patient or provider, it is critical they clearly state to both parties that the message is from the interpreter. (For example, the interpreter may interject, "The interpreter would like to say…").[4]

Finally, interpreters should allow the patient and provider adequate opportunity to communicate common understandings without interpreter intervention. Unless communication is seriously impaired, interpreters preferably wait until either of the parties asks for interpreter help in clarifying words or concepts that are not understood before interrupting the flow of the communication.

Role 3. Cultural Clarifier

Culture determines how people behave, make decisions, communicate and interact with each other. Culture and language are inseparable. Concepts and words sometimes exist in one language but not another. Finding equivalent expressions is complex. This accounts for the different number of words required to express a concept in a second language.[5]

Cultural beliefs about health and illness around the world vary significantly from the biomedical perspective. Many traditional health beliefs, practices, and healers lack equivalent terms. Interpreters have a fundamental role in helping both parties understand each other's explanations on health and illness (Kaufert & Koolage, 1984; Kleinman, Eisenberg, & Good, 1978; Kleinman, 1988).

The ***cultural-clarifier*** role goes beyond word clarification to include a range of actions that typically relate to an interpreter's ultimate purpose of facilitating communication between parties not sharing a common culture.[6] Interpreters are alert to cultural words or concepts that might lead to a misunderstanding, triggering a shift to the cultural clarifier role.

The patient may perceive a provider's questioning strategy or remarks as culturally inappropriate. The same is true of the provider's perception of patient's comments. This occurs even though no disrespect was intended by either party. It happens more frequently when patient and provider do not share a common understanding of illness and medical treatment.

When there is evidence that any of the parties, including the interpreter, may be confused by cultural differences, interpreters need to:

a. Interrupt the communication process with a word, comment, or a gesture, as appropriate.

b. Alert both parties to potential miscommunication or misunderstanding (Interpreters may say, for example, "As an interpreter, I think that there may be potential danger for miscommunication/ misunderstanding.…").

c. Suggest cultural concerns that could be impeding mutual understanding.

d. Assist the patient in explaining the cultural concept to the provider, or the provider in explaining the biomedical concept. When requested, interpreters also need to explain the cultural custom, health belief or practice of the patient to the provider, or educate the patient on the biomedical concept.

Role 4. Patient Advocate

"Interpreters cannot and should not be responsible for everything that everyone does, or doesn't do. But, if they happen to notice something starting to go wrong, it is reasonable to bring it to the attention of someone who can correct it before it becomes a problem, rather than sit back and watch a disaster unfold" (Kontrimas, 2000).

Limited-English speakers can face major cultural and linguistic barriers in

accessing and utilizing services at all levels of the healthcare system (e.g., eligibility and enrollment, making appointments, clinician visits, billing, understanding prescriptions). 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. **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.**

CHIA recognizes non-English speakers may experience discrimination not only from individual healthcare providers and staff but also from system-wide legislation, policies, and practices. As an organization committed to equal access to healthcare for LEP patients, CHIA supports LEP patient group advocacy efforts. For more information on group advocacy, please refer to Appendix C.

A. What is Patient Advocacy?

An individual patient's health and well-being is at the heart of the patient advocate role.[7] Healthcare interpreters enter into the ***patient advocate*** role when they actively support change in the interest of patient health and well-being. Interpreters require a clear rationale for the need to advocate on behalf of patients. Before intervening as a patient advocate it is critical that interpreters consider:

- What changes are required to meet the needs of the patient?
- What options exist for the patient?
- Who can potentially carry out the positive changes?
- Is the patient in agreement with this course of action?

In undertaking patient advocacy, interpreters must carefully balance the ethics of patient autonomy and impartiality with the need for supporting patient well-being. It may be helpful for interpreters to consider the ethical decision-making process discussed in Section 1 and the example in Appendix B in choosing an appropriate course of action.

Patient advocacy can be as simple as suggesting that the patient needs an interpreter scheduled for follow-up appointments or giving the patient information needed to lodge a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Interpreters sometimes educate patients about their right to linguistically accessible services and about healthcare policy and culture. The patient advocate role may become more controversial, in such situations as assisting patients in filling out a grievance form or seeking resolution for a systemic problem. Since a wide variety of institutional policies and procedures exist, not all interpreters may be allowed to intervene in some instances, or feel comfortable taking such action. Due to the complexity of patient advocate interventions and potential risk to patients, CHIA suggests that such interventions remain an option to interpreters for pursue after considering their advocacy skills and potential risks and benefits.

B. Potential Risks and Benefits of Intervening as a Patient Advocate

Potential benefits of patient advocacy for the patient may be readily apparent to the interpreter, since the decision to intervene often stems from the interpreter's interest in having patient needs better met. However, interpreters must also consider the potential risks of intervening. Even when handled by an experienced and trained interpreter, patient advocacy may carry potential negative consequences for both patient and interpreter.

The healthcare provider or staff member may resent the interpreter's efforts. They might react in a way that actually diminishes quality of care or access for the patient. Lasting resentment may have a long-term impact on the

interpreter, resulting in a less effective working relationship. Depending on the type of patient advocacy intervention and whether the action is discussed with the patient, interpreters also risk usurping patient autonomy in determining how their cases are handled.

C. An Example of Patient Advocacy: Addressing Individual Discrimination in the Interpreted Encounter

When interpreters witness discriminatory actions against a patient, they may feel they lack the power to make a change, even when they are the only ones who could advocate for the patient. Understandably, interpreters may be concerned about their future working relationship with the provider and the possible impact on subsequent performance evaluations or employment. Interpreters may also believe that their duty to uphold the principle of impartiality conflicts with their concern for patient health and well-being.

When interpreters witness discrimination by healthcare providers or staff members, interpreters may need to:

a. Remind the parties of the ethical principle requiring interpretation of everything said in the interaction (Refer to Ethical Principle 2. Accuracy and Completeness).

b. Ask the parties to explain the intentions of their comments or actions, to eliminate the possibility that the perception of discrimination is not, in fact, a misunderstanding.

c. Provide the patient with the appropriate information or resources, or refer them to other staff for further assistance.

d. If the above strategies are not effective, interpreters could document the incident and bring it to the attention of their supervisor or another appropriate department. Institutional policies may limit the actions of

interpreters in this role. At least a discussion with the interpreter's supervisor (within boundaries of confidentiality ethics) is suggested. This allows the supervisor to become aware of the incident and that a response may be required in the future.

