

Improving Healthcare: Specialization for Sign Language Interpreters

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Healthcare affects us at every stage of life; not only are we consumers of the healthcare system from before birth until the end of our lives, but healthcare has become a large part of our national discourse and consumes more of our financial resources every day. Another increasingly common piece of healthcare is interpreting—caused in part by, recommendations from The Joint Commission (Wilson-Stronks, 2008), rules in the Affordable Care Act (Tietalbaum, 2012) and an increasing number of lawsuits brought by the Deaf Community (12 in Minnesota alone in the last 10 years). It seems the right time for sign language interpreters to increase our focus on healthcare and ensure our effectiveness in this important area of practice.

A Growing Need

Nathan Ellis, the director of the Deaf Immigrant Center for Education (DICE) in Minneapolis, shared that one in every three encounters at the massive Hennepin County Medical Center involves a spoken or sign language interpreter. Another indicator of this growth locally is the recent hiring of multiple staff sign language interpreters at the six largest health systems in Minnesota. There are reports of similar increases in requests for interpreters and expansion of interpreting pools in other large metropolitan communities.

In 2012, the National Interpreter Education Center (NIEC) surveyed sign language interpreters, who identified medical interpreting as one of the most common settings for freelance/contract interpreting services. It was also rated as the second most common setting where practitioners most urgently need training. In my work for the Collaborative for the Advancement of Teaching Interpreting Excellence (CATIE) Center and the National Consortium of Interpreter Education Centers (NCIEC), we have found nationally that it is common for freelance interpreters to interpret in clinics without any education, training or supervised experience in healthcare interpreting. A comparison of two earlier studies found a slight, but growing, interest among sign language interpreters wanting to specialize in medical interpreting (Cokely, 2010). Considering these increases in the demand for interpreters and the interpreting field's growing interest along with widely admitted unpreparedness and training needs, how are we preparing ourselves, if at all, to do this life-impacting work?

An Important Starting Point

A key aspect of optimal healthcare is the relationship between doctor and patient. While the importance of communication in doctor-patient interactions has been well documented (Frey, 2010), the complex work of healthcare interpreters has not. It was only recently that efforts were made to categorize the body of knowledge sign language interpreters should master before interpreting in medical healthcare settings. The CATIE Center-led investigation for NCIEC identified the following core competencies:

- Health Care Systems
- Multiculturalism and Diversity
- Self-Care



- Boundaries
- Preparation
- Ethical and Professional Decision Making
- Language and Interpreting
- Technology
- Research
- Leadership
- Communication Advocacy
- Professional Development (www.healthcareinterpreting.org, 2008)

This list of domains and competencies is an excellent resource for beginning our development and focus in healthcare interpreting. In addition to the list above, there are other strategies interpreters may consider for professional development and building competence.

Reflective Practice

The tendency to go into much of our work with “insufficient skills sets” was discussed by Anna Witter-Merithew in her article, [Sign Language Interpreters: Breaking Down Silos Through Reflective Practice](#). This concept agrees with what the NCIEC identified and interpreters report themselves (NIEC 2013). Despite having identified a body of knowledge and skills outlined in the Medical Interpreting Domains and Competencies, individuals are largely taking on these specializations without additional preparation or supervision, perpetuating the professional isolation discussed in Witter-Merithew’s article. We need to consciously move from this condition of isolation into a process of reflective practice, or as Witter-Merithew described, “examining critical incidents that occur within our work to gain a deeper understanding of what they mean for what we do.” She also provided a concrete list for how to actively reflect on interpreting work and decisions. As I considered this, it struck me that I had seen concrete applications of reflective practice put into action by my colleagues in healthcare interpreting.

Improving Practice with Colleagues

In Minnesota, we take pride in our innovation and excellence in healthcare, and being home to many healthcare industry leaders. I see this similar pride shared across the Midwest among sign language interpreters working in healthcare. Three local groups provide excellent examples for reflective practice and use of case conferencing:

- *Medical Interpreters Consortium (MedIC)* of the Twin Cities, consisting of staff interpreters working for five local health systems. They represent a variety of perspectives from primary, secondary and tertiary care. The focus of their discussions is on the perspectives they bring as interpreters functioning as employees in major health systems, and the various and complex ways their roles differ from those of contract interpreters. They use case scenarios to illustrate issues working within the system as a staff person and how this needs to be different for contractors not directly employed by the system.
- *Minnesota Hospital Consortium (MHC)*, a group of community interpreters who contract as part of a unified system established for the sole purpose of providing interpreting services 24 hours a day for urgent and emergency care needs at 21 hospitals and 8 urgent care centers across the Twin Cities metropolitan area. MHC represents many of the same health systems as MedIC. The interpreters’ role and subsequent group discussions are uniquely focused on issues leading to improvements in their response to urgent and emergency care needs for the facilities, staff and patients. They introduce specific scenarios to illustrate issues of concern or situations needing



attention. Through their sharing they have identified systematic problems and gaps in communication access.

