# Core Competencies for Healthcare Interpreters

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## Abstract

*Linguistic barriers lead to denial of needed benefits and services, client misunderstanding of treatment, receipt of the wrong benefits or services, significant delays in treatment, misdiagnosis, clients' poor decision making, ethical compromises (e.g. difficulty obtaining informed consent, medical errors and clients not being given all available options of care), and rise in the cost of medical care. The encounter between Limited English Proficient patients and healthcare providers need to be mediated by a trained linguistic broker. To pave the way for setting uniform standards for healthcare interpreters, this paper developed a list of core competencies that are critical to every beginner interpreter. The development of a preliminary list of core competencies was informed by an extensive consultation of literature, a review of healthcare interpreter training curricula, and solicitation of the perspectives of curricular developers, interpreters, policy makers, administrators and providers. The investigators developed two survey instruments with both close-ended and open-ended questions to examine the attitudinal and perceptual consensus and difference between two cohorts of respondents: healthcare interpreter trainers/curriculum developers, and practicing interpreters/interpreters-in-training, regarding the core competencies essential to a high quality healthcare interpreting training. Telephone and in-person follow-up interviews were conducted with trainers and interpreters to gather additional insights.*

**Key Words:** Healthcare Interpreter Training, Patient-Provider Communication, Health Disparities

## *Introduction and Background*

### 1.1. Implications of language barriers on the quality, outcome and costs

Research in the United States indicates that inadequate language services negatively impact access to, and quality of, healthcare for Limited English Proficient (LEP) persons. Health outcomes and healthcare costs are affected by the lack of language access, further contributing to healthcare disparities.).

- **Impact on access to preventive services**

LEP persons are less likely to use preventive services, thus potentially neglecting health problems until they become acute and expensive to treat. Research found that limited English proficiency is a deterrent to seeking medical care as much as lack of health insurance (Derose & Baker, 2000).

- **Impact on service delivery and outcomes**

Linguistic barriers lead to denial of needed benefits and services, client misunderstanding of treatment, receipt of the wrong benefits or services, significant delays in treatment, doctors misdiagnosing clients, poor shared decision-making, ethical compromises (e.g., difficulty obtaining informed consent), medical errors, and clients not being given all available options for care (Commonwealth Fund, 2003).

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Language barriers increase risks for medical errors as they can lead to misdiagnoses and/or a compromised comprehension of required treatments and medication instructions. The rate of medical errors incurred as a result of encounters using professional interpreters has been found to be 12%, significantly less than errors incurred at encounters using no interpreters (20%) (Commonwealth Fund, 2003).Flores et al. noted an average of 31 errors per clinical encounter with an untrained interpreter, with 63% of all errors having potential clinical consequences (Flores& Mayo, 2003).Poorer adherence to medication and discharge instructions means non-English speakers are less likely to manage chronic conditions with appropriate follow-up care, negatively affecting healthcare outcomes (Youdelman, 2003).Having professional interpreters decrease communication errors, increase patient comprehension, equalize healthcare utilization, improve clinical outcomes, and increase satisfaction with communication and clinical services for LEP patients (Karliner, Jacobs, Chen &Mutha, 2007).

- **Impact on healthcare costs**

During a period of great concern over rising medical costs, all healthcare players need to understand how inadequate language access results in unnecessary costs of care. LEP and undocumented persons are more likely to use expensive emergency room services for their primary care needs (United Hospital Fund, 1999). Lack of effective provider-patient communication can lead to unnecessary and expensive diagnostic testing. Research documented that patients with limited English proficiency in a pediatric emergency department use more medical resources (time and tests) than other patients (Hampers et. al.1999). Inadequately addressed language barriers also open the door for potential liability issues such as lack of informed consent, malpractice, and negligence.

### 1.2. Myths about healthcare interpretation

Although there has been major developments in the field in the U.S. especially with the release of the US federal government's Culturally and Linguistically Competent Standards (CLAS) for healthcare which emphasized the importance of the provision of language assistance in a healthcare encounter and the codes of ethics and standards of practice released by the National Council for Interpreting in Health Care Interpreting(NCIHC, 2001), there are still several myths and misconceptions about the interpreting profession (Hale, 2008). Limited English Proficient patients are the not the sole beneficiaries of the language assistance. An interpreter's job is to facilitate*communication*between a LEP patient and all parties within the healthcare encounter; particularly providers. When communication is hindered because of lack of language and cultural concordance, the ability of the healthcare system to provide quality care to this segment of patients is seriously compromised (Hale, 2008).

Furthermore, effective diagnosis, treatment, and patient recovery are functions of the quality of patient-physician relationships. Such relationships can be seriously challenged by the inability to communicate effectively and seamlessly(Commonwealth Fund, 2003). Shattering the myth that language access is a patient problemand recognizing that it is a system problem would improve how policies are formulatedand ressources are directedto effectively meet the critical need for cultural and linguistic mediators. Quality interpreting is a community responsibility. Quality depends not only on the skills and ethics of an interpreter, but equally on all parties participating in the healthcare system. The policy context, conditions at healthcare facilities and ability of all players to work effectively with the interpreter also affects overall quality (Pochhacker, 1999).

