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**Interpreting in Medical Settings:
Synthesis of Effective Practices
Focus Group Discussions**

A Report Commissioned
by
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Background

In September 2006, a group of six experts from across the United States and Canada met at the CATIE Center at the College of St. Catherine in St. Paul, Minnesota. This group included Marty Barnum, Glendia Boon, Dan Langholtz, Karen Malcolm, Brenda Nicodemus and Carol Patrie, and was facilitated by Dr. Laurie Swabey and Dr. Marty Taylor. Using the National Standards of Practice for Interpreters in Health Care, the National Code of Ethics for Interpreters in Health Care (both documents produced by the National Council on Interpreting in Health Care) and the Californian Standards for Healthcare Interpreters by the California Healthcare Interpreting Association (CHIA), this group of experts developed a draft document on effective practices for ASL/English interpreters working in medical settings. Each expert then interviewed at least one other individual and solicited input on this draft document, resulting in the “Effective Practices Draft Document” dated November 28, 2006.

As part of the continuing process of validating and revising the “Effective Practices Draft Document” a representative sample of focus groups from across the United States were organized. The participants in the focus groups were asked to address specific areas of to provide additional input into the accuracy and completeness of the document. Following is a description of how the data were collected, as well as a synthesis of the participants’ responses and discussions to each of ten questions and a select number of questions from 18 scenarios. The final section includes a summary of the data collected and implications for education, further research, and questions to be considered.

It is important to note that the work of the CATIE Center is focused solely on interpreting in medical settings; it does not address working in mental health settings. Although there is a very fine line with such a distinction, the work of the National Consortium of Interpreter Education Centers (NCIEC) has divided this task between two centers. CATIE is focusing on interpreting in medical settings, while Northeastern University Regional Interpreter Education Center (NURIEC) is focusing on interpreting in mental health settings.

Summary of Data Collection and Process

A total of 12 focus groups held across the United States were convened between March and June 2007 to discuss effective practices for signed language interpreters working in medical settings. The focus groups represent a national sample of diversity including age, ethnicity, hearing status and years of experience. The focus groups were held in Georgia, Illinois, Kansas, Maine, Minnesota, New Mexico, Oregon, and Texas. In some instances more than one focus group was held in the same state. Eight of the groups consisted of non-deaf interpreters. One group included deaf-blind consumers, a second group included a combination of deaf and non-deaf sign language interpreters and

consumers, a third group included deaf interpreters, and a fourth group included interpreters and professionals who were deaf. For a detailed description of the specific demographics of the participants see the CATIE Center document, “Medical Interpreting Focus Groups Results for the Background and Experience Survey CATIE and NCIEC, Spring-Summer, 2007”.

This report and analysis includes a synthesis of the comments made by the 63 participants from all 12 focus groups. The participants met in small groups ranging in size from two to seven people. Each group had an experienced interpreter, either deaf or non-deaf, who functioned as a facilitator. Each facilitator was provided with the protocol for standardizing the selection of, the questions to ask, as well as the process and procedures for collecting the data. The protocol was based on a pilot focus group held in Canada and facilitated by the author of this report (see Appendix A). The discussions from this group are not included in this report but form the foundation of the standardized protocol used for selecting participants and documenting discussions. Following the prescribed protocol, facilitators were responsible to organize and manage the focus group process probing whenever possible to determine what interpreters say they do and what they “actually do”. In addition, a notetaker took notes throughout the discussions with two groups being videotaped. The notetaker was responsible to take notes writing complete thoughts in point form and asking questions of clarification needed for note taking purposes. With only one exception, neither the facilitator nor the notetaker participated in answering the questions that make up this report.

A total of ten questions were asked of each participant in nine of the 12 groups following the standardized protocol. One group provided their responses via email and two groups discussed scenarios related to interpreters’ role and boundaries (see Appendix B). The comments from the participants in the latter two groups are embedded within the summary of discussions related to the the ten questions. The ten questions were:

1. Assuming bilingual fluent interpreting skills, what do you see as requisite skills unique to interpreters working in medical settings?
2. Maintaining confidentiality, discuss examples of situations where advocacy and/or support occurred or did not occur when it could have.
 - a. Describe the situation in terms of what the interpreter did or did not do, and your perspective on the result.
 - b. How are advocacy and support the same and/or different?
 - c. What boundaries, if any, do you feel should be followed when interpreting in medical settings? How are these boundaries the same or different from other settings?
3. What is your experience with cultural differences in medical settings? What have you noticed?
4. What is your experience with diversity in medical settings? What have you noticed? (For facilitator only if needed -- e.g. Language, socioeconomics, age, educational background).
5. What is your experience working with Deaf Interpreters (DIs) in medical settings? Are the boundaries the same or different as hearing interpreters?

6. What is your experience interpreting documents when the professionals are not present? (e.g., Sight translation of informational brochures, consent forms)
7. Do you read the patient's chart prior to interpreting? Why or why not?
8. How active are you in conveying meaning? What is your experience using visual cues in the environment such as pictures, models (e.g., eye, heart, circulatory system). Do you think critically about how to construct meaning so the patient and doctor understand each other or do you tend to stay off to the side and sign what you hear and speak what you see, giving them the responsibility to construct meaning.
9. What is your experience when assignments crossover from medical to legal (e.g., interpreting pelvic examinations which could become a rape examination)?

In addition, when there was sufficient time, participants were asked to comment on the job description contained in the Effective Practices Draft Document (11/28/06) developed by the Expert Group. The focus group participants were asked the following question.

10. Comment on the job description of the health care interpreting specialist. Is this you? Who is it?
 - o **JOB DESCRIPTION:** A health care interpreting specialist is a credentialed professional with national certification (CI and CT or NIC) who facilitates communication between users of signed and spoken languages in health care settings from birth to death. This includes:
 - Bilingual fluency in English and ASL including sociolinguistic variation and limited language proficiency.
 - Awareness of the linguistic, social and cultural influences which may impact health care interactions, including specialized vocabulary, discourse styles, register, power and prestige, and triadic communication.
 - General knowledge of the physiological and psychological implications of health care.
 - Awareness of various health care approaches (e.g., Chinese, ayurvedic, holistic, homeopathic, Western medicine).
 - Understanding of various health care delivery systems and the roles of self and others on the health care team (e.g., including Certified Deaf Interpreters (CDIs) and advocates that can enhance the interpreting situation).
 - Sharing information and resources through advocacy, leadership, education, and liaison with individuals in health care settings.
 - Ability to balance the need for professional distance with empathy and flexibility.
 - Adherence to the Registry of Interpreters for the Deaf professional code of ethics and conduct.
 - Knowledge of laws and policies related to health care settings.

A synthesis of the comments of all 63 participants is provided in the next section. Each section is divided into the ten questions noted above with the discussion of the scenarios imbedded within each section. When direct quotes were taken directly from the notes,

quotation marks surround the comments. These illustrate a specific person's comment and are representative of several related comments found in the discussion notes.

Due to the natural flow of conversations within small group interactions, some comments occurred in more than one section. In addition, other comments were made in one section that may have echoed comments made by another group in a different section. When these incidents occurred, comments were combined in logical groupings under the most appropriate section.

1. Assuming bilingual fluent interpreting skills, what do you see as requisite skills unique to interpreters working in medical settings?

Knowledge

Prior to accepting assignments interpreters should know what type of medical appointment it is (e.g., pediatric, ophthalmology), who the health care professional and the patient are including gender, and all the necessary information regarding background of the situation. All of this information assists in forming a solid foundation that results in a more successful interaction between all of the parties involved.

The need for interpreters to have a strong background in medical terminology was a consistent theme mentioned in all 12 groups. Specifically, courses such as anatomy and physiology were recommended, as well as general science courses. Knowledge and understanding of common medical procedures and courses of treatments for common ailments are required for interpreting in medical settings.

Possessing a thorough understanding of the medical system and the interpreter's role in it (e.g., hierarchy) was also evident among all groups. Knowing more than one venue within hospital settings such as ICU and emergency room protocol are also important. Knowing various settings outside of hospitals such as clinical settings and dental offices are necessary. All interpreters, especially staff interpreters, realize there is more than "medical" interpreting involved in their work. One group reported that, "the number of layers is amazing". Hospital interpreting is typically very in depth, "for example, six pages of medication, various procedures, and extensive history" were not uncommon.

The ability to maneuver within the ever-changing demands of the setting and the variety and number of consumers is crucial. Of particular importance is knowing when to ask for a Deaf Interpreter (DI) or a Certified Deaf Interpreter (CDI), and most importantly which CDI to request as a part of the team. CDI's have different skill sets, therefore knowing who has what expertise is critical.

Linguistic Skills

One of the goals in providing interpretation is to give the best service possible to health care professionals, patients and family members. To accomplish this goal interpreters must possess fluency in both English and ASL, specifically working between the languages to convey the nuances and complicated information ever-present in medical settings. This need for a sophisticated level of fluency was mentioned in all of the groups. Specifically, interpreters should have a high level of receptive skills. They should be able to handle the speed and complexity of the environment. They should possess the ability to pronounce and sign a vast range of medical procedures, terms and medications. Particularly several groups noted the demand for the fluent use of classifiers.

