Interpreting in Healthcare Settings

Annotated Bibliography

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NCIEC
National Consortium of Interpreter Education Centers

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Table of Contents

Introduction

Background

In national surveys, Deaf Americans identify healthcare as the most difficult setting in which to obtain the services of a qualified interpreter (National Interpreter Education Center, 2008), and professional interpreters identify the healthcare setting as the area in which training is most critically needed (National Interpreter Education Center, 2012). Swabey and Nicodemus (2011) have argued that interpreting between ASL and English in healthcare settings needs to be recognized as a type of work that requires specialized education and credentialing. Several studies have identified the medical interview as an essential tool for both the diagnosis and treatment of patients (Ha, Anat, & Longnecker, 2010; Lichstein, 1990; Ong, de Haes, Hoos, & Lammes, 1995). Additionally, patients who perceive that the communication with their healthcare provider is good are more likely to convey important information about their health, follow prescribed treatment plans, and express satisfaction with their care (McKee, Barnett, Block, & Pearson, 2011; Williams, Weinman, & Dale, 1998).

Yet, despite these findings, few comprehensive programs exist to educate or prepare interpreters to work in the varied and demanding settings of the healthcare industry. Furthermore, there has been a lack of nationally agreed-upon standards for specialization in healthcare and a lack of educational materials, resources and supervised induction to create a qualified pool of healthcare interpreters. It has been observed that in most healthcare encounters with patients, the only professional involved that is not required to complete an accredited educational program and/or hold a license or credential to practice is the healthcare interpreter. In the CATIE Center's 2007 survey of expert healthcare interpreters, 61% of respondents reported not feeling appropriately prepared when they started interpreting in medical settings.

Since 2005 the CATIE Center at St. Catherine University has partnered with the NCIEC (National Consortium of Interpreter Education Centers) to develop effective practices for teaching healthcare interpreting. One of the first components of this endeavor was the development of the domains and competencies for medical interpreters, which serves as the framework for this annotated bibliography. The process for developing the domains and competencies for medical interpreters was conducted in 2007, and included a literature review, an expert panel review, and input from focus groups across the country (see Swabey & Malcolm, 2012, pp. 1-26, for a full description of the development process of the domains and competencies; see CATIE Center, 2007 for focus group results).

The CATIE Center has also developed other resources related to healthcare interpreting, including:

- A curriculum map for healthcare interpreter education;
- Body Language online modules, designed to guide novice interpreters and experienced practitioners new to the healthcare setting in understanding the common discourse of medical appointments, and building the knowledge needed to convey anatomy, physiology, common procedures and diseases in ASL. Seven modules are offered: healthcare discourse, the cardiac system, the digestive system, the respiratory system, the muscular/skeletal system, diabetes, and heart disease;
- Towards Reflective Practice: Case Studies for Interpreting in Healthcare. This manual consists of 30 case studies for healthcare interpreters and interpreter educators;
- A medical interpreting immersion program;
- A healthcare interpreting fellowship program.

More information about all of these resources can be found at stkate.edu/catie and HealthcareInterpreting.org.

Purpose

This annotated bibliography has the broad purpose of enhancing the study, practice and advancement of healthcare interpreting. We anticipate that it will be used by students, mentors, practitioners, educators and researchers. Specifically it is designed to be used as:

1) A reference or resource for the learning opportunities developed and supported by the CATIE Center/NCIEC (listed above), and
2) A foundation for readers for interpreting students/novice interpreters and healthcare interpreting specialists.

The readers are the next phase of this project. They will be developed through a process that includes input and review from a variety of experts. In many fields there is a shared foundation of common knowledge but, to date, this is not the case for healthcare interpreters. These recommended reading lists would be one step in that direction.

Process

Based on the previous bibliography, other resources in the field, and key word searches, we compiled a list of potential entries. When possible, we tried to select entries that would be most accessible to the largest number of potential users. Ideally we included links to articles, and if not, included articles that could be ordered by a university or large public library. After copies of the articles and books

were obtained, the annotations were written and then categorized by domain. Subsequently, this draft version was sent to a group of experts (researchers, educators, and expert practitioners) for their review of the importance/relevance of each entry, as well as their input on any additional sources for inclusion. The intent was not to develop a comprehensive bibliography, but to develop one with applicable, accessible, and relevant entries for the target audiences.

Organization

This bibliography is organized following the 13 domains from the *Medical Interpreting ASL-English Domains and Competencies* (CATIE Center, 2007). We believe this structure enhances the usefulness of this work and adds depth to the domains and competencies. The last section of the bibliography, Multiple Domains, contains readings that apply to several domains. This, in fact, may be a useful place for many readers to begin. For those who prefer to have more search options, the bibliography is also available as an Excel file from HealthcareInterpreting.org. In that format, it can be searched by domain, author or topic from the *Concept Map for Mental Health/Medical Interpreting Education* (Malcolm, 2008).

The number that precedes the author name (i.e. [4] Agency for Healthcare Research and Quality) refers to the line number of the reference in the spreadsheet.

Looking to the Future

We hope that this collection of annotated readings will be used in ways that we have imagined, and in ways we have not yet imagined. Providing increased access to available professional articles, peer-reviewed articles and books is one more step forward in the journey toward effective practices for healthcare interpreting and healthcare interpreting education.

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References

CATIE Center, College of St. Catherine and NCIEC. (2007). *Medical interpreting focus groups: Results for the background and experience survey*. Retrieved from Healthcare Interpreting website: http://www.medicalinterpreting.org/PDF/FocusGroupSurvey.pdf

CATIE Center, College of St. Catherine and NCIEC. (2008). *Medical interpreter: ASL-English domains and competencies*. Retrieved from Healthcare Interpreting website: http://healthcareinterpreting.org/tag/domains-and-competencies/

Ha, J. F., Anat, D. S., & Longnecker, N. (2010). Doctor-patient communication: A review. *The Ochsner Journal, 10*, 38-43

Lichstein, P. (1990). The medical interview. In H. Walker, W. Hall, J. Hurst (Eds), *Clinical methods: The history, physical, and laboratory examinations* (3rd ed.). Boston, MA: Butterworths.

Malcolm, K. (2008). *Concept map for mental health/medical interpreting education.* Retrieved from Healthcare Interpreting website: http://healthcareinterpreting.org/concept-map/

McKee, M. M., Barnett, S., Block, R. C., & Pearson, T. A. (2011). Impact of communication on preventive services among deaf American Sign Language users. *American Journal of Preventive Medicine, 41*(1), 75-79.

National Interpreter Education Center. (2008). *Phase one deaf consumer needs assessment: Final report.* Retrieved from http://www.interpretereducation.org/wp-content/uploads/2011/06/FinalPhaseIDCReport.pdf

National Interpreter Education Center. (2012). *Interpreter practitioner national needs assessment of 2012: Final report.* Retrieved from http://www.interpretereducation.org/wp content/uploads/2013/02/Practitioner_ FINAL_REPORT_021513.pdf

Ong, L. M., de Haes, J., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine, 40*(7), 903-918.

Swabey, L., & Nicodemus, B. (2011). Bimodal bilingual interpreting in the U.S. healthcare system: A critical linguistic activity in need of investigation. In B. Nicodemus & L. Swabey (Eds.), *Advances in interpreting research: Inquiry in action* (pp. 241–260). Amsterdam, The Netherlands: John Benjamins.

Williams, S., Weinman, J., & Dale, J. (1998). Doctor-patient communication and patient satisfaction: A review. *Family Practice, 15*(5), 480-492.

Domain 1: Healthcare Systems

The interpreter will have an understanding of the healthcare system and where they, as interpreters, fit into the system.

A. The interpreter demonstrates knowledge of the health care context, including differences between public and private health care systems and hospitals, various venues where medical care is provided, common diagnoses and treatments, institutional hierarchy, and roles and responsibilities of health care personnel.
B. The interpreter demonstrates knowledge of medical terms, procedures, and protocols of the health care system and specialized environments.
C. The interpreter possesses bilingual competence with technical vocabulary pertaining to common medical procedures, diagnoses and treatment (e.g., medications, physical exams, MRIs, radiation).
D. The interpreter discusses the role and function of the interpreter as part of the health care team in a professional manner.
E. The interpreter applies knowledge of health care systems and the rights and needs of Deaf, deaf-blind and hard of hearing people to affect positive, systemic change (e.g., health care literacy).

Related Readings

[4] Agency for Healthcare Research and Quality. (2007). *Questions and answers about health insurance* (AHRQ Publication No. 07-0043). Retrieved from http://www.ahrq.gov

A patient-centered explanation of healthcare types and the services that can be accessed through each insurance category. Breaks down individual insurance and group insurance as well as discusses government-funded insurance programs. Each category is further broken down into sub-categories such as HMOs, PPOs, and the several parts of Medicare.

[5] American Medical Association. (1995). *Family medical history*. Updated 2014. Retrieved from http://www.ama-assn.org//ama/pub/physician-resources/medical-science/genetics-molecular-medicine/family-history.page

Resource page for doctors and patients about taking family histories as it relates to inherited conditions. Additionally, there are several links to pamphlets and questionnaires that could be useful to interpreters seeking to understand the family history taking process.

[13] Bourhis, R. Y., Roth, S., & MacQueen, G. (1989). Communication in the hospital setting: A

survey of the medical and everyday language use amongst patients, nurses and doctors. *Social Science and Medicine, 28*(4), 339-346.

A research article that investigates actual communication events between doctors and patients and how each group uses medical terminology in context. While informative, this article is somewhat complex and does not contain a definitive conclusion about how and why medical language is used in certain ways by doctors and patients.

[15] Cerny, M. (2008). Some observations on the use of medical terminology in doctor-patient communication. *SKASE Journal of Translation and Interpretation, 3*(1), 39-53. Retrieved from http://www.skase.sk/Volumes/JTI03/pdf_doc/Czerny.pdf

A spoken language study about the use of medical terminology among physicians from various medical disciplines. Includes an interesting discussion about the definition of medical terminology and many examples of dialog between patients and physicians.

[20] Cochran, C. (1998). *Interpreting handbook for diagnostic procedures.* Overland Park, KS: Regional Interpreter Training Project.

This source, while slightly outdated, still contains a helpful overview of many diagnostic procedures. Each section contains an explanation of the procedure, typical questions asked by the medical professional and considerations for the interpreter such as where to stand, maintaining sightlines, protective shielding, and how interpreting process (lag) time can affect procedures. This article is also relevant to Domain 3: Self Care, and Domain 9: Technology.