### 1.3. Role of the healthcare interpreter

Interpreters are moving away from the narrow linguistic lens with which the interpreting profession has long been defined. They are embracing a more comprehensive role where the interpreter is not just a passive conduit and a neutral participant in the encounter (Morris, 2010). There is a recognition that the interpreter "does not leave his/her humanity at the door," and that because such encounters naturally have an imbalance of power between patient and provider and because LEP patients are usually a marginalized minority in a society, then the interpreter's role must go beyond mere interpreting of words to becoming an advocate and an expert (Morris, 2010).He/she must attempt to empower the patient by giving them voice, redressing power imbalance and ensuring that their rights are protected (Bahadir, 2010;Apostolou, 2009).

### 1.4. The case for specialized training of healthcare interpreters

- The interpreter's task is very complex. "Being bilingual does not mean that one has the ability to interpret (Hale, 2008).

- There is a misconception that "faithfulness equates to literalness." Lack of knowledge of cross linguistic differences and the difficulty in finding cross linguistic and cross pragmatic equivalents may lead to distorted communication (Hale, 2003).
- Accurate interpreting involves a complex process that does not involve literal word for word conversion. It is a process that undergoes multiple layers of grammatical, semantic and pragmatic analysis to move meaning from the word level to the discourse level (Hale, 2003). The interpreter needs to understand the original source language speech, decipher the intention of the speaker, navigate grammatical, semantic and pragmatic differences between both languages, and then recreate the speech from source to target language in a way that would illicit the same response/reaction as if conversion have not taken place (Hale, 2003).The interpreter must be knowledgeable not only about content but manner and style in both languages.
- Interpreters are not "translation machines" which exist to help providers overcome language barriers (Leanza, 2005). They are cultural and linguistic mediators who must help those within the healthcare encounter communicate effectively across the divides of culture and language (Hale, 2008). Some healthcare areas such as reproductive health, specifically require highly trained cultural and linguistic mediators. Such issues are highly sensitive in many cultures; candid discussions are often obstructed by cultural taboos. There is often a reluctance to speak about sexual matters. Bodily exposure and touch is taboo in certain cultures (US Department of Health & Human Services, 2000). Homosexuality and STDs are stigmatized. There are varying views on contraceptive methods, and some cultures use traditional medicines. Women who are survivors of rape, sexual torture and/or female genital mutilation may be reluctant to seek care or speak openly. These are factors that may cause great complications, if an interpreter is not specifically trained to mediate this difficult encounter between patient and healthcare provider.
- There is a need for universal or near universal standards and codes of professional ethics to improve the quality of outcomes. Because of the differences between group-based and individual-based identity building processes among cultures, an interpreter's cultural parameters may affect his/her conception of their professional roles and boundaries of practice (Rudvin, 2007).
- Training programs can help raise general professional standards, standardize working methods, give professionals a sense of belonging to a well-organized profession and provide research opportunities into interpretation (Chan, 2009; Pochhacher, 1999).
- "Specialized trainings are required to ensure high level of bilingualism and biculturalism, interpreting skills, content, subject matter, (medical) terminology, ethics, roles, training in linguistics (and) thorough understanding of cross-cultural pragmatic differences" (Hale, 2008, p.12).
- The use of untrained interpreters in a medical encounter has serious implications. Lack of training is a very serious issue when using a child, a family member and/or a stranger as an interpreter. Using a child as an interpreter may disrupt the family structure or subject the child to psychological damage. A patient may not disclose frightening or sexual information in the presence of a child. The use of a family member may also lead to ineffective communication, if he/she shields the patient from information. The use of a stranger may violate patient-physician confidentiality. Lack of knowledge of medical terminology significantly reduces the ability to communicate information effectively (Bonder & Miracle, 2001; Meadows, 2000; Steele, 2000).

### 1.5. A Theoretical Framework

The Comprehension of Technical Speech Model advanced by Gile (1995) is suggested as a theoretical framework for healthcare interpreter trainings since these interpretations include specialized and technical components, as well as non-specialized components. The model emphasizes the central role of comprehension in interpretation. Comprehension goes beyond transcoding word for word, and involves 3 components: (a) knowledge of the languages; (b) extralinguistic knowledge and analysis.

C = KL + ELK + A

Comprehension – C – implies understanding the intent of the discourse in one language and being able to convert it appropriately in the second language without distortions and using socially acceptable words, structures and styles of the second language.

Comprehension requires knowledge of the languages – KL – that are being used for communication in the healthcare encounter and the grammar of each language.

Since certain words in many languages can mean different things in different contexts, comprehension also mandates extralinguistic knowledge – ELK – which involves knowledge of the outside world, or world knowledge. A third critical component for comprehension is Analysis – A – which is needed to deepen understanding of discourse in cases when a patient in the medical encounter is for example illiterate, or the speech is difficult in content and deviates from standard speech as often is the case with medical conditions.. A patient may have a strong accent, use unusual metaphors, make errors or offer different chains of reasoning. These are all cases in which a significant level of analysis must be employed to ensure comprehension.