Endnotes

1. Multiple terms describing these roles are currently simultaneously in use in interpreter training and in the different academic fields, each with different analogies, connotations and controversies. This issue stems from the court interpreter ideal that the interpreter, as an individual person, should disappear from the interaction leaving only their physical voice presenting the correctly converted message in the right language. In sociolinguistics literature, this model has been called the ***conduit*** model (Kaufert & Koolage, 1984; Reddy, 1979). Reddy suggests thinking about language and communication as a sluice down which chunks of meaning, like pulp logs, are channeled from sender to receiver, arriving essentially unchanged. This "conduit" metaphor, however, is incorrect because there is clear evidence that language is a social construction within cultural communities (Hunt, 1993; Reddy, 1979). From a more current philosophical standpoint, the interpreter is obviously physically and intellectually present in the interaction. At the same time, there is not an exact one-to-one relationship between words and concepts across cultures and languages. This gives rise to the possibility that the interpreter becomes a third party in the conversation between patient and provider for a number of very specific communication and cultural issues. These roles have also been discussed in various literature (Angelelli, 2001; Metzger, 1999; Roy, 2000; Wadensjö, 1998). Some studies suggest that the "participation" or "intervention" of the interpreter is due to the nature of the medical encounter where the interpreter may be the only person able to identify the emergence of potentially critical patient health and safety issues (Kaufert & Koolage, 1984; Kaufert, Koolage, Kaufert, & D., 1984; Kaufert, Medd, & Mills, 1981; Kaufert & Putsch, 1997; Kaufert, Putsch, & Lavalee, 1999; Putsch, 1985). Other studies, bridging from communication studies, sociology and sociolinguistics,

consider interpreters as "co-participants" in the interaction and look at various instances of this role in typical interactions (Angelelli, 2001, 2002; Davidson, 2000; Metzger, 1999; Prince, 1996; Roy, 2000; Wadensjö, 1992, 1998).

2. Many healthcare interpreters may be familiar with the "***incremental intervention model***" of interpreting (Avery, 2001; Roat & et. al., 1999), presented in the "Bridging the Gap" training of the Seattle-based Cross Cultural Health Care Program. This model recognizes that the very presence of an interpreter in the patient-provider encounter is an "***intervention***" with the potential of positively or negatively impacting patient-provider relationships and outcomes (see Appendix D for a definition). The model attempts to maximize the positive and minimize the negative impact of having an interpreter present. It may be helpful to consider the "incremental intervention" model as a 'pyramid' or 'ladder' of increasing interpreter involvement in the content of the conversation, without making judgment about how frequently these roles may used in any encounter.

3. Not all messages will have an equivalent in the second language. Interpreters will then need to move into the role of ***message clarifier*** or ***cultural clarifier***.

4. The concept that the interpreter keeps both parties fully informed of what is happening, who is speaking, and what the interpreter is doing, is known as "***transparency***," or, "***transparent interpreting***."

5. Sapir, 1928: "People who speak different languages live in different worlds, not the same world with different labels" (Sapir & Mandelbaum, 1949, 1986).

6. This type of interpreter role has been previously called ***cultural brokering***, ***cultural mediating***, ***cultural bridging***, or ***cultural liaising*** (by authors such as: Avery, 2001; Roat et. al., 1999).

7. The patient advocate role of healthcare interpreters has been documented in health organizations with well-established interpreter services in the United States and Canada (Agger-Gupta, 2001) and in CHIA focus groups across California which reviewed earlier drafts of these standards (Angelelli, 2002).

Appendix A.

A Brief Overview of Language Barriers and Health Outcomes

The following are but a small fraction of studies of language barriers and health outcomes. A recent Institute of Medicine Report provides an extensive review of the research, strongly concluding that a need for trained interpreters exists (Smedley, Stith, & Nelson, 2002).

A survey commissioned by the Robert Wood Johnson Foundation found that one-fifth of Spanish-speaking Latinos living in communities with fast-growing Latino populations report not seeking medical treatment due to language barriers (Wirthlin Worldwide, 2001). The survey found both patients and providers agree that language barriers significantly compromise healthcare quality. Patients said language barriers made it much harder to explain symptoms, ask questions, and follow through with filling prescriptions, and caused them to doubt their physician's understanding of their medical needs. Ninety-four percent of providers said communication is a top priority in delivering quality care, identifying language barriers as a major challenge to delivering that care. Seventy three percent of providers said the aspect of care most compromised by language barriers is a patient's understanding of treatment advice and of their disease, 72 % said that barriers

can increase the risk of complications when the provider is unaware of other treatments, and 71% percent said barriers make it harder for patients to explain their symptoms and concerns.

The same study found that 51% of providers surveyed enlisted interpreting help from staff who speak Spanish, including clerical and maintenance staff. Another 29 % of providers said they rely on family members or friends of the patient to interpret. Patients said these practices often leave them feeling embarrassed, that their privacy has been compromised, and that information has been omitted. These concerns cause patients not to talk about personal issues when interpreters are present. Only 1% of providers actually used trained interpreters.

A 1996 study conducted in an emergency department in Los Angeles found 87% of Spanish-speaking patients with limited English who saw providers with limited Spanish were not given an interpreter whey they felt one should have been used (Baker, Parker, Williams, Coates, & Pitken, 1996). A 1997 survey of 495 primary care physicians in the San Francisco Bay Area showed 21% of visits were with non-English-speaking (NES) patients and that trained interpreters were used in only 6% of the encounters (Hornberger, Itakura, & Wilson, 1997). The other 94% of NES patients were "interpreted" by bilingual providers (27% of the time), untrained staff members (20%) and family members (36%), with no interpreter present in the remainder (11%).

Woloshin and colleagues (Woloshin, Schwartz, Katz, & Welch, 1997) found French-speaking women in Canada were less likely to receive mammograms and breast exams compared to patients who spoke English, even after controlling for socioeconomic factors.