[25] Commission on Law and Aging. (2011). *Giving someone a power of attorney for your health care: A guide with an easy-to-use, legal form for all adults.* Retrieved from American Bar Association website: http://www.americanbar.org/content/dam/aba/uncategorized/2011/2011_aging_hcdec_univhcpaform.authcheckdam.pdf

Although this document is meant for patients making decisions about medical power of attorney, it can also be a useful tool for interpreters to familiarize themselves with the purpose and structure of healthcare POAs. Potential questions asked by medical professionals or social workers who are working with a patient to complete a POA are included as descriptions with each section in the blank POA provided.

[27] Dahm, M. (2010). Does experience change understanding? The effects of personal experiences on patients' knowledge of medical terminology. In Y. Treis & R. De Busser (Eds.), *Selected papers from the 2009 Conference of the Australian Linguistic Society.* Retrieved from the Australian Linguistic Society website: http://www.als.asn.au/proceedings/als2009/dahm.pdf

A research study conducted with patients for whom English was a second language on their understanding of medical terminology. The article discusses the different uses of medical terminology by medical professionals and patients in terms of a hierarchy of meaning and discusses the implications for patients' understanding. Also argues that patients who have personal experience with a condition are typically more aware of the terminology associated with that condition.

[39] Fatahi, N., Hellström, M., Skott, C., & Mattsson, B. (2008). General practitioners' views on consultations with interpreters: A triad situation with complex issues. *Scandinavian Journal of Primary Health Care, 26*(1), 40-45.

Based on interviews of general medical practitioners in Sweden after their use of spoken language interpreters in patient interactions. This article, although written from the practitioners' perspective, gives an insight into how doctors think about interpreters; it emphasizes that interpreters should act as a bridge between the doctor and patient. It also discusses power-balance in the triad relationship and the doctor's responsibilities and view of interpreter responsibilities.

[45] Goldberg, C., & Thompson, J. (2009). *A practical guide to clinical medicine.* Retrieved from University of California, San Diego website: http://meded.ucsd.edu/clinicalmed/introduction.htm

This website was designed as an overview of clinical medicine for medical and pre-med students but contains useful and detailed information on bodily systems and medical procedures. Several pictures and video are also included that give students a visual of patient and clinician placement during a procedure, and what instruments may be used. However, the amount of information provided on this website can be daunting and the medical terminology is geared toward student practitioners, so may be different that what an interpreter would encounter in a clinical arena.

[47] Goold, S. D., & Lipkin, M. (1999). The doctor-patient relationship: Challenges, opportunities and strategies. *Journal of General Internal Medicine*, *14*, 26–33. Retrieved from National Center for Biotechnology Information website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496871/pdf/jgi_267.pdf

Practitioner-focused view of the patient-provider encounter as it relates to managed care systems. Another broad overview about the interactions between doctors and patients. Table 1 could function as a useful resource in discourse analysis of medical encounters as it outlines functions and structural elements of the medical interview.

[51] Harbinder, S., Adams, A., Singleton, L., Clark-Carter, D., & Kidd, J. (2009). The impact of gender dyads on doctor–patient communication: A systematic review. *Patient Education and Counseling, 76*(3), 348-355.

This article looks at how gender of both the patient and practitioner can influence

the length and bio-medical speech between the two parties. This resource could aid interpreters in understanding the typical interactions in healthcare systems without the intermediation of interpreters, as well as an awareness of cross-gender interpreting for medical appointments and how it may influence the information given by doctors and received by patients.

[60] Hsieh, E., Pitaloka, D., & Johnson, A. J. (2013). Bilingual health communication: Distinctive needs of providers from five specialties. *Health Communication, 28*(6), 557-567.

This study was conducted to understand how healthcare providers differed in their use and needs of spoken language interpreters depending on their specialty. The researchers looked at five specialties: obstetrics/gynecology, emergency medicine, oncology, mental health, and nursing. The overall findings were that nurses had differing views on interpreters and expected them to have an ally function that included working with the patient outside of the medical encounter and serving as a patient advocate during the encounter. This information could help interpreters better interface with providers in differing disciplines based on their knowledge about the practitioner's view of interpreters.

[74] Major, G., & Holmes, J. (2008). "Ok, just a wee jab": Describing medical procedures to patients. *Australian Journal of Advanced Nursing, 25*(4), 58-70. Retrieved from http://www.ajan.com.au/Vol25/Vol_25-4_Holmes.pdf

A short, useful article that outlines the nature of communication between nurses and patients when explaining hospital procedures. Defines effective communication and reviews transcripts from medical interactions between nurses and patients.

[78] Martin, D. (2003). Martin's map: A conceptual framework for teaching and learning the medical interview using a patient-centered approach. *Medical Education*, *37*(12), 1145-1153.

An in-depth look at how medical students are taught to think about medical history taking. Reviews the goals and objectives for each stage and includes a map that reviews critical areas a physician should be observing. This can aid interpreters in understanding the context and speaker goals within a medical interview.

[90] Moreland, C., Latimore, D., Sen, A., Arato, N., & Zazove, P. (2013). Deafness among physicians and trainees: A national survey. *Academic Medicine, 88*(2), 224-232.

Discusses the unique needs of physicians and trainees who are deaf and hard of hearing and where they are in their career paths. Also discusses barriers to success and accommodations used in their day-to-day job duties.

[91] Morere, D. A., Dean, P. M., & Mompremier, L. (2009). Mental health assessment of deaf

clients: Issues with interpreter use and assessment of person with diminished capacity and psychiatric populations. *Journal of the American Deafness & Rehabilitation Association*, *42,* 241-258.

Personal experience as well as a review of literature about working with deaf patients and a sign language interpreter in mental health settings written by a psychiatric resident. The review of deaf culture may be unnecessary, but the personal details and discussion on logistics may give interpreters a glimpse into the thoughts and feelings of clinicians. There is also a section on logistics that discuss the advantages and disadvantages to pre- and post-sessions with the interpreter and clinician.

[100] Nolan, T. W. (1998). Understanding medical systems. *Annals of Internal Medicine, 128*(4), 293-298.

An overview of broader medical systems meant for physicians as a starting point in understanding other disciplines and working towards collaboration with specialists with the goal of holistic patient care. This article may aid interpreters in understanding current medical systems and the differences in how certain divisions operate.

[103] Ong, L. M., de Haes, J., Hoos, A. M., & Lammes, F. B. (1995). Doctor-patient communication: A review of the literature. *Social Science & Medicine*, *40*(7), 903-918.

A literature review of doctor-patient communication and its functions for physicians. Understanding the functions of doctor-patient communication at its essence can help interpreters understand and predict discourse structure. This article breaks communication into three categories: (a) creating a good interpersonal relationship, (b) exchanging information, and (c) making treatment-related decisions. The charts and graphs used to compare literature may not be a necessary read but the discussion section presents information applicable to broad understanding of healthcare communication.

[116] Street, R. L. (1991). Information-giving in medical consultations: The influence of patients' communicative styles and personal characteristics. *Social Science & Medicine*, *32*(5), 541–548.

Looks at how patients talk to doctors as it correlates to level of care. Informative for interpreters working in the medical field to know that the patient may get a specific level of care based on the communicative approach used by the interpreter. Research component and methodology not as relevant to the interpreter's experience as the literature review and discussion section.

[123] U.S. Department of Health and Human Services, Office of Minority Health. (2013). *National standards for culturally and linguistically appropriate services in health and health care: A blueprint for advancing and sustaining CLAS policy and practice.*

Retrieved from
https://www.thinkculturalhealth.hhs.gov/pdfs/EnhancedCLASStandardsBlueprint.pdf

A guide to the national standards for hospitals and health care providers. Although complex, these standards are federally mandated and important for interpreters to know in order to justify provision of services.

[125] Wilce, J. M. (2009). Medical discourse. *Annual Review of Anthropology*, *38,* 199-215.

Written from the perspective of an anthropological study of medical discourse, this resource looks at multiple types of medical discourse in a variety of cultures and registers. Part of the article is devoted to conversation analysis, which may give insight into the way that physicians talk about health care with patients as well as among colleagues.

Domain 2: Multiculturalism and Diversity

The interpreter will be familiar with the unique linguistic and cultural backgrounds each party brings to the healthcare interaction and understands how this may impact communication.

A. The interpreter exhibits behaviors and practices that demonstrate respect for patients and healthcare providers from diverse backgrounds and with diverse beliefs, striving to provide interpreting services that respect the cultures, values and norms of the consumers involved. The interpreter demonstrates strategies for working with consumers for whom healthcare settings provoke increased anxiety.
B. The interpreter provides information to healthcare professionals regarding the importance of creating a visually accessible environment for Deaf, deaf-blind and hard of hearing people (e.g. communication boards, use of lights, avoid responding through an auditory intercom when patient presses call button).
C. The interpreter demonstrates strategies for working with Deaf people and healthcare professionals who have had prior negative experiences with access to health care (e.g., experiences of discrimination due to socioeconomic status or cultural beliefs).
D. The interpreter assesses and accommodates varied levels of language competency, knowing when to call in a specialist such as a CDI or Deaf Community Health Worker (CHW).
E. The interpreter demonstrates respect for consumers' autonomy allowing consumers to make their own decisions.
F. The interpreter maintains awareness of changes in the communities in which s/he works, such as an infusion of immigrants, and is able to interpret in medical settings effectively for patients and providers with varying cultural and religious needs.

Related Readings

[16] Cha-Chi, F., Lagha, R., Henderson, P., & Gomez, A. G. (2010). Working with interpreters: how student behavior affects quality of patient interaction when using interpreters. *Medical Education Online, 15*(1), 1-7.

This is a short article about a study of medical students who received training in how to work with an interpreter. Discusses the cross-cultural encounter as viewed by physician trainees and gives an interpreter insight into how medical personnel may be trained in pre-interview with interpreters, placement, and issues of confidentiality.

[19] Chin, N. P., Cuculick, J., Starr, M., Panko, T., Widanka, H., & Dozier, A. (2013). Deaf mothers and breastfeeding: Do unique features of deaf culture and language support breastfeeding success? *Journal of Human Lactation, 29*(4), 564-571.

This article describes a study done on breastfeeding mothers who were Deaf and ASL users. It describes the importance of cultural sensitivity in lactation coaching and concludes that a supportive environment (from the Deaf community and healthcare workers) and access to communication in ASL (via interpreters), lead to better breastfeeding outcomes.

[23] Cokely, D. (2001). Interpreting culturally rich realities. *Journal of Interpretation, 1*(4), 1-46.