The model suggests presenting and practicing the general elements in non-specialized interpretation, then addressing the specialized elements; i.e. medical terminologies and conditions. Generalized and specialized elements must be separated in the curriculum.

### 1.6. The Training Landscape in the United States

A review of the training landscape reveals that there is great diversity of programs in the United States and a wide variety in program type, setting, design and length. A training program nay range from few hours to few years. Settings also differ. Some programs are located in community-based organizations, some in hospitals and some in universities and educational institutions. Requirements and standards vary considerably. Some programs use technology assisted self study sessions to supplement face-to-face contact hours. Using online technology has been found to facilitate self-paced and self motivated practice, decrease anxiety and improve test scores (Hansen &Shlesinger, 2007).

A 2007 national study found that "there was no agreement across sites as to how much training is appropriate and there are no universally accepted benchmarks by which to judge the proficiency of interpreters….. The field still lacks benchmarks and tools to measure proficiency…. interpreter proficiency standards are lacking" (Wu et al., 2007).Currently, the interpreter training landscape is diverse and uneven. There is wide variation among training programs in course content and sequencing, length, intensity levels, delivery approaches, and pedagogical practices. At the same time, students arrive at the programs with different backgrounds, linguistic readiness, and learning styles.

Interpreter training programs are striving to fill this need but with little guidance on the core competencies all interpreters should have, the proficiency standards required to practice, and pedagogical practices needed to ensure that interpreters are well equipped to fulfill their roles.

The identification of core competencies is the foundation for the consistent assessment of interpreter qualifications and the development of effective training. The study contributes to deepening understanding of the core competencies that a beginning healthcare interpreter needs; and the pedagogical strategies used by training programs to impart these competencies.

## *2. Study Methodology*

In this study, both quantitative and qualitative research methodswere employed to obtain original and comprehensive data from a wide range of stakeholders including service providers, healthcare interpreter trainers and interpreters, policy makers and subject experts. Table 1 provides an overview of the methodology used, information generated and outcome produced.

To oversee and guide the conduct of this study, an advisory panel was formed, consisting of New York State (NYS) program planners, practitioners, and healthcare professionals from diverse backgrounds. In addition, the National Council on Interpreting in Health Care (NCIHC) participated as expert advisors.

**Table 1 Overview of Methodology**

| ***Methods*** | ***Scope*** | ***Participants Composition*** | ***Information Generated*** | ***Outcome*** |
|---|---|---|---|---|
| Literature Review | N= 90 | Peer-reviewed journal articles<br><br>Research reports issued by research institutions, key organizations specializing in language assistance and immigrant advocacy groups around the country | Gained an understanding of the current research on language assistance and issues regarding health disparities and immigrants<br>Identified the lack of standardization in health care interpreting training programs<br>Identified key factors affecting institutionalization of language assistance in health care provider organizations<br>Informed the development of draft survey instruments | Development of research questions<br>Research-based conceptual model to be used in steering the Strategy Roundtable discussions<br>Draft survey instruments<br>Discussion topics for the Listening Session and the Strategy Roundtable |
| Trainer/ Curricular Developer Survey | N =101 | Health care interpreting training programs around the country | Consensus regarding core competencies in knowledge, skills and attitudes from trainers' perspective | Electronic survey at surveymonkey.com |
| Trainee/ Interpreter-in-Training Survey | N=120 | Individuals enrolled in health care interpreting training programs in New York State | Consensus regarding core competencies in knowledge, skills and attitudes from the trainees' perspective | Electronic survey at surveymonkey.com<br><br>Hard copy of the survey distributed to trainees without Internet access |

We conducted a review of the literature, policies, national standards for interpreters suggested by the National Council for Interpreting in Health Care (NCIHC, 2001),interviews with directors of training programs, and review of curricula for two New York State interpreter training programs. The analysis of this information helped us produce a preliminary pool of core competencies.

Members of the Advisory Panel and NCIHC were asked to review the initial set of competencies and to suggest revisions, clarifications, additions ordeletions. We developed two surveys for two cohorts of subjects: trainers and curricula developers, and interpreters and interpreters in training.

Part I of both surveys focused on the knowledge base (what an interpreter should know and understand) and skill base (what an interpreter should be able to do), and the instructional methodologies used in training. Part II asked respondents for demographic and background information.

We developed an initial list of 135 interpreter training programs nationwide through existing literature, an internet search, and referrals from experts and colleagues in the field. E-mail messages inviting participation in the survey were circulated. The survey was also posted on a number of listservs, including the listserv maintained by NCIHC. Trainer respondents were asked to provide a description of their program, the number of instructional staff they had, the qualifications of their instructors, the number of students they trained, their recruitment strategies, and the criteria they used to select students for their training programs.

Preliminary drafts of the trainee survey were piloted in January 2008 with a purposeful sample of 10 practicing and interpreters in training, and with 7 trainers and curricular developers from an upstate NY program. Both cohorts were asked to review the survey instrument for clarity and understandability. As a result of the feedback, the language of the survey was modified to increase its level of understandability. Additional items were included based on a review of the curricula of two NY training programs.