Knowledge and skill to implement consecutive interpreting was mentioned as necessary when there was a need to clarify or elicit information. One group stated, “the more complex the topic/subject/procedure, the more the need for a consecutive interpretation.” It was also identified that there is the skill of making it clear to health care professionals why consecutive interpreting was being used and that perhaps more explanation or a different explanation is needed from either the interpreter and/or the health care professional.

Three groups mentioned that using time references was crucial, such as expressing terms like three times a day or once a week. If comprehension was not reached, then using environmental surroundings like calendars would be useful, marking the calendar so the patient could visually see when to take what pills. One group referred to this kind of communication assistance as “cultural mediation”. Another group used the same term, “cultural mediation,” when interpreters asked health care professionals to use the PDR to be sure medications were properly identified, “rather than guessing that the pink pill that starts with M is such and such”.

Possessing the ability to “determine patient’s level of health literacy and act on evaluation” was identified as a useful skill for interpreters. Several participants mentioned that some times deaf people simply nod indicating they understand the information relayed, but unfortunately are only nodding and are not understanding the information. For example, in some communities knowledge of HIV and AIDs is extremely limited. One participant stated, “50% of non-signing patients/general public leave the medical office not understanding what was discussed.”

Interpersonal skills

Interpreters must be able to work with a wide range of individuals with different needs and expectations. “Interpreter must use their interpersonal skills to navigate their way through the medical setting.” Rapport with health care professionals was identified as vital. It was noted that nurses have a great deal of power and can be of assistance when they have a clear understanding of interpreters’ role and their function. With a good rapport “things work smoothly.”

Interpreters must be sensitive to all the consumers involved in the interaction. Understanding the personal nature of assignments while maintaining ones' professional demeanor can be challenging. For example, interpreters may know deaf consumers through their involvement at Deaf community events or from their freelance work in the community. Realizing that this could be difficult or uncomfortable for deaf consumers is an important element of sensitivity.

Flexibility

All groups mentioned the need for interpreters to be flexible. The need to be flexible varied depending on the specific setting, for example a doctor's office, an emergency ward, and medical treatment intervention will require interpreters to be flexible in different ways. At times the space may be crowded or confined requiring interpreters to find ways to make the communication process as effective as logistically possible for all participants involved. Flexibility was also required when health care professionals were on-call or behind in their schedule which in turn affected interpreters and their own schedules.

Terms such as "humble", "comfortable" and "professional" came up throughout the focus group discussions. Interpreters must be humble enough to express their lack of understanding whether it is related to difficulty comprehending the English or ASL, even if this has to be done numerous times. They must be willing to try other methods of communication when the first and maybe the second attempt are unsuccessful. Interpreters must be comfortable in the medical environment and with medical procedures. They must be professional at all times regardless of the situation. They must know and be able to stand up for themselves in their role as interpreters, whether this is to gain clarification or to make health care professionals understand what the deaf person is conveying.

Personal Awareness

Interpreters must be aware of their emotions and their own limitations. If a routine doctor's appointment suddenly "becomes a surgical procedure, the interpreter must be able to decide if he/she is qualified, and if not, must ask to be replaced. Even though this may not be practical it is important for interpreters to know their limitations."

Interpreters have to remain calm in emergencies. They can't be afraid of blood. Basic physicals can turn into minor procedures. It is important to know when to sit down or step back, communicating at all times with the health care professionals and patients if the interpreter has to leave the room.

The ability to focus on the job at hand was highlighted in one group. Interpreters should have strategies to detach from the procedure knowing that the health care professionals are responsible for the outcome, not the interpreters.

Role & Boundaries

In addition to several groups mentioning the need to know one's limitations, most of the groups mentioned the importance of interpreters understanding their role as part of the medical team. Interpreters must be able to clearly convey their role to all participants involved in the interaction, for example providing explanation and rationale as to why interpreters leave the room when health care professionals leave. Interpreters as part of the medical team can take a leadership role, and often should, especially when access to communication is at risk. For example, "relaying to the medical professional that the patient relying on sign language communication is slipping out of consciousness (eyes rolling, eye lids closing) and how that affects communication" is within the expertise of interpreters' and may be outside of the health care professionals' expertise. At the same time interpreters should keep in mind that the goal of the communication process is the patient to professional relationship. The ownership of the interaction belongs to the health care professionals.

Interpreters must be trustworthy especially when it comes to confidentiality. They must also maintain their boundaries. When situations become more than interpreters can handle they must be able to remove themselves from the situation in a professional manner. For example when a medical assignment becomes a legal interaction such as making a police report while in the ER, then interpreters who are not qualified to interpret for legal settings would make it known that a legal interpreter is required to interpret for the police report.

Interpreters have several layers of decision-making that offer guidance to their work. One group referred to this as a "personal decision making tree" and encompassed the following components: "Code of Professional Conduct, laws that apply to the situation, personal ethics and regulations/rules in the medical setting." It was also reported that it is important for interpreters to know when to document information (e.g., when and where something occurred, or did not occur when it should have), for example when interpreting services were denied to deaf consumers or signers were used instead of professional interpreters. One participant in the focus group discussions stated, "if it's not documented, it didn't happen."

Safety

Knowledge of how to keep oneself safe within medical settings is crucial. Procedures like when to wear masks and gloves and knowing whom to ask if unsure are important aspects of working in medical settings. "At times, the medical professionals will caution you to suit up, but it's good to know safety" just in case the health care professional doesn't say anything in a particular situation.

"Interpreters never fully know patient's medical history" or the specifics of the situations. Interpreters should be well aware of what immunizations they have had and maintain

them if they require booster shots, or additional immunizations. Interpreters should also know about transmittable diseases. Knowing how diseases and illnesses are transmitted can assist interpreters in not catching them.

Interpreters should be aware of vicarious trauma and the effect this can have on themselves and on their work. Having support systems in place is vital for maintaining health and working through difficult situations to which interpreters are exposed.

Consumer Needs

Consumers of interpreting services include deaf, hard of hearing, deaf-blind and non-deaf people. It is difficult and at times impossible to predict what services interpreters will have to provide. Knowing in advance of the situation consumers' history is helpful in preparing for assignments and providing the best service possible. Knowing how to accommodate for a variety of special needs is important. For example, deaf-blind people may have minimal vision and use a modified visual approach to understanding a Signed Language interpreter or may require tactile interpreting services. If interpreters know this prior to appointments, then the interaction will likely be more successful.

There are a variety of situations when it is not the patient who is deaf. Instead it may be the health care professionals who are deaf and require the services of Signed Language interpreters to communicate with non-deaf patients. For example if the surgeon is deaf it is important for interpreters to know the protocol for surgery and how to scrub in.

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

- a. Describe the situation in terms of what the interpreter did or did not do, and your perspective on the result.**
- b. How are advocacy and support the same and/or different?**
- c. What boundaries, if any, do you feel should be followed when interpreting in medical settings? How are these boundaries the same or different from other settings?**

Interpreting in medical settings and making constant decisions while in this setting is a "human activity". The consensus across all groups was that "roles and boundaries are different in medical settings from general interpreting settings." Interpreters must be mindful of their boundaries and have good reasons to back up their decisions. "Support is mainly establishing rapport and respect for one another." It is not "supporting" or "influencing" consumers' decisions, such as whether an MRI or a CAT scan would be the best option. People in medical settings are often in vulnerable states and therefore holding or rubbing the patient's hand, carrying a bag or a small child was seen as within the boundaries of the interpreter's role and often referred to as "support". Encouraging deaf consumers to ask their questions directly to health care professionals, rather than

asking interpreters was sometimes called “support” and other times called “advocacy” during the focus group discussions. Whichever term was used the goal was that same which was to enable deaf people to use their own power.

Support and comfort for individual deaf people will vary from person to person. A woman who has gone through a procedure for an abortion may or may want to “chat” with the interpreter afterwards. When patients are diagnosed with terminal illnesses and then are dying, often interpreters are present for extended periods of time. One interpreter stated that her “role is primarily that of support while waiting”. Interpreters must be sensitive to deaf people’s individual needs.

The focus group participants made a distinction between being staff interpreters and working as community interpreters for an agency or independent contractors working for the hospitals. One interpreter reported, “as a staff interpreter the organization’s mission is primary where service and access are first.” The same interpreter went on to report, “as a freelancer my professional code is first” meaning the NAD-RID Professional Code of Conduct outlined by the Registry of Interpreters for the Deaf. Some staff interpreters felt that one-on-one conversations with health care professionals was acceptable, whereas, some contract interpreters felt this was outside of the interpreter’s role and therefore unacceptable.

“Youth and maturity affect decision making.” The ability to think through all the scenarios and possibilities is crucial. How one decides to approach situations are important aspects of working as an interpreter and understanding one’s roles and boundaries. For example, a less seasoned interpreter had a schedule of appointments, one of which was a critical medical situation that was taking longer than anticipated. The interpreter decided to leave this setting and go to her next interpreting appointment at a dentist’s office. Now looking back on the situation, the interpreter would make a different decision and stay with the critical medical situation, rather than leaving it for a routine dental appointment. In another example, the interpreter felt the doctor was not paying attention to the deaf patient and gave an inaccurate diagnosis. The interpreter did not do anything at the time. However, she did speak with a mentor afterwards and now wonders how this situation affected her work, roles and boundaries, from then on.