While not related directly to medical interpreting, Cokely examines the semantic sense of lexical items that represent "culturally rich realities" in ASL and the Deaf community that may not be apparent to the English-speaking community. This article stresses the importance of cultural mediation in interpreting work. It also emphasizes the challenges and the importance of crafting interpretations that convey the signer's or speaker's intended semantic sense of culturally-rich lexical items.

[36] de Vlaming, R. (1999). The medical interpreter: An integral part of the health care team. *VIEWS, 16*(3), 14-15.

A short article about how interpreters can function as part of the medical team in order to bridge cultural barriers and make effective communication possible in the healthcare setting.

[41] Fileccia, J. (2011). Sensitive care for the deaf: A cultural challenge. *Creative Nursing, 17*(4), 174-179.

Written for nurses and nursing students, this article discusses deaf culture and the use of ASL. It particularly reviews barriers that can be caused by a misunderstanding of Deaf Americans and hearing loss within the medical context.

[52] Harmer, L. M. (1999). Health care delivery and deaf people: Practice, problems, and recommendations for change. *Journal of Deaf Studies and Deaf Education, 4*(2), 73-110. Retrieved from http://jdsde.oxfordjournals.org/content/4/2/73.full.pdf+html

An overview of the deaf population's access to medical care that explains several factors contributing to the disparity of medical knowledge among the deaf population. Reviews both historical and communication factors for this disparity, as well as barriers in access to healthcare due to lack of communication or attitudes of medical providers.

[113] Schim, S., Doorenbos, A., Benkert, R., & Miller, J. (2007). Culturally congruent care: Putting the puzzle together. *Journal of Transcultural Nursing, 18*(2), 103-110.

Written for nurses as a framework to approach the idea of transcultural nursing. Discusses how culture influences nursing work from a nursing perspective. This article, although dense, could help interpreters to understand how nurses approach striving to be culturally sensitive. Some sections are irrelevant as they discuss establishing metrics on measuring cultural sensitivity of medical providers.

Domain 3: Self-Care

The interpreter understands hospital safety protocols and avoids unnecessary risk to self and patients.

A. The interpreter recognizes issues in the work environment that may create distress within oneself and employs strategies for dealing with feelings (e.g., vicarious trauma).
    - Mental, emotional, social and spiritual wellness (e.g., journaling, exercising, seeking support from a trusted confidante or professional counselor).
B. The interpreter monitors personal health and avoids unnecessarily exposing vulnerable patients to germs or contagious illnesses (e.g., cold, flu, tuberculosis).
C. The interpreter demonstrates awareness of personal safety practices in healthcare settings (e.g., stands behind a shield when x-rays are taken, wears a mask when a patient has an airborne disease, applies universal precautions).
D. The interpreter demonstrates physical and emotional stamina necessary for interpreting in healthcare settings, including how and when to call in a team member (e.g., procedures that last several hours, such as births; or procedures with intense smells).

Related Readings

[3] Agan, T. (2009). Protecting ourselves, protecting our consumers. *VIEWS, 26*(4), 31-32.

Reviews some of the communicable diseases that we can contract and spread as interpreters. The article gives an overview of the vaccinations and screenings that are required for healthcare professionals and explains the process and purpose for each procedure.

[31] Dean, R. K., & Pollard, R. Q. (2001). Application of demand-control theory to sign language interpreting: Implications for stress and interpreter training. *Journal of Deaf Studies and Deaf Education, 6*(1), 3-14. Retrieved from http://jdsde.oxfordjournals.org/content/ 6/1/1.full.pdf+html

Dean and Pollard's seminal work applying the demand control schema to interpreting. This article contains an explanation of the demand control schema and reviews the literature on interpreters and burnout. Most of the discussion is dedicated to creating of interpreter education standards and the creation of 4-year interpreting programs. The article is slightly outdated but still relevant.

[35] Dean, R. K., Pollard, R. Q., & Samar, V. J. (2010). RID research grant underscores occupational health risks: VRS and K-12 settings most concerning. *VIEWS*, *27*(4), 41-43.

A short article that details a study on interpreter occupational health risk. The study is not directly related to medical interpreting, but the published results indicate that interpreters exhibited higher occupational health risk than other practice professionals.

[53] Harvey, M. (2001). The hazards of empathy: Vicarious trauma of interpreters for the deaf. *Journal of Interpretation.* Silver Spring, MD: RID Publishing.

A therapist's analysis of the role empathy plays in vicarious trauma experienced by interpreters. Written in a narrative style, the article uses one interpreter's story to weave together themes of co-dependence, empathy, and victim, oppressor and bystander hazards. Not directly related to healthcare interpreting, but an important topic of consideration for healthcare interpreters.

[109] Registry of Interpreters for the Deaf. (2007). *Self-care for interpreters: Prevention and care of repetitive strain injuries.* Retrieved from http://www.rid.org/UserFiles/File/pdfs/Standard_Practice_Papers/Drafts_June_2006/Self-Care_SPP.pdf

RID standard practice paper defining repetitive strain injuries (RSIs). This paper gives practical advice for avoiding RSIs and a checklist of questions that may help interpreters determine if they are experiencing symptoms of RSIs. This article is written for general interpreters and not directed toward self-care specifically in the medical field.

[128] Zenizo, A. L. (2013). *Self-care in the field of interpreting* (master's thesis). Retrieved from Western Oregon University Digital Commons http://digitalcommons.wou.edu/cgi/viewcontent.cgi?article=1006&context=theses

A master's thesis written about general self-care for signed language interpreters. This small-scale research study defines a broader scope of self-care than the RID standard practice paper above. Discussion of self-care includes meeting an interpreter's physical, social and emotional needs as well as incorporating professional debriefing and discussion as components of self-care.

Domain 4: Boundaries

The interpreter promotes patient autonomy while actively working to assure the effectiveness of communication.

A. The interpreter declines medical interpreting assignments that are beyond her/his capability, be it emotional, physical, or level of language competence.
B. The interpreter limits personal involvement with all parties during interpreting (e.g., not sharing or eliciting overly personal information in conversations with patients or health care providers).
C. The interpreter separates her/his own personal values and beliefs from those of other parties (e.g., interprets all reproductive choices to Deaf patient regardless of own beliefs).
D. The interpreter does not assume the right to make decisions for the patient and her/his treatment or healthcare plan and is aware of how the interpreter's use of language can subtly change or influence decisions.
E. The interpreter works as part of an extended interpreting team sharing important information, language approaches, etc. with other interpreters serving the same patient, allowing for continuity of service.
F. The interpreter discloses or attempts to avoid potential conflicts of interest where professional boundaries may be compromised (e.g., does not interpret for a family member or close friends, may decline to interpret for a person's performance appraisal at work if that person is a regular consumer in a health care setting).
G. The interpreter promotes patient autonomy (e.g., does not offer patients a ride home, or offer to pick up patients' prescriptions).
H. The interpreter determines when it is appropriate to protect an individual from serious harm (e.g., intervenes on behalf of a patient with a life-threatening allergy, if the condition has been overlooked).
I. The interpreter consults with professional colleagues on matters of importance and concern (e.g., other interpreters, members of the health care team), and suggests ways to overcome communication or language challenges using a Deaf Interpreter, social worker, Community Health Worker (CHW) or patient advocate.
J. The interpreter works as part of an interdisciplinary team to ensure effective communication.

Related Readings

[28] Davidson, B. (2001). Questions in cross-linguistic medical encounters: The role of the hospital interpreter. *Anthropological Quarterly 74*(4), 170-178.

Spoken language study focusing primarily on Spanish-English interpreting in a hospital context. Includes a discussion about the sometimes contradictory roles interpreters are asked to play within the medical discourse, and the possible outcomes of these roles. Discusses interpreters as institutional gatekeepers and covert co-diagnosticians.

[38] Earhart, A., & Hauser, A. (2008). The other side of the curtain. In P. Hauser, K. Finch, & A. Hauser (Eds.), *Deaf professionals and designated interpreters* (pp. 143-164). Washington, DC: Gallaudet University Press.

A resource for interpreters who work with a physician who is Deaf/HH. Describes the role of the interpreter, the working relationship between the physician and interpreter, and other pertinent issues that this physician and interpreter have encountered in their working relationship.

[72] Llewellyn-Jones, P., & Lee, R. (2013). Getting to the core of role: Defining interpreters' role-space. *International Journal of Interpreter Education, 5*(2), 54-72. Retrieved from CIT website: http://cit-asl.org/IJIE/2013_Vol5(2)/PDF/IJIE%20Vol5(2)-complete.pdf

This article defines interpreter role as a three-dimensional construct where interpreters function within a range of possibilities along each axis. This allows interpreters to consider decision making as it impacts the role and space that they occupy in given situations and look at how those decisions can have certain outcomes. Geared toward fostering successful communication interactions. Although the article is not specifically toward medical interpreters, it contains implications for interpreters in the healthcare setting.

[99] Nicodemus, B., Swabey, L., & Witter-Merithew, A. (2011). Presence and role transparency in healthcare interpreting: A pedagogical approach for developing effective practice. *Rivista di Linguistica, 11*(3), 69–83.

An argument for a broader discussion on boundaries and interpreter role within interpreter training specific to healthcare interpreting. Reviews domains and competencies that identify these issues as a training imperative and identifies ways educators can effectively address these topics within their courses.

[127] Witter-Merithew, A., Johnson, L., & Nicodemus, B. (2010). Relational autonomy and decision latitude of ASL-English interpreters: Implications for interpreter education. In L. Roberson & S. Shaw (Eds.), *Conference of Interpreter Trainers Conference Proceedings* (pp. 49-66). San Antonio, TX: CIT. Retrieved from CIT website: http://www.cit-asl.org/members/PDF/Proceedings/CIT%202010.pdf

An important discussion of how to foster high autonomy in interpreting students to aid them in system-centric decision making. This article suggests activities and practice that enhance this type of decision making in interpreting students.

Domain 5: Preparation

The interpreter understands how to obtain the necessary information about the medical encounter in order to be prepared with appropriate content and linguistic knowledge.

A. The interpreter demonstrates awareness of her/his own emotional filters, attitudes, and health care biases, beliefs and values.
B. The interpreter obtains relevant information prior to the specific interpreting assignment and has the skills to sufficiently research the background on various procedures and treatments to allow effective visual representation of the procedures.
C. The interpreter attempts to obtain appropriately relevant information prior to and during the specific interpreting assignment (e.g., reason for the appointment, reading brochures, studying charts on the walls).
D. The interpreter possesses a readiness plan for working in various situations such as with refugees and immigrants, for example, who may not have acquired ASL or English (e.g., uses models and pictures, knows when/how to get a CDI or Deaf CHW).
E. The interpreter maintains a sufficient amount of professional liability insurance.