Trainee respondents were asked to provide information on the history of their language acquisition in their language pair, prior interpreting experiences, and their level of education and previous training in health-care related areas. In addition, open-ended questions were included to elicit more detailed information from trainees about the training program in which they participated or were currently participating. Questions were asked about the adequacy of the program, the content taught, and the instructional methods used.

The surveys were administered electronically using surveymonkey.com, although trainee respondents from the NYprograms had the option of completing the survey in hard copy. (Copies of the surveys are included as Appendix A and B. Thetwo NY programs actively recruited their current and past trainees; consequently, most of the trainee respondents came from these two programs. Respondents from theNY programs were also asked if they were willing to be interviewed and, if so, to enter their name and contact information at the end of the survey. Ten of these respondents were interviewed. They represented a number of languages (Russian, Ukrainian, Spanish, and Somali) as well as experienced and novice interpreters.

Analysis of findings utilized different methods including Chi square test to determine statistical significance between trainees' ranking of items and trainee characteristics. Fisher Exact test was performed to examine the relationship between program type and the respondents' rating of knowledge, skill and professional qualities. Spearman's rho was used to investigate the differences and similarities in responses by length of training in hours, size of the training program staff, and by number of interpreters trained.

## *3. Results& Analysis*

A total of 120 trainees and 101 trainers responded to the surveys. Findings suggest that although the identification of knowledge, skill and professional attribute items on the survey is determined by factors associated with program type, duration, number of trainees graduated, prior experience in interpreting, and language capabilities, there is considerable consensus between trainers and trainees regarding what constitute core competencies that should be taught in all healthcare interpreting training programs and utilized by all qualified interpreters.

- **Trainees' Perspective**

Trainees perceived that the most necessary knowledge they needed focused both on developing a solid knowledge of the terminology that was required and grounding themselves in a sound understanding of the role of the healthcare interpreter as a professional. Next, they perceived the importance of understanding key aspects of language, and how culture influences healthcare and the transmission of meaning within the healthcare setting. These items highlight areas of knowledge that have a direct impact on how the interpreter performs while in the interpreting encounter. Knowledge of the context of healthcare interpreting was seen as good background information but not necessary for beginning interpreters.

An analysis of trainee responses by key trainee characteristics was done to see whether these characteristics were related to how the trainees thought about the knowledge base. The key characteristics that were looked at were number of training hours received, whether or not the trainee had had previous training in healthcare interpreting, whether or not the trainee had taken other relevant courses, and estimated number of interpretations the trainee had done.

Regarding the relationship between trainees' ranking of knowledge-base items and the number of hours of basic training they received, the chi-square test results show that in most cases no statistically significant correlations were found. Only in 4 items were respondents' perceptions significantly related to the duration of basic training they received: (1) Patient responsibilities in their own healthcare ($p < .05$); (2) Help facilitate communication between patient & provider when values clash ($p < .01$); (3) Analyze situations and make linguistic decisions such as register, tone, etc. ($p < .05$); and (4) Interpret in the mental health setting ($p < .05$). The findings suggest that the longer the training, the more value respondents place on these competency items.

With regard to the relationship between respondents' core competency choices and whether or not they had received previous training, the test results show that trainees' experience with previous training significantly affects their perception of the following competency items: (1) the meaning of interpreter confidentiality ($p < .05$); and (2) how stereotypes and prejudices can influence behavior and communication ($p < .05$). The findings suggest that the respondents who have more experience with previous training are more likely to place a higher value on these competency items.

In addition, a higher percentage of trainees who had had previous training in healthcare interpreting than those without indicated that the following context items were considered necessary for beginning interpreters: insurance and referral procedures, and the implementation and enforcement of CLAS standards.

Other items that received higher percentages from trainees with previous training were: responsibilities of a dual role interpreter, understanding your own cultural heritage, and end of life issues.

Taking relevant courses prior to the training also affects how trainees perceive core competency. The chi square test results show a statistically significant correlation on the following items: (1) the culture (values & beliefs) of the U.S. healthcare system (biomedical model) ($p< .05$); (2) your own cultural heritage and how it affects your thinking and behavior ($p< .05$); (3) confidentiality rules and regulations(HIPPA) ($p < .01$); (4) medical terminology related to major body systems (e.g., diseases, specialties, and treatments) ($p< .05$); (5) legal and liability considerations related to confidentiality and mandated reporting of information ($p < .01$). In other words, a higher percentage of trainees who had taken relevant courses indicated that knowledge of related rules and regulations, and legal and liability considerations was necessary as was knowledge of the terms related to the major body systems and of one's own cultural heritage.