“Advocacy often occurs when a person is at a disadvantage, either due to physical, mental or emotional difficulties or due to oppression.” Advocacy was defined in several different ways. One participant described advocacy as borrowing someone else’s power; another participant described it as education. Providing information about how to acquire the services of interpreters, the need for qualified interpreters, and describing the role of interpreters were all considered to be advocacy. Giving health care professionals information on deaf-related resources was also considered advocacy – outside the role of the interpreter, but necessary.

However, one group of interpreters reported that deaf medical professionals did not require advocacy, but instead required information directly related to the encounters. For example, deaf professionals asked interpreters to let them know what the conversations

were around them, in other words “eavesdropping”. Also deaf professionals asked for interpreters’ opinions that interpreters provided in as neutral a manner as possible.

Among almost all of the focus group discussions the term advocating was used when the deaf person needed more clarification and the interpreter chose to “speak up” and make this known to the medical professional. This was seen as critical to the successful outcome of the interaction. In one instance it was mentioned that this was done because it was a “weighty health situation”. In other situations interpreters decided to maintain their perceived role and not indicate the the health care professionals that their message was not being understood. For example one interpreter mentioned that if she doesn’t have a boss to go to then she is less likely to say or do anything. She would not indicate the perceived lack of understanding.

At times health care professionals were unwilling to secure the services of interpreters, feeling that communication could occur without interpreters present. In these cases interpreters advocated for the right to communication access on behalf of the deaf patients. Interpreters explained laws and rights of deaf people to medical treatment and communication while undergoing examinations and treatments. In some instances Deaf interpreters were required and at times health care professionals were not willing to follow the non-deaf interpreter’s recommendation leaving the communication process at risk.

Also, in some cases, the role and boundaries became even more complex; interpreters are part of the Deaf community. Thus, in many instances interpreters cannot be as detached in the situation as health care professionals because the latter are typically not involved in the Deaf community, thereby don’t personally know the consumers.

3. What is your experience with cultural differences in medical settings? What have you noticed?

Cultural norms vary from group to group and from place to place. “Finding the line between general trends and cultural norms and individuality” requires a great deal of flexibility at all times. It is important to enter situations with open minds. For example, GLBT culture is unique; different sensitivities are required when interpreting in childbirth situations in typical Western culture and in Native American cultures; support groups such as AA or AIDS support groups have norms that are different from one another. It was identified as important to reflect cultural values and norms within the interpretation. It helps if interpreters learn about different cultures when preparing for assignments and working with consumers. Being aware of one’s language usage when talking with people from different cultures is very important.

Within the medical milieu, individual health care professionals have their own perspectives on deaf people and deafness. Especially when practitioners are themselves

from other countries, the cultural implications—medical culture, practitioner’s culture, Deaf culture—add more layers of challenge with which interpreters have to deal.

Differences between Deaf and non-deaf cultures were highlighted in all of the focus group discussions. Specifically, practitioners were often unaware of the fact that Deaf people have their own culture. Deaf culture and medical culture are not the same. In one instance it was stated, “Everything in the medical field is very, very quick and most deaf clients are not. They are digging in the bag for the prescription or taking 20 minutes for a urine sample.” Some deaf people have “learned helplessness” and are not able to articulate their medical history to health care professionals. At times, deaf people want interpreters to remember and to tell the professionals what is wrong or what prescriptions the patient is taking. Some deaf people want to ask many questions making sure they understand what is being said. The health care professional is most often in a hurry, requiring interpreters to use strategies to keep the doctor present to answer all of the deaf patient’s questions.

Health care professionals often made assumptions about deaf people. For example, some health care professionals encouraged deaf people to have cochlear implants even though this was not the health care provider’s area of specialization. Other health care professionals assumed deaf people had transportation or that the interpreter would take them home after their medical procedure. Education needs to occur informing health care professionals that this is not the case and interpreters are not responsible to provide transportation to patients.

Differences were apparent between deaf people from rural communities and those from urban centers. Urban deaf people had experiences that were more similar to the larger non-deaf population. Whereas, deaf people from rural communities tended to be more “grassroots”. In addition, the resources available to deaf people are much more limited than those available to the non-deaf community. As well, the information to which deaf people have access is not always accurate or up to date.

There was also mention of the differences between clinics located in suburban and urban centers. Urban centers tended to have lower socio-economic conditions. Usually patients were sicker, were less knowledgeable about their rights, and less likely to know medical culture. “Advocacy and support were perceived as being “much greater and more necessary in urban environments than in suburban environments”. All of these factors created a “greater burden” on interpreters to facilitate the communication process.

Deaf patients also have to deal with an insufficient availability of interpreters to provide adequate service and/or health care professionals unwilling to acquire interpreting services either because they don’t want to pay for the service or because they feel that they can communicate with deaf patients on their own.

Another issue that was raised in most of the groups was the work of Spoken language interpreters and how their behaviors impact health care professionals’ perceptions of Signed Language interpreters. For example in one community spoken language

interpreters in medical settings were billing illegally. This mandated a change in procedures by requiring all interpreters, spoken and signed, to have forms signed at all medical appointments. In some geographic areas there is inconsistency and lack of training among spoken language interpreters. For example, family members may provide interpretation, rather than hiring a professional interpreter. When this occurs, the expectations for the Signed Language interpreter can be negatively affected because health care professionals assume interpreters are family members or friends, not professionals.

There are times when signed and spoken language interpreters may work together such as when the child is deaf and the parents speak a language other than English. In this situation, a relationship between the interpreters is formed. A question arises which is “what is the background and training of the spoken language interpreter”? Does he or she follow a code of professional conduct as do Signed Language interpreters? It requires time and effort to establish mutual understanding and develop a working rapport with another interpreter to make the communication process effective. This adds to the complexity of the work and the time it takes to complete the interaction among all parties. There is a sense that “the level of professionalism has risen because spoken and Signed Language interpreters are working together.”

4. What is your experience with diversity in medical settings? What have you noticed? (For facilitator only if needed -- e.g. Language, socioeconomics, age, educational background).

The more interpreters know related to diversity in advance of the appointment the more prepared interpreters will be. Having the goal of providing communication access that allows for each party to maintain their dignity requires interpreters to notice cues, overt and subtle, from the people involved in the interaction. It is important that interpreters have “a range and ability to try different approaches through trial and error. Flexibility and sensitivity can not be over emphasized.”

Deaf people’s prior experience in seeing medical professionals with interpreters significantly affected interpreters’ work. For example, if deaf people were accustomed to working with interpreters AND were familiar with medical settings then interpreters felt that the expectations related to role and function of interpreters were already well understood.

It was reported that generally speaking older deaf individuals had less experience working with interpreters and often were used to writing notes back and forth with health care professionals. Depending on deaf people’s English literacy skills, they were unaware of the amount of information they may have missed during this process. On the other hand, younger deaf people often had more experience with interpreters, but certainly not always the case, and were also more familiar with their rights, possibly through their education, access to closed captions from a young age and advertising on

television. It was felt that younger deaf individuals who have grown up with closed caption have more experience with societal norms of the majority culture than older deaf people who may have limited exposure.

Language use among deaf individuals is diverse, ranging from ASL to the use of various sign systems and at times lipreading. There are differences among and between younger signers and older signers, males and females, and persons from different geographic locations. These differences among deaf individuals can be observed while chatting and waiting for the appointment to begin. During this waiting time, observations can be made on how the deaf person communicates, his/her educational level, his/her familiarity with the medical setting and whether or not a CDI is required. It is during this time that interpreters must compare their schemas with that of the deaf individual. A word of caution was mentioned, “Don’t assume that just because they’re highly educated they know what’s happening in the setting.”

Working with deaf individuals who have additional disabilities or with those who have minimal language skills (MLS) is extremely challenging. Determining how they were raised, what signs they know, what are references that will work in the interpretation process and what won’t are all crucial elements in establishing communication. Trying to find mutual understanding and a foundation on which to build is extremely important before proceeding with the actual interpretation.

Interpreting for health care professionals who had strong accents presented challenges for interpreters. Interpreters had to focus their time and energy on deciphering accents, thereby requiring interpreters to multi-task on both the linguistic understanding of the source message and the content health care professionals were conveying to deaf patients.

Gender plays an important part in the interpreting process. For example, “an older deaf woman assumes you, a female interpreter, understands and can explain better because you have that problem too.” One “male interpreter feels out of place with women.” It was noted that women can’t empathize with male situations on one hand, but on the other hand, women appear more comforting and open. “The deaf community sees women interpreters more often, so they seem more indifferent” to the female gender of interpreters.

There was uncertainty expressed as to whether or not health care professionals received specific training on diversity. If health care professionals and staff receive training on diversity it would be very useful for interpreters to participate in this training as well, particularly as it pertains to medical settings.

5. What is your experience working with Deaf Interpreters (DIs) in medical settings? Are the boundaries the same or different as hearing interpreters?

There was agreement that it is a judgment call as to when to use Deaf Interpreters (DIs), or a signing support staff who is used to working with certain deaf individuals. This decision is most often the responsibility of the non-deaf interpreter.