Related Readings

[46] Goldberg, R. (2003). Building your medical vocabulary: Some practical suggestions that don't involve going to medical school (sort of). *VIEWS, 20*(1), 6-7.

This article discusses how interpreters can prepare themselves for interpreting in medical situations. Provides a broad overview of what information is most useful for interpreters to know, such as pharmacology, body systems, and Latin and Greek roots. Gives practical suggestions for interpreters such as watching educational medical shows, reading your own chart, and shadowing your primary care physician.

Domain 6: Ethical and Professional Decision Making

The interpreter has an understanding of the professional ethical code(s) that guide decision making in healthcare interpreting and has tools to make sound judgments in difficult situations.

A. The interpreter applies ethical principles in decision making, and understands the ramifications of decisions (e.g., when to accept or decline assignments).
B. The interpreter demonstrates awareness of the impact of demographics on decision making (e.g., Deaf people may be well-known to the interpreter in a small town).
C. The interpreter demonstrates knowledge that the decision-making processes and the expectation to disclose and/or report certain information may be different between staff interpreters and freelance interpreters (e.g., staff interpreters may have more access to pertinent information and make different decisions than freelance interpreters).
D. The interpreter has advanced decision making skills and knows when ethical dilemmas need to be resolved in collaboration with the patient and healthcare provider in order to lead to the best outcome for patient treatment and recovery.
E. The interpreter recognizes the need for patient privacy and exercises discretion about staying in the room or leaving (e.g., during medical procedures, private family conversations).

Related Readings

[9] Beltran Avery, M. (2001). The role of the health care interpreter: An evolving dialogue. The National Council on Interpreting in Health Care Working Papers Series. Retrieved from http://memberfiles.freewebs.com/17/56/66565617/documents/The%20role_of_health_care_interpreter.pdf

A working paper written from the perspective of medical interpreters from several spoken-language groups about the roles and practices of healthcare interpreters. Gives a historical perspective for the framing of boundaries and roles within medical interpretation and the philosophical differences between two different interpreting models: the interpreter as conduit and the interpreter as manager of the cross-cultural/cross-language mediated clinical encounter.

[11] Bolden, G. B. (2000). Toward understanding practices of medical interpreting:

Interpreters' involvement in history taking. *Discourse Studies, 2*(4), 387-419.

This research study captures Russian language interpreters mediating history taking in a medical setting. Thoughtful discussion of the issues in interpreting medical histories and how they impact spoken language interpreter's choices in mediation of the interaction.

[22] Cokely, D. (2000). Exploring ethics: A case for revising the code of ethics. *Journal of Interpretation*, *10*(1), 25-60. Retrieved from Direct Learn Services Online Conferencing website: http://www.online-conference.net/downloads/sdp_free/ethics_keynote.pdf

Reexamines the code of ethics in light of the rights it should protect within the community. Cokely's model is rights-based or descriptive rather than a prescriptive model.

[32] Dean, R. K., & Pollard, R. Q. (2004). A practice profession model of ethical decision making. *VIEWS, 21*(9), 1, 28-29. Retrieved from New Mexico Courts website: http://www.nmcourts.gov/newface/court-interp/files/Practice_Profession_Model_of_Ethics.pdf?uid=71390464

A shorter article that describes the importance of interpreters understanding how to articulate reasons behind their decision-making. This article reviews the demand-control schema and gives examples of how interpreters can apply this framework to decision making.

[33] Dean, R. K., & Pollard, R. Q. (2006). From best practice to best practice process: Shifting ethical thinking and teaching. In E. Maroney (Ed.), *A new chapter in interpreter education: Accreditation, research, & technology* (pp. 119-132). San Diego, CA: CIT.

An article geared toward interpreter trainers encouraging the shift from deontological to teleological responses in interpreters toward ethical decisions. Argument is made that it is important for interpreters not only to make decisions but also justify the rationale behind their decision making. An expansion on information shared in "A Practice Profession Model of Ethical Decision Making" (2000).

[34] Dean, R. K., & Pollard, R. Q. (2011). Context based ethical reasoning in interpreting: A demand control schema perspective. *The Interpreter and Translator Trainer, 5*(1), 155-182.

This article targets interpreter educators and the need for a change in the framework of how ethical decision-making is presented in the classroom. Dean and Pollard argue for a demand-control framework that allows interpreters to understand inter and intra-personal demands and gives them tools to exercise

controls while taking into consideration the specific context of interpreting.

[37] Dysart-Gale, D. (2005). Communication models, professionalization, and the work of medical interpreters. *Health Communication, 17*(1), 91-103.

The author reviews interpreting roles as defined by codes of ethics on medical interpreting. Interviews with interpreters, interpreter supervisors, and doctors are shared to underline the importance of adherence to appropriate professional practices as an interpreter to garner trust from patients and physicians.

[40] Fatahi, N., Mattsson, B., Hasanpoor, J., & Skott, C. (2005). Interpreters' experiences of general practitioner–patient encounters. *Scandinavian Journal of Primary Health Care, 23*(3), 159-163.

Spoken language interpreting study of interpreter's perspectives on problems in cross-cultural communication. Discusses many stressors on the interpreter and the perceived views of the health care professional. Talks about potentially problematic situations, such as waiting room conversations, and lack of time to actually (and accurately) translate information.

[43] Garcés, C. V. (2007). Doctor-patient consultations in dyadic and triadic exchanges. In F. Pöchhacker, & M. Shlesinger (Eds.), *Healthcare interpreting: Discourse and interaction* (pp. 35-53). Philadelphia, PA: John Benjamins.

Detailed spoken language study on interpreter roles and differences in ad hoc and trained interpreters. This study examines audio recordings of several languages in two countries and compares interactions between non-interpreted interactions and interpreted interactions with trained and untrained interpreters. Findings indicate that trained interpreters have a narrower definition of role compared to untrained interpreters.

[48] Gottlieb, M. (2006). A template for peer ethics consultation. *Ethics & Behavior, 16*(2), 151-162.

This article, while not specific to interpreters or translators, offers a framework for consultation amongst colleagues as well as questions that prompt professionals to consider the potential implications of consultation.

[56] Hsieh, E. (2006). Conflicts in how interpreters manage their roles in provider–patient interactions. *Social Science & Medicine, 62*(3), 721-730. Retrieved from Academia website: http://www.academia.edu/338303/Conflicts_In_How_Interpreters_Manage_Their_Roles_In_Provider-Patient_Interactions

A research article based on interviews and observation of trained and/or certified

spoken language medical interpreters. Describes conflicts from the interpreter's point of view and includes some excerpts of interpreter's interviews. Includes discussion about interpreter's decision making when conflicts arise.

[57] Hsieh E. (2008). "I am not a robot!" Interpreters' views of their roles in health care settings. *Quality Health Research, 18*(10), 1367-83.

This spoken language interpreting research article dissects the interpreter's role as observed in actual events and as reported by the interpreters. It describes four main roles that interpreters assume during the communicative event and further divides those into specific behaviors.

[58] Hsieh, E. (2010). Provider–interpreter collaboration in bilingual health care: Competitions of control over interpreter-mediated interactions. *Patient Education and Counseling, 78*(2), 154-159.

This spoken language interpreting article provides an overview of several interpreting strategies from both the interpreter and provider perspective. There is a discussion about how some of these strategies can be misunderstood by providers who have little or no training on working with interpreters. Suggests a more collaborative approach and the adoption of a flexible model of interpreting.

[62] International Medical Interpreter Association. (2007). *Medical interpreting standards of practice*. Retrieved from http://www.imiaweb.org/uploads/pages/102.pdf

An introduction and guide for interpreters in the medical arena. Defines domains of interpreting and offers a checklist for interpreters/interpreter educators to utilize with students or mentors when interpreting a medical encounter.

[63] International Medical Interpreters Association. (2010). *IMIA guide on medical interpreter ethical conduct.* Retrieved from http://www.imiaweb.org/uploads/pages/376_2.pdf

An overview of spoken language interpreting ethics for medical settings. A summary is given, and then each tenet is expanded on in the following section. A good general guide that is more informative about the specific setting and therefore is a good addition to the RID CPC for healthcare interpreters.

[71] Leanza, Y. (2007). Roles of community interpreters in pediatrics as seen by interpreters, physicians and researchers. In F. Pöchhacker & M. Shlesinger (Eds.), *Healthcare interpreting: Discourse and interaction* (pp. 11-34). Philadelphia, PA: John Benjamins. Retrieved from http://www.stringham.net/doug/uvuasl/3330/3330_leanza_interpreterroles.pdf

Addresses the perception that interpreters benefit the healthcare system more than

the actual patient or patient community. Argues that a multi-faceted approach be taken to educate healthcare interpreters on their roles and responsibilities both in facilitation of meaningful health communication between patient and provider as well as cultural broker/intermediary. Proposes a four-fold approach to interpreter training.

[95] National Council on Interpreting in Health Care. (2004). *A national code of ethics for interpreters in health care*. Retrieved from Foreign Language Specialists website: http://www.flsincorp.net/fls_docs/A%20National%20Code%20of%20Ethics%20for%20Interpreters%20in%20Health%20Care.pdf

This code of ethics was specifically designed with the purpose of both interpreting and healthcare in mind. It begins with an introduction to ethics and also the core values that drove the development of the outlined ethical principles. It goes on to explain each ethical principle and give several examples of situations that could be problematic to interpreters within each section. This is an excellent resource for interpreters working in the medical arena.

Domain 7: Language and Interpreting

The interpreter is well versed in the various interpreting approaches and is able to justify their use. The interpreter asserts herself/himself when additional information or support is needed to ensure effective communication (i.e., requesting a certified deaf interpreter).