Examining responses by estimated number of interpretations showed considerable variation. Comparing the responses between those with no previous or limited experience as interpreters and those with more experience, show that those with no or limited previous experience are more concerned about the basics of interpreting than they are with contextual information. Those with more experience include competencies that focus on a more thorough understanding of the comprehensive nature of the interpreter role as well as other relevant information. The chi square test results show that trainees who had performed more interpretations tend to identify the following items as core competencies: (1) importance of on-going professional development ($p < .05$); (2) legal foundations of linguistic access in healthcare ($p < .05$); (3) referral procedures for in-hospital services ($p < .05$); (6) maintain completeness in converting messages from one language to another ($p < .05$); (7) maintain neutrality and not impose personal beliefs, judgments or values into your interpretations ($p < .05$); (8) interpret in the simultaneous mode ($p < .01$); (9) translate written materials such as informed consent forms ($p < .05$); (10) interpret in the mental health setting ($p < .05$).

Analysis of the items in the Skill category indicates that the majority of items identified by 90 or more percent of respondents as necessary are skills that assure accuracy, including correcting errors and attending to cultural meanings. Other items focused on the role of the interpreter, including setting the parameters of the interpreter role and maintaining neutrality. Items that were chosen by 80-89% percent of the respondents as necessary tended to be skills that required subtler and more analytic skills such as facilitating communication when values clash, advocating, and assisting with the negotiation of meaning where there is a lack of equivalence.

Included in the list of skills were items that addressed different modes of interpreting (consecutive, simultaneous, and sight translation), translation skills (of complex legal documents as well as short instructions), and the ability to interpret in two types of settings that are often mentioned by interpreters as posing unique challenges (emergency room and mental health). Of these skills, those that were considered necessary for beginning interpreters by the highest percentage of respondents were the following: the ability to interpret consecutively (92%); translating short instructions (96%), and interpreting in the emergency room (86%). The other skills received lower percentages showing that at least a fourth to a third of the respondents perceived these as more advanced skills. These included: interpreting in the simultaneous mode, sight translation, and translating more complex written materials such as informed consent forms. In the area of the skill base, little variation was found in the responses across different demographic characteristics. The only item that showed some variation was on the skill: translate written materials such as informed consent. Lower percentages identifying this as an essential skill were found among those with no interpreting experience than among those with the most interpreting experience.

- **Trainers' Perspective**

There were six different types of training programs in our sample: (a) hospital/clinic-based; (b) university/college-based; (c) community-based/nonprofit; (d) for profit/independent consultant; (e) state/county government; and (f) partnership/combination of different organizations. Regarding the relationship between program type and the respondents' rating of knowledge, skill and professional qualities items, the Fisher Exact test results show that program type is not significantly linked to the respondents' perception of core competencies. This suggests that there is considerable consensus among trainers across all settings about which areas of knowledge or skills constitute a set of core competencies.

We ran a Spearman's rho to investigate the differences and similarities in responses by length of training in hours, size of the training program staff, and by number of interpreters trained. With regard to the relationship between hours of training and core competency choices, in most cases no statistically significant correlations were found. There were, however, two exceptions. First, for the competency item "Understand the challenges of assuming dual roles," i.e. serving as an interpreter as well as a healthcare provider/worker at the same institution, there is a negative correlation between training hours and core competency choice ($p < .01$). Respondents whose organizations provide longer training programs less frequently recognized "Understanding of the dual role challenge" as a core competency than those with shorter training programs. A similar relationship is observed for the competency item "Understand and describe the interpreter role as a cultural broker." Programs with more training hours less frequently perceived "Understanding of the cultural broker role as a core competency" ($p < .05$).

As for the relationship between the size of the training program staff and competency choices, in most instances, the size of a training program staff is not related to core competencies. However, for two competency items: "Explain and apply the principles of honesty, integrity, professionalism, and accountability" and "Exhibit abilities to sight translate documents, including patient's informed consent"; staff size is negatively and significantly related to the responses. Programs with a larger instructional staff tended to discount the idea that these two items are core competencies ($p < .01$; $p< .05$, respectively). Regarding core competencies in relation to the number of interpreters trained by programs, four competency items were found to be significantly and positively related to the number of trainees: (1) Understand potential conflicts of interest and recognize when to withdraw from assignments ($p < .05$); (2) Demonstrate ability to balance values of the U.S. healthcare system and cultural values, such as patient's beliefs about individual autonomy and the right to know ($p <.05$,); (3) Show knowledge of institutional barriers that prevent people from accessing services ($p < .01$); and (4) Recognize and exercise appropriate interventions, strategies and techniques to address bias, prejudice and discriminatory practices ($p < .05$). These results suggest that those respondents who reported to have trained more medical interpreters tended to perceive the four items listed above as core competencies that are critical for all medical interpreters.

- **Instructional Methods**

Approximately 70-84 percent of trainees regarded as effective those instructional methods that brought the "real world" into the classroom through role plays and case scenarios, and that exposed them to professionals in the field. Respondents found instructional strategies that provided them with feedback and opportunities for error analysis to be very effective. Some drill type activities (i.e., terminology building exercises and message conversion practice drills) were also perceived as effective but other types of drill activities such as memory and note taking exercises were not perceived to be as effective.