Working collaboratively with DIs made the communication process “smoother and less stressful”. “Being able to combine medical language and knowledge with DIs ability to use language (e.g., classifiers, etc.)” was beneficial. In many instances using DIs was often the best way to ensure that the communication process was accurate and complete. It provided the opportunity for a successful outcome without which the communication may have broken down. In addition deaf patients felt comfortable. When a DI was present an increased level of trust was observed in the deaf patient. On the other hand one participant with limited experience working with DIs stated that the DI simply copied what she already signed. Therefore, the use of a DI was not useful or effective in this situation.

Health care professionals need to be educated as to the purposes of using DIs and the likelihood of more effective communication resulting than communicating with some deaf patients without a DI. In addition, some deaf people also need to understand the role of DIs because some deaf people feel insulted that a DI is present and providing the interpretation rather than the non-deaf interpreter.

Non-deaf interpreters working with DIs appreciate the opportunity to team. DIs tend to be very knowledgeable about resources and feel comfortable sharing this knowledge with the parties involved, whereas the non-deaf interpreter may wonder if she/he was overstepping the boundaries of the interpreter’s role. In some instances DIs have more conversation with deaf people than non-deaf interpreters. For example, with a deaf immigrant a great deal of conversation occurred between the DI and the new immigrant putting the deaf immigrant at ease. “Dynamics were more colloquial. Like a big party!” At other times when a DI is present it “becomes a much more relaxed atmosphere.” These examples, according to the focus group participants, show that the boundaries are different between DIs and non-deaf interpreters. Another participant mentioned, “the dynamics are very similar to two non-deaf interpreters working together”. The comments related to how the DI affects the situation were not consistent.

Several of the participants in the focus group discussions had no experience working with DIs. One interpreter had an experience working with an advocate who reinterpreted the information and the interpreter found this to be very effective. Other times deaf family members acted as interpreters and made cultural adjustments to the information so that it was more understandable to the deaf patient. Deaf community health workers were another source of assistance in communicating information to deaf patients. “In some situations there were deaf individuals present and the interpreter was unaware of their role, either as a DI or an advocate, which made the situation unclear.” These latter examples were not DIs but functioned similarly to that of a DI. According to the participants these roles are different and should not be confused with that of the professional DI. Roles should be made clear at the beginning of the interaction. Also, it was noted that it was confusing to the health care professionals when DIs and/or

advocates were used. The health care professionals were not clear what the roles were, what they should be and how they were the same or different from what they were used to experiencing with non-deaf interpreters. Thus, education of when and how to use DIs is important for all parties involved in the interaction.

6. What is your experience interpreting documents when the professionals are not present? (e.g., Sight translation of informational brochures, consent forms)

Some participants from each group reported that when asked by deaf people to interpret a variety of standard forms (e.g., medical history forms, intake forms) the interpreters would interpret them without assistance from health care professionals. One person felt that it was “providing access to health care”. However, if there were questions that interpreters were not certain about, then they only interpreted those items on the form with a health care professional present. There were also individuals in the focus groups who handled it differently, for example asking the receptionist how they would like the questions completed, either leave the form blank or come back up to the front desk for assistance. Usually the receptionist responded by saying leave it blank until the health care professional could ask and obtain the answers. It was also noted that nurses might hand the forms to the interpreters asking them to interpret the form to the deaf patient. However, it was felt that if patients were non-deaf, nurses would ask the questions aurally and complete the forms themselves. One group suggested that perhaps the standard should be the same and the nurse should ask the questions rather than the interpreter interpreting them to the deaf patient without a health care professional present.

The possibility was raised in one group that it could become a best practice to only interpret the forms when health care professionals are present. Supporting this latter comment, several participants stated that they used to interpret the forms but don't interpret them any more and don't allow the health care professionals to even hand the forms to the interpreters. Thus, interpreters never have control of the forms, either the health care professionals or the deaf patients maintain control of the forms at all times.

It was further discussed that some forms, such as consent for surgery forms, are not interpreted without a health care professional asking the questions and explaining the form. The risk and legal implications related to some forms (e.g., HIPPA) were an important factor when deciding whether or not to interpret a form without a health care professional present. In contrast, the risks are minimal when interpreting the content of a health history form because health care professionals will review the content of the form with the patients. Some of the focus group participants felt comfortable with interpreting these forms. Still others felt comfortable interpreting DNR forms “for compassionate purposes wanting to make sure patients understand DNR.” Other interpreters wanted health care professionals present for the DNR forms but warned them that it might take a long time because of its complexity and the need to be extremely clear so that deaf patients are making informed consent one way or the other. It was noted that when interpreters behave in divergent ways it makes it difficult for the next interpreter. Health

care professionals are unsure of interpreters' roles and boundaries when one interpreter interprets forms, one doesn't, and yet another interprets some forms but not other forms.

There was a concern noted that sometimes health care professionals watch deaf people's responses, particularly their head nodding. Health care professionals complete forms based on the nodding of the head, rather than the interpretation which may be different due to the linguistic differences in English and ASL.

7. Do you read the patient's chart prior to interpreting? Why or why not?

Reading charts can be helpful. "If interpreters are on staff at the hospital, it may be appropriate to use charts for preparation." Sometimes they are offered and sometimes they are not. Sometimes one interpreter reads the "medi-tech (database system) that lists appointments, history, primary documents, insurance, etc." This same interpreter never reads the paper chart. Another interpreter accesses charts regularly and "looks at previous appointments, history of interpreters, specialists, and whom the patient has seen." Another example is working with several patients in the ER and other wards at the same time. By reviewing charts interpreters are able to plan their schedules and commitments to each patient. At the same time HIPPA regulations may affect interpreters' access to charts. One interpreter "has found that medical professionals all react differently to interpreters having this information". One participant recommended that if interpreters have access to charts, deaf consumers should be informed.

Several of the participants said they do not access patients' chart. Instead, they use different strategies to acquire information such as using the nurse's board or talking to the staff about the basic history and the background of the situation. Also talking to doctors directly and becoming an ally was reported as useful. All of these methods can be very helpful to interpreters and their need to prepare for assignments.

Interpreters who work together on a regular basis may keep a "communication log" which includes protocol, medications, and doctor's names. It helps interpreters prepare and makes them aware of what they need to know from one appointment to the next. This is particularly useful when patients receive long term care on a unit and when one interpreter replaces another and needs to know what has occurred that affects the patient's care.

8. How active are you in conveying meaning? What is your experience using visual cues in the environment such as pictures, models (e.g., eye, heart, circulatory system). Do you think critically about how to construct meaning so the patient and doctor understand each other or do you tend to stay off to the side and sign what you hear and speak what you see, giving them the responsibility to construct meaning.

In all of the groups it was stated that conveying the meaning was of utmost importance. Interpreters used what was available to convey meaning to deaf consumers. Using one's own body was a strategy used by interpreters as well as asking health care professionals to draw diagrams that depict the procedure or the instrument that was going to be used. Also using the charts and models in the room was a commonly used and effective technique. These techniques support the communication process and were perceived by some of the participants in the focus groups as "advocacy" in helping deaf people understand their medical conditions or recommended treatments.

One of the groups talked about having "a portable visual library". The participants did not all agree on the use of this library. On one hand it could be useful for reference purposes and studying for interpreters themselves, but ultimately it was up to the practitioner to convey the message, not interpreters. Interpreters asked practitioners for clarification if they themselves were not clear on the intent of the message. Making sure they understood the message completely and accurately was paramount to interpreting in medical settings.

Another technique participants used was to "chat" with deaf consumers and actively observe how individual deaf people communicate. A general conversation can reveal many aspects of individuals that will become useful and shed light on providing effective communication once the actual appointment begins.

9. What is your experience when assignments crossover from medical to legal (e.g., interpreting pelvic examines which could become a rape examine)?

Of great importance is the ability to recognize when medical interpreting situations could become legal situations such as rape or assault cases, a minor with unusual injuries, or patients talking about malpractice. Deaf consumers in emergency may be treated for medical problems and at the same time want to make a police report related to their injuries. One participant reported that "walking into something and not knowing what you were walking into was very alarming." It is important to know one's limits and to have strategies for transitioning the work to legal interpreters.

During these situations boundaries and roles must be maintained with utmost care. Some hospitals have instituted policies where interpreters who are hired to interpret in the medical setting only interpret for the health care professionals and consumers. If police are present, the police are required to secure the services of different interpreters for their own purposes. Sometimes this occurs and sometimes it doesn't. Police sometimes listened to the conversation interpreted between the health care professionals and deaf consumers without securing their own interpreters. If the deaf consumer is released and goes to the police station, the boundaries are clearer and interpreters from the medical setting are not required to go to the police station.

Other gray areas were interpreting for personnel from the Department of Child and Family Services (DCSF) and interpreting about Power of Attorney because both involve serious legal implications. When personnel from DCSF appear some interpreters felt comfortable advocating on behalf of deaf consumers instructing them that they didn't have to answer the questions and provided them with information and resources. Also interpreters, especially staff interpreters, felt comfortable not interpreting for DCSF personnel. In the latter case, interpreting about Power of Attorney, most interpreters, depending on who was the deaf consumer, felt comfortable doing this if health care professionals were explaining what this entailed. A few interpreters stated that they did not interpret for this kind of interaction.