A. The interpreter demonstrates ASL and English interpreting skills, linguistic competency, cultural knowledge and fluency in medical discourse in both English and ASL.
B. The interpreter is able to interpret both consecutively and simultaneously, understanding the ramifications of each format and demonstrating the knowledge and skills to move effectively between these formats during a single appointment or procedure (e.g. considers factors such as acute care needs and the potential for disrupting a participant's train of thought when deciding whether or not to use consecutive interpreting).
C. The interpreter determines when an explanation of a specific interpreting process is required, and provides a rationale for its use (e.g. consecutive interpreting, simultaneous interpreting, or the use of a CDI).
D. The interpreter adapts the interpretation for age, gender, and culture (e.g., immigrants).
E. The interpreter adapts for individuals who are not proficient in ASL or English (e.g., uses a CDI when appropriate)
F. The interpreter communicates assertively in interactions with patients and service providers, in order to render an effective interpretation (e.g., if the health care provider is ready to leave the room before the interpretation is completed, the interpreter may intervene and ask the provider to wait for a moment in case there are questions).
G. The interpreter demonstrates skills in working as part of a team with CDIs and spoken language interpreters.
H. The interpreter is able to describe how language barriers can compromise access to health care for Deaf patients and health care providers.
I. The interpreter strives for accuracy when interpreting between all parties (e.g., knows when to seek clarification of the message).
J. The interpreter demonstrates strategies for interpreting in settings when the Deaf individual cannot see the interpreter (e.g., x-ray, eye exam, informs the providers that the resulting silence during the event does not constitute agreement).
K. The interpreter demonstrates strategies for interpreting in situations where the patient may become violent or is restrained (e.g., positioning self with ready access to the door).

L. The interpreter demonstrates strategies for use of first and third person pronouns and what to do when the healthcare provider uses the first and third person.
M. The interpreter demonstrates effective practices related to sight translation of relevant health care related documents (e.g., seeks medical staff input when unsure, medical staff present for signing forms such as surgery consent, informed consent, and other forms of a litigious nature).
    - As possible, the interpreter notes on consent forms and legally binding forms that the materials have been interpreted.

Related Readings

[6] Angelelli, C. (2003) The visible co-participant: The interpreter's role in doctor-patient encounters. In M. Metzger, S. Collins, V. Dively, & R. Shaw (Eds.), *From topic boundaries to omission: New research on interpretation* (pp. 3-26). Washington, DC: Gallaudet University Press.

Uses the transcripts of spoken language interpreted interactions to define the interpreter's role as a visible participant in a medical interaction. Angelelli concludes that this visibility is necessary as part of an interpreter's co-construction of the message as well as serving as a culture broker between both participants.

[21] Cokely, D. (1986). The effects of lag time on interpreter errors. *Sign Language Studies, (53)*4, 341-375. Retrieved from https://muse.jhu.edu/journals/sign_language_studies/v053/53.cokely.pdf

While this study was conducted on simultaneous interpreting done in a platform setting, the implications are still an important consideration. Findings indicate that the longer an interpreter takes to comprehend a message, the number of significant interpreting errors decreases.

[24] Cokely, D. (2007). The interpreted medical interview: It loses something in the translation. *Challenging sign language teachers and interpreters: The Reflector revisited.* Burtonsville, MD: Sign Media.

A short article originally published in *The Reflector* about potential errors (perception, memory, semantic, performance) in the interpretation arising within a medical interview. Cokely begins by expounding on the interpreting process and then looking at data collected during interpreted medical interviews to explore where and why these errors occurred.

[29] Davis, J. (2003). Cross-linguistic strategies used by interpreters. *Journal of Interpretation* (pp. 95-128). Silver Spring, MD: RID Publishing. Retrieved from Academia website: https://www.academia.edu/4058209/Cross-Linguistic_Strategies_Used_By_Interpreters

An article that compares lexical borrowing, code mixing and code switching between spoken language pairs and spoken-signed language pairs. There is a discussion on the multiple mediums used in ASL that facilitate ASL-English cross-linguistic transfer through lip movements and fingerspelling.

[49] Greene, D. (2011). Just what they said: Interpreting intentionally vague language. *VIEWS, 28*(2), 38-39.

A short article about vague language, its communication purpose, and the need for additional training of interpreters in this area. A paragraph is devoted to discussion of vague language in medical interpreting.

[54] Health Law Program (NHeLP) in collaboration with the American Translators Association and NCIHC. (2009). *Sight translation and written translation: Guidelines for healthcare interpreters.* Retrieved from NCIHC website: http://www.ncihc.org/assets/documents/publications/Whats_in_a_Word_Guide.pdf

This resource provides a broad overview of how an interpreter functions in healthcare settings. For the purposes of this domain, pages 9-11 are most relevant (comparison of face-to-face interpreting and telephone interpreting) and discussion of interpreting modes (consecutive, simultaneous, summary and sight translations). Page 11 has a helpful discussion of shifting roles.

[73] Luu, T. T. (2009). Building Vietnamese medical terminology via language contact. *Australian Journal of Linguistics, 29*(3), 315-336.

This spoken language article reviews how terminology is created and used within a language using its unique conventions and rules, and how that looks different from utilization of loan words. Discusses this effect on translation and contains many parallels to sign language interpreting.

[75] Major, G., & Napier, J. (2012). Interpreting and knowledge mediation in the healthcare setting: What do we really mean by "accuracy"? In V. Montalt & M. Shuttleworth (Eds.), *Linguistica Antiverpiesa: Translation and knowledge mediation in medical and health settings* (pp. 207-226). Antwerp, Belgium: Artesius University College. Retrieved from https://lans-tts.uantwerpen.be/index.php/LANS-TTS/article/view/304/194

An interaction-based research study on accuracy in healthcare interpreting that takes into account both linguistic and contextual variables. Although the study was conducted on Australian Sign Language interpreters, the findings and discussion are germane to any interpreted medical interaction.

[76] Major, G., Napier, J., Ferrara, L., & Johnston, T. (2012). Exploring lexical gaps in Australian sign language for the purpose of health communication. *Communication*

and Medicine, 9(1), 37-47.

Signed language interpreter research out of Australia looking at how interpreters cope with healthcare terminology that is not present as part of the Auslan lexicon. Applicable discussion that holds true for interpreters using ASL.

[80] McCabe, M., Gohdes, D., Morgan, F., Eakin, J., & Schmitt, C. (2006, January). Training effective interpreters for diabetes care and education: A new challenge. *The Diabetes Educator, 32(*5), 714-720.

A spoken language interpreting article about training Navajo interpreters in the field of diabetes care. Authors looking at the subtleties of meaning carried by certain medical terms and potential misunderstandings that were caused in patient focus groups due to the choices made in translation.

[84] Mercy, O. E. (2006). English-Edo medical translation. *Perspectives, 13*(4), 268–277.

This article looks at the difficulty of translation in a language of limited diffusion (Edo). It discusses strategies or coping mechanisms that interpreters can employ to produce a successful translation when one of the languages the interpreter is translating into does not have a standardized medical vocabulary.

[85] Metzger, M. (1999). *Deconstructing the myth of neutrality.* Washington, DC: Gallaudet University Press.

This book looks at both actual and role-played interpreter interactions to prove that interpreters are not just transmitting a message between participants. Metzger uses the data to show that interpreters actively participate through alignment with participants as well as their framing of the discourse.

[96] National Council on Interpreting in Health Care. (2009). *Sight translation and written translation: Guidelines for healthcare interpreters.* Retrieved from http://www.ncihc.org/assets/documents/publications/Translation_Guidelines_for_Interpreters_FINAL042709.pdf

A discussion about when and why sight translation is appropriate as opposed to written translation. Section A is most relevant to the sign language interpreter, as this paper does not take into account languages that have no written form.

[98] Nicodemus, B., Swabey, L., & Moreland, C. (2014). Conveying medication prescriptions in American Sign Language: Use of emphasis in translations by interpreters and deaf physicians. *The International Journal of Translation and Interpreting Research, 6*(1), 1-22. Retrieved from http://www.trans-int.org/index.php/transint/article/view/287

A research study examining the linguistic markers used by interpreters and Deaf physicians in conveying prescription information to deaf patients using ASL. The study found common markers including repetition, emphatic lexical signs, and prosodic markers.

[108] Pollard, R. Q., Dean, R. K., O'Hearn, A. M., & Haynes, S. L. (2009). Adapting health education material for deaf audiences. *Rehabilitation Psychology, 54*(2), 232-238.

Discusses the disparity in health literacy among the deaf population. Research conducted on outcomes of adapting healthcare information into culturally/linguistically appropriate ASL videos. Relevance to how information is presented to deaf patients.

[112] Sanheim, L. M. (2003). Turn exchange in an interpreted medical encounter. In M. Metzger, S. Collins, V. Dively, & R. Shaw (Eds.), *From topic boundaries to omission: New research on interpretation* (pp. 27-54). Washington, DC: Gallaudet University Press.

A review of Metzger's footing and framing data looking specifically at the setting of medical encounters and how turns are mediated by the interpreter. Data is compared to spoken language data from other research.

[120] Tebble, H. (1999). The tenor of consultant physicians: Implications for medical interpreting. *The Translator, 5*(2), 179-200.

This article focuses on translation not only of the content of medical interviews, but also on retaining the style with which they were expressed in a translation. The argument is made that certain linguistic cues need to be included in the translation as they serve to define the relationship between physician and patient. Tebble argues that both these components are integral parts of the medical interview.

[124] Wadensjo, C. (1998). *Interpreting as interaction.* New York, NY: Addison Wesley Longman, Ltd.

Wadensjo's seminal work that redefines interpreting as interactional. Her book includes data from audiotape transcripts of interpreters working in various community contexts. This book strives to explain what interpreters do and how the interpreter and participants work together to create meaning.

Domain 8: Technology

The interpreter understands both medical and communication-related technologies and is able to leverage technology to improve knowledge of the medical field.

A. The interpreter demonstrates knowledge of medical technology necessary to accurately interpret a procedure (e.g., use of classifiers for colonoscopy).
B. The interpreter is knowledgeable about video remote interpreting, pagers, video relay services and other forms of communication technology appropriate or necessary for the health care of Deaf, deaf-blind and hard of hearing individuals.
C. The interpreter uses information technology to broaden knowledge and research specific topics related to health care.

Related Readings

[1] Adams, M. K. (2008). VRI in medical settings: Responsible actions for optimal use. *VIEWS, 25*(7), 26-28.

This short article provides some thoughtful discussion for how VRI should be used in medical settings. Discussion sections include positioning, the production of sign language through video, and socio-political factors influencing a decision to use VRI.

[44] Garrett, J. (2012). VRI interpreting services cannot produce the same "quality" of interpreting in the hospital setting. *VIEWS*, *29*(1), 29.

This article looks at the adverse effect distance can have on interpreting quality. The argument is made that VRI interpreters are not privy to the same visual information and pre-appointment information as in-person interpreters which could affect the communication outcome.

[68] Kashar, A. (2009). Doctor, can we please communicate. *VIEWS, 26*(4), 12-13.

Discusses the requirements for VRI in medical settings and instances where VRI communication would not be appropriate. Provides a few scenarios of patients using VRI in medical settings to fuel the discussion.