Todd and his colleagues (1993) found Hispanics were less likely to receive pain medication in the emergency department for long-bone fractures, a risk they thought to be related to non-English-speaking status.

Carrasquillo et. al. (1999) reported data from the emergency department of five urban teaching hospitals suggesting that LEP patients were less satisfied

with care and less likely to return.

Hampers et. al. (1999) reported pediatric Emergency Department visits involving a language barrier were more expensive, took more time, and resulted more often in admission than visits without a language barrier.

Andrulis et. al. (2002) found greater dissatisfaction and more problems among LEP patients at safety-net hospitals who needed but did not receive an interpreter.

These are but a few studies. A full bibliography of research relating to health outcomes, language status and healthcare interpreting is in development and will be available through The California Endowment website: (http://www.calendow.org) in 2002.


CALIFORNIA HEALTHCARE INTERPRETING ASSOCIATION
CHIA

Appendix B.

Example of an Ethical Dilemma:

"Don't tell the doctor what I just told you!"

Often viewed by patients as their only link to the healthcare system, interpreters may find themselves receiving unsolicited health-related information from patients. This may happen in or out of the presence of a provider. In most circumstances after becoming recipients of information they do not seek, interpreters abide by the ethical principle of confidentiality (Ethical Principle 1). However, when patients do not want potentially important or critical medical information shared with the provider, the interpreter faces an ethical dilemma:

- Should interpreters take some action to help the provider receive this new information or should they remain silent and maintain patient confidentiality?

In order to answer this question, interpreters must consider several additional questions.

- If the interpreter reveals information without the patient's approval, how will this affect the level of trust level between interpreter and patient, or within the patient's community?

- What if the information revealed by the patient is critical for the patient's health or safety and therefore important for the provider to know?
- If the interpreter chooses to remain silent, will there be an impact on the patient's health and well-being?
- On the other hand, why would an LEP patient not be entitled to withhold information in the same way an English-proficient patient would?

(The heart of the dilemma is that interpreters do not possess the medical expertise to make such an informed decision. Before taking any action, including maintaining silence, interpreters must consider these questions and rank possible outcomes.)

1. Applying the Ethical Decision-Making Process

Using the process for ethical decision-making outlined below, interpreters would address this dilemma by taking the following actions:

1. Ask questions to determine whether there is a problem.
2. Identify and clearly state the problem, considering the ethical principles that may apply and ranking them in applicability.
3. Clarify personal values as they relate to the problem.
4. Consider alternative actions, including benefits and risks.
5. Decide to carry out the action chosen.
6. Evaluate the outcome and consider what might be done differently next time.

The following section illustrates each of these six points in detail.

1. Ask questions to determine whether there is a problem.

Explore the issue further to understand the patient's concerns and address possible misconceptions before deciding how to proceed.

2. *Identify and clearly state the problem, considering the ethical principles that may apply and ranking them in applicability.*

Problem: The interpreter does not know what to do with information shared by the patient.

Interpreters must consider their ethical duty to:

- Respect the patient's *autonomy*,[1] to maintain *impartiality*, and to uphold *confidentiality*.
- Determine whether there may be some degree of flexibility in deciding how and what information, if any, to share with the provider.
- Weigh these considerations in relation to the interpreter's overall concern for the health and well-being of the patient. (Among healthcare professionals, it is generally accepted that if the information is relevant to the patient's care, that information should be shared with others having healthcare responsibilities and who are also bound by the confidentiality ethic.
- Assess any impact on the level of trust between interpreter and patient (and potentially, trust within the patient's community) once the information is revealed.

3. *Clarify personal values as they relate to the problem.*

Interpreters may be influenced by one or more of the following factors:

- *Spiritual beliefs*. Animist, Buddhist, Christian, Hindu, and Muslim, among others. Spiritual beliefs differ and influence the way an interpreter approaches problems. Spiritual differences may pose a challenge for interpreters.
- *Traditional culture*. Different cultural beliefs influence interpreters.

Interpreters may struggle with a desire to protect a patient or themselves from possible ridicule.

- *Acculturation*. Interpreters need to expend additional effort to understand the patient who is less acculturated.
- *Personal honesty*. Interpreters may experience personal feelings of lack of honesty, accuracy, or transparency of their interpreting.
- *Guilt or shame*. Interpreters may face concerns about patient (and potentially community) reaction to revealing patient information.

4. Consider alternative actions, including benefits and risks.

ACTION	BENEFITS	RISKS
Remain silent (i.e., do not inform the doctor)	Patient continues to trust interpreter Allows patient the right to withhold information in the same way an English-speaking patient might	Compromises the doctor's ability to negotiate and understand the patient's health problem, recommend effective treatment, assess patient adherence or non-adherence to treatment The concealed information may be of sufficient importance to endanger the patient if the interpreter does not intervene Withholding potentially important information may cause the interpreter anxiety, uncertainty, and concern for the health and safety of the patient

ACTION	BENEFITS	RISKS
Tell the doctor	Increases the doctor's ability to understand the patient's health problem, to recommend and negotiate effective treatment options, and to assess patient adherence to treatment Relieves interpreter anxiety, uncertainty and concern about withholding potentially important information	Patient may lose trust in the interpreter Community may lose trust in interpreter if patient communicates dissatisfaction through formal or informal community networks
During the session	Patient may respect the courage of the interpreter in raising possibly important concerns with provider May increase trust for the interpreter. (This may depend on the culture, language group, and personality of the patient)	Patient may become angry and lose trust and respect for the interpreter (depends on the culture, language group and personality of patient)

ACTION	BENEFITS	RISKS
Outside the session	Patient may continue to trust interpreter Alerted by the interpreter, the provider may choose a culturally appropriate way to get the patient to discuss problems and concerns, thereby obtaining more complete information	Patient may lose trust in the interpreter Provider may be unable to talk immediately to the patient directly and to address any problems or concerns, or to obtain more information The concealed information may be of sufficient importance to endanger the patient if the interpreter does not find a way to intervene immediately