A review of the two training programs in NY indicated that these training programs did not remain static but rather evolved over time in terms of content and instructional methods. Two trainees from the same program could have given different answers about the instructional methods because they took the training at different points in time. It appears, for example that the inclusion of a formal internship evolved as the number of training hours increased. Forty-eight percent of trainee respondents report that their training program did not include an internship even though the two training programs from which most of the respondents come currently have some form of internship. Responses to the open ended questions and interviews verified the findings on the instructional methods and offered further insight. The importance of hands-on, practical, and practice-oriented learning activities that simulated or exposed trainees to "real-life situations" was highlighted. Respondents emphasized role plays as an effective tool to practice linguistic conversions, managing the flow of communication, and using other skills that helped trainees maintain accuracy.

Many respondents suggested that more time be given to role plays and other techniques that exposed them to real life situations such as watching and analyzing videos of real interpreting encounters, discussing and analyzing case scenarios of real situations faced by interpreters, hearing from experienced interpreters, and shadowing experienced interpreters. Respondents emphasized the importance of having more contact with healthcare providers while in training, through their participation in role plays in class, by visiting and observing providers at work in healthcare facilities, and, in general, having more direct exposure to the healthcare setting. Trainees also recognized the value in providing them with feedback. Respondents both acknowledged the effectiveness of analyzing errors and suggested that more such opportunities be provided through the use of audio and video recordings of their interpretations.

Another set of instructional methods that were reported as effective were exercises, drills, and quizzes that focused on building knowledge of medical terminology and relevant vocabulary. Respondents highlighted the value of having written materials, such as notes and visuals. Several mentioned the value of scripted role plays that could help with practicing conversion skills. More conversion drills were suggested by respondents. Some indicated that screening for fluency in both languages should have been done or adhered to more carefully so that less time could have been spent working on language issues during the training. Those who acknowledged needing English proficiency improvement wished for more assistance not just in learning English but also in improving their accent and pronunciation. Several suggested that tape recordings of interpreter encounters, language drills, and recordings of their own role plays could have helped. A number of suggestions requested bilingual coaches, interpreting coaches in each of the languages, or a core of trainees in their class who spoke the same language. Shadowing, in the sense of repeating exactly what is said in the same language, was mentioned by a number of respondents as an effective tool to gain fluency.

Those trainees who came with more background knowledge on the functions of the human body and basic understanding of related diseases and medical specialties thought less time could have been spent in this area and more time given to actually practicing interpreting and related skills. Those who had little or no background knowledge wanted more. Several participants highlighted the importance of the pre-screening in helping them understand the need for bilingual fluency or decide whether or not they had the language skills to continue with the course. Others mentioned that the pre-screening served as a self-assessment of their language skills or gave them a better understanding of the importance of the interpreter role. The internship was found to provide an opportunity to practice and confirm what had been learned in the classroom, to gain exposure to the real setting, and build confidence. Finally, the exam confirmed what had been learned and further boosted confidence that they were prepared to do the job.

## *4. Discussion& Conclusions*

Despite the perceptual divergence among our survey respondents, we were able to consolidate the responses from both trainers and trainees, and developed a list of core competency items that are critical to all beginning healthcare interpreters, (Table 2).

We acknowledge several limitations of this study; including the inability to examine program design or required instructor qualificationswhich affect our ability to offer guidance on the effectiveness of different program designs. The study also did not examine the screening that was done to determine the level of language proficiency, motivation and emotional stability to determine preparedness for the training and the fieldbefore a student is accepted into an interpreter training program. These are key issues that need to be addressed in future research.We also did not examine the level of formal education required for healthcare interpreters. We believe that the question of the relationship between formal education and the demands of healthcare interpreting needs to be further investigated.

Core competencies help healthcare professionals identify job responsibilities and duties that should be included in advertisements and vacant positions, determine minimum requirements for screening applicants, and set performance standards and evaluation criteria. They help determine training content and methods of training, and design assessment tests to measure effectiveness of trainings.

Future research should validate the perspectives of those experts by conducting a job analysis of healthcare interpretation. Job analysis will affirm the knowledge, skills and attitudes directly related to performance on the job, building on this study by analyzing content, context, and requirements of the job. It will provide evidence of the relationship between the tasks performed on the job and the competencies required to perform the tasks.