Domain 9: Research

The interpreter is familiar with current research in the interpreting/translation field as well as in the medical field.

A. The interpreter remains current by reading professional journal articles and incorporating new knowledge into practice, and shares this knowledge with team members (e.g., other interpreters, mentees).
B. The interpreter critically evaluates research relevant to interpreting issues (e.g., uses appropriate analytical methods to make inferences linking research to practice).
C. The interpreter demonstrates awareness of current health care policies.
D. The interpreter maximizes the commonly available resources in the medical setting (grand rounds, lectures, observation of procedures) that can increase familiarity with the treatments and situations to be encountered.
E. The interpreter continually seeks available resources in the community (e.g., maintains and adds medical related literature and resources to a personal library).

Related Readings

[10] Bhutta, Z. A. (2004). Beyond informed consent. *Bulletin of the World Health Organization, 82*(10), 771-777. Retrieved from SciELO Public Health Library website: http://www.scielosp.org/scielo.php?pid=S0042-96862004001000013&script=sci_arttext

Discussion of the translation of informed consent (for participation in research studies) as it relates to the Navajo population.

[12] Boudreault, P., & Palmer, C. G. S. (Forthcoming). Deaf studies and the medical field of genetic research: A collaboration model for linguistic and cultural minority populations. In B.K. Eldredge, D. Stringham, F. Fleischer, & K. Morton (Eds.), *Proceeding from Deaf Studies Today! 2008: Montage, April 10-12, 2008, Orem, Utah.*

In-press conference proceedings about the approach to conducting research on vulnerable populations, specifically within the deaf community. Emphasis on cultural and linguistic perspectives within the research team and incorporation of community feedback in interpreting the results of research done within their community.

[42] Flores, G. (2005). The impact of medical interpreter services on the quality of health care: A systematic review. *Medical Care Research and Review, 62*(3), 255-299.

Retrieved from MigHealth website:
http://mighealth.net/eu/images/3/3b/Flores2.pdf

A literature review of 36 articles that address issues regarding quality of care for limited English proficient (LEP) patients. Categorizes issues addressed in all 36 reviewed articles, and discusses issues such as interpreter error and the failure to provide interpreter services.

[66] Jacobson, H. (2009). Moving beyond words in assessing mediated interaction: Measuring interactional competence in healthcare settings. In C. Angelelli & H. Jacobson (Eds.), *Testing and assessment in translation and interpreting studies: A call for dialogue between research and practice* (pp. 49-70). Philadelphia, PA: John Benjamins.

A discussion about the difference between using an interaction-based research approach rather than a lexical-based omissions approach to the assessment of accuracy in medical interpreting.

[67] Johnston, T., & Napier, J. (2010). Medical signbank. *Sign Language Studies, 10*(2), 258-275.

Provides a detailed description of the process and stakeholders involved in developing a medical dictionary for Australian Sign Language. Relevant for graduate research and service learning projects.

[70] Laws, M. B., Heckscher, R., Mayo, S., Li, W., & Wilson, I. B. (2004). A new method for evaluating the quality of medical interpretation. *Medical Care, 42*, 71-80. Retrieved from Research Gate website:
http://www.researchgate.net/publication/8926562_A_new_method_for_evaluating_the_quality_of_medical_interpretation

A research article that aims to quantify the quality of an interpretation in Spanish/English medical interactions. Coding methodology goes beyond typical error analysis (addition, omission, condensation) to actually rating the utterance based on a perceived source language and target language goal equivalence. An interesting read for graduate students trying to codify transcripts of interpreted interactions.

[81] McCabe, M., Morgan, F., Curley, H., Begay, R., & Gohdes, D. (2005). The informed consent process in a cross cultural setting: Is the process achieving the intended result? *Ethnicity and Disease*, *15*(2), 300-304.

Discussion about the effectiveness of obtaining informed consent in a specific population (Navajo) especially when dealing with cultural and translation issues. Similar to Bhutta (2004).

[83] Meador, H. E., & Zazove, P. (2005). Health care interactions with deaf culture. *Journal of the American Board of Family Medicine*, *18*(3), 218-222.

Article geared specifically toward medical personnel relevant to both practice and research. Discussion of the cultural view of what it means to be deaf in comparison to the pathological view.

[105] Pöchhaker, F. (2006). Research and methodology in healthcare interpreting. *Themes in Translation Studies*, *5*, 135-159. Retrieved from https://lans-tts.uantwerpen.be/index.php/LANS-TTS/article/view/157/94

A review of the methods of research in healthcare interpreting and translation since the 1970s. Breaks research into different domains that have contextualized these studies. Concludes that the overarching theme is quality in interpreting but raises concerns about the usefulness and impact interpreting research will make in the healthcare realm without certain modifications.

[111] Samady, W., Sadler, G., Nakaji, M., & Malcarne, V. L. (2008). Translation of the multidimensional health locus of control scales for users of American Sign Language. *Public Health Nursing, 25*(5), 480-489.

Discussion on translation and the process of validation of an instrument post-translation. Covers the use of translation and back translation as well as piloting the translation with focus-groups.

[117] Swabey, L., & Nicodemus, B. (2011). Bimodal bilingual interpreting in the U.S. healthcare system: A critical linguistic activity in need of investigation. In B. Nicodemus & L. Swabey (Eds.), *Advances in interpreting research: Inquiry in action* (pp. 241-260). Amsterdam, The Netherlands: John Benjamins.

A review of the current research on interpreting in healthcare between a spoken and visual medium. The authors argue that although parallels can be drawn between spoken and signed language interpreters in healthcare interpreting, more research needs to be done specifically about how the medium impacts the message in healthcare interpreting.

[121] Tebble, H. (2013). Researching medical interpreting: An applied linguistics perspective. In E. Winston & C. Monikowski (Eds.), *Evolving paradigms in interpreter education* (pp. 42-75). Washington, DC: Gallaudet University Press.

A research study conducted on several medical interactions mediated by interpreters in Australia. Emphasized the need for interpreters to understand the context and content of medical interviews while looking at several linguistic aspects of the interpretation including turn-taking, eye gaze, personal pronouns, etc.

Domain 10: Legislation

The interpreter is familiar with legislation that grants Deaf individuals the right to an interpreter, as well as other relevant health laws such as HIPAA.

A. The interpreter demonstrates awareness and understanding of state and federal access and legislation related health care (e.g., HIPAA, Tarasoff, ADA, 504).
B. The interpreter demonstrates awareness of liability issues related to ineffective interpretation with grave errors, including risk to the participants and risk to the interpreter.

Related Readings

[2] Agan, T. (2004). HIPAA and the medical interpreter. *VIEWS, 21*(1), 1, 14.

Short article about the application of HIPAA to interpreters in the healthcare context.

[17] Chen, A. H., Youdelman, M. K., & Brooks, J. (2007). The legal framework for language access in healthcare settings: Title VI and beyond. *Journal of General Internal Medicine, 22*(2), 362-367. Retrieved from the National Center for Biotechnology Information website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150609/pdf/11606_2007_Article_366.pdf

Outlines the legal precedent for providing interpreters to limited English proficient (LEP) patients. Reviews federal mandates (OCR, HIPAA, EO) and State laws as well as gives information on Medicaid billing rules for interpreting services.

[64] International Medical Interpreter Association. (2014). *Lawsuits.* Retrieved from http://www.imiaweb.org/resources/legal.asp

A list of several lawsuits filed in the U.S. regarding failure to provide medical interpreters and links to court rulings or explanatory articles about each suit. Many of these lawsuits are related to sign language interpreting. Lawsuits cover both ADA violations and violations of Title VI of the Civil Rights Act of 1964. All lawsuits are against medical practitioners or hospitals.

[94] National Association of the Deaf. (n.d.). *Position statement on healthcare access for deaf patients.* Retrieved from http://nad.org/issues/health-care/position-statement-health-care-access-deaf-patients

This resource is directed toward physicians and details appropriate healthcare encounters working with the deaf and hard of hearing populations. There is a section on working with deaf interpreters as well as an overview of the relevant laws that mandate communication access for deaf patients.

[102] Ohio Legal Rights Service. (2006). *Your right to a sign language interpreter during appointments with medical and other treatment providers.* Retrieved from Disability Rights Ohio website: http://www.disabilityrightsohio.org/sites/default/files/ux/faq-interpreter-rights.pdf

Although this website is directed to residents of Ohio, most of the information given is about federal laws. The website is designed specifically to answer the questions of Deaf patients but can be a useful tool for interpreters as well.

[104] Perkins, J., & Youdelman, M. (2008). *Summary of state law requirements addressing language needs in health care.* Washington, DC: National Health Law Program. Retrieved from http://sites.lawhelp.org/documents/383231nhelp.lep.state.law.chart.final.pdf

Spoken language interpreter resource detailing the specific laws in each state that guarantee a patient with limited English proficiency the right to an interpreter. Each state is listed with a table of relevant legislation.

[122] Thress, R. (2005). HIPAA and the new rules: Have you signed YOUR contract? *VIEWS*, *22*(4), 17-18.

Explains the definition of interpreters under HIPAA as "business associates" which allows interpreters to legally gain access to privileged health information. Quick overview of the HIPAA laws and how they apply both to interpreters and the interpreted interaction.

Domain 11: Leadership

The interpreter functions as a liaison between interpreting agencies and hospitals, and provides leadership in training or mentoring new interpreters in healthcare settings.

A. The interpreter may serve as a liaison between interpreting services and the healthcare system (e.g., agencies, regional and national interpreting organizations).
B. The interpreter may serve as a liaison between interpreter education programs and the healthcare system.
C. The interpreter provides mentoring and evaluation opportunities to staff and new interpreters in the healthcare setting (e.g., displays positive role modeling).
D. The interpreter promotes the establishment of policies and education that improve access for Deaf, deaf-blind and hard of hearing people to healthcare interpreting services.
E. The interpreter maintains positive and strong connections to the Deaf community.
F. The interpreter locates and uses community resources, both Deaf and non-deaf, when necessary to support their work (e.g., patient assistant, ombudsman, social worker, advocate).

Related Readings

[14] Bournes, D. A., & DasGupta T. L. (1997). Professional practice leader: A transformational role that addresses human diversity. *Nursing Administration Quarterly, 21*(4), 61-68.

This article explains a new role in nursing that has been employed by many large hospitals in an attempt to return the focus of nursing back to patient-centered care. This article examines that role and offers suggestions on how professional practice leaders can drive the vision and mission of nursing into this new holistic direction.