5. Decide to carry out the action chosen.

Keep the information confidential by saying nothing		
Tell the doctor the information	**WITH** the patient's *knowledge and consent*, interpreters may choose to inform the provider by proceeding to:	Encourage the patient to tell the doctor directly, for example by exploring the patient's concerns and explaining that the doctor cannot provide adequate treatment without all information
		Volunteer to share the information on behalf of the patient, before, during or after the appointment with the doctor

(continued) **Tell the doctor the information**	**WITHOUT** the patient's *consent* to reveal the information but **WITH** the patient's *knowledge*, the interpreter may choose to inform the provider by proceeding to:	Share the information directly with the provider during the health encounter in the presence of the patient
	WITHOUT the patient's *consent and knowledge*, the interpreter may choose to inform the provider by proceeding to:	1. Share the information directly with the provider during a pre-session or post-session in the absence of the patient and without the patient knowing, and then, 2. Suggest culturally-appropriate ways for the provider to explore eliminating communication barriers with the patient during the next interpreted encounter, and to discuss the patient's concerns in order to obtain a more complete understanding of ways the interpreter can maintain trust with the patient.

(If other options exist, please convey them to the Committee!)

6. Evaluate the outcome and consider what might be done differently next time.

Reflect on the outcome of the action. If the patient gained benefit, the interpreter may take a similar action in the future in comparable

circumstances. If the outcome was negative, resulting in problems for the patient or community, the interpreter may consider talking a different action in the future.

In dealing with ethical dilemmas, interpreters need to keep in mind that their actions must be consistent with the ultimate goal of supporting the patient's health and well being and when possible supporting the patient/provider relationship.

Other Types of Information

When information is related to domestic violence, child abuse, suicide, or intent to harm others, other factors must be considered in the process of determining an appropriate course of action. While California interpreters are not specifically identified as legally obligated to report a potentially harmful situation to their supervisor, interpreters must become familiar with the policies and requirements of healthcare or other organizations that employ their services.

Advisory Ethics Committee

The Standards and Certification Committee recommends the California Healthcare Interpreting Association establish an Advisory Ethics Committee. This committee would involve medical and legal practitioners, as well as experienced interpreters. It would examine ethically challenging cases and determine a consistent and ethical course of action. The committee's goal would be to recommend an ethical course of action in cases that raise important and conflicting ethical considerations.

Endnote

1. Addressed in Principle 3: "Respect for Individuals and their Communities."

Appendix C.

Group Advocacy: Systemic Access and Discrimination Issues

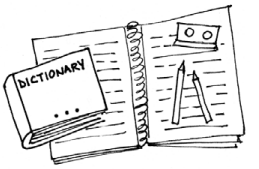
Systemic discrimination poses difficult challenges. Such matters typically involve members of an organization who may not recognize or comprehend the impact of established policies that are discriminatory. CHIA distinguishes between patient advocacy conducted in the interests of an individual LEP patient and advocacy on behalf of groups of individuals regarding LEP or other status.

Responding to a particular organization's discriminatory policies and practices often requires an interpreter to enlist support of others, whether internal or external to the organization. Systemic discrimination is not the focus of these Standards of Practice, since addressing such discrimination does not fall within the roles involved in the interpreted healthcare encounter.

However, in their capacity as healthcare professionals or concerned individuals, interpreters may play a role in eventually affecting change by documenting problems and raising the issues appropriately. Options are available for individuals and groups to influence such issues through organizations involved in community health, health advocacy, health access, and immigrant rights at the governmental level.


CALIFORNIA HEALTHCARE INTERPRETING ASSOCIATION
CHIA

Appendix D.
Definitions



The following terms, used throughout this document, are defined here. Some definitions are new, while others are borrowed or modified from a document produced by the Standards, Training and Certification Committee of the National Council on Interpreting in Health Care (2001), *The terminology of health care interpreting: A glossary of terms*, and yet others are from the ASTM standards document, 2000.
These definitions are so labeled.

Accreditation

A term usually referring to the recognition of educational institutions or training programs as meeting and maintaining standards that then qualify its graduates for professional practice (NCIHC).

See definition of *Certified Interpreter.*

Ad Hoc Interpreter

An untrained person who is called upon to interpret, such as a family member interpreting for her parents, a bilingual staff member pulled away from other duties to interpret, or a self declared bilingual in a hospital waiting-room who volunteers to interpret. Also called a *chance interpreter* or *lay interpreter* (NCIHC).
Webster's Dictionary: -unplanned, impromptu, extemporized." (Note that this could possibly also refer to a trained interpreter in an unplanned interpreting session).

Advocacy

The American Heritage Dictionary defines "advocacy" as "active support." In the healthcare interpreter setting, "advocacy" is an action taken by an interpreter intended to further the interests of, or rectify a problem encountered by one of the parties, to the interpreting session, usually the patient.

See *Role, Transparency.*

Autonomy

A central principle in bioethics: patients who are competent to make decisions should have a right to do so, and physicians should have the concomitant duty to respect patient preferences regarding their own health care (Beauchamp & Childress, 1994). However, this perspective is being reconsidered in light of differing cultural values. "When a doctor approaches his patient, he sees a person not only as a moral agent with autonomy and dignity to be respected, namely, the patient's concerns, preferences and choices to be respected and his rights protected. He also sees the patient as a relational being with certain family, community and social-historical contexts: a small self encompassed by one or many greater selves. In a Confucian context, the family, more than the individual, is often considered as one basic unit in the two aspects of doctor-patient relationships (Tsai, 2001).

Bilingual

A term describing a person who is proficient in two languages. Fluency in both languages, the most basic of the qualifications of a competent interpreter, by itself does not insure the ability to interpret.

Bilingual Provider A healthcare professional with proficiency in more than one language, enabling the person to provide services directly to limited-English proficient patients in their non-English language (NCIHC).

Bilingual Worker/ Employee An employee, with proficiency in more than one language, who is often called upon to interpret for limited-English proficient patients, but who is usually not trained as a professional interpreter (NCIHC).

See *Professional Interpreter*.