**Table 2: Core Competenices of Healthcare Interpreters Knowledge Base**

| | |
|---|---|
| **Domain 1: The Context of Healthcare Interpreting: General, Regulatory and Legal Requirements** | |
| **General Requirements** | • Demonstrate basic knowledge and understanding of the U.S. health care system; including public benefits, insurance procedures and insurance terminology, as well as referral procedures of in-hospital services.<br>• Show knowledge of institutional barriers that prevent people from accessing services. |
| **Regulatory Requirements** | • Demonstrate awareness of standards pertaining to delivering culturally and linguistically appropriate health care (CLAS standards) and awareness of standards pertaining to the provision of linguistic access, including how CLAS standards are implemented and enforced.<br>• Understand the Patient's Bill of Rights and demonstrate knowledge of patient responsibilities. |
| **Legal Requirements** | • Understand and recognize legal and liability considerations of maintaining confidentiality and addressing situations of necessary information disclosure; including confidentiality and mandated reporting information [Mandated reporting of information – federal, state, organization].<br>• Demonstrate knowledge of HIPAA laws and their application in the medical interpreting profession.<br>• Understand the general legal parameters of linguistic access including local, state and federal legislation |
| **Domain 2: The Healthcare Interpreting Profession** | |
| **Interpreter Role & Responsibilities** | • Understand and describe the core interpreter functions and the following functions often performed by interpreters: conduit who gives voice to every word said by each party; clarifier who intervenes to verify and validate understanding; and, cultural broker who bridges the cultures of both parties and facilitates deconstruction of cultural misunderstanding.<br>• Understand principles of advocacy and when to utilize advocacy to protect individuals from harm and avoid mistreatment and abuse.<br>• Recognize the importance of maintaining faithfulness to meaning, including offensive content<br>• Understand the concept of transparency in the clinical encounter.<br>• Understand the challenges of assuming dual roles; i.e., serving as an interpreter as well as health care provider/worker at the same institution. |
| **Interpreter Standards and Boundaries** | • Recognize the ethical principles in the Code of Ethics and the Standards of Practice of the National Council on Interpreting in Health Care.<br>• The meaning of interpreter confidentiality.<br>• Understand potential conflicts of interest and recognize when to withdraw from assignments. |
| **Domain 3: Medical Terminology & Understanding the Human Body** | |
| **Medical Terminology** | • Demonstrate knowledge of key medical terms related to the basic systems of the human body, including related diseases, specialties, and treatment and human anatomy and physiology.<br>• Show knowledge of medical equipments, tests, medication categories.<br>• Understand the building blocks of medical terminology – e.g., suffixes, prefixes. |
| **Understanding the Human Body** | • Demonstrate knowledge of basic anatomy and physiology including an understanding of the major body systems and their functions. |
| **Domain 4: Culture** | |
| **Intersection of culture and healthcare** | • Understand the concept of culture and how it affects health care.<br>• Demonstrate knowledge of one's own cultural heritage and how it affects one's thinking and behavior.<br>• Show knowledge of how personal biases and stereotypical attitudes and prejudice can influence interaction and communication.<br>• Demonstrate knowledge of the cultural heritage, values, world views, healing practices, family structures, hierarchies, community characteristics and beliefs of the groups for whom interpreting is provided and how they may influence the medical encounter.<br>• Demonstrate an understanding of the connection between the language and the culture of the speakers of the language.<br>• Understand the biomedical culture (values and beliefs) of the U.S. health care system and how it differs from traditional medicine.<br>• Understand the cultural challenges that end-of-life issues, such as proxy, living will, advanced directives, can raise.<br>• Understand how different levels of acculturation can cause different cultural challenges for the particular groups served. |
| **Domain 5: language** | |
| **Linguistic Techniques** | • Understand the difference between true and false cognates (words in different languages that are or appear to be related in meaning)<br>• Demonstrate basic understanding of the structure of language (e.g., grammar, how words are constructed, word order, etc.)<br>• Demonstrate understanding of different aspects of language fluency (accents, register, etc.)<br>• Recognize colloquial expressions used in medicine as well as common acronyms<br>• Demonstrate awareness of regional differences/dialects in the interpreter's language pair. |

## Skill Base

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| **Use protocols of medical interpreting** | • Introduce oneself in culturally appropriate ways.<br>• Introduce the role of the interpreter in a variety of situations (e.g., provider in a hurry, complete introduction, abbreviated introduction].<br>• Utilize proper positioning, gaze, and intervention strategies |
| **Use different interpreting & translating techniques** | • Demonstrate ability to interpret in consecutive mode.<br>• Ability to translate materials such as informed consent, discharge instructions and medications instructions stated and explained by health care providers. |
| **Maintain accuracy and completeness** | • Demonstrate ability to convert a spoken message in one language into its equivalent in a second language without changing the meaning, adding, omitting or substituting.<br>• Recognize mistakes and correct them appropriately.<br>• Utilize strategies to ensure accuracy by asking for pauses or clarifications.<br>• Utilize memory enhancing tools such as note taking.<br>• Ask for clarification in culturally appropriate ways.<br>• Demonstrate ability to analyze the situation, make linguistic decisions and include paralinguistic elements central to conveying equivalence in meaning of the message (e.g. register, style and tone.)<br>• Demonstrate ability to interpret difficult and/or offensive messages fully and accurately |
| **Manage the Interaction** | • Demonstrate ability to effectively manage the flow of the communication<br>• Exhibit ability to maintain patient privacy and autonomy through proper positioning and facilitating direct communication between patient and provider. |
| **Address cross-cultural communication** | • Demonstrate ability to assist provider and patient in understanding cultural issues, clarifying misunderstandings.<br>• Exhibit skill of negotiating the meaning of words and ideas that do not have equivalence in the other language, (culturally bound terms such as idioms, sayings, slang and some technical terminology)<br>• Ability to support patient autonomy and the right to know while respecting the patient's cultural values and belief systems. |
| **Behave ethically and make ethical decisions** | • Maintain neutrality/impartiality and refrain from passing judgments or interjecting personal beliefs, values or advice. |

## Professional Attributes

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| **Professional Qualities & Behaviors** | • Exhibit ability to respect the dignity of all parties in professional and culturally appropriate ways<br>• Demonstrate ability to respect patient independence<br>• Act in accordance with the principles of honesty, integrity, professionalism, and accountability |
| **Self - Development** | • Understand that continuing education and self development are needed to continue to improve performance<br>• Recognize signs of "professional burnout" and demonstrate knowledge of mitigating strategies<br>• Describe relaxation, concentration and stress management techniques |

### *References*


Apostolou, F. (2009). Mediation, manipulation, empowerment: Celebrating the complexity of the interpreter's role. Interpreting: International Journal of Research and Practice in Interpreting, 11(1), 1–19.