10. Comment on the job description of the health care interpreting specialist. Is this you? Who is it?

- a. JOB DESCRIPTION: A health care interpreting specialist is a credentialed professional with national certification (CI and CT or NIC) who facilitates communication between users of signed and spoken languages in health care settings from birth to death. This includes:**
- i. Bilingual fluency in English and ASL including sociolinguistic variation and limited language proficiency.**
 - ii. Awareness of the linguistic, social and cultural influences which may impact health care interactions, including specialized vocabulary, discourse styles, register, power and prestige, and triadic communication.**
 - iii. General knowledge of the physiological and psychological implications of health care.**
 - iv. Awareness of various health care approaches (e.g., Chinese, ayurvedic, holistic, homeopathic, Western medicine).**
 - v. Understanding of various health care delivery systems and the roles of self and others on the health care team (e.g., including CDIs and advocates that can enhance the interpreting situation).**
 - vi. Sharing information and resources through advocacy, leadership, education, and liaison with individuals in health care settings.**
 - vii. Ability to balance the need for professional distance with empathy and flexibility.**
 - viii. Adherence to the Registry of Interpreters for the Deaf professional code of ethics and conduct.**
 - ix. Knowledge of laws and policies related to health care settings.**

Five of the twelve groups had time to comment on the job description. One participant stated, "Hopefully, this survey will result in this training/workshops/refresher courses

even at a surface level before an interpreter goes out and starts working. It is interesting and exciting to have this opportunity.” Another person stated, “Anything that improves our skills serves us well.” And a third person remarked, “I’m proud to be a part of a team that has the majority of these skills.” A fourth person reported, “If an interpreter completed a graduate program with the skills listed it would be a great asset to the community.” The groups reported that there is a definite need for specific training on an on-going basis along with information that is regularly updated to keep pace with the rapidly changing medical field. The caveat noted was that there are no legal requirements, state or federal, mandating education or certification in medical interpreting like there is in legal interpreting. It was felt that legal interpreters take their work seriously, and due to the lack of legislation for medical interpreters they are not willing to put the time, energy and expense toward additional training.

The importance of bilingual fluency, as well as awareness of linguistic, social and cultural influences cannot be overemphasized. It was reported that the “people skills are missing from the description” which is vital in working in medical settings. It is important to interact well with the health care professionals and deaf consumers. Also dental is an area that should be reflected in the description because this is an area of specialization that is different from hospitals and medical clinics, yet still medical in nature.

As in many of the comments in previous sections within this report, the differences between working as staff interpreters and freelance interpreters are significant. What staff interpreters do and are expected to do are very different from freelance interpreters who are called in to work on an “as needed basis”. Perhaps different job descriptions need to be developed for staff and freelance interpreters.

One group reported that the job description is really an identification of skills rather than a job description. However the list of skills, the bulleted portion of the description, is informative and contains useful goals for interpreters working in medical settings. Some of these will be learned on the job and are not necessarily requirements prior to employment. One group reported that they had weaknesses in the areas of various health care approaches, and in laws and policies.

Several participants recommended that CDI be added to the certification requirement. In addition, a number of groups mentioned that national certification is not specialized enough for interpreting in medical settings. One group did not support the requirement of national certification. Instead, they had state certification with the possibility of the state providing a medical endorsement in the future. The medical endorsement would provide more specific expectations than a generalist national certification does at this time. This group felt that state certification should be recognized. One interpreter reported, “if you are only going to work in the medical field, I think it’s more beneficial to get the medical training as opposed to national certification.”

Summary and Implications

These findings represent the perspectives of 63 experienced interpreters and consumers in the area of interpreting in medical settings. The protocol (see Appendix A) for standardizing the selection of participants, the questions to ask, and the process and procedures for collecting the data was effective. The data provided obvious patterns within and between groups of participants from different parts of the United States.

The most significant result and the reason for conducting a large number of focus groups representing deaf and non-deaf experienced interpreters and consumers was to validate and, if necessary, update and revise the “Effective Practices Draft Document” written November 28, 2006. Indeed, the “Effective Practices Draft Document” needs to be revised reflecting the findings in this document in addition to reflecting the continuing work the CATIE Center has completed over the past 10 months related to interpreting in medical settings. This work includes the identification of spoken language medical interpreting programs, two literature reviews (one related to Signed Language interpreters in medical settings and another related to adult education in the practice professions), a substantial bibliography and conference presentations.

Updating and revising the “Effective Practices Draft Document” will then assist in the next stages of developing appropriate programming for Signed Language interpreters currently working in the medical setting and those who would like to work in this specialized setting. From the next iteration of the “Effective Practices Draft Document” domains and competencies related specifically to interpreting in medical settings can be identified which in turn will contribute to the foundation of identifying and establishing effective and best practices for educators of interpreters working in medical settings.

Implications for Education

It is clear from this data that specialized training for deaf and non-deaf interpreters working in medical settings is needed and desired. There is an expressed need for training prior to beginning work as an interpreter in medical settings, as well as on-going professional training for those interpreters already working in this setting. The training needs to include theory and application related to the various aspects of specializations within medical interpreting. Structured mentorship opportunities for experienced and inexperienced interpreters to work together would be a way to apply the theory of the classroom to the real world experience, encourage cooperative learning, and create a network of interpreters who are grounded in best practices education.

Educating consumers about the role of interpreters, particularly deaf interpreters, would be helpful in paving the way for deaf consumers providing and/or using health care services.

It is important to note that the CATIE Center and thus this research do not include working in legal or mental health settings, although the boundaries overlap with medical

interpreting. On occasion as noted by the focus groups, medical settings include legal and/or mental health situations. Therefore any education for interpreters in medical settings should also include knowledge and skill development related to other areas of expertise because these unpredictable incidents will occur within medical settings; it is impossible for interpreters to avoid them.

The “Effective Practices Draft Document” addresses effective practices of interpreters working in medical settings. When this document is revised, it will lay the foundation for developing effective and best practices for educators to teach interpreters.

Implications for Research

Recommended research initiatives include several more focus groups consisting of all deaf interpreters, as well as deaf consumers and non-deaf consumers who work with Signed Language interpreters on a regular basis. This additional research will add to the depth of the current body of work where only one all deaf interpreter focus group and one deaf-blind focus group occurred. Also focus groups of deaf and non-deaf health care professionals would provide important perspectives on the work at hand.

This report clearly indicates that there are differences between staff interpreters and independent contractors working in medical settings. Additional research focusing on the similarities and differences between these two groups of individuals would provide important information for material and curriculum development.

Continued research on the roles and boundaries of interpreters working in medical settings would help to clarify this murky area, particularly issues of support and advocacy can be further explored. Talking with leaders within Deaf, hard of hearing and deaf-blind associations would shed light on this important area.

Questions To Be Considered

- Is a generalist interpreting certificate a pre-requisite to working in medical settings? Is there a need for specialized certification in medical interpreting? If so, what does this entail?
- How can diversity in all its forms be best addressed in training and working in medical settings?
- How can CATIE work with the NCIEC’s other initiatives such as mental health, legal, and deaf interpreters to capitalize on the momentum of this report and the CATIE Center’s other related work?
- What kind of education do deaf, hard of hearing and deaf-blind consumers require related to working with interpreters in medical settings?
- How can the “Effective Practices Draft Document” become the standard practice for interpreters in medical settings?

Submitted by:
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Interpreting Consolidated
Edmonton, Alberta
Canada

APPENDIX A



Effective Practices for Interpreting in Medical Settings FOCUS GROUP GUIDELINES

We know you are experts in your area and have no doubt that you can pull together the focus group we'd like to see happen. We have prepared for your convenience a planning check list and other materials which might help as you make preparations. We appreciate your willingness to follow our standard format and questions, as it will provide consistency in our data collection process.

1. Select a date for the focus group. We recommend that you plan 3.5 hours for the event, 30 minutes for logistics and getting settled, and 3 hours for the facilitated process. A sample agenda has been attached below.
2. Reserve a room that is comfortable for all to participate easily. Our pilot group had people seated in a semi-circle with movable chairs.
3. To facilitate your work and this process the CATIE Center at the College of St. Catherine will support your efforts with the following stipends:
 - i. Facilitator (you) \$200
 - ii. Notetaker \$100
 - iii. 6 Participants \$50 each (in the form of a gift card to Target)
 - iv. Refreshments and supplies \$25
4. Each facilitator and notetaker will receive a contract for his/her services prior to the focus group meeting. Please let Richard Laurion at rclaurion@stkate.edu know the names and addresses of the individuals who will contract with the CATIE Center through the National Consortium of Interpreter Education Centers (housed at Northeastern University). Contract will be sent to you from the National Consortium, and then you will be paid within about 30 days.
5. The \$50 gift cards for each participant will be sent to you by Richard Laurion to the address you provide him. Along with the gift cards, forms will be enclosed for each participant to sign indicating they have received the gift card. Please let Richard know the dates of your focus group, and the number of participants so that he will know how many gift cards to enclose.
6. Please invite 6 participants. A sample invitation is attached below. Your group of individuals will be one of the following groups as determined in advance during your discussions with a representative from the CATIE Center. Hearing facilitators will conduct their focus groups in English with all hearing participants. Deaf facilitators will conduct their focus groups in sign with all deaf participants.
 - i. Hearing individuals who have experience as interpreters in medical settings, preferably certified but certainly experienced.
 - ii. Deaf interpreters who have experience as interpreters in medical settings, preferably certified but certainly experienced.
 - iii. Hearing health care providers who work directly with deaf individuals and/or who use interpreters regularly.
 - iv. Deaf health care providers who work directly with deaf individuals and/or who use interpreters regularly.