Certification A process by which an accredited governmental or professional organization attests to or certifies that an individual is qualified to provide a particular service. Certification calls for formal assessment, using an instrument that has been tested for validity and reliability, so that the certifying body can be confident that the individuals it certifies have the qualifications needed to do the job. "Certificates of completion" given by training institutions to interpreters taking their courses, may not be equivalent to professional certification.

See *Certified Interpreter*.

Certified Interpreter An individual certified as competent by an accredited professional organization or government entity through rigorous testing based on appropriate and consistent criteria that have been used in developing valid and reliable tests. Screening tests administered by

an employing health, interpreter or referral agency may only convey "certification" for that particular agency.

Consecutive Interpreting

The ***mode*** of interpreting whereby the interpreter relays a message in a sequential manner after the speaker has paused or has completed a thought. In other words, the interpreter waits until the speaker has finished the ***utterance*** before rendering it in the other language (Green, 1995).

See *Mode, Simultaneous Interpreting.*

Cultural Clarifier

Transparently providing cultural information, particularly about cultural health beliefs. Also called *cultural brokering*, *cultural liaiso*n, or *cultural bridging.*

See *Incremental Intervention Model, Role, Transparency.*

Cultural Competency (in healthcare)

A continuous process of seeking cultural sensitivity, knowledge and skills to work effectively with individuals and families from diverse cultural communities and with their culturally diverse providers.

Other definitions currently in use:

a) The ability of health organizations, inclusive of health care practitioners, to recognize the cultural beliefs, attitudes and health practices of diverse populations and to use that knowledge – to prescribe the best possible intervention/treatment – at the systems level or at the individual level (Pacheco, 2002).

b) Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (Bazron, Cross, Dennis, & Isaacs, 1989) as cited in DHHS CLAS Standards (2001).

Cultural Responsiveness

A measure of the knowledge, skill and sensitivity of healthcare professionals and their organizations to become aware of the individual and systemic needs of culturally diverse populations, and their subsequent receptivity and openness in developing, implementing and evaluating culturally-appropriate institutional responses to these needs.

Cultural Sensitivity

Awareness of one's own cultural assumptions, biases, behaviors and beliefs, and the knowledge and skills to interact with and understand people from other cultures without imposing one's own cultural values on them. Cultural sensitivity is required at both the individual level and at systemic, professional and organizational levels (Agger-Gupta, 1997).

First-person (interpreting)

The use of the direct utterances of each speaker by the interpreter as though the interpreter was the voice of the person speaking in the language of the listener. For example, if the patient says, "My stomach hurts," the interpreter says (in the listener's language), "My stomach hurts," and not "She says her stomach hurts," (This would be in the *third person*) (Adapted NCIHC).

Healthcare Interpreting

Interpreting that takes place between a patient (or the patient and one or more family members) and a healthcare provider (doctor, nurse, lab technician) in settings across the healthcare continuum, including, but not limited to, doctor's offices, clinics, hospitals, home health visits, mental health clinics, and public health presentations.

See *Medical Interpreting.*

Healthcare Interpreter

A healthcare interpreter is one who has 1) been trained in healthcare interpreting, 2) adheres to the professional code of ethics and protocols of healthcare interpreters, 3) is knowledgeable about medical terminology, and 4) can accurately and completely render communication from one language to another. Ideally, healthcare interpreters have been tested for their fluency in the languages in which they interpret. A healthcare interpreter may include a bilingual or multilingual provider or medical staff. Minor children lack the training, skills and competencies, as well as being ethically inappropriate, to be a healthcare interpreter.

See *Healthcare Interpreting, Interpreter, Transparency.*

Healthcare Team The patient, provider (doctors, nurses, social workers, lab technicians), and the healthcare interpreter, who work together for a positive health outcome for the patient.

Informed Consent The process whereby a physician informs his/her patient about the options for the treatment, including surgery, for the patient's illness. As part of this process, the likely risks and benefits of the procedure are described to the patient so that they are able to make a rational decision regarding what he/she wants to be done (Bernstein, 2001).

Interpreter An individual who mediates spoken or ***signed*** communication between people speaking different languages without adding, omitting, or distorting meaning or editorializing. The objective of the professional interpreter is for the complete transfer of the thought behind the utterance in one language into an utterance in a second language. Professional interpreters abide by a code of professional ethics and practice what is called, "transparent interpreting".

See *Transparency.*

Interpreting The process of understanding and analyzing a spoken or signed message and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account ASTM, 2000. The purpose of interpreting is to enable communication between two or more individuals who do not speak each other's languages.

Interpretation While the two words have the same meaning in the context of oral/signed communication, the term *interpreting* is preferred, because it emphasizes process rather than product and because the word *interpretation* has so many other uses outside the field of translation and interpreting (NCIHC).

See *Interpreting*.

LEP See *Limited English Proficient*.

Licensed Having formal permission or authority, from either government or a professional body to perform some professional role, such as interpreting.

See *Accreditation or Certification.*

Licensure The process of obtaining an official license or authorization to perform a particular job (NCIHC).

See *Licensed.*

Limited English Proficiency (LEP) "Limited English-Proficient" or "(LEP)" means a limited ability or inability to speak, read, write, or understand the English language at a level that permits the person to interact effectively with health care providers or social service agencies (California draft Senate Bill AB2739).

Medical Interpreting

This term is often used interchangeably with healthcare interpreting, but does not usually include interpreting in the broader continuum of healthcare – nursing homes, public health, population health, community and home care nursing, and social work, among others.

See *Healthcare Interpreting.*

Message Clarifier

An interpreter role involving helping a speaker to explain a message or concept in an alternate or more easily understood way to facilitate communication between any of the parties during the interpreting session.

See *Role, Message Converter.*

Message Converter

The basic role of the interpreter involving facilitating the flow of the conversation between two parties wherein the interpreter hears the original message in one language and then provides a verbal utterance, equivalent in content and register, in the second language.

See *Role, Message Clarifier, Register, Utterance.*

Mode

Interpreting involving different formats and differing ways of interacting with the two parties during the interpreting interaction. Modes include: *Consecutive, Simultaneous, or Summary*. They can be either done *proximally* (on-site and in-person), or *remotely* (via telephone, ***video,*** or computer). The standard mode for healthcare interpreting is consecutive; summary mode is not an acceptable mode in healthcare interpreting.