Bahadır, Ş. (2010). The task of the interpreter in the struggle of the other for empowerment: Mythical utopia or sine qua non of professionalism?*Translation and Interpreting Studies*, 5(1), 124-139.

Bonder, B, Martin, L. & Miracle, A. (2001). Achieving cultural competence: The challenge for clients and healthcare workers in a multicultural society. *Generations*, 25(1), 35-42.

Breen, L. (1999). What should I do if my patient does not speak English*? Journal of the American Medical Association*, 282(1). Retrieved from http://jama.ama-assn.org/content/282/9/822.full.pdf

Chan, A. (2009) Effectiveness of translator certification as a signaling device: Views from the translator recruiters. T*ranslation and Interpreting Studies*, 4(2), 155–171.

Derose, K., Baker, D. (2000). Limited English Proficiency and Latinos' use of physician services.*Medical Care Research and Review*, 57(1), 76-91.

*Emergency Services: Conditions Stable?*(1999, April). Hospital Watch, United Hospital Fund. 10(1). Retrieved from http://www.uhfnyc.org/assets/549

Flores, BL., Mayo, S. (2003). "Errors in medical interpretation and their potential clinical consequences in pediatric encounters.*Pediatrics*, 111 (1), 6-14.

Gile, D. (1995). *Basic Concepts and Models for Interpreter and Translator Training*. Amsterdam, Netherlands: Benjamin Translation Library.

Hale, S. (2008, March). The use of interpreters in courts and tribunals. Paper presented at the AIJA Conference. Retrieved from http://www.aija.org.au/Interpreters%2009/Papers/Hale%20PPT.pdf

Hale, S. (2003, March). What does "to fully and faithfully interpret the evidence" mean?. Paper presented at the Interpreters and Legal Professionals Working Together in Courts and Tribunals Conference. Retrieved from http://www.ausit.org/pics/accuracycourtintr.pdf

Hampers LC. et. al. (1999).Language barriers and resource utilization in a pediatric emergency department.*Pediatrics*, 103(1), 1253.56.

Hansen, IG.,Shlesinger, M. (2007). The silver lining: Technology and self-study in the interpreting classroom. Interpreting: *International Journal of Research and Practice in Interpreting*, 9(1), 95–118.

Karliner, L. Jacobs, EA. Chen, AH. Mutha, S. (2007). Display settings: Do professional interpreters improve clinical care for patients with limited English proficiency? A systematic review of the literature.*Health Service Research*, 42(2):727-54.

Leanza, Y. (2005). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers.*Interpreting, 7*, 167-192.

Meadows, Michelle. (2000, January).Moving toward consensus on cultural competency in healthcare.*Closing the Gap*. Retrieved from http://www.ltgevaluationta.net/includes/documents/28.pdf

Morris, R. (2010). Images of the court interpreter: Professional identity, role definition and self-image.
Retrieved from http://www.ruth-morris.info/wp-content/uploads/2010/03/ImagesTIS2010.pdf

Pöchhacker, F. (1999). Getting organized': The evolution of community interpreting. *Interpreting*, 4(1), 125–140.

Rand Corporation. (2007). *Language Access Services for Latinos with Limited English Proficiency: Lessons Learned from HablamosJuntos*. California, United States: Wu, S., Ridgely, S. ,Escarce, J., Morales, L.

Rudvin, M. (2007). Professionalism and ethics in community interpreting: The impact of individualist versus collective group identity. Interpreting, 9(1), 47–69.

Steele, DJ. (2000). Overcoming cultural and language barriers. In S.A. Cole & J. Bird (Eds), The *medical interview: The three function approach.* St. Louis, United Stated: Mosby.

The Common Wealth Fund.(2002). *Providing Language Interpretation Services in Health Care Settings: Examples from the Field.* New York, New York: Youdelman, M., Perkins, J. Retrieved from http://www.commonwealthfund.org/usr_doc/youdelman_languageinterp_541.pdf

U.S. Department of Health and Human Services. (2000).*Family Planning Services for Iowans from Diverse Cultures. (*Family Planning*" Healthy People 2010)*. Iowa, United States: Kahler, S. and Leeper, K.

Youdelman, M. (2003, October). Providing Language Access in Healthcare Settings.Presented at the *Working Together to Increase Immigrant Women's Access to Reproductive Healthcare*. Retrieved from www.albany.edu/womeningov/publications