## How did you become a founder of the NCIHC in 1998?

A Love Story.

1. I had a 1989 postdoc in Leningrad. I improved my Russian and fell in love with a Russian violinist. Back in the US, we got married.
2. Seven years later, I was finishing a stint teaching at Hamilton College, my Russian husband was treating cancer patients; our son in Kindergarten. My Russian in-laws had just arrived as refugees. They joined the 20,000 refugees in Utica, 1/3 of the total population.
3. Mira and Leonid visited many doctors. I accompanied them as an untrained interpreter--dictionary in hand to check terms. But how to check on the interpreter's role? For example, if my father-in -law, whispering in Russian, criticized his heart doctor, did I interpret his comments?
4. I took my in-laws for TB tests. The lead Public Health Nurse saw my language struggles and shared hers. Her monolingual nurses had to tell speakers of Russian, Bosnian, Vietnamese and Spanish how to report to them by phone the appearance of the Mantoux patch on their skin. At this time, there were no trained medical interpreters anywhere. The health department couldn't do basic tasks.
5. Linda asked me to join her in establishing an interpreter program. We'd train and dispatch interpreters. We'd allow medical facilities to comply with the 1964 CR Act requiring them to give skilled interpreters to non-English-speaking patients. We'd create a valuable profession for bilingual refugees We'd enable doctors to treat non-English speakers. Linda could connect us to far-flung advocates.
6. Excited, I said 'yes.'
7. We talked to the NY Task Force on Immigrant Health (Francesca Gany) and, though her, to the National Council on Interpreting in Health Care. Buoyed by present and future alliances, Linda and I organized potential interpreters and incorporated in 1998. We chose a name with a memorable acronym: the Multicultural Association of Medical Interpreters," or M-A-M-I. 'When in trouble, call MAMI.'
8. The Task Force gave our first interpreter training in 1998. That same year, I was honored when the Council elected me to its board.
9. I fell in love with a person and then with a profession.

## The Most Significant Change in the Field since 1998:

**NCIHC Code of Ethics and Standards of Practice (and training curricula)**

**I added training curricula to the Ethics and Standards of Practice.**

- To promote language access in an area devoid of it (CNY), we at MAMI needed a product: trained interpreters. To get them, we needed a training manual; the Council had one.
- We decided to adopt Bridging the Gap. With Cindy Roat as lead author, the text has a clear, engaging style. It's organized around individual interpreting ethics and practice role plays. Instead of getting lost in abstractions, our student-interpreters learned through doing and discussing. The Council certified us as BTG instructors in 2000.
- Bridging the Gap is adjustable. We used it to teach interpreting for over 20 years. When we sent interpreters into new settings, we'd make edits. We started this pattern preparing interpreters to help survivors of domestic violence. We added new terminology, role plays, and "culture bumps." Always, we welcomed the familiar BTG foundation.
- When the Council published Standards of Practice with corresponding ethics in 2005, we brought them into our training. The Standards show how to implement each ethic. For instance, alongside the ethic of Accuracy, we see several standards of practice. One reads, "the medical interpreter advises parties that everything said will be interpreted. For example, an interpreter may explain the interpreting process to a provider by saying 'everything you say will be repeated to the patient.'"
    - Many students were surprised that a medical interpreter does more than just convert words from one language to another. In this case, the interpreter must alert parties that everything they say will be interpreted. We discussed in class how this requirement builds trust between patient and doctor.
- Perhaps the height of the Council's success will be having its ethics, standards, training and certifications adopted as national standards. I saw a hint of this reading a 2017 article on interpreter quality in the AMA Journal of Ethics. The article starts: "National standards for medical interpreting are set by the US Dept of Health and Human Services and the National Council on Interpreting in Health Care." Let's wait for all practitioners to agree.

## The Most Significant Challenge in Medical Interpreting Today:

1. As first priority, let's improve medical interpreting law. A good law will lift up all efforts to build understanding between doctors and LEP.
2. Under the 1964 Civil Rights Act, in 2000 MAMI submitted complaints to the NYS Attorney General about facilities' failures to provide interpreters.
3. The AG sent two lawyers to Utica who interviewed patients through our newly-minted interpreters. One year later, a banner newspaper headline pronounced: "State & Utica Hospitals Settle on Translators."
4. Usage shot up. Hospitals and other medical facilities requested trained interpreters.
5. The settlement process, though, created barriers to compliance. Prompting culture change, the settlement includes undefined concepts, like "medical interpreter." The settlement stipulates staff interpreters must receive "training in medical interpretation" but doesn't specify which curriculum or standards. Then it adds exceptions- like, "no one under 16 will be used as an interpreter except in 'extraordinary circumstances.'" A second challenge arises from funding. The law doesn't pay for the newly required service. Angry hospitals label the settlement "an unfunded mandate."
6. Despite launching a crucial service, the method of submitting complaints pits service advocates (like MAMI) against service providers (like the Utica hospitals).
7. In 2016, the AHA surveyed 4,500 hospitals finding "only 50% offered some sort of [language access]."
8. A new movement may better align health care practitioners and advocates. It's called "value-based healthcare," created by Dr. Green of Harvard Medical School. Providers are paid "not just on the number of visits each day, but on the quality of care and outcomes." Value-based care reimburses hospitals for interpreting services on condition that the LEP patient doesn't "have to return more than once because a language barrier has led to a treatment problem."
9. "Value-based healthcare" may finesse disagreements about qualified interpreters and unfair costs by aligning the interests of health care facilities and interpreter advocates. Providers will share advocates' interest in establishing a national quality standard for interpreters; both will welcome funding arrangements supporting a professional service.

## What would be your hope/ or dream for the field of health care interpreting in the future?

**“I dream of raising awareness among LEP so they know they have a right to medical interpreting and can advocate for it.”**

### Advocacy through Conversation

Intro:

- Recently, I met a former MAMI Russian interpreter. She said her community called our organization “*Mamochka*,” meaning something like “Dear Mommy.” While glad to be seen as caring, I saw we’d infantilized the refugee population. What if former refugees, some LEP and some not, could advocate for their community?

Refugees advocating for themselves.

- An AMA article on Caring for LEP Patients envisions an ideal hospital environment.
- The hospital’s interpreter advocate does daily rounds informing patients about their right to a qualified interpreter and asking if their communication needs are being met.

Refugees advocating for their community.

- As a model, I’d replace the old method of opposition with conversation, like the conversation between the hospital interpreter advocate and the patient.
- First gathering. An interpreter trainer, trained interpreter, and a group of refugees sharing a non-English language [“the refugees”] gather to discuss communication needs. The trainer starts by explaining LEP’s right to a trained interpreter. Then the trainer asks the refugees whether their communication needs are being met (perhaps in a particular facility). The refugees identify one/two unmet needs linked to using an unqualified interpreter. The trainer suggests which interpreting ethic is involved (say, confidentiality). The refugees select one or two scenarios in which confidentiality problems have arisen.
- Second gathering. A hospital interpreter advocate joins the meeting. With this addition, the “advocacy group” develops one/two skits showing how an untrained interpreter created a problem that a trained interpreter could have avoided.
- Third gathering. The advocacy group presents the skits to selected hospital staff. Everyone discusses the problems and the solutions.
- Follow-up. The advocacy group arranges a follow-up meeting to discuss results.

Anticipated Outcomes

- More caring and communication between LEP patients and health care providers.
- Better health outcomes.
- Morale boost for all.