See *Consecutive Interpreting, Simultaneous Interpreting, Summary Interpreting, On-site Interpreting, Remote Interpreting, Video Interpreting, and Role.*

Multilingual

A term describing a person who has some degree of proficiency in two or more languages.

On-site Interpreting

Interpreting taking place within a specific facility or location. This term was used as an equivalent for the concept of "proximal," or *face-to-face interpreting.* Many organizations now have interpreters working as remote, telephonic interpreters for patient/provider interactions within their site or facility.

See *Mode, Remote Interpreting, Telephonic Interpreting.*

Patients (or consumers, or clients)

Individuals, including accompanying family members, guardians, or companions, seeking physical or mental health care services, or other health-related services (Fortier et. al., 2001).

Professional Interpreter

An individual who has been trained and tested, adheres to a code of professional ethics and standard protocols, and is paid to interpret.

See *Interpreter, Ad Hoc Interpreter, Lay Interpreter.*

Register (language)

A speaker's linguistic features of pronunciation and choice of vocabulary and grammar which contribute to the speaker's perceived level of education or social class.

Whether interpreters should shift register to facilitate understanding for either party is currently a controversial issue.

See *Transparency.*

Remote Interpreting

Interpreting provided by an interpreter who is not in the presence of the speakers, e.g., interpreting via telephone or videoconferencing (ASTM).

See *Telephone Interpreting, Video Interpreting, On-site Interpreting.*

Role(s) (interpreter)

The healthcare interpreter, in working toward positive health outcomes for the patient, takes on a variety of roles, depending on the circumstances as required. (see Section 3 in this document on interpreter roles and interventions for more detail.) Roat calls the shifting between intervening roles the *incremental intervention* model (Roat & et. al., 1999). Among possible roles, the interpreter functions as *"message converter"* (often called the *"conduit"* or *"message passing"* role); the *"message clarifier,"* the *"cultural clarifier,"* and the *"patient advocate."* These terms are defined in Section 3 of this document. The interpreter should be aware, at all times, that the most appropriate role is the least invasive role that will assure effective communication and care.

Session (Encounter, Interaction)

(Definition 6 of 13) a meeting or period devoted to a particular activity <an interpreting *session*> (adapted from Merriam-Webster's Collegiate Dictionary).

Sight Translation — An interpreter reads a document written in one language and interprets it into a second language (NCIHC).

Simultaneous Interpreting — Converting a speaker or signer's message into another language while the speaker or signer continues to speak or sign (NCIHC).

See *Consecutive Interpreting.*

Sign(ed) Language — See *Visual Languages.*

Source Language — The language used by the speaker or signer and out of which the message is interpreted into a target language.

See *Target Language.*

Spirit — *(Definition 5 of 7)* The activating or essential principle influencing a person. (Used in a sentence: '…acted in a *spirit* of helpfulness.') from Merriam Webster's Collegiate Dictionary

Summarizing (Summary interpreting) — A limited interpretation focusing only on the principal points of the interpreted speech that excludes all or most details— Not a full interpretation. Summarizing speech is not considered acceptable in healthcare interpreting.

Target Language — The language of the listener; the language into which an utterance is interpreted.

See *Source Language.*

Telephone (or telephonic) Interpreting — Interpreting carried out with the interpreter connected by telephone to the principal parties, typically provided through a speakerphone or headsets.

See R*emote Interpreting.*

Therapeutic Relationship — The three-party relationships between and among the provider, the patient and the healthcare interpreter, each of whom provides necessary expertise in working toward the positive health outcome for the patient.

Translation — The conversion of a written text into a written text in a second language corresponding to and equivalent in meaning to the text in the first language. (Note that translation refers to written to written conversion while interpreting refers to the conversion of spoken or verbal communication from one language into a second language.)

See *Sight Translation.*

Translator — A person who converts written texts from one language into a text in a second language with an equivalent meaning, especially one who does so professionally.

See *Translation, Interpreter.*

Transparency/ Transparent Interpreting

The idea that the interpreter keeps both parties in the interpreting session fully informed of what is happening, who is speaking, and what the interpreter is doing, is known as "transparency." Whenever interpreters intervene by voicing their own thoughts and not the interpreted words of one of their clients, it is critical that they ensure that a) the message is conveyed to all parties and b) everyone is aware that the messages is from the interpreter (for example, "*…the interpreter would like to say,…*").

Utterance

A verbal or spoken word, thought or expression.

Video Interpreting

Interpreting when one or more of the parties are not present in the same room, using a video camera to enable the parties to see and hear each other, including the interpreter, via a TV monitor.

See *Remote Interpreting.*

Visual Language

All the different forms of communication used by interpreters for the deaf, including American Sign Language (ASL), Quebecois French (LSQ) and other sign language variants in other parts of the world (e.g., British, Spanish, French, Mexican), transliterated English (word by word interpretation from English into visual language), lip reading, and tactile interpretation. Note that sign languages for the deaf are unique languages with their own syntax and are not signed versions of English or other spoken languages. For more information see the Registry of Interpreters for the Deaf website (http://www.rid.org).

Appendix E.
References

Agger-Gupta, N. (1997). *Terminologies of Diversity 97: A Dictionary of Terms for Individuals, Organizations and Professions.* (2nd ed.). Calgary, Alberta, Canada: Human Rights & Citizenship Services Branch, Alberta Department of Community Development.

Agger-Gupta, N. (2001). *From "making do" to established service, the development of health care interpreter services in Canada and the United States of America: A grounded theory study of health organization change and the growth of a new profession (PhD dissertation).* Santa Barbara: The Fielding Graduate Institute / UMI (available at http://www.umi.com).

Andrulis, D., Goodman, N., & Pryor, C. (2002). *What a difference an interpreter makes: Health care experiences of uninsured with limited English proficiency*. Boston, Massachusetts: The Access Project, a program of the Center for Community Health Research and Action of the Heller School for Social Policy and Management at Brandeis University.

Angelelli, C. (2001). *Deconstructing the Invisible Interpreter: A critical study of the interpersonal role in a cross-cultural/linguistic communicative event (PhD. Dissertation*): Stanford University / UMI.