- v. Individuals who are deaf-blind and have experience as patients using interpreters.
7. Prior to the meeting contact one person to act as notetaker. Choose someone who can quickly process information and accurately synthesize it in writing. Ideally they will be able to take notes directly on a laptop, making edits immediately after the meeting. This person will not participate in the discussions but devote his/her full attention to accurate and complete notetaking. We will need the notes one week after your focus group has been completed. We prefer it in an electronic form. Please send it Richard Laurion at rclaurion@stkate.edu. A sample of the style and content of notes taken for the pilot group is attached.
8. In advance of the meeting, once the group has been selected and confirmed, please email the agenda (see below for an example), along with the attached demographic form and the consent form to the participants. The questions are not to be sent in advance. We want them to be discussed "live", not prepared. They should bring the completed forms to the focus group for you to collect and return to us. If participants have any questions about the consent form, please have them contact Laurie Swabey at laswabey@stkate.edu.
9. We suggest that you bring a few extra hard copies of the demographic survey, consent forms and other materials to the group just in case participants forget their copies.
10. Plan for some refreshments (e.g. coffee, tea, juice, muffins, fruit, chocolate)
11. If you need background information on the NCIEC, please contact Richard Laurion and/or go to <http://www.asl.neu.edu/nciec/> or www.stkate.edu/catie.
12. Please keep the group's attention focused on interpreting in medical settings. We have an entirely different initiative focused on mental health settings.
13. Primarily focus on questions included with FORM A (see below). We are more interested in the discussion and comments generated from these questions. The facilitator and notetaker will need hard copies of these questions during the discussions.
14. If time permits, please take no more than 20 minutes on FORM B. You will need to provide each participant with a copy of Form B.
15. Please collect and return the completed demographic forms and consent forms to: Richard Laurion, CATIE Center, College of St. Catherine, 2004 Randolph Avenue, St. Paul, MN 55105. If you would like us to send you an addressed, stamped envelope, let us know.
16. Within one week of the completion of the focus group, please send an electronic version of the notes to Richard Laurion at rclaurion@stkate.edu.



Effective Practices for Interpreting in the Medical Setting

FOCUS GROUP PROCESS

Definition-write this up on the flipchart or white board

Effective practice for interpreting in medical settings are characterized by optimal performance that meets or exceeds current standards of interpreting professionals and consistently provides quality interpreting service to all participants (e.g., deaf, hard of hearing, deaf-blind, and hearing people) in line with the unique requirements of this specialized setting.

Purpose: Explain this to the participants. This is part of a national project for the NCIEC led by the CATIE Center at the College of St. Catherine. The medical initiative workteam is collecting data to determine effective practices for interpreters working in medical settings. This is not addressing effective practices for mental health situations, although it is recognized that the competencies may be very closely linked.

Explain the role of each person present.

| ROLES | | |
|--|---|---|
| Facilitator | Notetaker | Participants |
| <ul style="list-style-type: none">• Will organize and manage the focus group process | <ul style="list-style-type: none">• Will ask for clarification when ever s/he needs it.• Will write complete thoughts in point form. | <ul style="list-style-type: none">• Agree to be open, honest, and respectful in communication.• Information shared is confidential |

Process for the focus group

- 1) Turn off cell phones, pagers
- 2) Introductions and years of experience, a little bit about your experience in medical settings (how long, what kind of jobs)
- 3) Rules of speaking- check to see if these work for participants:
 - a. Goal is to have as much time as you would like, and to share the floor equally with the other participants
 - b. If you are comfortable, everyone will speak to each question
 - c. Every question will have a different person begin the discussion



Effective Practices for Interpreting in Medical Settings Questions

Facilitator probe whenever possible to get at what interpreters say they do and what they “actually do”.

1. Assuming bilingual fluent interpreting skills, what do you see as requisite skills unique to interpreters working in medical settings?
2. Maintaining confidentiality, discuss examples of situations where advocacy and/or support occurred or did not occur when it could have.
 - a. Describe the situation in terms of what the interpreter did or did not do, and your perspective on the result.
 - b. How are advocacy and support the same and/or different?
 - c. What boundaries, if any, do you feel should be followed when interpreting in medical settings? How are these boundaries the same or different from other settings?
3. What is your experience with cultural differences in medical settings? What have you noticed?
4. What is your experience with diversity in medical settings? What have you noticed? (For facilitator only if needed -- e.g. Language, socioeconomics, age, educational background).
5. What is your experience working with DIs in medical settings? Are the boundaries the same or different as hearing interpreters?
6. What is your experience interpreting documents when the professionals are not present? (e.g., Sight translation of informational brochures, consent forms)
7. Do you read the patient’s chart prior to interpreting? Why or why not?
8. How active are you in conveying meaning? What is your experience using visual cues in the environment such as pictures, models (e.g., eye, heart, circulatory system). Do you think critically about how to construct meaning so the patient and doctor understand each other or do you tend to stay off to the side and sign what you hear and speak what you see, giving them the responsibility to construct meaning.
9. What is your experience when assignments crossover from medical to legal (e.g., interpreting pelvic examines which could become a rape examine)?



Effective Practices for Interpreting in the Medical Setting Questions for Focus Group (AS TIME ALLOWS)

10. Comment on the job description of the health care interpreting specialist. Is this you? Who is it?
- A health care interpreting specialist is a credentialed professional with national certification (CI and CT or NIC) who facilitates communication between users of signed and spoken languages in health care settings from birth to death. This includes:
 - Bilingual fluency in English and ASL including sociolinguistic variation and limited language proficiency.
 - Awareness of the linguistic, social and cultural influences which may impact health care interactions, including specialized vocabulary, discourse styles, register, power and prestige, and triadic communication.
 - General knowledge of the physiological and psychological implications of health care.
 - Awareness of various health care approaches (e.g., Chinese, ayurvedic, holistic, homeopathic, Western medicine).
 - Understanding of various health care delivery systems and the roles of self and others on the health care team (e.g., including CDIs and advocates that can enhance the interpreting situation).
 - Sharing information and resources through advocacy, leadership, education, and liaison with individuals in health care settings.
 - Ability to balance the need for professional distance with empathy and flexibility.
 - Adherence to the Registry of Interpreters for the Deaf professional code of ethics and conduct.
 - Knowledge of laws and policies related to health care settings.



Effective Practices for Interpreting in the Medical Setting

SAMPLE AGENDA

- 9:00 (Facilitator name here) will collect your consent forms and demographic surveys upon your arrival. Getting acquainted and settled.
- 9:30 Begin discussing questions regarding interpreting in medical settings.
- 10:45 Break (whatever time you would like)
- 12:15 Wrap up and closing remarks –
- Any last minute comments
 - A summary of notes from all the focus groups will be distributed to all participants through the CATIE Center.
- 12:30 Hugs & goodbye



INVITATION SAMPLES

To the Notetaker

Hi _____,

I hope all is going well for you.

Would you be willing to be a notetaker for a focus group on medical interpreting? I know you would have some great input into this discussion. After the meeting you could give me that input along with talking to me about the notes you took.

I am trying to get a focus group together on medical interpreting on INSERT DATE, INSERT TIME to discuss effective practices. It is for a project that I am doing with the CATIE Center at the College of St. Catherine in Minnesota. Would you be interested and willing to join us and be the notetaker? There will be about six people. I would send you some info in advance of the meeting. It would require maybe one hour of your time to read and become familiar with the document we are going to address on effective practices. Then just come ready with pen and paper in hand or laptop at the ready. Can you recommend some other fine folks who could note-take if you are unavailable or interpreters who have experience interpreting in the medical setting?

Thanks for letting me know.

Facilitator's name here

Invitation to the Participants

Hi _____,

I am trying to pull together a focus group on medical interpreting on INSERT DATE, INSERT TIME to discuss effective practices. It is for a project that I am doing with the CATIE Center at the College of St. Catherine in Minnesota. Would you be interested and willing to join us? I need about six people. It would require about 3.5 hours of your time. You will basically need to show up and share your input with five of your colleagues on a few topics that we are struggling with. Can you recommend some other fine folks who have experience interpreting in the medical setting?

Thanks for letting me know.

Facilitator's name



Effective Practices for Interpreting in the Medical Setting

SAMPLE CORRESPONDENCE FOR THOSE WHO ACCEPT INVITATION

Hi all,

First, thank you so much for agreeing to join a focus group meeting for medical interpreters. I am doing this as part of a project with the CATIE Center at the College of St. Catherine in Minnesota. They are part of the National Consortium of Interpreter Education Centers and have been leading the effort to identify "effective practices" for interpreters in medical settings. You have been convened to provide input as community interpreters working in medical settings. Thank you for committing your time and energy to this effort. This group is intentionally small so that we can have plenty of lively and honest discussion.

