



The Time is Now for Healthcare Interpreting 2.0

By Katharine Allen

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We mustn't hide from the stark truth that [healthcare interpreting] standards and training reflect a workplace that existed prior to the sweeping changes being ushered in by new technology.

Some of you may have wondered why my blog hasn't been updated in a couple of months. Others already know. Six weeks ago my family was hit with a catastrophic medical crisis when my 14 year-old son fell sick with hantavirus, a rare but often lethal illness prevalent in the Southwestern US.* His survival is due solely to the quick and highly-competent medical care he received every step along the way.

As our lives settle and I reinsert into my professional activities, I have reflected deeply on our experience. I can't help but imagine how our crisis would have played out if we had been one of the millions of families in this country who are limited English proficient. In truth, I fear an LEP child facing a similar health crisis likely would not have survived, where my son did.

I have been a healthcare/community interpreter for over 20 years. I have accompanied countless families through slices of their healthcare experiences, including critically ill and gravely disabled children. I have been the "voice" that delivers the devastating diagnosis or which provides the life-saving care. Working as a face-to-face interpreter, I have seen the insidious nature of how linguistic and cultural differences can block true equal access to care. Even with an interpreter present, excellent and capable providers frequently treat LEP patients differently than their English-speaking counterparts. They provide less explanation, offer fewer alternatives. This response often seems unconscious and unintended, but happens nonetheless.

Now I have been on the other side of the equation. During our son's illness, my family spent two full weeks engaged 24/7 with some of the most complex aspects of our healthcare system. We started at our local clinic, progressed immediately to our local ER, then to the nearest tertiary care hospital via a life flight airplane trip, followed by a second, off-the-charts risky life flight to our regional trauma center. Within the first 72 hours of care, we interacted with over two-dozen caregivers. By the end of two weeks, that number had at least doubled.

We received critically important updates from acute care physicians at midnight and two and at five in the morning. We spent the better part of each day meeting with round after round of specialists and their care teams. In the quiet hours between midnight and dawn we conferred with respiratory therapists and hung onto the words of the nurse every time

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our son's vitals were checked. Throughout, we received phone calls, emails, and even text messages from specialists and hospital administrative staff.

The most important consent is done over the phone as we drive down the highway at 80 mph. My son, in critical condition and on life support, is being flown overhead en route to the trauma center. My daughter is crying on my shoulder and I can barely think. The phone rings. "This is the Pediatric ICU. Your son has arrived at the hospital and we need your immediate consent to put him on the lung bypass machine." I say, "Of course, do whatever is necessary to keep him alive." The timing is so critical they almost don't save him. He goes into a six-minute cardiac arrest before he is finally stabilized.

I shudder to think what might have happened if that call came through and I had needed an interpreter. The simple exchange might have prolonged into 10, 15 or 20 minutes as an interpreter is found or a telephonic service is called. Would my son have survived the delay?

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Currently, healthcare interpreting and language access listserves are in the middle of a robust debate as to the relative benefits and disadvantages of video medical interpreting [VMI] and the increasing proliferation of smartphone translation and interpreting apps. (Absent is almost any conversation about a similar increase in email, chat, and online communication between doctors and patients, currently untouched by our interpreting service delivery methods.) Frequently the debate centers on an "either/or" thought process. There is great fear that onsite interpreters will be replaced by technology. There are passionate defenses of the nuance and caring that can only really be achieved through face-to-face interpreting.

Personally, I think we are missing the point.

If my family were limited English proficient, we would have needed non-stop, competent interpreting services every step of the way, but we would not have gotten it. If we were lucky, we would have had the intermittent services of an onsite professional interpreter for some of the doctor consults that took place during the day, every day. We would not have had that interpreter for any of the critical consents that took place after hours or as we were traveling during the first 72 hours of his care, which were essential to saving his life. The rest of the time, we would likely have had a mix of bilingual hospital staff, some telephonic interpreting, maybe some video as well, and then a lot of smiles and hand signals during midnight vitals checks, respiratory treatments and medication doses.

If we had needed interpreting services, I would have welcomed every mode of communication available to me, whether delivered face-to-face or digitally, via a smartphone app or a video screen. If the nurse had used a machine translation-driven app at 4:00am to let me know my son's vitals and status, I would have been grateful. If telephone and VMI services were easily accessed during the endless sessions with

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rounding doctors, I would have used them with no hesitation. I can't imagine the additional stress, confusion, and worry that not being able to communicate with every single one of his providers would have caused.

The reality is that actual demand for language access far outstrips the number of face-to-face interpreters currently available in healthcare settings. Let's face it, miniscule numbers of hospitals across this country have onsite interpreters during nights and weekends. And the economics of that demand make it impossible for healthcare facilities to hire enough onsite interpreters to be there 24/7. We *need* multiple models to cover this demand and achieve true equal access to care. The debate should not be *whether* to embrace these models, but *how, when, and under what circumstances*.

Over the past 3 decades, the healthcare interpreting profession has grown out of its childhood and is now squarely in the middle of its adolescence. 15 years ago, we had no national consensus on the proper role, training, and competence that defined healthcare interpreters. We now have a structured and increasingly recognized profession thanks to the dedicated individuals who make up our accomplished collective leadership. We have literally put a new profession on the map and improved meaningful access to life-and-death healthcare services for millions of LEP residents. We have much to be proud of and to celebrate.

But if we fail to take control of the digital and mobile revolutions currently flipping how healthcare services are being delivered, they threaten to wipe these accomplishments off the map. We mustn't hide from the stark truth that our standards and training reflect a workplace that existed prior to the sweeping changes being ushered in by new technology. We urgently need to update the frame supporting our profession, or risk returning to a 21st-century version of the bad ol' days, where instead of grabbing the nearest family member or custodian to interpret complex medical information, doctors and nurses access apps and mobile services that are unvetted, poorly designed and implemented without our input and with no quality control.

Healthcare interpreting in the US is at a pivotal crossroads. Just as the internet has evolved from the static Web 1.0 to Web 2.0, allowing for reciprocal and meaningful communication across geographic borders and time zones, so too must our profession. Healthcare Interpreting 2.0 is upon us. It is up to us to guide our profession according to greater and better heights. No one else will do it for us.