Angelelli, C. (2002). *Focus Group Study on California Standards for Healthcare Interpreters: Proposed Ethical Principles, Protocols and Guidance on Interpreter Interventions and Roles* (Qualitative analysis of four focus groups). San Diego: California Healthcare Interpreting Association (CHIA). (Available online at http://www.chia.ws/standards.htm).

Avery, M. P. B. (2001). *The role of the health care interpreter: An evolving dialogue*. Boston: National Council on Interpreting in Health Care (NCIHC).

Baker, D. W., MD, MPH., Parker, R. M., MD., Williams, M. V., MD., Coates, W. C., MD., & Pitken, K., MPH. (1996). Use and Effectiveness of Interpreters in an Emergency Department. *Journal of the American Medical Association*, 275 (10), 783-788.

Bazron, B., Cross, T. L., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care, Volume I: a monograph on effective services for minority children who are severely emotionally disturbed (Vol. I). Georgetown: Child and Adolescent Service System Program (CASSP).

Beauchamp TL, Childress JF. *Principles of biomedical ethics* [4th ed]. New York: Oxford University Press, 1994.

Bernstein, M. M. D. (2001). *Dr. Maurice Bernstein's Medical Bio-Ethics Discussion Page (USC)*. On University of Southern California website: (http://www.hsc.usc.edu/~mbernste/ethics.informed_consent.html). Retrieved, from the World Wide Web: http://www.hsc.usc.edu/~mbernste/ethics.informed_consent.html)

California State Assembly. (1973). Dymally-Alatorre Bilingual Services Act, *Calif. Gov't Code Sec. 7290, et. Seq.*

California State Assembly. (1975). Knox-Keene health care service plan act of 1975, *Health and safety code section 1340-1345.*

California State Assembly. (1983). Health & Safety Code 1259, *California Government Code* (Vol. Sec. 1259, et. Seq.).

Carrasquillo, O., Orav, E. J., Brennan, T. A., & Burstin, H. R. (1999). Impact of language barriers on patient satisfaction in an emergency department. *Journal of General Internal Medicine*, 1999 (14), 82-87.

Centers for Disease Control and Prevention. (1998). Tobacco Use Among U.S. Racial/Ethnic Minority Groups: A Report of the Surgeon General.

Davidson, B. C. (2000). *Interpreting medical discourse: A study of cross-linguistic communication in the hospital clinic (PhD Dissertation)*. Unpublished Ph.D., Stanford, Palo Alto, California.

Fortier, J. P., AB, Harris, G., & Jacobs, C. G. (2001). *Final Report: National standards for culturally and linguistically appropriate services in health care*. Washington, DC.: U.S. Department of Health and Human Services, OPHS, Office of Minority Health. Available online at: http://www.omhrc.gov/inetpub/wwwroot/omh/programs/2pgprograms/cultural4.htm

Forum, L. I. (1997). *Who's Planning for the Future of the Bay Area?* Oakland: Latino Issues Forum.

Garber, N. (2000). *Standards of practice for community interpreters: version 2* (Draft Standards). London, Ontario: Across Languages.

Green, C. E. (1995). *Medical Interpretation Curriculum Training Program:* Vista Community Clinic, California.

Hampers, L. C., Cha, S., Gutglass, D. J., Binns, H. J., & Krug, S. E. (1999). Language barriers and resource utilization in a pediatric emergency department. *Pediatrics, 103* (6 Pt 1), 1253-1256.

Hornberger, J., Itakura, H., & Wilson, S. R. (1997). Bridging language and cultural barriers between physicians and patients. *Public Health Rep, 112* (5), 410-417.

Hunt, R. A. (1993). Texts, textoids and utterances: Writing and reading for meaning, in and out of classrooms. In S. B. Straw & D. Bogdan (Eds.), *Constructive reading: Teaching beyond communication* (pp. 113 -129). Portsmouth, New Hampshire: Heinemann-Boynton/Cook (article available online at: http://www.stthomasu.ca/~hunt/ttu.htm).

Kaufert, J. M., & Koolage, W. W. (1984). Role conflict among 'culture brokers': the experience of native Canadian medical interpreters. *Social Science & Medicine, 18* (3), 283-286.

Kaufert, J. M., Koolage, W. W., Kaufert, P. L., & D., O. N. J. (1984). The use of "trouble case" examples in teaching the impact of sociocultural and political factors in clinical communication. *Medical Anthropology, 8*, 36-45.

Kaufert, J. M., Medd, L., & Mills, A. (1981). *Utilization of medical services by families in a reserve community: a comparison of client and service provider perspectives*. Paper presented at the Canadian Public Health Association Annual Meeting.

Kaufert, J. M., & Putsch, R. W. I. (1997). Communication through interpreters in healthcare: ethical dilemmas arising from differences in class, culture, language and power. *The Journal of Clinical Ethics, 8* (1), 71-87.

Kaufert, J. M., Putsch, R. W. I., & Lavalee, M. (1999). End-of-life decision making among Aboriginal Canadians: interpretation, mediation, and discord in the communication of "bad news". *Journal of Palliative Care, 15* (1/1999), 31-38.

Kleinman, A., Eisenberg, L., & Good, B. (1978). Culture, illness and care: Clinical lessons, Anthropologic and Cross-cultural research. *Annals of Internal Medicine, 88*, 251-258.

Kleinman, A., M.D. (1988). *Rethinking psychiatry: from cultural category to personal experience* (1st ed.). New York: The Free Press, A Division of Macmillan, Inc.

Kontrimas, J. (2000). The trouble with the term "advocacy". *Massachusetts Medical Interpreters Association Newsletter, 3* (Fall).

Massachusetts Medical Interpreters Association & Education Development Center, I. M. (1995). *Medical Interpreting Standards of Practice*. Boston: Massachusetts Medical Interpreters Association.

Metzger, M. (1999). *Sign Language Interpreting: deconstructing the myth of neutrality*. Washington, DC: Gallaudet University Press.