When: INSERT DATE

Where: INSERT PLACE

PREP WORK

- 1) Could you please print the attachments and complete the demographic survey form and the release forms before you arrive at the meeting.
- 2) Let facilitator (facilitator name here) know that you received this email and can open the attachments okay.
- 3) Also let me know what you would like to snack on while we "work". Coffee, tea, water, juice, muffins, fruit, chocolate? I will bring whatever you request rather than bring things you don't want. Be specific and I will be happy to provide what you want.

NAME, will be joining us as the "notetaker extraordinaire" so that we don't lose anything important in what you all have to say.

I will await your email replies! Thank you again for joining the group!! I really appreciate it.

See you on INSERT DATE.



CATIE
College of St. Catherine
ASL and Interpreting Department

Consent Form for Medical Interpreting Focus Groups (videotaped)

Name of Principal Investigator (PI): Laurie Swabey, Ph.D. Director, CATIE Center; Chair/Associate Professor, ASL and Interpreting Dept., College of St. Catherine

Title of Project: Medical Interpreting Curriculum Development Project – Focus Groups

Dates of this Project. March 1, 2007 – February 29, 2008

Request to Participate in Research

We invite you to participate in a research study being conducted by Laurie Swabey at CATIE at the College of St. Catherine, one of the six centers of the National Consortium of Interpreter Education Centers (NCIEC), located at Northeastern University. The purpose of this study is to identify best practices across the U.S. in interpreting in the medical setting. You are being asked to participate in this study because of your knowledge related to interpreters in the medical setting. It is anticipated that the data collected will begin to clarify the strategies, ethical perspectives, and training needs of medical interpreters. The National Consortium of Interpreter Education Centers will use these data in curriculum development and for improving medical interpreting.

You must be at least 18 years old to be in this research project.

We will ask you to participate in a focus group. During the focus group, you and your fellow focus group members will be asked to respond to a series of discussion questions and scenarios about the work of interpreters in the medical setting. The focus group will take approximately three hours and will take place in a classroom setting. Your focus group will be videotaped for purposes of transcribing the focus group discussion. In addition to the focus group, you will be asked to complete a brief survey about your background, demographics and experiences.

There are no identifiable risks to you for taking part in this study.

There are no direct benefits to you for participating in this study. However, your answers will help us to learn more about the effective strategies and processes in medical interpreting. What we learn in this focus group will be foundational in developing curriculum and educational opportunities for medical interpreters. You will receive \$50 at the completion of your participation in the focus group.

Results that are presented will be anonymous. Any reports, presentations or publications based on this focus group will not identify you individually and will not link any of your specific quotes or comments to you. Your focus group will be videotaped to facilitate writing a transcript of the focus group. Again, no names or identifying information will be included in presentations and/or publications. Focus group videotapes will be kept in the locked offices of CATIE at the College of St. Catherine.

The decision to participate in this research project is up to you. You do not have to participate and you can refuse to answer any question. You may withdraw from the study at any time with no negative effects on relationships with the principal investigator, CATIE or the National Consortium for Interpreter Education Centers.

If you have any questions about this study, please feel free to call Laurie Swabey at 651-690-6797 or laswabey@stkate.edu

If you have any questions about your rights in this research, you may contact Vivienne A. Conner, Coordinator, Human Subjects Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University, Boston, MA 02115, telephone 617-373-7570. You may call anonymously if you wish. You may also contact John Schmitt (Chair) of the College of Saint Catherine Institutional Review Board at (651) 690-6203.

You may keep a copy of this form for yourself.

Thank you,

Laurie Swabey, Ph.D.

Consent:

You are making a decision whether or not to participate in this focus group and allow your data to be used for presentations and/or research purposes. Any reports, presentations or publications based on this focus group will not identify you individually and will not link any of your specific quotes or comments to you. The reason for videotaping is to transcribe the focus group session after it has occurred. Signing this consent form indicates that you have read this information, your questions have been answered, you consent to participate in the study and allow us to use the transcribed data

for presentations and research purposes, and you consent to having the focus group videotaped. Even after signing, please know that you may withdraw from the study at any time.

Participant's signature

Date

Researcher's signature

Date



CATIE
College of St. Catherine
ASL and Interpreting Department

Consent Form for Medical Interpreting Focus Groups (non-videotaped)

Name of Principal Investigator (PI): Laurie Swabey, Ph.D. Director, CATIE Center;
Chair/Associate Professor, ASL and Interpreting Dept., College of St. Catherine

Title of Project: Medical Interpreting Curriculum Development Project – Focus Groups

Dates of this Project: March 1, 2007 – February 29, 2008

Request to Participate in Research

We invite you to participate in a research study being conducted by Laurie Swabey at CATIE at the College of St. Catherine, one of the six centers of the National Consortium of Interpreter Education Centers (NCIEC). The purpose of this study is to identify best practices across the U.S. in interpreting in the medical setting. You are being asked to participate in this study because of your knowledge related to interpreters in the medical setting. It is anticipated that the data collected will begin to clarify the strategies, ethical perspectives, and training needs of medical interpreters. The National Consortium of Interpreter Education Centers will use these data in curriculum development and for improving medical interpreting.

You must be at least 18 years old to be in this research project.

We will ask you to participate in a focus group. During the focus group, you and your fellow focus group members will be asked to respond to a series of discussion questions and scenarios about the work of interpreters in the medical setting. The focus group will take approximately three hours and will take place in a classroom setting. In addition to the focus group, you will be asked to complete a brief survey about your background, demographics and experiences.

There are no identifiable risks to you for taking part in this study.

***There are no direct benefits to you for participating in this study.** However, your answers will help us to learn more about the effective strategies and processes in medical interpreting. What we learn in this focus group will be foundational in developing curriculum and educational opportunities for medical interpreters. You will receive \$50 at the completion of your participation in the focus group.*

***Results that are presented will be anonymous.** Any reports or publications based on this focus group will not identify you individually and will not link any of your specific quotes or comments to you.*

***The decision to participate in this research project is up to you.** You do not have to participate and you can refuse to answer any question. You may withdraw from the study at any time with no negative effects on relationships with the principal investigator, CATIE or the National Consortium for Interpreter Education Centers.*

If you have any questions about this study, please feel free to contact Laurie Swabey at 651-690-6797 or laswabey@stkate.edu

If you have any questions about your rights in this research, you may contact Vivienne A. Conner, Coordinator, Human Subjects Research Protection, Division of Research Integrity, 413 Lake Hall, Northeastern University, Boston, MA 02115, telephone 617-373-7570. You may call anonymously if you wish. You may also contact John Schmitt (Chair) of the College of Saint Catherine Institutional Review Board at (651) 690-6203.

You may keep a copy of this form for yourself.

Thank you,

Laurie Swabey, Ph.D.

Consent:

You are making a decision whether or not to participate in this focus group and allow your data to be used for presentations and/or research purposes. Any reports, presentations or publications based on this focus group will not identify you individually and will not link any of your specific quotes or comments to you. Signing this consent form indicates that you have read this information, your questions have been answered, you consent to participate in the study and allow us to use your data for presentations and research purposes. Even after signing, please know that you may withdraw from the study at any time.

Participant's signature

Date

Researcher's signature

Laurie Swabey

Date



CATIE Center
College of St. Catherine, Minnesota

Medical Interpreting Focus Groups Members - Background and Experience

1. Gender: Female Male

2. What is your hearing status? (please circle one)
 Hearing Deaf Hard of Hearing Deaf Blind

3. What is your age?
_____ 18 - 29 years old
_____ 30 - 39 years old
_____ 40 - 49 years old
_____ 50 - 59 years old
_____ 60 - 69 years old
_____ 70 or better

4. What is the highest educational level you have achieved?
_____ High school
_____ Certificate/diploma
_____ AA degree
_____ Bachelors degree
_____ Masters degree
_____ Doctorate

5. Ethnicity
_____ Native American/American Indian
_____ Asian/Pacific Islander
_____ African-American/Black
_____ Hispanic/Latino
_____ White Non-Hispanic/European American
_____ Other Please specify _____

6. Which of the following characterizes your role? (check all that apply).
_____ Signed language interpreter
_____ Spoken language interpreter
_____ Deaf, Deaf Blind or Hard of Hearing consumer
_____ Interpreter educator
_____ Language instructor

_____ Medical professional
_____ Other: _____

7. What state do you live in? _____

8. How many years have you been interpreting? _____

9. How long have you been accepting work in medical settings?

_____ Less than 3 years

_____ 3-5 years

_____ 6-10 years

_____ 11-15 years

_____ 16+ years

10. How often do you interpret in a medical setting? (please check one)

_____ Less than once per month

_____ 1-2 times per month

_____ 3-5 times per month

_____ 6-10 times per month

_____ More than 10 times per month

_____ I have a staff interpreter position at a health care facility.

_____ I am currently not interpreting in medical settings, but I have in the past.

11. Have you ever worked as a staff interpreter for a health care facility? Yes _____

No _____

(If yes, how long?) _____

12. Are you a certified interpreter? Yes _____ No _____

If yes, how long have you been certified? _____

If yes, what certification do you hold? _____

13. When you first started interpreting in medical settings, did you feel appropriately prepared? Yes _____ No _____

Please explain: _____

14. What type of education did you have that prepared you to work in the medical setting?

_____ None

_____ College courses on medical interpreting

_____ College courses on related topics (medical terms, anatomy, etc.)

_____ Workshops on medical interpreting. If so, how long/how many? _____

Other: Describe _____

15. How would you describe the amount of simultaneous and consecutive interpreting you use in your medical interpreting work?