[114] Seiberlich, A. (2012, September 10). *Leadership in sign language interpreting: Where are we?* Retrieved from Street Leverage website: http://www.streetleverage.com/2012/09/leadership-in-sign-language-interpreting-where-are-we/

While not directly relevant to healthcare interpreting, this short article details the birth of the field of sign language interpreting and our continued need for leaders to emerge within the profession. At the end, there is a section on how interpreters can offer leadership within both the professional and deaf community as well as within

professional organizations.

[119] Taylor, M. (2013). Leadership: Perspectives from deaf leaders and interpreting leaders. *International Journal of Interpreter Education, 5*(2), 43-53. Retrieved from CIT website: http://www.cit-asl.org/Journal/2013_Vol5(2)/taylor-marty.html

Research article about leadership characteristics among Deaf individuals and signed language interpreters in Canada and the U.S. Stresses the importance of engagement in the community as a key factor in developing leadership ability for both groups.

[126] Witter-Merithew, A. & Johnson, L. (2004). Market disorder within the field of sign language interpreting: Professionalization implications. *Journal of Interpretation*. Silver Spring, MD: RID Publishing. Retrieved from the University of Northern Colorado website: http://www.unco.edu/doit/resources/Publication_PDFs/JOI%20Market%20Disorder%20article.pdf

An article about current professional credentialing systems for ASL/English interpreters and how the multitude of systems create a lack of clarity about what constitutes an entry-level professional. The authors view professionalization and its impact on market disorder through the lens of trait theory. Recommendations are offered to further the professionalization of the field of sign language interpreting in America.

Domain 12: Communication Advocacy

The interpreter knows how to appropriately advocate for communication access needs and empowers consumers to be part of the decision making process about their communication access.

A. The interpreter demonstrates awareness of the political, sociological and cultural implications of advocacy (e.g., does not serve as an advocate when Deaf patients are capable of advocating on their own behalf).
B. The interpreter demonstrates knowledge of resources locally and nationally that can support a patient's care (e.g., awareness of group homes or other facilities and entities that can assist in patients' healthcare).
C. The interpreter demonstrates understanding of healthcare culture and institutional hierarchy. When faced with patient care discrepancies, the interpreter reports the discrepancy to the appropriate personnel.
D. The interpreter encourages and supports self-advocacy when possible (e.g., may discuss self-advocacy with the Deaf or hard of hearing patient).
E. The interpreter demonstrates standard and professional responses to common issues that arise regarding provider and patient rights, laws and procedures (e.g., may provide information to a patient about accessing grievance procedures).
F. The interpreter practices effective timing of providing communication advocacy (e.g., may provide information pre-, during, or post-patient/provider interactions, improve skills and enhance knowledge for how to work with interpreters).
G. The interpreter may work collaboratively with the Deaf community for advocacy efforts in healthcare settings (e.g., may present at Deaf meetings and events on healthcare advocacy issues).
H. The interpreter demonstrates knowledge of the NAD-RID Code of Professional Conduct and the implications of providing advocacy. The interpreter is also aware of the NCIHC code of ethics and its position on advocacy.
I. The interpreter provides healthcare providers with information about interpreting, and refers providers to Deaf, hard of hearing and deaf-blind people who can discuss Deaf culture, deafness, blindness and how the needs of individuals from these communities can be best met in the health care system.
J. The interpreter may provide family members of the Deaf patient with information about interpreting and may discuss the communication needs of the Deaf person and how to obtain access through interpretation.

K. The interpreter may provide Deaf, deaf-blind and hard of hearing communities with information about interpreting and how their needs can be best met in the healthcare system.

Related Readings

[7] Angelelli, C. V. (2004). *Medical interpreting and cross-cultural communication.* Cambridge, UK: Cambridge University Press.

This book looks at both research studies on spoken language interpreters in a hospital context as well as real-life perceptions and perspectives of medical interpreters. Sections 1 (questioning invisibility) and 2 (communication in the medical encounter) are good references for looking at the purpose of communication and the interpreter's roles. Chapter 7 (interpreter's voices) could be used as case-study material for exploring ethical dilemmas and dissecting aspects of the interpreter's role. Finally, Chapter 8 (emerging metaphors and final words) is a useful out-of the box summation of what the research says about how interpreters approach their positions.

[59] Hsieh, E., & Kramer, E. (2012). Medical interpreters as tools: Dangers and challenges in the utilitarian approach to interpreters' roles and functions. *Patient Education and Counseling*, *89*(1), 158-162.

This study questions the roles of interpreters and examines how doctors and patients expect them to function in health care settings. It also questions the utilitarian approach in which interpreters give more credence to communication from the healthcare providers compared to the patients. Although it is a research study, it is a fairly easy read and is filled with anecdotes from interpreter and provider interviews. This is also relevant to Domain 4: Boundaries, and Domain 7: Language and Interpreting.

[69] Kehl, K. A., & Gartner, C. M. (2010). Can you hear me now? The experience of a deaf family member surrounding the death of loved ones. *Palliative Medicine, 24*(1), 88-93.

Case study on the experience of a family member with little communication access to family members and doctors when his family member was dying. Discussion of the importance of providing communication access to non-patients who need to make health-related decisions.

[82] McKee, M. M., Barnett, S., Block, R. C., & Pearson, T. A. (2011). Impact of communication on preventive services among deaf American Sign Language users. *American Journal of Preventive Medicine*, *41*(1), 75-79. Retrieved from the National Center for Biotechnology Information website: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3117257/?report=reader

Study conducted on the care received by deaf patients who had an ASL-using physician compared to a non-signing physician examining the amount of preventative care received. Higher preventative care reported when clinicians and patients shared a language.

[87] Middleton, A., Turner, G., Graham, H., Bitner-Glindzicz, M., Lewis, P., Richards, M., Clarke, A., & Stephens, D. (2010). Preferences for communication in clinic from deaf people: A cross-sectional study. *Journal of Evaluation in Clinical Practice, 16*(4), 811–817.

This article from the U.K. reviews the deaf population's communication preferences when engaging with the healthcare system. Data was collected through a survey where participants were given the option to select one or more communication preferences. The authors recommend all physicians receive cultural sensitivity training and be aware of the variety of communication preferences that exist within the deaf population.

[88] Mikkelson, H. (1995, January). The art of working with interpreters: A manual for health care professionals. International Interpretation Research Center, Monterey Institute of International Studies. Retrieved from http://works.bepress.com/holly_mikkelson/26

Spoken language resource for physicians about working with an interpreter. There are many salient points for working with sign language interpreters including the section on why communication breaks down.

[93] Napier, J., & Kidd, M. R. (2013). English literacy as a barrier to health care information for deaf people who use Auslan. *Australian Family Physician, 42*(12), 896-899.

Explanation of the low reported English health-literacy of Auslan-using deaf patients. A discussion about the needed resources to provide interpreting services as appropriate means of communication and raising health literacy in the Australian Deaf community.

[101] O'Hearn, A. (2006). Deaf women's experiences and satisfaction with prenatal care: A comparative study. *Family Medicine 2006, 38*(10), 712-716.

Examines patient satisfaction using a questionnaire and comparing Deaf and hearing women's overall satisfaction with prenatal care. Discussion about how communication barriers led to less satisfaction and lower levels of care for Deaf women.

[107] Pollard, R., & Barnett, S. (2009). Health-related vocabulary knowledge among deaf adults. *Rehabilitation Psychology, 54*(2), 182-185. Retrieved from Research Gate wesbite: http://www.researchgate.net/publication/26241110_Health-

related_vocabulary_knowledge_among_deaf_adults/links/0046352a86fa9065f3000000

Results of a study designed to measure health literacy among deaf adults accessing medical care. Participants were administered a standard health literacy test (REALM) and ask to respond to whether or not it was understood. Researchers determined that participants with a higher level of education had a correspondingly higher level of health literacy.

[115] Steinberg, A., Wiggins, E., Barmada, C. H., & Sullivan, V. J. (2002). Deaf women: Experiences and perceptions of healthcare system access. *Journal of Women's Health, 11*(8), 729-741.

This article is aimed at healthcare professionals and educating them about the outcomes of health for Deaf women, including the importance of communication and the common lack of medical knowledge within the community. Excerpts from interviews give insight into patient's understanding of medical terminology and possible communication errors that interpreters should seek to avoid.

Domain 13: Professional Development

The interpreter engages in professional development both for personal growth and the growth of the healthcare interpreting profession.

A. The interpreter stays current with practices in healthcare settings (e.g., immediately aware of universal precaution changes and updates, and may shadow health care personnel for educational purposes).
B. The interpreter develops and implements annual professional development plans (e.g., assesses gaps in knowledge addressing them with measurable goals).
C. The interpreter promotes the use of mentors from the Deaf, deaf-blind and hard of hearing communities (e.g., seeks out qualified mentors to assist in professional development activities).
D. The interpreter attends continuing education opportunities related to healthcare and interpreting (e.g., medical-related seminars, workshops and conferences).
E. The interpreter develops a portfolio for interpreting in healthcare, including credentials and professional experience (e.g., certifications, research, evidence of workshop attendance, independent studies).

Related Readings

[8] Angelelli, C. (2006). Designing curriculum for healthcare interpreting education: A principles approach. In C. Roy (Ed.), *New Approaches to Interpreter Education* (pp. 23-46). Washington, DC: Gallaudet University Press.

Looks at the history of interpreter training programs and the reasons for their contextualization in the university setting. Discusses the need for context-based curriculum design.

[65] Isham, B. (2007). Beyond the Classroom: Self-Directed Growth for Interpreters. In D. Cokely (Ed.), *Challenging sign language teachers and interpreters: The Reflector revisited* (pp. 15-17). Burtonsville, MD: Sign Media.

A guide for new interpreters who are seeking professional development. Discusses different types of development such as self-analysis, goal-setting, and mentoring.

[77] Malcolm, K., & Russell, D. (2013) Co-Mentoring: Accountability in action. In E. Winston & R. Lee (Eds.), *Mentorship in sign language interpreting* (pp. 97-104). Washington, DC: RID Press.

The authors outline a model for creating a peer mentoring relationship and offering supervision, goal setting, and feedback to other interpreters in a relatively similar stage in their career. This short chapter gives an introduction to the co-mentoring approach and offers some suggestions for how to engage in this process while stressing the importance of goal setting and accountability.

[86] Metzger, M. (2000). Interactive role-plays as a teaching strategy. In C. Roy (Ed.), *Innovative practices in teaching sign language interpreters* (pp. 83-108). Washington, DC: Gallaudet University Press.