National Council on Interpreting in Health Care. (2001). *The terminology of health care interpreting: A glossary of terms* (Working Papers Series, Volume #3). Washington, DC: Standards, Training and Certification Committee of the National Council on Interpreting in Health Care (NCIHC) on contract with the Department of Health and Human Services Office of Minority Health (available online at http://www.ncihc.org/papers.html).

Office of Diversity Mount St. Joseph Hospital. (1996). *Health Care Interpreter Standards of Practice*. Vancouver, British Columbia, Canada: Mount St. Joseph Hospital.

Pacheco, G. (Office of Minority Health, US Department of Health & Human Services). (2002). *Presentation: National movement in health work force diversity and cultural competency update*. Paper presented at the Health Work Force Diversity and Cultural Competency Convening (The California Endowment). Manhattan Beach, California.

Perkins, J., Simon, H., Cheng, F., Olson, K., & Vera, Y. (1998). *Ensuring Linguistic Access in Health Care Settings: Legal Rights and Responsibilities*. Los Angeles, California: National Health Law Program and Henry J. Kaiser Family Foundation.

Pollard, R. Q. J., Miraglia, K., Pollard, K., Chapel, S., Elliott, M., & Abernethy, A. (1997). *Mental health interpreting: A mentored curriculum*. Rochester, New York: Department of Psychiatry, University of Rochester School of Medicine (email: Robert_Pollard@urmc.rochester.edu).

Prince, C. (1986). *Hablando con el Doctor (Unpublished Dissertation)*. Stanford University, Stanford.

Putsch, R. W. I. (1985). Cross-cultural communication: The special case of interpreters in health care. *Journal of the American Medical Association, 254* (23), 3344-3348.

Putsch, R. W. I. (1998). Language and meaning in health care: what's in the message? *Across Cultures (newsletter of the Cross-Cultural Health Care Program)* (January).

Reddy, M. J. (1979). The conduit metaphor: a case of frame conflict in our language. In A. Ortony (Ed.), *Metaphor and thought* (pp. 284-324). New York: Cambridge University Press.

Roat, C. E., et. al. (1999). *Bridging the Gap: A Basic Training for Medical Interpreters: Interpreter's Handbook* (3rd (1st Edition - 1996) ed.). Seattle, Washington: Cross Cultural Health Care Program of Pacific Medical Clinics.

Roy, C. B. (2000). *Interpreting as a discourse process*. New York: Oxford University Press.

Sapir, E., & Mandelbaum, D. G. (Eds.). (1949, 1986). *Selected Writings of Edward Sapir in Language, Culture and Personality* (Reprint edition (November 1986) ed.). Berkeley: University of California Press.

Smedley, B. D., Stith, A. Y., & Nelson, A. R. (Eds.). (2002). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington, D.C.: Institute of Medicine, National Academy Press.

Subcommittee F15.34 of American Society of Testing and Materials (ASTM). (2000). *Standard Guide for Quality Language Interpretation Services* (document F2089). Conshohocken, PA.: American Society for Testing and Materials (ASTM) (available online at: http://www.astm.org).

Todd, K. H., MD., Samaroo, N., & Hoffman, J. R., MD. (1993). Ethnicity as a risk factor for inadequate emergency department analgesia. J*ournal of the American Medical Association, 1993* (269), 1537-1539.

Torres, R. E. (1998). The pervading role of language on health. *Journal of Health Care for the Poor and Underserved, 9* (Special Issue), S21-S25.

Tsai, D. F.. How should doctors approach patients? A Confucian reflection on personhood. *J Med Ethics* 2001; 27:44-50

Wadensjö, C. (1992). *Interpreting as interaction: on dialogue-interpreting in immigration hearings and medical encounters* (Vol. 83). Linköping, Sweden: Linköping University: Distributed by Dept. of Communication Studies.

Wadensjö, C. (1998). *Interpreting in interaction*. London: Longman.

Wirthlin Worldwide. (2001). *Hablamos Juntos / Survey of Interpreter Need* (available online at: http://www.rwjf.org/newsEvents/mediaRelease.jsp?id=100811116867) Washington, D.C.: Robert Wood Johnson Foundation.

Woloshin, S., Bickell, N., Schwartz, L. M., Gany, F., & Welch, H. G. (1995). Language Barriers in Medicine in the United States. *Journal of the American Medical Association, 273* (9, March 1, 1995), 724-728.

Woloshin, S., Schwartz, L. M., Katz, S. J., & Welch, H. G. (1997). Is language a barrier to the use of preventive services? *Journal of General Internal Medicine, 1997* (12), 472-477.

Working Group of Minnesota Interpreter Standards Advisory Committee. (1998). *Bridging the language gap: how to meet the need for interpreters in Minnesota*. Minneapolis, MN: Minnesota Interpreter Standards Advisory Committee, printed by Minneapolis Department of Health and Family Support.

Become a CHIA *member*

CHIA would like to invite you to join us and become part of the organization.

CHIA's membership includes interpreters and translators, interpreter teachers and trainers, healthcare advocates, administrators, nurses, doctors, lawyers, refugee healthcare activists, and public policy experts. Corporate members include cultural diversity and interpreter training programs, hospitals, community clinics, social service organizations, language service providers, government agencies, and community colleges.

CHIA members have the following benefits:

- The right to vote in Board elections.
- Elegible for election to CHIA's Board of Directors.
- Discount on registration for CHIA regional trainings, webinars, and annual conference.
- Networking with peers via CHIA activities and social media.
- Access to up-to-date information on healthcare interpreting.
- Receive news and announcements from CHIA.
- The satisfaction of being an involved and active participant in meeting the challenges of developing the healthcare interpreting profession.
- Opportunity to share common goals and a mutual sense of purpose with other members.

What does your membership mean to CHIA?
You are CHIA*!* We need your ideas, your expertise, your voice!

CHIA is committed to be there for you! We need you to support CHIA's mission to overcome linguistic and cultural barriers to high-quality health care, for the development of the healthcare interpreter profession, advocating for culturally and linguistically appropriate healthcare services, and promoting education and trainingfor healthcare interpreters.

www.chiaonline.org

Thank you for your support!


CALIFORNIA HEALTHCARE INTERPRETING ASSOCIATION
CHIA