- Mostly all simultaneous
- About half simultaneous and half consecutive
- Mostly all consecutive

16. From the following effective practices, place a check next to the FOUR that are most important for interpreters working in medical settings.

- Knowledge of Health Care Systems
- Culture and Diversity
- Self-Care
- Role & Boundaries
- Preparation
- Ethical and Professional Decision Making
- ASL and English needed for interpreting in medical settings
- Interpreting Skills
- Technology
- Knowledge of laws that effect interpreters
- Leadership
- Advocacy
- Professional Development and Continuing Education

17. How often have you worked with a Deaf Interpreter (DI/CDI) in a medical setting?

- Never
- 1-5 times in my interpreting career
- Less than once per month
- 1-2 times per month
- 3-5 times per month
- 6-10 times per month
- More than 10 times per month
- I am currently not interpreting in medical settings but I have worked with a DI or CDI in
medical settings in the past. How often? _____

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

19. Do you see a need for specific advanced education in medical interpreting?

Post baccalaureate certificate Yes _____ No _____

Masters degree Yes _____ No _____

Why or why not? _____

20. Additional comments: _____

THANK YOU for your participation!

APPENDIX B



CATIE Center
College of St. Catherine, Minnesota

MEDICAL INTERPRETING – SCENARIOS FOR DISCUSSION

- 1) The hearing parents of a deaf 6-year-old are meeting with a healthcare professional about the child's incontinence. The practitioner's assessment is that incontinence is normal for deaf 6 year old children. (The implication is that it isn't normal for hearing children at age 6, but it is normal for deaf children.) The parents accepted this conclusion to be true.

(**The interpreter in this situation was very uncomfortable with the healthcare provider's ignorance about Deaf children, and his attitude that they were usually lagging in all developmental areas.)

- 2) A Deaf youth from a group home is brought in by a staff member for a medical appointment and you have been hired to interpret. The group home is for hearing youth. This support staff member does not sign. When the health care professional starts her explanation, the support staff person interrupts and says "He doesn't understand. Just tell me the information quickly and I'll give it back to the staff at the group home and we can deal with it there."

(**The interpreter was uncomfortable with this situation and wanted to provide information about group homes serving Deaf youth as well as advocating that the doctor give his explanation to the Deaf youth. However, the interpreter did neither, fearing she was 'stepping out of role'.)

- 3) The doctor refers the Deaf patient to a specialty clinic. The Deaf patient says that he is afraid that they won't provide an interpreter at that clinic so he doesn't want to go. The doctor says to go anyway, even if they won't provide an interpreter.

(**In this situation, the interpreter provided information about how to get an interpreter at the specialty clinic.)

- 4) A cancer surgery patient in the recovery room with the patient. The healthcare professionals have informed the patient of the results of her surgery but she is too groggy to understand the news. A while later the patient is coherent and asks the interpreter, "Is it gone?" Do you (the interpreter) repeat the news?

(**In this situation, the interpreter considered this to be consecutive interpreting with a long delay and did inform the patient.)

5) The interpreter is with an elderly patient before surgery. In chatting with the patient, it became clear to the interpreter that the elderly patient wanted her adult son with her. The interpreter asked, "Would you like your son here for support while I interpret?" The patient did indeed want this and the interpreter went out and found the son. However, it turned out that the doctor did not want the son present.

6) A female interpreter has a three-day assignment at a Native Sweat Lodge. Menstruating females are not permitted to attend the events. The interpreter has her period or gets her period during the assignment. What does she do?

(Medical and religious interpreting can overlap during pastoral visits, healing circles, bedside prayer vigils and last rights.

7) A Deaf person of Hispanic descent has a cultural diet at home which is not conducive to the new diet prescribed by the doctor. The patient will die if he does not change his diet. He is not comfortable informing his (hearing) family about the required change in food. He tells that to the doctor. The doctor doesn't offer any suggestions but insists he must tell his mother that he must have a different diet. The patient feels this will be a huge insult to his mother and family and does not appear willing to do this, even though it has a huge impact on his life.

8) The interpreter arrives for the medical appointment and finds the middle-aged Deaf woman has her daughter with her (age twenty-something). When the appointment begins, the CODA begins to interpret at the same time as the interpreter.

9) A staff interpreter at a hospital in a large metropolitan area is called to interpret between a young Deaf mother and the healthcare team. The mother's baby has a congenital heart defect. Although the mother understands that something is wrong with her baby's heart, the interpreter believes that the mother doesn't understand anatomy and that the mother thinks that the baby has a second heart that can allow her to function, even without the 'bad' heart. The healthcare team doesn't seem to be aware of the patient's lack of health literacy. When asked by the healthcare team if she understands the diagnosis and options, the mother says she understands. However, the interpreter doesn't believe that the mother understands the severity of the situation or the options, including end-of-life care and the ramifications of being on a long transplant list. The mother is new to town, has limited resources and does not have a support network. The mother's family (parents and siblings) are hearing, do not sign and are not supportive of the mother and baby. The interpreter believes the mother is not aware of the fact that the baby will die soon. The interpreter also believes that the mother has strong religious beliefs that are impacting her decisions, and that the healthcare team is unaware of these beliefs.

(**The interpreter did call in another staff interpreter for a consult. The second interpreter agreed that there were major gaps in the mother's understanding of health. They informed the healthcare team but they didn't act on the information. What would a CDI do in this situation? Would it be different than what an experienced, certified hearing interpreter would do?)

10) The interpreter arrives to do an intake visit for hospice care with a visiting nurse at the patient's home. Before the nurse and the interpreter ring the doorbell, the nurse asks the interpreter not use the sign for 'DEATH' because it will upset the Deaf patient and her family. The nurse wants the patient to agree to hospice care and doesn't want to scare her on this initial intake visit.

11) A male interpreter is interpreting for a Deaf Hispanic male and the American female physician asks the patient if he has had an extramarital affair because he is exhibiting symptoms of an STD. The patient answers no. The provider leaves the room and in confidence, while the physician is out, the patient tells the interpreter that he indeed has had an extramarital affair.

12) Some interpreter referral agencies are now implementing policies that interpreters cannot stay in exam rooms if a healthcare provider is not present. What are the ramifications of such policies for those involved (interpreter(s), Deaf patients, healthcare providers). How do you make the decision about whether to stay in the examining room with the patient or not?

Emergency Department Scenarios

13) You are called to interpret for a woman who is complaining of pelvic aches and pains. In doing the physical examine, the doctor finds evidence of bruising. In further questioning, the doctor asks how the injuries might have occurred. You get information back that the injuries were a result of a sexual episode.

- You've got to figure out if she's talking about rough sex or rape.
- You wonder if the client knows the difference.
- What if, the hospital's internal investigation team comes in - is that a problem?
- What if county victims' rights workers come in?
- What if representatives from a local shelter want to talk with the woman?
- Is it an issue if the state Department of Health is there to ask questions?
- What about when the police arrive?

14) A minor presents with injuries from a fall. The medical staff builds their treatment plan and asks questions. You recognize they are going down the road of a parent inflicted injury. The police and family violence investigation team comes in to continue questioning. Even with all these folks asking questions, the Deaf parent still has not figure out they have become a suspect in what will soon be considered a criminal case.

- Does this inform or change how you do the work you do?
- What decisions do you make?
- What actions do you take?

15) You are working with someone being treated for mild poisoning. The medical staff is not picking up on the subtle clues but you are realizing that this might be a self-inflicted condition. You suspect the individual may have a mental illness or other complicating mental condition. You believe the medical staff would know this if everyone shared the same first language and cultural background. If this information comes out this person could be committed for psychiatric care. It could lead to a formal commitment.

- Do you compensate for this lack of language and cultural information?
- If yes, how do you convey these subtleties through your interpretation?

For the three scenarios above:

1. Where is the point at which these scenarios became legal assignments? If you are not legally trained, how do you handle this transition?
2. Suppose that, in any of the above situations, that the Deaf person is a refugee and new American. S/he is learning ASL as their first language. How might this change the process and the decisions the interpreter makes?
3. What if you were working with a foreign language interpreter who, in your opinion, is demonstrating poor ethics and boundaries?

16) What are some of the challenges you have faced with these populations: interpreting for Deaf children (with Deaf parents and/or with hearing parents); interpreting for Deafblind patients; interpreting for Deaf healthcare providers; interpreting for elderly patients; interpreting for Deaf patients with multiple disabilities; interpreting for Deaf patients who are new to this country.

17) Do you read charts? Why or why not?

18) Do you translate forms without a healthcare provider present?