This article offers ideas about teaching turn-taking in medical interactions using guided role-play as a stimulus for discussion as well as an opportunity for students to apply what they learned from course readings.

Multiple Domains

Resources listed here engage in topics and further discussion relevant to multiple domains.

Related Readings

[18] CHIA Standards & Certification Committee. (2002). *California standards for healthcare interpreters: Ethical principles, protocols, and guidance on roles & intervention.* Retrieved from the California Endowment website: http://www.calendow.org/uploadedFiles/ca_standards_healthcare_interpreters.pdf

Domain 3: Health and wellbeing of the interpreter (p. 37)

Domain 4: Guidance on interpreter roles and intervention (pp. 40-47)

Domain 6: Ethical principles for healthcare interpreters (pp. 24-32)

Domain 12: Appendix C—Group advocacy (p. 62)

This resource contains a plethora of information based on the CHIA standards for healthcare interpreters. Outlines standard and best practices in California hospitals for spoken language interpreters, with sections that deal with ethical principles, interpreter roles, and expected protocols. Appendices can also be a useful resource for interpreters and educators as examples of how to approach ethical decision making in the healthcare field.

[26] Crezee, I. H. M. (2013). *Introduction to healthcare for interpreters and translators*. Philadelphia, PA: John Benjamins.

Domain 1: Most of the book

Domain 2: Chapter 3 (pp. 23-32)

Domain 5: Chapter 3 (pp. 25)

Domain 7: Most of the book

This textbook is structured in parts. Part I gives a general overview of interpreting in healthcare settings, culture, and general medical terminology. Part II is breaks down the different places and systems interpreters may be interpreting in (hospitals, outpatient, clinics, surgery, etc) and discusses common terminology. Part III gives an overview of each body system and terminology and common ailments affecting each system. Well structured book that could be used as a textbook for a healthcare interpreting course.

[30] Dean, R., Davis, J., Dostal-Barnett, H., Graham, L., Hammond, L., & Hinchey, K. (2003). Training medically qualified interpreters: new approaches, new applications,

promising results. *VIEWS, 20*(1), 1, 10-12.

Domain 3: (Self-care)

Domain 5: (Preparation)

Domain 6: (Ethics and Decision Making)

This article explains how demand-control schema was applied to an interpreter education program class on medical interpreting. Discusses the importance of students being prepared with medical knowledge as well as a framework for decision-making in medical contexts. Instructor and student views both represented.

[50] Hale, S. (2007). Interdisciplinarity: Community interpreting in the medical context. *Community interpreting* (pp. 34-64). New York, NY: Palgrave Macmillan.

Domain 1: Communicating in doctor-patient interaction (p. 36)

Domain 4: 2.3.1 and 2.3.2 (pp. 41-48)

Domain 7: The significance of questioning style in achieving effective communication (p. 37)

A succinct discussion about spoken language medical interpreting and its context within community or non-conference interpreting. Hale canvasses issues of boundaries, roles, logistics, decision making, and the communication events that take place in interpreted interactions in medical settings.

[55] Hiraga, M., & Langholtz, D. (1996). The challenges of interpreting in HIV settings. *VIEWS, 13*(4), 31-32.

Domain 1: (Healthcare Systems)

Domain 2: (Multiculturalism and Diversity)

Domain 7: (Language and Interpreting)

An overview of how interpreting in the context of HIV can be different than regular medical interpreting. A succinct discussion about stigma, culture/gender stereotypes and language use.

[61] Iezzoni, I., O'Day, L., Killeen, M., & Harker, H. (2004). Communicating about health care: Observations from persons who are deaf or hard of hearing. *Annals of Internal Medicine, 140*(5), 356-363.

Domain 9: (Research)

Domain 12: (Communication Advocacy)

A research study investigating patient's perception of medical interactions. Identifies barriers to accessing medical appointments. Also methodology section could be useful for graduate interpreting students conducting research.

[79] Martinez, M. (1999). Interpreting the birth experience. *VIEWS, 16*(3), 10-11.

Domain 1: (Healthcare Systems)

Domain 6: (Ethics and Decision Making)

Domain 7: (Language and Interpreting)

A short article that reviews unique needs and questions relevant to interpreting for prenatal care and labor and delivery.

[89] Moore, J., & Swabey, L. (2007). *Medical interpreting: A review of the literature (draft).* Retrieved from Healthcare Interpreting website: http://www.healthcareinterpreting.org.

Domain 1: Settings and types of medical interpreting (p. 5-6)

Domain 2: Interpreters and cultural differences (pp. 14-15)

Domain 5: Preparing to work in medical settings (pp. 17-19)

Domain 6: Conduit or co-participant (pp. 10-13), Professional ethics and standards (pp. 15-16)

Domain 7: Deaf patient perceptions, non-deaf perceptions (pp. 1-4)

Domain 10: Legal issues, HIPAA and privacy issues (pp. 6-8)

Domain 12: Deaf patient perceptions, non-deaf perceptions (pp. 1-4), Logistical issues (pp. 8-9)

Domain 13: Education and resources (pp. 19-23)

This literature review contains many resources both from signed language and spoken language interpretation. The structure of the review walks readers through the potential settings where medical interpreters will work, reviews pertinent legal and privacy issues, discusses preparation to work in medical settings and reviews cultural information. A helpful summary of the necessary elements interpreters should consider when preparing to work in the medical field.

[92] Moxham, T. (2005). Deaf patients, hearing medical personnel: Interpreting and other considerations. Hillsboro, OR: Butte Publications, Inc.

Domain 1: Chapter 5, Scenarios; Chapter 8, Context

Domain 3: Chapter 7 Interpreter's self care

Domain 4: Chapter 4 Roles and responsibilities

Domain 5: Chapter 2, Protocol

Domain 6: Chapter 6, Professionalism and ethics

This short overview of medical interpreting, although slightly outdated, covers many of the domains and competencies.

[97] Nicodemus, B., & Metzger, M. (Eds.). (2014). *Investigations in healthcare interpreting.* Washington, DC: Gallaudet University Press.

Domain 1: Brueck, P., Rode, J., Hessmann, J., Meinicke, B., Unruh, D., & Bergmann, A. Diagnosing healthcare assignments: A year of medical interpreting for deaf people in Austria and Germany (pp. 128-184)

Domain 7: Angelelli, C. "Uh…I am not understanding you at all": Constructing (Mis)understanding in provider/patient interpreted medical encounters (pp. 1-31)

Hsieh, E. Emerging trends and the corresponding challenges in bilingual health communication (pp. 70-103)

Major, G. "Sorry could you explain that"? Clarification requests in interpreted healthcare interaction (pp. 32-69)

Smeijers, A., van den Bogaerde, B., Ens-Dokkum, M., & Oudesluys-Murphy, A. Scientific-based translation of standardized questionnaires into Sign Language of the Netherlands (pp. 277-303)

Swabey, L., Nicodemus, B., & Moreland, C. An examination of medical interview questions rendered in American Sign Language by deaf physicians and interpreters (pp. 104-127)

Domain 8: Pöchhacker, F. Remote possibilities: Trialing simultaneous video interpreting for Austrian Hospitals (pp. 302-325)

Domain 12: Leeson, L., Sheikh, A., Rozanes, I., Grehan, C., & Matthews, P. Critical care required: Access to interpreted healthcare in Ireland (pp. 185-232)

Napier, J., & Sabolcec, J. Direct, interpreter-mediated or translated? A qualitative study of access to preventative and on-going healthcare information for Australian deaf people (pp. 233-276)

van den Bogaerde, B., & de Lange, R. Healthcare accessibility and the role of sign language interpreters (pp. 326-358)

A conglomeration of spoken and signed language research across the globe that provides evidence-based research on interpreting in healthcare settings. This volume covers a variety of domains and speaks to a wide range of audiences in the field of interpreting.

[106] Pöchhacker, F. & Shlesinger, M. (Eds.). (2007). *Healthcare interpreting: Discourse and interaction.* Philadelphia, PA: John Benjamins.

Domain 6: Doctor-patient consultations in dyadic and triadic exchanges (pp. 35-52)

Domain 7: Exploring untrained interpreters' use of direct versus indirect speech (pp. 53-76); Dialog interpreting as a specific case of reported speech (pp. 77-100)

Domain 9: Discourse-based research on healthcare interpreting (pp. 1-11)

A book on spoken language interpreting in healthcare including several chapters that cover interpreter role, turn-taking, and the use of direct or indirect speech. Also contains a section on conducting interpreting research.

[110] Roat, C. E. (2013). *Healthcare interpreting in small bites: 50 nourishing selections from the "Pacific Interpreters Newsletter," 2002-2010.* Victoria, BC, Canada: Trafford Publishing.

Domain 1: Section 2 (pp. 69-114); Part II (pp. 189-251)

Domain 3: Staying healthy while serving the sick (p. 143)

Domain 4: My daughter speaks English—Why are YOU here? (p. 121)

Domain 5: The pre-session (p. 15); Memory techniques (p. 43)

This book contains many excerpts from interpreters' personal experience working in healthcare settings that lead to a discussion on issues that impact the interpreter as well as the patients and medical professionals. The layout makes it an easy read even though each piece was published individually.

[118] Swabey, L. & Malcolm, K. (Eds.). (2012). *In our hands*. Washington, DC: Gallaudet University Press.

All domains: Swabey, L., & Craft Faber, Q. Domains and competencies for healthcare interpreting: Applications and implications for educators (pp. 1-26)

Domain 3: Bontempo, K., & Malcolm, K. An ounce of prevention is worth a pound of cure: educating interpreters about the risk of vicarious trauma in healthcare settings (pp. 105-130)

Domain 7: Major, G., Napier, J., & Stubbe, M. "What happens truly, not textbook!": Using authentic interactions in discourse training for healthcare interpreters (pp. 27-53)

Domain 11: Moreland, C., & Agan, T. Educating interpreters as medical specialists with deaf healthcare professionals (pp. 147-163)

Domain 12: Hedding, T., & Kaufman, G. Health literacy and deafness: Implications for interpreter education (pp. 164-189). Morgan, P. & Adam, R. Deaf interpreters in mental health settings: Some reflections on and thoughts about deaf interpreter education (pp. 190-208)

Domain 13: Dean, R. & Pollard, R. Beyond "interesting": Using demand control schema to structure experiential learning (pp. 77-104)

This collection covers a multitude of domains on teaching healthcare interpreting. Each author brings their own research and experience to the table. Some chapters are relevant to curriculum, others to reviewing research and evidence-based practices. A must-have for healthcare interpreter educators.