- *Case Study Mentors*, consisting of members in and outside of Minnesota. This is a pilot project sponsored through the CATIE Center that includes staff and contract interpreters from several midwestern communities. The group's focus is on using reflective practices and case studies as learning tools when working with healthcare interpreting colleagues. The mentors meet monthly (via the Internet) with a facilitator, define a case study and then individually meet with their local group of healthcare interpreters to work through the scenario.

Each of these groups has found it effective to use case studies and conferencing as a means for reflective practice. Each group has formed around a sole focus and perspective for their discussions. They use strategies for neutralizing the content and "sorting out the important details and a reason for bringing it into discussion," as suggested in Kendra Keller's Street Leverage post, [Case Discussion: Sign Language Interpreters Contain Their Inner "What the...!!!"](#) They have identified how to challenge each other and respectfully examine the decisions they choose. These sign language interpreters choose to further their competence and practice in medical healthcare through reflective discussion.

Engaging Deaf Experts

One doesn't need a formal group to do this reflective work with colleagues. In Minnesota, we are also fortunate to have Deaf Community Health Workers (CHW). The certified CHWs, which are also found in other communities such as the Hmong and Somali, are trained to function as cultural bridges to the complex healthcare and government systems patients encounter. Several Deaf CHWs have made themselves available to interpreters to discuss difficult cases, complex medical treatments and linguistic choices as they pertain to healthcare.

Another ally is the Association of Medical Professionals with Hearing Loss (AMPHL). This past spring the AMPHL conference made a special effort to host a professional development track for sign language interpreters. I was able to attend and found Deaf medical professionals excited and eager to work with me as an interpreter specializing in healthcare.

Supporting Quality Care

The demand for skilled healthcare interpreters is growing. Those of us working regularly as healthcare interpreters are keenly aware, despite the lack of in-depth documentation in the field, of the depth of knowledge and skills required to do this work well.

As mentioned, my colleagues are continuing to develop themselves and build their specialization as healthcare interpreters. As a field, healthcare interpreting should continue along the path toward specialization. We should even consider further defining specialization in medical healthcare, mental healthcare, and addiction and recovery.

More Work Ahead

Yet, unlike legal and educational interpreting, there is no certification or credential for healthcare interpreting among sign language interpreters. I have introduced a motion for the 2013 RID conference next month requesting that RID investigate the need for a specialty certificate in healthcare interpreting. This effort will only help to advance the important conversations we need about how we build interpreting practices in healthcare that are reflective and based on the delivery of quality care and practice.

<http://www.streetleverage.com/2013/07/improving-healthcare-specialization-for-sign-language-interpreters>



For example, there has been a dramatic increase in healthcare as an area of specialized practice for spoken language interpreting. In the past few years, two national organizations for the medical certification of spoken language interpreters have emerged. Texas has developed such an interest in this certification that the state is currently working on a statewide medical certification for all interpreting language pairs—signed and spoken. Yet, as an organization, RID has not yet made this commitment. A small step has begun with the creation of the first members section for interpreters in healthcare, but as a field we are still struggling to focus on the work sign language interpreters do in healthcare and on providing the support, research, and training this important work requires.

Specialized Practice

In healthcare settings, we are often the only professionals who have not completed a standardized, accredited program recognized by the healthcare field. As we continue to develop and to take our place as greater and active members of the healthcare team, we will need to consider what our model of practice might look like. What behaviors must we demonstrate that indicate to the nurses, technicians and doctors that we are their colleagues, not friends or the patient's family members? As professional colleagues, what are our obligations to these medical team members? How are we focusing on supporting the best health outcomes for the patient?

Systematically discussing questions like those above are only part of the bigger picture of developing standards of practice and quality care. I believe the time has come to build a specialized practice of interpreters in healthcare. We need to advocate that healthcare interpreters, Deaf or hearing, should have the education and supervised work experience to support full access to effective communication in healthcare settings for Deaf and DeafBlind people. Communication is an important part of the doctor – patient relationship (Frey, 2012), when needed sign language interpreters should be an important part too.

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